

PPO Copay Plans
Plan Design and Benefits



For Member Firms of the
Oklahoma Bar Association
and
Oklahoma Society of CPAs

	PPO 500		PPO 1000		PPO 2500	
Member Benefits	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible						
Individual	\$500		\$1,000		\$2,500	
Family	\$1,000		\$2,000		\$5,000	
	Once Family Deductible has been met all covered family members will be considered to have met deductibles for the remainder of the calendar year.					
Coinsurance - percentage paid by carrier after deductible	80%	60%	80%	60%	80%	60%
	Applies to all expenses unless otherwise stated once deductible has been met and until out-of-pocket maximum has been met.					
Out of Pocket Maximum						
Individual	\$1,000	\$2,000	\$1,500	\$2,000	\$2,500	\$5,000
Family	\$2,000	\$4,000	\$3,000	\$4,000	\$5,000	\$10,000
	Does not include deductible, copays, penalties, or non-covered expenses.					
Lifetime Maximum	\$5,000,000 (per member lifetime)		\$5,000,000 (per member lifetime)		\$5,000,000 (per member lifetime)	
Certification Requirements	Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$500 per occurrence.					
Preventive Care						
Routine Adult Physical Exams	\$25 Office visit copay	60%	\$25 Office visit copay	60%	\$25 Office visit copay	60%
	1 exam every 12 mos age 65+; 1 exam every 24 mos under age 65					
Routine Well Child Exams	\$25 Office visit copay	60%	\$25 Office visit copay	60%	\$25 Office visit copay	60%
	7 exams in the first 12 months of life, 2 exams in the 13th -24th months of life, 1 exam every 12 months thereafter to age 18.					
Child Immunizations birth to age 18	100% Deductible Waived		100% Deductible Waived		100% Deductible Waived	
Routine Gynecological Care Exams	\$25 Office visit copay	60%	\$25 Office visit copay	60%	\$25 Office visit copay	60%
	1 exam every 12 months. (Includes Pap smear and related lab fees)					
Routine Mammograms	100% Deductible Waived		100% Deductible Waived		100% Deductible Waived	
	1 baseline for females ages 35-39, 1 mammogram every 12 months for females 40 and over.					
Routine Digital Rectal Exam / Prostate-Specific Antigen Test	\$25 Office visit copay	60%	\$25 Office visit copay	60%	\$25 Office visit copay	60%
	1 exam every 12 months for covered males age 40 and over.					
Routine Colorectal Cancer Screening	80% Deductible Waived	60%	80% Deductible Waived	60%	80% Deductible Waived	60%
	Members age 50 and over.					
Routine Eye Exams 1 every 24 Months	\$25 Office visit copay	60%	\$25 Office visit copay	60%	\$25 Office visit copay	60%
Routine Hearing Exams 1 every 24 Months	\$25 Office visit copay	60%	\$25 Office visit copay	60%	\$25 Office visit copay	60%
Physician Services						
Office Visits to: Internist, General Physician, Family Practitioner or Pediatrician	\$25 Office visit copay	60%	\$25 Office visit copay	60%	\$25 Office visit copay	60%
Office Visits to Specialist (Non Surgical)	\$25 Office visit copay	60%	\$25 Office visit copay	60%	\$25 Office visit copay	60%
Office Visits to Specialist (Surgical)	80%	60%	80%	60%	80%	60%
Allergy Testing	\$25 Office visit copay	60%	\$25 Office visit copay	60%	\$25 Office visit copay	60%
Allergy Injections	80%	60%	80%	60%	80%	60%
Diagnostic Procedures						
Diagnostic Laboratory and X-Ray	\$25 Office visit copay*	60%	\$25 Office visit copay*	60%	\$25 Office visit copay*	60%
	* If performed as a part of a physician office visit and billed by the physician.					
Emergency Care						
Urgent Care Provider	80%	60%	80%	60%	80%	60%
Non-Urgent Use of Urgent Care Provider	Not Covered		Not Covered		Not Covered	
Emergency Room	80%	80%	80%	80%	80%	80%
Non-Emergency Care in Emergency Room	Not Covered		Not Covered		Not Covered	
Ambulance	80%	60%	80%	60%	80%	60%

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Hospital Care	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Inpatient Coverage	80%	60%	80%	60%	80%	60%
Outpatient Hospital Expenses	80%	60%	80%	60%	80%	60%
Mental Health						
Inpatient	80%	60%	80%	60%	80%	60%
Outpatient	\$25 copay	60%	\$25 copay	60%	\$25 copay	60%
Alcohol/Drug Abuse Lifetime Maximum \$50,000						
Inpatient	80%	60%	80%	60%	80%	60%
Limited to 30 days per calendar year.						
Outpatient	\$25 copay	60%	\$25 copay	60%	\$25 copay	60%
Limited to 40 visits per calendar year.						
Other Services						
Maternity	80%	60%	80%	60%	80%	60%
Convalescent Facility	80%	60%	80%	60%	80%	60%
Limited to 100 days per calendar year.						
Home Health Care	80%	60%	80%	60%	80%	60%
Unlimited Visits	Each visit by nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.					
Hospice Care-Inpatient	Covered 100%		Covered 100%		Covered 100%	
Unlimited Visits						
Hospice Care-Outpatient	Covered 100%		Covered 100%		Covered 100%	
Unlimited Visits						
Transplants	80%	60%	80%	60%	80%	60%
In-Network benefits apply only if procedure is performed at an Institute of Excellence (IOE) facility.						
Private Duty Nursing	80%	60%	80%	60%	80%	60%
Limited to 70 eight-hour shifts per calendar year.						
Outpatient Speech, Physical and Occupational Therapy	80%	60%	80%	60%	80%	60%
Limited to 60 visits per calendar year.						
Spinal Manipulation Therapy	\$25 copay	60%	\$25 copay	60%	\$25 copay	60%
Durable Medical Equipment	80%	60%	80%	60%	80%	60%
Maximum annual benefit of \$10,000 per member per calendar year.						
Diabetic Supplies	Covered same as any other medical expense if not covered under Pharmacy benefit.					
Infertility Treatment	Member cost sharing is based on type of service performed and place rendered.					
Voluntary Sterilization	Member cost sharing is based on type of service performed and place rendered.					
Contraceptive Drugs and Devices not obtainable at a pharmacy	80%	60%	80%	60%	80%	60%
Includes coverage for contraceptive visits.						
Pharmacy Benefits						
Retail						
Generic Up to a 30 day supply	\$5 copay	60% after \$5 copay	\$5 copay	60% after \$5 copay	\$5 copay	60% after \$5 copay
Brand Name Up to a 30 day supply	\$50 copay	60% after \$50 copay	\$50 copay	60% after \$50 copay	\$50 copay	60% after \$50 copay
Mail Order						
Generic 31-90 day supply	\$10 copay	Not Applicable	\$10 copay	Not Applicable	\$10 copay	Not Applicable
Brand Name 31 - 90 day supply	\$100 copay	Not Applicable	\$100 copay	Not Applicable	\$100 copay	Not Applicable
Self-injectibles	Covered through Aetna Specialty Pharmacy Only.					

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