

PPO Copay Plans
Plan Design and Benefits



For Members 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 their 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 1 exam every 12 months	\$25 Office visit copay	60%	\$25 Office visit copay	60%	\$25 Office visit copay	60%
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%
* Office visit copay applies if performed as a part of a physician office visit and billed by the physician.						
Emergency Care						
Urgent Care Provider	\$75 copay	60%	\$75 copay	60%	\$75 copay	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	50%	50%	50%	50%	50%	50%
Ambulance	80%	60%	80%	60%	80%	60%

	PPO 500		PPO 1000		PPO 2500	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospital Care						
<i>Inpatient Coverage</i>	80%	60%	80%	60%	80%	60%
<i>Outpatient Hospital Expenses</i>	80%	60%	80%	60%	80%	60%
Mental Health						
<i>Inpatient</i>	80%	60%	80%	60%	80%	60%
<i>Outpatient</i>	\$25 copay	60%	\$25 copay	60%	\$25 copay	60%
Alcohol/Drug Abuse						
Lifetime Maximum \$50,000						
<i>Inpatient</i>	80%	60%	80%	60%	80%	60%
Limited to 30 days per calendar year.						
<i>Outpatient</i>	\$25 copay	60%	\$25 copay	60%	\$25 copay	60%
Limited to 40 visits per calendar year.						
Other Services						
<i>Maternity</i>	80%	60%	80%	60%	80%	60%
<i>Convalescent Facility</i>	80%	60%	80%	60%	80%	60%
Limited to 120 days per calendar year.						
<i>Home Health Care</i> Unlimited Visits	80%	60%	80%	60%	80%	60%
Each visit by nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.						
<i>Hospice Care-Inpatient</i> Unlimited Visits	Covered 100%		Covered 100%		Covered 100%	
<i>Hospice Care-Outpatient</i> Unlimited Visits	Covered 100%		Covered 100%		Covered 100%	
<i>Transplants</i>	80%	60%	80%	60%	80%	60%
In-Network benefits apply only if procedure is performed at an Institute of Excellence (IOE) facility.						
<i>Private Duty Nursing</i>	80%	60%	80%	60%	80%	60%
Limited to 70 eight-hour shifts per calendar year.						
<i>Outpatient Speech, Physical and Occupational Therapy</i>	80%	60%	80%	60%	80%	60%
<i>Spinal Manipulation Therapy</i>	80%	60%	80%	60%	80%	60%
<i>Durable Medical Equipment</i>	80%	60%	80%	60%	80%	60%
Maximum annual benefit of \$10,000 per member per calendar year.						
<i>Diabetic Supplies</i>	Covered same as any other medical expense if not covered under Pharmacy benefit.					
<i>Infertility Treatment</i>	Member cost sharing is based on type of service performed and place rendered.					
<i>Voluntary Sterilization</i>	Member cost sharing is based on type of service performed and place rendered.					
<i>Contraceptive Drugs and Devices not obtainable at a pharmacy</i>	80%	60%	80%	60%	80%	60%
Includes coverage for contraceptive visits.						
Pharmacy Benefits						
<i>Retail</i>						
<i>Generic</i> Up to a 30 day supply	\$5 copay	60% after \$5 copay	\$5 copay	60% after \$5 copay	\$5 copay	60% after \$5 copay
<i>Brand Name</i> Up to a 30 day supply	\$50 copay	60% after \$50 copay	\$50 copay	60% after \$50 copay	\$50 copay	60% after \$50 copay
<i>Mail Order</i>						
<i>Generic</i> 31-90 day supply	\$10 copay	Not Applicable	\$10 copay	Not Applicable	\$10 copay	Not Applicable
<i>Brand Name</i> 31 - 90 day supply	\$100 copay	Not Applicable	\$100 copay	Not Applicable	\$100 copay	Not Applicable
<i>Self-injectibles</i>	Covered through Aetna Specialty Pharmacy Only.					

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