

Open Access Plus Plan (OAP)

	Open Access Plus Plan		Additional Benefits	
Calendar Year Deductible (CYD)- (When Applicable)				
	In Network	Out of Network	Health Center	Max HRA \$
Individual	\$750	\$1,500	\$0.00	\$300
2 Member Family	\$1,500	\$3,000	\$0.00	\$600
3 or More Member Family	\$2,250	\$4,500	\$0.00	\$600
Coinsurance- (When Applicable)				
	In Network	Out of Network	Health Center	HRA \$ funded
Plan Reimbursement	80%	60%	100%	100%
Member Responsibility	20%	40%	\$0.00	\$0.00
Maximum Out of Pocket				
	In Network	Out of Network	Health Center	HRA \$
Individual	\$6,600 (\$2,500Med/\$4,100Rx)	\$90,000	\$0.00	applicable for use
2 Member Family	\$13,200 (\$5,000Med/\$8,200Rx)	\$90,000	\$0.00	applicable for use
3 or More Member Family	\$19,800(\$7,500Med/\$12,300Rx)	\$90,000	\$0.00	applicable for use
What Applies to the Out-of-Pocket Max	Deductibles, Coinsurance, Copays & Rx		No Max	N/A
Physician Office Visits				
	In Network	Out of Network**	Health Center	HRA \$
Primary Care Physician (PCP)	\$20 Copay	40% After CYD	\$0.00	applicable for use
Specialists (No Referral Required)	\$35 (CCN)/\$50 (Non-CCN)	40% After CYD	\$0.00	applicable for use
Diagnostic Services				
	In Network	Out of Network**	Health Center	HRA \$
Clinical Lab (Blood Work) at Independent	\$10 Copay	40% After CYD	\$0.00	applicable for use
X-rays at Independent Facility	\$10 Copay	40% After CYD	\$0 w/referral	applicable for use
Advanced Imaging (MRI, PET, CAT, MRA)	\$250 Copay Per Scan	40% After CYD	\$0 w/referral	applicable for use
Hospital Services				
	In Network	Out of Network**	Health Center	HRA \$
Inpatient Hospital	20% After CYD	40% After CYD	N/A	applicable for use
Outpatient Hospital	20% After CYD	40% After CYD	N/A	applicable for use
Physician Services at Outpatient Hospital	20% After CYD	40% After CYD	N/A	applicable for use
Emergency Room (Waived If Admitted)	\$250 Copay		N/A	applicable for use
Urgent Care Facility	\$75 Copay		\$0.00	applicable for use
Mental Health / Alcohol & Substance Abuse				
	In Network	Out of Network**	Health Center	HRA \$
Inpatient	20% After CYD	40% After CYD	N/A	applicable for use
Outpatient Facility	No Charge	40% After CYD	Behavior Spec Availa	applicable for use
Physician Office Visit	\$35 (CCN)/\$50 (Non-CCN)	40% After CYD	Behavior Spec Availa	applicable for use
Prescription Drugs (Rx)				
	In Network	Out of Network**	Health Center	HRA \$
Tier 1 - Generic	\$5 Copay	Not Covered	\$0.00	applicable for use
Tier 2 - Preferred Brand Name	40% of Cost, \$35 Min & \$75 Max		\$0 if available	applicable for use
Tier 3 - Non-Preferred Brand Name	60% of Cost, \$70 Min & \$100 Max		\$0 if available	applicable for use
Tier 4 - Speciality Drugs/Self Inject.	\$250 Copay		Not applicable	applicable for use
Mail-Order Program (90 Day supply)	2.5x Retail Copay		\$0.00	applicable for use

Calendar Year Deductible (CYD) must be met before any co-insurance applies.

****Out-Of-Network Balance Billing**

For information regarding out-of network balance billing that may be charged by an out-of-network provider for services rendered, please refer to the Out-Of-Network Benefits section on the Summary of Benefits and Coverage (SBC).