Effective 1/1/2018

CommunityCare™
Employer's Choice

ORU
ORAL ROBERTS UNIVERSITY

Benefit Booklet

CommunityCare

Welcome!

CommunityCare is 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 network providers who deliver high quality care and services.

Questions?

If you have questions, please call our Member Services department for assistance. Representatives are available from 7 a.m. until 6 p.m., Monday through Friday. The local phone number in the Tulsa area is (918) 594-5201. If calling from outside the Tulsa area, the toll free number is (888) 589-5214. For more information, please visit the CommunityCare website 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™ | MEMBER CONNECTION

We are pleased to offer you access to CareWeb Member Connection, the secure online member area of the CommunityCare website. Member Connection is a helpful resource for CommunityCare members.

How do you register?

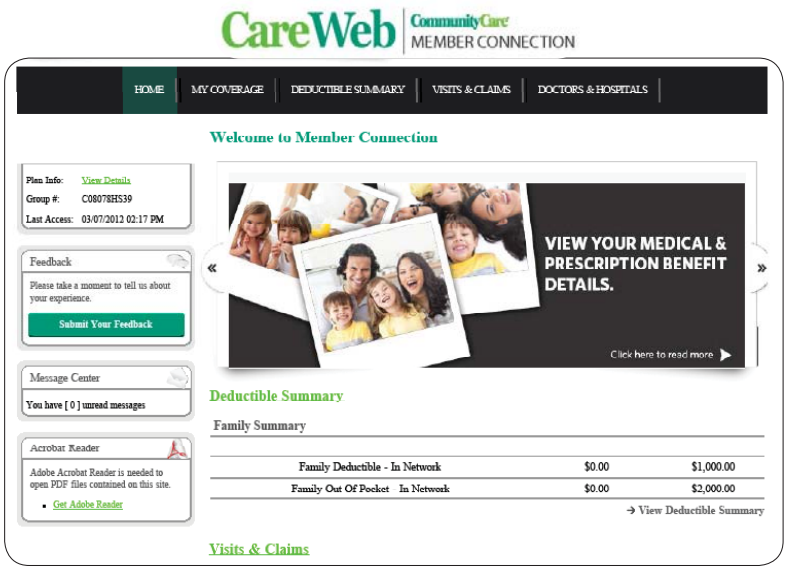
Go to www.ccok.com, select the Members link and then choose Secure Login. You will be directed to enter your information and follow a five-step registration process. You will need your CommunityCare member ID card available before you begin.

Some of the features within Member Connection include:

- Access visits and claims history
- View your EOBs 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

NEW!

Members registered for Member Connection will receive an email notification when EOBs are available to view online. Log in to Member Connection to find out more!



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 (800) 777-4890

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) 594-5242 or (800) 777-4890.

CommunityCare™

This information is a summary and for general information only.

In Network Preventive Health Care Coverage

CommunityCare's standards for preventive care are those adopted by most international health care groups and are designed to ensure that all of our members receive the preventive care that can make a difference in their health.

Screenings*

» **Cancer Screening:**
- ◊ Pap Smear
- ◊ Mammography
- ◊ Colorectal Cancer
- ◊ Prostate Cancer Screening

» **Periodic Adult Exams:**
- ◊ Blood Pressure, Height and Weight
- ◊ Cholesterol/Lipids
- ◊ TB Skin Tests
- ◊ Chlamydia screening
- ◊ Gonorrhea screening
- ◊ Herpes testing
- ◊ Cardiovascular screening
- ◊ Abdominal aortic aneurysm screening
- ◊ Diabetes screening
- ◊ Glaucoma screening
- ◊ HIV screening
- ◊ Lead screening
- ◊ Iron deficiency screening
- ◊ Lipid disorder screening

» **Well Baby/Well Child Exams**
- ◊ Lead screening: Once per lifetime
- ◊ Vision and hearing screenings
- ◊ Depression screening (ages 12-18)
- ◊ Congenital hypothyroidism screening
- ◊ Hearing loss, universal screening in newborns
- ◊ Iron deficiency screening

» **Routine Immunizations for Children:**
- ◊ Diphtheria, Tetanus, Pertussis (DPT)
- ◊ Tetanus, Diphtheria, Pertussis booster (Tdap)
- ◊ H. influenza type b (HIB)
- ◊ Polio
- ◊ Rotavirus
- ◊ Measles, Mumps, Rubella (MMR)
- ◊ Meningitis (Meningococcal through age 19)
- ◊ Varicella (Chickenpox)
- ◊ Hepatitis A
- ◊ Hepatitis B
- ◊ HPV (Gardasil)
- ◊ Pneumococcal (Prevnar)
- ◊ Influenza – Injection and Flu Mist

» **Respiratory Syncytial Virus (RSV):**
- ◊ Services must be authorized and directed by the Primary Care Physician, Neonatologist or Pediatrician

» **Routine Immunizations for Adults:**
- ◊ Tetanus, Diphtheria boosters (TD)
- ◊ Tetanus, Diphtheria, Pertussis booster (Tdap)
- ◊ Rubella
- ◊ Hepatitis A
- ◊ Hepatitis B
- ◊ Pneumococcal
- ◊ Influenza

A. Ages 60 years and older
- ◊ Zostavax

B. Ages 65 years and older
- ◊ Pneumococcal vaccine

**** Physician Note: Please discuss with your physician which screenings are appropriate for your particular situation and risk factors.***

Notes: Each service may only be covered for certain age groups or based on risk factors. For specific details on recommendations, please consult your member handbook. Members do not have coverage for preventive care out of network.

