



BENEFITS GUIDE

<p>Please note: All covered services must be medically necessary.</p>	<p>SoonerCare Traditional & Choice Children Under 21</p>	<p>SoonerCare Traditional Adults 21 and Over</p>	<p>SoonerCare Choice Adults 21 and Over</p>	<p>SoonerCare Traditional-Expansion Adults 19-64</p>	<p>SoonerCare Choice-Expansion Adults 19-64</p>
<p>Ambulance or Emergency Transportation</p>	<p>Covered <i>Emergency Only</i></p>	<p>Covered <i>Emergency Only</i></p>	<p>Covered <i>Emergency Only</i></p>	<p>Covered <i>Emergency Only</i></p>	<p>Covered <i>Emergency Only</i></p>
<p>Child Health Wellness Screens <i>(Including health and immunization history; physical exams; various health assessments and counseling; lab and screening tests; and necessary follow-up care.)</i></p>	<p>Covered</p>	<p>N/A</p>	<p>N/A</p>	<p>N/A <i>For individuals 21 and over</i> Covered <i>Expansion adults 19-20 are eligible to receive EPSDT services.</i></p>	<p>N/A <i>For individuals 21 and over</i> Covered <i>Expansion adults 19-20 are eligible to receive EPSDT services.</i></p>

<p>Please note: All covered services must be medically necessary.</p>	<p>SoonerCare Traditional & Choice Children Under 21</p>	<p>SoonerCare Traditional Adults 21 and Over</p>	<p>SoonerCare Choice Adults 21 and Over</p>	<p>SoonerCare Traditional-Expansion Adults 19-64</p>	<p>SoonerCare Choice-Expansion Adults 19-64</p>
<p>Dental Services <i>(Non-exempt SoonerCare adult members will be charged a \$4 copay per visit for non-emergency dental services.)</i></p>	<p>Covered</p>	<p>Covered <i>Preventive (dental cleanings and fluoride); restorative (silver and tooth-colored fillings); full and partial dentures and extractions.</i></p>	<p>Covered <i>Preventive (dental cleanings and fluoride); restorative (silver and tooth-colored fillings); full and partial dentures and extractions.</i></p>	<p>Covered <i>Preventive (dental cleanings and fluoride); restorative (silver and tooth-colored fillings); full and partial dentures and extractions.</i></p>	<p>Covered <i>Preventive (dental cleanings and fluoride); restorative (silver and tooth-colored fillings); full and partial dentures and extractions.</i></p>
<p>Diabetic Supplies <i>(100 glucose strips and lancets per month; one spring-loaded lancet device; three replacement batteries per year. Additional supplies require prior authorization.)</i></p>	<p>Covered <i>Plus one glucometer per year.</i></p>	<p>Covered <i>\$4 per claim.</i></p>	<p>Covered <i>\$4 per claim.</i></p>	<p>Covered <i>\$4 per claim.</i></p>	<p>Covered <i>\$4 per claim.</i></p>

<p>Please note: All covered services must be medically necessary.</p>	<p>SoonerCare Traditional & Choice</p>	<p>SoonerCare Traditional</p>	<p>SoonerCare Choice</p>	<p>SoonerCare Traditional-Expansion</p>	<p>SoonerCare Choice-Expansion</p>
	<p>Children Under 21</p>	<p>Adults 21 and Over</p>	<p>Adults 21 and Over</p>	<p>Adults 19-64</p>	<p>Adults 19-64</p>
<p>Durable Medical Equipment</p>	<p>Covered <i>When prescribed by medical provider and may require prior authorization.</i></p>	<p>Covered <i>When prescribed by medical provider and may require prior authorization. \$4 copay per claim.</i></p>	<p>Covered <i>When prescribed by medical provider and may require prior authorization. \$4 copay per claim.</i></p>	<p>Covered <i>When prescribed by medical provider and may require prior authorization. \$4 copay per claim.</i></p>	<p>Covered <i>When prescribed by medical provider and may require prior authorization. \$4 copay per claim.</i></p>
<p>Emergency Department <i>(ER services)</i></p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>
<p>Family Planning Services</p>	<p>Covered <i>Birth control information and supplies; pap smears; and pregnancy tests.</i></p>	<p>Covered <i>Birth control information and supplies; pap smears; pregnancy tests; tubal ligations and vasectomies.</i></p>	<p>Covered <i>Birth control information and supplies; pap smears; pregnancy tests; tubal ligations and vasectomies.</i></p>	<p>Covered <i>Birth control information and supplies; pap smears; pregnancy tests; tubal ligations and vasectomies.</i></p>	<p>Covered <i>Birth control information and supplies; pap smears; pregnancy tests; tubal ligations and vasectomies.</i></p>

