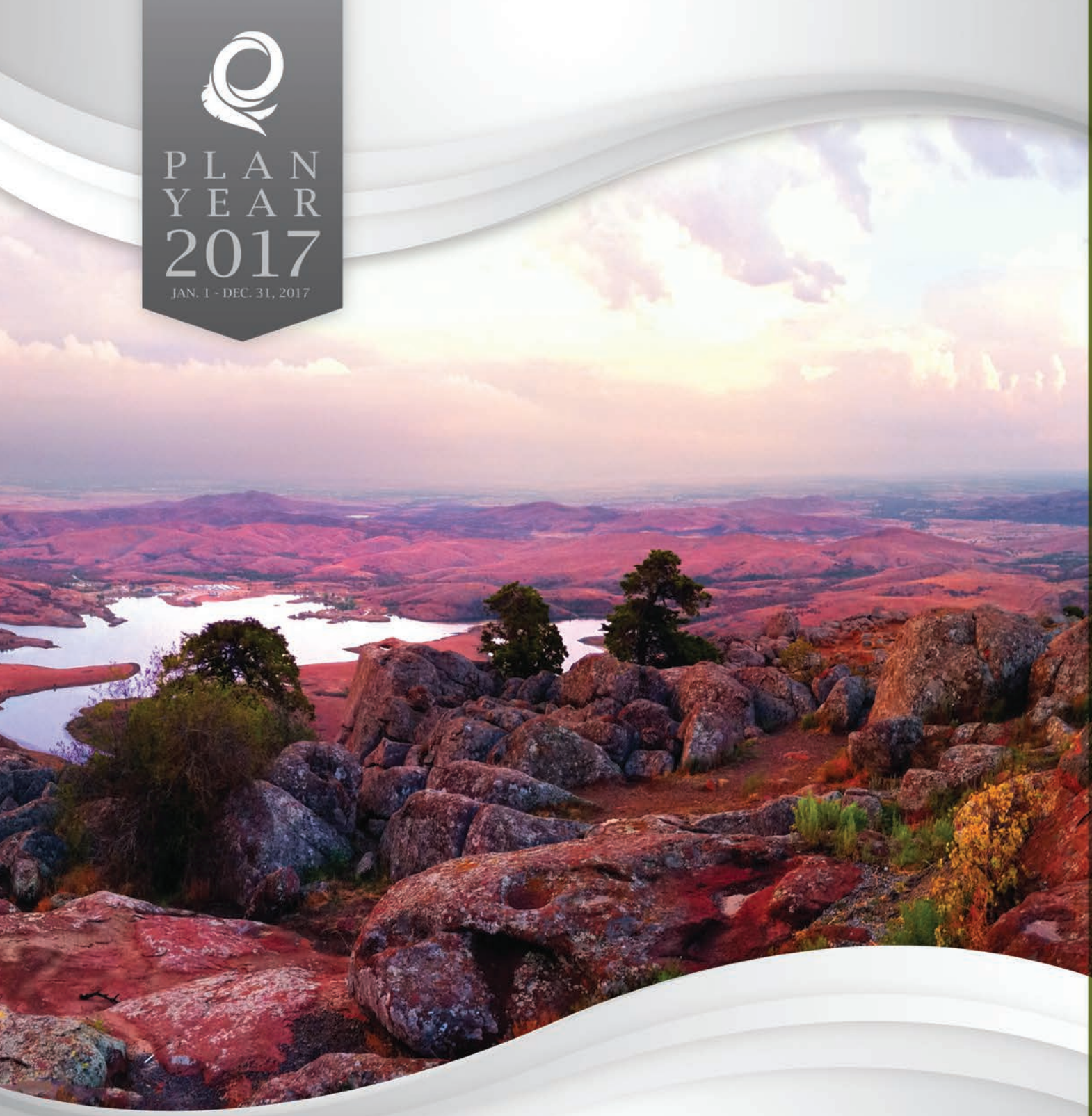
PLAN YEAR 2017

JAN. 1 - DEC. 31, 2017



MEDICARE SUPPLEMENT | MA-PD | DENTAL | LIFE | VISION

BENEFITS

OPTION PERIOD GUIDE

3488

You should have already received a schedule of retiree Option Period meetings. If you plan to attend one of these meetings, please bring this guide with you.

Enrollment Information

Your Option Period Enrollment/Change Form is being securely mailed in a separate envelope. **When you receive your form, review your personalized information and current coverage listed in the upper right corner.** Review the premiums and plan changes for 2017.

If you DO NOT WANT TO make changes:

- Do **NOT** return your Option Period Enrollment/Change Form. Your current coverage will automatically continue Jan. 1. However, if you are on BlueSecure, you must choose a new health plan.
- You will **NOT** receive a Confirmation Statement from the Employees Group Insurance Department. Keep your form as proof of your coverage.
- If you live in a long-term care facility, such as a skilled nursing facility or nursing home, and want to remain enrolled in your current coverage, do not allow your facility to enroll you in another plan with Part D benefits. Enrollment in another plan with Part D benefits will end your Part D benefits through EGID.

If you WANT TO make changes:

- If you are considering a Medicare Advantage Prescription Drug (MA-PD) plan, check the ZIP code service area to make sure you are eligible.
- Check with the MA-PD HMO plans to make sure your provider participates in the plan's network.
- Enroll in only one plan with Part D coverage.
- Check the appropriate boxes on your Option Period Enrollment/Change Form to make changes.
- Return your form before Dec. 7.

Note: If an MA-PD plan is not listed as a selection on your personalized Option Period Enrollment/Change Form, you are not eligible to enroll in that MA-PD plan.

If you have questions, please contact EGID Member Services at 405-717-8780 or toll-free 1-800-752-9475. TDD users call 405-949-2281 or toll-free 1-866-447-0436.

Monthly Premiums for Medicare Eligible Members

Plan Year Jan. 1 through Dec. 31, 2017

MEDICARE SUPPLEMENT PLANS	
HealthChoice SilverScript High Option Medicare Supplement	$375.58 per covered person
HealthChoice SilverScript Low Option Medicare Supplement	$300.60 per covered person

MEDICARE ADVANTAGE PRESCRIPTION DRUG (MA-PD) PLANS	
Aetna Medicare	$287.81 per covered person
CommunityCare Senior Health Plan	$267.00 per covered person
Generations by GlobalHealth	$189.00 per covered person

DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Assurant Freedom Preferred	$30.26	$30.10	$22.58	$60.68
Assurant Heritage Plus with SBA (Prepaid)	$11.74	$ 8.86	$ 7.60	$15.20
Assurant Heritage Secure (Prepaid)	$ 7.20	$ 5.98	$ 5.20	$10.38
CIGNA Dental Care Plan (Prepaid)	$ 9.16	$ 6.00	$ 4.08	$ 9.18
Delta Dental PPO	$33.64	$33.62	$29.26	$74.04
Delta Dental PP-O Plus Premier	$44.52	$44.52	$38.78	$98.06
Delta Dental PPO – Choice	$15.06	$34.18	$34.44	$83.60
HealthChoice Dental	$34.30	$34.30	$27.40	$72.64
MetLife Classic	$36.98	$36.98	$31.68	$78.78
MetLife Value MAC	$27.24	$27.24	$23.34	$58.02
MetLife Value PDP	$29.48	$29.48	$25.24	$62.80

VISION PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Primary Vision Care Services (PVCS)	$ 9.36	$ 8.00	$ 8.00	$11.00
Superior Vision	$ 7.40	$ 7.36	$ 6.96	$14.30
Vision Care Direct	$15.90	$11.26	$11.26	$22.74
Vision Service Plan (VSP)	$ 9.40	$ 6.29	$ 6.19	$13.58

LIFE PLAN	From $5,000 to $40,000	$1.88 per $1,000 unit

Age-Rated Life – Cost per $1,000 from $41,000 and up			
< 30 ---------- $0.06	30 - 34 ------- $0.06	35 - 39 ------- $0.06	40 - 44 ------- $0.08
45 - 49 ------- $0.14	50 - 54 ------- $0.26	55 - 59 ------- $0.40	60 - 64 ------- $0.46
65 - 69 ------- $0.74	70 - 74 ------- $1.28	75+ ---------- $1.96	

DEPENDENT LIFE	$0.94 per $500 unit, per dependent

These rates do not reflect any contribution from your retirement system.

