

**Optima Plus 15/80%M
Summary of Benefits**

**New Horizons
Regional Education Center
Effective 10/1/2010**

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. There are two benefit columns. One column lists Your Copayment or the percent Coinsurance the Plan will pay for In-Network benefits. The other column lists Your Copayment or the percent Coinsurance the Plan will pay for Out-of-Network benefits.

To use Your In-Network benefits all covered services must be received from Plan Providers. All Covered Services received from Non Plan Providers will be covered under Out-of-Network benefits. All covered laboratory services received from Non Plan laboratories will be covered under Out-of-Network benefits. Covered Services received from Non-Plan Providers while the Member is receiving care at plan facilities will be covered under Out-of-Network benefits. Some benefits require Pre-Authorization before You receive them.

Maximum Plan Benefit, Deductibles and Maximum Out of Pocket Amounts

	In-Network Benefits	Out-of-Network Benefits
Maximum Lifetime Plan Benefit¹	Your Plan does not have a Maximum Lifetime In-Network Benefit	\$3,000,000
Deductibles per Calendar Year²	Your Plan does not have an In-Network Deductible	\$400 per Member \$800 per Family
Maximum Out-of-Pocket Amount per Calendar Year	\$2,000 per Member ³ \$4,000 per Family ³	\$5,000 per Member ⁴ \$10,000 per Family ⁴

PHYSICIAN SERVICES

Pre-Authorization is required for in-office surgery.⁵ Copayment or Coinsurance applies to Covered Services performed in the Physician's office. An additional Copayment or Coinsurance may apply to outpatient therapy, rehabilitative services, injectable and infused medications, and outpatient advanced imaging procedures done in the physician's office.

Physician Office Visits	In-Network Benefits	Out-of-Network Benefits
Primary Care Physician (PCP) Office Visit	\$15 Copayment then covered at 100% ⁸	After Deductible Covered at 70% ^{AC}
Specialist Office Visit	\$30 Copayment then covered at 100% ⁸	After Deductible Covered at 70% ^{AC}
Vaccines and Immunotherapeutic Agents Member is responsible for Coinsurance amount up to a maximum Copayment amount of \$250 per dose.	Covered at 50% ⁸	After Deductible Covered at 50% ^{AC}
Preventive Care Visits	In-Network Benefits	Out-of-Network Benefits
Routine Annual Physical Exams Well Baby Exams Annual Gyn Exams and Pap Smears PSA Tests Colorectal Cancer Tests Routine Adult and Childhood Immunizations	\$15 Copayment	After Deductible Covered at 70% ^{AC}
Screening Colonoscopy Screening Mammograms	Covered at 100% ⁸	After Deductible Covered at 70% ^{AC}

Outpatient Therapy and Rehabilitation Services

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

Short Term Therapy Services	In-Network Benefits	Out-of-Network Benefits
<p>Physical Therapy Occupational Therapy Speech Therapy Pre-Authorization is required.⁵</p> <p>Physical Therapy, Occupational Therapy, and Speech Therapy are limited to a maximum combined benefit with In-Network and Out-of-Network benefits of 90 consecutive days per condition per lifetime.⁶</p>	<p>\$15 Copayment per PCP office visit. \$30 Copayment per Specialist office visit. Covered at 80%⁸ per outpatient facility visit.</p>	<p>After Deductible Covered at 70%^{AC}</p>
Short Term Rehabilitation Services	In-Network Benefits	Out-of-Network Benefits
<p>Cardiac Rehabilitation Pulmonary Rehabilitation Vascular Rehabilitation Vestibular Rehabilitation Pre-Authorization is required.⁵</p> <p>Limited to a maximum combined benefit with In-Network and Out-of-Network benefits of 90 consecutive days per condition per lifetime.⁶</p>	<p>\$15 Copayment per PCP office visit. \$30 Copayment per Specialist office visit. Covered at 80%⁸ per outpatient facility visit</p>	<p>After Deductible Covered at 70%^{AC}</p>
Other Outpatient Treatments	In-Network Benefits	Out-of-Network Benefits
<p>Chemotherapy Radiation Therapy IV Therapy Inhalation Therapy Pre-Authorization is required for IV Therapy with medications and Inhalation therapy.⁵</p>	<p>\$15 Copayment per PCP office visit. \$30 Copayment per Specialist office visit. Covered at 80%⁸ per outpatient facility visit.</p>	<p>After Deductible Covered at 70%^{AC}</p>
<p>Pre-Authorized Injectable and Infused Medications Includes injectable and infused medications, biologics, and IV therapy medications that require prior-authorization. <i>(This does not include chemotherapy medications, allergy injections or serum.)</i> Coinsurance applies when medications are provided in a Physician's office, an outpatient facility, or in the Member's home as part of Skilled Home Health Care Services benefit. Coinsurance is in addition to any applicable office visit or outpatient facility Copayment or Coinsurance.</p>	<p>Covered at 80%⁸</p>	<p>After Deductible Covered at 70%^{AC}</p>

