Opex Corporation
Schedule of Benefits
January 1, 2025
This is a Grandfathered Plan

Benefits	Participating	Non-Participating
***In-Network Services** *(Participating)* Allowables are based on the Negotiated Rate established in a contractual arrangement with a Provider and/or Facility.		
***Out-of-Network Services** *(Non-Participating)-Limited to 125% of the Medicare Reimbursement Rate*		
Plan Year Maximum	Unlimited	Unlimited
Note *: The maximums listed below are the total for Participating and Non-Participating expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar year maximum is 60 days total which may be split between Participating and Non-Participating providers.*		
Please see pre-certed services at the end of the schedule of benefits.		
Deductible *(Per Calendar Year)*		
Per Covered Person	None	$100
Per Family Unit	None	$250
Out of Pocket Maximum *(Excluding deductibles)*		
Per Covered Person	$500	$500
Per Family Unit	$1,000	$1,000
The plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered charges for the rest of the Calendar Year unless otherwise stated. The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: deductible(s), copayment(s), cost containment penalties and Private Duty Nursing.		
Co-Payments		
Teladoc Consultation	$0	N/A
Physician Office Visits	Covered 100% after $30 copay	Covered 80% after deductible
Specialist Office Visits	Covered 100% after $30 copay	Covered 80% after deductible
Physician Visits for Radiation/Chemotherapy	Covered 100% after $30 copay	Covered 80% after deductible
Urgent Care	Covered 100% after $30 copay	Covered 80% after deductible
Second Surgical Opinion *($200 penalty for failure to obtain)*	Covered 100%	Covered 80% after deductible
Emergency Services		
Ambulance Service	Covered 80% after $100 deductible *(Must be medically necessary and not hospital billed)*	Paid at In-Network Level
Emergency Room Services		
Accident or True Medical Emergency	Covered 100% after $50 copay *(waived if admitted)*	Paid at In-Network Level
Illness	Covered 100% after $100 copay *(waived if admitted)*	Paid at In-Network Level
The Emergency room co-payment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator must be notified within 48 hours of the admission (please refer to your ID card for phone number), even if the patient is discharged within 48 hours of the admission.		
Injury or True Medical Emergency *- accidental physical injury to the body caused by unexpected external means or sudden onset of a condition with acute symptoms requiring immediate medical care.*		

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Covered Services		
Allergy Testing & Treatment	Covered 100%	Covered 80% after deductible
Chiropractic Care/Spinal Manipulation *(Combined in and out-of-network)*	Covered 80% after $100 deductible	Covered 80% after deductible
15 Visits Calendar Year Maximum. Maximum payment of $600 per year. $50 Maximum benefit payment per visit.		
Diabetic Education Classes	Covered 100%	Covered 80% after deductible
Dialysis Treatment - Outpatient	Covered 100%	Covered 80% after deductible
Durable Medical Equipment	Covered 100%	Covered 80% after deductible
Hearing Aid	75% of the purchase price to a Maximum of $1,000. This includes all fitting fees. *(Benefit is limited to the purchase of one (1) non-surgical hearing aid every 60 months.)Any Provider may be utilized.*	
Hearing Exam	Covered 100% to a Maximum of $100 per exam. One Exam every 24-months.	
Home Health Care *(Physician certification Required.)*	Covered 100%	Covered 80% after deductible
100 Nursing visits per Calendar Year (each visit is equal to 4 hours). $25,000 Calendar Year Maximum combined for all home health care services and supplies to include, but not limited to, nursing services, supplies, medications, intravenous drugs, physical, speech and occupational therapy.		
Hospice Care *(Physician certification Required.)*	Covered 100%	Covered 80% after deductible
Six (6) months life expectancy. $25,000 Inpatient/Outpatient Calendar Year Maximum.		
Hospital Inpatient Care (*Pre-certification Required*) *(Average semi-private room rate)*		
Inpatient Admission	Covered 100% per person up to 31 days, then 80% after $100 deductible	Covered 80% after deductible
Inpatient Physician Services *(one visit per day)*	Covered 100%	Covered 80% after deductible
Hospital Intensive Care Unit *(Pre-certification required) (Hospital's average ICU rate)*	Covered 100% per person up to 31 days, then 80% after $100 deductible	Covered 80% after deductible
Maternity Benefits *(Pre and Post Natal Care)*		
Inpatient Hospital Charges	Covered 100% per person up to 31 days, then 80% after $100 deductible	Covered 80% after deductible
Obstetric Care/Physician Charges	Covered 100%	Covered 80% after deductible
Ultrasound	Covered 100%	Covered 80% after deductible
Mental Health/Alcohol and Drug Use/Applied Behavioral Analysis (ABA)		
Inpatient *(Pre-certification required)*	Covered 100% per person up to 31 days, then 80% after $100 deductible	Covered 80% after deductible
Outpatient	Covered 100% after $30 copay	Covered 80% after deductible
ABA Only Home	Covered 100%	Covered 80% after deductible
Nutritional Counseling	Covered 100%	Covered 80% after deductible
Organ Transplants	Covered 100%	Covered 80% after deductible
Oral Surgery	Covered 100%	Covered 80% after deductible
Outpatient Pre-Admission Testing	Covered 100%	Covered 100% after deductible
Prosthetics / Orthotics	Covered 100%	Covered 80% after deductible
Prosthetics Appliances and Devices External *(Limited to $25,000 every 24 months)*	Covered 100%	Covered 80% after deductible