<p>Please note: All covered services must be medically necessary.</p>	<p>SoonerCare Traditional & Choice Children Under 21</p>	<p>SoonerCare Traditional Adults 21 and Over</p>	<p>SoonerCare Choice Adults 21 and Over</p>	<p>SoonerCare Traditional–Expansion Adults 19–64</p>	<p>SoonerCare Choice–Expansion Adults 19–64</p>
<p>Habilitation Services</p>	<p>Covered</p>	<p>No Coverage</p>	<p>No Coverage</p>	<p>Covered as PT, ST, OT visits <i>(In addition to the therapy visit benefit.)</i> <i>No prior authorization required; 15 visits per year per discipline in hospital outpatient; \$4 copay per visit.</i></p>	<p>Covered as PT, ST, OT visits <i>(In addition to the therapy visit benefit.)</i> <i>No prior authorization required; 15 visits per year per discipline in hospital outpatient; \$4 copay per visit.</i></p>
<p>Hearing Services</p>	<p>Covered <i>Evaluations, hearing aids and supplies.</i></p>	<p>Covered <i>Evaluation only.</i> <i>Hearing aids covered when provided within nursing facilities</i></p>	<p>Covered <i>Evaluation only</i> <i>Hearing aids covered when provided within nursing facilities</i></p>	<p>Covered <i>Evaluation only.</i> <i>Hearing aids covered when provided within nursing facilities</i></p>	<p>Covered <i>Evaluation only</i> <i>Hearing aids covered when provided within nursing facilities</i></p>
<p>Home Health Care Services</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>
<p>Hospice</p>	<p>Covered</p>	<p>No Coverage</p>	<p>No Coverage</p>	<p>Covered <i>Effective Oct. 1, 2021</i></p>	<p>Covered <i>Effective Oct. 1, 2021</i></p>

<p>Please note: All covered services must be medically necessary.</p>	<p>SoonerCare Traditional & Choice Children Under 21</p>	<p>SoonerCare Traditional Adults 21 and Over</p>	<p>SoonerCare Choice Adults 21 and Over</p>	<p>SoonerCare Traditional-Expansion Adults 19-64</p>	<p>SoonerCare Choice-Expansion Adults 19-64</p>
<p>Inpatient Hospital Services</p>	<p>Covered</p>	<p>Covered \$10 per day for first seven days – \$5 on the eighth day.</p>	<p>Covered \$10 per day for first seven days – \$5 on the eighth day.</p>	<p>Covered \$10 per day for first seven days – \$5 on the eighth day.</p>	<p>Covered \$10 per day for first seven days – \$5 on the eighth day.</p>
<p>Immunizations <i>(As recommended by the Advisory Committee of Immunization Practices)</i></p>	<p>Covered</p>	<p>Covered As recommended for adults; \$4 per date of service.</p>	<p>Covered As recommended for adults; \$4 per date of service.</p>	<p>Covered As recommended for adults; \$4 per date of service. No copay if service is preventive</p>	<p>Covered As recommended for adults; \$4 per date of service. No copay if service is preventive.</p>
<p>Laboratory and X-ray</p>	<p>Covered</p>	<p>Covered \$4 per visit.</p>	<p>Covered \$4 per visit.</p>	<p>Covered \$4 per visit. No copay if service is preventive.</p>	<p>Covered \$4 per visit. No copay if service is preventive.</p>
<p>Nursing Facility Services</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>
<p>Mammograms</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered No copay if service is preventive.</p>	<p>Covered No copay if service is preventive.</p>
<p>Nurse Midwife Services</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>

