

Product Guide 2011

V: 02.11

OptimaHealth 

Individual Health Plans

Optima Individual

Affordable Health Insurance

Why Should Your Clients Buy Optima Individual?

Optima Health offers a variety of plans to fit almost anyone's budget and needs. Whether your clients are students, early retirees, self-employed, between jobs, or need coverage for their family, Optima Individual features a wide range of affordable plans for Virginians that include prescription benefits, wellness programs, preventive services, as well as useful tools to manage their healthcare costs.

All Optima Individual plans include:

Customer Service

- As a Virginia-based healthcare organization, your clients can take comfort in knowing their claims, customer service, and medical management is personally handled by fellow Virginians who live and work in the Commonwealth.
- Exceptional track record for timely claims payments, meets or exceeds an accuracy rate of 99 percent, processes 98 percent of claims within 30 days, and 95 percent within 20 days (Optima Performance Management Report, YTD, Nov., 2009).
- Access to online tools to assist members in managing their healthcare costs.

Affordability

- Non durational rating: With Optima Health, the renewal rate is the new business rate. Presently, Optima Health does not raise rates on existing members to subsidize premiums for new members.
- 12-month rate guarantee offers peace of mind for your clients who are tightly managing their household expenses.
- Competitive rates and benefits. Compare Optima Individual to other carriers and see the value we offer.

Broker Services:

Optima Individual has an exclusive broker assistance number for questions about:

- Sales support for training, certification, sales materials and tips on growing your business
- Underwriting pre-screening
- Application status updates, renewals and policy changes
- Commission and billing inquiries

Phone: (757) 552-7217 or toll free at (866)-927-4785

Email: brokerservices@optimahealth.com

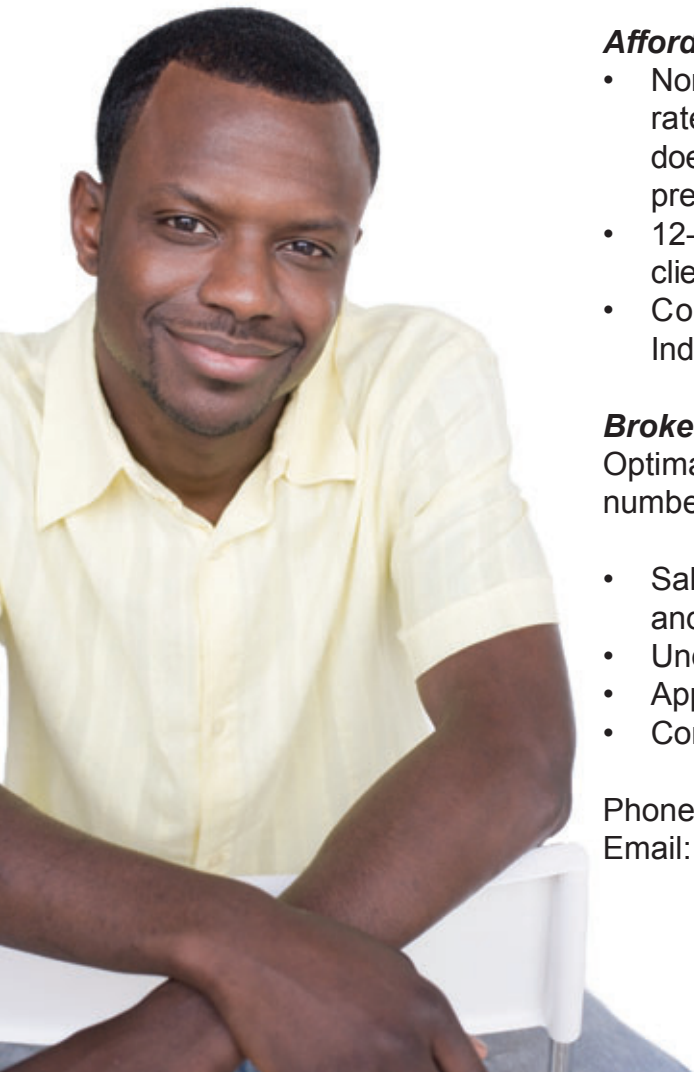


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Optima Plus

At A Glance

Plan Choices

- Deductible choices: \$500, \$750, \$1,000, \$3,000, and \$5,000
- Family Deductible is 2 times the Individual Deductible (in-network)
- Out-of-pocket maximums include Deductible
- Deductible carry over credit for any Deductible expenses incurred in the 4th quarter

Unlimited Office Visits

- \$25 Primary Care Physician
- \$40 Specialist

Preventive Visits

- Covered at 100% in-network

Preventive Screening

- Covered at 100% in-network
- Includes: colonoscopy, mammograms, PAP tests, and PSA tests
- Benefit not limited to attained age

Childhood Immunizations

- Birth to 36 months

Vision

- One eye exam every 24 months covered at 100% in-network
- Vision network: EyeMed
- Discounts for materials, frames, and lenses

Prescription

- Our most comprehensive plan covering generic and brand name drugs

Maternity

- Optional – See page 22 for more information

Optima Plus Individual Plans

Services	25/500		25/750	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	\$500 / \$1,000	\$1,000 / \$2,000	\$750 / \$1,500	\$1,500 / \$3,000
Lifetime Maximum	None		None	
Out-of-Pocket Max	\$1,500 / \$3,000	\$2,500 / \$5,000	\$2,250/\$4,500	\$4,500 / \$8,000
Physician Office Services - Includes covered services performed in the physician's office during the physician's office visit.				
PCP Office Visit (no deductible in-network)	\$25 Copayment	60% ^{AD}	\$25 Copayment	60% ^{AD}
Specialist Office Visit (no deductible in-network)	\$40 Copayment	60% ^{AD}	\$40 Copayment	60% ^{AD}
Preventive Care Services (\$250 person max coverage – out-of-network)	Covered 100%	60% ^{AD}	Covered 100%	60% ^{AD}
Preventive Screenings (mammograms & colonoscopies)	Covered 100%	60% ^{AD}	Covered 100%	60% ^{AD}
Preventive Vision (1 visit per 24 months)	\$0 Copayment	\$30 max reimbursement	\$0 Copayment	\$30 max reimbursement
Well Child Immunizations	Covered 100% - birth to age 36 months	60% ^{AD} birth to age 36 months	Covered 100% - birth to age 36 months	60% ^{AD} birth to age 36 months
Outpatient Services – Includes covered surgery, therapy, rehabilitation, and diagnostic services received in outpatient facility.				
Outpatient Surgery	80% ^{AD}	60% ^{AD}	80% ^{AD}	60% ^{AD}
Outpatient Therapy Services (\$1,000 max benefit - combined in and out)	80% ^{AD}	60% ^{AD}	80% ^{AD}	60% ^{AD}
Outpatient Rehab (\$1,000 max benefit - combined in and out)	80% ^{AD}	60% ^{AD}	80% ^{AD}	60% ^{AD}
Dialysis Services	80% ^{AD}	60% ^{AD}	80% ^{AD}	60% ^{AD}
Outpatient Advanced Imaging (MRI, MRA, CT, CTA, and PET Scans)	80% ^{AD}	60% ^{AD}	80% ^{AD}	60% ^{AD}
Outpatient Chemo-Radiation, IV, Inhalation Services	80% ^{AD}	60% ^{AD}	80% ^{AD}	60% ^{AD}
Inpatient Hospital Services – Includes, but not limited to, room and board, general nursing care, lab, X-ray, and other diagnostic services.				
Inpatient Care	80% ^{AD}	60% ^{AD}	80% ^{AD}	60% ^{AD}
Emergency Services – Includes those emergency department facility, physician, and ancillary services that are rendered during an emergency visit.				
Emergency Department	80% ^{AD}	80% ^{AD}	80% ^{AD}	80% ^{AD}
Urgent Care Center	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Ambulance	80% ^{AD}	60% ^{AD}	80% ^{AD}	60% ^{AD}
Behavioral Healthcare and Substance Abuse Services – Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental health. Inpatient mental healthcare and outpatient psychological testing require pre-authorization				
Adults (age 19 and over)	80% ^{AD}	60% ^{AD}	80% ^{AD}	60% ^{AD}
• Inpatient Mental Healthcare	20 day max (combined in & out)	20 day max (combined in & out)	20 day max (combined in & out)	20 day max (combined in & out)
• Outpatient Mental Healthcare (max 20 visits-combined in and out)	\$40 Copayment, visits 1-5; 50% for visits 6-20	60% ^{AD} (visits combined in & out)	\$40 Copayment, visits 1-5; 50% for visits 6-20	60% ^{AD} (visits combined in & out)
Children (under age 19)	80% ^{AD}	60% ^{AD}	80% ^{AD}	60% ^{AD}
• Inpatient Mental Healthcare	25 day max (combined in & out)	60% ^{AD} (combined in & out)	25 day max (combined in & out)	60% ^{AD} (combined in & out)
• Outpatient Mental Healthcare (max 20 visits - combined in and out)	\$40 Copayment, visits 1-5; 50% for visits 6-20	60% ^{AD} (visits combined in & out)	\$40 Copayment, visits 1-5; 50% for visits 6-20	60% ^{AD} (visits combined in & out)
Other Services				
DME (\$1,000 max per calendar year - combined in and out)	80% ^{AD}	60% ^{AD}	80% ^{AD}	60% ^{AD}
DME Replacements (\$500 max repair & replacement - combined in and out)	80% ^{AD}	60% ^{AD}	80% ^{AD}	60% ^{AD}
Diabetes Supplies & Education	80% ^{AD}	60% ^{AD}	80% ^{AD}	60% ^{AD}
Prescription Drug Benefit - (\$5,000 max coverage /\$150 annual deductible per person) Generic Plus/limited name brands. No mail order option	Tier 1- \$15 Copayment; Tier 2 - 40% Coinsurance or \$30 Copayment *; Tier 3 - select brands \$50 Copayment or 50% Coinsurance* *(whichever is greater)			

