



OptiMed GAP Plans Brochure

- Participation requirements apply
- 20 hours per week minimum

OptiMed GAP Plans

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(800) 482-8770 x 215

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Boca Raton, FL 33431
(800) 810-9892 x 4770

Southeastern Regional Office
(866) 553-0862

This OptiMed Program is not available in all states, including , Montana, and the state of Washington. Please check with your OptiMed Group Sales Representative to confirm that OptiMed is available in the state or states in which you may have an interest in offering OptiMed.

Please obtain an official proposal from your OptiMed Group Sales Representative. OptiMed is not bound to accept proposals that were not issued by OptiMed.

THE GAP PLANS

With the slowing economy and employers finding it increasingly difficult to afford traditional health insurance premiums, OptiMed GAP fills a rapidly growing niche in the group health insurance marketplace by assisting employers to provide affordable health coverage to their employees.

OptiMed Gap is specifically designed to help save direct health insurance premium costs by allowing employers and employees greater freedom in selecting lower cost high deductible health plans. Simply put, by plugging in OptiMed Gap, employers may be able to raise deductibles and coinsurance to obtain lower cost coverage. OptiMed GAP helps to fill the gap in coverage for higher deductible health plans in relation to eligible expenses for deductibles, coinsurance and copays.

OptiMed GAP is a guaranteed issue insurance product with multiple plan options available, allowing employers to pick and choose the best fit.

OptiMed Gap is only available on an employer group basis to employees who have an underlying employer sponsored comprehensive major medical plan. Employees who are not covered under the employer's major medical plan may not enroll in OptiMed Gap.

OPTIMED GAP FEATURES

- Expenses must be covered by the insured person's major medical or comprehensive medical plan to be covered under this policy.
- Covers certain portions of the insured person's cost sharing under their major medical or comprehensive medical plan (coinsurance, co-pays and deductibles) up to the maximum benefit selected.

- Each plan of insurance includes benefits for In-Hospital expenses. Optional Outpatient, Physician Office Visit and Wellness Benefits may be added, if elected by the employer
- Uses the primary medical plan's EOB (explanation of benefits) as a basis for determining what is covered.
- Up to two OptiMed GAP plans may be sold per comprehensive major medical plan maintained by the employer (one employer-paid plan and one voluntary buy-up plan). Employers who purchase an employer-paid plan for which the maximum inpatient benefit amount is less than the total major medical plan out-of-pocket expense may also include a buy-up option for the employees.

The employer must pay the entire premium for a maximum \$500 inpatient benefit for all employees covered by the employer's group medical plan. The employer may select additional Inpatient Hospital benefit amounts to make available for employees to purchase. This amount, when combined with the employer-paid plan's maximum benefit amount, may not exceed the insured person's total out-of-pocket exposure under the major medical plan.

The buy-up amount selected by the employer applies to each employee; it cannot vary by individual within the group.



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HOW DOES IT WORK?

The insured submits a claim form with an EOB. As long as the claim is an eligible expense under the underlying major medical plan OptiMed pays the insured the appropriate amount, subject to the exclusions, limitations and other provisions of the policy.

INPATIENT BENEFIT

If, as a result of a covered injury or sickness an insured person is hospital confined, under the regular care and attendance of a physician and the expenses are covered by the insured person's major medical/comprehensive policy, OptiMed will pay up to the maximum indemnity benefit per calendar year. Hospital confinement must begin after the effective date of coverage.

Benefits are limited to:

- The deductible the insured person is required to pay under the major medical/comprehensive Policy.
- Copays and the coinsurance amount the insured person is required to pay under the major medical/comprehensive Policy.

Benefits also will be payable for a covered Hospital emergency room treatment as follows:

- Injury – up to the Maximum Benefit, subject to Exclusions & Limitations.
- Sickness – up to the Maximum Benefit subject to Exclusions and Limitations, if the sickness results in Hospital Confinement within 24 hours of the Hospital emergency room treatment.

OUTPATIENT BENEFIT

Benefits are payable for outpatient treatment for a covered Injury or Sickness up to the maximum benefit per family, per calendar year maximum. A per person, calendar year maximum equal to 50% of the family calendar year maximum also applies.