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<p>Medication Assisted Treatment <i>Includes:</i> <i>Drugs and agents used for substance use disorder treatment and opioid treatment programs (OTPs).</i></p>	<p>Covered <i>Some drugs may require prior authorization. OTP services require prior authorization.</i></p>	<p>Covered <i>Some drugs may require prior authorization. OTP services require prior authorization.</i></p>	<p>Covered <i>Some drugs may require prior authorization. OTP services require prior authorization.</i></p>	<p>Covered <i>Some drugs may require prior authorization. OTP services require prior authorization.</i></p>	<p>Covered <i>Some drugs may require prior authorization. OTP services require prior authorization.</i></p>
<p>Mental Health or Substance Use Disorder Medical Detoxification–Inpatient</p>	<p>Covered <i>With prior authorization.</i></p>	<p>Covered <i>With prior authorization. Copay for inpatient - \$10 per day, up to a maximum of \$75.</i></p>	<p>Covered <i>With prior authorization. Copay for inpatient - \$10 per day, up to a maximum of \$75.</i></p>	<p>Covered <i>With prior authorization. Copay for inpatient - \$10 per day, up to a maximum of \$75.</i></p>	<p>Covered <i>With prior authorization. Copay for inpatient - \$10 per day, up to a maximum of \$75.</i></p>
<p>Mental Health or Substance Use Disorder–Outpatient</p>	<p>Covered <i>With prior authorization.</i></p>	<p>Covered <i>With prior authorization. Some services may require a \$3 copay.</i></p>	<p>Covered <i>With prior authorization. Some services may require a \$3 copay.</i></p>	<p>Covered <i>With prior authorization. Some services may require a \$3 copay.</i></p>	<p>Covered <i>With prior authorization. Some services may require a \$3 copay.</i></p>
<p>Organ Transplants</p>	<p>Covered <i>With prior authorization.</i></p>	<p>Covered <i>With prior authorization.</i></p>	<p>Covered <i>With prior authorization.</i></p>	<p>Covered <i>With prior authorization.</i></p>	<p>Covered <i>With prior authorization.</i></p>

<p>Please note: All covered services must be medically necessary.</p>	<p>SoonerCare Traditional & Choice Children Under 21</p>	<p>SoonerCare Traditional Adults 21 and Over</p>	<p>SoonerCare Choice Adults 21 and Over</p>	<p>SoonerCare Traditional-Expansion Adults 19-64</p>	<p>SoonerCare Choice-Expansion Adults 19-64</p>
<p>Orthodontic Services</p>	<p>Covered <i>With prior authorization.</i></p>	<p>No Coverage</p>	<p>No Coverage</p>	<p>No Coverage</p>	<p>No Coverage</p>
<p>Outpatient Hospital and Surgery Services</p>	<p>Covered <i>If medically necessary.</i></p>	<p>Covered <i>If medically necessary. \$4 copay per visit.</i></p>	<p>Covered <i>If medically necessary. \$4 copay per visit.</i></p>	<p>Covered <i>If medically necessary. \$4 copay per visit.</i></p>	<p>Covered <i>If medically necessary. \$4 copay per visit.</i></p>
<p>Over-the-Counter Contraceptives</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>
<p>Personal Care</p>	<p>Covered <i>As prescribed in treatment plan.</i></p>	<p>Covered <i>As prescribed in treatment plan.</i></p>	<p>Covered <i>As prescribed in treatment plan.</i></p>	<p>Covered As prescribed in treatment plan.</p>	<p>Covered <i>As prescribed in treatment plan.</i></p>

