CommunityCare™ Employer's Choice

Standard Plan Option

	In-Network	Out-of-Network
Calendar Year Deductible		
Per Member	$1,000	$2,000
Per Family	$2,000	$4,000
Out-of-Pocket Limit Per Calendar Year		
Per Member	$1,500	$3,000
Per Family	$3,000	$6,000
Total Medical Annual Expense Risk		
Per Member	$2,500	$5,000
Per Family	$5,000	$10,000
Physician Services		
(Additional Coinsurances/Copayments may apply)		
Primary Care Office Visits	$40 Copayment per Visit	50% Coinsurance *
Preferred Primary Care and Hormone Management		
-Axis/Anointed Healthcare	$20 Copayment per Visit	
-Eastern Oklahoma Wellness Center Medical	$20 Copayment per Visit	
Pediatrician Office Visits *(Up to age 19)*	$25 Copayment per Visit	50% Coinsurance *
Specialty Care Office Visits	$40 Copayment per Visit	50% Coinsurance *
Preventive Care	No Copayment	50% Coinsurance *
(Please see Handbook for details)		
Virtual Visits		
Primary Care Office Visits	No Copayment	50% Coinsurance *
Specialty Care Office Visits	$40 Copayment per Visit	50% Coinsurance *
Preventive Care	No Copayment	50% Coinsurance *
Outpatient Mental, Alcohol and Drug Services	No Copayment	50% Coinsurance *
Emergency Care and Urgent Care		
(Additional Coinsurances/Copayments may apply) (Benefits will be denied if not medically necessary)		
Hospital Emergency Room	20% Coinsurance *	20% Coinsurance *
Urgent Care Facility	$60 Copayment per Visit	50% Coinsurance *
Medwise Urgent Care	$40 Copayment per Visit	
Inpatient Hospital Care		
(Must be medically necessary and may be subject to prior authorization)		
Room and Board	20% Coinsurance *	50% Coinsurance *
(Including all other medically necessary services)		

*After Deductible, the Coinsurance/Copayment will apply.

^See prescription drug benefit plan for additional information.

Mental Health, Alcohol and Drug Services

(Must be medically necessary and may be subject to prior authorization)

Inpatient	20% Coinsurance *	50% Coinsurance *
Outpatient	$40 Copayment per Visit	50% Coinsurance *
Preferred Mental Health		
-Synergy Wellbeing	$20 Copayment per Visit	
-Axis/Anointed Healthcare	$20 Copayment per Visit	
Oakwood Springs		
Inpatient		
Active and Retired Officers	100% paid, No Coinsurance	
Non-Officer Spouse and Dependents	20% Coinsurance*	
Outpatient	$40 Copayment per Visit	

Outpatient Surgery

(Must be medically necessary and may be subject to prior authorization)

Primary Care Office Visits	$40 Copayment per Visit	50% Coinsurance *
Pediatrician Office Visits *(Up to age 19)*	$25 Copayment per Visit	50% Coinsurance *
Specialty Care Office Visits	$40 Copayment per Visit	50% Coinsurance *
Outpatient Surgical Facility	20% Coinsurance *	50% Coinsurance *

Outpatient Diagnostic Services

(Must be medically necessary and may be subject to prior authorization)

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

Laboratory	No Additional Copayment	50% Coinsurance *
Outpatient Radiology	No Additional Copayment	50% Coinsurance *
MRI, CT Scan and PET Scan	20% Coinsurance *	50% Coinsurance *
Various Heart and Calcium CT Scans	***No Coinsurance when performed at Ascension St. John, Saint Francis, Hillcrest or Oklahoma Heart Institute. All other locations, please refer to Outpatient Diagnostic Services.***	

Rehabilitation Therapy

(Must be medically necessary and may be subject to prior authorization)

(Up to 60 treatment visits per benefit type)

Inpatient Rehabilitation	20% Coinsurance *	50% Coinsurance *
Outpatient Physical, Occupational and Speech Therapy	$40 Copayment per Visit	50% Coinsurance *

