SoonerCare

BENEFITS GUIDE

Please note: All covered services must be medically necessary.	SoonerCare Traditional & Choice Children Under 21	SoonerCare Traditional Adults 21 and Over	SoonerCare Choice Adults 21 and Over	SoonerCare Traditional–Expansion Adults 19–64	SoonerCare Choice–Expansion Adults 19–64
Alternative Treatment for Pain Management *Includes therapeutic exercises and activities and manual spinal manipulation*	**Covered**	**Covered** *With prior authorization* *12 hours (or 48 units) of therapeutic exercises and activities* *12 visits of manual spinal manipulation* *$4 copay per visit*	**Covered** *With prior authorization* *12 hours (or 48 units) of therapeutic exercises and activities* *12 visits of manual spinal manipulation* *$4 copay per visit*	**Covered** *With prior authorization* *12 hours (or 48 units) of therapeutic exercises and activities* *12 visits of manual spinal manipulation* *$4 copay per visit*	**Covered** *With prior authorization* *12 hours (or 48 units) of therapeutic exercises and activities* *12 visits of manual spinal manipulation* *$4 copay per visit*
Ambulance or Emergency Transportation	**Covered** *Emergency Only*	**Covered** *Emergency Only*	**Covered** *Emergency Only*	**Covered** *Emergency Only*	**Covered** *Emergency Only*

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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**	**N/A**	**N/A** *For individuals 21 and over* **Covered** *Expansion adults 19–20 are eligible to receive EPSDT services*	**N/A** *For individuals 21 and over* **Covered** *Expansion adults 19–20 are eligible to receive EPSDT services*
Dental Services *(Non-exempt SoonerCare adult members will be charged a $4 copay per visit for non-emergency dental services)*	**Covered**	**Covered** *Preventive (dental cleanings and fluoride); restorative (silver and tooth-colored fillings); full and partial dentures and extractions*	**Covered** *Preventive (dental cleanings and fluoride); restorative (silver and tooth-colored fillings); full and partial dentures and extractions*	**Covered** *Preventive (dental cleanings and fluoride); restorative (silver and tooth-colored fillings); full and partial dentures and extractions*	**Covered** *Preventive (dental cleanings and fluoride); restorative (silver and tooth-colored fillings); full and partial dentures and 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** *$4 per claim*	**Covered** *$4 per claim*	**Covered** *$4 per claim*

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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* *$4 copay per claim*	**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* *$4 copay per claim*
Emergency Department *(ER services)*	**Covered**	**Covered**	**Covered**	**Covered**	**Covered**
Family Planning Services	**Covered** *Birth control information and supplies; pap smears; and pregnancy tests*	**Covered** *Birth control information and supplies; pap smears; pregnancy tests; tubal ligations and vasectomies*	**Covered** *Birth control information and supplies; pap smears; pregnancy tests; tubal ligations and vasectomies*	**Covered** *Birth control information and supplies; pap smears; pregnancy tests; tubal ligations and vasectomies*	**Covered** *Birth control information and supplies; pap smears; pregnancy tests; tubal ligations and vasectomies*

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

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Inpatient Hospital Services	**Covered**	**Covered** *$10 per day for first seven days – $5 on the eighth day*	**Covered** *$10 per day for first seven days – $5 on the eighth day*	**Covered** *$10 per day for first seven days – $5 on the eighth day*	**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** *No copay*	**Covered** *No copay*	**Covered** *No copay*	**Covered** *No copay*
Laboratory and X-ray	**Covered**	**Covered** *$4 per visit*	**Covered** *$4 per visit*	**Covered** *$4 per visit* *No copay if service is preventive*	**Covered** *$4 per visit* *No copay if service is preventive*
Nursing Facility Services	**Covered**	**Covered**	**Covered**	**Covered**	**Covered**
Mammograms	**Covered**	**Covered**	**Covered**	**Covered** *No copay if service is preventive*	**Covered** *No copay if service is preventive*
Nurse Midwife Services	**Covered**	**Covered**	**Covered**	**Covered**	**Covered**

