Effective 1/1/2016

CommunityCare™
Employer's Choice

ORU
ORAL ROBERTS UNIVERSITY

Benefit Booklet

www.ccok.com

CommunityCare™

Welcome!

Thank you for choosing CommunityCare as your health insurance carrier! We are pleased to be your partner in health care. Our goal is to provide you with the highest level of service possible. We are also committed to offering you providers in our networks who deliver high quality care and services.

Questions?

- Call our **Member Services** department at (918) 594-5201 or (888) 589-5214

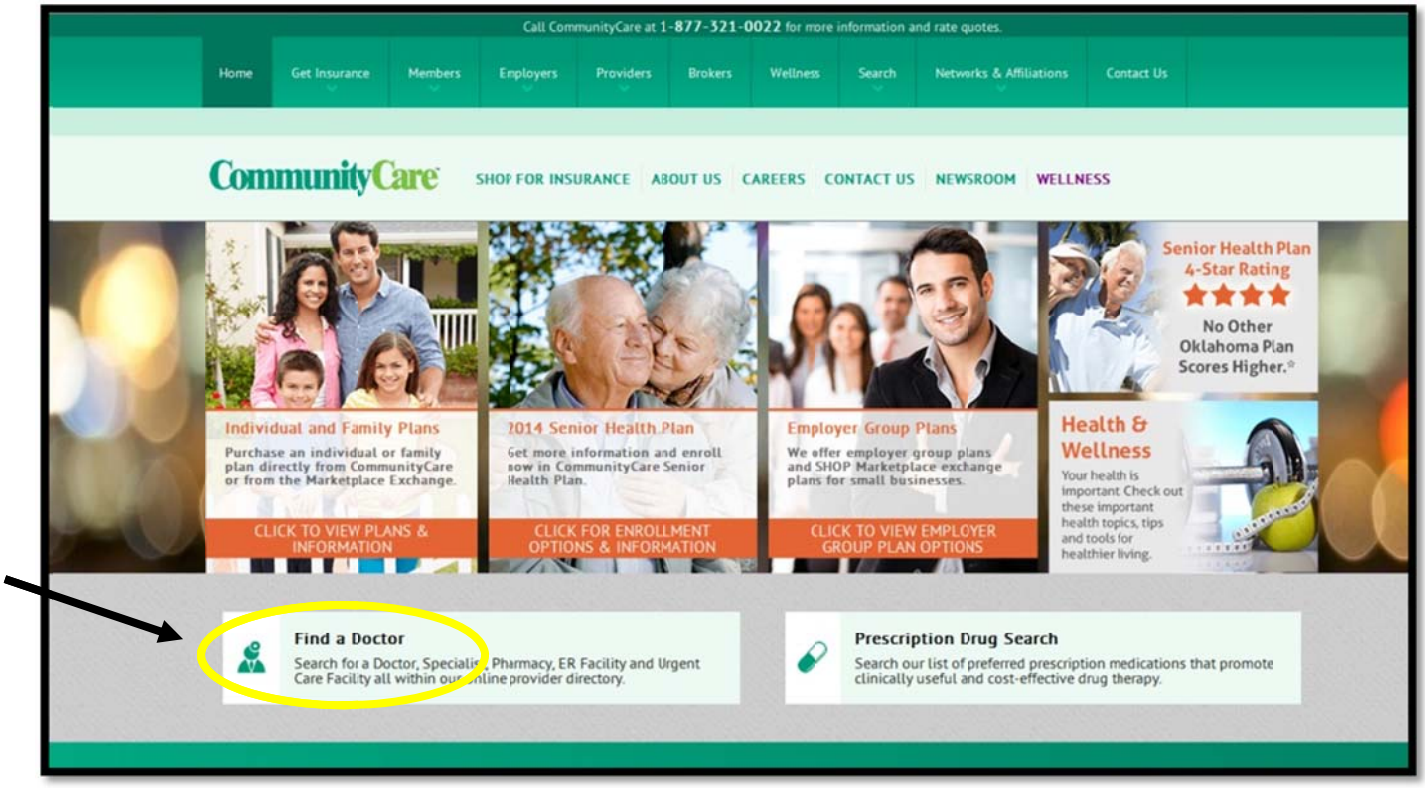
- Visit our Web site at **www.ccok.com** for the following resources:

    - Provider, facility & pharmacy searches
    - Formulary drug search
    - Benefit materials
    - View EOBs and access claims history
    - Print temporary member ID cards
    - Popular forms & resources
    - Mail order prescription drug program
    - Wellness resources and more

CommunityCare™

To locate CommunityCare contracted providers & pharmacies:

Please access our website:
www.ccok.com.



Select "Find a Doctor" on the CommunityCare home page to begin your search.

CommunityCare™ | MEMBER CONNECTION

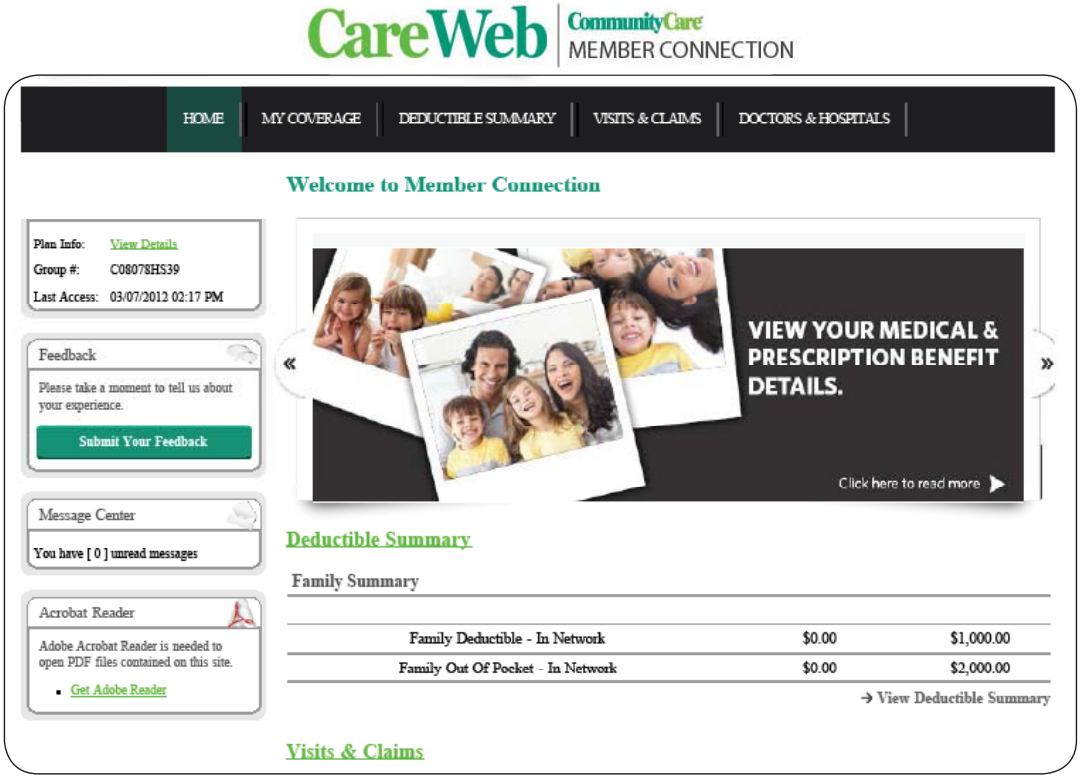
We are pleased to offer you access to Member Connection, the online member portal on the CommunityCare website! Member Connection is a helpful, friendly tool for all CommunityCare members.

So how do you begin?

Go to www.ccok.com and click on the Members link. You will be directed to enter your information and follow a five-step registration process. You will need your CommunityCare member ID card available before you begin.

Some of the features within Member Connection include:

- Access visits and claims history
- View your EOB online
- Print temporary ID cards
- Order replacement ID cards
- Search your provider directory
- Search your formulary list
- View your deductible and out of pocket summary



CommunityCare™

Special Benefits for CommunityCare Members

24-Hour Nurseline

- A free, 24-hour nurse staffed information line is available for CommunityCare members
- You may speak to a registered nurse who can recommend a proper course of treatment for medical conditions or problems
- Features an audio health library with more than 400 topics
- Call the 24-hour nurse line at (8ψψ) υψωζυςρτ

CommunityCare Website – www.ccok.com

- Access your CommunityCare benefit materials
- View EOBs and access visit and claims history
- Searchable provider and pharmacy directories
- Searchable prescription drug formulary
- Order replacement member ID cards
- Access health and wellness information

Member Reassurance Program

- Identifies members who have had a serious, traumatic event resulting in long-term, reoccurring care and/or hospital stay
- Designed to reassure members that CommunityCare is monitoring their claims for prompt payment
- A dedicated Member Reassurance Coordinator contacts the members and monitors claims

Questions? Call Member Services at (918) 594-52τυ or (8όό) ωόύζωφυψ.