Monthly COBRA Premiums for Medicare Eligible Members

Plan Year Jan. 1 through Dec. 31, 2017

MEDICARE SUPPLEMENT PLANS	
HealthChoice SilverScript High Option Medicare Supplement	$375.58 per covered person
HealthChoice SilverScript Low Option Medicare Supplement	$300.60 per covered person

MEDICARE ADVANTAGE PRESCRIPTION DRUG (MA-PD) PLANS	
Aetna Medicare	$287.81 per covered person
CommunityCare Senior Health Plan	$267.00 per covered person
Generations by GlobalHealth	$189.00 per covered person

DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Assurant Freedom Preferred	$30.87	$30.70	$23.03	$ 61.89
Assurant Heritage Plus with SBA (Prepaid)	$11.97	$ 9.04	$ 7.75	$ 15.50
Assurant Heritage Secure (Prepaid)	$ 7.34	$ 6.10	$ 5.30	$ 10.59
CIGNA Dental Care Plan (Prepaid)	$ 9.34	$ 6.12	$ 4.16	$ 9.36
Delta Dental PPO	$34.31	$34.29	$29.85	$ 75.52
Delta Dental PPO Plus Premier	$45.41	$45.41	$39.56	$100.02
Delta Dental PPO – Choice	$15.36	$34.86	$35.13	$ 85.27
HealthChoice Dental	$34.99	$34.99	$27.95	$ 74.09
MetLife Classic	$37.72	$37.72	$32.31	$ 80.36
MetLife Value MAC	$27.78	$27.78	$23.81	$ 59.18
MetLife Value PDP	$30.07	$30.07	$25.74	$ 64.06

VISION PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Primary Vision Care Services (PVCS)	$ 9.55	$ 8.16	$ 8.16	$11.22
Superior Vision	$ 7.55	$ 7.51	$ 7.10	$14.59
Vision Care Direct	$16.22	$11.49	$11.49	$23.19
Vision Service Plan (VSP)	$ 9.59	$ 6.42	$ 6.31	$13.85

EGID policy states that one person must always pay the primary member premium. When a spouse, child or children are insured under a particular benefit, but the member did not keep that coverage, one person is always billed the primary member rate.

Monthly Life Insurance Premiums for Surviving Dependents

Dependents of Current Employees	Low – $2.60	Standard – $4.32	Premier – $8.64
• Spouse	$6,000	$10,000	$20,000
• Child (live birth to age 26)	$3,000	$ 5,000	$10,000
Dependents of Former Employees	$0.94 per $500 unit, per dependent		

Note: This section does not apply to COBRA premiums. Life insurance coverage is not available to COBRA members.

TABLE OF CONTENTS

Health Plan Identification

Plan Administrator

Office of Management and Enterprise Services (OMES)
Employees Group Insurance Department (EGID)
3545 N.W. 58th St., Ste. 110, Oklahoma City, OK 73112
405-717-8780 or toll-free 1-800-752-9475
TDD 405-949-2281 or 1-866-447-0436

HealthChoice Medicare Supplement Plans

Member Services, Monday through Friday, 7:30 a.m. to 4:30 p.m. Central Time
405-717-8780 or toll-free 1-800-752-9475; Fax: 405-717-8942
TDD 405-949-2281 or toll-free 1-866-447-0436
www.healthchoiceok.com

Aetna MA-PD

Member Services, Monday through Friday, 8 a.m. to 6 p.m.
P.O. Box 981106, El Paso, TX 79998-1106
Toll-free 1-888-267-2637 or TTY 711
Prospective Members, Monday through Friday, 8 a.m. to 9 p.m. Eastern Time
Toll-free 1-800-307-4830 or TTY 711
www.aetnamedicare.com/en/for-members/group-plans.html

CommunityCare Senior Health Plan

Member Services, Monday through Sunday, 8 a.m. to 8 p.m. Central Time
P.O. Box 3327, Tulsa, OK 74101
Toll-free 1-800-642-8065
Relay Service for the Hearing Impaired toll-free 1-800-722-0353
www.ccok.com

Generations State of Oklahoma Retiree Plan by GlobalHealth

Customer Care, Monday through Sunday, 8 a.m. to 8 p.m. Central Time
P.O. Box 1747
Oklahoma City, OK 73101-1747
Current Members: 405-280-5555 or toll-free 1-844-280-5555 or TTY 711
Prospective Members: toll-free 1-844-322-8422 or TTY 711
www.globalhealth.com/medicare

Medicare

Customer Service, 24 hours a day, 7 days a week
Toll-free 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048
www.medicare.gov

Plan Changes

Plan changes are indicated by bold text in the plans' Comparison of Benefits charts. For details on general changes listed below, refer to these charts. Contact the plans if you need more information.

Medicare Supplement Plans

HealthChoice SilverScript High Option

- $100 pharmacy deductible per person.

BlueSecure High and Low

- The BlueSecure plans will be discontinued for 2017. If you are enrolled in one of these plans, you must choose a new health plan.

MA-PD Plans

New for 2017 – MA-PD PPO Plan

Aetna Medicare

- Aetna Medicare is a new plan option. It is an MA-PD PPO, not an HMO. You do not need to designate a primary care physician or need a referral to see a specialist. You can receive services nationwide as long as you use a Medicare provider. They do follow MA-PD plan guidelines for eligibility requirements. Aetna is being offered in their service area that mostly includes the Oklahoma City and Tulsa regions. Refer to their ZIP code lists on page 27 to see if you live within their service area.

MA-PD HMO Plans

CommunityCare Senior Health Plan

- CommunityCare has copay changes for their urgent care services benefits.

Generations State of Oklahoma Retiree Plan by GlobalHealth

- Generations has expanded their service area to include additional counties. Refer to their ZIP code lists on pages 28-31 to see if you live within their service area.
- Generations has some copay changes to their medical and pharmacy benefits. They have redesigned their pharmacy benefit structure, which includes a standard and a preferred retail and mail order benefit. This guide includes only the preferred copay information. Generations can provide you with details on their benefits.

Dental Plans

NEW for 2017

MetLife

- MetLife is a new dental plan offering three dental plan options. Refer to pages 34-35 for benefit information or contact the plan.

Vision Plans

Discontinued Plans

- Humana Vision Care Plan and UnitedHealthcare Vision will not be available for 2017. If you are enrolled in either of these plans and want to continue vision coverage next year, you must choose a new vision plan.

Primary Vision Care Services

- Primary Vision Care Services is offering additional discounts on laser vision correction surgery.

Vision Service Plan

- Vision Service Plan is increasing their allowance for frames.

General Information

Read Your Option Period Guide Carefully

The information provided in this guide is only a summary of each plan's benefits for 2017. If you need additional information to help you make a coverage decision, contact the individual plan. Refer to Contact Information at the back of this guide.

The Annual Option Period Ends Dec. 7

You have from Oct. 15 until Dec. 7 to make changes to your coverage. Changes received after the deadline cannot be accepted. If you do not return your form by Dec. 7, you will remain in the same coverage you currently have.

Confirmation Statement

Plan changes made during Option Period are reflected on the Confirmation Statement you receive from EGID.

- Review your statement to make sure your coverage is correct. Contact member services right away if it is incorrect so corrections can be made as soon as possible.
- If you do not make any changes, you will not receive one. Keep your personalized Option Period Enrollment/Change Form as proof of your coverage.

