Optima Vantage 10/25M
Summary of Benefits

SURA/Jefferson Science Associates
Effective April 1, 2009

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

Other than as shown herein, except for covered Emergency Services, the Plan shall have no responsibility to pay for Covered Services rendered by Non-Plan Providers.

DEDUCTIBLE

Not Applicable

MAXIMUM OUT-OF-POCKET AMOUNT

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

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

PHYSICIAN SERVICES

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

Physician Office Visits	*Copayments/Coinsurance*	*Comments*
Primary Care Physician (PCP) Office Visit	$10 Copayment	
Specialist Office Visit	$25 Copayment	

Preventive Care Visits	*Copayments*	*Comments*
Routine Annual Physical Exams **Well Baby Exams** **Annual Gyn Exams and Pap Smears** **PSA Tests** **Colorectal Cancer Tests** **Routine Adult and Childhood Immunizations**	$10 Copayment	
Screening Colonoscopy **Screening Mammograms** An outpatient diagnostic Copayment or coinsurance will apply to any diagnostic procedures performed during routine screenings	Covered at 100% [3]	
Vaccines and Immunotherapeutic Agents	Covered at 50% [3]	Member is responsible for Coinsurance amount up to a maximum copayment amount of $250 per dose.

SHORT TERM OUTPATIENT THERAPY AND REHABILITATION SERVICES

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

Outpatient Therapy Services	*Copayments*	*Comments*
Physical Therapy **Occupational Therapy** **Speech Therapy**	$10 Copayment per PCP office visit $25 Copayment per Specialist office visit $25 Copayment per outpatient facility visit/treatment.	**Pre-Authorization is required.**

Outpatient Rehabilitation Services	*Copayments*	*Comments*
Cardiac Rehabilitation **Pulmonary Rehabilitation** **Vascular Rehabilitation** **Vestibular Rehabilitation**	$10 Copayment per PCP office visit $25 Copayment per Specialist office visit $25 Copayment per outpatient facility visit/treatment.	**Pre-Authorization is required.**

OTHER OUTPATIENT TREATMENTS

Copayment or Coinsurance applies to Covered Services provided in a free-standing outpatient facility, hospital outpatient facility, in a Physician's office, or in the Member's home as part of Skilled Home Health Care Services benefit.

Other Outpatient Treatments	*Copayments*	*Comments*
Chemotherapy **Radiation Therapy** **IV Therapy** **Inhalation Therapy**	$10 Copayment per PCP office visit $25 Copayment per Specialist office visit $25 Copayment per outpatient facility visit/treatment.	**Pre-Authorization is required for IV Therapy with medications and Inhalation therapy**.

Outpatient Dialysis Services

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

Outpatient Surgery

Copayment or Coinsurance applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.

	Copayments	*Comments*
Outpatient Surgery	$100 Copayment per Admission	**Pre-Authorization is required.**

Outpatient Diagnostic Procedures

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

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

OUTPATIENT ADVANCED IMAGING PROCEDURES

Copayment or Coinsurance applies to procedures done in a free-standing outpatient facility, hospital outpatient facility or in a Physician's office.

Magnetic Resonance Imaging (MRI) **Magnetic Resonance Angiography (MRA)** **Positron Emission Tomography (PET Scans)** **Computerized Axial Tomography (CT Scans)** **Computerized Axial Tomography Angiogram (CTA Scans)**	$100 Copayment	**Pre-Authorization is required.**

MATERNITY CARE

Copayment or Coinsurance is in addition to any applicable inpatient hospital admission Copayment or Coinsurance. Covered Services include prenatal, delivery, and postpartum services provided by the delivering obstetrician.

	Copayments	*Comments*
Maternity Care	$100 Global Copayment for delivering Obstetrician prenatal, delivery, and postpartum services [2]	**Pre-Authorization is required for prenatal services.**

INPATIENT SERVICES

	Copayments	*Comments*
Inpatient Hospital Services **Transplants are covered at contracted facilities only.**	$100 Copayment per day up to a $500 maximum Copayment per inpatient Admission	**Pre-Authorization is required.**
Skilled Nursing Facilities/Services Following inpatient hospital care or in lieu of hospitalization Covered Services include up to 100 days per calendar year per illness or condition that in the Plan's judgment requires Skilled Nursing Services .[4]	Covered at 100%[3] after inpatient hospital Copayment has been met.	**Pre authorization is required.**

AMBULANCE SERVICES[5]

For emergency transportation, or as Medically Necessary and Pre-Authorized by the Plan.