AD - after deductible

Optima Plus Individual Plans

Services	25/1000	
	In-Network	Out-of-Network
Deductible	\$1,000 / \$2,000	\$2,000 / \$4,000
Lifetime Maximum	None	
Out-of-Pocket Max	\$3,000 / \$6,000	\$6,500 / \$11,000
Physician Office Services - Includes covered services performed in the physician's office during the physician's office visit.		
PCP Office Visit (no deductible in-network)	\$25 Copayment	60% ^{AD}
Specialist Office Visit (no deductible in-network)	\$40 Copayment	60% ^{AD}
Preventive Care Services (\$250 person max coverage – out-of-network)	Covered 100%	60% ^{AD}
Preventive Screenings (mammograms & colonoscopies)	Covered 100%	60% ^{AD}
Preventive Vision (1 visit per 24 months)	\$0 Copayment	\$30 max reimbursement
Well Child Immunizations (no deductible in-network)	Covered 100% - birth to age 36 months	60% ^{AD} birth to age 36 months
Outpatient Services – Includes covered surgery, therapy, rehabilitation, and diagnostic services received in outpatient facility.		
Outpatient Surgery	80% ^{AD}	60% ^{AD}
Outpatient Therapy Services (\$1,000 max benefit - combined in and out)	80% ^{AD}	60% ^{AD}
Outpatient Rehab (\$1,000 max benefit - combined in and out)	80% ^{AD}	60% ^{AD}
Dialysis Services	80% ^{AD}	60% ^{AD}
Outpatient Advanced Imaging (MRI, MRA, CT, CTA, and PET Scans)	80% ^{AD}	60% ^{AD}
Outpatient Chemo-Radiation, IV, Inhalation Services	80% ^{AD}	60% ^{AD}
Inpatient Hospital Services – Includes, but not limited to, room and board, general nursing care, lab, X-ray, and other diagnostic services.		
Inpatient Care	80% ^{AD}	60% ^{AD}
Emergency Services – Includes those emergency department facility, physician, and ancillary services that are rendered during an emergency visit.		
Emergency Department	80% ^{AD}	80% ^{AD}
Urgent Care Center	80% ^{AD}	50% ^{AD}
Ambulance	80% ^{AD}	60% ^{AD}
Behavioral Healthcare and Substance Abuse Services – Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental health. Inpatient Mental healthcare and outpatient psychological testing require pre-authorization.		
Adults (age 19 and over)	80% ^{AD}	60% ^{AD}
• Inpatient Mental Healthcare	20 day max (combined in & out)	20 day max (combined in & out)
• Outpatient Mental Healthcare (max 20 visits - combined in and out)	\$40 Copayment, visits 1-5; 50% for visits 6-20	60% ^{AD} (visits combined in & out)
Children (under age 19)	80% ^{AD}	60% ^{AD}
• Inpatient Mental Healthcare	25 day max (combined in & out)	(combined in & out)
• Outpatient Mental Healthcare (max 20 visits - combined in and out)	\$40 Copayment, visits 1-5; 50% for visits 6-20	60% ^{AD} (visits combined in & out)
Other Services		
DME (\$1,000 max per calendar year-combined in and out)	80% ^{AD}	60% ^{AD}
DME Replacements (\$500 max repair & replacement - combined in and out)	80% ^{AD}	60% ^{AD}
Diabetes Supplies & Education	80% ^{AD}	60% ^{AD}
Prescription Drug Benefit (\$5,000 max coverage /\$150 annual deductible per person) Generic Plus/limited name brands. No mail order option	Tier 1- \$15 Copayment; Tier 2 - 40% Coinsurance or \$30 Copayment*; Tier 3 - select brands \$50 Copayment or 50% Coinsurance* *(whichever is greater)	

AD - after deductible

Optima Plus Individual Plans

Services	25/3000	
	In-Network	Out-of-Network
Deductible	\$3,000 / \$6,000	\$5,000 / \$8,000
Lifetime Maximum	None	
Out-of-Pocket Max	\$6,000 / \$10,000	\$11,000 / \$16,000
Physician Office Services - <i>Includes covered services performed in the physician's office during the physician's office visit.</i>		
PCP Office Visit (no deductible in-network)	\$25 Copayment	60% ^{AD}
Specialist Office Visit (no deductible in-network)	\$40 Copayment	60% ^{AD}
Preventive Care Services (no deductible in-network) \$250 person max out-of-network	Covered 100%	60% ^{AD}
Preventive Screenings (mammograms & colonoscopies)	Covered 100%	60% ^{AD}
Preventive Vision (1 visit per 24 months)	\$0 Copayment	\$30 max reimbursement
Well Child Immunizations (no deductible in-network) birth to age 36 months	Covered 100%	60% ^{AD}
Outpatient Services - <i>Includes covered surgery, therapy, rehabilitation, and diagnostic services received in outpatient facility.</i>		
Outpatient Surgery	80% ^{AD}	60% ^{AD}
Outpatient Therapy Services (\$1,000 max benefit - combined in and out)	80% ^{AD}	60% ^{AD}
Outpatient Rehab (\$1,000 max benefit - combined in and out)	80% ^{AD}	60% ^{AD}
Dialysis Services	80% ^{AD}	60% ^{AD}
Outpatient Advanced Imaging (MRI, MRA, CT, CTA, and PET Scans)	80% ^{AD}	60% ^{AD}
Outpatient Chemo-Radiation, IV, Inhalation Services	80% ^{AD}	60% ^{AD}
Inpatient Hospital Services - <i>Includes, but not limited to, room and board, general nursing care, lab, X-ray, and other diagnostic services.</i>		
Inpatient Care	80% ^{AD}	60% ^{AD}
Emergency Services - <i>Includes those emergency department facility, physician, and ancillary services that are rendered during an emergency visit.</i>		
Emergency Department	80% ^{AD}	80% ^{AD}
Urgent Care Center	80% ^{AD}	50% ^{AD}
Ambulance	80% ^{AD}	60% ^{AD}
Behavioral Healthcare and Substance Abuse Services - <i>Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental health. Inpatient Mental healthcare and outpatient psychological testing require pre-authorization.</i>		
Adults (age 19 and over)	80% ^{AD}	60% ^{AD}
• Inpatient Mental Healthcare	20 day max (combined in & out)	20 day max (combined in & out)
• Outpatient Mental Healthcare (max 20 visits - combined in and out)	\$40 Copayment, visits 1-5; 50% for visits 6-20	60% ^{AD} (visits combined in & out)
Children (under age 19)	80% ^{AD}	60% ^{AD}
• Inpatient Mental Healthcare	25 day max (combined in & out)	(combined in & out)
• Outpatient Mental Healthcare (max 20 visits - combined in and out)	\$40 Copayment, visits 1-5; 50% for visits 6-20	60% ^{AD} (visits combined in & out)
Other Services		
DME (\$1,000 max per calendar year-combined in and out)	80% ^{AD}	60% ^{AD}
DME Replacements (\$500 max repair & replacement - combined in and out)	80% ^{AD}	60% ^{AD}
Diabetes Supplies & Education	80% ^{AD}	60% ^{AD}
Prescription Drug Benefit (\$5,000 max coverage /\$150 annual deductible per person) Generic Plus/limited name brands. No mail order option	Tier 1- \$15 Copayment; Tier 2 - 40% Coinsurance or \$30 Copayment*; Tier 3 - select brands \$50 Copayment or 50% Coinsurance* *(whichever is greater)	