OUTPATIENT DIALYSIS SERVICES

Dialysis Services	In-Network Benefits	Out-of-Network Benefits
<p>Dialysis Services Copayment or Coinsurance applies regardless of place of service.</p>	<p>Covered at 80%⁸</p>	<p>After Deductible Covered at 70%^{AC}</p>

Outpatient Surgery

Outpatient Surgery	In-Network Benefits	Out-of-Network Benefits
<p>Outpatient Surgery Pre-Authorization is required.⁵ Coinsurance or Copayment applies to services provided in a free-standing ambulatory surgery center or hospital outpatient surgical facility.</p>	<p>\$100 Copayment then covered at 80%⁸</p>	<p>After Deductible Covered at 70%^{AC}</p>

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.

	In-Network Benefits	Out-of-Network Benefits
Diagnostic Procedures Pre-Authorization is required. ⁵	Covered at 80% ⁸	After Deductible Covered at 70% ^{AC}
X-Ray Ultrasound Doppler Studies	Covered at 80% ⁸	After Deductible Covered at 70% ^{AC}
Lab Work	Covered at 80% ⁸	After Deductible Covered at 70% ^{AC}

Outpatient Advanced Imaging Procedures

	In-Network Benefits	Out-of-Network Benefits
Magnetic Resonance Imaging (MRI) Magnetic Resonance Angiography (MRA) Positron Emission Tomography (PET Scans) Computerized Axial Tomography (CT Scans) Computerized Axial Tomography Angiogram (CTA Scans) Pre-Authorization is required. ⁵ Copayment or Coinsurance applies to procedures done in a Physician's office, a free-standing outpatient facility, or a hospital outpatient facility.	Covered at 80% ⁸	After Deductible Covered at 70% ^{AC}

Maternity Care ⁷

	In-Network Benefits	Out-of-Network Benefits
Maternity Care Pre-Authorization is required for prenatal services. ⁵ Includes prenatal, delivery, postpartum services, and home health visits. Copayment or Coinsurance is in addition to any applicable inpatient hospital Copayment or Coinsurance. Coverage for any maternity related services for obstetrical, prenatal, perinatal, or post-partum care for a Dependent child is excluded from Coverage unless covered under a Rider.	Covered at 80% ⁸	After Deductible Covered at 70% ^{AC}

Inpatient Services

	In-Network Benefits	Out-of-Network Benefits
Inpatient Hospital Services Pre-Authorization is required. ⁵ Transplants are covered at contracted facilities only.	\$300 Inpatient Copayment per admission then covered at 80% ⁸	After Deductible Covered at 70% ^{AC}
Skilled Nursing Facilities/Services Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 100 days combined in and out of network per calendar year per illness or condition that in the Plan's judgment requires Skilled Nursing Facility Services. ⁶	Covered at 80% ⁸ after inpatient hospital Copayment has been met.	After Deductible Covered at 70% ^{AC}

Ambulance Services		
	In-Network Benefits	Out-of-Network Benefits
Ambulance Services For emergency transportation, or as Medically Necessary and Pre-Authorized by the Plan. Pre-Authorization is required for non-emergent transportation only. ⁵	\$25 Copayment per transport each way then covered at 80% ^{8,9}	Same as In-Network Benefit
Emergency Department Services		
	In-Network Benefits	Out-of-Network Benefits
Emergency Department Services Pre-Authorization is not required. Includes those emergency department facility, physician, and ancillary services that are provided during an emergency department visit. If the Member is admitted as an inpatient the Member will be responsible for the inpatient hospital Copayment or Coinsurance.	\$200 Copayment then covered at 80% ^{8,9}	Same as In-Network Benefit
Urgent Care Services		
	In-Network Benefits	Out-of-Network Benefits
Urgent Care Services Pre-Authorization is not required. Includes urgent care center services, physician services, and other ancillary services received at an Urgent Care facility. If you are transferred to an emergency department from an urgent care center, you will be responsible for any applicable emergency department Copayment or Coinsurance.	\$30 Copayment	After Deductible Covered at 70% ^{AC} (for non-emergency services only)
Behavioral Health Care		
Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental illnesses.		
	In-Network Benefits	Out-of-Network Benefits
Inpatient Services Pre-Authorization is required for all inpatient services, and partial hospitalization services. ⁵	\$300 Inpatient Copayment per admission then covered at 80% ⁸	After Deductible Covered at 70% ^{AC}
Outpatient Services Pre-Authorization is required for intensive outpatient Program (IOP), psychological and neuro-psychological testing, and electro-convulsive therapy. ⁵	\$30 Copayment	After Deductible Covered at 70% ^{AC}
Employee Assistance Program (EAP)⁶ Includes short-term problem assessment by licensed behavioral health providers, and referral services for employees and dependent family members. To access EAP services call 757-363-6777 or 1-800-899-8174	\$0 Copayment for up to five Employee Assistance Program (EAP) Provider visits per presenting issue as determined by treatment protocols.	Covered In-Network only from Optima EAP providers.