<p>Please note: All covered services must be medically necessary.</p>	<p>SoonerCare Traditional & Choice Children Under 21</p>	<p>SoonerCare Traditional Adults 21 and Over</p>	<p>SoonerCare Choice Adults 21 and Over</p>	<p>SoonerCare Traditional-Expansion Adults 19-64</p>	<p>SoonerCare Choice-Expansion Adults 19-64</p>
<p>Physician Services</p>	<p>Covered</p>	<p>Covered 4 Visits Per Month <i>Including any specialist visits. \$4 copay per visit.</i></p>	<p>Covered 4 Visits Per Month <i>Including any specialist visits. \$4 copay per visit.</i></p>	<p>Covered 4 Visits Per Month <i>Including any specialist visits. \$4 copay per visit.</i> *Expansion adults may exceed physician visit limits, if medically necessary and with prior authorization.</p>	<p>Covered 4 Visits Per Month <i>Including any specialist visits. \$4 copay per visit.</i> *Expansion adults may exceed physician visit limits, if medically necessary and with prior authorization.</p>
<p>Primary Care Provider/Primary Care Medical Home</p>	<p>Covered <i>Unlimited medically necessary services.</i></p>	<p>No Coverage</p>	<p>Covered <i>Unlimited medically necessary services. \$4 copay per visit.</i></p>	<p>No Coverage</p>	<p>Covered <i>*Expansion adults may exceed physician visit limits, if medically necessary and with prior authorization. \$4 copay per visit.</i></p>

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<p>Pregnancy and Maternity Services <i>(Including prenatal, delivery and postpartum) *For Soon-to-be-Sooners, refer to the notes at the bottom of this document.</i></p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>
<p>Prescription Drugs <i>(Prenatal vitamins and smoking cessation products do not count toward prescription limits.) No copays for children and pregnant women. ** For Home and Community-Based Waiver Services copays, refer to the notes at the bottom of this document.</i></p>	<p>Unlimited Coverage</p>	<p>6 Per Month Limit <i>Up to 2 brand-name. \$4 copay for each prescription. \$4 copay per visit.</i></p>	<p>6 Per Month Limit <i>Up to 2 brand-name. \$4 copay for each prescription. \$4 copay per visit.</i></p>	<p>6 Per Month Limit <i>Up to 2 brand-name. \$4 copay for each prescription. \$4 copay per visit.</i></p>	<p>6 Per Month Limit <i>Up to 2 brand-name. \$4 copay for each prescription. \$4 copay per visit.</i></p>

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<p>Preventive care and screening</p>	<p>Covered</p>	<p>Limited Coverage <i>Covered preventive services are provided within outpatient hospitals; as laboratory and X-ray services; diagnosis and treatment of conditions found; clinic services; screening services and rehabilitative services.</i></p>	<p>Covered</p>	<p>Limited Coverage <i>Covered preventive services are provided within outpatient hospitals; as laboratory and X-ray services; diagnosis and treatment of conditions found; clinic services; screening services and rehabilitative services.</i></p>	<p>Covered</p>
<p>Prosthetics and Orthotics</p>	<p>Covered With prior authorization. Orthotics are covered.</p>	<p>Limited Coverage <i>With prior authorization. Orthotics are not covered.</i></p>	<p>Limited Coverage With prior authorization. Orthotics are not covered.</p>	<p>Covered <i>With prior authorization</i> *Prosthetics and orthotics are covered for expansion adults without limitations, when medically necessary.</p>	<p>Covered <i>With prior authorization</i> *Prosthetics and orthotics are covered for expansion adults without limitations, when medically necessary.</p>

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<p>Psychiatric Residential Treatment Facility</p>	<p>Covered <i>With prior authorization.</i></p>	<p>No Coverage</p>	<p>No Coverage</p>	<p>No Coverage For expansion adults 21 and over. Covered For expansion adults 19-20</p>	<p>No Coverage For expansion adults 21 and over. Covered For expansion adults 19-20</p>
<p>Inpatient Rehab Hospital</p>	<p>Covered</p>	<p>Covered <i>90 days per individual per state fiscal year (July-June), when medically necessary with prior authorization.</i></p>	<p>Covered <i>90 days per individual per state fiscal year (July-June), when medically necessary with prior authorization.</i></p>	<p>Covered <i>90 days per individual per state fiscal year (July-June). * Expansion adults may exceed day limits, if medically necessary with prior authorization.</i></p>	<p>Covered <i>90 days per individual per state fiscal year (July-June). * Expansion adults may exceed day limits, if medically necessary with prior authorization.</i></p>
<p>SoonerRide <i>Transportation to non-emergency covered medical services</i></p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>	<p>Covered</p>