	Copayments	*Comments*
Ambulance Services	$25 Copayment per transport each way	**Pre-Authorization is required for non-emergent transportation only.**

EMERGENCY DEPARTMENT SERVICES[5]

Includes those emergency department facility, Physician, and ancillary services that are rendered during an emergency department visit.

	Copayments	*Comments*
Emergency Department Services	$100 Copayment per emergency department visit. If the Member requires inpatient Hospital Admission the emergency Copayment will be waived, and the Member will be responsible for the applicable inpatient Hospital Admission Copayment or Coinsurance.	**A referral is not required.** **Pre-Authorization is not required.**

URGENT CARE CENTER SERVICES[5]

	Copayments	*Comments*
Urgent Care Services Includes urgent care center services, physician services, and other ancillary services received at an Urgent Care facility. If you are transferred to an emergency room from an urgent care center, you will be responsible for any applicable emergency room Copayment or Coinsurance.	$25 Copayment	**A referral is not required.** **Pre-Authorization is not required.**

MENTAL HEALTH CARE AND SUBSTANCE ABUSE SERVICES[5]

Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental illnesses.

	Copayments	*Comments*
Inpatient Services	$100 Copayment per day up to a $500 maximum Copayment per inpatient Admission	**Pre-Authorization is required.**
Outpatient Services	$25 Copayment per outpatient visit/hour	**Pre-Authorization is required for outpatient psychological testing.**

OTHER COVERED SERVICES

	Copayments	Comments
Artificial Limb Services [4] For adults 18 and over, artificial limbs, including repair and replacement, will be covered up to a $10,000 lifetime maximum per limb, per occurrence. For children under age 18, artificial limbs, including repair and replacement, will be covered up to $10,000 per limb for a maximum of two occurrences.	Covered at 100% [3]	**Pre-Authorization is required for Artificial Limb Services.**
Diabetic Supplies and Equipment Includes FDA approved equipment and supplies for the treatment of diabetes and in-person outpatient self-management training and education including medical nutrition therapy. Insulin, syringes, and needles are covered under the Plan's Prescription Drug Benefit for the applicable Copayment per 31-day supply.	Covered at 80% [3] for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion. No Copayment is required for insulin pumps. No Copayment is required for outpatient self-management training and education, including medical nutritional therapy.	
Durable Medical Equipment (DME) and Supplies [4] **Orthopedic Devices and Prosthetic Appliances** [4] Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, iliostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement. **Services are covered up to a maximum benefit of $3,000 per member per calendar year.**	Covered at 100% [3]	**Pre-Authorization is required for single items over $750.** **Pre-Authorization is required for all rental items.** **Pre-Authorization is required for repair and replacement.**
Early Intervention Services. [4] Covered for Dependents from birth to age three who are certified as eligible by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices . Coverage is limited to $5,000 per Member per calendar year.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.	**Pre-authorization is required.**
Home Health Care Skilled Services A member must be homebound and unable to receive services outside the home to receive care. An outpatient therapy Copayment or Coinsurance will also apply to physical, occupational, and speech therapy received in the home.	Covered at 100% [3]	**Pre-Authorization is required**.

Hospice Care	Covered at 100%[3]	**Pre-Authorization is required.**
Preventive Vision & Materials Rider **EyeMed Vision Services administers this benefit for vision care services and materials.** Members may call EyeMed at [1-888-610-2268] for information about Participating Providers. Each Covered Person is eligible to receive a routine eye examination, refraction; lenses and frames; or contact lenses once every 24 months from a Participating EyeMed Provider.	$15 Copayment per eye examination and materials. Contact lens examinations require the eye examination Copayment plus the difference between the contact lens examination cost and the eyeglass examination cost. Lenses (single, vision, bifocal, trifocal) covered in full. Frames covered in full up to $100 retail. Contact lenses (in lieu of glasses) covered in full up to $100 retail.	For eye examinations from Out-of-Network providers, Members will be reimbursed up to $30 for an eye examination only. Copayments or Coinsurance for covered services under this rider are not applied toward any Plan maximum out of pocket and must continue to be paid after the maximum is met.
Reduction Mammoplasty Coinsurance will apply to all applicable services associated with Reduction Mammoplasty including but not limited to Physician, facility, surgical, and/or diagnostic services.	Covered at 50%[3]	**Pre-Authorization is required.** This does not include Reduction Mammoplasty procedures associated with reconstructive breast surgery following mastectomy.