Medical Benefit Plan Options for

ORU
ORAL ROBERTS UNIVERSITY

Effective Jan. 1, 2016

Plan Benefit	HRA (EPG 2000c)	IDEA Plus 2B	PPO 6A	
			In-Network	*Out-of-Network*
Office Visits - PCP	$30 Copay^	$30 Copay	**$30 Copay**	40%*
Office Visits - Specialist	**$50 Copay^**	**$50 Copay**	**$50 Copay**	40%*
Preventive Care	No Copay	No Copay	No Copay	30%*
Urgent Care	$50 Copay	$50 Copay	$50 Copay	40%*
Emergency Room	$150 Copay^	$100 Copay*	$50 Copay	$50 Copay
Lab & X-rays	Lab - No Additional Copay^ X-rays - $25 Copay^	No Additional Copay	No Additional Copay	30%*
MRIs/CT Scans/PET Scans	$200 Copay^	$150 Copay*	20%*	40%*
Inpatient Hospital Care	$200 Copay Per Day^ *(max. of $1,000 copay per admission)*	$200 Copay Per Day* *(max. of $1,000 copay per admission)*	$250 Per Confinement & 20%*	$250 Per Confinement & 40%*
Outpatient Surgical Facility	$100 Copay^	$150 Copay*	$250 & 20%*	$250 & 40%*
HRA Account	$1,000 Per Individual $2,000 Per Family	N/A	N/A	N/A
Calendar Year Deductible (EPG)	$2,000 Per Individual $4,000 Per Family	$1,000 Per Individual $2,000 Per Family	$1,000 Per Individual $2,000 Per Family	$2,000 Per Individual $4,000 Per Family
Out-of-Pocket Per Calendar Year ***(includes all copays and deductibles)***	$6,000 Per Individual $12,000 Per Family	$3,000 Per Individual $6,000 Per Family	$3,500 Per Individual $7,000 Per Family	Unlimited Per Individual Unlimited Per Family
Prescription Drug Benefit	$0/$15/$60/$85/**$120**	$0/$15/$60/$85/**$120**	$0/**$15**/$35/$60/$60	
Mail Order Prescription Drug Benefit	2 copays for a 3-month supply	2 copays for a 3-month supply	2 copays for a 3-month supply	

^ Subject to deductible if HRA account has been spent

* Subject to calendar year deductible

Changes are indicated in RED

CommunityCare

CommunityCare Employers Choice

CommunityCare HealthShare EPG 2000c H Lg

How the Plan Works:

Preventive Care

No Co-payment for approved Preventive Services. This benefit is not subject to the Employee Paid Gap.

A.) Health Reimbursement Account (HRA)

100% Coverage for approved medical expenses up to the maximum account level.

B.) Employee Paid Gap (EPG)

A deductible amount for which each Member is responsible.

C.) Standard Benefit Level

The "standard benefit level" begins once the HRA has been exhausted and the EPG has been satisfied. The standard benefit level includes standard HMO benefits, such as co-payments. Please refer to your schedule of benefits for the standard benefit level.

HRA Points to Consider: Available HRA funds will be applied first to any covered medical services you incur. During this phase, you may be required to pay all or a portion of the visit, which will be reimbursed to you upon CommunityCare's receipt of the claim from the physician. Unused HRA funds may be carried forward each year and accrued up to the account maximum listed below.

EPG Points to Consider:
You will be responsible for a deductible amount also known as the Employee Paid Gap (EPG). HRA funds may not be used to satisfy the EPG amount. Only covered medical services will be credited toward the EPG.

Standard Benefit Level Points to Consider: Once the EPG is satisfied, covered medical benefits will then be provided according to the attached schedule of benefits. For the remainder of the Calendar Year in question, members will only be responsible for the co-payments listed in their schedule of benefits until their Out of Pocket Limit has been reached. Once the Out of Pocket Limit has been satisfied, the Plan will then provide coverage at 100%.

	Per Individual	or	Per Family
HRA Account Maximum Per Calendar Year	$1,000		$2,000
HRA Account Rollover Maximum	$3,000		$6,000
Employee Paid Gap (EPG) Amount Per Calendar Year	$2,000		$4,000
Out-of-Pocket Limit Per Calendar Year	$6,000		$12,000

CommunityCare Employers Choice

CommunityCare HealthShare EPG 2000c H Lg

Physician Services	
(Additional Co-insurances/Co-payments may apply)	
Primary Care Office Visits	$30 Co-payment per Visit *
Specialty Care Office Visits	$50 Co-payment per Visit *
Maternity Care	$30 Co-payment*
(Co-payment for initial maternity care visit only)	
Preventive Care	No Co-payment
(Please see Member Handbook for details)	
Emergency Care and Urgent Care	
(Additional Co-insurances/Co-payments may apply)	
Hospital Emergency Room	$150 Co-payment per Visit *
(Co-payment waived if admitted inpatient)	
After Hours, Urgent Care Facility	$50 Co-payment per Visit
Inpatient Hospital Care	
Room and Board	$200 Co-payment per day maximum of $1,000 per admission *
(Including all other medically necessary services)	
Mental Health, Alcohol and Drug Services	
Inpatient	$200 Co-payment per day maximum of $1,000 per admission *
Outpatient	$30 Co-payment per Visit *
Outpatient Surgery	
Primary Care Office Visits	$30 Co-payment per Visit *
Specialty Care Office Visits	$50 Co-payment per Visit *
Outpatient Surgical Facility	$100 Co-payment per Visit *
Outpatient Diagnostic Services	
(Additional Co-insurances/Co-payments may apply, regardless of where outpatient services are rendered)	
Laboratory	No Co-payment *
Outpatient Radiology	$25 Co-payment per Visit *
MRI, CT Scan and PET Scan	$200 Co-payment per Visit *
Rehabilitation Therapy	
(Up to 60 treatment days per disability per calendar year)	
Inpatient Rehabilitation	$100 Co-payment per Day *
Outpatient Physical, Occupational and Speech Therapy	$50 Co-payment per Visit *

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

^See prescription drug benefit plan for additional information.

Other Covered Services	
(Quantity limits may apply)	
Allergy Serum	50% Co-insurance *
Ambulance - Emergency Only	$50 Co-payment *
Chiropractic Care	$50 Co-payment per Visit *
(12 visits per month not to exceed 30 visits per year)	
Diabetic Supplies	20% Co-insurance
Durable Medical Equipment	20% Co-insurance *
Fertility Evaluation	50% Co-insurance *
General Anesthesia (during dental procedures as specified by state law)	No Co-insurance *
Hearing Aids (Children up to 18 years of age)	20% Co-insurance *
Home Health Services	20% Co-insurance *
Hospice Care	No Co-insurance
Immunosuppressives, Injectables (except immunizations) and Drugs administered in the physician's office	Non-Preferred Prescription Co-payment ^
(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 Co-payment ^
(Except for specialty drugs within this category - see Specialty Drugs below)	
Administered in an outpatient facility	No Co-payment *
Administered in a home setting	20% Co-insurance *
(Except for specialty drugs within this category - see Specialty Drugs below)	
Organ Transplants	No Co-insurance *
Orthotics and Prosthetics	20% Co-insurance *
Ostomy and Urologic Supplies	20% Co-insurance
Prescription Drug Benefit	See Outpatient Prescription Drug Benefit ^
Radiation Therapy	No Co-payment *
Skilled Nursing Facility Care	$25 Co-payment per Visit *
(Up to 60 treatment days per disability per calendar year)	
Specialty Drugs	Specialty Prescription Co-payment ^
(Must be medically necessary and may be subject to prior authorization)	
All Other Covered Services	No Co-payment *

Comments

- Pro-rating the HRA account will apply as follows: If a member is initially enrolled in the medical plan with an effective date of January 1 through June 30, he or she will receive the full HRA account amount. If a member is initially enrolled in the medical plan with an effective date of July 1 through December 31, he or she will receive half of the HRA account amount.
- EPG must be satisfied before standard benefit levels begin.
- Co-payments do not apply toward the EPG.
- Prescription drugs and non-covered items do not apply to the HRA or EPG.