The benefits are limited to the difference between the benefit paid by the underlying major medical/comprehensive policy and the actual outpatient expenses incurred, which includes any out-of-pocket expenses such as deductible, co-pays and coinsurance.

Outpatient benefits include treatment under the regular care and attendance of a Physician at a Hospital, an outpatient surgical or emergency facility or a diagnostic testing facility or similar facility that is licensed to provide outpatient treatment.

Expenses incurred means the charges for a service or supply that is covered by this Rider and given to an insured person due to an injury or sickness. The expense incurred must be medically necessary for the condition being treated. An expense or charge is deemed to be incurred on the date the service or supply that causes the expense or charge is given or obtained.



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Physician Benefit Rider (Optional)

Pays benefits for Physicians' services for treatment of Injury or Sickness if services are rendered in a physician's office, hospital, emergency or outpatient facility. The employer may elect a benefit that pays up to either \$15 or \$20 per visit. Depending on the per visit benefit maximum selected, benefits will not exceed either: (a) \$15 per visit up to the lesser cost of \$120 or 8 visits per family, per calendar year; or (b) \$20 per visit up to the lesser cost of \$240 or 12 visits per family, per calendar year. The Rider pays in addition to the base policy.



Note: Benefits for outpatient treatment performed in a physician's office may be payable under both the Outpatient Benefit Rider and Physician Benefit Rider. The intent of the Outpatient Benefit Rider is to cover treatment, supplies and other non-physician related outpatient charges, while the Physician Benefit Rider covers the physician's services (office visit).



Wellness Benefit Rider (Optional)

Pays benefits for routine health or check-up exams, and charges incurred in relation to the exams, and routine well-child visits. Wellness benefits include services performed at a laboratory or diagnostic testing facility. The maximum benefit amounts available are \$100, \$200 and \$500 per family, per calendar year.

NOTES:

The Employer Group will not be eligible if their underlying major medical or comprehensive medical plan contains separate and/or higher deductibles, coinsurance and/or co-pays for maternity.

- Groups with less than twenty-five (25) eligible employees must submit a copy of their most recent State Quarterly Wage or Unemployment Withholding Report with their group application to verify each employee's current status (full-time, part-time, terminated, etc.).

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CUSTOMER SERVICE

- Provided in English or Spanish for the insured’s convenience.
- Single, toll-free call-center number for all customer issues and benefits.
- Assisting insureds in locating and contacting new providers.
- Explanation of benefits, coverage, claims payment and claim history.
- Verification of coverage to providers.
- Addressing the provider’s expectations.



CUSTOMER SERVICE

OptiMed customer service is standing by to assist insureds with an explanation of benefits and coverage. The insured is walked through their benefit program, how it works and how to best maximize their benefit dollars. In addition, OptiMed customer service is also available to explain claim payment and claim history.

OPTIMED FEELS COMMUNICATION IS KEY

Effective communication is key in the successful rollout and implementation of any limited benefit plan. The purpose of offering a benefit program is to provide your employees a valuable benefit which will in return help boost retention rates. OptiMed feels we can bring our unique energy, superior service, attention to detail and experience at performing large scale enrollments to the table to best suit your needs.

OPTIMED OFFERS A FULL SUITE OF OPTIONS FOR CLIENTS TO CONSIDER

ENROLLMENT SUPPORT

- Customizable bilingual communication template pieces: letters, payroll stuffers, posters, enrollment kits.
- Telephonic both inbound and outbound options by trained enrollment specialists.
- Full online functionality in both HR and insured online tools:
 - HR Tools:** full suite of online HR tools permitting terms and adds, report generation, eligibility and bill review.
 - Insured Tools:** Insured online suite permits enrollment, plan design review, ID card request and printing of temporary ID cards, EOB and claims history review.
- Train-the-Trainers Support: Includes outbound telephonic management training sessions.

TELEPHONIC COMMUNICATION SUPPORT

- Toll-free number, bilingual benefits call center, customer services staffed by trained claim examiners.
- Benefit explanations available before and after enrollment.
- Benefit verification In-Bound and out-bound provider relations including: Access & benefit verification.
- Patient advocacy.



