CommunityCare™

Silver 719

Medical Calendar Year Deductible	
Per Member	$5,000
Per Family	$10,000
Combined Medical and Pharmacy Out-of-Pocket Limit Per Calendar Year	
Per Member	$8,150
Per Family	$16,300
Physician Services	
(Additional Coinsurances/Copayments may apply)	
Primary Care Office Visits	$30 Copayment per Visit
Specialty Care Office Visits	$45 Copayment per Visit
Preventive Care	No Copayment
(Please see Member Handbook for details)	
Emergency Care and Urgent Care	
(Additional Coinsurances/Copayments may apply)	
Hospital Emergency Room	30% Coinsurance *
Urgent Care Facility	$50 Copayment per Visit
Inpatient Hospital Care	
Room and Board	30% Coinsurance *
(Including all other medically necessary services)	
Mental Health, Alcohol and Drug Services	
Inpatient	30% Coinsurance *
Outpatient	30% Coinsurance *
Physician's Office	$30 Copayment per Visit
Outpatient Surgery	
Primary Care Office Visits	$30 Copayment per Visit
Specialty Care Office Visits	$45 Copayment per Visit
Outpatient Surgical Facility	30% Coinsurance *

*After Deductible, the Coinsurance/Copayment will apply.

^See prescription drug benefit plan for additional information.

Outpatient Diagnostic Services

(Additional Coinsurances/Copayments may apply, regardless of where outpatient services are rendered)

Laboratory	30% Coinsurance *
Outpatient Radiology	30% Coinsurance *
MRI, CT Scan and PET Scan	30% Coinsurance *

Rehabilitation/Habilitation Therapy

(Up to 60 treatment days per disability per calendar year. Rehabilitation and Habilitation maximums apply separately)
(Limit 390 visits per member with autism)

Inpatient Therapy	30% Coinsurance *
Outpatient Physical, Occupational and Speech Therapy	30% Coinsurance

Other Covered Services

(Quantity limits may apply)

Allergy Serum	30% Coinsurance *
Ambulance - Emergency Only	$50 Copayment *
Chiropractic Care	$45 Copayment per Visit
Diabetic Supplies	30% Coinsurance
Durable Medical Equipment	30% Coinsurance *
General Anesthesia (during dental procedures as specified by state law)	30% Coinsurance *
Glasses (Children under the age of 19)	30% Coinsurance *
Home Health Services	30% Coinsurance *
Hospice Care	No Coinsurance
Immunosuppressives, Injectables (except immunizations) and Drugs administered in the physician's office	Non-Preferred Prescription Copayment ^
(Except for specialty drugs within this category - see Specialty Drugs below)	
Infusion	
(Must be medically necessary and may be subject to prior authorization)	
Administered in a physician's office	Non-Preferred Prescription Copayment ^
(Except for specialty drugs within this category - see Specialty Drugs below)	
Administered in an outpatient facility	30% Coinsurance *
Administered in a home setting	30% Coinsurance *
(Except for specialty drugs within this category - see Specialty Drugs below)	
Organ Transplants	30% Coinsurance *

*After Deductible, the Coinsurance/Copayment will apply.

^See prescription drug benefit plan for additional information.

Orthotics and Prosthetics	30% Coinsurance *
Ostomy and Urologic Supplies	30% Coinsurance
Prescription Drug Benefit	See Outpatient Prescription Drug Benefit
Private Duty Nursing	30% Coinsurance *
(85 visits per calendar year)	
Radiation Therapy	30% Coinsurance *
Skilled Nursing Facility Care	30% Coinsurance *
(Up to 60 treatment days per disability per calendar year)	
Specialty Drugs	Specialty Prescription Copayment ^
(Must be medically necessary and may be subject to prior authorization)	
All Other Covered Services	30% Coinsurance *

Comments

- Deductible must be satisfied before Coinsurance/Copayment begins.
- Copayments do not apply toward the deductible.
- Prescription drugs and non-covered items do not apply toward the medical calendar year deductible.
- Expenses incurred during the last three months of the calendar year and applied to the current year's deductible may be used to help meet the deductible requirement of the next year.
- Any number of members of the family may combine individual medical deductibles to satisfy the family medical deductible requirement.
- All covered out-of-pocket expenses are applied toward your out-of-pocket limit.
- A calendar year is defined as the time period from January 1 - December 31.

Urgent and Emergency Care

It is important that you follow-up with your PCP within 48 hours of any Urgent or Emergent Care Services. This will allow your PCP to direct or coordinate all of your follow-up care. Follow-up care that is not arranged by your PCP may not be covered. Your PCP is available 24 hours a day, seven days a week.

For a list of Exclusions and Limitations, please see your Member Handbook.