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

^See prescription drug benefit plan for additional information.

- Expenses incurred during the last three months of the calendar year and applied to the current year's EPG amount may be used to help meet the EPG requirement of the next year.
- Any number of members of the family may combine to meet two times the individual EPG to satisfy the family EPG requirements. Each individual within the family may not contribute more than the individual EPG amount.
- 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.

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

^See prescription drug benefit plan for additional information.

CommunityCare

Outpatient Prescription Drug Benefit

Combined Pharmacy and Medical Calendar Year Out-of-Pocket Max $6,000 Per Individual $12,000 Per Family Per Calendar Year

Benefit Co-payments

Some preferred generic drugs have a $0 Co-payment.
Please note that Quantity Limits or Prior Authorization may apply.
Refer to your prescription drug formulary guide for additional information.
If the cost of the prescription is less than the applicable Co-payment, you will only be charged the cost of the prescription.

Retail Pharmacy

Up to a 30-day supply for each prescription.
A select list of prescription drugs may be eligible for up to a 60-day supply through the tablet-splitting program.
(Refer to your prescription drug formulary guide.)

Tier 1 - Preferred Generic Drugs	$15
Tier 2 - Preferred Brand Drugs	$60
Tier 3 - Non-Preferred Brand or Generic Drugs	$85
20% Co-insurance - Diabetic, Ostomy, and Urologic Supplies	

Mail Order Pharmacy

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

Tier 1 - Preferred Generic Drugs	$30
Tier 2 - Preferred Brand Drugs	$120
Tier 3 - Non-Preferred Brand or Generic Drugs	$170
20% Co-insurance - Diabetic, Ostomy, and Urologic Supplies	

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	$120

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 Co-payment, Deductible or Co-insurance 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
- Diabetic supplies other than Bayer or Roche products
- Convenience or unit dose packaging
- 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 cosmetic purposes or hair growth
- Drugs used for weight management, including anorexiants and body building drugs
- Feiba
- Fertility Drugs
- 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

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 1 (800) 774-2677 or visit www.ccok.com. For all other questions, please call CommunityCare at (877) 293-8628.

+Products are excluded except as required by law.

CommunityCare Employers Choice

IDEA Plus 2B H Lg

Medical Calendar Year Deductible	
Per Individual	$1,000
Per Family	$2,000
Combined Medical and Pharmacy Out-of-Pocket Limit Per Calendar Year	
Per Individual	$3,000
Per Family	$6,000
Physician Services	
(Additional Co-insurances/Co-payments may apply)	
Primary Care Office Visits	$30 Co-payment per Visit
Specialty Care Office Visits	$50 Co-payment per Visit
Maternity Care	$30 Co-payment
(Co-payment for initial maternity care visit only)	
Preventive Care	No Co-payment
(Please see Member Handbook for details)	
Emergency Care and Urgent Care	
(Additional Co-insurances/Co-payments may apply, regardless of where outpatient services are rendered)	
Hospital Emergency Room	$100 Co-payment per Visit *
(Co-payment waived if admitted inpatient)	
After Hours, Urgent Care Facility	$50 Co-payment per Visit
Inpatient Hospital Care	
Room and Board	$200 Co-payment per day maximum of $1,000 per admission *
(Including all other medically necessary services)	

*After Deductible, the Co-insurance/Co-payment will apply.

^See prescription drug benefit plan for additional information.

Mental Health, Alcohol and Drug Services	
Inpatient	$200 Co-payment per day maximum of $1,000 per admission *
Outpatient	$30 Co-payment per Visit
Outpatient Surgery	
Primary Care Office Visits	$30 Co-payment per Visit
Specialty Care Office Visits	$50 Co-payment per Visit
Outpatient Surgical Facility	$150 Co-payment per Visit *
Outpatient Diagnostic Services	
(Additional Co-insurances/Co-payments may apply, regardless of where outpatient services are rendered)	
Laboratory	No Co-payment
Outpatient Radiology	No Co-payment
MRI, CT Scan and PET Scan	$150 Co-payment per Visit *
Rehabilitation Therapy	
(Up to 60 treatment days per disability per calendar year)	
Inpatient Rehabilitation	$150 Co-payment per Day *
Outpatient Physical, Occupational and Speech Therapy	$30 Co-payment per Visit *
Other Covered Services	
(Quantity limits may apply)	
Allergy Serum	20% Co-insurance *
Ambulance - Emergency Only	$50 Co-payment *
Chiropractic Care	$50 Co-payment per Visit *
(12 visits per month not to exceed 30 visits per year)	
Diabetic Supplies	20% Co-insurance
Durable Medical Equipment	20% Co-insurance *
Fertility Evaluation	50% Co-insurance *
General Anesthesia (during dental procedures as specified by state law)	No Co-insurance *
Hearing Aids (Children up to 18 years of age)	20% Co-insurance *

*After Deductible, the Co-insurance/Co-payment will apply.

^See prescription drug benefit plan for additional information.

Home Health Services	20% Co-insurance *
Hospice Care	No Co-insurance
Immunosuppressives, Injectables (except immunizations) and Drugs administered in the physician's office	Non-Preferred Prescription Co-payment ^
(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 Co-payment ^
(Except for specialty drugs within this category - see Specialty Drugs below)	
Administered in an outpatient facility	No Co-insurance *
Administered in a home setting	20% Co-insurance *
(Except for specialty drugs within this category - see Specialty Drugs below)	
Organ Transplants	No Co-insurance *
Orthotics and Prosthetics	20% Co-insurance *
Ostomy and Urologic Supplies	20% Co-insurance
Prescription Drug Benefit	See Outpatient Prescription Drug Benefit ^
Skilled Nursing Facility Care	$25 Co-payment per Visit *
(Up to 60 treatment days per disability per calendar year)	
Specialty Drugs	Specialty Prescription Co-payment ^
(Must be medically necessary and may be subject to prior authorization)	
All Other Covered Services	No Co-insurance *

Comments

- Deductible must be satisfied before Co-insurance/Co-payment begins.
- Co-payments 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 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.

*After Deductible, the Co-insurance/Co-payment will apply.

^See prescription drug benefit plan for additional information.

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.

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*After Deductible, the Co-insurance/Co-payment 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 $3,000 Per Individual $6,000 Per Family Per Calendar Year

Benefit Co-payments

Some preferred generic drugs have a $0 Co-payment.
Please note that Quantity Limits or Prior Authorization may apply.
Refer to your prescription drug formulary guide for additional information.
If the cost of the prescription is less than the applicable Co-payment, you will only be charged the cost of the prescription.

Retail Pharmacy

Up to a 30-day supply for each prescription.
A select list of prescription drugs may be eligible for up to a 60-day supply through the tablet-splitting program.
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20% Co-insurance - Diabetic, Ostomy, and Urologic Supplies	

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Covered Drugs and Devices

- Compound Drugs - at least one ingredient must be a legend drug
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- Drugs used for chemical dependency/alcohol treatment
- Immunizations (no Co-payment, Deductible or Co-insurance 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
- Diabetic supplies other than Bayer or Roche products
- Convenience or unit dose packaging
- 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 cosmetic purposes or hair growth
- Drugs used for weight management, including anorexiants and body building drugs
- Feiba
- Fertility Drugs
- 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

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+Products are excluded except as required by law.

MCO - HRA EXCLUSIONS and LIMITATIONS

The following headings are descriptive in nature and may not indicate a specific type of service.
The Plan does not cover the following:

1. Services and Supplies

- Services or supplies that are not Medically Necessary or that are not listed in the Plan's schedule of benefits as a Covered Service; services or supplies that are received prior to the Plan Participant's effective date of coverage or after the date the Plan Participant's coverage has terminated.

2. Ancillary Services and Supplies

- Assisted living, custodial, intermediate, domiciliary, convalescent or personal care (e.g. in-home meals, childcare, in-home daycare, and housekeeping services) rendered other than as part of skilled nursing services. Respite care or Inpatient services primarily for environmental change are not covered.

- Skilled Nursing Facility or skilled nursing services whose duration, per disability, exceeds sixty consecutive calendar days after the first date of treatment.