SIMPLE AND EASY PLAN ADMINISTRATION

OptiMed’s integrated seamless and simple approach to the administration process frees employers from major headaches associated with health plan administration.

- One dedicated account executive available by phone and email.
- One dedicated billing contact available by phone and email.
- “Train-the-Trainer” support for the employer’s managers & HR.
- Single source administration allows rapid support and issue resolution.
- Online HR administration tools and options allow immediate administration including adds/terms, report generation and a host of additional tools.
- Online insured tools allow plan design information review, provider searches, EOB & claim history review, ability to print temporary ID cards, online enrollment options and email support.
- Free dedicated website for each client, upon request.
- Automated data/file exchange options.
- Point-to-Point online billing and email billing options.
- Simple list billing or direct insured billing options
- High level direct access to Claims Manager, Manager of Administration and Chief Financial Officer via telephone and email should the client have the need.
- Free COBRA administration.



(Note: This is not an insurance benefit)

OPTIMED'S TELEPHONIC DOCTOR VISITS

OptiMed's Unlimited Telephonic Doctor Visits provides **on-demand, 24/7 phone and e-mail access to licensed physicians.** Individuals and families can consult immediately with our national network of U.S.-based, state-licensed doctors for common, non-emergent medical conditions.

OptiMed's Unlimited Telephonic Doctor Visits redefines traditional healthcare delivery by harnessing the power of digital telephony and the Internet. The result: Americans nationwide can now experience real-time, quality physician care 24/7.

OPTIMED UNLIMITED TELEPHONIC DOCTOR VISITS

- *On-demand physician care.
- Call or e-mail a doctor 24/7, without long waits at the doctor's office.
- Easy-to-use online health tools.
- Request prescription medication* or a refill.
- All physicians are U.S.-based, licensed and board certified.

OPTIMED UNLIMITED TELEPHONIC DOCTOR EMPLOYER

BENEFITS

- Lower employee absenteeism.
- Improve access to care.
- Enhance employee productivity.
- Augment your consumer-driven healthcare strategy.



HOW TO USE YOUR TELEPHONIC DOCTOR VISITS

1.	<p><u>On-Call Tele-Consult</u> <i>Talk to a doctor immediately</i> <i>On-demand consultation</i> <i>Receive medical advice</i></p>
2.	<p><u>By Priority Appointment Tele-Consult</u> <i>Set a time to talk to a doctor</i> <i>Comprehensive consultation</i> <i>Get prescription medication*</i> <i>Call back within an hour</i></p>
3.	<p><u>E-Consult</u> <i>E-mail a doctor about sensitive medical issues</i> <i>Secure, discreet, compliant</i> <i>Doctor response within 24 hours</i></p>

WHEN TO USE OPTIMED'S UNLIMITED TELEPHONIC DOCTOR VISITS

- Need information for non-emergent medical issues.
- After-hours or on weekends and holidays, when your primary care physician is unavailable.
- Require medical advice and care, without the inconvenience of time off work.
- Need prescription medication for a common malady or a refill*.
- While traveling or on-the-go.

OPTIMED UNLIMITED TELEPHONIC DOCTOR: INSUREDS

Entitles covered employees and their families to **unlimited** access to OptiMed's Unlimited Telephonic Doctor visits.

UNLIMITED CALLS & E-MAILS
There are no limits on usage!

OptiMed's Telephonic Doctor Visits
are provided by Consult-A-Doctor

(Note: The OptiMed Telephonic Doctor Visits is not an insurance benefit)

*There is no guarantee that you will be prescribed medication. Physicians do not prescribe controlled medications. This is not health insurance and does not replace your primary care physician. If you have an emergency please dial 911. All services are HIPAA-compliant.



Would you like to help your employees take advantage of a federal program that assists them in paying for affordable healthcare on a monthly basis?

Employers can do this by giving eligible employees the Advance Earned Income Tax Credit (AEITC) with their pay, and by subtracting the payments you make from payroll taxes. This is possible through the Advance Earned Income Tax Credit (AEITC) programs. This credit reduces the amount of tax owed by the taxpayer and can be used to pay for health insurance premiums on a monthly basis.