Other Covered Services

(Quantity limits may apply)		
Allergy Serum/Injections	Subject to the PCP or Specialist Copayment	50% Coinsurance *
Allergy Testing & Treatment	If an office visit is charged, subject to the PCP or Specialist office visit Copayment	50% Coinsurance *
Allergy Testing & Treatment not in a Physician's Office	20% Coinsurance *	50% Coinsurance *
Ambulance	20% Coinsurance *	20% Coinsurance *
(Emergency only)		
Chiropractic Care	$ 0 Copayment per Visit	50% Coinsurance *
(limited to a total of 60 visits per calendar year, to include direct contracts and insurance contracts combined)		
Diabetic Supplies *(Some services may be subject to prior authorization)*	20% Coinsurance *	50% Coinsurance *
Durable Medical Equipment	20% Coinsurance *	50% Coinsurance *
Fertility Evaluation	20% Coinsurance *	Not Covered
General Anesthesia *(for eligible dental procedures only)*	20% Coinsurance	50% Coinsurance *
Hearing Aids (Children under the age of 19)	20% Coinsurance *	50% Coinsurance *
Home Health Services	20% Coinsurance *	50% Coinsurance *
Hospice Care *(Inpatient requires pre-certification)*	20% Coinsurance *	50% Coinsurance *
Immunosuppressives, Injectables (except immunizations) and Drugs administered in the physician's office	20% Coinsurance *	50% Coinsurance *
Infusion		
(Must be medically necessary and may be subject to prior authorization)		
Administered in a physician's office	$40 Copayment per Visit	50% Coinsurance *
(Except for specialty drugs within this category - see Specialty Drugs below)		
Administered in an outpatient facility	20% Coinsurance *	50% Coinsurance *
Administered in a home setting	20% Coinsurance *	50% Coinsurance *
(Except for specialty drugs within this category - see Specialty Drugs below)		
Organ Transplants *(Must be medically necessary and may be subject to prior authorization)*	20% Coinsurance *	Not Covered outside the transplant network
Orthotics and Prosthetics	20% Coinsurance *	50% Coinsurance *
Ostomy and Urologic Supplies	20% Coinsurance *	50% Coinsurance *

Prescription Drug Benefit	See Outpatient Prescription Drug Benefit ^	See Outpatient Prescription Drug Benefit ^
Radiation Therapy	20% Coinsurance *	50% Coinsurance *
Skilled Nursing Facility Care	20% Coinsurance *	50% Coinsurance *
(Up to 60 treatment days per disability per calendar year)		
Specialty Drugs from a medical provider	20% Coinsurance	50% Coinsurance *
(Must be medically necessary and may be subject to prior authorization)		
All Other Covered Services	20% Coinsurance *	50% Coinsurance *

Comments

- Deductible must be satisfied before Coinsurance begins, where it applies.
- 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 to meet two times the individual medical Deductible to satisfy the family medical Deductible requirement.
- All covered medical out-of-pocket expenses will accrue toward a separate prescription drug out-of-pocket limit.
- A calendar year is defined as the time period from January 1 - December 31.
- Deductible amounts and out-of-pocket limitations are separate for in-network provider and out-of-network provider benefits.
- All services will be reviewed for medically necessity. If services are deemed to not meet medical necessity services may be denied.
- Certain services require prior authorization. Failure to obtain authorization may result in non-payment of claims

Out-of-Network Requirements

- All out-of-network provider calculations are based on the out-of-network fee schedule as described in your Handbook. The enrollee is also responsible for any amount charged by a provider in excess of the out-of-network fee schedule.
- Call the phone number on the back of your ID card before an elective surgery or 7 days in advance of a hospital stay arranged through a non-network healthcare provider. Failure to follow these procedures will result in eligible benefits for out-of-network hospital care or surgery being reduced by $500.
- For emergencies, call your primary care physician for follow-up care.
- "Balance Billed Amounts" do not apply to out-of-pocket limitation.

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.

If you have an emergency that is considered life or limb threatening, go to the nearest hospital or emergency room. After you have sought emergency care, please notify your PCP to arrange for any follow-up care that may be necessary. Forward any bills to CommunityCare Plus for reimbursement. Consult your Handbook for examples of medical emergencies.

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

THIS IS NOT A CONTRACT. This Schedule of Benefits does not contain a complete listing of conditions which apply to the benefits shown. Please refer to this handbook for additional information, including exclusions and limitations.