THIS IS NOT A CONTRACT. This summary does not contain a complete listing of conditions which apply to the benefits shown. It is intended only as a source of general information and is subject to the terms of the Group Health Care Services Agreement. See your Member Handbook for additional information regarding exclusions and limitations.

*After Deductible, the Coinsurance/Copayment will apply.

^See prescription drug benefit plan for additional information.

CommunityCare™

Outpatient Prescription Drug Benefit

Combined Pharmacy and Medical Calendar Year Out-of-Pocket Max $8,150 Per Individual $16,300 Per Family Per Calendar Year

Retail Pharmacy

Up to a 30-day supply for each prescription.
Refer to your prescription drug formulary guide.
Covers up to a 30 day supply for retail, a 90 day supply at retail for maintenance drugs at a cost share equal to 3 retail copayments, and a 90 day supply for mail order.

Tier 1 - Preferred Generic Drugs	$15
Tier 2 - Preferred Brand Drugs	$40
Tier 3 - Non-Preferred Brand or Generic Drugs	$70
Diabetic, Ostomy, and Urologic Supplies	30%

Mail Order Pharmacy

Up to a 90-day supply for each prescription.
Certain prescriptions, including specialty pharmacy drugs, are not eligible for mail order Copayments.
Refer to your prescription drug formulary guide for additional information.

Tier 1 - Preferred Generic Drugs	$30
Tier 2 - Preferred Brand Drugs	$80
Tier 3 - Non-Preferred Brand or Generic Drugs	$140
Diabetic, Ostomy, and Urologic Supplies	30%

Specialty Pharmacy

Up to a 30-day supply for each prescription.
Refer to your formulary guide for a list of medications covered under the Specialty Pharmacy Program.
Specialty Pharmacy Drugs can be obtained from a contracted Specialty Pharmacy Provider.

Tier 4 - Specialty Pharmacy Drugs	$160
Tier 5 - Non-Preferred Specialty Pharmacy Drugs	$210

Member Responsibility

Please note that Quantity Limits or Prior Authorization may apply.
Refer to your prescription drug formulary guide for additional information.
Brand/Generic Difference Program: If you receive a brand name drug when an equivalent generic drug is available, you will be responsible for the difference between the cost of the brand name drug and the allowed amount of the generic drug equivalent. This amount is in addition to any Deductible, Copayment and/or Coinsurance amount set forth in this Schedule of Benefits. Only the Deductible, Copayment and/or Coinsurance will apply to the Out-of-Pocket Limit.
If the cost of the prescription is less than the applicable Copayment, you will only be charged the cost of the prescription.
Copayments and Coinsurance amounts you must pay under the plan, amounts you incur that apply toward the Out-of-Pocket maximum for a Covered Service, and amounts that are applied toward your Deductible for covered prescription drugs will not be carried over.

Covered Drugs and Devices

- Compound Drugs - at least one ingredient must be a legend drug
- Contraceptive implants, IUDs, diaphragms, contraceptive devices, contraceptive kits, emergency contraception, oral/injectable/patch contraceptives
- Drugs used for chemical dependency/alcohol treatment
- Fertility Drugs - 50% Coinsurance after applicable Copayment
- Immunizations (no Copayment, Deductible or Coinsurance applies to childhood immunizations from birth-age 21)
- Immunosuppressive Drugs
- Injectible/Infused Drugs, including insulin, epinephrine and glucagons
- Legend Drugs - drugs that require a prescription under federal/state law
- Smoking Cessation Drugs

Excluded Drugs and Devices+

- Anti-fungal Drugs used for nail fungus
- Convenience or unit dose packaging
- Diabetic supplies other than Bayer or Roche products
- Drugs obtained at a non-contracted pharmacy
- Drugs and their equivalents that may be purchased without a prescription
- Drugs that are not listed on CommunityCare's prescription drug formulary; non-formulary drugs
- Drugs used for weight management, including anorexiants and body building drugs
- Feiba
- Drugs used for cosmetic purposes or hair growth
- Human Growth Hormones and other drugs used to stimulate growth
- Investigational/Experimental Drugs or used for non-FDA approved indications, including new drug therapies that have not been added to CommunityCare's prescription drug formulary
- Lost, damaged or stolen prescriptions
- NovoSeven
- Oral Antihistamines and Antihistamine/Decongestant Combinations
- Prescriptions reimbursable under Workers' Compensation or any other government program, or with respect to which the member has no obligation to pay in the absence of insurance
- Take home drugs provided by a hospital

Please consult your pharmacy directory for a list of participating pharmacies in Oklahoma. To find a participating pharmacy outside the state of Oklahoma, please call (877) 293-8628 or visit www.ccok.com. For all other questions, please call CommunityCare at (877) 293-8628.

+Products are excluded except as required by law. See the Member Handbook for additional information.