

# Standard HMO Plan

| PLAN FEATURES   | PARTICIPATING PROVIDERS/REFERRED  |
|---|---|
| <b>Deductible</b> (per calendar year)   | None, Individual<br>None, Family  |
| <b>Member Coinsurance</b>   | Covered 100%  |
| <b>Out-of-Pocket Maximum*</b><br>(per calendar year)  | \$2,500 Individual<br>\$5,000 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 non-primary care physicians services, except for direct-access services. |
| PREVENTIVE CARE   | PARTICIPATING PROVIDERS/REFERRED  |
| <b>Routine Adult Physical Exams/Immunizations</b><br>(Age and frequency schedules apply.)   | \$10 copay  |
| <b>Well-Child Exams/Immunizations</b><br>(Age and frequency schedules apply.)   | No copay per visit<br>Childhood immunizations covered 100% birth through age 18   |
| <b>Routine Gynecological-Care Exams</b><br>Includes Pap smear and related lab fees. One routine exam per 365 days.  | \$10 copay  |
| <b>Routine Mammograms</b><br>One baseline mammogram for females ages 35–39,<br>and one annual mammogram for females age 40 and over.  | Covered 100%  |
| <b>Routine Digital Rectal Exams/Prostate-Specific Antigen Test</b><br>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><br>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><br>(Age and frequency schedules apply.)   | \$40 copay  |
| <b>Routine Hearing Screening</b><br>Audiological services and hearing aids are covered every 48 months for children up to age 18.   | \$30 copay  |
| PHYSICIAN FEATURES  | PARTICIPATING PROVIDERS/REFERRED  |
| <b>Primary Care Physician Visits†</b>   | Office hours: \$30 copay<br>After office hours/home: \$30 copay   |
| <b>Specialist Office Visits</b>   | \$40 copay  |
| <b>Maternity Ob/Gyn Visits</b>  | \$30 copay for initial visit only; thereafter covered 100%  |
| <b>Allergy Treatment</b>  | \$30 copay/PCP; \$40 copay/Specialist   |
| <b>Allergy Testing</b>  | \$30 for 6-week supply of antigen (including shots)   |
| DIAGNOSTIC PROCEDURES   | PARTICIPATING PROVIDERS/REFERRED  |
| <b>Diagnostic Laboratory</b><br>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. | No copay  |
| <b>Diagnostic X-ray</b><br>Outpatient hospital or other outpatient facility.  | No copay<br>\$150 copay for MRI, MRA, PET and CAT   |
| EMERGENCY MEDICAL CARE  | PARTICIPATING PROVIDERS/REFERRED  |
| <b>Urgent Care</b>  | \$40 copay  |
| <b>Non-urgent Use of Urgent Care Provider</b>   | Not covered   |
| <b>Emergency Room</b>   | \$150 copay; waived if admitted   |
| <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>   | \$350 per admission copay; must be preauthorized  |
| <b>Inpatient Maternity Coverage**</b>   | \$350 per admission copay; must be preauthorized  |
| <b>Outpatient Surgery**</b>   | \$250 per visit copay; must be preauthorized  |

† 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>   |  | \$350 per admission copay; must be preauthorized   |
| <b>Inpatient Nonbiologically Based Mental Illness**</b>  |  | \$350 per admission copay; must be preauthorized   |
| <b>Outpatient Biologically Based Mental Illness**</b>  |  | \$30 copay/PCP; \$40 copay/Specialist  |
| <b>Outpatient Nonbiologically Based Mental Illness**</b>   |  | \$30 copay/PCP; \$40 copay/Specialist  |
| <b>ALCOHOLIC/DRUG ABUSE SERVICES</b>   |  | <b>PARTICIPATING PROVIDERS/REFERRED</b>  |
| <b>Inpatient Detoxification**</b>  |  | \$350 per admission copay; must be preauthorized   |
| <b>Outpatient Detoxification**</b>   |  | \$40 per visit copay   |
| <b>OTHER SERVICES</b>  |  | <b>PARTICIPATING PROVIDERS/REFERRED</b>  |
| <b>Skilled Nursing Facility**</b><br>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><br>(Includes speech, physical and occupational therapy.)<br>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><br>Limited to 15 visits per calendar year.  |  | \$40 per visit copay   |
| <b>Durable Medical Equipment</b>   |  | 20% coinsurance initial device<br>20% coinsurance repair and replacement   |
| <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>   |  | No copay per admission<br>Coverage is provided at an Institute of Excellence (IOE) contracted facility only.                                     |
| <b>FAMILY PLANNING</b>   |  | <b>PARTICIPATING PROVIDERS/REFERRED</b>  |
| <b>Infertility Treatment</b><br>Diagnosis and treatment of the underlying medical condition.   |  | If identified; or 25% after professional services copay  |
| <b>Voluntary Sterilization</b><br>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><br>Up to a 30-day supply or 100-unit doses, whichever is greater, at participating pharmacies.   |  | \$10 copay for formulary generic drugs<br>\$30 copay for formulary brand-name drugs<br>\$50 copay for nonformulary brand-name and generic drugs  |
| <b>Mail Order</b><br>Up to a 31- to 90-day supply or 100-unit doses, whichever is greater, at participating pharmacies.  |  | \$20 copay for formulary generic drugs<br>\$60 copay for formulary brand-name drugs<br>\$100 copay for nonformulary 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<br>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.