Options for Medicare Members

During Option Period, you can:

- Change health and dental plans already in place.
- Drop benefits and dependents.
- Decrease the amount of your life insurance coverage.
- Enroll in a vision plan if you have not dropped that coverage within the past 12 months.
- Drop or change vision plans.

Note: If you need to update your life insurance beneficiary information, complete and return a Beneficiary Designation Form available at **www.healthchoiceok.com** or from member services at 405-717-8780 or toll-free 1-800-752-9475. TDD users call 405-949-2281 or toll-free 1-866-447-0436.

Finding a Provider

To find a health, dental or vision provider or to check the network status of a provider, visit the plan's website or call the plan for assistance. Refer to Contact Information at the back of this guide.

Eligibility Requirements

To participate in the Medicare supplement plans described in this guide, you must be:

- Entitled to benefits under Medicare Part A.
- Enrolled in only one plan that provides Part D prescription drug benefits. (Enrolling in another plan that provides Part D benefits will end your current Part D coverage.)

To participate in the MA-PD plans described in this guide, you must be:

- A permanent resident of the MA-PD plan's service area.
- Enrolled in both Medicare Part A and Part B and continue to pay your monthly Part B premium.

Enrollment in Medicare Part B

The Medicare supplement plans offered through EGID do not require you to be enrolled in Part B, but pay benefits as if you are. To maximize your benefits, you need to be enrolled in Medicare Part B.

The MA-PD plans offered through EGID require you to have both Medicare Part A and Part B.

Health Benefits

The health benefits provided by the Medicare supplement and MA-PD plans described in this guide are designed to provide Medicare-covered benefits according to Part A and Part B guidelines. Benefits will be adjusted effective Jan. 1 to coincide with Medicare.

Charges for Services Not Covered by Medicare

Any charges for services or supplies not covered by Medicare, or under your plan, are your financial responsibility.

Grievance and Appeals Procedures

Under Medicare guidelines, each plan has a process in place to handle grievances and appeals regarding member health or pharmacy benefit complaints. Contact each plan for details.

Income Related Monthly Adjustment Amount

If you are a member of one of the HealthChoice SilverScript or MA-PD plans offered through EGID, your premium for Part D prescription drug coverage is included in your regular monthly premium. Part B premiums are paid through Social Security. However, if your income is above a certain level, the law requires your Part B and Part D premiums be adjusted, which is called an income related monthly adjustment amount (IRMAA). If you have to pay an extra amount, Social Security will notify you. For more information, call Social Security toll-free at 1-800-772-1213. TTY users call toll-free 1-800-325-0778.

Note: If you fail to pay any Part D IRMAA as a HealthChoice SilverScript member, HealthChoice must move you to a plan without Part D.

Extra Help Paying For Part D (Medicare Low Income Subsidy)

People with limited incomes may get Extra Help paying for prescription drug costs. To learn more or apply, call Social Security toll-free at 1-800-772-1213. TTY users call toll-free 1-800-325-0778. More information is also available at **www.socialsecurity.gov**. You can also call Medicare toll-free at 1-800-MEDICARE (1-800-633-4227). TTY users call toll-free 1-877-486-2048.

If you already get help paying for your prescription drugs, the premium and drug cost information in this guide is not correct for you. The amounts of your monthly premiums and pharmacy costs will be less. EGID may request a copy of your letter from Social Security confirming you are qualified. Once you enroll in a Part D plan with Part D benefits, Medicare or your plan will tell us the amount of assistance you will receive. We will then send you information about the amount you will pay.

If you qualify for Extra Help, the chart below shows your maximum prescription drug costs for 2017:

Rx Group	Your maximum prescription drug costs for 2017
1	$0 deductible
	$0 copay
2	$0 deductible
	$1.20 generic and Preferred brand copay
	$3.70 non-Preferred brand and other drug copays
3	$0 deductible
	$3.30 generic and Preferred brand copay
	$8.25 non-Preferred brand and other drug copays
4-7	$82 deductible
	15% copay

If You Enroll in Another Plan With Part D Benefits

Your Medicare Part D benefits through your Medicare supplement plan or MA-PD plan provide Part D prescription drug coverage. If you enroll in another plan with Part D benefits, Medicare must disenroll you from your current plan. EGID will change your coverage to a plan without Part D benefits. Your coverage will be similar and include prescription drug coverage, but not Part D benefits. You must continue on the plan without Part D benefits and pay the higher premium for that plan until the next Option Period. Since you have other Part D (or prescription) coverage, you can drop your health and prescription coverage through EGID, or drop your other Part D coverage, whichever you decide. If you drop your health plan through EGID, you cannot regain coverage through EGID in the future, and you will lose any premium contribution made by your retirement system. Exceptions may apply to members who qualify for Extra Help from Social Security.

If You Currently Have Health Coverage Through Your Employer or Union

If you or your spouse have health coverage through an employer or union, joining one of the plans offered by EGID may change your current coverage. Please read the information sent to you by your employer or union. If you have questions, contact your benefits administrator.

Creditable Coverage Notice

The Medicare supplement and MA-PD plans available through EGID provide creditable coverage. If you drop your health coverage with EGID and do not get other Part D coverage or coverage as good as Medicare's (Creditable Coverage) in the future, you may have to pay Medicare's late enrollment penalty in addition to your premium for Part D prescription drug coverage.

Getting Help From Medicare

To get information directly from Medicare, call toll-free 1-800-MEDICARE (1-800-633-4226) or TTY 1-877-486-2048. You can also visit Medicare's website at **www.medicare.gov**.

You can read the 2017 *Medicare & You* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits and answers to the most frequently asked questions about Medicare. If you don't have a copy of the booklet, you can get it from Medicare's website or by calling Medicare.

Network Pharmacy Access

Network pharmacies provide electronic claims processing, so there are no paper claims to file. Sometimes a pharmacy leaves the network. When this occurs, you will have to get your prescriptions filled at another network pharmacy.

Non-Network Pharmacy Access

In most cases, your prescriptions are covered only if they are filled at a network pharmacy. In certain Part D emergency or urgent situations, your prescriptions can be covered as if you filled them at a network pharmacy. Non-network pharmacies cannot file claims electronically, so you must pay the full cost for your medications up front and then file a paper claim for your plan to reimburse you for its share of the cost.

An exception can be made if you cannot access a network pharmacy due to the following circumstances:

- You travel outside the service area and lose or run out of medication or become ill and need a Part D medication.
- You cannot fill a Part D specialty drug timely because it is not in stock.
- There is no network pharmacy within reasonable driving distance with 24/7 service.
- You receive a Part D drug while in an emergency, observation or other outpatient setting.
- Evacuation or displacement from your residence due to a federal disaster or other public health emergency declaration.

Replacing Medications Lost or Damaged in a Declared Disaster or Public Health Emergency

You can also replace medications that were lost or damaged due to a federally declared disaster or other public health emergency. Your pharmacy must contact your plan's pharmacy helpline to provide early refills or override the maximum supply per fill. You must still pay the applicable copay per fill.

Information on Medicare Supplement Plans

Enrolling in a Medicare Supplement Plan

If you are enrolling in or changing your coverage to a Medicare supplement plan, you must complete and return the Application for Medicare Supplement Plan to EGID along with your Option Period Enrollment/Change Form. This application is available at **www.sib.ok.gov**. Go to "Members" and select "Medicare Members," then select "Forms and Applications." You can also request an application by contacting member services at 405-717-8780 or toll-free 1-800-752-9475. TDD users call 405-949-2281 or toll-free 1-866-447-0436.

Monthly Premiums for Medicare Supplement Plans

If you currently pay a premium for Medicare Part A, Part B or Part D, you must continue to pay your premiums in order to keep your Medicare coverage.

If you have a higher income, you may have to pay an additional monthly premium to Social Security for your Medicare prescription drug coverage. Refer to "Income Related Monthly Adjustment Amount" on page 5.

