**Costshares**

- In-Network services subject to copays and coinsurance, balance billing allowed.
- Out-of-Network services subject to deductible.
- $10 Office Visit Copay Effective 7/1/2016
- $15 Office Visit Copay Effective 7/1/2017
- $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

**Preventive Care**

- **Pediatric**
  - No Copay
  - No Copay

- **Adult**
  - No Copay
  - No Copay

- **Vision**
  - No Copay
  - Covered once every 24 months
  - Covered once every 24 months

- **Hearing**
  - No Copay
  - Screening part of physical exam
  - Screening part of physical exam

- **Gynecological**
  - No Copay
  - No Copay

**Medical Services**

- **Medical Office Visit**
  - Copay based on date of service
  - Copay based on date of service

- **Outpatient PT/OT/ST/Chiro.**
  - Copay based on date of service
  - Copay based on date of service
  - 60 Combined Days
  - 60 Combined Days
  - per calendar year per member
  - per calendar year per member

- **Allergy Services**
  - Copay based on date of service for office visits and testing
  - No copay for injections
  - Copay based on date of service for office visits and testing
  - No copay for injections

- **Diagnostic Lab & X-ray**
  - Covered
  - Covered

- **Inpatient Medical Services**
  - Covered
  - Covered

- **Surgery Fees**
  - Covered
  - Covered

- **Office Surgery**
  - Covered
  - Covered

- **Outpatient MH/SA**
  - Copay based on date of service
  - Copay based on date of service

**Emergency Care**

- **Emergency Room**
  - $75 Copay (waived if admitted)
  - $75 Copay (waived if admitted)

- **Urgent Care**
  - $25 Copay
  - $25 Copay

- **Ambulance**
  - Covered
  - Covered
<table>
<thead>
<tr>
<th>Benefit</th>
<th>OAP Plus</th>
<th>OAP Basic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Hospital</td>
<td></td>
<td></td>
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<tr>
<td>General/Medical/Surgical</td>
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<tr>
<td>Maternity (Semiprivate)</td>
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<tr>
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<td>$200 Copay Effective 7/1/2017</td>
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<tr>
<td>Ancillary Services</td>
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<tr>
<td>Medication, Supplies</td>
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<tr>
<td>Psychiatric</td>
<td>Unlimited days</td>
<td>Unlimited days</td>
</tr>
<tr>
<td>Substance Abuse/Detox</td>
<td>Unlimited days</td>
<td>Unlimited days</td>
</tr>
<tr>
<td>Skilled Nursing/Rehabilitation Facility</td>
<td>Covered up to 180 days per calendar year</td>
<td>Covered up to 180 days per calendar year</td>
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<tr>
<td>Hospital</td>
<td>Covered</td>
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<tr>
<td>Outpatient Hospital</td>
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<tr>
<td>Outpatient Surgery</td>
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<tr>
<td>Facility Charges</td>
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<td>$50 Copay Effective 7/1/2016</td>
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<td></td>
<td>$100 Copay Effective 7/1/2017</td>
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<td>(Prior Authorization Required)</td>
<td>(Prior Authorization Required)</td>
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<tr>
<td>Diagnostic Lab &amp; X-ray</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Pre-Admission Testing</td>
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<tr>
<td>Other Services</td>
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<tr>
<td>Durable Medical Equipment</td>
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<tr>
<td>Prosthetics</td>
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<tr>
<td>Home Health Care</td>
<td>Unlimited days</td>
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<td>Prescriptions</td>
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<td>Three Tier Formulary RX Rider</td>
<td>Three Tier Formulary RX Rider</td>
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</tbody>
</table>

* 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.