

Benefit Booklet
Effective 7/1/2015

CommunityCare™

Employer's Choice



Tulsa FOP 93 Health & Welfare Trust Standard Plan



fop.ccok.com

CommunityCare™

Welcome!

Thank you for choosing CommunityCare as your health insurance Third Party Administrator (TPA)! 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 (800) 777-4890

➤ Visit our Web site at fop.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

For More Information:

For more information regarding other value added services and benefits, please contact Rooney Insurance Agency at fop93@rooneyinsurance.com or call Jo McDaniel at 918-878-3425 or Sydney Jones at 918-878-3373.



	<u>In-Network</u>	<u>Out-of-Network</u>
<u>Calendar Year Deductible</u>		
Per Member	\$1,000	\$2,000
Per Family	\$2,000	\$4,000
<u>Out-of-pocket Limit Per Calendar Year (Does not include deductible)</u>		
Per Member	\$1,500	\$3,000
Per Family	\$3,000	\$6,000

Physician Services

(Additional Co-insurance/Co-payments may apply)

Primary Care Office Visits	\$35 Co-payment per Visit	50% Co-insurance*
Specialty Care Office Visits	\$45 Co-payment per Visit	50% Co-insurance*
Maternity Care	\$35 Co-payment	50% Co-insurance*
<i>(Co-payment for initial maternity care visit only)</i>		
Preventive Care	No Co-payment	50% Co-insurance*
<i>(Please see your Member Handbook for details)</i>		

Emergency Care and Urgent Care

(Additional Co-insurance/Co-payments may apply) (Benefits will be denied if not medically necessary)

Hospital Emergency Room	20% Co-insurance*	20% Co-insurance*
Urgent Care Facility	\$50 Co-payment per Visit	50% Co-insurance*

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

^ See prescription drug benefit plan for additional information.

Inpatient Hospital Care

Room and Board	20% Co-insurance*	50% Co-insurance*
----------------	-------------------	-------------------

(Including all other medically necessary services)

Mental Health, Alcohol and Drug Services

Inpatient	20% Co-insurance*	50% Co-insurance*
-----------	-------------------	-------------------

Outpatient	\$35 Co-payment per Visit	50% Co-insurance*
------------	---------------------------	-------------------

Outpatient Surgery

Primary Care Office Visits	\$35 Co-payment per Visit	50% Co-insurance*
----------------------------	---------------------------	-------------------

Specialty Care Office Visits	\$45 Co-payment per Visit	50% Co-insurance*
------------------------------	---------------------------	-------------------

Outpatient Surgical Facility	20% Co-insurance*	50% Co-insurance*
------------------------------	-------------------	-------------------

Outpatient Diagnostic Services

(Additional Co-insurances/Co-payments may apply, regardless of where outpatient services are rendered)

Laboratory	No Additional Co-payment	50% Co-insurance*
------------	--------------------------	-------------------

Outpatient Radiology	No Additional Co-payment	50% Co-insurance*
----------------------	--------------------------	-------------------

MRI, CT Scan and PET Scan	20% Co-insurance*	50% Co-insurance*
---------------------------	-------------------	-------------------

Rehabilitation Therapy

(Up to 60 treatment visits per benefit type)

Inpatient Rehabilitation	20% Co-insurance*	50% Co-insurance*
--------------------------	-------------------	-------------------

Outpatient Physical, Occupational and Speech Therapy	\$45 Co-payment per Visit	50% Co-insurance*
--	---------------------------	-------------------

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

^ See prescription drug benefit plan for additional information.

Other Covered Services

[(Quantity limits may apply)]

Allergy Serum / Injections	Subject to the PCP or Specialist Co-payment	50% Co-insurance*
Allergy Testing & Treatment	If an office visit is charged, subject to the PCP or Specialist office visit Co-payment	50% Co-insurance*
Allergy Testing & Treatment not in a Physician's Office	20% Co-insurance*	50% Co-insurance*
Ambulance - Air Transportation (Emergency Only)	20% Co-insurance*	50% Co-insurance*
Ambulance - Ground Transportation (Emergency Only)	20% Co-insurance*	50% Co-insurance*
Chiropractic Care (limited to 60 visits per calendar year)	\$45 Co-payment per Visit	50% Co-insurance*
Diabetic Supplies	20% Co-insurance*	50% Co-insurance*
Durable Medical Equipment	20% Co-insurance*	50% Co-insurance*
Fertility Evaluation	20% Co-insurance*	Not Covered
General Anesthesia (for eligible dental procedures only)	20% Co-insurance	50% Co-insurance*
Hearing Aids (Children under the age of 19)	20% Co-insurance*	50% Co-insurance*
Home Health Services	20% Co-insurance*	50% Co-insurance*
Hospice Care (Inpatient requires pre-certification)	20% Co-insurance*	50% Co-insurance*
Immunosuppressives, Injectables (except immunizations) and Drugs administered in the physician's office	20% Co-insurance*	50% Co-insurance*