Are you or your dependents also covered by another health plan?

Coordination of Benefits

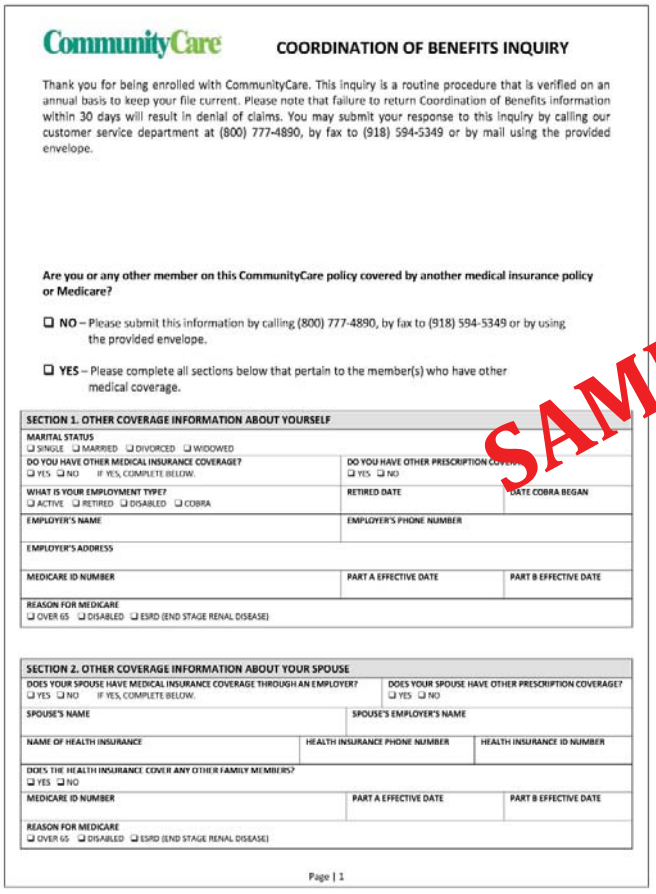
Your CommunityCare health plan has a Coordination of Benefits (COB) provision. This provision applies when you or your dependents are eligible for benefits under more than one health plan.

It is the responsibility of members to advise CommunityCare of their participation in any other health care plan. **CommunityCare will request information from you about other health coverage during initial enrollment and then annually at your group's renewal.**

If we do not receive a response in the required time, CommunityCare may deny payment of your claims. Please be sure to respond to the COB request within the required timeframe to ensure claims payment.

If you have questions regarding the COB provision, please call Member Services at (800) 777-4890.

Two Easy Ways to Complete the COB Form



CommunityCare

COORDINATION OF BENEFITS INQUIRY

Thank you for being enrolled with CommunityCare. This inquiry is a routine procedure that is verified on an annual basis to keep your file current. Please note that failure to return Coordination of Benefits information within 30 days will result in denial of claims. You may submit your response to this inquiry by calling our customer service department at (800) 777-4890, by fax to (918) 594-5349 or by mail using the provided envelope.

Are you or any other member on this CommunityCare policy covered by another medical insurance policy or Medicare?

❑ **NO** – Please submit this information by calling (800) 777-4890, by fax to (918) 594-5349 or by using the provided envelope.

❑ **YES** – Please complete all sections below that pertain to the member(s) who have other medical coverage.

SECTION 1. OTHER COVERAGE INFORMATION ABOUT YOURSELF

MARITAL STATUS
❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED

DO YOU HAVE OTHER MEDICAL INSURANCE COVERAGE? ❑ YES ❑ NO IF YES, COMPLETE BELOW.	DO YOU HAVE OTHER PRESCRIPTION COVERAGE? ❑ YES ❑ NO	
WHAT IS YOUR EMPLOYMENT TYPE? ❑ ACTIVE ❑ RETIRED ❑ DISABLED ❑ COBRA	RETIRED DATE	DATE COBRA BEGAN
EMPLOYER'S NAME	EMPLOYER'S PHONE NUMBER	
EMPLOYER'S ADDRESS		
MEDICARE ID NUMBER	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE
REASON FOR MEDICARE ❑ OVER 65 ❑ DISABLED ❑ ESRD (END STAGE RENAL DISEASE)		