- Eye glass frames, corrective lenses, contact lenses (including prescriptions and fitting for contact lenses provided as a supplemental benefit), CommunityCare will cover corrective eyeglass or contact lenses following, cataract surgery (1 pair per lifetime).

- Radial keratotomy, LASIK or other similar refractive eye surgery, vision therapy or orthoptic treatment (e.g. eye exercises).

- Hearing aids, except as required by state law.

- Replacement of Durable Medical Equipment (e.g. prosthetic devices, orthopedic braces, and hearing aids) necessitated by loss, theft or misuse.

- Non-psychiatric or non-psychological education and therapy including but not limited to, materials, devices, and equipment.

- Personal hygiene and convenience items, including but not limited to, air conditioners, humidifiers, air and water purifiers, hypo- allergenic bedding, physical fitness equipment, whirlpool, bathtubs, stair lifts, ramps, or other modifications to the home or automobile.

- Arch supports, heel wedges, lifts, orthopedic shoes and foot orthotics are excluded except:

    - Therapeutic shoes/customized shoes are covered as Medically Necessary in the treatment of diabetic foot conditions.
    - Heel lifts/wedges are covered for the treatment of traumatic or postoperative leg-length discrepancy or significant hip disease (e.g. Legg Perthes disease).
    - Custom orthotics for the treatment of inflammatory foot conditions after failure of over-the-counter orthotics.

- Routine foot care, including but not limited to, trimming or removal of corns, calluses and nails; corn excision, treatment for fallen arches, flat or pronated feet, cramping of feet, bunions and muscle trauma, except as Medically Necessary to prevent or treat complications from diabetes.

- Massage of any type.

- Dance, poetry, music or art therapy.

- Surgical treatment of sleep disorders.

- Non-standard speech generating devices (e.g. PDAs) or software or hardware for non-standard speech generating devices.

- Durable Medical Equipment, oxygen and accessories for travel.

3. Chiropractic Maintenance Therapy

4. Cosmetic or Plastic Surgery

- Surgery performed primarily to improve or alter the Plan Participant's external appearance; except for Medically Necessary Reconstructive Surgery due to accidental injury within 5 years of the initial injury, functional congenital defects, or deformities that are the result of treatment or illness that substantially impairs bodily function.

- Services rendered to treat complications from cosmetic surgery.

- Breast reconstruction surgery, unless post-mastectomy for breast cancer or another breast condition for which mastectomy was Medically Necessary.

- Breast reduction surgery, for cosmetic purposes.

- Breast alteration surgery for males and females.

5. Dental Services

- Treatment on or to the teeth, replacement of teeth, treatment of gums (other than for tumors), restorative care, extractions, root canals, bonding, artificial teeth, crowns, dentures, orthodontia, dental prostheses or orthoses, splints and similar devices or appliances, or other dental service or surgery. CommunityCare will cover replacement or re-implantation of teeth within 30 days of the time of accidental injury and Medically Necessary follow up care.

- Correction of occlusive jaw defects, dental implants, grafting of alveolar ridges, as Medically Necessary to treat a congenital defect.

- Treatment of soft tissue for the purpose of facilitating dental procedures.

- Orthognathic conservative treatment limit $1500 per year for non-surgical treatment, as authorized and as Medically Necessary.

6. Experimental or Investigational Therapies

- Experimental or investigational medications, surgeries, devices, medical treatment or other health care procedures.

- Services and technologies whose long-term efficacy or effect is undetermined or unproven, or whose efficacy is no greater than that of traditionally accepted standard treatment.

7. Genetic Analysis, Services or Testing

- Genetic testing and counseling for Family planning purposes.

8. Medical Care or Hospital Services

- All non-emergency medical and hospital services rendered without authorization from CommunityCare, when this handbook or the Schedule of Benefits indicates that prior authorization is required.

- Services or Supplies not deemed Medically Necessary.

- Charges related to telemedicine or for online, e-mail or telephone evaluation and management services.

- Services or supplies rendered by the Plan Participant or his or her relative (e.g., spouse, Child, brother, sister or the Plan Participant's parent or spouse).
- Services to treat an injury or illness resulting from war or acts of war, declared or undeclared, or to treat an injury or illness incurred during or as a result of serving in the military or an auxiliary unit thereto.

- Illness or injury resulting from or occurring during the commission of a crime by the Plan Participant or while the Plan Participant is engaged in an illegal act, illegal occupation, felonious act or aggravated assault.

- Coverage for services or supplies while the Plan Participant is incarcerated after the adjudication of guilt and sentencing to a penal institution.

- Private Rooms, unless Medically Necessary.

- Services and supplies for treatment of conditions where the Plan Participant is entitled to care or reimbursement under Workers' Compensation insurance.

9. Non-Covered Services

- Services or supplies which are incident to an Excluded Service or supply. Additionally, inpatient or outpatient care which is necessitated in whole or in part by a non-covered condition or service.

10. Non-licensed Professionals

- Any confinement, treatment, service or supply not recommended by, or recommended other than by, an In-Network Provider.

11. Obstetrical and Infertility Services

- In-vitro fertilization, artificial insemination, embryo transfers and ovarian transplants; and related testing and procedures (e.g., harvesting and monitoring, etc.).

- Any pharmaceuticals used in the augmentation of fertility, including services to evaluate patients during treatment with these agents, preparing the patient for treatment or monitoring treatment of these agents or treating the known complications of these agents.

- Services resulting from the non-emergent delivery of a baby performed by a Provider who is not part of CommunityCare's Provider Network without prior authorization.

- Any expense related to surrogacy or adoption. Maternity charges incurred by a covered person acting as a surrogate mother are not covered. For the purpose of this Plan, the Child of a surrogate mother will not be considered a Dependent of the surrogate mother or her spouse if the mother has entered into a contract or other understanding pursuant to which she expresses intent to relinquish custody of the Child following birth to an adoptive or foster parent.

- Reversal of voluntary infertility.

- Contact Customer Services prior to initiating any services for family planning or infertility to determine if those services are excluded under your Plan.

- Abortions.

12. Pharmaceuticals

- Human growth hormones (HGH) or similar medications or therapies.

- Over-the-counter medications and Prescription Drugs with an over-the-counter equivalent, except as required by law.

- Medical supplies that are available over-the-counter, including but not limited to, dressings, antiseptics, needles, syringes, blood pressure monitoring devices, braces, splints, wound care supplies and personal comfort and convenience items. This exclusion does not include blood glucose monitoring strips, needles and syringes for diabetes when purchased from a Network pharmacy.
- Convenience or unit dose packaging, drugs used for cosmetic purposes or hair growth, lost, damaged or stolen prescriptions, prescriptions reimbursable under Workers' Compensation or any other government program or insurance Plan and prescriptions written by Out-of-Network Providers.

- Additional pharmacy exclusions apply, regardless of where services are rendered. See Prescription Drug benefit for details.

13. Physical Occupational and Speech Therapy

- Physical, occupational or speech therapy in excess of sixty treatment days (including inpatient and outpatient) per condition per calendar year.

- Any treatment that will not result in significant improvement within sixty treatment days.

14. Private Duty Nursing Services

15. Psychiatric Services

- Halfway house.

- Family and marital counseling.

- Psychiatric treatment for conditions, which, in the professional judgment of Providers, is not subject to significant improvement through short-term therapy.

- Psychological testing, except when pre-authorized and conducted to diagnose a psychiatric disorder or evaluate the need for a change in treatment plans.

- Charges associated with support groups are not covered unless part of the contracting Provider's authorized treatment program.

- Alternative treatment programs for anorexia, bulimia, obesity or weight control. Evaluations other than for diagnosing or treating a medical or mental health condition (e.g., Child custody).

- Educational evaluation and/or intervention for the purpose of improving learning in school.

16. Transplants

- Transplants and related services deemed not appropriate and/or not Medically Necessary by CommunityCare.

- Any transplant services (including evaluations related thereto) that are rendered without prior authorization from CommunityCare or that are rendered by a Provider that is not within CommunityCare's transplant Network.

- CommunityCare will not cover services incurred by the Plan Participant to donate an organ to another person who is not also a Plan Participant. CommunityCare will cover the organ donors Medically Necessary transplant services if the organ recipient is a Plan Participant.

- Animal to human transplants; transplants, procedures or artificial or mechanical devices that are considered to be experimental, investigational or unproven; transplants rendered at a non-designated transplant facility and artificial or mechanical devices.