* After deductible, the Co-insurance/Co-payment 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 <i>(except for specialty drugs within this category - see Specialty Drugs below)</i>	\$45 Co-payment per Visit	50% Co-insurance*
Administered in an outpatient facility	20% Co-insurance*	50% Co-insurance*
Administered in a home setting <i>(except for specialty drugs within this category - see Specialty Drugs below)</i>	20% Co-insurance*	50% Co-insurance*
Organ Transplants (Must be medically necessary and may be subject to prior authorization)	20% Co-insurance*	Not Covered outside of the Transplant Network
Orthotics and Prosthetics	20% Co-insurance*	50% Co-insurance*
Ostomy and Urologic Supplies	20% Co-insurance*	50% Co-insurance*
Prescription Drug Benefit	See Outpatient Prescription Drug Benefit^	Not Covered
Radiation Therapy	20% Co-insurance*	50% Co-insurance*
Skilled Nursing Facility Care <i>(Up to 60 treatment days per disability per calendar year)</i>	20% Co-insurance*	50% Co-insurance*
Specialty Drugs <i>(must be medically necessary and may be subject to prior authorization)</i>	Specialty Prescription Co-Payment^	50% Co-insurance*
All Other Covered Services	20% Co-insurance*	50% Co-insurance*

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

^ See prescription drug benefit plan for additional information.

Comments

- Deductible must be satisfied before Co-insurance begins, where it applies.
- 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 medical out-of-pocket expenses are applied toward your medical out-of-pocket limit. Your total out-of-pocket limit equals your medical out-of-pocket amount plus your deductible. Please note: Your prescription drug out-of-pocket expenses will accrue toward a separate prescription drug out-of-pocket limit.
- A calendar year is defined as the time period from January 1- December 31.
- Deductible amounts and out-of-pocket limitations are separate for in-network provider and out-of-network provider benefits.

Out-of-Network Requirements

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

Urgent and Emergency Care

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

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

For a list of Exclusions and Limitations, please see 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 member handbook for additional information regarding exclusions and limitations.*

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

^ See prescription drug benefit plan for additional information.



Standard Plan (without Biometrics)

	<u>In-Network</u>	<u>Out-of-Network</u>
<u>Calendar Year Deductible</u>		
Per Member	\$1,250	\$2,250
Per Family	\$2,500	\$4,500
<u>Out-of-pocket Limit Per Calendar Year (does not include deductible)</u>		
Per Member	\$1,500	\$3,000
Per Family	\$3,000	\$6,000

Physician Services

(Additional Co-insurance/Co-payments may apply)

Primary Care Office Visits	\$35 Co-payment per Visit	50% Co-insurance*
Specialty Care Office Visits	\$45 Co-payment per Visit	50% Co-insurance*
Maternity Care	\$35 Co-payment	50% Co-insurance*
<i>(Co-payment for initial maternity care visit only)</i>		
Preventive Care	No Co-payment	50% Co-insurance*
<i>(Please see your Member Handbook for details)</i>		

Emergency Care and Urgent Care

(Additional Co-insurance/Co-payments may apply) (Benefits will be denied if not medically necessary)

Hospital Emergency Room	20% Co-insurance*	20% Co-insurance*
Urgent Care Facility	\$50 Co-payment per Visit	50% Co-insurance*

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

^ See prescription drug benefit plan for additional information.

Inpatient Hospital Care

Room and Board	20% Co-insurance*	50% Co-insurance*
----------------	-------------------	-------------------

(Including all other medically necessary services)

Mental Health, Alcohol and Drug Services

Inpatient	20% Co-insurance*	50% Co-insurance*
-----------	-------------------	-------------------

Outpatient	\$35 Co-payment per Visit	50% Co-insurance*
------------	---------------------------	-------------------

Outpatient Surgery

Primary Care Office Visits	\$35 Co-payment per Visit	50% Co-insurance*
----------------------------	---------------------------	-------------------

Specialty Care Office Visits	\$45 Co-payment per Visit	50% Co-insurance*
------------------------------	---------------------------	-------------------

Outpatient Surgical Facility	20% Co-insurance*	50% Co-insurance*
------------------------------	-------------------	-------------------

Outpatient Diagnostic Services

(Additional Co-insurances/Co-payments may apply, regardless of where outpatient services are rendered)

Laboratory	No Additional Co-payment	50% Co-insurance*
------------	--------------------------	-------------------

Outpatient Radiology	No Additional Co-payment	50% Co-insurance*
----------------------	--------------------------	-------------------

MRI, CT Scan and PET Scan	20% Co-insurance*	50% Co-insurance*
---------------------------	-------------------	-------------------

Rehabilitation Therapy

(Up to 60 treatment visits per Benefit Type)

Inpatient Rehabilitation	20% Co-insurance*	50% Co-insurance*
--------------------------	-------------------	-------------------

Outpatient Physical, Occupational and Speech Therapy	\$45 Co-payment per Visit	50% Co-insurance*
--	---------------------------	-------------------

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

^ See prescription drug benefit plan for additional information.

