## MEDICAL SCHEDULE OF BENEFITS – OAP4 (NG3)

	PARTICIPATING PROVIDERS	NON-PARTICIPATING		
	7,11,176.17,111,167,182,18	PROVIDERS (Subject to Usual		
		and Customary Charges)		
LIFETIME MAXIMUM BENEFIT	Unlimited			
PLAN YEAR MAXIMUM BENEFIT	Unlin	nited		
PLAN/Calendar YEAR DEDUCTIBLE				
Single	\$500	\$1,000		
Family	\$1,000	\$2,000		
PLAN/Calendar YEAR OUT-OF-POCKET MAXIMUM				
(includes Deductible, Coinsurance and				
Copays – combined with Prescription Drug				
Card))				
Single	\$2,000	\$4,000		
Family	\$4,000	\$8,000		
MEDICAL BENEFITS				
Acupuncture	\$40 Copay, then 100%;	70%, after Deductible		
	Deductible waived			
Allergy Services (all)	PCP: \$20 Copay, then 100%;			
	Deductible waived	70%, after Deductible		
	Specialist: \$40 Copay, then			
	100%; Deductible waived			
Ambulance Services	90%, after Deductible	70%, after Deductible		
Chiropractic Care/Spinal Manipulation	\$40 Copay, then 100%;	70%, after Deductible		
Dlay/Calanday Vasy Maximaya Dayafit	Deductible waived			
Plan/Calendar Year Maximum Benefit	20 visits			
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	90%, after Deductible	70%, after Deductible		
Durable Medical Equipment (DME)	90%, after Deductible	70%, after Deductible		
Emergency Services – Emergency Medical	\$150 Copay, then Deductible,	Paid at the Participating		
Condition	then 100%	Provider level of benefits.		
Emergency Room – Non-Emergency	Not Covered	Not Covered		
Medical Condition	1101 0010104	.vot Govered		
NOTE: The Copay will be waived if the person	is admitted directly as an Inpati	ent to the Hospital.		
Home Health Care	90%, after Deductible	70%, after Deductible		
Plan/Calendar Year Maximum Benefit		visits		
Hospice Care	90%, after Deductible	70%, after Deductible		
Hospital Expenses or Long-Term Acute Care				
Facility/Hospital (facility charges)				
Inpatient	90%, after Deductible	70%, after Deductible		
Room and Board Allowance*	Semi-Private Room rate*	Semi-Private Room rate*		
Intensive Care Unit	90%, after Deductible	70%, after Deductible		
Miscellaneous Services & Supplies	90%, after Deductible	70%, after Deductible		
Outpatient	90%, after Deductible	70%, after Deductible		
A private room will be considered elig	ible when Medically Necessary.	Charges made by a Hospital		
having only single or private rooms w				

private room.

Lifetime Maximum Benefit \$40 Copay, then 100%; Deductible Massage Therapy \$40 Copay, then 100%; Deductible Massage Therapy Preventive Prenatal and Breastfeeding Support (other than lactation consultations)  Lactation Consultations 100%; Deductible waived All Other Prenatal and Postnatal Care 100%; Deductible waived 70%, after Deductible Delivery 90%, after Deductible Waived 70%, after Deductible Delivery 90%, after Deductible Mental Disorders and Substance Use Disorders  Inpatient 90%, after Deductible 70%, after Deductible Outpatient \$20 Copay, then 100%; Deductible waived 70%, after Deductible Deductible Waived 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 Plan/Calendar Year Maximum Benefit Physician's Services  Inpatient/Outpatient Services 90%, after Deductible Waived Physician's Services  Inpatient/Outpatient Services 90%, after Deductible 70%, after Deductible Office Visits:  Primary Care Physician Services 90%, after Deductible 70%, after Deductible Deductible waived Specialist \$40 Copay', then 100%; Deductible waived \$40	Infertility	Same as any other illness	Same as any other illness
Massage Therapy			
Deductible waived	Massage Therapy		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)  Lactation Consultations  All Other Prenatal and Postnatal Care Delivery 90%, after Deductible waived 70%, after Deductible Mental Disorders and Substance Use Disorders  Inpatient 90%, after Deductible 70%, after Deductible Outpatient 90%, after Deductible waived Postnatal Care Delivery 90%, after Deductible Wester Disorders  Inpatient 90%, after Deductible 70%, after Deductible Outpatient 90%, after Deductible waived Post Disorders and Substance Use Disorders  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 \$40 Copay, then 100%; Deductible waived Physician's Services  Inpatient/Outpatient Services 90%, after Deductible Waived 70%, after Deductible Office Visits:  Primary Care Physician \$20 Copay*, then 100%; Deductible waived \$40 Copay*,		• • •	,
