SoonerCare

COMPARE OUR BENEFITS

Please note:
All covered services must be medically necessary.

	SoonerCare Traditional		SoonerCare Choice	
	Children Under 21	*Adults 21 and Over*	*Children Under 21*	*Adults 21 and Over*
Ambulance or Emergency Transportation	**Covered** *Emergency Only*	**Covered** *Emergency Only*	**Covered** *Emergency Only*	**Covered** *Emergency Only*
Behavioral Health and Substance Abuse Services *(Some services may require prior authorization.)*	**Covered**	**Covered** *Some services may require a $3 copay; Behavioral Health Inpatient - $10 per day, up to a maximum of $75*	**Covered**	**Covered** *Some services may require a $3 copay; Behavioral Health Inpatient - $10 per day, up to a maximum of $75*
Child Health Wellness Screens *(Including health and immunization history; physical exams, various health assessments and counseling; lab and screening tests and necessary follow-up care.)*	**Covered**	**N/A**	**Covered**	**N/A**
Dental Services	**Cleanings** *(Twice a year.)* **X-rays Fillings Crowns**	**Emergency Extractions**	**Cleanings** *(Twice a year.)* **X-rays Fillings Crowns**	**Emergency Extractions**
Diabetic Supplies *(100 glucose strips and lancets per month; one spring-loaded lancet device, three replacement batteries per year. Additional supplies require prior authorization.)*	**Covered** *Plus one glucometer per year.*	**Covered** *$4 per claim.*	**Covered** *Plus one glucometer per year.*	**Covered** *$4 per claim.*
Durable Medical Equipment	**Covered** *When prescribed by medical provider and may require prior authorization.*	**Covered** *When prescribed by medical provider and may require prior authorization. $4 copay per claim.*	**Covered** *When prescribed by medical provider and may require prior authorization.*	**Covered** *When prescribed by medical provider and may require prior authorization. $4 copay per claim.*
Emergency Department *(ER services)*	**Covered**	**Covered**	**Covered**	**Covered**

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 or Insure Oklahoma helpline representative prior to receiving services. Coverage, copays and limitations are subject to change. Updated June 10, 2020.

Please note:
All covered services must be medically necessary.

	SoonerCare Traditional		SoonerCare Choice	
	Children Under 21	*Adults 21 and Over*	*Children Under 21*	*Adults 21 and Over*
Family Planning Services	**Birth control** *(Information and supplies.)* **Pap smears Pregnancy tests**	**Birth control** *(Information and supplies.)* **Pap smears Pregnancy tests Tubal Ligations Vasectomies**	**Birth control** *(Information and supplies.)* **Pap smears Pregnancy tests**	**Birth control** *(Information and supplies.)* **Pap smears Pregnancy tests Tubal Ligations Vasectomies**
Hearing Services	**Covered** *Evaluations, hearing aids and supplies.*	**Covered** *Evaluation only.*	**Covered** *Evaluations, hearing aids and supplies.*	**Covered** *Evaluation only.*
Home Health Care Services	**Covered**	**36 Visits** *Covered annually without prior authorization when prescribed by a physician - $4 copay per visit.*	**Covered**	**36 Visits** *Covered annually without prior authorization when prescribed by a physician - $4 copay per visit.*
Inpatient Hospital Services	**Covered**	**Covered** *$10 per day for first seven days - $5 on the eighth day*	**Covered**	**Covered** *$10 per day for first seven days - $5 on the eighth day*
Immunizations *(As recommended by the Advisory Committee of Immunization Practices)*	**Covered**	**Covered** *As recommended for adults; $4 per date of service.*	**Covered**	**Covered** *As recommended for adults; $4 per date of service.*
Laboratory and X-ray	**Covered**	**Covered** *$4 per visit.*	**Covered**	**Covered** *$4 per visit.*
Long-term Care	**Covered**	**Covered**	**No Coverage**	**No Coverage**
Mammograms	**Covered**	**Covered**	**Covered**	**Covered**
Nurse Midwife Services	**Covered**	**Covered**	**Covered**	**Covered**
Orthodontic Services	**Covered** *With prior authorization.*	**No Coverage**	**Covered** *With prior authorization.*	**No Coverage**
Outpatient Hospital and Surgery Services	**Covered** *If medically necessary.*	**Covered** *If medically necessary. $4 copay per visit.*	**Covered** *If medically necessary.*	**Covered** *If medically necessary. $4 copay per visit.*
Over-the-Counter Contraceptives	**Covered**	**Covered**	**Covered**	**Covered**
Personal Care	**Covered** *As prescribed in treatment plan.*	**Covered** *As prescribed in treatment plan.*	**Covered** *As prescribed in treatment plan.*	**Covered** *As prescribed in treatment plan.*
Physician Services	**Covered**	**4 Visits Per Month** *Including any specialist visits. $4 copay per visit.*	**Covered**	**Unlimited Medical Home PCP Visits** *Up to 4 specialist or non-PCP visits per month. $4 copay per visit.*