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

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

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

Please note: All covered services must be medically necessary.	**SoonerCare Traditional & Choice** **Children Under 21**	**SoonerCare Traditional** **Adults 21 and Over**	**SoonerCare Choice** **Adults 21 and Over**	**SoonerCare Traditional–Expansion** **Adults 19–64**	**SoonerCare Choice–Expansion** **Adults 19–64**
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**	**Covered**
Prescription Drugs *(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*	**Unlimited Coverage**	**6 Per Month Limit** *Up to 2 brand-name* *$4 copay for each prescription* *$4 copay per visit*	**6 Per Month Limit** *Up to 2 brand-name* *$4 copay for each prescription* *$4 copay per visit*	**6 Per Month Limit** *Up to 2 brand-name* *$4 copay for each prescription* *$4 copay per visit*	**6 Per Month Limit** *Up to 2 brand-name* *$4 copay for each prescription* *$4 copay per visit*

Please note: All covered services must be medically necessary.	**SoonerCare Traditional & Choice** **Children Under 21**	**SoonerCare Traditional** **Adults 21 and Over**	**SoonerCare Choice** **Adults 21 and Over**	**SoonerCare Traditional–Expansion** **Adults 19–64**	**SoonerCare Choice–Expansion** **Adults 19–64**
Preventive care and screening	**Covered**	**Limited Coverage** *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*	**Covered**	**Limited Coverage** *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*	**Covered**
Prosthetics and Orthotics	**Covered** *With prior authorization* *Orthotics are covered*	**Limited Coverage** *With prior authorization* *Orthotics are not covered* *$4 copay per prescription*	**Limited Coverage** *With prior authorization* *Orthotics are not covered* *$4 copay per prescription*	**Covered** *Without limitations, when medically necessary and with prior authorization* *$4 copay per prescription*	**Covered** *Without limitations, when medically necessary and with prior authorization* *$4 copay per prescription*

Please note: All covered services must be medically necessary.	**SoonerCare Traditional & Choice** **Children Under 21**	**SoonerCare Traditional** **Adults 21 and Over**	**SoonerCare Choice** **Adults 21 and Over**	**SoonerCare Traditional–Expansion** **Adults 19–64**	**SoonerCare Choice–Expansion** **Adults 19–64**
Psychiatric Residential Treatment Facility	**Covered** *With prior authorization*	**No Coverage**	**No Coverage**	**No Coverage** For adults 21 and over **Covered** For adults 19-20	**No Coverage** For adults 21 and over **Covered** For adults 19-20
Inpatient Rehab Hospital	**Covered**	**Covered** *90 days per individual per state fiscal year (July–June), when medically necessary with prior authorization*	**Covered** *90 days per individual per state fiscal year (July–June), when medically necessary with prior authorization*	**Covered** *90 days per individual per state fiscal year (July–June)* *May exceed day limits, if medically necessary with prior authorization*	**Covered** *90 days per individual per state fiscal year (July–June)* *May exceed day limits, if medically necessary with prior authorization*
Routine Patient Cost in Qualifying Clinical Trials *With a coverage determination*	**Covered**	**Covered** *Existing copay applies for the for the individual service/item provided*	**Covered** *Existing copay applies for the for the individual service/item provided*	**Covered** *Existing copay applies for the for the individual service/item provided*	**Covered** *Existing copay applies for the for the individual service/item provided*
SoonerRide *Transportation to non-emergency covered medical services*	**Covered**	**Covered**	**Covered**	**Covered**	**Covered**

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**
Stop Smoking (Cessation) Products	**No Duration Limits** *for a member's use of FDA approved cessation products (except Chantix which has a 180 day limit)*	**No Duration Limits** *for a member's use of FDA approved cessation products (except Chantix which has a 180 day limit)*	**No Duration Limits** *for a member's use of FDA approved cessation products (except Chantix which has a 180 day limit)*	**No Duration Limits** *for a member's use of FDA approved cessation products (except Chantix which has a 180 day limit)*	**No Duration Limits** *for a member's use of FDA approved cessation products (except Chantix which has a 180 day limit)*
Substance Use Disorder Residential Treatment	**Covered** *With prior authorization; Starting at age 13*	**Covered** With prior authorization	**Covered** With prior authorization	**Covered** With prior authorization	**Covered** *With prior authorization*

