

| SoonerCare Obstetrical Coverage                                                                                                                                                                                                                                                                                                                                                                                    | SoonerCare Choice                                                              | Soon-to-be-Sooners                                                                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                                                                    | Health care coverage for pregnant and postpartum women eligible for SoonerCare | Coverage for the pregnant woman limited to pregnancy-related health care services for the benefit of the baby. <b>Benefits for the mother end upon delivery or at time of miscarriage.</b> |
| <b>Office Visits</b>                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                                                                                            |
| Routine Visits                                                                                                                                                                                                                                                                                                                                                                                                     | Covered                                                                        | Covered                                                                                                                                                                                    |
| Specialty Visits                                                                                                                                                                                                                                                                                                                                                                                                   | 4 per month                                                                    | Covered                                                                                                                                                                                    |
| <b>Hospital Care</b>                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                                                                                            |
| Delivery Services                                                                                                                                                                                                                                                                                                                                                                                                  | Covered                                                                        | Covered                                                                                                                                                                                    |
| Inpatient                                                                                                                                                                                                                                                                                                                                                                                                          | Covered                                                                        | Covered for obstetrical emergencies only                                                                                                                                                   |
| <b>Ultrasounds</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                                                                                            |
| <b>Must be performed by an OB/GYN*, radiologist, OHCA-contracted maternal-fetal medicine specialist (MFM)*, nurse midwife, family practice physician, or advanced nurse practitioner in OB, certified in OB ultrasonography.</b>                                                                                                                                                                                   |                                                                                |                                                                                                                                                                                            |
| 1st Trimester Abdominal or Transvaginal                                                                                                                                                                                                                                                                                                                                                                            | 1 per pregnancy                                                                | 1 per pregnancy                                                                                                                                                                            |
| Abdominal During 2nd or 3rd Trimester                                                                                                                                                                                                                                                                                                                                                                              | 1 per pregnancy                                                                | 1 per pregnancy                                                                                                                                                                            |
| <b>Specialty Ultrasounds*</b>                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                                                            |
| <b>For women with suspected or identified fetal maternal abnormalities. A small number of conditions do not require MFM referral but still require a PA for high-risk OB (HROB) services.</b>                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                                                            |
| Fetal/Maternal Evaluation with Detailed Fetal Anatomic Exam (initial)                                                                                                                                                                                                                                                                                                                                              | One to confirm HROB without PA                                                 | One to confirm HROB without PA                                                                                                                                                             |
| Additional Specialty Ultrasounds                                                                                                                                                                                                                                                                                                                                                                                   | Prior Authorization (PA) required for more than 3                              | PA required required for more than 3                                                                                                                                                       |
| <b>Other Covered Services</b>                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                                                            |
| Pap Smears                                                                                                                                                                                                                                                                                                                                                                                                         | Covered                                                                        | Not Covered                                                                                                                                                                                |
| SoonerRide                                                                                                                                                                                                                                                                                                                                                                                                         | Covered                                                                        | Covered                                                                                                                                                                                    |
| Prescriptions                                                                                                                                                                                                                                                                                                                                                                                                      | Covered, some require PA                                                       | Products related to pregnancy are covered, some require PA                                                                                                                                 |
| Labs and Some Diagnostics Related to Pregnancy                                                                                                                                                                                                                                                                                                                                                                     | Covered                                                                        | Covered                                                                                                                                                                                    |
| Vaccine                                                                                                                                                                                                                                                                                                                                                                                                            | All ACIP recommended vaccines are covered                                      | Influenza and TDAP only                                                                                                                                                                    |
| Maternal and Infant Health Social Work Services                                                                                                                                                                                                                                                                                                                                                                    | Covered while pregnant and up to 60 days postpartum                            | Covered while women are pregnant only                                                                                                                                                      |
| Lactation Consultation Services                                                                                                                                                                                                                                                                                                                                                                                    | Covered while pregnant and up to 60 days postpartum                            | Covered while women are pregnant only                                                                                                                                                      |
| Tobacco Cessation                                                                                                                                                                                                                                                                                                                                                                                                  | Covered, counseling and tobacco cessation medications                          | Covered, counseling and tobacco cessation medications                                                                                                                                      |
| Genetic Counseling/Testing                                                                                                                                                                                                                                                                                                                                                                                         | Covered for counseling and testing                                             | Covered for counseling; Genetic testing is not covered                                                                                                                                     |
| Diabetes Testing Supplies                                                                                                                                                                                                                                                                                                                                                                                          | Covered-PA required after 150 strips/lancets per month                         | Covered-PA required after 150 strips/lancets per month                                                                                                                                     |
| <b>HROB Care - Additional limited services for approved high risk pregnancy conditions</b>                                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                            |
| Fetal Non-stress Tests                                                                                                                                                                                                                                                                                                                                                                                             | PA required (max of 5; more allowed for multiple fetuses)                      | PA required (max of 5; more allowed for multiple fetuses)                                                                                                                                  |
| Biophysical Profiles                                                                                                                                                                                                                                                                                                                                                                                               | PA required (max of 5; more allowed for multiple fetuses)                      | PA required (max of 5; more allowed for multiple fetuses)                                                                                                                                  |
| Additional Ultrasounds                                                                                                                                                                                                                                                                                                                                                                                             | PA required                                                                    | PA required                                                                                                                                                                                |
| Enhanced Antepartum Management                                                                                                                                                                                                                                                                                                                                                                                     | PA required                                                                    | PA required                                                                                                                                                                                |
| <b>Vision Coverage</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                |                                                                                                                                                                                            |
| Vision Checks                                                                                                                                                                                                                                                                                                                                                                                                      | Only for individuals age 20 and under                                          | Not covered                                                                                                                                                                                |
| <b>Insure Oklahoma Individual Plan</b> - Pregnant women on the IO Individual Plan are exempt from copays for prenatal care. Medications are limited to six per month, not including prenatal vitamins and smoking cessation products, and physician visits (including specialty care) are limited to four per month. These members are eligible for genetic testing, but their benefits do not include SoonerRide. |                                                                                |                                                                                                                                                                                            |

\*These providers can be board eligible/board certified.

\*\*Effective September 1, 2015, obstetricians may request HROB services without MFM participation. See Medical Authorization Unit webpage for list of covered diagnoses: [www.okhca.org/mau](http://www.okhca.org/mau).

Coverage benefits effective 11/13/2019-accurate at time of posting and is subject to change