Your monthly premium will be less if you are receiving Extra Help with your prescription costs. Refer to “Extra Help Paying for Part D” on page 5.

Health Provider Network

You can choose any health care provider you want, but selecting a provider who accepts Medicare assignment will lower your out-of-pocket costs. Assignment means your provider has agreed to accept Medicare-approved amounts as full payment for covered services.

When you receive services from doctors and other health care providers who do not accept Medicare assignment, Medicare’s limiting charge applies. Under Medicare guidelines, this is the highest amount you can be charged for a covered health service. The limiting charge is 15 percent above Medicare’s approved amount and does not apply to medical supplies or equipment.

The Medicare supplement plans offered through EGID provide coverage throughout the United States. If you move out of the United States, you must notify your plan so you can be disenrolled.

Plan Formularies (Lists of Covered Drugs)

The HealthChoice SilverScript plans have a formulary, or a list of medications covered by the plan. Medicare has reviewed and approved these lists of covered drugs. To find out how your medications are covered, contact the plan or visit their website.

Be aware of restrictions on certain drugs as noted in the plan's formulary, such as:

- Prior Authorization
- Step Therapy
- Quantity Limits

All plans cover brand-name and generic drugs which are sorted into five tiers:

HealthChoice SilverScript Plans
• Tier 1 – Generics
• Tier 2 – Preferred Brand
• Tier 3 – Non-Preferred Medications
• Tier 4 – Very High Cost and Unique Medications
• Tier 5 – Tobacco Cessation Medications

Drugs not listed in the plan's formulary are not covered.

Medications that Require Pharmacy Prior Authorization

Medications that require prior authorization are covered by your plan if the prescribed use meets approved guidelines. Prior authorization requests must be submitted by your physician. The plans may have added or removed certain medications from their lists of drugs that require prior authorization.

- To review the list of medications that require prior authorization from HealthChoice, visit **www.healthchoiceok.com**.

Quantity Limits

Pharmacy benefits generally cover up to a 30- or 90-day supply. For safety and cost reasons, plans may limit the amount of covered prescription drugs over a certain period of time. Specific therapeutic categories, medications and dosage forms may have more restrictive quantity and duration of therapy limitations. Some medications have a maximum quantity limitation and the medication is not dispensed in a tablet or capsule form. Be aware that quantity limitations for some medications may have been added or removed for 2017.

When Changes Affect a Drug You Currently Take

If you take a drug that is not listed in your plan's formulary or coverage for your drug has changed, e.g., your brand-name drug has been replaced by a new generic or has moved to a higher cost-sharing tier, or it has new restrictions, you have a few options:

- In some situations, your plan covers a one-time, temporary supply of your drug when your current supply runs out. This temporary supply is for up to 30 days. Refer to “Transition Supply of Medication” below.
- You and your doctor can find a covered drug that treats your medical condition.
- Your doctor can ask for an exception/prior authorization for your current medication.

If coverage changes for a drug you are taking, you will be notified 60 days before the change so you can review your options. If a drug is immediately removed from your plan’s formulary because it was recalled by the FDA for being found unsafe or for other reasons, you will be notified at that time. Your pharmacy provider will also be aware of this change and can work with you to find another formulary drug for your condition.

Transition Supply of Medication

During the first 90 days of your transition to a new Medicare supplement plan with Part D coverage or transition to a Part D formulary medication, you can be authorized to purchase a one-time supply of your current medication that is non-formulary under your new plan. This total temporary supply is for up to a maximum 30-day supply of medication and is available prior to initiating or completing the plan review process for a medication requiring prior authorization or if your provider is requesting a medically necessary exception on a drug. Please note that under certain circumstances, such as if you reside in a long-term care facility, the supply is extended.

Comparison of Benefits for the High and Low Option Medicare Supplement Plans

Medicare Part A (Hospitalization) Services
All Benefits are Based on Medicare-Approved Amounts

Part A Network Services	HealthChoice SilverScript
Hospitalization Includes semiprivate room, meals, drugs as part of your inpatient treatment, and other hospital services and supplies	
First 60 days	You pay $0
Days 61 through 90	You pay $0
Days 91 and after while using Medicare's 60 lifetime reserve days	You pay $0
The plan's additional lifetime reserve days	You pay $0 for additional lifetime reserve days Limited to 365 days
Beyond the plan's lifetime reserve days	You pay 100%
Skilled Nursing Facility Care Must meet Medicare requirements, including inpatient hospitalization for at least 3 days and entering a Medicare-approved facility within 30 days of leaving the hospital; limited to 100 days per calendar year	
First 20 days	You pay $0
Days 21 through 100	You pay $0
Days 101 and after	You pay 100%
Hospice Care Your doctor and hospice provider must certify you are terminally ill and you elect hospice Includes physical care, counseling, equipment, supplies, respite care, inpatient care and drugs for pain and symptom control	You pay up to $5 per prescription for palliative drugs or biologicals You also pay 5% of Medicare amounts for inpatient respite care
Blood Limited to the first 3 pints unless you or someone else donates blood to replace what you use	You pay $0

Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115% of the Medicare-approved amount.

Medicare Part B (Medical) Services
All Benefits are Based on Medicare-Approved Amounts

Part B Network Services	HealthChoice SilverScript
Medical Expenses Medically necessary outpatient services and supplies Includes doctor's visits, outpatient hospital treatment, surgical services, physical and speech therapy and diagnostic tests	You pay the Part B deductible
Clinical Diagnostic Laboratory Services Blood tests, urinalysis and tissue pathology	You pay $0
Home Health Care Intermittent skilled care and medical supplies	You pay $0
Durable Medical Equipment Items such as nebulizers, wheelchairs and walkers	You pay the Part B deductible
Diabetes Monitoring Supplies Glucose monitors, test strips and lancets for those with diabetes Must be requested by your doctor	You pay the Part B deductible
Ostomy Supplies Includes ostomy bags, wafers and other ostomy supplies for those who have a need based on their condition	You pay the Part B deductible
Blood Includes amounts in addition to the coverage under Part A unless you or someone else donates blood to replace what you use	You pay the Part B deductible
Outpatient Prescriptions Includes infused, oral end-stage renal disease drugs and some cancer and transplant drugs	You pay the Part B deductible

Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115% of the Medicare-approved amount.

Coverage for Additional Medical Services

Service	HealthChoice SilverScript
Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.	You pay the first $250 each calendar year, then 20% and all amounts over the $50,000 lifetime maximum

Medicare Preventive Services

Medicare Part B covers many preventive services, such as your annual flu vaccination, wellness visit or screening mammogram, at 100 percent when you use a doctor or other health care provider who accepts Medicare assignment; however, certain preventive services may still require the Part B deductible or coinsurance. Coinsurance can apply depending on where you receive certain services.

For Medicare to cover preventive services, you must follow their guidelines for each service. Guidelines can include criteria for age, frequency and disease risk.

For a list of preventive services and details on Medicare coverage, go to **www.cms.gov** or **www.medicare.gov**. You can also refer to the 2017 *Medicare & You* handbook.

High Option Medicare Supplement Plans

Pharmacy Copay Structure for Part D Network Benefits

General Information	HealthChoice SilverScript High Option
These plans use a formulary Mandatory generic and brand medications you get at a network pharmacy Some drugs require prior authorization Quantity limits apply to certain drugs Only copays for covered drugs purchased at network pharmacies count toward out-of-pocket maximums Pharmacy benefits must meet the minimum requirements for benefits as outlined in the *Medicare Modernization Act* of 2003 You will be notified before any changes are made to your plan's formulary	**Pharmacy Deductible** **You pay the first $100 in medication costs before the copays listed below apply**. No Coverage Gap. There is an annual out-of-pocket maximum. **30-Day Supply** **Generic (Tier 1) Drugs** Up to $10 copay **Preferred (Tier 2) Drugs** Up to $45 copay **Non-Preferred (Tier 3) Drugs** Up to $75 copay **Specialty (Tier 4) Drugs** Up to $100 copay **Preferred Tobacco Cessation (Tier 5) Drugs** $0 copay **31- to 90-Day Supply** **Generic (Tier 1) Drugs** Up to $25 copay **Preferred (Tier 2) Drugs** Up to a $90 copay **Non-Preferred (Tier 3) Drugs** Up to $150 copay **Specialty (Tier 4) Drugs** Specialty drugs are available in only a 30-day supply **Preferred Tobacco Cessation (Tier 5) Drugs** $0 copay Once you reach the **$4,950** out-of-pocket maximum, you pay 0% for covered prescription drugs at network pharmacies for the remainder of the calendar year.