17. Transportation/Lodging

- Ambulance Services, unless Medically Necessary and authorized by CommunityCare, or rendered as Emergency Services. Additionally, ambulance and emergency medical technician services may not be covered if the Plan Participant refuses to be transported to the nearest emergency facility.

- Transportation and Lodging are not covered, except in connection with authorized transplants occurring at an In-Network facility.

18. Sex change services and procedures

- Services or procedures related to changing a Plan Participant's sex. This includes all services and medications that are given in preparation for, or that are necessary as a result following, sex reassignment surgery.
  - For example, the Plan does not cover pre- or post-surgery hormone therapy psychiatric evaluations or therapy related to sex reassignment, or services to treat complications arising from sex reassignment services or procedures.

19. Weight Reduction Programs

- Outpatient or inpatient weight loss programs, materials or meal replacements.
- Weight Reduction Surgery/Procedures of any type.
- Weight loss drugs.
- Food, food replacements, food supplements and food substitutes. This is not intended to exclude meals that the Member receives during a covered inpatient hospital stay.

20. Services to prevent or terminate pregnancy, including, but not limited to, the following

- Sterilization procedures, including, but not limited to, vasectomies
- Sterilization reversal procedures by any means.

21. Expanded Women's Health

- EC Plan B One-step (the "morning after pill"); Ella; Ulipristal Acetate (the "week after pill"); copper intrauterine devices; hormonal intrauterine devices; any drug, device, procedure, or mechanism which has the purpose or effect of preventing an already fertilized egg from developing further by inhibiting or terminating its attachment to the uterus.

Questions You May Have About

CommunityCare™

How do I choose a Primary Care Physician (PCP)?
When you enroll in CommunityCare MCO, you choose a PCP from CommunityCare MCO's provider directory. Your PCP will manage and coordinate your health care needs. You may choose a different PCP/network for each covered family member. Your health care will be arranged within the network you choose, which includes your PCP, specialists, obstetrician/gynecologist, hospital and mental health providers.

You may change your PCP selection throughout the year. Please call our Member Services department for information regarding PCP changes.

What about specialists?
Contracted specialists are listed separately in the provider directory. CommunityCare MCO members may set up an appointment with most physicians in their network **without referral** by their PCP. Plus, pre-authorization is easy for those services that require it.

What about emergency care?
If an emergency threatens life or limb, go immediately to the nearest emergency room. If you receive out-of-network emergency care services, you may wish to contact your PCP to coordinate your care.

What about urgent care?
You might need urgent care if your illness or injury is severe enough to need treatment within 24 hours. If you receive out-of-network urgent care services, you may wish to contact your PCP to coordinate your care.

What about preventive care?
Preventive care services, including an annual physical, an annual well woman exam and an annual vision screening, are covered benefits. The 24-hour nurse and health information line is also available and is free to every member.

What if I have questions?
If you have further questions or need help selecting a doctor, call CommunityCare MCO Member Services at (918) 594-5242 in Tulsa or (8ᎳᎳ) ᏦᏔᏁ-ᏦlhᏦ statewide, or visit our website at www.ccok.com.

Oklahoma's best choice for health care.

NOTES

CommunityCare Employers Choice

PPO Plan 6A FH Lg

	In-Network	Out-of-Network
Medical Calendar Year Deductible		
Per Member	$1,000	$2,000
Per Family	$2,000	$4,000
Combined Medical and Pharmacy Out-of-Pocket Limit Per Calendar Year		
Per Member	$3,500	Unlimited
Per Family	$7,000	Unlimited
Physician Services		
(Additional Co-insurances/Co-payments may apply)		
Primary Care Office Visits	$30 Co-payment per Visit	40% Co-insurance *
Specialty Care Office Visits	$50 Co-payment per Visit	40% Co-insurance *
Preventive Care	No Co-payment	30% Co-insurance *
(Please see your Certificate for details)		
Emergency Care and Urgent Care		
(Additional Co-insurances/Co-payments may apply)		
Hospital Emergency Room	$50 Co-payment per Visit	$50 Co-payment per Visit
(Co-payment waived if admitted inpatient) (Benefits will be reduced by 50% if care is not deemed to be a medical emergency)		
Urgent Care Facility	$50 Co-payment per Visit	40% Co-insurance *
Inpatient Hospital Care		
Room and Board	$250 Co-payment per admission then 20% Co-insurance *	$250 Co-payment per admission then 40% Co-insurance *
(Requires pre-certification, except maternity) *(Including all other medically necessary services)*		

*After Deductible, the Co-insurance/Co-payment will apply.

^See prescription drug benefit plan for additional information.

Mental Health, Alcohol and Drug Services		
Inpatient	$250 Co-payment per admission then 20% Co-insurance *	$250 Co-payment per admission then 40% Co-insurance *
(Inpatient requires pre-certification)		
Outpatient	$30 Co-payment per Visit	40% Co-insurance *
Outpatient Surgery		
Primary Care Office Visits	$30 Co-payment per Visit	40% Co-insurance *
Specialty Care Office Visits	$50 Co-payment per Visit	40% Co-insurance *
Outpatient Surgical Facility	$250 Co-payment per admission then 20% Co-insurance *	$250 Co-payment per admission then 40% Co-insurance *
(Requires pre-certification)		
Outpatient Diagnostic Services		
(Additional Co-insurances/Co-payments may apply, regardless of where outpatient services are rendered)		
Laboratory	No Co-payment	30% Co-insurance *
Outpatient Radiology	No Co-payment	30% Co-insurance *
MRI, CT Scan and PET Scan	20% Co-insurance *	40% Co-insurance *
(Requires pre-certification)		
Rehabilitation Therapy		
(Up to 60 treatment days per disability per calendar year)		
Inpatient Rehabilitation	20% Co-insurance *	40% Co-insurance *
(Inpatient requires pre-certification)		
Outpatient Physical, Occupational and Speech Therapy	20% Co-insurance *	40% Co-insurance *
Other Covered Services		
(Quantity limits may apply)		
Allergy Serum	20% Co-insurance *	40% Co-insurance *
Ambulance - Air Transportation	20% Co-insurance *	50% Co-insurance up to plan maximum of $20,000 after plan pays $7,500
(Emergency only)		
Ambulance - Ground Transportation	20% Co-insurance *	20% Co-insurance *
(Emergency only)		
Chiropractic Care	20% Co-insurance *	40% Co-insurance *
(12 visits per month not to exceed 30 visits per year)		

*After Deductible, the Co-insurance/Co-payment will apply.

^See prescription drug benefit plan for additional information.

Diabetic Supplies	20% Co-insurance	50% Co-insurance
(Insulin pumps, including related supplies, and continuous glucose monitors, require pre-certification)		
Durable Medical Equipment	20% Co-insurance *	40% Co-insurance *
Fertility Evaluation	50% Co-insurance *	50% Co-insurance *
General Anesthesia (during dental procedures as specified by state law)	No Co-insurance *	30% Co-insurance *
Hearing Aids (Children up to 18 years of age)	20% Co-insurance *	40% Co-insurance *
Home Health Services	20% Co-insurance *	40% Co-insurance *
(Up to 60 treatment days per disability per calendar year)		
Hospice Care	No Co-insurance	30% Co-insurance
(Inpatient requires pre-certification)		
Immunosuppressives, Injectables (except immunizations) and Drugs administered in the physician's office	Non-Preferred Prescription Co-payment ^	40% Co-insurance *
(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 Co-payment ^	40% Co-insurance *
(Except for specialty drugs within this category - see Specialty Drugs below)		
Administered in an outpatient facility	20% Co-insurance *	40% Co-insurance *
Administered in a home setting	20% Co-insurance *	40% Co-insurance *
(Except for specialty drugs within this category - see Specialty Drugs below)		
Organ Transplants	20% Co-insurance *	40% Co-insurance *
(Inpatient requires pre-certification)		
Orthotics and Prosthetics	20% Co-insurance *	40% Co-insurance *
Ostomy and Urologic Supplies	20% Co-insurance *	40% Co-insurance *
Prescription Drug Benefit	See Outpatient Prescription Drug Benefit ^	Not Covered
Radiation Therapy	20% Co-insurance *	40% Co-insurance *
Skilled Nursing Facility Care	20% Co-insurance *	40% Co-insurance *
(Up to 60 treatment days per disability per calendar year) *(Inpatient requires pre-certification)*		
Specialty Drugs	Specialty Prescription Co-payment ^	40% Co-insurance *
(Must be medically necessary and may be subject to prior authorization)		
All Other Covered Services	20% Co-insurance *	40% Co-insurance *

*After Deductible, the Co-insurance/Co-payment will apply.