SECTION 2. OTHER COVERAGE INFORMATION ABOUT YOUR SPOUSE

DOES YOUR SPOUSE HAVE MEDICAL INSURANCE COVERAGE THROUGH AN EMPLOYER? ❑ YES ❑ NO IF YES, COMPLETE BELOW.		DOES YOUR SPOUSE HAVE OTHER PRESCRIPTION COVERAGE? ❑ YES ❑ NO
SPOUSE'S NAME	SPOUSE'S EMPLOYER'S NAME	
NAME OF HEALTH INSURANCE	HEALTH INSURANCE PHONE NUMBER	HEALTH INSURANCE ID NUMBER
DOES THE HEALTH INSURANCE COVER ANY OTHER FAMILY MEMBERS? ❑ YES ❑ NO		
MEDICARE ID NUMBER	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE
REASON FOR MEDICARE ❑ OVER 65 ❑ DISABLED ❑ ESRD (END STAGE RENAL DISEASE)		

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SECTION 3. OTHER COVERAGE INFORMATION ABOUT DEPENDENTS

ARE THERE DEPENDENTS ON YOUR POLICY WHO HAVE OTHER MEDICAL INSURANCE COVERAGE?
❑ YES ❑ NO IF YES, LIST DEPENDENT AND OTHER INSURANCE IFORMATION BELOW.

DEPENDENT'S NAME	POLICYHOLDER'S NAME	INSURANCE COMPANY	INS. CO. PHONE NUMBER	ID NUMBER	POLICY EFFECTIVE DATE

ARE THERE DEPENDENTS ON YOUR POLICY WHO HAVE OTHER PRESCRIPTION INSURANCE COVERAGE?
❑ YES ❑ NO IF YES, LIST DEPENDENTS BELOW.

DEPENDENT'S NAME	DEPENDENT'S NAME	DEPENDENT'S NAME	DEPENDENT'S NAME

SECTION 4. ADDITIONAL DEPENDENT INFORMATION

PLEASE FILL OUT THIS SECTION ONLY IF ANY OF YOUR DEPENDENTS HAVE ADDITIONAL HEALTH CARE COVERAGE DUE TO DIVORCE, SEPARATION, ETC.

IS THERE A COURT ORDER THAT DETERMINES RESPONSIBILITY FOR HEALTH CARE COVERAGE AND/OR CUSTODY?
❑ YES ❑ NO
IF YES, PLEASE ATTACH A COPY OF THE SECTION OF THE COURT ORDER THAT APPLIES TO HEALTH CARE RESPONSIBILITY AND/OR CUSTODY ARRANGEMENTS.

NAME OF PERSON RESPONSIBLE FOR CHILD'S HEALTH CARE COVERAGE	RESPONSIBLE PARTY'S DATE OF BIRTH
EMPLOYER'S NAME	
INSURANCE COMPANY NAME	INSURANCE CO. PHONE NUMBER
POLICY NUMBER / GROUP NUMBER / EFFECTIVE DATE	

	DEPENDENT'S NAME (FIRST AND LAST)	WHO IS THE NATURAL CUSTODIAL PARENT?
1		
2		
3		

Thank you for your assistance in our efforts to keep your records up to date. If you have any questions about this inquiry, please call us at (918) 594-5242 or (800) 777-4890 and one of our representatives will assist you.

Sincerely,
CommunityCare

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SAMPLE

1. Complete the form and return it in the provided postage paid envelope.

2. Call Member Services at (800) 777-4890 to provide your COB information by phone.

NOTES

Medical Benefit Plan Options for

ORU
ORAL ROBERTS UNIVERSITY

Effective Jan. 1, 2018

Plan Benefit	EPG 2000c H Lg	IDEA Plus 2B H Lg	PPO Plan 6A FH Lg	
			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
Rx Benefit (Preferred Pharmacy Copays) **- Walgreens & Walmart**	**$0 / $15 / $60 / $110 / $160**	**$0 / $15 / $60 / $110 / $160**	**$0 / $15 / $40 / $70 / $160**	
Rx Benefit (Non-Preferred Pharmacy Copays) **- Other network pharmacies**	**$5 / $20 / $70 / $135 / $200**	**$5 / $20 / $70 / $135 / $200**	**$5 / $20 / $50 / $90 / $200**	
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

2018 Changes are indicated in RED

CommunityCare HealthShare

EPG 2000c MH Lg

How the Plan Works:

Preventive Care

No Copayment 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 copayments. 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 copayments 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 HealthShare EPG 2000c MH Lg

Physician Services	
(Additional Coinsurances/Copayments may apply)	
Primary Care Office Visits	$30 Copayment per Visit *
Specialty Care Office Visits	$50 Copayment per Visit *
Preventive Care	No Copayment
(Please see Member Handbook for details)	
Emergency Care and Urgent Care	
(Additional Coinsurances/Copayments may apply)	
Hospital Emergency Room	$150 Copayment per Visit *
(Copayment waived if admitted inpatient)	
Urgent Care Facility	$50 Copayment per Visit
Inpatient Hospital Care	
Room and Board	$200 Copayment per Day maximum of $1,000 per Admission *
(Including all other medically necessary services)	
Mental Health, Alcohol and Drug Services	
Inpatient	$200 Copayment per Day maximum of $1,000 per Admission *
Outpatient	No Copayment *
Physician's Office	$30 Copayment per Visit *
Applied Behavior Analysis	No Copayment *

*You are responsible for this copayment 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 copayments for the beginning of the standard benefit level. If this occurs, you may be responsible for the copayment required as part of the standard benefit level.