NOTES

The benefits herein are subject to the terms and conditions set forth in the *Evidence of Coverage* form number OHP.HMO.EOC.7.08

1 Out of Pocket Maximum means the total amount a Member and/or eligible Dependent pays during a Calendar or contract year. Applicable Copayments or Coinsurances for non-biologically based outpatient mental health care, vision care, outpatient prescription drugs, any ridered benefits except morbid obesity, any covered medical expenses paid at a rate of 50% or less, do not count toward the Out-Of-Pocket Maximum and must continue to be paid after the Out-Of-Pocket Maximum has been met.

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

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

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

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

Optima Health Prescription Drug Rider
$10/$20/$40/$40

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.

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

- **Preferred (Tier 1) include**: The majority of commonly prescribed and widely available generic drugs. Preferred drugs are covered at the lowest Copayment level. Some brand-name drugs may be included in this category if the Plan recognizes they show documented long-term decreases in Illness and death. Large published peer-reviewed clinical trials are used to make this determination.

- **Standard (Tier 2) include**: Brand-name drugs that are considered by the Plan to be standard therapy; and generic drugs with significantly higher costs than the average Preferred (Tier 1) generic drugs, that are considered by the plan to be standard therapy.

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

- **Premium Plus (Tier 4) include:** Those generic and brand name drugs not classified by the Plan as Preferred (Tier 1), Standard (Tier 2), or Premium (Tier 3); those drugs not excluded from Coverage under the Pharmacy Rider; and those drugs that are not recognized by the Plan to be any more effective than other drugs available at the Preferred (Tier 1), Standard (Tier 2), or Premium (Tier 3) tiers or over the counter**.**

Member Copayments

- $10.00 Copayment for Preferred (First) tier drugs.
- $20.00 Copayment for Standard (Second) tier drugs.
- $40.00 Copayment for Premium (Third) tier drugs.
- $40.00 Copayment for Premium Plus (Fourth) tier drugs.

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Optima Health Prescription Drug Rider
$10/$20/$40/$40

Mail Order Pharmacy Benefit

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

Caremark
P.O. Box 94467
Palatine, IL 60094-4467

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

- $20.00 Copayment for Preferred (First) tier drugs.
- $40.00 Copayment for Standard (Second) tier drugs.
- $80.00 Copayment for Premium (Third) tier drugs.
- $80.00 Copayment for Premium Plus (Fourth) tier drugs.

Certain prescription drugs will be covered at a generic product level established by the Plan. If a generic product level has been established for a drug and the Member or prescribing Physician requests the brand-name drug or a higher costing generic, the Member must pay the difference between the cost of the dispensed drug and the generic product level in addition to the Standard or Premium tier Copayment charge.

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

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

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

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.

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Optima Health Prescription Drug Rider
$10/$20/$40/$40

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 drugs.

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

1. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from Coverage.
2. Diabetic supplies and equipment, in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law, other than those listed as covered under this prescription drug rider are covered under the Plan's medical benefit.
3. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
4. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from coverage.
5. Immunization agents, biological sera, blood or blood products are excluded from Coverage.
6. Infertility drugs are excluded from Coverage.
7. Injectables (other than those self-administered and insulin) are excluded from Coverage.
8. Medication taken or administered to the Member in the Physician's office is excluded from Coverage.
9. Medication taken or administered in whole or in part, while he/she is a patient in a licensed Hospital, rest home, sanatorium, extended care facility, convalescent Hospital, nursing home, or similar institution is excluded from Coverage .
10. Investigational or experimental medications are excluded from Coverage.
11. Medications for cosmetic purposes only, including but not limited to Retin-A for aging, are excluded from Coverage.
12. Medications for smoking cessation, including but not limited to Nicorette gum, nicotine patches, nicotine spray are excluded from Coverage.
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 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.

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