Plan changes are indicated by **bold text**.

Low Option Medicare Supplement Plans

Pharmacy Copay Structure for Part D Network Benefits

General Information	HealthChoice SilverScript Low Option
These plans use a formulary Mandatory generic and brand medications you get at a network pharmacy Some drugs require prior authorization Quantity limits apply to certain drugs Only copays for covered drugs purchased at network pharmacies count toward the out-of-pocket maximums Pharmacy benefits must meet the minimum requirements for benefits as outlined in the *Medicare Modernization Act* of 2003 You will be notified before any changes are made to your plan's formulary	**Pharmacy Deductible** You pay the first **$400** in medication costs. **Initial Coverage Limit** After the deductible, you and HealthChoice share prescription drug costs. You pay 25% ($825) and HealthChoice pays 75% ($2,475) until total drug spending reaches **$3,700**. **Coverage Gap** You pay 100% of your prescription drug costs at discounted rates – **51%** of the cost of generic drugs and **40%** of the cost of brand-name drugs. What you pay for brand-name drugs plus the 50% manufacturer discount payment applies to your out-of-pocket to get out of the Coverage Gap. For generic drugs, only what you pay applies. **Catastrophic Coverage** Once you reach the **$4,950** out-of-pocket maximum, you pay $0 for covered prescription drugs purchased at network pharmacies for the remainder of the calendar year.

Plan changes are indicated by **bold text**.

Information on Medicare Advantage Prescription Drug (MA-PD) Plans

Plan Guidelines

- You may not be eligible to enroll in an MA-PD plan if you have been diagnosed with end-stage renal disease. If you are currently enrolled in an MA-PD plan and develop ESRD or undergo a successful transplant, you can remain with your plan.
- You must be enrolled in both Medicare Part A (Hospital) and Part B (Medical) and continue to pay your monthly Part B premium.
- You must permanently reside in the MA-PD plan's ZIP code service area. This is a federally qualified area where the MA-PD plan provides coverage. You must have a home address; a post office box number is not acceptable. Check the ZIP code lists on pages 27-31 to see if you live within an MA-PD plan's service area.
- If you permanently move out of your plan's service area or are absent from the service area for more than six consecutive months, you must disenroll from your MA-PD plan and select another plan that provides coverage in your new area.
- Your MA-PD plan replaces Medicare and administers your health benefits according to Medicare Part A and Part B guidelines.

MA-PD PPO Plan

- You can receive services anywhere in the United States as long as the provider is a Medicare eligible provider.
- You do not have to designate a primary care physician (PCP) to direct your care.
- Referrals and medical precertification are not required.

MA-PD HMO Plans

- You must select and designate a PCP to coordinate all your medical and hospital services. There are exceptions in cases of out-of-network emergency or urgent care.
- If you do not use your PCP for routine care, you will be financially responsible for any charges related to those services.
- You can change doctors for any reason as long as the physician you select participates in your MA-PD plan's network. To change your PCP, please contact the MA-PD plan.
- If your provider leaves your plan, you must select another provider within your plan's network. You cannot change plans until the next annual Option Period.

Enrolling in an MA-PD Plan

Note: If an MA-PD plan is not listed as a selection on your personalized Option Period Enrollment/Change Form, you are not eligible to enroll in that MA-PD plan.

- If you are interested in enrolling in one of the MA-PD plans and need additional benefit information, contact the plan directly. Be sure to indicate that you are with the State of Oklahoma account.
- You must select an MA-PD plan on your Option Period Enrollment/Change Form and also complete an Application for Medicare Advantage Prescription Drug (MA-PD) Plan and return both to EGID. The application is available at **www.sib.ok.gov** by selecting the "Option Period" link or contacting member services at 405-717-8780 or toll-free 1-800-752-9475. TDD users call 405-949-2281 or toll-free 1-866-447-0436.
- You will receive a letter from your MA-PD plan confirming your enrollment and effective date. Just before your effective date, you will receive your plan ID card and handbook.
- If you are currently enrolled in CommunityCare MA-PD plan or Generations MA-PD plan and want to continue your coverage for next year, you do not have to return your Option Period Enrollment/Change Form unless you want to make changes to other coverage or enroll in vision coverage. Please keep your personalized form as proof of your coverage.

When a Dependent is Not Yet Eligible for Medicare

All covered dependents must enroll in the same plan. For example, if you are enrolled in an MA-PD plan, your pre-Medicare dependents must enroll in the HMO option of that same plan. As the primary member, you must indicate that you have elected an MA-PD plan option and complete all the required information regarding your dependents on your Option Period Enrollment/Change Form.

Disenrolling or Transferring Plans

- If you are changing from one MA-PD plan to another, your new plan coverage will begin on Jan. 1, and you will automatically be disenrolled from your previous plan.
- If you are changing from an MA-PD plan to a Medicare supplement plan, Medicare requires that you provide a signed written request or your Option Period form to EGID to advise them of your disenrollment. You will receive a letter from your former plan advising you of the date your coverage ends. You must also complete and submit your Option Period Enrollment/Change Form and complete an Application for Medicare Supplement Plan and submit to EGID indicating your change in plans.
- Failure to notify your current MA-PD plan of your disenrollment can result in additional expenses that will not be reimbursed by Medicare or your new plan.
- Failure to notify your plan and EGID in a timely manner can result in delayed or denied enrollment in your new plan and create problems receiving services.

Comparison of Benefits for the Medicare Advantage Prescription Drug Plans

MA-PD PPO Plan

All Benefits are Based on Medicare-Covered Services

Services	Aetna Medicare
Hospitalization Semiprivate room (private room if medically necessary) Nursing services, medications and all meals Laboratory tests, X-rays and other radiology services Inpatient physician and surgical services, including anesthesia Necessary medical supplies and appliances Blood and its administration Operating room, special care units and rehabilitation services	You pay $0 per stay after $150 plan deductible
Organ Transplants Must be performed in a Medicare-approved transplant facility	You pay $0 per stay after $150 plan deductible
Skilled Nursing Facility (Inpatient Services) Semi-private room, regular nursing services and all meals Physical, occupational and speech therapy Drugs and necessary medical equipment and supplies furnished by the facility Blood and its administration Inpatient radiology and pathology Use of appliances such as wheelchairs	You pay $0 per stay after $150 plan deductible

Services	Aetna Medicare
Outpatient Hospital Services Outpatient surgical services in an ambulatory surgical center or outpatient hospital facility	You pay $0 after $150 plan deductible
Urgent Care Services Urgently needed services worldwide	You pay $0
Emergency Services Emergency services needed worldwide	You pay $0
Ambulance Services When medically necessary	You pay $0
Professional Services Office visit Consultation, diagnosis and treatment by a specialist Medical and surgical care Allergy tests and treatment (serum) Diagnostic tests and treatment Medical supplies including casts, dressings and splints	You pay $0 after $150 plan deductible
Physical, Occupational and Speech Therapy Services	You pay $0 after $150 plan deductible
Laboratory Services	You pay $0 after $150 plan deductible
X-Ray/Diagnostic Radiology	You pay $0 after $150 plan deductible
Hearing Examinations	You pay $0
Chiropractic Limited to manual manipulation of the spine as medically necessary	You pay $0 after $150 plan deductible

Services	Aetna Medicare
Part-Time or Intermittent Skilled Nursing Care Home health aide in conjunction with skilled care Physical, speech and occupational therapy Medical supplies and equipment (excluding medications) provided by the agency	You pay $0 after $150 plan deductible
Durable Medical Equipment Durable medical equipment (DME) and supplies Prosthetic devices Therapeutic shoes/inserts for severe diabetes	You pay $0 after $150 plan deductible

Medicare Preventive Services

Aetna Medicare covers many Part B preventive services, such as your annual flu vaccination, wellness visit or screening mammogram, at 100 percent when you use a doctor or other health care provider who is a Medicare eligible provider.