^See prescription drug benefit plan for additional information.

Outpatient Surgery	
Primary Care Office Visits	$30 Copayment per Visit *
Specialty Care Office Visits	$50 Copayment per Visit *
Outpatient Surgical Facility	$100 Copayment per Visit *
Outpatient Diagnostic Services	
(Additional Coinsurances/Copayments may apply, regardless of where outpatient services are rendered)	
Laboratory	No Copayment *
Outpatient Radiology	$25 Copayment per Visit *
MRI, CT Scan and PET Scan	$200 Copayment per Visit *
Rehabilitation Therapy	
(Up to 60 treatment days per disability per calendar year)	
Inpatient Rehabilitation	$100 Copayment per Day *
Outpatient Physical, Occupational and Speech Therapy	$50 Copayment per Visit *
Other Covered Services	
(Quantity limits may apply)	
Allergy Serum	50% Coinsurance *
Ambulance - Emergency Only	$50 Copayment *
Chiropractic Care	$50 Copayment per Visit *
Diabetic Supplies	20% Coinsurance
Durable Medical Equipment	20% Coinsurance *
Fertility Evaluation	50% Coinsurance *
General Anesthesia (during dental procedures as specified by state law)	No Copayment *
Home Health Services	20% Coinsurance *
Hospice Care	No Coinsurance

*You are responsible for this copayment 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 copayments for the beginning of the standard benefit level. If this occurs, you may be responsible for the copayment required as part of the standard benefit level.

^See prescription drug benefit plan for additional information.

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	No Copayment *
Administered in a home setting	20% Coinsurance *
(Except for specialty drugs within this category - see Specialty Drugs below)	
Organ Transplants	No Copayment *
Orthotics and Prosthetics	20% Coinsurance *
Ostomy and Urologic Supplies	20% Coinsurance
Prescription Drug Benefit	See Outpatient Prescription Drug Benefit
Radiation Therapy	No Copayment *
Skilled Nursing Facility Care	$25 Copayment per Day *
(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	No Copayment *

*You are responsible for this copayment 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 copayments for the beginning of the standard benefit level. If this occurs, you may be responsible for the copayment required as part of the standard benefit level.

^See prescription drug benefit plan for additional information.

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.
- Copayments do not apply toward the EPG.
- Prescription drugs and non-covered items do not apply to the HRA or EPG.
- 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 individual EPGs to satisfy the family EPG requirements. Each individual within the family may not contribute more than the individual EPG amount.
- All covered out-of-pocket expenses are applied toward your out-of-pocket limit.
- A calendar year is defined as the time period from January 1 - December 31.

Urgent and Emergency Care

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

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

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

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*You are responsible for this copayment 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 copayments for the beginning of the standard benefit level. If this occurs, you may be responsible for the copayment required as part of the standard benefit level.

^See prescription drug benefit plan for additional information.

CommunityCare Employer's Choice

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

Retail Pharmacy

Up to a 30-day supply for each prescription.
Refer to your prescription drug formulary guide.
A 90 day supply is available for maintenance drugs.
A select list of prescription drugs may be eligible for the tablet-splitting program.

	Preferred	Non-Preferred
Tier 1 - Preferred Generic Drugs	$15	$20
Tier 2 - Preferred Brand Drugs	$60	$70
Tier 3 - Non-Preferred Brand or Generic Drugs	$110	$135
Diabetic, Ostomy, and Urologic Supplies	20%	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 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	$220
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	$160	$200

Member Responsibility

Please note that Quantity Limits or Prior Authorization may apply.
Refer to your prescription drug formulary guide for additional information.
Brand/Generic Difference Program: If you receive a brand name drug when an equivalent generic drug is available, you will be responsible for the difference between the cost of the brand name drug and the allowed amount of the generic drug equivalent. This amount is in addition to any Deductible, Copayment and/or Coinsurance amount set forth in this Schedule of Benefits. Only the Deductible, Copayment and/or Coinsurance will apply to the Out-of-Pocket Limit.
If the cost of the prescription is less than the applicable Copayment, you will only be charged the cost of the prescription.
Some select generic drugs are eligible for either a $0 or $5 copayment based on pharmacy.

Covered Drugs and Devices

- Compound Drugs - at least one ingredient must be a legend drug
- 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
- Contraceptive implants, IUDs, diaphragms, contraceptive devices, contraceptive kits, emergency contraception
- Convenience or unit dose packaging
- Diabetic supplies other than Bayer or Roche products
- Drugs obtained at a non-contracted pharmacy
- Drugs and their equivalents that may be purchased without a prescription
- Drugs that are not listed on CommunityCare's prescription drug formulary; non-formulary drugs
- Drugs used for weight management, including anorexiants and body building drugs
- Feiba
- 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 (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. See the Member Handbook for additional information.

