APPENDIX E
HEALTH BENEFIT PLAN SUMMARIES

BENEFIT	OAP Plus	OAP Basic
Cost shares		
	In-Network services subject to copays Out-of-Network services subject to deductible and coinsurance; balance billing allowed $20 Office Visit Copay $75 Emergency Room Copay Deductible - $250/$750 Coinsurance - 80% $1,500/$4,500 OOP Max Lifetime Maximum In-Network - Unlimited Lifetime Maximum Out-Of-Network - Unlimited	In-Network services subject to copays $20 Office Visit Copay $75 Emergency Room Copay Lifetime Maximum In-Network - Unlimited
Preventive Care		
Pediatric	No Copay	No Copay
Adult	No Copay	No Copay
Vision	No Copay Covered once every 24 months	No Copay Covered once every 24 months
Hearing	No Copay Screening part of physical exam	No Copay Screening part of physical exam
Gynecological	No Copay	No Copay
Medical Services		
Medical Office Visit	$20 Copay	$20 Copay
Outpatient PT/OT/ST Chiro.	$20 Copay 60 Combined Days per calendar year per member	$20 Copay 60 Combined Days per calendar year per member
Allergy Services	$20 Copay for office visits and testing No copay for injections	$20 Copay for office visits and testing No copay for injections
Diagnostic Lab & X-ray	Covered	Covered
Inpatient Medical Services	Covered	Covered

APPENDIX E
HEALTH BENEFIT PLAN SUMMARIES (CONTINUED)

BENEFIT	OAP Plus	OAP Basic
Surgery Fees	Covered	Covered
Office Surgery	Covered	Covered
Outpatient MH/SA	$20 Copay	$20 Copay
Emergency Care		
Emergency Room	$75 Copay (waived if admitted) Sudden & Serious Guidelines	$75 Copay (waived if admitted) Sudden & Serious Guidelines
Urgent Care	$25 Copay	$25 Copay
Ambulance	Covered	Covered
Inpatient Hospital		
General/Medical/ Surgical/Maternity (Semi-private)	**Pre-cert only for Out-of-network** $200 Copay	$200 Copay
Ancillary Services Medication, supplies	Covered	Covered
Psychiatric	Unlimited days	Unlimited days
Substance Abuse/ Detox	Unlimited days	Unlimited days
Skilled Nursing/Rehabilitation Facility	Covered up to 180 days per calendar year	Covered up to 180 days per calendar year
Hospice	Covered	Covered
Outpatient Hospital		
Outpatient Surgery Facility Charges	$100 Copay (Prior Authorization Required)	$100 Copay (Prior Authorization Required)
Diagnostic Lab & X-ray	Covered	Covered
Pre-Admission Testing	Covered	Covered

APPENDIX E
HEALTH BENEFIT PLAN SUMMARIES (CONTINUED)

BENEFIT	OAP Plus	OAP Basic
Other Services		
Durable Medical Equipment	Covered	Covered
Prosthetics	Covered	Covered
Home Health Care	Unlimited days (Prior Authorization Required)	Unlimited days (Prior Authorization Required)
Express Scripts		
Prescriptions	$5/$20/$35 Unlimited maximum Three Tier Formulary RX Rider	$5/$20/$35 Unlimited maximum Three Tier Formulary RX Rider

*** All benefits listed are for In-Network. For Out-of-Network benefits, please refer to your Employee Benefit Summary. OAP Basic plan has no Out-of-Network benefit.**

**** All plans are Non-Gatekeeper. No referrals are required. No primary care physician is required.**

STATE MANDATES: Are excluded from the OAP Plus plan but are included in the OAP Basic plan.

INFERTILITY: Coverage excludes GIFT, ZIFT and is subject to a $5,000 lifetime maximum for OAP Plus and OAP Basic plans.

ELIGIBILITY: Dependent children to age 26 for ALL plans.