Other Covered Services

	In-Network Benefits	Out-of-Network Benefits
<p>Artificial Limb Services ⁶ Pre-Authorization is required⁵ 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.</p>	Covered at 80% ⁸	After Deductible Covered at 70% ^{AC}
<p>Chiropractic Care ⁶ Administered by American Specialty Health Networks (ASHN). Pre-Authorization is required by ASHN for all chiropractic care services To receive services, contact ASHN's Member Services at 1-800-678-9133. Representatives are available from 8 AM to 9 PM Monday-Friday.</p> <p>Coverage is limited to a combined maximum benefit with in and out of network benefits of \$500 per Member, per calendar year.</p> <p>Chiropractic appliances are covered up to \$50 maximum benefit per Member per calendar year when medically necessary.</p> <p>For providers not in the ASHN network the Member will be responsible for payment of all charges in excess of ASHN's allowable charge in addition to any coinsurance amount. Allowable charge is the lesser of the provider's actual charge or ASHN's in-network fee schedule for the same services.</p>	Covered at 80% of ASHN fee schedule	Covered at 60% of ASHN fee schedule
<p>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.</p>	<p>Covered at 80%⁸ for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion sets.</p> <p>Covered at 100%⁸ for insulin pumps.</p> <p>Covered at 100%⁸ for outpatient self-management training and education, including medical nutritional therapy.</p>	After Deductible Covered at 70% ^{AC}
<p>Durable Medical Equipment (DME) and Supplies ⁶ Orthopedic Devices and Prosthetic Appliances ⁶ Pre-Authorization is required for single items over \$750⁵ Pre-Authorization is required for all rental items⁵ Pre-Authorization is required for repair and replacement⁵. Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, ileostomy, 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.</p>	Covered at 80% ⁸	After Deductible Covered at 70% ^{AC}

<p>Early Intervention Services.⁶ Pre-authorization is required⁵. 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.</p>	<p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.</p>	<p>Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.</p>
<p>Home Health Care Skilled Services Pre-authorization is required⁵. Maximum combined benefit with In and Out-of-Network benefit of 100 visits per calendar year.</p> <p>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.</p>	<p>Covered at 80%⁸</p>	<p>After Deductible Covered at 70%^{AC}</p>
<p>Hospice Care Pre-authorization is required⁵.</p>	<p>Covered at 80%⁸</p>	<p>After Deductible Covered at 70%^{AC}</p>
<p>Preventive Vision Services Administered by EyeMed Vision Services. Covered for one examination every 24 months performed by a Participating EyeMed Provider.</p>	<p>\$15 Copayment per eye examination Contact lens examinations require the eye examination Copayment plus the difference between the contact lens examination cost and the eyeglass examination cost.</p>	<p>For eye examinations from Out-of-Network providers, Members will be reimbursed up to \$30 for an eye examination only.</p>
<p>Reduction Mammoplasty Pre-authorization is required⁵. Coinsurance will apply to all applicable services associated with Reduction Mammoplasty including but not limited to Physician, facility, surgical, and/or diagnostic services. This does not include Reduction Mammoplasty procedures associated with reconstructive breast surgery following mastectomy.</p>	<p>Covered at 50%.⁸</p>	<p>After Deductible Covered at 50%^{AC}</p>

Notes

The Covered Services herein are subject to the terms and conditions set forth in the Certificate of Insurance form number **OHIC.PPO.COI.709**