NOTES

CommunityCare Employer's Choice

IDEA Plus 2B MH 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 Coinsurances/Copayments may apply)	
Primary Care Office Visits	$30 Copayment per Visit
Specialty Care Office Visits	$50 Copayment per Visit
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	$100 Copayment per Visit *
(Copayment waived if admitted inpatient)	
Urgent Care Facility	$50 Copayment per Visit
Inpatient Hospital Care	
Room and Board	$200 Copayment per Day maximum of $1,000 per Admission *
(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	
Inpatient	$200 Copayment per Day maximum of $1,000 per Admission *
Outpatient	No Coinsurance *
Physician's Office	$30 Copayment per Visit
Applied Behavior Analysis	No Coinsurance *
Outpatient Surgery	
Primary Care Office Visits	$30 Copayment per Visit
Specialty Care Office Visits	$50 Copayment per Visit
Outpatient Surgical Facility	$150 Copayment per Visit *
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	$150 Copayment per Visit *
Rehabilitation Therapy	
(Up to 60 treatment days per disability per calendar year)	
Inpatient Rehabilitation	$150 Copayment per Day *
Outpatient Physical, Occupational and Speech Therapy	$30 Copayment per Visit *
Other Covered Services	
(Quantity limits may apply)	
Allergy Serum	20% Coinsurance *
Ambulance - Emergency Only	$50 Copayment *
Chiropractic Care	$50 Copayment per Visit
Diabetic Supplies	20% Coinsurance
Durable Medical Equipment	20% Coinsurance *

*After Deductible, the Coinsurance/Copayment will apply.

^See prescription drug benefit plan for additional information.

Fertility Evaluation	50% Coinsurance *
General Anesthesia (during dental procedures as specified by state law)	No Coinsurance *
Home Health Services	20% Coinsurance *
Hospice Care	No Coinsurance
Immunosuppressives, Injectables (except immunizations) and Drugs administered in the physician's office	Non-Preferred Prescription Copayment ^
(Except for specialty drugs within this category - see Specialty Drugs below)	
Infusion	
(Must be medically necessary and may be subject to prior authorization)	
Administered in a physician's office	Non-Preferred Prescription Copayment ^
(Except for specialty drugs within this category - see Specialty Drugs below)	
Administered in an outpatient facility	No Coinsurance *
Administered in a home setting	20% Coinsurance *
(Except for specialty drugs within this category - see Specialty Drugs below)	
Organ Transplants	No Coinsurance *
Orthotics and Prosthetics	20% Coinsurance *
Ostomy and Urologic Supplies	20% Coinsurance
Prescription Drug Benefit	See Outpatient Prescription Drug Benefit
Skilled Nursing Facility Care	$25 Copayment per Day *
(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	No Coinsurance *

*After Deductible, the Coinsurance/Copayment will apply.

^See prescription drug benefit plan for additional information.

Comments

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

Urgent and Emergency Care

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

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

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

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*After Deductible, the Coinsurance/Copayment will apply.

^See prescription drug benefit plan for additional information.

CommunityCare Employer's Choice

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

Retail Pharmacy

Up to a 30-day supply for each prescription.
Refer to your prescription drug formulary guide.
A 90 day supply is available for maintenance drugs.
A select list of prescription drugs may be eligible for the tablet-splitting program.

	Preferred	Non-Preferred
Tier 1 - Preferred Generic Drugs	$15	$20
Tier 2 - Preferred Brand Drugs	$60	$70
Tier 3 - Non-Preferred Brand or Generic Drugs	$110	$135
Diabetic, Ostomy, and Urologic Supplies	20%	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 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	$220
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	$160	$200

Member Responsibility

Please note that Quantity Limits or Prior Authorization may apply.
Refer to your prescription drug formulary guide for additional information.
Brand/Generic Difference Program: If you receive a brand name drug when an equivalent generic drug is available, you will be responsible for the difference between the cost of the brand name drug and the allowed amount of the generic drug equivalent. This amount is in addition to any Deductible, Copayment and/or Coinsurance amount set forth in this Schedule of Benefits. Only the Deductible, Copayment and/or Coinsurance will apply to the Out-of-Pocket Limit.
If the cost of the prescription is less than the applicable Copayment, you will only be charged the cost of the prescription.
Some select generic drugs are eligible for either a $0 or $5 copayment based on pharmacy.

Covered Drugs and Devices

- Compound Drugs - at least one ingredient must be a legend drug
- 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
- Contraceptive implants, IUDs, diaphragms, contraceptive devices, contraceptive kits, emergency contraception
- Convenience or unit dose packaging
- Diabetic supplies other than Bayer or Roche products
- Drugs obtained at a non-contracted pharmacy
- Drugs and their equivalents that may be purchased without a prescription
- Drugs that are not listed on CommunityCare's prescription drug formulary; non-formulary drugs
- Drugs used for weight management, including anorexiants and body building drugs
- Feiba
- 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 (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. See the Member Handbook for additional information.