<p>Please note: All covered services must be medically necessary.</p>	<p>SoonerCare Traditional & Choice</p>	<p>SoonerCare Traditional</p>	<p>SoonerCare Choice</p>	<p>SoonerCare Traditional-Expansion</p>	<p>SoonerCare Choice-Expansion</p>
	<p>Children Under 21</p>	<p>Adults 21 and Over</p>	<p>Adults 21 and Over</p>	<p>Adults 19-64</p>	<p>Adults 19-64</p>
<p>Stop Smoking (Cessation) Products</p>	<p>No Duration Limits <i>for a member's use of FDA approved cessation products (except Chantix which has a 180 day limit).</i></p>	<p>No Duration Limits <i>for a member's use of FDA approved cessation products (except Chantix which has a 180 day limit).</i></p>	<p>No Duration Limits <i>for a member's use of FDA approved cessation products (except Chantix which has a 180 day limit).</i></p>	<p>No Duration Limits <i>for a member's use of FDA approved cessation products (except Chantix which has a 180 day limit).</i></p>	<p>No Duration Limits <i>for a member's use of FDA approved cessation products (except Chantix which has a 180 day limit).</i></p>
<p>Substance Use Disorder Residential Treatment</p>	<p>Covered <i>With prior authorization. Starting at age 13.</i></p>	<p>Covered <i>With prior authorization.</i></p>	<p>Covered <i>With prior authorization.</i></p>	<p>Covered <i>With prior authorization.</i></p>	<p>Covered <i>With prior authorization.</i></p>
<p>Therapy Services <i>Physical (PT), Speech (ST), Occupational (OT).</i></p>	<p>Covered <i>May require prior authorization.</i></p>	<p>PT, ST, OT <i>No prior authorization required; 15 visits per year per discipline in hospital outpatient; \$4 copay per visit.</i></p>	<p>PT, ST, OT <i>No prior authorization required; 15 visits per year per discipline in hospital outpatient; \$4 copay per visit.</i></p>	<p>PT, ST, OT <i>No prior authorization required; 15 visits per year per discipline in hospital outpatient; \$4 copay per visit.</i></p>	<p>PT, ST, OT <i>No prior authorization required; 15 visits per year per discipline in hospital outpatient; \$4 copay per visit. May require prior authorization for expansion adults members 19-20.</i></p>

Please note: All covered services must be medically necessary.	SoonerCare Traditional & Choice	SoonerCare Traditional	SoonerCare Choice	SoonerCare Traditional-Expansion	SoonerCare Choice-Expansion
	Children Under 21	Adults 21 and Over	Adults 21 and Over	Adults 19-64	Adults 19-64
Urgent Care Center	Covered	Covered	Covered	Covered	Covered
Vision Services	Covered	Covered <i>For eye diseases or eye injuries only.</i>	Covered <i>For eye diseases or eye injuries only.</i>	Covered <i>For eye diseases or eye injuries only.</i>	Covered <i>for expansion adults (19-20). Coverage for expansion adults (21-64) is limited to an eye exam related to an eye injury or eye disease.</i>

Please note: All covered services must be medically necessary.	SoonerPlan
Ambulance or Emergency Transportation	No Coverage
Child Health Wellness Screens <i>(Including health and immunization history; physical exams, various health assessments and counseling; lab and screening tests and necessary follow-up care.)</i>	No Coverage
Dental Services	No Coverage
Diabetic Supplies <i>(100 glucose strips and lancets per month; one spring-loaded lancet device, three replacement batteries per year. Additional supplies require prior authorization.)</i>	No Coverage
Durable Medical Equipment	No Coverage