^See prescription drug benefit plan for additional information.

Comments

- Deductible amounts and out-of-pocket limitations are separate for in-network provider and out-of-network provider benefits.
- Your medical coverage includes one or more features to help control medical costs. Some features will affect the amount of benefits payable. See the special provisions section of your Certificate for further explanation.
- All services will be reviewed for medical necessity. If services are determined not to be medically necessary, coverage will be denied.
- There will be a reduction of 25% (up to a maximum of $1,000 per occurrence) for failing to receive pre-certification for those services that require it. These penalty amounts will not apply to the out-of-pocket limitations.
- In-network benefits are available for transplant services rendered at one of CommunityCare's in-network transplant facilities. Please contact (800) 544-8922 for a directory of in-network providers. Out-of-network benefits are available for transplant services; however, all transplants require pre-certification. For meals, lodging and transportation benefit information, please refer to your Certificate.
- A calendar year is defined as the time period from January 1 - December 31.
- Out-of-network providers have the right to balance bill regardless of the level of the benefits payable.
- 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.

Out-of-Network Requirements

- All out-of-network provider calculations are based on the out-of-network fee schedule as described in your Certificate. The enrollee is also responsible for any amount charged by a provider in excess of the out-of-network fee schedule.
- "Balance Billed Amounts" do not apply to out-of-pocket limitation.

Urgent and Emergency Care

If you have an emergency that is considered life or limb threatening, go to the nearest hospital or emergency room.

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

THIS IS NOT A CONTRACT. It is intended only as a source of general information and is subject to the terms of your Certificate.

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*After Deductible, the Co-insurance/Co-payment 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 $3,500 Per Individual $7,000 Per Family Per Calendar Year

Benefit Co-payments

Some preferred generic drugs have a $0 Co-payment.
Please note that Quantity Limits or Prior Authorization may apply.
Refer to your prescription drug formulary guide for additional information.
If the cost of the prescription is less than the applicable Co-payment, you will only be charged the cost of the prescription.

Retail Pharmacy

Up to a 30-day supply for each prescription.
A select list of prescription drugs may be eligible for up to a 60-day supply through the tablet-splitting program.
(Refer to your prescription drug formulary guide.)

Tier 1 - Preferred Generic Drugs	$15
Tier 2 - Preferred Brand Drugs	$35
Tier 3 - Non-Preferred Brand or Generic Drugs	$60
20% Co-insurance - Diabetic, Ostomy, and Urologic Supplies	

Mail Order Pharmacy

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

Tier 1 - Preferred Generic Drugs	$30
Tier 2 - Preferred Brand Drugs	$70
Tier 3 - Non-Preferred Brand or Generic Drugs	$120
20% Co-insurance - Diabetic, Ostomy, and Urologic Supplies	

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	$60

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 Co-payment, Deductible or Co-insurance 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
- Diabetic supplies other than Bayer or Roche products
- Convenience or unit dose packaging
- 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 cosmetic purposes or hair growth
- Drugs used for weight management, including anorexiants and body building drugs
- Feiba
- Fertility Drugs
- 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

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 1 (800) 774-2677 or visit www.ccok.com. For all other questions, please call CommunityCare at (877) 293-8628.

+Products are excluded except as required by law.

PPO - EXCLUSIONS and LIMITATIONS

The following headings are descriptive in nature and may not indicate a specific type of service. Except as specifically provided elsewhere in the Agreement, no coverage will be provided by CommunityCare for the following:

1. Services and Supplies

- Services or supplies that are not Medically Necessary or that are not listed in the Plan's schedule of benefits as a Covered Service; services or supplies that are received prior to the Plan Participant's effective date of coverage or after the date the Plan Participant's coverage has terminated.

2. Ancillary Services and Supplies

- Assisted living, custodial, intermediate, domiciliary, convalescent or personal care (e.g. in-home meals, childcare, in-home daycare, and housekeeping services) rendered other than as part of skilled nursing services. Respite care or Inpatient services primarily for environmental change are not covered.

- Skilled Nursing Facility or skilled nursing services whose duration, per disability, exceeds sixty consecutive calendar days after the first date of treatment.

- Eye glass frames, corrective lenses, contact lenses (including prescriptions and fitting for contact lenses provided as a supplemental benefit), CommunityCare will cover corrective eyeglass or contact lenses following, cataract surgery (1 pair per lifetime).

- Radial keratotomy, LASIK or other similar refractive eye surgery, vision therapy or orthoptic treatment (e.g. eye exercises).

- Hearing aids, except as required by state law.

- Replacement of Durable Medical Equipment (e.g. prosthetic devices, orthopedic braces, and hearing aids) necessitated by loss, theft or misuse.

- Non-psychiatric or non-psychological education and therapy including but not limited to, materials, devices, and equipment.

- Personal hygiene and convenience items, including but not limited to, air conditioners, humidifiers, air and water purifiers, hypo- allergenic bedding, physical fitness equipment, whirlpool bathtubs, stair lifts, ramps, or other modifications to the home or automobile.
- Arch supports, heel wedges, lifts, orthopedic shoes and foot orthotics are excluded except:
    - Therapeutic shoes/customized shoes are covered as Medically Necessary in the treatment of diabetic foot conditions.
    - Heel lifts/wedges are covered for the treatment of traumatic or post-operative leg-length discrepancy or significant hip disease (e.g. Legg Perthes disease).
    - Custom orthotics for the treatment of inflammatory foot conditions after failure of over-the-counter orthotics.
- Routine foot care, including but not limited to, trimming or removal of corns, calluses and nails; corn excision, treatment for fallen arches, flat or pronated feet, cramping of feet, bunions and muscle trauma, except as Medically Necessary to prevent or treat complications from diabetes.
- Massage of any type.

- Dance, poetry, music or art therapy.
- Surgical treatment of sleep disorders.
- Non-standard speech generating devices (e.g. PDAs) or software or hardware for non-standard speech generating devices.

3. Chiropractic Maintenance Therapy

4. Cosmetic or Plastic Surgery

- Surgery performed primarily to improve or alter the Member's external appearance, except for Medically Necessary Reconstructive Surgery due to accidental injury within 5 years of the initial injury, functional congenital defects or deformities that are the result of treatment or illness that substantially impairs bodily function.
- Services rendered to treat complications from cosmetic surgery.
- Breast reconstruction surgery, unless post-mastectomy for breast cancer or another breast condition for which mastectomy was Medically Necessary.
- Breast reduction surgery, for cosmetic purposes.
- Breast alteration surgery for males and females.

5. Dental Services

- Treatment on or to the teeth, replacement of teeth, treatment of gums (other than for tumors), restorative care, extractions, root canals, bonding, artificial teeth, crowns, dentures, orthodontia, dental prostheses or orthoses, splints and similar devices or appliances, or other dental service or surgery. CommunityCare will cover replacement or re-implantation of teeth within 30 days of the time of accidental injury and Medically Necessary follow up care.
- Correction of occlusive jaw defects, dental implants, grafting of alveolar ridges, as Medically Necessary to treat a congenital defect.
- Treatment of soft tissue for the purpose of facilitating dental procedures.
- Orthognathic conservative treatment limit $1500 per year for non-surgical treatment, as authorized and as Medically Necessary.

6. Experimental or Investigational Therapies

- Experimental or investigational medications, surgeries, devices, medical treatment or other health care procedures.
- Services and technologies whose long-term efficacy or effect is undetermined or unproven, or whose efficacy is no greater than that of traditionally accepted standard treatment.

7. Genetic Analysis, Services or Testing

- Genetic testing and counseling for Family planning purposes.

8. Medical Care or Hospital Services

- All non-emergency medical and hospital services rendered without authorization from CommunityCare, when this evidence of coverage or the Schedule of Benefits indicates that prior authorization is required
- Services and Supplies not deemed Medically Necessary.

- Charges related to telemedicine of for online, e-mail or telephone evaluation and management services.

- Treatment and related services rendered in an inpatient or outpatient facility or emergency department before the Member leaves against medical advice, as well as services to treat a worsening of the same condition thereafter.