1. Maximum benefits payable under the Plan.
2. Deductible means the dollar amount of covered medical expenses for which a Member is responsible to pay each calendar year before benefits are payable under the Plan. A Plan may have a separate deductible for in network services and for out of network services. Any such amount will not be reimbursed under the Plan. Any part of the calendar year deductible that is satisfied in the last three months of a calendar year can be carried forward to the next calendar year. Amounts which a member is required to pay for outpatient prescription drugs, preventive vision, vision materials, will not be applied to any Deductible amount in the Plan. The Deductible does not apply to Physician office visits and the Member is required to pay applicable office visit Copayment only. Amounts applied to an in-network deductible will apply toward the Plan's in-network out of pocket maximum amount. Amounts applied to an out-of-network deductible will apply toward the Plan's out of network out of pocket maximum amount.
3. Maximum Out of Pocket Amount means the total amount a Member or family will pay during a calendar year for covered In-Network Services. Applicable Copayments or Coinsurances for vision care, outpatient prescription drugs, any ridered benefits except morbid obesity, Reduction Mammoplasty benefits, except for procedures associated with reconstructive breast surgery following mastectomy, or amounts which a covered person is required to pay as a result of a benefit penalty due to failure to comply with the Plan's Pre-Authorization procedures do not count toward the In-Network Maximum Out of Pocket Amount and must continue to be paid after the Maximum Out of Pocket Amount has been met. The Out-Of-Network Deductible does not apply toward the In-Network Maximum Out of Pocket Amount. Copayments or Coinsurances for Out-Of-Network Covered Services do not count toward the In-Network Maximum Out of Pocket Amount.
4. Maximum Out of Pocket Amount means the total amount a Member or family will pay during a calendar year for covered Out-of-Network Services. Applicable Copayments or Coinsurances for vision care, outpatient prescription drugs, any ridered benefits except morbid obesity, Reduction Mammoplasty benefits, except for procedures associated with reconstructive breast surgery following mastectomy amounts which a covered person is required to pay as a result of a benefit penalty due to failure to comply with the Plan's Pre-Authorization procedures, or amounts which are in excess of the Plan's In-Network Allowable Charge do not count toward the Out-Of-Network Maximum Out of Pocket Amount and must continue to be paid after the Maximum Out of Pocket Amount has been met. The In-Network Deductible does not apply toward the Out-Of-Network Maximum Out of Pocket Amount. Copayments or Coinsurances for In-Network Covered Services do not count toward the Out-Of-Network Maximum Out of Pocket Amount.
5. Pre-authorization is required. A Member's benefits under the Plan may be reduced, after any deductible amount, if he does not comply with the Plan's Pre-authorization. Details concerning Pre-authorization procedures, including possible benefit reductions for not following the program, are provided under Section III in the Evidence of Coverage. Failure to obtain pre-authorization, when applicable, may result in a penalty of up to \$500.
6. Maximum amounts are combined maximums of both In-Network and Out-Of Network Covered Services unless otherwise indicated. Amounts in excess of a benefit dollar limit and/or visit limit as stated herein or added by a Plan rider are excluded from Coverage.
7. Coverage for obstetrical services as an inpatient in a general hospital or obstetrical services by a physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and Copayments that are no less favorable than for physical illness generally.
8. Benefits are payable at the percent specified of the Plan's fee schedule.
9. 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.

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.

Optima Plus \$10/20/40/40 Outpatient Prescription Drug Rider

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. Some 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 and Coinsurances

Outpatient Prescription Drug Copayments or Coinsurance do not apply to the Plan's maximum out of pocket amount and must continue to be paid after the maximum out of pocket amount has been met.

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. [The member copayment, coinsurance amount or the difference between the brand and generic drug do not apply to the Plan's maximum out of pocket amount and must continue to be paid after the maximum out of pocket amount has been met.

Members are responsible for Copayments or Coinsurance listed below. For a single Copayment or Coinsurance charge a Member may receive up to a consecutive 31-day supply of a covered outpatient prescription drug.

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

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Plus_ \$10/20/40/40 4 Tier Open Formulary

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Outpatient Prescription Drug Rider

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.

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.

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.

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

Limited over the counter drugs may be covered at quantities approved by the Plan. The Member must have a Physician's prescription for the drug, and the drug must be included on the Plan's list of covered Preferred and Standard drugs.

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

1. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from Coverage.
2. Diabetic supplies and equipment, in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using

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Outpatient Prescription Drug Rider

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. Injectables (other than those self-administered and insulin) are excluded from Coverage.
7. Medication taken or administered to the Member in the Physician's office is excluded from Coverage.
8. 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 .
9. Investigational or experimental medications are excluded from Coverage.
10. Medications for cosmetic purposes only, including but not limited to Retin-A for aging, are excluded from Coverage.
11. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
12. Medications with no approved FDA indications are excluded from Coverage.
13. Over-the-counter (OTC) medications that do not require a Physician's authorization by state or federal law and any prescription that is available as an OTC medication are excluded from Coverage unless listed as covered on the Plan's formulary.
14. Replacement prescriptions resulting from loss, theft or breakage are excluded from Coverage.
15. 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.
16. 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.
17. Infertility drugs are excluded from Coverage.
18. Medications for smoking cessation, including but not limited to Nicorette gum, nicotine patches, nicotine spray are excluded from Coverage.