Please note: All covered services must be medically necessary.	**SoonerCare Traditional & Choice** **Children Under 21**	**SoonerCare Traditional** **Adults 21 and Over**	**SoonerCare Choice** **Adults 21 and Over**	**SoonerCare Traditional–Expansion** **Adults 19–64**	**SoonerCare Choice–Expansion** **Adults 19–64**
Therapy Services *Physical (PT), Speech (ST), Occupational (OT)*	**Covered** *May require prior authorization*	**PT, ST, OT** *No prior authorization required; 15 visits per year per discipline in hospital outpatient; $4 copay per visit*	**PT, ST, OT** No prior authorization required; 15 visits per year per discipline in hospital outpatient; $4 copay per visit	**PT, ST, OT** No prior authorization required; 15 visits per year per discipline in hospital outpatient; $4 copay per visit	**PT, ST, OT** 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.
Urgent Care Center	**Covered**	**Covered**	**Covered**	**Covered**	**Covered**
Vision Services	**Covered**	**Covered** *For eye diseases or eye injuries only*	**Covered** *For eye diseases or eye injuries only*	**Covered** *For eye diseases or eye injuries only*	**Covered** *For eye diseases or eye injuries only*

Please note: All covered services must be medically necessary.	**SoonerPlan**
Ambulance or Emergency Transportation	**No Coverage**
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**

Please note: All covered services must be medically necessary.	**SoonerPlan**
Dental Services	**No Coverage**
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**
Durable Medical Equipment	**No Coverage**
Emergency Department *(ER services)*	**No Coverage**
Family Planning Services	**Birth Control Information, Services and Supplies** *Men and women ages 19 and over* **Gardasil** *Men and women through age 45* **Tubal Ligation & Vasectomy** *Persons ages 21 and older - $0 copay for any family planning-related service or supply*
Hearing Services	**No Coverage**
Home Health Care Services	**No Coverage**
Inpatient Hospital Services	**No Coverage**
Immunizations *(As recommended by the Advisory Committee of Immunization Practices)*	**No Coverage**
Laboratory and X-ray	**Services Related to Family Planning Only** *$0 copay*
Long-term Care	**No Coverage**

Please note: All covered services must be medically necessary.	**SoonerPlan**
Mammograms	**No Coverage**
Mental Health or Substance Use Disorder Medical Detoxification- Inpatient	**No Coverage**
Mental Health or Substance Use Disorder-Outpatient	**No Coverage**
Nurse Midwife Services	**No Coverage**
Orthodontic Services	**No Coverage**
Outpatient Hospital and Surgery Services	**Services Related to Family Planning Only** *$0 copay*
Over-the-Counter Contraceptives	**Contraceptives Only** *$0 copay*
Personal Care	**No Coverage**
Physician Services	**Physician Visits and Physical Exams** *Related to family planning only - $0 copay*
Pregnancy and Maternal 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*
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*

Please note: All covered services must be medically necessary	**SoonerPlan**
Prosthetic Devices	**No Coverage**
SoonerRide *Transportation to non-emergency covered medical services*	**Covered**
Substance Use Disorder Residential Treatment	**No Coverage**
Stop Smoking (Cessation) Products	**No Coverage**
Substance Abuse Treatment *(Medical detoxification only)*	**No Coverage**
Therapy Services *Physical, Speech, Occupational*	**No Coverage**
Transplant Services	**No Coverage**
Vision Services	**No Coverage**

***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 the pregnancy. Section 317:30-22-8

Home and Community-Based Services (HCBS)1915(c) Waiver Programs	HCBS members receive the SoonerCare Traditional services in addition to the HCBS services within the waiver program they are enrolled which are: · 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 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.

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 January 10, 2025

OKLAHOMA
Health Care Authority