

# Alternative HMO Plan

PLAN FEATURES	PARTICIPATING PROVIDERS/REFERRED
<b>Deductible</b> (per calendar year)	None, Individual None, Family
<b>Member Coinsurance</b>	Covered 100%
<b>Out-of-Pocket Maximum*</b> (per calendar year)	\$2,000 Individual \$4,000 Family
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated
<b>Primary Care Physician (PCP) Selection</b>	Required
<b>Referral Requirements</b>	Required for all non-emergency, non-urgent, and nonprimary care physicians services, except for direct-access services.
PREVENTIVE CARE	PARTICIPATING PROVIDERS/REFERRED
<b>Routine Adult Physical Exams/Immunizations</b> (Age and frequency schedules apply.)	\$10 copay
<b>Well Child Exams/Immunizations</b> (Age and frequency schedules apply.)	No copay per visit Childhood immunizations covered 100% birth through age 18.
<b>Routine Gynecological Care Exams</b> Includes Pap smear and related lab fees. One routine exam per 365 days.	\$10 copay
<b>Routine Mammograms</b> One baseline mammogram for females age 35–39, and one annual mammogram for females age 40 and over.	Covered 100%
<b>Routine Digital Rectal Exams/Prostate-Specific Antigen Test</b> For males age 40 and over.	Member cost-sharing is based on the type of service performed and the place of service where it is rendered.
<b>Colorectal Cancer Screening</b> For all members age 50 and over. Frequency schedule applies.	Member cost-sharing is based on the type of service performed and the place of service where it is rendered.
<b>Routine Eye Exam</b> Age/Frequency Schedule may apply.	\$40 copay
<b>Routine Hearing Screening</b> Audiological services and hearing aids are covered every 48 months for children up to age 18.	\$10 copay
PHYSICIAN FEATURES	PARTICIPATING PROVIDERS/REFERRED
<b>Primary Care Physician Visits†</b>	Office hours: \$25 copay After office hours/home: \$25 copay
<b>Specialist Office Visits</b>	\$40 copay
<b>Maternity Ob/Gyn Visits</b>	\$40 copay; for initial visit only, thereafter covered 100%
<b>Allergy Treatment</b>	\$20 copay
<b>Allergy Testing</b>	\$20 copay
DIAGNOSTIC PROCEDURES	PARTICIPATING PROVIDERS/REFERRED
<b>Diagnostic Laboratory</b> If performed as part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit cost-sharing.	\$40 copay
<b>Diagnostic X-ray</b> Outpatient hospital or other outpatient facility.	\$40 copay
EMERGENCY MEDICAL CARE	PARTICIPATING PROVIDERS/REFERRED
<b>Urgent Care</b>	\$75 copay
<b>Non-urgent Use of Urgent Care Provider</b>	Not covered
<b>Emergency Room</b>	\$100 copay
<b>Non-emergency Care in an Emergency Room</b>	Not covered
<b>Ambulance</b>	Covered 100%
HOSPITAL CARE	PARTICIPATING PROVIDERS/REFERRED
<b>Inpatient Coverage**</b>	\$500 per admission copay
<b>Inpatient Maternity Coverage**</b>	\$500 per admission copay
<b>Outpatient Surgery**</b>	\$250 per visit copay

† Employees Benefits Council – Oklahoma Health Benefit – One PCP visit with blood work only for Oklahoma Health participants.

<b>MENTAL HEALTH SERVICES</b>		<b>PARTICIPATING PROVIDERS/REFERRED</b>
<b>Inpatient Biologically Based Mental Illness**</b>		\$500 per admission copay
<b>Inpatient Nonbiologically Based Mental Illness**</b> Limited to 30 days per calendar year.		\$500 per admission copay
<b>Outpatient Biologically Based Mental Illness**</b>		\$40 per visit copay
<b>Outpatient Nonbiologically Based Mental Illness**</b> Limited to 26 visits per calendar year.		\$40 per visit copay
<b>ALCOHOLIC/DRUG ABUSE SERVICES</b>		<b>PARTICIPATING PROVIDERS/REFERRED</b>
<b>Inpatient Detoxification**</b>		\$500 per admission copay
<b>Outpatient Detoxification**</b> Limited to 26 visits per year.		\$40 per visit copay
<b>OTHER SERVICES</b>		<b>PARTICIPATING PROVIDERS/REFERRED</b>
<b>Skilled Nursing Facility**</b> Limited to 100 days per year.		No copay per admission
<b>Home Health Care</b>		Covered 100%
<b>Hospice Care**</b> – Inpatient		No copay per admission
<b>Hospice Care**</b> – Outpatient		No copay per admission
<b>Private Duty Nursing</b>		Not covered unless preauthorized
<b>Outpatient Rehabilitation Therapy</b> (Includes speech, physical, and occupational therapy.) Treatment over a 60-day consecutive period per incident of illness or injury beginning with the first day of treatment.		\$40 per visit copay
<b>Subluxation</b> Limited to 15 visits per calendar year.		\$40 per visit copay
<b>Durable Medical Equipment</b>		20% of contracted rate
<b>Diabetic Supplies</b>		Pharmacy cost-sharing applies if pharmacy coverage is included, otherwise PCP office visit cost-sharing applies.
<b>Dental</b>		Not covered
<b>Transplants</b>		\$40 copay, coverage is provided at an IOE-contracted facility only.
<b>FAMILY PLANNING</b>		<b>PARTICIPATING PROVIDERS/REFERRED</b>
<b>Infertility Treatment</b> Diagnosis and treatment of the underlying medical condition.		If identified or, 25% after professional services copay.
<b>Voluntary Sterilization</b> Including tubal ligation and vasectomy, excludes reversal of voluntary sterilization.		Subject to applicable service type member cost-sharing.
<b>PHARMACY – PRESCRIPTION DRUG BENEFITS</b>		<b>PARTICIPATING PROVIDERS/REFERRED</b>
<b>Retail</b> Up to a 30-day supply or 100 unit doses at participating pharmacies.		\$15 copay for formulary generic drugs. \$35 copay for formulary brand-name drugs. \$60 copay for nonformulary brand-name and
<b>Mail-Order</b> Up to a 31- to 90-day supply or 100 unit doses at participating pharmacies.		\$30 copay for formulary generic drugs. \$70 copay for formulary brand-name drugs. \$120 copay for non-formulary brand-name and generic drugs.
<b>No Mandatory Generic</b>		Member is responsible to pay the applicable copay only.
<b>Plan Includes</b>		Contraceptive drugs and devices obtainable from a pharmacy. Precertification included and step-therapy included.
<b>Medical Spending Fund</b>		Not included

Notice: In accordance with Oklahoma Regulation 365:40-5-22, this benefit summary provides information about any provisions in this health benefit plan that are different from those of last year.

\*Member cost-sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred out-of-pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum. Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.

\*\*The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.