Please note:
All covered services must be medically necessary.

	SoonerCare Traditional		SoonerCare Choice	
	Children Under 21	*Adults 21 and Over*	*Children Under 21*	*Adults 21 and Over*
Pregnancy and Maternity Services *(Including prenatal, delivery and postpartum)* ** For Soon-to-be-Sooners, refer to the notes at the bottom of this document.*	**Covered**	**Covered**	**Covered**	**Covered**
Prescription Drugs *(Prenatal vitamins and smoking cessation products do not count towards 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.*	**Unlimited Coverage**	**6 Per Month Limit** *Up to 2 brand-name. $4 copay for each prescription. $4 copay per visit.*	**Unlimited Coverage**	**6 Per Month Limit** *Up to 2 brand-name. $4 copay for each prescription. $4 copay per visit.*
Prosthetic Devices	**Covered** *With prior authorization; Orthotics are covered.*	**Limited Coverage** *With prior authorization; Orthotics are not covered.*	**Covered** *With prior authorization; Orthotics are covered.*	**Limited Coverage** *With prior authorization; Orthotics are not covered.*
Psychiatric Residential Treatment Facility	**Covered** *With prior authorization.*	**No Coverage**	**Covered** *With prior authorization.*	**No Coverage**
Residential Substance Abuse Treatment	**No Coverage**	**No Coverage**	**No Coverage**	**No Coverage**
SoonerRide *Transportation to non-emergency covered medical services*	**Covered**	**Covered**	**Covered**	**Covered**
Stop Smoking (Cessation) Products	**90 Days** *Without authorization.*	**90 Days** *Without authorization.*	**90 Days** *Without authorization.*	**90 Days** *Without authorization.*
Substance Abuse Treatment *(Medical detoxification only.)*	**Covered** *With prior authorization.*	**Covered**	**Covered** *With prior authorization.*	**Covered**
Therapy Services *Physical (PT), Speech (ST), Occupational (OT).*	**Covered** *May require prior authorization.*	**PT, ST, OT** *No prior authorization required; 15 visits per year in hospital outpatient; $4 copay per visit.*	**Covered** *May require prior authorization.*	**PT, ST, OT** *No prior authorization required; 15 visits per year in hospital outpatient; $4 copay per visit.*
Transplant Services	**Covered** *With prior authorization.*	**Covered** *With prior authorization.*	**Covered** *With prior authorization.*	**Covered** *With prior authorization.*
Vision Services	**Covered**	**Covered** *For eye diseases or eye injuries only.*	**Covered**	**Covered** *For eye diseases or eye injuries only.*

***Soon-to-be-Sooners**

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 pregnancy. Section 317:30-22-8

****Prescription Drugs for Home and Community-Based Services**

Members in Home and Community-Based Services waivers pay the following copays for prescriptions: $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.