NOTES

CommunityCare Employer's Choice

PPO Plan 6A MH Lg

	In-Network	Out-of-Network
Medical Calendar Year Deductible		
Per Individual	$1,000	$2,000
Per Family	$2,000	$4,000
Combined Medical and Pharmacy Out-of-Pocket Limit Per Calendar Year		
Per Individual	$3,500	Unlimited
Per Family	$7,000	Unlimited
Physician Services		
(Additional Coinsurances/Copayments may apply)		
Primary Care Office Visits	$30 Copayment per Visit	40% Coinsurance *
Specialty Care Office Visits	$50 Copayment per Visit	40% Coinsurance *
Preventive Care	No Copayment	30% Coinsurance *
(Please see your Certificate for details)		
Emergency Care and Urgent Care		
(Additional Coinsurances/Copayments may apply)		
Hospital Emergency Room	$50 Copayment per Visit	$50 Copayment per Visit
(Copayment waived if admitted inpatient) (Benefits will be reduced by 50% if care is not deemed to be a medical emergency)		
Urgent Care Facility	$50 Copayment per Visit	40% Coinsurance *

*After Deductible, the Coinsurance/Copayment will apply.

^See prescription drug benefit plan for additional information.

Inpatient Hospital Care		
Room and Board	$250 Copayment per Admission then 20% Coinsurance *	$250 Copayment per Admission then 40% Coinsurance *
(Requires pre-certification, except maternity) *(Including all other medically necessary services)*		
Mental Health, Alcohol and Drug Services		
Inpatient	$250 Copayment per Admission then 20% Coinsurance *	$250 Copayment per Admission then 40% Coinsurance *
(Inpatient requires pre-certification)		
Outpatient	20% Coinsurance *	40% Coinsurance *
Physician's Office	$30 Copayment per Visit	40% Coinsurance *
Applied Behavior Analysis	20% Coinsurance *	40% Coinsurance *
Outpatient Surgery		
Primary Care Office Visits	$30 Copayment per Visit	40% Coinsurance *
Specialty Care Office Visits	$50 Copayment per Visit	40% Coinsurance *
Outpatient Surgical Facility	$250 Copayment per Admission then 20% Coinsurance *	$250 Copayment per Admission then 40% Coinsurance *
(Requires pre-certification)		
Outpatient Diagnostic Services		
(Additional Coinsurances/Copayments may apply, regardless of where outpatient services are rendered)		
Laboratory	No Copayment	30% Coinsurance *
Outpatient Radiology	No Copayment	30% Coinsurance *
MRI, CT Scan and PET Scan	20% Coinsurance *	40% Coinsurance *
(Requires pre-certification)		

*After Deductible, the Coinsurance/Copayment will apply.

^See prescription drug benefit plan for additional information.

Rehabilitation Therapy		
(Up to 60 treatment days per disability per calendar year)		
Inpatient Rehabilitation	20% Coinsurance *	40% Coinsurance *
(Inpatient requires pre-certification)		
Outpatient Physical, Occupational and Speech Therapy	20% Coinsurance *	40% Coinsurance *
Other Covered Services		
(Quantity limits may apply)		
Allergy Serum	20% Coinsurance *	40% Coinsurance *
Ambulance	20% Coinsurance *	20% Coinsurance *
(Emergency only)		
Chiropractic Care	$50 Copayment per Visit	40% Coinsurance *
Diabetic Supplies	20% Coinsurance	50% Coinsurance *
(Insulin pumps, including related supplies, and continuous glucose monitors, require pre-certification)		
Durable Medical Equipment	20% Coinsurance *	40% Coinsurance *
Fertility Evaluation	50% Coinsurance *	50% Coinsurance *
General Anesthesia (during dental procedures as specified by state law)	20% Coinsurance *	40% Coinsurance *
Home Health Services	20% Coinsurance *	40% Coinsurance *
(Up to 60 treatment days per disability per calendar year)		
Hospice Care	No Coinsurance	30% Coinsurance *
(Inpatient requires pre-certification)		
Immunosuppressives, Injectables (except immunizations) and Drugs administered in the physician's office	Non-Preferred Prescription Copayment ^	40% Coinsurance *
(Except for specialty drugs within this category - see Specialty Drugs below)		

*After Deductible, the Coinsurance/Copayment will apply.

^See prescription drug benefit plan for additional information.

