CommunityCare™
Oklahoma Individual Plan

IDEA Plus Benefit Plan

5.0

Calendar Year Deductible	**$5,000**	**Per Person+**
Out-of-Pocket Limit Per Calendar Year	**$2,000**	**Per Person+**
Annual Maximum		**$2,000,000**

All pharmaceuticals are subject to the prescription drug benefit limits. See prescription drug benefit plan for details.

Physician Services *(If outpatient diagnostic services are needed, the corresponding copay(s) will also apply.)*

Primary Care Physician Office Visits (additional copays may apply)	$35 Copay per Visit
Specialist Office Visits (additional copays may apply)	$45 Copay per Visit

Preventive Care *(Except as listed in Exclusions)* **No Copay Per Visit**

Please see Member Handbook for details.

Additional Benefits

Emergency Care *(If outpatient diagnostic services are needed, the corresponding copay(s) will also apply.)*

Hospital Emergency Room (copay waived if admitted inpatient)	$150 Copay Per Visit*
After Hours, Urgent Care Facility	$50 Copay Per Visit

Inpatient Hospital Care **$250 Copay Per Day (maximum of $1250 copay per admission)***

Room and Board
Inpatient Medical Detoxification
Anesthesia and Physician Visits
Services and Supplies
Laboratory/Radiology/Diagnostic Testing
All Other Medically Necessary Services

**You are responsible for this copay and if the deductible has not been completely satisfied, you are also responsible for payment for the balance of the services. These payments will count toward satisfying the deductible. As you get close to meeting the deductible requirement, a claim for services you receive could split between the remainder of the deductible and the copays for the beginning of the standard benefit level. If this occurs, you may be responsible for the copay required as part of the standard benefit level.*

+Deductible does not apply to out-of-pocket maximum.

Mental Health and Alcohol and Drug Services

All admissions and services must be approved by a CCHMO Behavioral Health Case Manager. Please call (800) 774-2677.

Inpatient	$250 Copay Per Day	*(maximum of $1250 copay per admission)**
Outpatient	$35 Copay per Visit	

Outpatient Surgery

Primary Care Physician's Office	$35 Copay Per Visit
Specialist's Office	$45 Copay Per Visit
Outpatient Surgical Facility	$125 Copay Per Visit*

Outpatient Diagnostic Services (Additional copays may apply, regardless of where outpatient services are rendered. i.e. emergency room or outpatient surgical facility)

Laboratory	No Additional Copay
Outpatient Radiology (no copay for routine mammography screening)	No Additional Copay
MRI, CT Scan and PET Scan	$150 Copay Per Visit*

Physical, Occupational & Speech Therapy *(up to 60 treatment days per disability per cal. year)*

Inpatient Rehabilitation	$125 Copay Per Day*
Outpatient Physical, Occupational & Speech Therapy	$40 Copay Per Visit*

Chiropractic Care **$45 copay per visit***
(12 visit limit per month not to exceed 30 visits per year)

Other Covered Services ***(Quantity limits may apply)***

Allergy Serum	50% Copayment*
Ambulance	$100 Copay*
Diabetic Supplies^	20% Copayment
Durable Medical Equipment^	20% Copayment*
General anesthesia during dental procedures as specified by state law	No Copay*
Hearing aids for children up to age 18	20% Copayment*
Home Health (nursing services provided in the home; see member handbook for details)	20% Copayment*
Hospice (includes services related to hospice plan of care; see member handbook for details)	No Copay*
Immunosuppressives, Injectables (except immunizations) and drugs administered in the physician's office^	Non-Preferred Prescription Copay+

(except for specialty drugs within this category - see Specialty Drugs below; must be medically necessary and may be subject to prior authorization)

**You are responsible for this copay and if the deductible has not been completely satisfied, you are also responsible for payment for the balance of the services. These payments will count toward satisfying the deductible. As you get close to meeting the deductible requirement, a claim for services you receive could split between the remainder of the deductible and the copays for the beginning of the standard benefit level. If this occurs, you may be responsible for the copay required as part of the standard benefit level.*

+See prescription drug benefit plan for additional information.

^Out-of-pocket limits do not apply to these benefits or to any benefit provided under the outpatient prescription

Benefit	Copay
Infusion^ *(must be medically necessary and may be subject to prior authorization)*	
Administered in a physician's office *(except for specialty drugs within this category - see Specialty Drugs below)*	Non-Preferred Prescription Copay+
Administered in an outpatient facility	No Additional Copay
Administered in a home setting (except for specialty drugs within this category - see Specialty Drugs below)	20% Copayment*
Organ Transplants	No Copay*
Orthotics^ & Prosthetics^ (except as listed in exclusions)	20% Copayment*
Ostomy/Urologic Supplies^	20% Copayment
Prescription Drug Benefit^	See Outpatient Prescription Drug Benefit
Skilled Nursing Facility (up to 60 consecutive treatment days per disability)	$35 Copay Per Day*
Specialty Drugs, including Self-Administered Injectables & Infusion Therapies^ (if applicable) *(must be medically necessary and may be subject to prior authorization)*	Specialty Prescription Copay+

**You are responsible for this copay and if the deductible has not been completely satisfied, you are also responsible for payment for the balance of the services. These payments will count toward satisfying the deductible. As you get close to meeting the deductible requirement, a claim for services you receive could split between the remainder of the deductible and the copays for the beginning of the standard benefit level. If this occurs, you may be responsible for the copay required as part of the standard benefit level.*

+See prescription drug benefit plan for additional information.

^Out-of-pocket limits do not apply to these benefits or to any benefit provided under the outpatient prescription drug benefit.

Comments

- Deductible must be satisfied before copayment begins.
- Copayments do not apply toward the deductible.
- Prescription drugs and non-covered items do not apply to 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.
- A calendar year is defined as the time period from Jan. 1-Dec. 31.

For a list of Exclusions and Limitations please see the Member Handbook

CommunityCare **1-800-777-4890** **www.ccok.com**