For Aetna Medicare to cover preventive services, you must follow the guidelines for each service. Guidelines can include criteria for age, frequency and disease risk.

For a list of preventive services as governed by Medicare, go to **www.cms.gov** or **www.medicare.gov**. You can also refer to the 2017 *Medicare & You* handbook.

MA-PD HMO Plans

All Benefits are Based on Medicare-Covered Services

Services	CommunityCare Senior Health Plan	Generations by GlobalHealth
Hospitalization Semiprivate room (private room if medically necessary) Nursing services and medications Laboratory tests, X-rays and other radiology services Inpatient physician and surgical services, including anesthesia Necessary medical supplies and appliances Blood and its administration Operating room, special care units and rehabilitation services	$50 copay each day for days 1-5 $0 copay each day for days 6-90 for a Medicare-covered stay in a network hospital Prior authorization is required, except in an emergency You are covered for unlimited days each benefit period. A benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received hospital or skilled nursing care for 60 days in a row. You must pay the inpatient hospital copay for each benefit period.	$250 copay per admission You are covered for unlimited days each benefit period. Prior authorization is required, except in an emergency.
Organ Transplants Cornea, heart, heart-lung, kidney, liver, lung, bone marrow, intestinal and multivisceral, pancreas and stem cell Must be performed in a Medicare-approved transplant facility	$50 copay each day for days 1-5 $0 copay each day for days 6-90	$250 copay per admission You are covered for unlimited days each benefit period. Prior authorization is required except in the case of an emergency.
Outpatient Hospital Services Outpatient surgical services in an ambulatory surgical center or outpatient hospital facility. Radiation therapy Blood	$0 copay for each visit Prior authorization is required $0 copay for radiation therapy service $0 copay for blood services	$0 copay per surgery in an ambulatory surgery center or preferred outpatient hospital $200 copay per surgery in a non-preferred outpatient hospital **20% coinsurance** for radiation therapy service $0 per pint, 3 pint deductible waived

Plan changes are indicated by **bold text**.
This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

Services	CommunityCare Senior Health Plan	Generations by GlobalHealth
In-Area Urgent Care Services	**$20** copay for each Medicare-covered visit	$20 copay for each visit
Out-of-Area Urgent Care Services During a temporary absence from service area	**$20** copay for each Medicare-covered visit nationwide	$25 copay for each visit nationwide
Emergency Services	$50 copay for each Medicare-covered visit worldwide Waived if admitted inpatient to hospital within 48 hours for same condition	$50 copay for each visit nationwide - all inclusive Waived if admitted inpatient to hospital or for outpatient surgery within 24 hours for same condition
Ambulance Services Medically necessary services as covered by Medicare	$50 copay Waived if admitted inpatient to hospital	$50 copay Waived if admitted inpatient to hospital
Skilled Nursing Facility (Inpatient Services) Semi-private room and regular nursing services	$0 copay for days 1-20 $50 copay for days 21-100 for each benefit period No prior hospital stay required Prior authorization is required	$0 copay per day for days 1-20 $160 copay per day for days 21-100 No prior hospital stay required Prior authorization is required
Physical, occupational and speech therapy	$20 copay for each visit; prior authorization is required	Covered under the skilled nursing facility copayment
Drugs and necessary medical equipment and supplies furnished by the facility	Covered under the skilled nursing facility copayment	Covered under the skilled nursing facility copayment
Blood and its administration	$0 copay for blood services	Covered under the skilled nursing facility copayment
Inpatient radiology and pathology	$0 copay for each radiation therapy service	Covered under the skilled nursing facility copayment
Use of appliances such as wheelchairs	$0 to $50 or 20% copay for each Medicare-covered item Prior authorization is required	Covered under the skilled nursing facility copayment

Plan changes are indicated by **bold text**.
This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

Services	CommunityCare Senior Health Plan	Generations by GlobalHealth
Professional Services Office visit Consultation, diagnosis and treatment by a specialist Medical and surgical care Allergy tests and treatment (serum) Diagnostic tests and treatment Medical supplies including casts, dressings and splints	$10 copay for each PCP visit $20 copay for each specialist visit	$0 copay for each PCP visit $20 copay for each specialist visit Prior authorization is required, except for OB/GYN
X-Ray/Diagnostic Radiology Services	$0 copay	$0 copay
Laboratory Services	$0 copay for each diagnostic and therapeutic radiology or lab service $0 to $100 copay for each diagnostic procedure or test Prior authorization is required	$0 copay
Physical, Occupational and Speech Therapy Services	$20 copay for each visit Prior authorization is required	$20 copay for each visit Prior authorization is required
Hearing Examinations	$10 copay for routine hearing tests $20 copay for diagnostic hearing exams You pay 100% for hearing aids	**$0** copay for each PCP diagnostic evaluation $20 copay for each specialist exam to diagnose and treat hearing and balance issues
Chiropractic Limited to manual manipulation of the spine as medically necessary	$15 copay each visit Prior authorization is required	$20 copay each visit

Plan changes are indicated by **bold text**.
This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

Services	CommunityCare Senior Health Plan	Generations by GlobalHealth
Part-Time or Intermittent Skilled Nursing Care Home health aide in conjunction with skilled care Physical, speech and occupational therapy Medical supplies and equipment (excluding medications) provided by the agency	$0 copay for Medicare-covered home health visits Prior authorization is required	$0 copay for home health visits Prior authorization is required
Durable Medical Equipment Durable medical equipment and supplies Prosthetic devices Therapeutic shoes/inserts for severe diabetes	$0 to $50 copay or 20% coinsurance for each item Prior authorization is required $0 copay for each device Prior authorization is required	20% coinsurance for each item Prior authorization required $0 if surgically implanted 20% coinsurance per external device Prior authorization is required 20% coinsurance Prior authorization is required

Medicare Preventive Services

The MA-PD HMO plans cover many Part B preventive services, such as your annual flu vaccination, wellness visit or screening mammogram, at 100 percent when you use a network provider.

For your plan to cover preventive services, you must follow the guidelines for each service. Guidelines can include criteria for age, frequency and disease risk.

For a list of these preventive services as governed by Medicare, go to **www.cms.gov** or **www.medicare.gov**. You can also refer to the 2017 *Medicare & You* handbook.

Medicare Advantage Prescription Drug Plans

Pharmacy Copay Structure for Part D Network Benefits

General Information	Aetna Medicare
These plans use a formulary Mandatory generic and brand medications you get at a network pharmacy Some drugs require prior authorization Quantity limits apply to certain drugs Pharmacy benefits must meet the minimum requirements for benefits as outlined in the *Medicare Modernization Act* of 2003 You will be notified before changes are made to your plan's formulary	**30-Day Supply** $9 copay – Tier 1 $45 copay – Tier 2 $75 copay – Tier 3 33% coinsurance (up to $150) – Tier 4 **31- to 90-day supply** $9 copay – Tier 1 $90 copay – Tier 2 $150 copay – Tier 3 33% coinsurance (up to $300) – Tier 4 Once you reach the $4,950 out-of-pocket maximum, you pay 0% for covered prescription drugs at network pharmacies for the remainder of the year. Retail and mail order are available for up to a 90-day supply.