Infusion		
(Must be medically necessary and may be subject to prior authorization)		
Administered in a physician's office	Non-Preferred Prescription Copayment ^	40% Coinsurance *
(Except for specialty drugs within this category - see Specialty Drugs below)		
Administered in an outpatient facility	20% Coinsurance *	40% Coinsurance *
Administered in a home setting	20% Coinsurance *	40% Coinsurance *
(Except for specialty drugs within this category - see Specialty Drugs below)		
Organ Transplants	20% Coinsurance *	40% Coinsurance *
(Inpatient requires pre-certification)		
Orthotics and Prosthetics	20% Coinsurance *	40% Coinsurance *
Ostomy and Urologic Supplies	20% Coinsurance *	40% Coinsurance *
Prescription Drug Benefit	See Outpatient Prescription Drug Benefit	Not Covered
Radiation Therapy	20% Coinsurance *	40% Coinsurance *
Skilled Nursing Facility Care	20% Coinsurance *	40% Coinsurance *
(Up to 60 treatment days per disability per calendar year) *(Inpatient requires pre-certification)*		
Specialty Drugs	Specialty Prescription Copayment ^	40% Coinsurance *
(Must be medically necessary and may be subject to prior authorization)		
All Other Covered Services	20% Coinsurance *	40% Coinsurance *

*After Deductible, the Coinsurance/Copayment 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.
- Any number of members of the family may combine individual medical deductibles to satisfy the family medical deductible requirement.
- 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 Coinsurance/Copayment will apply.

^See prescription drug benefit plan for additional information.

CommunityCare Employer's Choice

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

Member Responsibility

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.
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, Co-payment and/or Co-insurance amount set forth in this Schedule of Benefits. Only the Deductible, Co-payment and/or Co-insurance will apply to the Out-of-Pocket Limit.

	Preferred	Non-Preferred
Retail Pharmacy		
Up to a 30-day supply for each prescription.		
(Refer to your prescription drug formulary guide.)		
A 90 day supply is available for maintenance drugs.		
A select list of prescription drugs may be eligible for the tablet-splitting program.		
Tier 1 - Preferred Generic Drugs	$15	$20
Tier 2 - Preferred Brand Drugs	$40	$50
Tier 3 - Non-Preferred Brand or Generic Drugs	$70	$90
Diabetic, Ostomy, and Urologic Supplies	20%	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 Co-payments.		
Refer to your prescription drug formulary guide for additional information.		
Tier 1 - Preferred Generic Drugs	$30	
Tier 2 - Preferred Brand Drugs	$80	
Tier 3 - Non-Preferred Brand or Generic Drugs	$140	
Diabetic, Ostomy, and Urologic Supplies	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	$160	$200

Covered Drugs and Devices

- Compound Drugs - at least one ingredient must be a legend drug
- 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
- Contraceptive implants, IUDs, diaphragms, contraceptive devices, contraceptive kits, emergency contraception
- 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 (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. See the Member Handbook for additional information.

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.

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

The CommunityCare formulary is online at www.ccok.com.

CommunityCare™

Understanding Your Prescription Drug Program 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

•The 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

•The 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 online at 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 prescription drug program that emphasizes quality, choice and value

•The prescription drug program identifies four categories or types of prescription drugs

•Each category has a corresponding copayment level

•Your prescription drug plan includes a description of each category

•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 use the searchable pharmacy directory online 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 preferred 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.*

**CommunityCare's preferred pharmacies are Walgreens and Walmart. CommunityCare's preferred pharmacy program is included with some of our prescription drug plans. Please check your specific benefit descriptions to confirm if your drug program includes the preferred pharmacy benefit.*

4/2016

CommunityCare

Multi-Language Interpreter Services – Taglines for Notices

Language	Translated Taglines
Spanish	Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de CommunityCare. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-800-777-4890.
Vietnamese	Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình CommunityCare. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-800-777-4890.
Chinese	本通知有重要的訊息。本通知有關於您透過[插入 SBM 項目的名稱 CommunityCare 提交的申請或 保險的重要訊息。請留意本通知內的重要日期。 您可能需要在截止日期之前採取行動， 以保留您的健康保險 或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 [在此插入數字1-800-777-4890
Korean	본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 CommunityCare 을 통한 커버리지 에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1-800-777-4890로 전화하십시오.
German	Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch CommunityCare. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-800-777-4890.
Arabic	يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال CommunityCare.ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصور على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بـ 1-800-777-4890
Burmese	ဤစာရွက် အေရးႀကီးေသာ အခ်က္အလက္ ပါဝင္ပါသည္။ ဤစာရြက် သင္၏ေလွ်ာက္လြႊာ သို႔မဟုတ္ CommunityCare ႏွင့္သက္ဆိုင္ေသာ သင့္ခံစားခြင့္အခ်က္အလက္မ်ား ပါဝင္ပါသည္။ အဓိကရက္စြဲမ်ားကို ဤစာရြက္စာတမ္းတြင္ ရွာေဖြပါ။ သတ္မွတ္ထားေသာ ေနာက္ဆံုးရက္ မတိုင္မီ က်န္းမာေရးခံစားခြင့္ သို႔မဟုတ္ စရိတ္စံခံစားခြင့္ ဆက္လက္ရရွိေနေစရန္ ေဆာင္ရြက္ရာရွိသည္တို႔ကို ေဆာင္ရြက္ပါ။ ဤကိစၥႏွင့္ပတ္သက္၍ မွန္ကန္ေသာအခ်က္အလက္မ်ားရရွိရန္ ကုန္က်စရိတ္ ေပးရန္မလိုဘဲ မိမိဘာသာစကားျဖင့္ အကူအညီရယူႏိုင္သည္။ 1-800-777-4890။

