BENEFIT	OAP Plus	OAP Basic
Costshares		
	In-Network services subject to copays	In-Network services subject to copays
	Out-of-Network services subject to deductible	OAP Basic plan has no Out-of -Network benefit
	and coinsurance; balance billing allowed	
	$15 Office Visit Copay	$15 Office Visit Copay
	$75 Emergency Room Copay	$75 Emergency Room Copay
	Deductible - $250/$750	
	Coinsurance - 80%	
	$1,500/$4,500 OOP Max	
	Lifetime Maximum In-Network - Unlimited	Lifetime Maximum In-Network - Unlimited
	Lifetime Maximum Out-Of-Network - Unlimited	
	OAP Plus not available after June 30, 2021	
Preventive Care		
Pediatric	No Copay	No Copay
Adult	No Copay	No Copay
Vision	No Copay	No Copay
	Covered once every 24 months	Covered once every 24 months
Hearing	No Copay	No Copay
	Screening part of physical exam	Screening part of physical exam
Gynecological	No Copay	No Copay
Medical Services		
Medical Office Visit	Copay	Copay
Outpatient PT/OT/ST/Chiro.	Copay	Copay
	60 Combined Days	60 Combined Days
	per calendar year per member	per calendar year per member
Allergy Services	office visits and testing; Copay	office visits and testing; Copay
	No copay for injections	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)
	Sudden & Serious Guidelines	Sudden & Serious Guidelines
Urgent Care	$25 Copay	$25 Copay
Ambulance	Covered	Covered

BENEFIT	OAP Plus	OAP Basic
Inpatient Hospital		
General/Medical/Surgical/	**Pre-certification required**	
Maternity (Semi-private)		
	$200 Copay Effective 7/1/2017	$200 Copay Effective 7/1/2017
Ancillary Services	Covered	Covered
Medication, Supplies		
Psychiatric	Unlimited days	Unlimited days
Substance Abuse/Detox	Unlimited days	Unlimited days
Skilled Nursing/Rehabilitation	Covered up to 180 days per calendar year	Covered up to 180 days per calendar year
Facility		
Hospice	Covered	Covered
Outpatient Hospital		
Outpatient Surgery		
Facility Charges	$100 Copay	$100 Copay
	(Prior Authorization Required)	(Prior Authorization Required)
Diagnostic Lab & X-ray	Covered	Covered
Pre-Admission Testing	Covered	Covered
Other Services		
Durable Medical Equipment	Covered	Covered
Prosthetics	Covered	Covered
Home Health Care	Unlimited days	Unlimited days
	(Prior Authorization Required)	(Prior Authorization Required)
Pharmacy Benefits		
Prescriptions	$5/$20/$35	$5/$20/$35
	Unlimited maximum	Unlimited maximum
	Three Tier Formulary RX Rider	Three Tier Formulary RX Rider
All Benefits listed are for In-Network. For Out-of-Network benefits, please refer to your Employee Benefit Summary.		
INFERTILITY: Coverage is subject to a $5,000 lifetime maximum for the OAP Plus and OAP Basic plans.		
ELIGIBILITY: Dependent children covered to age 26 for medical and prescription plans.		