AD - after deductible

Optima Plus Individual Plans

Services	25/5000	
	In-Network	Out-of-Network
Deductible	\$5,000 / \$10,000	\$9,000 / \$14,000
Lifetime Maximum	None	
Out-of-Pocket Max	\$10,000 / \$15,000	\$16,000 / \$22,000
Physician Office Services - <i>Includes covered services performed in the physician's office during the physician's office visit</i>		
PCP Office Visit (no deductible in-network)	\$25 Copayment	60% ^{AD}
Specialist Office Visit (no deductible in-network)	\$40 Copayment	60% ^{AD}
Preventive Care Services (no deductible in-network) \$250 person max out-of-network	Covered 100%	60% ^{AD}
Preventive Screenings (mammograms & colonoscopies)	Covered 100%	60% ^{AD}
Preventive Vision (1 visit per 24 months)	\$0 Copayment	\$30 max reimbursement
Well Child Immunizations (no deductible in-network) birth to age 36 months	Covered 100%	60% ^{AD}
Outpatient Services - <i>Includes covered surgery, therapy, rehabilitation, and diagnostic services received in outpatient facility.</i>		
Outpatient Surgery	80% ^{AD}	60% ^{AD}
Outpatient Therapy Services (\$1,000 max benefit - combined in and out)	80% ^{AD}	60% ^{AD}
Outpatient Rehab (\$1,000 max benefit - combined in and out)	80% ^{AD}	60% ^{AD}
Dialysis Services	80% ^{AD}	60% ^{AD}
Advanced Diagnostic Imaging (MRI, MRA, CT, CTA, and PET Scans)	80% ^{AD}	60% ^{AD}
Outpatient Chemo-Radiation, IV, Inhalation Services	80% ^{AD}	60% ^{AD}
Inpatient Hospital Services - <i>Includes, but not limited to, room and board, general nursing care, lab, X-ray, and other diagnostic services</i>		
Inpatient Care	80% ^{AD}	60% ^{AD}
Emergency Services - <i>Includes those emergency department facility, physician, and ancillary services that are rendered during an emergency visit</i>		
Emergency Department	80% ^{AD}	80% ^{AD}
Urgent Care Center	80% ^{AD}	50% ^{AD}
Ambulance	80% ^{AD}	60% ^{AD}
Behavioral Healthcare and Substance Abuse Services - <i>Mental healthcare and substance abuse services require pre-authorization.</i>		
Adults (age 19 and over)	80% ^{AD}	60% ^{AD}
<ul style="list-style-type: none"> • Inpatient Mental Healthcare 20 day max (combined in & out) 		20 day max (combined in & out)
<ul style="list-style-type: none"> • Outpatient Mental Healthcare (max 20 visits - combined in and out) \$40 Copayment visits 1-5; 50% for visits 6-20 		60% ^{AD} (visits combined in & out)
Children (under age 19)	80% ^{AD}	60% ^{AD}
<ul style="list-style-type: none"> • Inpatient Mental Healthcare 25 day max (visits combined in & out) 		(visits combined in & out)
<ul style="list-style-type: none"> • Outpatient Mental Healthcare (max 20 visits - combined in and out) \$40 Copayment, visits 1-5; 50% for visits 6-20 		60% ^{AD} (visits combined in & out)
Other Services		
DME (\$1,000 max per calendar year - combined in and out)	80% ^{AD}	60% ^{AD}
DME Replacements (\$500 max repair & replacement - combined in and out)	80% ^{AD}	60% ^{AD}
Diabetes Supplies & Education	80% ^{AD}	60% ^{AD}
Prescription Drug Benefit (\$5,000 max coverage /\$250 annual deductible per person) Generic Plus/limited name brands. No mail order option	Tier 1-\$15 Copayment; Tier 2- 40% Coinsurance or \$30 Copayment*; Tier 3-select brands \$50 Copayment or 50% Coinsurance* *(whichever is greater)	

Optima FourSight At A Glance

Plan Choices

- Individual Deductible choices: \$500, \$750, \$1,000, \$2,500, and \$5,000
- Family Deductible is 2 times the Individual Deductible (in-network)
- Out-of-pocket maximums include Deductible
- Deductible carry over credit for any Deductible expenses incurred in the 4th quarter

Unlimited Office Visits

- First four visits subject to \$30 Copayment
- Fifth visit and beyond subject to \$30 Copayment, Deductible, and Coinsurance

Preventive Services

- Covered at 100% in-network
- Includes: routine exam, mammogram, colonoscopy, GYN exams, PSA tests, colorectal cancer tests, routine immunizations, child health exams

Childhood Immunizations

- Birth to 36 months

Outpatient Diagnostic Services

- 100 percent coverage up to first \$500, then Deductible and Coinsurance
- Includes X-ray, lab, MRI, PET, CTA, MRA, and CT scans

Vision

- One eye exam every 24 months covered at 100% in-network
- Vision network: EyeMed
- Discounts for materials, frames, and lenses