- Services or supplies rendered by you or a relative (e.g. your spouse, Child, brother, sister, or the parent of you or your spouse).

- Services to treat an injury or illness resulting from war or acts of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an Employer.

- Illness or injury resulting from or occurring during the commission of a crime by the Member or while the Member is engaged in an illegal act, illegal occupation, felonious act or aggravated assault.

- Coverage for services or supplies while the Member is incarcerated after the adjudication of guilt and sentencing to a penal institution.

- Private Rooms, unless Medically Necessary.

- Services and supplies for treatment of conditions where the Member is entitled to care or reimbursement under Workers' Compensation insurance.
- Charges incurred while a permanent resident outside of the United States.

9. Non-Covered Services

- Services or supplies which are incidental to an Excluded Service or supply. Additionally, Inpatient or Outpatient care which is necessitated in whole or in part by a non-covered condition or service.

10. Non-licensed Professionals

- Any confinement, treatment, service or supply not recommended by or recommended other than by, a duly licensed physician or other health care Provider whose services are otherwise covered under this Plan.

11. Obstetrical and Infertility Services

- Any pharmaceuticals used in the augmentation of fertility, including services to evaluate patients during treatment with these agents, preparing the patient for treatment or monitoring treatment of these agents or treating the known complications of these agents.

- Any expense related to surrogacy or adoption. Maternity charges incurred by a covered person acting as a surrogate mother is not covered. For the purpose of this Plan, the Child of a surrogate mother will not be considered a Dependent of the surrogate mother or her spouse if the mother has entered into a contract or other understanding pursuant to which she expresses intent to relinquish custody of the Child following birth to an adoptive of foster parent.

- Reversal of voluntary infertility.

- Contact Member Services prior to initiating any services for family planning or infertility to determine if those services are excluded under your Plan.

- Abortions.

12. Pharmaceuticals

- Human growth hormones (HGH) or similar medications or therapies.

- Over-the-counter medications and Prescription Drugs with an over-the- counter equivalent, except as required by law.

- Medical supplies that are available over-the-counter, including but not limited to, dressings, antiseptics, needles, syringes, blood pressure monitoring devices, braces, splints, wound care supplies and personal comfort and convenience items. This exclusion does not include blood glucose monitoring strips, needles and syringes for diabetes when purchased from a Network pharmacy.

- Convenience or unit dose packaging, drugs used for cosmetic purposes or hair growth, lost, damaged or stolen prescriptions, prescriptions reimbursable under Workers' Compensation or any other government program or insurance Plan, or with respect to which the Member has no obligation to pay in the absence of insurance.

- Additional Pharmacy exclusions apply, regardless of where services are rendered. See Prescription drug benefit for details.

13. Physical Occupational and Speech Therapy

- Physical, occupational or speech therapy in excess of sixty treatment days (including Inpatient and Outpatient) per calendar year.

- Any treatment that will not result in significant improvement within sixty days.

14. Private Duty Nursing Services

15. Psychiatric Services

- Halfway house

- Family and marital counseling.

- Psychiatric treatment for conditions, which, in the professional judgment of Providers, is not subject to significant improvement through short-term therapy.

- Psychological testing, except when pre-certified and conducted to diagnose a psychiatric disorder or evaluate the need for a change in treatment plans.

- Charges associated with support groups are not covered unless part of the Provider's authorized treatment program.

- Alternative treatment programs for anorexia, bulimia, obesity or weight control.

- Evaluations for legal purposes (e.g. Child custody, competency).

- Educational evaluation and/or intervention for the purpose of improving learning in school.

16. Transplants

- Transplants and related services deemed not appropriate and/or not Medically Necessary by CommunityCare.

- Any transplant services (including evaluations related thereto) that are rendered without pre- certification from CommunityCare.

- CommunityCare will not cover services incurred by the Member to donate an organ to another person who is not a CommunityCare Member. CommunityCare will cover the organ donors Medically Necessary transplant services if the organ recipient is a CommunityCare Member.

- Animal to human transplants; transplants, procedures or artificial or mechanical devices that are considered to be experimental, investigational or unproven; transplants rendered at a non-designated transplant facility and artificial or mechanical devices.

17. Transportation/Lodging

- Ambulance Services, unless Medically Necessary or rendered as Emergency Services. Additionally, ambulance and emergency medical technician services may not be covered if the Member refuses to be transported to the nearest emergency facility.

- Transportation and Lodging are not covered, except in connection with authorized transplants occurring at an In-Network facility. See certificate for additional information.

18. Sex Change Services and Procedures

- Services or procedures related to changing a Plan Participant's sex. This includes all services and medications that are given in preparation for, or that are necessary as a result following, sex reassignment surgery. For example, the Plan does not cover pre- or post-surgery hormone therapy psychiatric evaluations or therapy related to sex reassignment, or services to treat complications arising from sex reassignment services or procedures.

19. Weight Reduction Programs

- Outpatient or inpatient weight loss programs, materials or meal replacements.

- Weight Reduction Surgery/Procedures of any type.

- Weight loss drugs.

- Food, food replacements, food supplements and food substitutes. This is not intended to exclude meals that the Member receives during a covered inpatient hospital stay.

20. Services to prevent or terminate pregnancy, including, but not limited to, the following

- Sterilization procedures, including, but not limited to, vasectomies.

- Sterilization reversal procedures by any means.

21. Expanded Women's Health

- EC Plan B One-step (the "morning after pill"); Ella; Ulipristal Acetate (the "week after pill"); copper intrauterine devices; hormonal intrauterine devices; any drug, device, procedure, or mechanism which has the purpose or effect of preventing an already fertilized egg from developing further by inhibiting or terminating its attachment to the uterus.

NOTES

CommunityCare™

Mail Order Prescription Drug Program

Receive a 90-day supply for two copays

Interested in receiving your maintenance medications through the mail instead of going to the pharmacy? CommunityCare is pleased to provide a convenient way to order your maintenance medications and have them delivered to you.

Maintenance medications are those taken on a regular or long-term basis, often for chronic conditions such as diabetes, arthritis and heart disease. For just two copays, you will receive a 90-day supply of your maintenance medication.

Mail Order Prescription Drug Program Benefits

√ Convenient
√ No waiting in lines at the pharmacy – saves time
√ Greater confidentiality
√ Delivery to your home, office or other location
√ Pharmacists readily available to answer your questions
√ Prescription transfers upon request
√ Ordering is easy – especially refills
√ Orders are processed quickly
√ Your doctor will automatically be contacted if you order expired prescriptions or run out of refills

Ordering is Easy

CommunityCare offers two choices for the mail order prescription drug program. To participate in the mail order prescription drug program, simply complete and mail the order form attached to the mail service prescription program brochure. You will need to enclose your original prescription or transfer information and the copay for each prescription ordered. If you need a brochure, please call our pharmacy help desk at 1-877-293-8628.

You may also register for the program on the Internet. Visit **www.ccok.com** to link to the mail order prescription drug program online.

Ordering Refills

There are several ways to order refills:

√ Phone
√ Fax
√ Internet
√ Mail

Questions?

If you have questions about the program or your prescription drug benefit, please call the pharmacy help desk at 1-877-293-8628.

Please note: 1.) Exclusions and limitations apply. 2.) Controlled substances and acute medications are not available via mail order.

The CommunityCare formulary is on the Web at www.ccok.com.

CommunityCare™

Understanding Your CommunityCare Pharmacy Benefits

➢Your prescription drug benefit

•A prescription drug program with a range of choices while continuing to help control costs

•Program is set up to help you get the appropriate prescription for any medical condition that's covered under your plan

➢What is a formulary?

•A formulary is a list of preferred drugs

•The formulary meets our standards for safety, effectiveness and affordability

•Formulary is extensive and includes more than 1,500 generic and brand name drugs

➢Who reviews drugs for the formulary?

•Formulary drugs are constantly monitored and reviewed by our Pharmacy and Therapeutics Committee

•Pharmacy and Therapeutics Committee is made up of physicians, pharmacists and other health care professionals

Need a copy of the formulary?