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Skilled Nursing Facility *(Pre-certification Required)*	Covered 100%	Covered 80% after deductible
One-half hospital average semi-private room and board rate. 60 Days Calendar Year Maximum		
Specialty Drugs	Not Covered	Not Covered
Supplemental Accident Benefit *(Charges must incur within 90 days of accident)*	Covered 100%	Covered 100% up to $300, Balance at 80% after deductible
Surgical Sterilization	Covered 100%	Covered 80% after deductible
Wig After Chemotherapy	Covered 100%	Covered 80% after deductible
Preventive Well Care as defined by PPACA		
Breast Feeding Support and Counseling	Covered 100% after $30 copay	Not Covered
Contraceptive Methods and Counseling	Covered 100% after $30 copay	Not Covered
Routine Colonoscopy*/Cologuard	Covered 100%	Not Covered
** A colonoscopy for the screening of colorectal cancer is considered **medically appropriate** in accordance with the guidelines set by the United States Preventative Services Task Force.*		
Routine Mammogram *(Including 3D mammogram) (Not subject to routine physical maximum)*	Covered 100% after $30 copay	Not Covered
Routine Newborn Care *(While confined to hospital)*	Covered 100%	Covered 80% after deductible
Routine Physical Exams** *(Age 13 and over) "Coverage subject to appropriate medical guidelines"*	Covered 100% after $30 copay	Not Covered
***Includes: prostate screening, routine physical examination, GYN exams, immunizations, x-rays and laboratory blood tests.*		
Routine Well Child Care *(Includes physical, laboratory blood tests, x-rays and immunizations)*	Covered 100% after $30 copay *(Well Child Care covered to age 12)*	Not Covered
Smoking Cessation *(Included in Routine Physical Exam Maximum)*	Covered 100% after $30 copay up to $500 Calendar Year Maximum	Not Covered
Surgical Benefits		
Ambulatory Surgical Center/Free Standing Facility	Covered 100%	Covered 80% after deductible
Anesthesia at Ambulatory Surgical Center/Free Standing Facility	Covered 100%	Covered 80% after deductible
Physician Services at Ambulatory Surgical Center/Free Standing Facility	Covered 100%	Covered 80% after deductible
Physician Office	Covered 100% under office visit benefit	Covered 80% after deductible
Hospital Inpatient Surgery	Covered 100%	Covered 80% after deductible
Anesthesia Hospital Inpatient	Covered 100%	Covered 80% after deductible
Physician Services Hospital Inpatient	Covered 100%	Covered 80% after deductible
Hospital Outpatient Surgery	Covered 100%	Covered 80% after deductible
Anesthesia Hospital Outpatient	Covered 100%	Covered 80% after deductible
Physician Services Hospital Outpatient	Covered 100%	Covered 80% after deductible
Bariatric Surgery	Covered 100%	Covered 80% after deductible

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Diagnostic X-Rays and Ultrasound-Charge By Place of Service		
Physician's Office	Covered 100%	Covered 80% after deductible
Independent Facility	Covered 100%	Covered 80% after deductible
Hospital-Outpatient	Covered 100%	Covered 80% after deductible
Laboratory-Charge By Place of Service		
Physician's Office	Covered 100%	Not Covered
Independent Facility	Covered 100%	Not Covered
Hospital-Outpatient	Covered 100%	Not Covered
Therapy Services		
Chemotherapy / Radiation	Covered 100% after $30 copay	Covered 80% after deductible
Occupational Therapy	Covered 100%	Covered 80% after deductible
Physical Therapy *(Must be rendered by a Licensed Physical Therapist)*	Covered 100%	Covered 80% after deductible
Speech Therapy *(Must be due to Injury, Sickness or Congenital Defect)*	Covered 100%	Covered 80% after deductible
Combined Calendar Year Maximum of $5,000 for Speech, Occupational and Physical Therapy(includes diagnosis of autism)		
Vision Care Benefits		
Eye Exam, per person, in a 12-month Period	$50.00	
Frame-Type Lenses in a 24-month Period		
Single Vision	$50.00	
Bi-Focal	$65.00	
Tri-Focal	$80.00	
Lenticular	$100.00	
Frames in a 24-month period	$100.00	
Contact Lenses in a 12-month period	$150.00	
(Benefit is limited to the purchase of glasses **OR** contact lenses…**Not Both.)**		
Prescription Drug Benefit		
Pharmacy Option		
Benefit limited to a maximum of a 90-day supply		
Generic Drugs	20% coinsurance	N/A
Brand Name Drugs	25% coinsurance	N/A
Specialty Drugs	Not Covered	N/A
Mail Order Prescription Drug Option		
Benefit limited to a 90-day supply		
Generic Drugs	20% coinsurance	N/A
Brand Name Drugs	25% coinsurance	N/A
Specialty Drugs	Not Covered	N/A

Precertification List
The following services require Precertification
Inpatient hospitalization
Transplant candidacy evaluation and transplant (organ and/or tissue)
Inpatient Mental/Nervous facility based programs
Inpatient Substance Abuse facility based programs
Skilled nursing facility stays