Eligible employees can receive part of their Advance Earned Income Tax Credit in their paychecks throughout the year, instead of waiting until they file their tax returns. To be eligible for this AEITC payment, an employee must have a qualifying child and expect to fall within certain income limits. OptiMed handles all aspects of this program, by working with the employee to complete required forms, and by assisting the employee in determining the amount of their monthly tax credit. The Employer’s payroll department then takes over.

The advance payment deduction is added to the employee’s net pay for the pay period and then re-directed to OptiMed for purposes of paying health insurance. Since the AEITC is not wages, you don’t withhold any Income Tax, Social Security, or Medicare taxes from the AEITC portion of the payment.

Generally, you make the advance payments from withheld income tax, employee & employer Social Security and Medicare taxes. However, the payment does not change the amount of employment taxes you would usually withhold from the employee’s pay. If the employee is entitled to an advance payment that is more than his or her withholding, you can still make a payment to the employee.

Report the payments made to your employees by showing the total payments on the AEITC line of your employment tax return, Form 941, Form 943, or Schedule H of Form 1040, whichever applies, and subtract this amount from your total employment taxes.

The IRS States “ Employers...are not required to determine if a completed and signed W-5 is correct.” Employees alone determine if they qualify for the AEITC. The employer has no role in making this determination.

Who is Qualified for AEITC?

To be eligible, the employees must have a qualifying child and earn **less** than the following amounts in the year:

Single Employees	Married Employees
\$35,340	\$38,460

How Much is the AEITC?

This depends on marital status and earnings, as set forth in the following table. As you can see, the AEITC becomes smaller as the employee’s earnings increase (figures are for tax year 2009).

Monthly Earnings	Single	Married
\$1,200	\$152.00	\$152.00
\$1,400	\$149.00	\$152.00
\$1,600	\$129.00	\$152.00
\$1,800	\$110.00	\$135.00
\$2,000	\$91.00	\$116.00
\$2,200	\$72.00	\$97.00
\$2,400	\$53.00	\$78.00

(Note: This is not an insurance benefit)



OPTIMed GAP PLANS DESIGNS

BENEFIT	PLAN 1	PLAN 2	PLAN 3	PLAN 4	PLAN 5	PLAN 6	PLAN 7	PLAN 8
INPATIENT BENEFIT (HOSPITAL/FACILITY) PER PERSON	\$500	\$750	\$1,000	\$1,250	\$1,500	\$1,750	\$2,000	\$2,500
OUTPATIENT BENEFIT (HOSPITAL/FACILITY) PER PERSON	\$250	\$250	\$500	\$500	\$750	\$750	\$1,000	\$1,250
PHYSICIAN OFFICE BENEFIT	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
WELLNESS BENEFIT	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

BENEFIT	PLAN 9	PLAN 10	PLAN 11	PLAN 12	PLAN 13	PLAN 14	PLAN 15	PLAN 16
INPATIENT BENEFIT (HOSPITAL/FACILITY) PER PERSON	\$3,000	\$3,500	\$4,000	\$5,000	\$6,000	\$7,000	\$8,000	\$10,000
OUTPATIENT BENEFIT (HOSPITAL/FACILITY) PER PERSON	\$1,500	\$1,750	\$2,000	\$2,500	\$2,500	\$2,500	\$2,500	\$2,500
PHYSICIAN OFFICE BENEFIT	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
WELLNESS BENEFIT	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

PHYSICIAN OFFICE VISIT (OPTIONAL)

UP TO \$15 COPAY PER VISIT
 8 VISITS CALENDAR YEAR MAXIMUM PER FAMILY
 UP TO A LESSER OF \$120

WELLNESS (OPTIONAL)

NOT AN INDEMNITY BENEFIT-PAYS OUT-OF-POCKET EXPENSES UP TO \$200 PER CALENDAR YEAR MAXIMUM (\$100 & \$500 ARE ALSO AVAILABLE)

GENERIC RX (OPTIONAL)