<p>Please note: All covered services must be medically necessary.</p>	<p>SoonerPlan</p>
<p>Emergency Department <i>(ER services)</i></p>	<p>No Coverage</p>
<p>Family Planning Services</p>	<p>Birth Control Information, Services and Supplies <i>Men and women ages 19 and over.</i></p> <p>Gardasil <i>Men and women through age 26.</i></p> <p>Tubal Ligation & Vasectomy <i>Persons ages 21 and older - \$0 copay for any family planning-related service or supply.</i></p>
<p>Hearing Services</p>	<p>No Coverage</p>
<p>Home Health Care Services</p>	<p>No Coverage</p>
<p>Inpatient Hospital Services</p>	<p>No Coverage</p>
<p>Immunizations <i>(As recommended by the Advisory Committee of Immunization Practices)</i></p>	<p>No Coverage</p>
<p>Laboratory and X-ray</p>	<p>Services Related to Family Planning Only <i>\$0 copay.</i></p>
<p>Long-term Care</p>	<p>No Coverage</p>
<p>Mammograms</p>	<p>No Coverage</p>
<p>Mental Health or Substance Use Disorder Medical Detoxification- Inpatient</p>	<p>No Coverage</p>
<p>Mental Health or Substance Use Disorder-Outpatient</p>	<p>No Coverage</p>
<p>Nurse Midwife Services</p>	<p>No Coverage</p>

<p>Please note: All covered services must be medically necessary.</p>	<p>SoonerPlan</p>
<p>Orthodontic Services</p>	<p>No Coverage</p>
<p>Outpatient Hospital and Surgery Services</p>	<p>Services Related to Family Planning Only \$0 copay.</p>
<p>Over-the-Counter Contraceptives</p>	<p>Contraceptives Only \$0 copay.</p>
<p>Personal Care</p>	<p>No Coverage</p>
<p>Physician Services</p>	<p>Physician Visits and Physical Exams <i>Related to family planning only - \$0 copay</i></p>
<p>Pregnancy and Maternal Services <i>(Including prenatal, delivery and postpartum) * For Soon-to-be-Sooners, refer to the notes at the bottom of this document.</i></p>	<p>Pregnancy Tests for Women \$0 copay.</p>
<p>Prescription Drugs <i>(Prenatal vitamins and smoking cessation products do not count towards prescription limits. No copays for children and pregnant women.)</i> <i>**For Home and Community-Based Waiver Services copays, refer to the notes at the bottom of this document.</i></p>	<p>Contraceptives Only \$0 copay.</p>
<p>Prosthetic Devices</p>	<p>No Coverage</p>
<p>SoonerRide <i>Transportation to non-emergency covered medical services.</i></p>	<p>Covered</p>
<p>Substance Use Disorder Residential Treatment</p>	<p>No Coverage</p>
<p>Stop Smoking (Cessation) Products</p>	<p>No Coverage</p>

Please note: All covered services must be medically necessary.	SoonerPlan
Substance Abuse Treatment <i>(Medical detoxification only.)</i>	No Coverage
Therapy Services <i>Physical, Speech, Occupational.</i>	No Coverage
Transplant Services	No Coverage
Vision Services	No Coverage

*Soon-to-be-Sooners	<p>Members in Soon-to-be Sooners receive pregnancy and maternity services only. The individual who is covered for pregnancy-related benefits under Soon-to-be-Sooners retains eligibility until the end of the pregnancy. Section 317:30-22-8</p>
Home and Community-Based Services (HCBS)1915(c) Waiver Programs	<p>HCBS members receive the SoonerCare Traditional services in addition to the HCBS services within the waiver program they are enrolled which are:</p> <ul style="list-style-type: none"> · Advantage Waiver Program Services · Medically Fragile Program Services · Community Waiver Program Services · Homeward Bound Program Services · In-Home Supports for Adults Program Services · In-Home Supports for Children Program Services <p>Members in HCBS waiver programs only pay copays for prescriptions as follows: \$0.65 copay per drug costing \$10.00 or less; \$1.20 copay per drug costing \$10.01-\$25.00; \$2.40 copay per drug costing \$25.01-\$50.00; \$3.50 copay per drug costing \$50.01 or more.</p>

The covered benefits list provided is not all-inclusive. All covered benefits must be medically necessary. Coverage of above benefits is dependent upon meeting requirements provided in accordance with various state and federal regulations. Please verify coverage or consult with a SoonerCare helpline representative prior to receiving services. Coverage, copays and limitations are subject to change. Updated June 1, 2020.