Prescription

- Covers generic and limited brand names

Optima Individual Foursight Plans

Services	30/500		30/750	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	\$500 / \$1,000	\$1,000 / \$2,000	\$750 / \$1,500	\$1,500 / \$3,000
Lifetime Maximum	None		None	
Out-of-Pocket Max	\$1,500 / \$3,000	\$2,500 / \$5,000	\$2,250 / \$4,500	\$4,500 / \$8,000
Physician Office Services - Includes covered services performed in the physician's office during the physician's office visit.				
Physician Visits (visits 1- 4 combined in and out) no deductible	\$30 Copayment then 100%	\$30 Copayment then 50%	\$30 Copayment then 100%	\$30 Copayment then 50%
Physician Visits (5 and over)	\$30 Copayment ^{AD} then paid at 80% ^{AD}	\$30 Copayment ^{AD} then paid at 50% ^{AD}	\$30 Copayment ^{AD} then paid at 80% ^{AD}	\$30 Copayment ^{AD} then paid at 50% ^{AD}
Preventive Services (mammograms & colorectal cancer screenings) \$250 person max coverage per year -out-of-network	Covered 100%	50% ^{AD} up to max \$250	Covered 100%	50% ^{AD} up to max \$250
Preventive Vision (1 visit every 24 months)	\$0 Copayment	\$30 max reimbursement	\$0 Copayment	\$30 max reimbursement
Well Child Immunizations	Covered 100% - birth to age 36 months	50% ^{AD}	Covered 100% - birth to age 36 months	50% ^{AD}
Outpatient Services - Includes covered surgery, therapy, rehabilitation, and diagnostic services received in outpatient facility.				
Outpatient Surgery	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Outpatient Therapy Services (max \$1,000 per person combined in and out)	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Outpatient Rehab (max \$1,000 per person combined in and out)	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Dialysis Services	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Outpatient Diagnostic Services (X-ray, Lab, MRI, MRA, CT, CTA and PET Scans) no deductible on first \$500 - combined in and out	100% up to \$500 then 80% ^{AD}	100% up to \$500 then 50% ^{AD}	100% up to \$500 then 80% ^{AD}	100% up to \$500 then 50% ^{AD}
Outpatient Chemo - Radiation, IV, Inhalation services	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Inpatient Hospital Services - Includes, but not limited to, room and board, general nursing care, lab, X-ray, and other diagnostic services.				
Inpatient Care	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Emergency Services - Includes those emergency department facility, physician, and ancillary services that are rendered during an emergency visit.				
Emergency Department	80% ^{AD}	80% ^{AD}	80% ^{AD}	80% ^{AD}
Urgent Care Center	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Ambulance (\$1,000 max benefit)	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Behavioral Healthcare and Substance Abuse Services - Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental health. Inpatient Mental healthcare and outpatient psychological testing require pre-authorization				
Adults (age 19 and over)	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
<ul style="list-style-type: none"> Inpatient Mental Healthcare Outpatient Mental Healthcare (visits combined in and out) 	20 day max (combined in & out)	50% ^{AD} 20 day max (combined in & out)	80% ^{AD} 20 day max (combined in & out)	20 day max (combined in & out)
Children (under age 19)	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
<ul style="list-style-type: none"> Inpatient Mental Health Care Outpatient Mental Health Care (visits combined in and out) 	25 day max (visits combined in & out)	50% ^{AD} (visits combined in & out)	80% ^{AD} 25 day max (visits combined in & out)	50% ^{AD} (visits combined in & out)
Other Services	\$30 Copayment, visits 1-5; 50% ^{AD} for visits 6-20	\$30 Copayment then 50% visits 1-5; 50% ^{AD} for visits 6-20	\$30 Copayment, visits 1-5; 50% ^{AD} for visits 6-20	\$30 Copayment then 50% visits 1-5; 50% ^{AD} for visits 6-20
DME (\$1,000 max per calendar year - combined in and out)	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
DME Replacements (\$500 max repair & replacement - combined in and out)	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Diabetes Supplies & Education	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Prescription Drug Benefit - (\$5,000 max coverage /\$250 annual deductible per person) - Generic Plus / limited name brands. No mail order option	Tier 1- \$15 Copayment; Tier 2 - \$30 Copayment or 40% Coinsurance*; Tier 3 - select brands \$50 Copayment or 50% Coinsurance* *(whichever is greater)			

AD - after deductible

Optima Individual Foursight Plans

Services	30/1000		30/2500	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	\$1,000 / \$2,000	\$2,000 / \$4,000	\$2,500 / \$5,000	\$5,000 / \$8,000
Lifetime Maximum	None		None	
Out-of-Pocket Max	\$3,000 / \$6,000	\$6,500 / \$11,000	\$6,000 / \$10,000	\$11,000 / \$16,000
Physician Office Services - Includes covered services performed in the physician's office during the physician's office visit.				
Physician Visits (visits 1- 4 combined in and out) no deductible	\$30 Copayment then 100%	\$30 Copayment then 50%	\$30 Copayment then 100%	\$30 Copayment then 50%
Physician Visits (5 and over)	\$30 Copayment ^{AD} then paid at 80% ^{AD}	\$30 Copayment ^{AD} then paid at 50% ^{AD}	\$30 Copayment ^{AD} then paid at 80% ^{AD}	\$30 Copayment ^{AD} then paid at 50% ^{AD}
Preventive Services - (mammograms & colorectal cancer screenings) \$250 max person coverage – out-of-network	Covered 100%	50% ^{AD} up to max \$250	Covered 100%	50% ^{AD} up to max \$250
Preventive Vision (1 visit every 24 months)	\$0 Copayment	\$30 max reimbursement	\$0 Copayment	\$30 max reimbursement
Well Child Immunizations (no deductible)	Covered 100% - birth to age 36 months	50% ^{AD}	Covered 100% - birth to age 36 months	50% ^{AD}
Outpatient Services – Includes covered surgery, therapy, rehabilitation, and diagnostic services received in outpatient facility.				
Outpatient Surgery	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Outpatient Therapy Services (max \$1,000 per person combined in and out)	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Outpatient Rehab (max \$1,000 per person combined in and out)	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Dialysis Services	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Outpatient Diagnostic Services (X-ray, Lab, MRI, MRA, CT, CTA and PET Scans) no deductible on first \$500 - combined in and out	100% up to \$500 then 80% ^{AD}	100% up to \$500 then 50% ^{AD}	100% up to \$500 then 80% ^{AD}	100% up to \$500 then 50% ^{AD}
Outpatient Chemo-Radiation, IV, Inhalation services	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Inpatient Hospital Services – Includes, but not limited to, room and board, general nursing care, lab, X-ray, and other diagnostic services.				
Inpatient Care	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Emergency Services – Includes those emergency department facility, physician, and ancillary services that are rendered during an emergency visit.				
Emergency Room	80% ^{AD}	80% ^{AD}	80% ^{AD}	80% ^{AD}
Urgent Care Center	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Ambulance (\$1,000 max benefit)	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Behavioral Healthcare and Substance Abuse Services – Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental health. Inpatient Mental healthcare and outpatient psychological testing require pre-authorization				
Adults (age 19 and over)	80% ^{AD}	50% ^{AD} 20 day max (combined in & out)	80% ^{AD} 20 day max (combined in & out)	50% ^{AD} 20 day max (combined in & out)
<ul style="list-style-type: none"> Inpatient Mental Healthcare 	20 day max (combined in & out)	50% ^{AD} 20 day max (combined in & out)	80% ^{AD} 20 day max (combined in & out)	50% ^{AD} 20 day max (combined in & out)
<ul style="list-style-type: none"> Outpatient Mental Healthcare (visits combined in and out) 	\$30 Copayment, visits 1-5; 50% ^{AD} for visits 6-20	\$30 Copayment then 50% visits 1-5; 50% ^{AD} for visits 6-20	\$30 Copayment, visits 1-5; 50% ^{AD} for visits 6-20	\$30 Copayment then 50% visits 1-5; 50% ^{AD} for visits 6-20
Children (under age 19)	80% ^{AD}	50% ^{AD} (visits combined in & out)	80% ^{AD} 25 day max (visits combined in & out)	50% ^{AD} (visits combined in & out)
<ul style="list-style-type: none"> Inpatient Mental Healthcare 	25 day max (visits combined in & out)	50% ^{AD} (visits combined in & out)	80% ^{AD} 25 day max (visits combined in & out)	50% ^{AD} (visits combined in & out)
<ul style="list-style-type: none"> Outpatient Mental Healthcare (visits combined in and out) 	\$30 Copayment, visits 1-5; 50% ^{AD} for visits 6-20	\$30 Copayment then 50% visits 1-5; 50% ^{AD} for visits 6-20	\$30 Copayment, visits 1-5; 50% ^{AD} for visits 6-20	\$30 Copayment then 50% visits 1-5; 50% ^{AD} for visits 6-20
Other Services				
DME (\$1,000 max per calendar year - combined in and out)	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
DME Replacements (\$500 max repair & replacement - combined in and out)	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Diabetes Supplies & Education	80% ^{AD}	50% ^{AD}	80% ^{AD}	50% ^{AD}
Prescription Drug Benefit- (\$5,000 max coverage /\$250 annual deductible per person) Generic Plus/limited name brands. No mail order option	Tier 1- \$15 Copayment; Tier 2 - \$30 Copayment or 40% Coinsurance*; Tier 3 - select brands \$50 Copayment or 50% Coinsurance* *(whichever is greater)			