Updated 05/10/2017

CommunityCare

Multi-Language Interpreter Services – Taglines for Notices

Hmong	**Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb.** Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm CommunityCare. Saib cov caij nyoog los yog tej hnub tseem ceeb uas sau rau hauv daim ntawv no kom zoo. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 1-800-777-4890.
Tagalog	Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng CommunityCare. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 1-800-777-4890.
French	Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de CommunityCare. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 1-800-777-4890.
Laotian	ການແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ການແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະ ໝັກຫຼືການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ CommunityCare. ເບິ່ງສຳລັບກຳນົດວັນທີສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈຳເປັນຕ້ອງໃຊ້ເວລາດຳເນີນການໂດຍກຳນົດເວລາທີ່ແນ່ນອນ ຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານຫຼືການຊ່ວຍເຫຼືອທີ່ມີຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດທີ່ຈະໄດ້ຮັບຂໍ້ມູນຂ່າວສານນີ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານທີ່ບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ໂທ 1-800-777-4890.
Thai	ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้มีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน CommunityCare ดูกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 1-800-777-4890
Urdu	اس اشتہار میں اہم معلومات ہے۔ اس اشتہار میں CommunityCare سے اپ کے درخواست اور خدمات کے بارے میں اہم معلومات ہے۔اشتہار میں اہم تاریخوں کا نظر کریں۔ ہو سکتا ہے کی صحت کی خدمات کو برقرار رکھنے اور اخراجات کی ادائگی میں مالی مدد ملنے کے لیے، اپ کو خاص تاریخ یا ڈیڈ لائن سے پہلے کچھ کارروائی کرنی پڑے گی۔ اپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ 1-800-777-4890 فون کریں۔
Cherokee	ᎤᎳᏫᏗ ᏚᏃᏣᏢᎢ ᎤᏁᏫᏫᏗ. ᎯᎠ ᎤᎳᏫᏗ ᏒᎶᏃ4 ᏗᎶᎳᎵᏣᎢ ᏒᎶᏋᏫᏫᏙᏗ ᎤᏂᏫᎯᎳᏫᏬ ᎯᎵᏂᏙᎻ ᏒᎶᏚ4ᏫᏫᏬᏯ CommunityCare ᏚᎶᏫᏫᏓᏁᏅᎢ. ᏣᏚᎡᏫᏚᏫᏗ ᏓᏙᏬᏢᎡ ᎯᎠ ᏚᏃᏣᏢᎢ. ᎡᎷᏫ ᎪᎢᏫᏗ ᏦᎷᎶᏗ ᎠᎵ ᎶᏫᏂᎯᏯ ᏯhᏫᎯᎳᏫᏬ ᎤᏫᏢᏫᏗ ᏂᏚᎪᎷᎷᎶ. ᏙᏯ ᏀᏚᏁ ᎠhᎠᏬᏯᏯᏚ ᏀᎤᵛ ᎠᎵ ᏧᎬᏩᎳᏬᎢ ᏴᎡ ᎤᏁᏣᏴᏫᏗ hᏴᎡᎾ ᏀᏰᏩᏗ. ᎠᏬᏫᎯᎳᏫᏬ ᎠᏬᏫᏚᏩᏗ ᎡᏀᏁᏗ ᏃᎵ ᎡᎶᏃᏁᏗ ᏀᏚᏢᏫᎬ ᏀᏚᏩhᎯᏫᏗ ᎬᏁ ᏃᎵ ᏧᎬᏩᎳᏗ hᏴᎡᎾ ᏴᎡᎢ. ᏗᎳᏃᏢᏗ ᏗᏎᏫᏗ ᎯᎠ 1-800-777-4890.
Persian-Farsi	ابطوبورامش ای همیشوشوپ اوایضاقت فم مم درباره اعلا ا ومای هیلاعا نین ا شابهچم ت اعلا ا ومای هیلاعا ن ای ای ازم شوشوپ ظقح رای ربخیشوخ های خیرات بت لت ترا نهک امش .دیتاماجنوخیلاعا نین مم در مم های خیرات بت CommunityCare رای کمکم بت خارخ م بت لزلزم ای لزلزم کمک ماجنابوبزول ا نیاکیرتا را نیاقح امش.دیشابنلیاک و کمک ا اعلا ا نیا و کمک هلبز زبان خوبت طورایگان ریاهنز تفای دیا. 1-800-777-4890

CommunityCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CommunityCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CommunityCare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact CommunityCare's Senior Manager of Quality Improvement/Compliance. If you believe that CommunityCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

CommunityCare
Attn: Senior Manager of Quality Improvement/Compliance
P.O. Box 3249 Tulsa, Oklahoma 74101
(918) 594-5303 (phone)
(918) 879-4048 (fax)
G&A@ccok.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, CommunityCare's Senior Manager of Quality Improvement/Compliance is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.