MEDICAL SCHEDULE OF BENEFITS – OAP7 (NG5)

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
PLAN YEAR MAXIMUM BENEFIT	Unlimited	
PLAN/Calendar YEAR DEDUCTIBLE		
Single	$1,000	$2,000
Family	$2,000	$4,000
PLAN/Calendar YEAR OUT-OF-POCKET MAXIMUM (includes Deductible, Coinsurance and Copays – combined with Prescription Drug Card))		
Single	$3,000	$6,000
Family	$6,000	$12,000
MEDICAL BENEFITS		
Acupuncture	$40 Copay, then 100%; Deductible waived	60%, after Deductible
Allergy Services (all)	PCP: $20 Copay, then 100%; Deductible waived Specialist: $40 Copay, then 100%; Deductible waived	60%, after Deductible
Ambulance Services	80%, after Deductible	60%, after Deductible
Chiropractic Care/Spinal Manipulation	$40 Copay, then 100%; Deductible waived	60%, after Deductible
Plan/Calendar Year Maximum Benefit	20 visits	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	80%, after Deductible	60%, after Deductible
Durable Medical Equipment (DME)	80%, after Deductible	60%, after Deductible
Emergency Services – Emergency Medical Condition	$150 Copay, then Deductible, then 100%	Paid at the Participating Provider level of benefits.
Emergency Room – Non-Emergency Medical Condition	Not Covered	Not Covered
NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.		
Home Health Care	80%, after Deductible	60%, after Deductible
Plan/Calendar Year Maximum Benefit	90 visits	
Hospice Care	80%, after Deductible	60%, after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	80%, after Deductible	60%, after Deductible
Room and Board Allowance*	Semi-Private Room rate*	Semi-Private Room rate*
Intensive Care Unit	80%, after Deductible	60%, after Deductible
Miscellaneous Services & Supplies	80%, after Deductible	60%, after Deductible
Outpatient	80%, after Deductible	60%, after Deductible
• A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		

Infertility	Same as any other illness	Same as any other illness
Lifetime Maximum Benefit	$15,000	
Massage Therapy	$40 Copay, then 100%; Deductible waived	60%, after Deductible
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	60%, after Deductible
Lactation Consultations	100%; Deductible waived	100%; Deductible waived
All Other Prenatal and Postnatal Care	100%; Deductible waived	60%, after Deductible
Delivery	80%, after Deductible	60%, after Deductible
Mental Disorders and Substance Use Disorders		
Inpatient	80%, after Deductible	60%, after Deductible
Outpatient	$20 Copay, then 100%; Deductible waived	60%, after Deductible
NOTE: Emergency care (ambulance and Emergency Services) will be paid the same as the benefit for ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Outpatient Therapies (e.g. physical, speech, occupational)	$40 Copay, then 100%; Deductible waived	60%, after Deductible
Combined Plan/Calendar Year Maximum Benefit	60 visits	
Physician's Services		
Inpatient/Outpatient Services	80%, after Deductible	60%, after Deductible
Office Visits:		
Primary Care Physician	$20 Copay*, then 100%; Deductible waived	60%, after Deductible
Specialist	$40 Copay*, then 100%; Deductible waived	60%, after Deductible
Physician Office Surgery:		
Primary Care Physician	$20 Copay*, then 100%; Deductible waived	60%, after Deductible
Specialist	$40 Copay*, then 100%; Deductible waived	60%, after Deductible
*Copay applies per visit regardless of what services are rendered.		
Preventive Services and Routine Care (includes the office visit and any other eligible item or service rendered at the same time as the preventive service or routine care, whether billed at the same time or separately)	100%; Deductible waived	60%, after Deductible
Routine Eye Examination	100%; Deductible waived	60%, after Deductible
Maximum Benefit Per 24-Month Period	1 exam	
Skilled Nursing Facility and Rehabilitation Facility	80%, after Deductible	60%, after Deductible
Combined Plan/Calendar Year Maximum Benefit	90 days	
Transplants	80%, after Deductible (Aetna IOE Program)*	60%, after Deductible

Urgent Care Facility	$50 Copay*, then 100%; Deductible waived	$50 Copay*, then 100%; Deductible waived
*Copay applies per visit regardless of what services are rendered.		
All Other Eligible Medical Expenses	80%, after Deductible	60%, after Deductible

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Calendar Year Out-of-Pocket Maximum (includes Copays – combined with major medical Out-of-Pocket Maximum)		
Single Family	$3,000 $6,000	$6,000 $12,000
Retail Pharmacy: 30-day		
Generic Drug	$10 Copay, then 100%	60%
Formulary Drug	$40 Copay, then 100%	60%
Non-Formulary Drug	$60 Copay, then 100%	60%
Preventive	100%	100%
Mail Order Pharmacy: 90-day supply		
Generic Drug	$25 Copay, then 100%	Not Covered
Formulary Drug	$100 Copay, then 100%	Not Covered
Non-Formulary Drug	$150 Copay, then 100%	Not Covered
Preventive	100%	Not Covered