Other Covered Services

(Quantity limits may apply)

Allergy Serum / Injections	Subject to the PCP or Specialist Co-payment	50% Co-insurance*
Allergy Testing & Treatment	If an office visit is charged, subject to the PCP or Specialist office visit Co-payment	50% Co-insurance*
Allergy Testing & Treatment not in a Physician's Office	20% Co-insurance*	50% Co-insurance*
Ambulance - Air Transportation <i>(Emergency Only)</i>	20% Co-insurance*	50% Co-insurance*
Ambulance - Ground Transportation <i>(Emergency Only)</i>	20% Co-insurance*	50% Co-insurance*
Chiropractic Care <i>(limited to 60 visits per calendar year)</i>	\$45 Co-payment per Visit	50% Co-insurance*
Diabetic Supplies	20% Co-insurance*	50% Co-insurance*
Durable Medical Equipment	20% Co-insurance*	50% Co-insurance*
Fertility Evaluation	20% Co-insurance*	Not Covered
General Anesthesia (for eligible dental procedures only)	20% Co-insurance	50% Co-insurance*
Hearing Aids (Children under the age of 19)	20% Co-insurance*	50% Co-insurance*
Home Health Services	20% Co-insurance*	50% Co-insurance*
Hospice Care <i>(Inpatient requires pre-certification)</i>	20% Co-insurance*	50% Co-insurance*
Immunosuppressives, Injectables (except immunizations) and Drugs administered in the physician's office	20% Co-insurance*	50% Co-insurance*

* After deductible, the Co-insurance/Co-payment 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 <i>(except for specialty drugs within this category - see Specialty Drugs below)</i>	\$45 Co-payment per Visit	50% Co-insurance*
Administered in an outpatient facility	20% Co-insurance*	50% Co-insurance*
Administered in a home setting <i>(except for specialty drugs within this category - see Specialty Drugs below)</i>	20% Co-insurance*	50% Co-insurance*
Organ Transplants (Must be medically necessary and may be subject to prior authorization)	20% Co-insurance*	Not Covered outside of the Transplant Network
Orthotics and Prosthetics	20% Co-insurance*	50% Co-insurance*
Ostomy and Urologic Supplies	20% Co-insurance*	50% Co-insurance*
Prescription Drug Benefit	See Outpatient Prescription Drug Benefit^	Not Covered
Radiation Therapy	20% Co-insurance*	50% Co-insurance*
Skilled Nursing Facility Care <i>(Up to 60 treatment days per disability per calendar year)</i>	20% Co-insurance*	50% Co-insurance*
Specialty Drugs <i>(must be medically necessary and may be subject to prior authorization)</i>	Specialty Prescription Co-Payment^	50% Co-insurance*
All Other Covered Services	20% Co-insurance*	50% Co-insurance*

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

^ See prescription drug benefit plan for additional information.

Comments

- Deductible must be satisfied before Co-insurance begins, where it applies.
- 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 medical out-of-pocket expenses are applied toward your medical out-of-pocket limit. Your total out-of-pocket limit equals your medical out-of-pocket amount plus your deductible. Please note: Your prescription drug out-of-pocket expenses will accrue toward a separate prescription drug out-of-pocket limit.
- A calendar year is defined as the time period from January 1- December 31.
- Deductible amounts and out-of-pocket limitations are separate for in-network provider and out-of-network provider benefits.

Out-of-Network Requirements

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

Urgent and Emergency Care

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

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

For a list of Exclusions and Limitations, please see 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 member handbook for additional information regarding exclusions and limitations.*

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

^ See prescription drug benefit plan for additional information.

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 CommunityCare members.

So how do you begin?