AD - after deductible

Optima Individual Foursight Plans

Services	30/5000	
	In-Network	Out-of-Network
Deductible	\$5,000 / \$10,000	\$9,000 / \$14,000
Lifetime Maximum	None	
Out-of-Pocket Max	\$10,000 / \$15,000	\$16,000 / \$22,000
Physician Office Services - <i>Includes covered services performed in the physician's office during the physician's office visit</i>		
Physician Office Visit (visits 1- 4 combined in and out) no deductible	\$30 Copayment then 100%	\$30 Copayment then 50%
Physician Visits (5 and over)	\$30 Copayment ^{AD} then paid at 80% ^{AD}	\$30 Copayment then 50% ^{AD}
Preventive Services (\$250 person max coverage – out-of-network)	Covered 100%	50% ^{AD}
Preventive Vision (1 visit per 24 months)	\$0 Copayment	\$30 max reimbursement
Well Child Immunizations	Covered 100% - birth to age 36 months	50% ^{AD}
Outpatient Services – <i>Includes covered surgery, therapy, rehabilitation, and diagnostic services received in outpatient facility.</i>		
Outpatient Surgery	80% ^{AD}	50% ^{AD}
Outpatient Therapy Services (max \$1,000 per person combined in and out)	80% ^{AD}	50% ^{AD}
Outpatient Rehab (max \$1,000 per person combined in and out)	80% ^{AD}	50% ^{AD}
Dialysis Services	80% ^{AD}	50% ^{AD}
Outpatient Diagnostic Services (X-ray, Lab, MRI, MRA, CT, CTA and PET Scans) no deductible on first \$500 - combined in and out	100% up to \$500 then 80% ^{AD}	100% up to \$500 then 50% ^{AD}
Outpatient Chemo - Radiation, IV, Inhalation Services	80% ^{AD}	50% ^{AD}
Inpatient Hospital Services – <i>Includes, but not limited to, room and board, general nursing care, lab, X-ray, and other diagnostic services</i>		
Inpatient Care	80% ^{AD}	50% ^{AD}
Emergency Services – <i>Includes those emergency room facility, physician, and ancillary services that are rendered during an emergency room visit</i>		
Emergency Room	80% ^{AD}	80% ^{AD}
Urgent Care Center	80% ^{AD}	50% ^{AD}
Ambulance (\$1,000 max benefit)	80% ^{AD}	50% ^{AD}
Behavioral Healthcare and Substance Abuse Services – <i>Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental health. Inpatient Mental healthcare and outpatient psychological testing require pre-authorization.</i>		
Adults (age 19 and over)	80% ^{AD}	50% ^{AD} 20 day max (combined in & out)
<ul style="list-style-type: none"> Inpatient Mental Healthcare 	20 day max (combined in & out)	
<ul style="list-style-type: none"> Outpatient Mental Healthcare (max 20 visits combined in & out) 	\$30 Copayment, visits 1-5; 50% ^{AD} for visits 6-20	\$30 Copayment then 50% for visits 1-5; 50% ^{AD} for visits 6-20
Children (under age 19)	80% ^{AD}	50% ^{AD}
<ul style="list-style-type: none"> Inpatient Mental Healthcare 	25 day max (visits combined in & out)	25 day max (visits combined in & out)
<ul style="list-style-type: none"> Outpatient Mental Healthcare (max 20 visits combined in & out) 	\$30 Copayment, visits 1-5 50% ^{AD} for visits 6-20	\$30 Copayment then 50% for visits 1-5; 50% ^{AD} for visits 6-20
Other Services		
DME (\$1,000 max per calendar year - combined in and out)	80% ^{AD}	50% ^{AD}
DME Replacements (\$500 max repair & replacement - combined in and out)	80% ^{AD}	50% ^{AD}
Diabetes Supplies & Education	80% ^{AD}	50% ^{AD}
Prescription Drug Benefit - (\$5,000 max coverage /\$250 annual deductible per person) Generic Plus/limited name brands. No mail order option	Tier 1-\$15 Copayment; Tier 2- \$30 Copayment or 40% coins *; Tier 3- select brands \$50 Copayment or 50% Coinsurance* *(whichever is greater)	

AD - after deductible

Optima Equity

At A Glance

Plan Choices

- Select a \$2,500 or a \$3,500 Deductible with either 100 percent or 80 percent Coinsurance
- Family Deductible is 2 times the Individual Deductible (in-network)
- A family Deductible is satisfied once 2 members have satisfied their Individual Deductible or if 2 or more family members have Deductible expenses that add up to the family Deductible limit

Preventive Visits

- Covered at 100% in-network

Preventive Screening

- Covered at 100% in-network
- Includes: colonoscopy, mammograms, PAP tests, and PSA tests
- Benefit not limited to attained age

Childhood Immunizations

- Birth to 36 months

Vision

- One eye exam every 24 months covered at 100% in-network
- Vision network: EyeMed
- Discounts for materials, frames, and lenses

Fully Integrated Health Plans

- Simple enrollment – Starting an HSA plan is as easy as answering one question on the health application
- No enrollment or monthly fees
- Debit card free of charge
- Online banking tool that makes it easy to manage savings
- Claims payment or reimbursement from an HSA with a click of the mouse

Optima Equity Individual Plans

Services	2500/100		2500/80	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	\$2,500 / \$5,000	\$5,000 / \$10,000	\$2,500 / \$5,000	\$5,000 / \$10,000
Lifetime Maximum	None		None	
Out-of-Pocket Max	\$2,500 / \$5,000	\$10,000 / \$20,000	\$4,000 / \$8,000	\$10,000 / \$20,000
Physician Office Services - Includes covered services performed in the physician's office during the physician's office visit.				
PCP Office Visit	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Specialist Office Visit	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Preventive Care (\$250 person max coverage – out-of-network)	Covered 100%	60% up to \$250 max benefit	Covered 100%	50% up to \$250 max benefit
Preventive Screenings (mammograms & colonoscopies) \$250 person max coverage – out-of-network	Covered 100%	60% ^{AD} up to \$250 max benefit	Covered 100%	50% ^{AD} up to \$250 max benefit
Preventive Vision (1 visit per 24 months)	\$0 Copayment	\$30 max reimbursement	\$0 Copayment	\$30 max reimbursement
Well Child Immunizations	Covered 100% - birth to age 36 months	60% ^{AD} birth to age 36 months	Covered 100% - birth to age 36 months	50% ^{AD} birth to age 36 months
Outpatient Services – Includes covered surgery, therapy, rehabilitation, and diagnostic services received in outpatient facility.				
Outpatient Surgery	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Outpatient Therapy Services (max \$1000 per person combined in and out)	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Outpatient Diagnostics	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Dialysis Treatment	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Diagnostic Imaging Services (MRI, MRA, CTA, & PET Scans)	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Outpatient Chemo - Radiation, IV, Inhalation Services	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Inpatient Hospital Services – Includes, but not limited to, room and board, general nursing care, lab, X-ray, and other diagnostic services.				
Inpatient Care	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Emergency Services – Includes those emergency room facility, physician, and ancillary services that are rendered during an emergency room visit.				
Emergency Department	100% ^{AD}	100% ^{AD}	80% ^{AD}	80% ^{AD}
Urgent Care Center	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Ambulance (\$1,000 annual limit)	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Behavioral Healthcare and Substance Abuse Services – Mental healthcare and substance abuse services require pre-authorization.				
Adults (age 19 and over)	100% ^{AD} 20 day max (combined in & out)	60% ^{AD} 20 day max (combined in & out)	80% ^{AD} 20 day max (combined in & out)	50% ^{AD} 20 day max (combined in & out)
• Inpatient Mental Healthcare				
• Outpatient Mental Healthcare	100% ^{AD} visits 1-5; 60% ^{AD} for visits 6-20	60% ^{AD} (visits combined in & out)	80% ^{AD} visits 1-5; 50% ^{AD} for visits 6-20	50% ^{AD} (visits combined in & out)
Children (under age 19)	100% ^{AD} 25 day max (visits combined in & out)	60% ^{AD} (visits combined in & out)	80% ^{AD} 25 day max (visits combined in & out)	50% ^{AD} (visits combined in & out)
• Inpatient Mental Healthcare				
• Outpatient Mental Healthcare	100% ^{AD} visits 1-5; 60% ^{AD} for visits 6-20	60% ^{AD} (visits combined in & out)	80% ^{AD} visits 1-5; 50% ^{AD} for visits 6-20	50% ^{AD} (visits combined in & out)
Other Services				
DME (\$1,000 max per calendar year - combined in and out)	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
DME Replacements (\$500 max repair & replacement - combined in and out)	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Diabetes Supplies & Education	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Prescription Drug Benefit (\$5,000 annual max benefit per person) No mail order option	100% ^{AD}	100% ^{AD}	50% ^{AD}	50% ^{AD}