Please note: All covered services must be medically necessary.	**SoonerPlan**	**Insure Oklahoma Individual Plan Adults**
Ambulance or Emergency Transportation	**No Coverage**	**Covered** *Emergency ground only.*
Behavioral Health and Substance Abuse Services *(Some services may require prior authorization.)*	**No Coverage**	**Covered** *Psychiatrist visits included in 4 physician services limit per month. Copays vary: Physicians & Outpatient - $4 copay per visit.*
Child Health Wellness Screens *(Including health and immunization history; physical exams, various health assessments and counseling; lab and screening tests and necessary follow-up care.)*	**No Coverage**	**No Coverage**
Dental Services	**No Coverage**	**Limited** *Emergency extractions, $0 copay.*
Diabetic Supplies *(100 glucose strips and lancets per month; one spring-loaded lancet device, three replacement batteries per year. Additional supplies require prior authorization.)*	**No Coverage**	**Covered** *$4 copay per claim*
Durable Medical Equipment	**No Coverage**	**Covered** *When prescribed by medical provider with copay ($4 copay for durable, non-durable supplies; $8 copay for DME equipment)*
Emergency Department *(ER services)*	**No Coverage**	**Covered** *$30 copay (waived if admitted).*
Family Planning Services	**Birth Control Information, Services and Supplies** *Men and women age 19 and over.* **Gardasil** *Men and women through age 26.* **Tubal Ligation & Vasectomy** *Persons age 21 and older - $0 copay for any family planning-related service or supply,*	**Birth Control Information, Services and Supplies** **Pap smears** **Pregnancy tests** *$0 copay* **Tubal Ligation & Vasectomy** *Persons age 21 and older.*
Hearing Services	**No Coverage**	**No Coverage**
Home Health Care Services	**No Coverage**	**36 Visits Covered Annually** *Without prior authorization when prescribed by a physician - $4 copay per visit*
Inpatient Hospital Services	**No Coverage**	**Covered** *$50 copay per admission.*
Immunizations *(as recommended by the Advisory Committee of Immunization Practices)*	**No Coverage**	**Covered** *As recommended for adults. $4 copay per visit.*

Please note: All covered services must be medically necessary.	**SoonerPlan**	**Insure Oklahoma Individual Plan Adults**
Laboratory and X-ray	**Services Related to Family Planning Only** *$0 copay.*	**Covered** *No copay for standard radiology ($4 copay per specialized scan - MRI, MRA, PET, CT).*
Long-term Care	**No Coverage**	**No Coverage**
Mammograms	**No Coverage**	**Covered** *$0 copay*
Nurse Midwife Services	**No Coverage**	**Covered**
Orthodontic Services	**No Coverage**	**No Coverage**
Outpatient Hospital and Surgery Services	**Services Related to Family Planning Only** *$0 copay.*	**Covered** *Medically necessary - $4 copay per visit.* *Therapeutic radiology - $4 copay per visit.*
Over-the-Counter Contraceptives	**Contraceptives Only** *$0 copay.*	**Covered** *$0 copay.*
Personal Care	**No Coverage**	**No Coverage**
Physician Services	**Physician Visits and Physical Exams** *Related to family planning only - $0 copay.*	**4 Visits Per Month** *Includes any specialist visits - $4 copay per visit.*
Pregnancy and Maternity Services *(Including prenatal, delivery and postpartum)* ** For Soon-to-be-Sooners, refer to the notes at the bottom of this document.*	**Pregnancy Tests for Women** *$0 copay.*	**Covered** *$0 copay.*
Prescription Drugs *(Prenatal vitamins and smoking cessation products do not count towards 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.*	**Contraceptives Only** *$0 copay.*	**6 Per Month Limit** *Up to 2 brand-name with copay. $4 copay for generic - $8 copay for brand name.*
Prosthetic Devices	**No Coverage**	**Limited Coverage** *With prior authorization; orthotics are not covered.*
Psychiatric Residential Treatment Facility	**No Coverage**	**No Coverage**
Residential Substance Abuse Treatment	**No Coverage**	**No Coverage**
SoonerRide *Transportation to non-emergency covered medical services*	**Covered**	**No Coverage**

Please note: All covered services must be medically necessary.	**SoonerPlan**	**Insure Oklahoma Individual Plan Adults**
Stop Smoking (Cessation) Products	**No Coverage**	**90 Days Without An Authorization** *$4 copay for generic; $8 copay for brand name.*
Substance Abuse Treatment *(Medical detoxification only.)*	**No Coverage**	**Outpatient** *$4 per visit.*
Therapy Services *Physical, Speech, Occupational.*	**No Coverage**	**PT, ST, OT** *No prior authorization required; 15 visits per year in hospital outpatient; $4 copay per visit.*
Transplant Services	**No Coverage**	**No Coverage**
Vision Services	**No Coverage**	**Coverage** *For eye diseases or eye injuries only - $4 copay.*
***Soon-to-be-Sooners**	**N/A**	**N/A**
****Prescription Drugs for Home and Community-Based Services**	**N/A**	**N/A**

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