CommunityCare 2800 With HSA

Medical Calendar Year Deductible	
Per Member	$2,800
Per Family	$5,000
Combined Medical and Pharmacy Out-of-Pocket Limit Per Calendar Year	
Per Member	$5,000
Per Family	$10,000
Physician Services	
(Additional Coinsurances/Copayments may apply)	
Primary Care Office Visits	20% Coinsurance *
Specialty Care Office Visits	20% Coinsurance *
Preventive Care	No Copayment
(Please see Member Handbook for details)	
Emergency Care and Urgent Care	
(Additional Coinsurances/Copayments may apply, regardless of where outpatient services are rendered)	
Hospital Emergency Room	20% Coinsurance *
Urgent Care Facility	20% Coinsurance *
Inpatient Hospital Care	
Room and Board	20% Coinsurance *
(Including all other medically necessary services)	
Mental Health, Alcohol and Drug Services	
Inpatient	20% Coinsurance *
Outpatient	20% Coinsurance *
Physician's Office	20% Coinsurance *
Applied Behavior Analysis	20% Coinsurance *
Outpatient Surgery	
Primary Care Office Visits	20% Coinsurance *
Specialty Care Office Visits	20% Coinsurance *
Outpatient Surgical Facility	20% 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	No Copayment *
Outpatient Radiology	No Copayment *
MRI, CT Scan and PET Scan	20% Coinsurance*
Rehabilitation Therapy	
(Up to 60 treatment days per disability per calendar year)	
Inpatient Rehabilitation	20% Coinsurance *
Outpatient Physical, Occupational and Speech Therapy	20% Coinsurance *
Telemedicine	
Primary Care Office Visits	No Copayment *
Specialty Care Office Visits	20% Coinsurance *
Preventive Care	No Copayment
Other Covered Services	
(Quantity limits may apply)	
Allergy Serum	20% Coinsurance *
Ambulance - Emergency Only	20% Coinsurance *
Chiropractic Care	20% Coinsurance *
Diabetic Supplies	20% Coinsurance *
Durable Medical Equipment	20% Coinsurance *
Fertility Evaluation	20% Coinsurance *
General Anesthesia (during dental procedures as specified by state law)	20% Coinsurance *
Home Health Services	20% Coinsurance *
Hospice Care	20% 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	20% Coinsurance *

*After Deductible, the Coinsurance/Copayment will apply.

^See prescription drug benefit plan for additional information.

Administered in a home setting	20% Coinsurance *
(Except for specialty drugs within this category - see Specialty Drugs below)	
Organ Transplants	20% Coinsurance *
Orthotics and Prosthetics	20% Coinsurance *
Ostomy and Urologic Supplies	20% Coinsurance *
Prescription Drug Benefit	See Outpatient Prescription Drug Benefit
Skilled Nursing Facility Care	20% 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	20% Coinsurance *

Comments

- Deductible must be satisfied before Coinsurance/Copayment begins.
- Pharmacy and Medical deductibles are combined.
- 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 Application. 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 Deductible $2,800 Per Individual Per Calendar Year/ $5,000 Deductible Per Family Per Calendar Year*
Combined Pharmacy and Medical Calendar Year Out-of-Pocket Max $5,000 Per Individual $10,000 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 90 day supply at retail and mail order for maintenance drugs

Tier 1 - Preferred Generic Drugs	20% *
Tier 2 - Preferred Brand Drugs	20% *
Tier 3 - Non-Preferred Brand or Generic Drugs	20% *
Diabetic, Ostomy, and Urologic Supplies	20% *

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	20% *
Tier 2 - Preferred Brand Drugs	20% *
Tier 3 - Non-Preferred Brand or Generic Drugs	20% *
Diabetic, Ostomy, and Urologic Supplies	20% *

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	20% *

Member Responsibility

The above Coinsurance/Copayments apply after the Deductible has been met.
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.
Member Cost Share will not exceed $30 for a 30 day supply for insulin, $60 for a 60 day supply for insulin, and $90 for a 90 day supply for insulin. Deductible does not apply to insulin

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
- 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 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
- Fertility Drugs
- 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.

*After Deductible, the Coinsurance/Copayment will apply.