AD - after deductible

OPTIMA Equity Individual Plans

Services	3500/100		3500/80	
	In-Network	Out-of- Network	In-Network	Out-of- Network
Deductible	\$3,500 / \$7,000	\$7,000 / \$14,000	\$3,500 / \$7,000	\$7,000 / \$14,000
Lifetime Maximum	None		None	
Out-of-Pocket Max	\$3,500 / \$7,000	\$14,000 / \$28,000	\$5,000 / \$10,000	\$14,000 / \$28,000
Physician Office Services - <i>Includes covered services performed in the physician's office during the physician's office visit</i>				
PCP Office Visit	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Specialist Office Visit	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Preventive Care (\$250 person max coverage – out-of-network)	Covered 100%	60% up to \$250 max benefit	Covered 100%	50% up to \$250 max benefit
Preventive Screenings (mammograms & colonoscopies) \$250 person max coverage – out-of-network	Covered 100%	60% ^{AD} up to \$250 max benefit	Covered 100%	50% ^{AD} up to \$250 max benefit
Preventive Vision (1 visit per 24 months)	\$0 Copayment	\$30 max reimbursement	\$0 Copayment	\$30 max reimbursement
Well Child Immunizations	Covered 100% birth to age 36 months	60% ^{AD} birth to age 36 months	Covered 100% birth to age 36 months	50% ^{AD} birth to age 36 months
Outpatient Services – <i>Includes covered surgery, therapy, rehabilitation, and diagnostic services received in outpatient facility.</i>				
Outpatient Surgery	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Outpatient Therapy Services (max \$1,000 per person combined in and out)	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Outpatient Diagnostics	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Dialysis Treatment	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Diagnostic Imaging Services (MRI, MRA, CTA, & PET Scans)	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Outpatient Chemo - Radiation, IV, Inhalation Services	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Inpatient Hospital Services – <i>Includes, but not limited to, room and board, general nursing care, lab, X-ray, and other diagnostic services</i>				
Inpatient Care	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Emergency Services – <i>Includes those emergency room facility, physician, and ancillary services that are rendered during an emergency room visit</i>				
Emergency Department	100% ^{AD}	100% ^{AD}	80% ^{AD}	80% ^{AD}
Urgent Care Center	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Ambulance (\$1,000 annual limit)	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Behavioral Healthcare and Substance Abuse Services – <i>Mental healthcare and substance abuse services require pre-authorization.</i>				
Adults (age 19 and over)	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
• Inpatient Mental Healthcare	20 day max (combined in & out)	20 day max (combined in & out)	20 day max (combined in & out)	20 day max (combined in & out)
• Outpatient Mental Healthcare	100% ^{AD} visits 1-5; 60% ^{AD} for visits 6-20	60% ^{AD} (visits combined in & out)	80% ^{AD} visits 1-5; 50% ^{AD} for visits 6-20	50% ^{AD} (visits combined in & out)
Children (under age 19)	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
• Inpatient Mental Healthcare	25 day max (visits combined in & out)	(visits combined in & out)	25 day max (visits combined in & out)	(visits combined in & out)
• Outpatient Mental Healthcare	100% ^{AD} visits 1-5; 60% ^{AD} for visits 6-20	60% ^{AD} (visits combined in & out)	80% ^{AD} visits 1-5; 50% ^{AD} for visits 6-20	50% ^{AD} (visits combined in & out)
Other Services				
DME (\$1,000 max per calendar year - combined in and out)	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
DME Replacements (\$500 max repair & replacement - combined in and out)	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Diabetes Supplies & Education	100% ^{AD}	60% ^{AD}	80% ^{AD}	50% ^{AD}
Prescription Drug Benefit (\$5,000 annual max benefit per person) No mail order option	100% ^{AD}	100% ^{AD}	50% ^{AD}	50% ^{AD}

AD - after deductible

Pharmacy Benefits

Please Note:

The following pages are excerpts from the member plan summary and are written from the member perspective.

Optima Plus

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 formulary. 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 Tiers according to the following:

- **Select Generic (Tier 1) include:** The majority of commonly prescribed and widely available generic drugs.
- **Standard Generics (Tier 2) include:** Newly FDA-approved generic drugs and those generic drugs with significantly higher costs than the average Select Generic (Tier 1) drugs.
- **Brand (Tier 3) include:** Brand name drugs that do not have a generic equivalent or a generic alternative to treat life-threatening chronic illnesses.

Maximum Benefit

Outpatient Prescription Drug Deductible: \$150 per Covered Person per calendar year.

Maximum Benefit of \$5,000 per Covered Person per calendar year. The maximum benefit does not apply to Physician prescribed diabetic supplies covered under the prescription drug benefit.

Deductibles, Copayments and Coinsurances

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.

- \$15.00 Copayment after deductible for Select Generic (First) tier drugs.
- \$30.00 Copayment **or** 40%* Coinsurance, whichever is greater, after deductible for Standard Generic (Second) tier drugs.
- \$50.00 Copayment **or** 50%* Coinsurance, whichever is greater, after deductible for Brand (Third) tier drugs

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

Optima FourSight

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 formulary. 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 Tiers according to the following:

- **Select Generic (Tier 1) include:** The majority of commonly prescribed and widely available generic drugs.
- **Standard Generics (Tier 2) include:** Newly FDA-approved generic drugs and those generic drugs with significantly higher costs than the average Select Generic (Tier 1) drugs.
- **Select Brand (Tier 3) include:** Select brand name drugs that do not have a generic equivalent or a generic alternative to treat life-threatening chronic illnesses.

Maximum Benefit

Outpatient Prescription Drug Deductible : \$250 per Covered Person per calendar year.

Maximum Benefit of \$5,000 per Covered Person per calendar year. The maximum benefit does not apply to Physician prescribed diabetic supplies covered under the prescription drug benefit.

Deductible, Copayments and Coinsurances

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.

- \$15.00 Copayment after deductible for Select Generic (First) tier drugs.
- \$30.00 Copayment **or** 40%* Coinsurance, whichever is greater, after deductible for Standard Generic (Second) tier drugs.
- \$50.00 Copayment **or** 50%* Coinsurance, whichever is greater, after deductible for Select Brand (Third) tier drugs

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

Optima Equity

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 formulary. 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 Tiers according to the following:

- **Select Generic (Tier 1) include:** The majority of commonly prescribed and widely available generic drugs.
- **Standard Generics (Tier 2) include:** Newly FDA-approved generic drugs and those generic drugs with significantly higher costs than the average Select Generic (Tier 1) drugs.
- **Brand (Tier 3) include:** Select brand name drugs that do not have a generic equivalent or a generic alternative to treat life-threatening chronic illnesses.

Maximum Benefit

Deductible: Members are responsible for all applicable Plan deductibles as stated on the Plan Schedule of Benefits.

Maximum Benefit of \$5,000 per Covered Person per calendar year. The maximum benefit does not apply to Physician prescribed diabetic supplies covered under the prescription drug benefit.

Deductibles, Copayments and Coinsurances

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

In-Network 80 Plans:

Covered at 50%⁸ after deductible for Tier 1, Tier 2, and Tier 3 drugs.

Out-of-Network 80 Plans:

Covered at 50%^{AC} after deductible for Tier 1, Tier 2, and Tier 3 drugs.

In-Network 100 Plans:

Covered at 100%⁸ after deductible for Tier 1, Tier 2, and Tier 3 drugs.

Out-of-Network 100 Plans:

Covered at 100%^{AC} after deductible for Tier 1, Tier 2, and Tier 3 drugs.

Prescription Drug Rider

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 tier Copayment or Coinsurance 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.

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.

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.

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.

Prescription Drug Rider

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.
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 Preferred or Standard drug list.
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.

Requests for Coverage of Non-Formulary Outpatient Prescription Drugs.

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 Your 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.

⁸ Benefits are payable at the percent specified of the Plan's fee schedule.

AC Benefits for Covered Services performed by any provider who is not a Plan Provider will be based on either a negotiated or agreed upon reimbursement or on an allowable charge which is the lesser of the provider's actual charge or the Plan's in-network fee schedule for the same service performed by the same type of provider. The Member will be responsible for payment of all charges in excess of the Plan's allowable charge in addition to any copayment and coinsurance amounts he/she is required to pay. Charges from non-Plan providers will generally exceed the Plan's allowable charge.