Support (other than lactation consultations)  Lactation Consultations)  All Other Prenatal and Postnatal Care Delivery  Mental Disorders and Substance Use Disorders  Inpatient  Outpatient  S20 Copay, then 100%; Deductible waived  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.  Combined Plan/Calendar Year Maximum Benefit  Physician's Services  Inpatient/Outpatient Services  Office Visits: Primary Care Physician  Physician Office Surgery: Primary Care Physician  Physician Office Surgery: Primary Care Physician  S20 Copay*, then 100%; Deductible waived  Physician Office Surgery: Primary Care Physician  S20 Copay*, then 100%; Deductible waived  Physician Office Surgery: Primary Care Physician  S20 Copay*, then 100%; Deductible waived  \$20 Copay*, then 100%; Deductible waived  \$40	Maternity (Professional Fees)*		
Lactation Consultations Lactation Consultations All Other Prenatal and Postnatal Care Delivery  Mental Disorders and Substance Use Disorders Inpatient Outpatient  Outpatient  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)  Combined Plan/Calendar Year Maximum Benefit  Primary Care Physician Specialist Spe	Preventive Prenatal and Breastfeeding	100%; Deductible waived	70%, after Deductible
Lactation Consultations All Other Prenatal and Postnatal Care Delivery 90%, after Deductible waived 70%, after Deductible Delivery 90%, after Deductible 70%, after Deductible Mental Disorders and Substance Use Disorders Inpatient 90%, after Deductible Outpatient Substance Green (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) Combined Plan/Calendar Year Maximum Benefit Physician's Services Inpatient/Outpatient Services Inpatient/Outpatient Services Inpatient/Outpatient Services Specialist Specialist Substance Specialist S	Support (other than lactation		
All Other Prenatal and Postnatal Care Delivery D	consultations)		
Delivery  Mental Disorders and Substance Use Disorders  Inpatient  Outpatient  Outpatient  NOTE: Emergency care (ambulance 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.  Combined Plan/Calendar Year Maximum Benefit  Physician's Services  Inpatient/Outpatient Services   90%, after Deductible waived   70%, after Deductible    S40 Copay, then 100%; peductible valved   70%, after Deductible    Formany Care Physician   520 Copay*, then 100%; peductible waived   70%, after Deductible    Office Visits: Primary Care Physician   520 Copay*, then 100%; peductible waived   70%, after Deductible    Physician Office Surgery: Primary Care Physician   520 Copay*, then 100%; peductible waived   70%, after Deductible    Physician Office Surgery: Primary Care Physician   520 Copay*, then 100%; peductible waived   70%, after Deductible    Physician Office Surgery: Primary Care Physician   520 Copay*, then 100%; peductible waived   70%, after Deductible    Physician Office Surgery: Primary Care Physician   520 Copay*, then 100%; peductible waived   70%, after Deductible    Physician Office Surgery: 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)  Routine Eye Examination   100%; Deductible waived   70%, after Deductible    Maximum Benefit Per 24-Month Period   1 exam    Skilled Nursing Facility and Rehabilitation   90%, after Deductible   70%, after Dedu	Lactation Consultations	100%; Deductible waived	100%; Deductible waived
Mental Disorders and Substance Use Disorders   100%; Inpatient   100%; Deductible   100	All Other Prenatal and Postnatal Care	100%; Deductible waived	70%, after Deductible
Inpatient 90%, after Deductible 70%, after Deductible Outpatient \$20 Copay, then 100%; Deductible waived 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) Deductible waived Deductible waived  Combined Plan/Calendar Year Maximum Benefit Per Vater Services 90%, after Deductible 70%, after Deductible Office Visits:  Physician's Services Deductible Waived Primary Care Physician Specialist Speci	Delivery	90%, after Deductible	70%, after Deductible
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Outpatient    \$20 Copay, then 100%; Deductible waived	Disorders		