\$10 generic co-pay
 \$2,500 CALENDAR YEAR MAXIMUM PER PERSON
 \$5,000 FAMILY CALENDAR YEAR MAXIMUM

Additional Included OptiMed Programs - These are not insurance benefits

- Advance Earned Income Tax Credit
- Patient Advocacy Service
- Consult-A-Doctor
- Free Cobra Administration
- Free Section 125 Premium Only Plans (POP)

- Pays up to a selected maximum benefit per person per calendar year for hospital confinement due to an injury or sickness that begins after the Effective Date if the Insured Person’s Major Medical/Comprehensive Policy covers the expenses. Benefits are limited to the deductible, co-payment and coinsurance amounts the insured is required to pay under their Major Medical/Comprehensive Policy, subject to the provisions, limitations and exclusions of the policy.
- This product is not HSA (Health Savings Account) compatible.

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OPTIMED GAP PLANS REQUIREMENTS

1. Employer may choose a base plan on a voluntary basis, with no employer contribution. To offer a buy-up option the employer must pay 100% of the base plan.
2. Must be actively at work for at least 20 hours per week on the employee's effective date of coverage.
3. Must be covered under a major medical or comprehensive medical plan (this does not include any limited medical plan).
4. To qualify for benefits, an employee must be a W2'd employee of the employer. 1099 workers or contractors are not eligible.
5. Minimum group size is 5 eligible employees with a minimum of 5 enrolled.
6. If the insured Employee/Spouse's Major Medical/Comprehensive Policy covers Pregnancy, benefits will be payable for pregnancy.
7. Benefits are also payable for hospital emergency room treatment for a covered injury or sickness. Benefits for emergency room treatment due to sickness require that the sickness result in Hospital Confinement within 24 hours of the Hospital emergency room treatment.
8. This policy does not have a pre-existing condition limitation, however, a condition must be covered under the insured's major medical or comprehensive medical plan in order for benefits to be payable under this plan. Therefore, any pre-existing condition limitation applied to the major medical or comprehensive medical plan would, in effect, limit coverage under this plan.
9. Benefits from any other hospital indemnity insurance plan covering an eligible insured will be taken into consideration when paying benefits under this plan. Unless the total benefits are less than \$100, benefits may be reduced so the total benefits paid under all plans do not exceed the lesser of the total charges incurred or the elected benefit amount.
10. For participation purposes, only those employees who are covered under one of the employer's major medical or comprehensive medical plans will be considered eligible employees.
11. Expenses must be covered by the insured's comprehensive major medical plan to be covered under this product.
12. Uses primary medical plan's EOB (explanation of benefits) as a basis for determining what is covered.
13. Pregnancy is covered same as any other illness for insured employees and their insured spouses, but pregnancy (except for Complications of Pregnancy) is not covered for dependent children, unless required by state.

Rates are valid for only 31 days after issuance of quote. Rates are subject to change

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OPTIMED GAP PLANS EXCLUSIONS

1. Declared or undeclared war or any act thereof;
2. Suicide or intentionally self-inflicted Injury or any attempt thereat, while sane or insane (while sane, in Colorado and Missouri);
3. Any Hospital Confinement or other covered treatment for Injury or Sickness while an Insured Person is in the service of the armed forces of any country. Orders to active military service for training purposes of two months or less do not, for this exclusion, constitute service in the armed forces of any country. Upon notification to the Company of entering the armed forces of any country, the Company will return to the Insured pro rata premium paid, less any benefits which have been paid, for any period during which the Insured Person is in such service;
4. Confinement in a Hospital or other covered treatment provided in a facility operated by an agency of the United States government or one of its agencies, unless the Insured Person is legally required to pay for the services;
5. Confinement or other covered treatment for Injury or Sickness which is not Medically Necessary;
6. Confinement or other covered treatment for Dental or Vision not related to an accidental Injury;
7. Mental or nervous disorders;
8. Alcoholism, drug addiction or complications thereof;
9. Any Hospital Confinement or other covered treatment for Injury or Sickness for which compensation is payable under any Workers' Compensation Law, any Occupational Disease Law, the 4800 Time Benefit Plan or similar legislation;
10. Any Hospital Confinement or other covered treatment for Injury or Sickness that is payable under any insurance that does not require Deductible and/or Coinsurance payments by the Insured Person;
11. Any Hospital Confinement or other covered treatment for Injury or Sickness for which benefits are not payable under the Insured Person's Major Medical/Comprehensive Policy;
12. Any Hospital Confinement or other covered treatment for Injury or Sickness if, on the Insured Person's effective date of coverage, the Insured Person was not covered by a Major Medical/Comprehensive Policy, Our sole obligation will then be to refund all premiums paid for that Insured Person; and
13. An Insured Person engaging in any act or occupation, which is a violation of the law of the jurisdiction where the loss or cause occurred. A violation of the law includes both misdemeanor and felony violations.