Medicare Advantage Prescription Drug Plans

Pharmacy Copay Structure for Part D Network Benefits

General Information	CommunityCare Senior Health Plan	Generations by GlobalHealth
These plans use a formulary Mandatory generic and brand medications you get at a network pharmacy Some drugs require prior authorization Quantity limits apply to certain drugs Pharmacy benefits must meet the minimum requirements for benefits as outlined in the *Medicare Modernization Act* of 2003 You will be notified before changes are made to your plan's formulary	**30-day supply** $0 copay for Preferred generic drugs $10 copay for generic drugs $30 copay for Preferred brand drugs $60 copay for non-Preferred drugs 33% coinsurance for specialty drugs and certain injectables **90-day supply** $0 copay for Preferred generic drugs $20 copay for generic drugs $60 copay for Preferred brand drugs $120 copay for non-Preferred drugs 33% coinsurance for specialty drugs and certain injectables Mail order is available for up to a 90-day supply.	**Preferred Retail – 30-day supply** **$5** copay – Tier 1 **$15** copay – Tier 2 **$42** copay – Tier 3 **40% coinsurance** – Tier 4 **33%** coinsurance – Tier 5 **31- to 90-day supply** **$15** copay – Tier 1 **$45** copay – Tier 2 **$126** copay – Tier 3 **40% coinsurance** – Tier 4 **Preferred Mail Order – 30-day supply** **$5** copay – Tier 1 **$15** copay – Tier 2 **$42** copay – Tier 3 **30% coinsurance** – Tier 4 **33%** coinsurance – Tier 5 **31- to 90-day supply** **$0** copay – Tier 1 **$15** copay – Tier 2 **$84** copay – Tier 3 **30% coinsurance** – Tier 4 Once you reach the $4,950 out-of-pocket maximum, you pay Medicare-defined amounts for covered generic and brand prescription drugs purchased at network pharmacies for the remainder of the year.

Plan changes are indicated by **bold text**.

ZIP Code Service Areas for MA-PD Plans

County	Aetna Medicare
Canadian	73014, 73022, 73036, 73064, 73078, 73085, 73090, 73099
McClain	73010, 73031, 73065, 73080, 73093, 73095, 74831
Oklahoma	73003, 73007, 73008, 73012, 73013, 73020, 73025, 73034, 73045, 73049, 73054, 73066, 73083, 73084, 73097, 73100, 73101, 73102, 73103, 73104, 73105, 73106, 73107, 73108, 73109, 73110, 73111, 73112, 73113, 73114, 73115, 73116, 73117, 73118, 73119, 73120, 73121, 73122, 73123, 73124, 73125, 73126, 73127, 73128, 73129, 73130, 73131, 73132, 73134, 73135, 73136, 73137, 73139, 73140, 73141, 73142, 73143, 73144, 73145, 73146, 73147, 73148, 73149, 73150, 73151, 73152, 73154, 73155, 73156, 73157, 73159, 73162, 73163, 73164, 73167, 73169, 73172, 73173, 73177, 73178, 73179, 73180, 73184, 73185, 73190, 73193, 73194, 73195, 73196, 73197, 73198, 73199
Pottawatomie	74801, 74802, 74804, 74826, 74840, 74851, 74852, 74854, 74866, 74873, 74878
Rogers	74015, 74016, 74017, 74018, 74019, 74031, 74036, 74053, 74080
Tulsa	74008, 74011, 74012, 74013, 74021, 74033, 74037, 74043, 74050, 74055, 74063, 74070, 74073, 74100, 74101, 74102, 74103, 74104, 74105, 74106, 74107, 74108, 74110, 74112, 74114, 74115, 74116, 74117, 74119, 74120, 74121, 74126, 74127, 74128, 74129, 74130, 74132, 74133, 74134, 74135, 74136, 74137, 74141, 74145, 74146, 74147, 74148, 74149, 74150, 74152, 74153, 74155, 74156, 74157, 74158, 74159, 74169, 74170, 74171, 74172, 74182, 74183, 74184, 74186, 74187, 74189, 74192, 74193, 74194

You must live within the ZIP code listed for your county to be eligible for Aetna Medicare.

However, you can receive services anywhere within the United States as long as the provider is a Medicare eligible provider. The Aetna Medicare plan has an extended service area network beyond the network within their ZIP code service area.

ZIP Code Service Areas for MA-PD Plans

County	CommunityCare Senior Health Plan	Generations by GlobalHealth
Adair		74347, 74457, 74931, 74960, 74964, 74965
Alfalfa		73716, 73719, 73722, 73726, 73728, 73739, 73741, 73749
Blaine		**73040, 73043, 73724, 73744, 73755, 73763, 73770, 73772**
Caddo		**73001, 73005, 73006, 73009, 73015, 73017, 73029, 73033, 73038, 73042, 73047, 73048, 73053**
Canadian		73014, 73022, 73036, 73040, 73047, 73064, 73078, 73085, 73090, 73099, 73127, 73128, 73129, 73762
Cherokee		74427, 74434, 74441, 74444, 74451, 74452, 74464, 74465, 74471**, 74931**
Cleveland		73019, 73020, 73026, 73051, 73068, 73069, 73070, 73071, 73072, 73139, 73149, 73150, 73153, 73159, 73160, 73165, 73169, 73170, 73173, 73189, 74851, 74852, 74857, 74878
Cotton		**73531, 73562, 73568, 73572**
Craig		74301, 74332, 74333, 74349, 74369
Creek	74010, **74023**, 74028, 74030, 74033, **74038**, 74039, 74041, 74044, 74046, 74047, 74052, 74063, 74066, 74067, 74068, 74071, 74079, 74081, **74085**, 74131, 74132, **74859**	74010, 74028, 74030, **74033**, 74038, 74039, 74041, 74044, 74046, 74047, 74052, **74063,** 74066, 74067, 74068, 74071, 74079, 74081, **74085**, 74131, 74132
Dewey		**73646, 73654, 73658, 73659, 73663, 73667, 73835, 73859**
Garfield		**73056, 73701, 73702, 73703, 73705, 73706, 73720, 73727, 73730, 73733, 73735, 73736, 73738, 73739, 73743, 73753, 73754, 73773, 74630, 74640**
Garvin		73052, 73057, 73074, 73075, 73098, 73433, 73434, 73444, 74872
Grady		73002, 73004, 73010, 73011, 73017, 73018, 73023, 73055, 73059, 73067, 73079, 73082, 73089, 73092

The ZIP codes listed in blue indicate partial participation within the ZIP code.
The ZIP codes listed in bold indicate new service areas for 2017.

ZIP Code Service Areas for MA-PD Plans

County	CommunityCare Senior Health Plan	Generations by GlobalHealth
Grant		73758, 73759, 73761, 73766, 73771, 74636, 74640, 74643
Haskell		74440, 74462, 74472, 74552, 74941, 74943, 74944
Hughes		**74531, 74827, 74839, 74848, 74850, 74883**
Jefferson		**73456, 73520, 73548, 73561, 73565, 73569, 73573**
Kingfisher		73016, 73734, 73742, 73750 73756, 73762, 73764
Kiowa		**73041, 73062, 73559, 73564, 73566, 73651, 73655**
Lincoln		73045, 73054, 74023, 74026, 74079, 74824, 74832, 74834, 74851, 74855, 74864, 74869, 74875, 74881
Logan		73007, 73016, 73025, 73027, 73028, 73034, 73044, 73050, 73056, 73058, 73063, 73073, 74881
Major		73718, 73729, 73737, 73747, 73755, 73760, 73768, 73838
Mayes		74016, 74330, 74332, 74337, 74340, 74349, 74350, 74352, 74361, 74362, 74364, 74365, 74366, 74367, 74452
McClain		73002, 73010, 73011, 73031, 73052, 73057, 73065, 73072, 73074, 73080, 73093, 73095, 74831, 74872
McIntosh		74426, 74428, 74432, 74438, 74455, 74459, 74461, 74845
Muskogee		74401, 74402, 74403, 74422, 74423, 74428, 74434, 74436, 74439, 74450, 74455, 74463, 74468, 74769, 74470
Noble		73061, 73073, 73077, 73757, 74630, 74644, 74651
Nowata		**74027, 74042, 74048, 74072, 74083**
Okfuskee		74829, 74833, 74859, 74860, 74880

The ZIP codes listed in blue indicate partial participation within the ZIP code.
The ZIP codes listed in bold indicate new service areas for 2017.