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  Combined Plan/Calendar Year Maximum Benefit  Physician's Services	Inpatient	90%, after Deductible	70%, 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)  Combined Plan/Calendar Year Maximum Benefit  Physician's Services Inpatient/Outpatient Services  Inpatient/Outpatient Services  Primary Care Physician Specialist Special	Outpatient	\$20 Copay, then 100%;	70%, after Deductible
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) S40 Copay, then 100%; Deductible waived  Combined Plan/Calendar Year Maximum Benefit  Physician's Services Inpatient/Outpatient Services 90%, after Deductible 70%, after Deductible Office Visits: Primary Care Physician Specialist Specialist S40 Copay*, then 100%; Deductible waived Specialist Specialist S40 Copay*, then 100%; Deductible waived Specialist Specialist S40 Copay*, then 100%; Deductible waived Specialist S40 Copay*, then 100%; Deductible waived Specialist S40 Copay*, then 100%; Deductible waived S40 Copay*, then 100%; Deductible waived Specialist S40 Copay*, then 100%; Deductible waived S40 Copay*, after Deductible S40 Copay*, then 100%; Deductible waived S40 Copay*, after Deductible S40 Copay*, then 100%; Deductible waived S40 Copay*, after Deductible S40 Copay*, after Deductib			
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Combined Plan/Calendar Year Maximum Benefit			1
Combined Plan/Calendar Year Maximum Benefit  Physician's Services Inpatient/Outpatient Services Office Visits: Primary Care Physician Specialist Specialist Physician Office Surgery: Primary Care Physician Physician Office Surgery: Primary Care Physician Specialist	1 .	• • •	70%, after Deductible
Benefit     Physician's Services       Inpatient/Outpatient Services     90%, after Deductible     70%, after Deductible       Office Visits:     \$20 Copay*, then 100%; Deductible waived     70%, after Deductible       Specialist     \$40 Copay*, then 100%; Deductible waived     70%, after Deductible       Physician Office Surgery:     \$20 Copay*, then 100%; Deductible waived     70%, after Deductible       Primary Care Physician     \$20 Copay*, then 100%; Deductible waived     70%, after Deductible       *Specialist     \$40 Copay*, then 100%; Deductible waived     70%, after Deductible       **Copay applies per visit regardless of what services are rendered.     **Tomation office visit and any other     **Tomation 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     70%, after Deductible       Routine Eye Examination     100%; Deductible waived     70%, after Deductible       Skilled Nursing Facility and Rehabilitation Facility     90%, after Deductible     70%, after Deductible       Combined Plan/Calendar Year Maximum Benefit     90%, after Deductible     70%, after Deductible	(e.g. physical, speech, occupational)	Deductible waived	
Benefit     Physician's Services       Inpatient/Outpatient Services     90%, after Deductible     70%, after Deductible       Office Visits:     \$20 Copay*, then 100%; Deductible waived     70%, after Deductible       Specialist     \$40 Copay*, then 100%; Deductible waived     70%, after Deductible       Physician Office Surgery:     \$20 Copay*, then 100%; Deductible waived     70%, after Deductible       Primary Care Physician     \$20 Copay*, then 100%; Deductible waived     70%, after Deductible       *Specialist     \$40 Copay*, then 100%; Deductible waived     70%, after Deductible       **Copay applies per visit regardless of what services are rendered.     **Tomation office visit and any other     **Tomation 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     70%, after Deductible       Routine Eye Examination     100%; Deductible waived     70%, after Deductible       Skilled Nursing Facility and Rehabilitation Facility     90%, after Deductible     70%, after Deductible       Combined Plan/Calendar Year Maximum Benefit     90%, after Deductible     70%, after Deductible			
Physician's Services   90%, after Deductible   70%, after Deductible		60 vi	isits