Coverage will continue as long as the policy remains in force, the premiums are paid, and the insured remains eligible for coverage under the policy.

Not available in all states. Some provisions, benefits, exclusions or limitations may vary by state.

Underwritten by Fidelity Security Life Insurance Company; Policy Forms M-9054, R-02822, R-02798, R-02799; M-9031.

Disclosures:

Policy Form Numbers: M-9054; M-9031, R-02822; R-02798; R02799.

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Outpatient Prescription Drug Policy Exclusions and Limitations

Outpatient Prescription Drug benefits are not payable for the following items except as set forth in the rider:

- 1) all over-the counter products and medications unless shown under the definition of Prescription Drug. This includes, but is not limited to, electrolyte replacement, infant formulas, miscellaneous nutritional supplements and all other over-the-counter products and medications;
- 2) blood glucose meters and insulin injecting devices;
- 3) Depo-Provera, levonorgestral, condoms, contraceptive sponges, spermicides, sexual dysfunction drugs;
- 4) biologicals (including allergy tests), blood products, growth hormones, hemophiliac factors, MS injectables, immunizations, all other injectables unless shown under the definition of Prescription Drug;
- 5) Aerochamber, Aerochamber with Mask, Peak Flow Meter, all other medical supplies and durable medical equipment unless shown under the definition of Prescription Drug;
- 6) liquid nutritional supplement, pediatric Legend Drug vitamins, prenatal Legend Drug vitamins, prescribed versions of Vitamins A, D, K, B12, Folic Acid and Niacin – used in treatment versus as a dietary supplement, all other Legend Drug vitamins and nutritional supplements;
- 7) anorexiant; Any cosmetic drugs including, but not limited to, Renova, skin pigmentation preps, Any drugs or products used for the treatment of baldness, Topical dental fluorides;
- 8) refills in excess of that specified by the prescribing physician, or refills dispensed after one year from the original date of prescription;
- 9) all newly marketed pharmaceuticals or currently marketed pharmaceuticals with a new FDA approved indication for a period of one year from such FDA approval for its intended indication;
- 10) any drug labeled “Caution – limited by Federal Law for Investigational Use” or experimental drugs;
- 11) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment;
- 12) drugs needed due to conditions caused, directly or indirectly, by an Insured Person taking part in a riot or other civil disorder, or the Insured Person taking part in the commission of a felony;
- 13) drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war; or drugs dispensed to an Insured Person while on active duty in any armed forces;
- 14) any expenses related to the administration of any drug;
- 15) needles or syringes unless shown under the definition of Prescription Drug;
- 16) drugs or medicines taken while in or administered by a hospital or any other health care facility or office;
- 17) Drugs covered under Workers’ Compensation, Medicare, Medicaid or other governmental programs;
- 18) Drugs, medicines or products which are not Medically Necessary;
- 19) Brand Name Prescription Drugs (unless specifically provided for in the policy);
- 20) Diaphragms, Erectile dysfunction Legend Drugs, unless specifically listed in the definition of Prescription Drug, Infertility Legend Drugs;
- 21) Epi-Pen, Epi-Pen Jr., Ana-Kit, Ana-Guard, Glucagon-auto injection, Imitrex-auto injection;
- 22) Smoking deterrents, Legend or over-the-counter.

Limitation: Retail-the lesser of a 30-day supply or specified unit doses. Mail order not available.

Disclosures:

Policy Form Numbers: M-9054; M-9031, R-02822; R-02798; R02799.

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