This document contains a general summary description of benefits. Once enrolled Optima Members should always refer to their individual coverage policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the member's policy will govern. Optima Health individual PPO policy form numbers: OHIC.IND.POLICY.08; OHIC.Ind.RX.08. Optima Health enrollment applications: OHC.INDAPP.08

Vision Benefits

Please Note:

The following pages are excerpts from the member plan summary and are written from the member perspective.

In-Network Coverage:

EyeMed Vision Services administers the vision care services benefit. Members are eligible to receive a routine eye examination, refraction, and prescription for eyeglass lenses, once every 24 months, from an EyeMed network provider. There is no Copayment required at the time of service.

What members need to do to receive covered services:

1. Select a participating EyeMed network provider from the Plan's provider directory or by calling 1-888-610-2268. Automated location information is available 24 hours a day. Customer service representatives are available Monday through Saturday 8:00 a.m. – 11:00 p.m., and Sundays 11:00 a.m. – 8:00 p.m.
2. Visit or call the participating provider, and identify themselves as a member by providing their member ID information. The provider will verify eligibility, covered services, and any applicable Copayment or Coinsurance. Payment is due at the time of service.
3. If the vision provider determines a need for additional medical care, members should contact their PCP or other physician for treatment options.

Out-of-Network Coverage:

If members use a provider that is not in the EyeMed network for an examination, they will be responsible for paying the provider in full at the time services are rendered. For covered services, members will be reimbursed according to the out-of-network benefit on the Face Sheet. For reimbursement, members may call Customer Service at 1-888-610-2268 to verify eligibility, and to request a claim form. Members should mail the completed form with a copy of their bill to:

EyeMed Vision Services
Attn: Vision Care Department
P.O. Box 8504
Mason, OH 45040-7111

Additional Information:

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

Additional Benefits

Please Note:

The following pages are excerpts from the member plan summary and are written from the member perspective.

Optima Plus Maternity Services Coverage Rider

This rider adds benefits for Maternity Services to Your policy. Premium, copayments and coinsurance amounts for this rider are listed in the table below.

Definitions: Maternity Services means:

1. Obstetrical and prenatal care.
2. Inpatient Hospital services including use of delivery room, hospital bed and board for the mother, routine nursery care.
3. Postpartum inpatient care
4. A Postpartum home visit or visits which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists.
5. Genetic testing limited to Amniocentesis, HLAB 27, and infant chromosomal analysis.
6. All care and services related to a miscarriage.
7. A minimum length of stay of 48 hours for a vaginal delivery, 96 hours following a cesarean section. The attending Physician and patient may decide that a shorter Hospital stay is appropriate. Pre-authorization is not required for delivery.

This rider covers pregnancies that begin at least six (6) months after the rider is effective. Conception must occur at least six (6) months after the rider is effective. A pregnancy that occurs within six (6) months of the rider effective date will not be covered even if you qualify for credit toward your policy's pre-existing condition exclusion waiting period. Complications of a pregnancy are covered under your Policy and not subject to the waiting period. If you are a HIPAA Eligible Individual as defined on Optima's enrollment application, and conception occurred prior to the effective date of the maternity rider, you will not have to wait six (6) months before your coverage begins.

Maternity Services for a Dependent child are not covered.

Home Births are not covered.

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. Your costs for Maternity Services are listed in the box below. Your Policy Deductible is listed on Your Policy Schedule of Benefits. Your costs for outpatient diagnostic services are on Your Policy Schedule of Benefits.

MEMBER PREMIUM, COPAYMENTS AND COINSURANCES		
	<i>In-Network Coverage</i>	<i>Out-of-Network Coverage</i>
The additional charge to Your monthly policy premium payment for this rider is \$116.13 per month.		
Maternity Care Pre-Authorization is required for pre-natal services.	\$350 Global Copayment for delivering Obstetrician for prenatal, delivery, and postpartum services After Deductible Covered at 80% ¹ for Inpatient hospital services.	After Deductible Covered at 60% ^{AC} for delivering Obstetrician for prenatal, delivery, and postpartum services After Deductible Covered at 60% ^{AC} for Inpatient hospital services
1. Benefits are payable at the percent specified of the Plan's fee schedule.		
AC Benefits for Covered Services performed by any provider who is not a Plan Provider will be based on either a negotiated or agreed upon reimbursement or on an allowable charge which is the lesser of the provider's actual charge or the Plan's in-network fee schedule for the same service performed by the same type of provider. The Member will be responsible for payment of all charges in excess of the Plan's allowable charge in addition to any copayment and coinsurance amounts he/she is required to pay. Charges from non-Plan providers will generally exceed the Plan's allowable charge.		

Prosthetics Devices and Components Rider

This rider adds coverage for medically necessary prosthetic devices. This also includes repair, fitting, replacement, and components. Member Copayments, Coinsurance, and Deductibles are listed below. Pre-Authorization is required for all services under this rider.

Definitions:

“**Component**” means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

“**Limb**” means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

“**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.

MEMBER PREMIUM, COPAYMENTS AND COINSURANCES		
<i>Prosthetics Devices and Components</i>	<i>In-Network Coverage</i>	<i>Out-of-Network Coverage</i>
An additional premium will apply. Please contact Optima Health		
Pre-Authorization is required	After Deductible Covered at 70% of the Plan's fee schedule	After Deductible Covered at 50% ^{AC}
<p>AC means Allowable Charge. Benefits for Covered Services performed by any provider who is not a Plan Provider will be based on either a negotiated or agreed upon reimbursement or on an allowable charge which is the lesser of the provider's actual charge or the Plan's in-network fee schedule for the same service performed by the same type of provider. The Member will be responsible for payment of all charges in excess of the Plan's allowable charge in addition to any Copayment and coinsurance amounts he/she is required to pay. Charges from non-Plan providers will generally exceed the Plan's allowable charge.</p>		

Rider for Coverage of Child Health Supervision Services

This coverage rider provides for coverage for child health supervision services under the Policy to provide for the periodic examination of covered children.

Child health supervision services means the periodic review of a child's physical and emotional status by a licensed and qualified physician or pursuant to a physician's supervision. A review shall include but not be limited to a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards.

Benefits for child health supervision services will be provided at approximately the following age intervals: birth, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, three years, four years, five years, and six years. Child health supervision services which are rendered during a periodic review shall only be covered to the extent that such services are provided by or under the supervision of a single physician during the course of one visit.

Benefits for coverage for child health supervision services shall be exempt from any copayment, coinsurance, deductible, or other dollar limit provision stated in the Policy or on the Schedule of Benefits of the Policy.

Child health benefits at no copayment, coinsurance or deductible must be purchased as a policy rider at an additional premium cost in order to be covered benefits. This document contains a general summary description of benefits. Once enrolled Optima Members should always refer to their individual coverage policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the member's policy will govern.

Morbid Obesity Treatment Rider

Coverage includes treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity.

The reimbursement for the treatment of morbid obesity shall be determined according to the same formula by which charges are developed for other medical and surgical procedures. Such Coverage shall have durational limits, dollar limits, deductibles, Copayments and coinsurance factors that are no less favorable than for physical illness generally. The Plan will not restrict access to surgery for morbid obesity based upon dietary or any other criteria not approved by the National Institutes of Health.

"Morbid Obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, BMI equals weight in kilograms divided by height in meters squared.

The Member will be responsible for all applicable In-Network or Out-of-Network Copayments, Coinsurances, and/or Deductibles depending on the type and place of service related to treatment for Morbid Obesity. Copayments, Coinsurances and/or Deductibles are listed on the Schedule of Benefits of this Policy.

Coverage for treatment of morbid obesity must be purchased as a policy rider at an additional premium cost in order to be covered benefits. This document contains a general summary description of benefits. Once enrolled Optima Members should always refer to their individual coverage policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the member's policy will govern.