Go to fop.ccok.com and click on the [CareWeb Member Connection](#) icon located on the right side of the page. 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

CareWeb | CommunityCare MEMBER CONNECTION

The screenshot shows the CareWeb Member Connection portal. At the top is a navigation bar with links: HOME, MY COVERAGE, DEDUCTIBLE SUMMARY, VISITS & CLAIMS, and DOCTORS & HOSPITALS. Below the navigation bar is a "Welcome to Member Connection" message. On the left side, there are several utility boxes: "Plan Info" with a "View Details" link, "Feedback" with a "Submit Your Feedback" button, "Message Center" showing 0 unread messages, and an "Acrobat Reader" warning box. The main content area features a large banner with a family photo and the text "VIEW YOUR MEDICAL & PRESCRIPTION BENEFIT DETAILS." Below the banner is a "Deductible Summary" section with a "Family Summary" table. The table lists "Family Deductible - In Network" as \$0.00 and "Family Out Of Pocket - In Network" as \$0.00, with a maximum of \$1,000.00 and \$2,000.00 respectively. A link to "View Deductible Summary" is provided. At the bottom, there is a "Visits & Claims" section.

Questions You May Have About

CommunityCare

How do I choose a Primary Care Physician (PCP)?

If you enroll in the Value Select plan or Standard plan, you will need to choose a PCP. 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. PCPs are listed in the printed provider directory or online at fop.ccok.com.

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 members may set up an appointment with most physicians in their network **without a referral** by their PCP.



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 Member Services at (918) 594-5201 in Tulsa or (800) 777-4890 statewide, or visit fop.ccok.com.



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 (Pevnar)
- ◇ 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

» **Women's Preventive Health Services:**

- ◇ As required by the Patient Protection and Affordable Care Act

** 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.



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

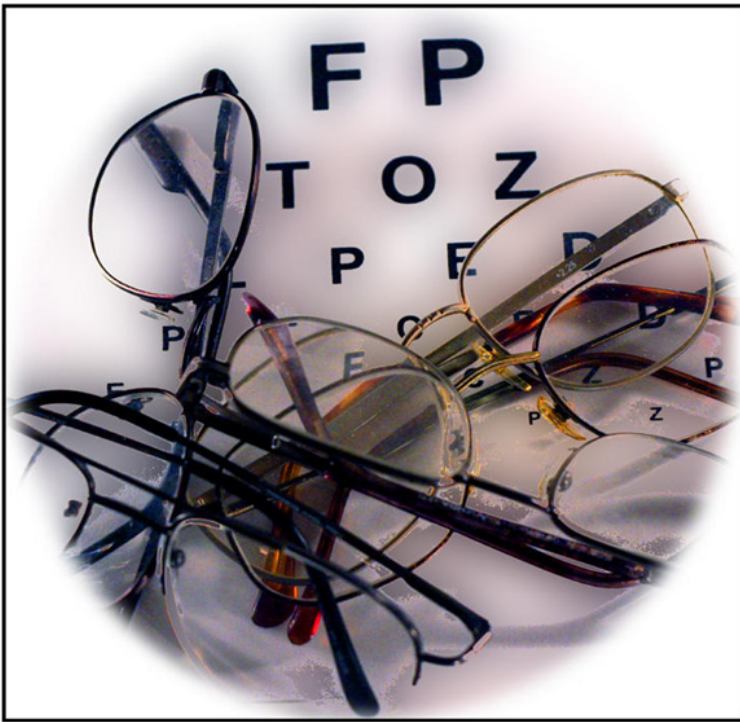
CommunityCare Website – fop.ccok.com

- 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) 594-5201 or (800) 777-4890.



CommunityCare™

Vision Benefit for CommunityCare Members

As a CommunityCare member, **vision** is one of the services covered under your preventive care benefit... at no copay for in-network services!



Find out more about your vision benefit:

- Annual vision screening, glaucoma screening and refraction for glasses from an in-network vision provider
- Contracted vision providers offer a 10-15 percent discount for eyeglasses and contacts purchased at the vision provider's office
- You do not need to contact CommunityCare or your primary care physician before scheduling your annual vision appointment
- Search for vision providers at fop.ccok.com

Questions about your vision benefit? Call Member Services at (918) 594-5201 or (800) 777-4890.

Pharmacy Only Calendar Year Out-of-Pocket Max \$2,000 Per Individual \$4,000 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	\$10
Tier 2 - Preferred Brand Drugs	\$20
Tier 3 - Non-Preferred Brand or Generic Drugs	\$50
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	\$10
Tier 2 - Preferred Brand Drugs	\$20
Tier 3 - Non-Preferred Brand or Generic Drugs	\$50
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	Lesser of \$200 or 20% per script
-----------------------------------	-----------------------------------

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
- Injectable/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 and their equivalents that may be purchased without a prescription; for example, over-the-counter medications are not covered
- 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 anorexians 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 (877) 293-8628 or visit www.mycatamaranrx.com. For all other questions, please call CommunityCare at (877) 293-8628.

+Products are excluded except as required by law.

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



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 fop.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 <i>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).</i>	Other Brands <i>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.</i>	
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		
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		

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.



Mail Order Prescription Drug Program

Receive a 90-day supply for one copay

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 one copay, 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

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 fop.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 online at fop.ccok.com.