•Receive a copy of CommunityCare's formulary by calling CommunityCare's Pharmacy Help Desk at (877) 293-8628

•You may also access the formulary by visiting www.ccok.com

➢Understanding brand and generic drugs

•In most cases, you can choose a generic equivalent of a brand name drug

• The term "generic" does not mean it's less effective or poor quality

•The chemical makeup of generic drugs is identical to their brand name equivalents

•Both generic and brand name drugs must meet the same strict Food and Drug Administration standards

•Generic drugs generally cost less because the price does not reflect development and advertising costs

•CommunityCare encourages the use of generic drugs as a safe, effective way to help control health care costs

•To receive the greatest value from your plan, always ask your doctor or pharmacist for a generic when you receive a prescription

•Check for generic availability because if you or your doctor request a brand name drug when its generic equivalent is available, you will pay an additional cost

➢A pharmacy program that emphasizes quality, choice and value

•Your pharmacy benefit identifies four categories or types of prescription drugs

•Each category has a corresponding copayment level

•Refer to your prescription drug plan for descriptions of the four categories

•Copayment amounts for these categories vary by plan

•Copayment amounts are indicated on your ID card

•These benefits only apply if you use a participating CommunityCare network pharmacy

•You can verify if your pharmacy participates in the CommunityCare pharmacy network by calling the Pharmacy Help Desk at (877) 293-8628 or by referring to your pharmacy directory

•A searchable pharmacy directory is also available at www.ccok.com

CommunityCare's $0 Copay Program
Commercial Plans
For Select Formulary Generic Drugs

CommunityCare continually searches for ways to help members save money on prescription drugs while improving health outcomes. CommunityCare has a voluntary program developed to lower out-of-pocket costs for certain prescription drugs and promote compliance with prescribed drug therapy. Essentially, this program reduces the copayment for **select formulary generic drugs** to $0! Prescriptions filled at a participating pharmacy (retail or mail order) for any of the generic drugs listed below will be filled for a $0 copay!

$0 Copay Generic Drug List

***Please note*: Only the select generic drugs listed in the first column qualify for a $0 copay.**

Select Generic Drugs	*Brand Name Drugs*	
	Equivalent Brand ***Note: To take one of the $0 copay select generic drugs instead of one of the equivalent brand name drugs below, simply request the change at the pharmacy (a new prescription is not needed).***	**Other Brands** ***Note: To take one of the $0 copay select generic drugs instead of one of the brand name drugs below, you will need a doctor's prescription for the select generic drug.***
Antidepressants		
Fluoxetine	Prozac	Lexapro (escitalopram), Paxil CR(paroxetine ER)
Paroxetine	Paxil	
Sertraline	Zoloft	
Citalopram	Celexa	
Bupropion, Bupropion SR	Wellbutrin, Wellbutrin SR	Wellbutrin XL (budeprion XL), Effexor (venlafaxine), Effexor XR (venlafaxine ER)
Mirtazepine	Remeron	
Anticholesterol Agents		
Lovastatin	Mevacor	Advicor, Altoprev, Crestor, Lescol (fluvastatin), Lescol XL, Lipitor (atorvastatin), Zetia
Simvastatin	Zocor	
Pravastatin	Pravachol	
Blood Pressure Agents		
Benazepril/HCTZ	Lotensin, Lotensin HCT	Aceon, Accupril (quinapril), Accuretic (quinaretic), Altace (ramipril), Mavik (trandolapril), Monopril & Monopril HCT (fosinopril & fosinopril HCT), Univasc (moexipril), Uniretic (moexipril HCTZ), Atacand & Atacand HCT, Avapro (irbesartan), Avalide (irbesartan HCTZ), Benicar & Benicar HCT, Cozaar (losartan), Hyzaar (losartan), Diovan & Diovan HCT(valsartan HCTZ), Micardis & Micardis HCT, Teveten (eprosartan) & Teveten HCT, Procardia (nifedipine),verapamil, diltiazem, Norvasc (amlodipine)
Captopril, Captopril/HCTZ	Capoten, Capozide	
Lisinopril, Lisinopril/ HCTZ	Zestril/Zestoretic, Prinivil/Prinzide	
Enalapril, Enalapril/ HCTZ	Vasotec, Vaseretic	
Hydrochlorthiazide	Oretic	
Chlorthalidone	Hygroton	
Atenolol	Tenormin	Procardia (nifedipine),Verapamil, Diltiazem, Norvasc (amlodipine), Toprol XL (metoprolol succinate)
Metoprolol	Lopressor	
Anti-inflammatory Agents		
Diclofenac	Voltaren	Anaprox & Anaprox DS, Ansaid, Arthrotec (diclofenac/misoprostol), Celebrex, Daypro (oxaprozin), etodolac & etodolac CR, fenoprofen, flurbiprofen, ketoprofen, Mobic (meloxicam), Voltaren (diclofenac sodium), oxaprozin, Relafen (nabumetone), tolmetin
Indomethacin	Indocin	
Piroxicam	Feldene	
Sulindac	Clinoril	

*If your prescription drug plan includes a deductible, the deductible must be satisfied **before** the $0 copay applies.* *11/2015*

Save on your normal monthly copay by splitting a higher strength tablet in half (of eligible medications) to reach the prescribed daily dose!

CommunityCare's Copay Savings Program *(for tablet splitting)*

Eligible Medication Dosage Guidelines

Note: This program only applies to the medications listed below.

If your current daily dose is:	**Your out-of-pocket cost will be reduced with a prescription for the higher strength tablet when the tablet is split in half. One copay will apply to a 60-day supply at retail.**
Cholesterol-Lowering Drugs	
Crestor® 5mg	Crestor® 10mg: ½ tablet daily
Crestor® 10mg	Crestor® 20mg: ½ tablet daily
Crestor® 20mg	Crestor® 40mg: ½ tablet daily
Lipitor® 10mg	Lipitor® 20mg: ½ tablet daily
Lipitor® 20mg	Lipitor® 40mg: ½ tablet daily
Lipitor® 40mg	Lipitor® 80mg: ½ tablet daily
Lovastatin/Mevacor® 10mg	Lovastatin/Mevacor® 20mg: ½ tablet daily
Lovastatin/Mevacor® 20mg	Lovastatin/Mevacor® 40mg: ½ tablet daily
Pravachol® 10mg	Pravachol® 20mg: ½ tablet daily
Pravachol® 20mg	Pravachol® 40mg: ½ tablet daily
Pravachol® 40mg	Pravachol® 80mg: ½ tablet daily
Zocor® 5mg	Zocor® 10mg: ½ tablet daily
Zocor® 10mg	Zocor® 20mg: ½ tablet daily
Zocor® 20mg	Zocor® 40mg: ½ tablet daily
Zocor® 40mg	Zocor® 80mg: ½ tablet daily
Antidepressants	
Citalopram/Celexa® 10mg	Citalopram/Celexa® 20mg: ½ tablet daily
Citalopram/Celexa® 20mg	Citalopram/Celexa® 40mg: ½ tablet daily
Effexor® 37.5mg	Effexor® 75mg: ½ tablet daily
Effexor® 50mg	Effexor® 100mg: ½ tablet daily
Fluoxetine 10mg TABLET	Fluoxetine 20mg: ½ tablet daily
Fluvoxamine 25mg	Fluvoxamine 50mg: ½ tablet daily
Fluvoxamine 50mg	Fluvoxamine 100mg: ½ tablet daily
Lexapro® 5mg	Lexapro® 10mg: ½ tablet daily
Lexapro® 10mg	Lexapro® 20mg: ½ tablet daily
Mirtazapine/Remeron® 15mg	Mirtazapine/Remeron® 30mg: ½ tablet daily
Paroxetine/Paxil® IR 10mg	Paroxetine/Paxil® IR 20mg: ½ tablet daily
Paroxetine/Paxil® IR 20mg	Paroxetine/Paxil® IR 40mg: ½ tablet daily
Zoloft® 25mg	Zoloft® 50mg: ½ tablet daily
Zoloft® 50mg	Zoloft® 100mg: ½ tablet daily

Program Participation: CommunityCare's Pharmacy and Therapeutics Committee has reviewed all medications eligible for this program to ensure that there is no change in clinical effectiveness when tablets are split. You will need to have a new prescription written for the higher strength tablets identified for splitting:

- **Retail prescriptions:** A quantity of 30 tablets will be prescribed, which will give you a 60-day supply for one copay.
- **Mail order prescriptions:** Mail order prescriptions are **NOT** eligible for this program.

Please call the pharmacy help desk at 877-293-8628, Monday-Friday, 8 a.m.-6 p.m., to request a free tablet splitter.
Note: Members are under no obligation to participate in this voluntary program.