Saving More

Optima Health Members Have the Opportunity to Save Money on Health Products and Services Including:*

Acupuncture	Receive up to 25% discount for acupuncture exams and treatment. For additional information, call toll-free 1-877-327-2746.
Chiropractic Care	Receive up to 25% discount for routine chiropractic care. For additional information, call toll-free 1-877-327-2746.
Hearing Extras	Receive reduced pricing for hearing care services, including functional testing, hearing aid evaluation, fitting, programming, training, and up to 50% discount (from manufacturer's suggested retail) for hearing aid. For additional information, call toll-free 1-866-956-5400.
Massage Therapy	Receive up to 25% discount for massage therapy. For additional information, call toll-free 1-877-327-2746.
Vitamins and Herbs	Receive up to 25% discount for vitamins and herbs with online ordering convenience and free shipments directly to the member. For additional information, call toll-free 1-877-327-2746.
Vision Extras	Receive significant savings on routine eye exams, lenses and frames, and contact lenses. For additional information, call toll-free 1-888-610-2268.
Laser Vision	Receive up to 15% discount for the cost of laser vision surgery. For additional information, call toll-free 1-888-610-2268.
Fitness Centers	Access to a national network of fitness clubs that offer either a minimum of 10% discount off initiation and or monthly dues, or the best available public rate based on the type of membership selected. For additional information, call toll-free 1-877-335-2746.
Remember	<p>These discounts apply to all Optima Health members and do not, in any way, affect premiums, nor are they covered benefits under their health plan.</p> <p>These discounts cannot be used in conjunction with any other discount, rider or benefit and you will be responsible for applicable taxes.</p> <p>* Optima Medicare Advantage plans: The products and services described above are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Optima Medicare grievance process. Optima Medicare: A Medicare Advantage organization with a Medicare contract.</p> <p>Optima Health is the trade name of Optima Health Plan, Optima Health Insurance Company, and Sentara Health Plans, Inc. Optima Vantage HMO products and Point-of-Service products are underwritten by Optima Health Plan. Optima Plus PPO products and Optima Individual Plans are underwritten by Optima Health Insurance Company. Sentara Health Plans, Inc. provides administrative and TPA services for self insured group health plans. The services listed in this brochure are value added benefits available to Optima Health plan members and not covered benefits under any Optima Health Plan.</p>

Preventive Vision Discount Fee Schedule

Vision Care Services	Member Cost
Complete Pair of Glasses Purchase*: Frame, lenses, and lens options must be purchased in the same transaction to receive full discount.	
Standard Plastic Lenses: <div style="text-align: right; padding-right: 20px;"> Single Vision Bifocal Trifocal </div>	\$50 \$70 \$105
Frames: Any frame available at provider location	40% off retail price
Lens Options: <div style="text-align: right; padding-right: 20px;"> UV Coating Tint (Solid and Gradient) Standard Scratch-Resistance Standard Polycarbonate Standard Progressive (Add-on to Bifocal) Standard Anti-Reflective Coating Other Add-Ons and Services </div>	\$15 \$15 \$15 \$40 \$65 \$45 20% discount
Contact Lens Materials: (Discount applied to materials only) <div style="text-align: right; padding-right: 20px;"> Disposable Conventional </div>	No discount on disposable 15% off retail price
Laser Vision Correction: <div style="text-align: right; padding-right: 20px;"> Lasik or PRK </div>	15% off retail price - or - 5% off promotional price

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

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

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

Exclusions & Limitations

Exclusions and Limitations

The following is a general list of services, supplies, equipment and benefits that are limited in or excluded from Coverage under Optima Health Individual Plan policies. Once enrolled Optima Members should always refer to their individual coverage policy for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the member's policy will govern.

PRE-EXISTING CONDITIONS

A Pre-existing Condition means a condition that, during the 12 month period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received within 12 months immediately preceding the effective date of coverage. Benefits for pre-existing conditions are not payable until the covered person's coverage has been in force for 12 consecutive months with Optima Health unless the member can demonstrate prior creditable 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 services 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.

Artificial Limbs - are 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 - except as listed as covered under the Plan's benefits for Hemophilia and Congenital Bleeding Disorders in Section 8 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.

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, and Breast Reduction - 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.

C

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

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.
- 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.
- Vitaligo

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.

Crime/Illegal Occupation - Expenses incurred for an illness or injury suffered in connection with the commitment of or intent to commit a felony.

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, gauze pads, 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.

- 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, gauze pads, 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.
- 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 Surgery - is excluded from Coverage, including, but not limited to, Radial Keratotomy, PRK and LASIK.

E

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, stair climbers, and pool or health club memberships.

Experimental 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

F

Food Allergy Testing - is excluded from Coverage.

Foot Care -

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

G

Genetic Testing and Counseling - are excluded from Coverage except for amniocentesis, HLAB 27, infant chromosomal analysis, BRAC1 and BRAC2, and FAP or AFAP 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.

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

Home Births – are excluded from Coverage.

Home Health - Home Health Care 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.

Illegal Occupation/Crime - Expenses incurred for an illness or injury suffered in connection with the commitment of or intent to commit a felony.

Immunizations –

- Immunizations for foreign travel and/or employment are excluded from Coverage.
- Immunizations not specifically listed as covered are excluded from Coverage.

Implants - Breast implants, except after mastectomy to produce symmetry, 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 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.

Influenza Vaccines - Preservative free influenza vaccines and flu-mist vaccines are excluded from Coverage unless authorized by the Plan.

Intoxicants and Narcotics - The Plan is not liable for any loss resulting from the insured being drunk, or under the influence of any narcotic unless taken on the advice of a physician.

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.

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 -

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

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, gauze pads, 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 by Sentara Behavioral Health Services, Inc. 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 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.

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

Narcotics and Intoxicants - The Plan is not liable for any loss resulting from the insured being drunk, or under the influence of any narcotic unless taken on the advice of a physician.

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

Neuropsychiatric Services - 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 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.

Orthopedic Devices - are 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 Preauthorized by the Plan.

P

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, ice bags, 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 is covered when authorized by the Plan.
- 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.

Private Duty Nursing - is excluded from Coverage.

Prosthetic Appliances or Devices are 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, gauze pads, alcohol, iodine, peroxide.

S

Saliva Tests - are excluded from Coverage.

Second Opinions – A second opinion is covered when authorized by the Plan.

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.

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 - is excluded from Coverage. Spinal manipulation means 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 of the spinal nerves and its associated effects related to such structural imbalance, misalignment or distortion, by physical or mechanical means.

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, gauze pads, 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;
- Therapies to maintain current status or level of care are excluded from Coverage;
- 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 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 outside the Plan's Service Area unless Pre-authorized by the Plan;
- Services received from Non-Plan 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.

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.

Tubal Ligation - is excluded from Coverage.

U

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

V

Vaccines - Influenza preservative free and flu-mist vaccines are excluded from Coverage unless authorized by the Plan.

Vasectomy - is excluded from Coverage.

Virtual Colonoscopy - is excluded from Coverage.

Vision Materials - Any vision supplies or materials not specifically listed as covered are 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.

XYZ

Optima Health is the trade name of Optima Health Plan and Optima Health Insurance Company. All Optima plans have benefit exclusions and limitations and terms and conditions under which a policy may be continued in force or discontinued. This document contains a general summary of Optima Health Individual plans. Some services may require the purchase of additional coverage riders. For costs and complete details of coverage contact your Optima Health representative. An application must be submitted and accepted before coverage begins. Once enrolled Optima members should always refer to their individual coverage policy for the actual terms and conditions of coverage that apply. In the event there are discrepancies with information in this document the terms and conditions of the member's policy will govern.

Optima Health individual policy form numbers:
OHIC.IND.POLICY.08; OHIC.Ind.RX.08; OHIC.IND.FOUR.08; OHIC.mat.08;
OHIC.INDHSA.PPO.08; OHIC.IND.CHILD.08; OHIC.IND.RX.07; OHIC.
INDCHOICE.PPO.08; OHIC.MO.07; OHIC.IPlusB.mat.09; OHIC.IFOURB.09;
OHIC.IPlusB.09; OHIC.IFourBRX.09; OHIC.IPlusBRx.09; OHIC.IFOUR.5/750;
OHIC.ICHOICE.5/750; OHIC.IProsthetics.09.
Optima Health enrollment applications: OHC.INDAPP.08; OHIC1881.08



4417 Corporation Lane, Virginia Beach, VA 23462
www.optimahealth.com