Inpatient/Outpatient Services  Office Visits: Primary Care Physician  Specialist  Physician Office Surgery: Primary Care Physician  Physician Office Surgery: Primary Care Physician  Specialist  Primary Care Physician  Specialist  Physician Office Surgery: Primary Care Physician  Specialist  Sp			I
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Physician Office Surgery: Primary Care Physician Specialist Specia	Specialist	• • •	70%, after Deductible
Primary Care Physician  \$20 Copay*, then 100%; Deductible waived \$40 Copay*, then 100%; Deductible waived  *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)  Routine Eye Examination  Maximum Benefit Per 24-Month Period  Skilled Nursing Facility and Rehabilitation Facility  Combined Plan/Calendar Year Maximum Benefit  \$20 Copay*, then 100%; Deductible waived  100%; Deductible waived  70%, after Deductible  70%, after Deductible  70%, after Deductible  70%, after Deductible	Physician Office Company	Deductible walved	
Specialist  Specialist  Peductible waived \$40 Copay*, then 100%; Deductible waived  *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)  Routine Eye Examination  Maximum Benefit Per 24-Month Period  Skilled Nursing Facility and Rehabilitation Facility  Combined Plan/Calendar Year Maximum Benefit  Deductible waived  70%, after Deductible  70%, after Deductible  70%, after Deductible  70%, after Deductible  90%, after Deductible  900 days		\$20 Canay* than 100%	700/ ofter Deductible
*Copay applies per visit regardless of what services are rendered.  *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)  Routine Eye Examination 100%; Deductible waived 70%, after Deductible  Maximum Benefit Per 24-Month Period 1 exam  Skilled Nursing Facility and Rehabilitation Facility 90%, after Deductible 70%, after Deductible  Ombined Plan/Calendar Year Maximum 800 days  Benefit	Primary Care Physician		70%, 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)  Routine Eye Examination  Maximum Benefit Per 24-Month Period  Skilled Nursing Facility and Rehabilitation Facility  Combined Plan/Calendar Year Maximum Benefit	Specialist		70% 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)  Routine Eye Examination  Maximum Benefit Per 24-Month Period  Skilled Nursing Facility and Rehabilitation Facility  Combined Plan/Calendar Year Maximum  Benefit  **Copay applies per visit regardless of what services are rendered.  70%, after Deductible	Specialist		70%, after Deductible
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)  Routine Eye Examination  Maximum Benefit Per 24-Month Period  Skilled Nursing Facility and Rehabilitation Facility  Combined Plan/Calendar Year Maximum Benefit  100%; Deductible waived 70%, after Deductible 70%, after Deductible 70%, after Deductible 70%, after Deductible	*Conay applies per visit regardless of what ser		
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eligible item or service rendered at the same time as the preventive service or routine care, whether billed at the same time or separately)  Routine Eye Examination  Maximum Benefit Per 24-Month Period  Skilled Nursing Facility and Rehabilitation Facility  Combined Plan/Calendar Year Maximum Benefit		10070, Deductible Walved	7070, arter beddetible
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Routine Eye Examination  Maximum Benefit Per 24-Month Period  Skilled Nursing Facility and Rehabilitation Facility  Combined Plan/Calendar Year Maximum Benefit			
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Facility Combined Plan/Calendar Year Maximum Benefit 90 days			1
Combined Plan/Calendar Year Maximum 90 days Benefit			
Benefit	-	90 d	ays
Transplants90%, after Deductible70%, after Deductible			
	Transplants	90%, after Deductible	70%, after Deductible

	(Aetna IOE Program)*	
Urgent Care Facility	\$50 Copay*, then 100%;	\$50 Copay*, then 100%;
	Deductible waived	Deductible waived
*Copay applies per visit regardless of what services are rendered.		
All Other Eligible Medical Expenses	90%, after Deductible	70%, 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	\$2,000	\$4,000
Family	\$4,000	\$8,000
Retail Pharmacy: 30-day		
Generic Drug	\$10 Copay, then 100%	70%
Formulary Drug	\$40 Copay, then 100%	70%
Non-Formulary Drug	\$60 Copay, then 100%	70%
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