ZIP Code Service Areas for MA-PD Plans

County	CommunityCare Senior Health Plan	Generations by GlobalHealth
Oklahoma		73003, 73007, 73008, 73012, 73013, 73020, 73025, 73034, 73045, 73049, 73054, 73066, 73083, 73084, 73097, 73101, 73102, 73103, 73104, 73105, 73106, 73107, 73108, 73109, 73110, 73111, 73112, 73113, 73114, 73115, 73116, 73117, 73118, 73119, 73120, 73121, 73122, 73123, 73124, 73125, 73126, 73127, 73128, 73129, 73130, 73131, 73132, 73134, 73135, 73136, 73137, 73139, 73140, 73141, 73142, 73143, 73144, 73145, 73146, 73147, 73148, 73149, 73150, 73151, 73152, 73154, 73155, 73156, 73157, 73159, 73162, 73163, 73164, 73167, 73169, 73172, 73173, 73178, 73179, 73184, 73185, 73190, 73193, 73194, 73195, 73196, 73197, 73198, 73199, 74857
Okmulgee		**74047, 74421, 74422, 74431, 74437, 74445, 74447, 74456, 74460**
Osage	74002, 74035, 74054, 74060, 74063, 74070, 74084, 74126, 74127	74001, 74002, 74003, 74035, 74054, 74056, 74060, **74063**, 74070, 74073, 74084, 74126, 74127, 74633, 74637, 74650, 74652
Pawnee		74020, 74034, 74038, 74045, 74058, 74081, 74650
Pittsburg		**74425, 74430, 74442, 74501, 74502, 74522, 74528, 74529, 74546, 74547, 74553, 74554, 74560, 74561, 74565, 74570, 74576**
Pontotoc		**74820, 74821, 74825, 74842, 74843, 74844, 74865, 74871**
Pottawatomie		73045, 74801, 74802, 74804, 74826, 74840, 74849, 74851, 74852, 74854, 74855, 74864, 47866, 74873, 74878

The ZIP codes listed in blue indicate partial participation within the ZIP code.
The ZIP codes listed in bold indicate new service areas for 2017.

ZIP Code Service Areas for MA-PD Plans

County	CommunityCare Senior Health Plan	Generations by GlobalHealth
Pushmataha		**74521, 74523, 74536, 74543, 74549, 74557, 74558, 74562, 74567, 74574**
Rogers	74015, 74016, 74017, 74018, 74019, 74021, 74031, 74036, **74048**, 74053, 74055, 74080, 74116, **74332**, **74361**	74015, 74016, 74017, 74018, 74019, **74021**, 74031, 74036, 74053, 74055, 74080, 74116, 74332
Seminole		74818, 74830, 74837, 74849, 74854, 74867, 74868, 74884
Tillman		**73530, 73542, 73546, 73551, 73553, 73555, 73570**
Tulsa	74008, 74011, 74012, 74013, 74014, 74015, 74021, 74033, 74037, 74043, 74047, 74050, 74055, 74063, 74066, 74070, 74073, 74101, 74102, 74103, 74104, 74105, 74106, 74107, 74108, 74110, 74112, 74114, 74115, 74116, 74117, 74119, 74120, 74121, 74126, 74127, 74128, 74129, 74130, 74132, 74133, 74134, 74135, 74136, 74137, 74141, 74145, 74146, 74147, 74148, 74149, 74150, 74152, 74153, 74155, 74156, 74157, 74158, 74159, 74169, 74170, 74171, 74172, 74182, 74183, 74184, 74186, 74187, 74189, 74192, 74193, 74194	74008, 74011, 74012, 74013, **74014**, **74015**, 74021, 74033, 74037, 74043, 74047, 74050, 74055, 74063, **74066**, 74070, 74073, 74101, 74102, 74103, 74104, 74105, 74106, 74107, 74108, 74110, 74112, 74114, 74115, 74116, 74117, 74119, 74120, 74121, 74126, 74127, 74128, 74129, 74130, 74132, 74133, 74134, 74135, 74136, 74137, 74141, 74145, 74146, 74147, 74148, 74149, 74150, 74152, 74153, 74155, 74156, 74157, 74158, 74159, 74169, 74170, 74171, 74172, 74182, 74183, 74184, 74186, 74187, 74189, 74192, 74193, 74194
Wagoner	74008, 74014, 74015, 74108, 74337, **74352**, 74403, 74429, 74434, 74436, 74446, 74454, 74458, **74466**, 74467, 74477	**74008**, 74014, 74015, 74108, **74337**, **74352**, **74403**, 74429, 74434, 74436, 74446, 74454, 74458, **74466**, 74467, 74477
Washington	74003, 74005, 74006, 74029, 74051, 74061, 74070	
Woods		**73717, 73726, 73729, 73731, 73746, 73842, 73860**

The ZIP codes listed in blue indicate partial participation within the ZIP code.
The ZIP codes listed in bold indicate new service areas for 2017.

Comparison of Benefits for the Dental Plans

Allowable Fees apply for all benefits	Assurant Employee Benefits Freedom Preferred	Assurant Employee Benefits Heritage Plus with SBA and Heritage Secure	CIGNA Dental Care Plan (Prepaid)
Annual Deductible	$25 per person, waived for in-Network preventive services	No deductibles	No deductible or plan maximum $5 office copay applies
Diagnostic and Preventive Care Cleanings, routine oral exams	Network: Plan pays 100% of allowable amounts No deductible Non-Network: Plan pays 100% of usual and customary after deductible	No charge for routine cleaning (once every 6 months) No charge for topical fluoride application (up to age 18) No charge for periodic oral evaluations Heritage Plus: Sealant per tooth: $15 copay Heritage Secure: Sealant per tooth: $22 copay	Sealant per tooth: $17 copay Routine cleaning (once every 6 months): No charge Topical fluoride application (up to age 18) Periodic oral evaluations: no charge
Basic Care Extractions, oral surgery	Network: Plan pays 85% of allowable amounts after deductible Non-Network: Plan pays 70% of usual and customary after deductible	Fillings Minor oral surgery Heritage Plus: Amalgam, one surface, permanent teeth: $25 copay Heritage Secure: Amalgam, one surface, permanent teeth: $32 copay	Amalgam: One surface, permanent teeth $23 copay
Major Care Dentures, bridge work	Network: Plan pays 60% of allowable amounts after deductible Non-Network: Plan pays 50% of usual and customary after deductible	Heritage Plus: Root canal anterior: $165 copay Periodontal/Scaling/Root planing 1-3 teeth, per quadrant: $36 copay Specialty rider pays specialist at set copays Heritage Secure: Root canal anterior: $175 copay Periodontal/Scaling/Root planing 1-3 teeth, per quadrant: $54 copay Endodontist: 15% discount	Root canal, anterior: $375 copay Periodontal/scaling/root planing 1-3 teeth (per quadrant): $75 copay
Orthodontic Care	Network: Plan pays 60% Non-Network: Plan pays 50% up to lifetime maximum of $2,000 for dependents under age 19	25% discount Adults and children	$2,472 out-of-pocket for children $3,384 out-of-pocket for adults 24-month treatment excludes orthodontic treatment plan and banding
Plan Year Maximum	$2,000 per person, per policy year	No annual maximum, per policy year	No plan year dollar maximum
Filing Claims	Member/provider must file claims	No claims to file	No claims to file

Comparison of Benefits for the Dental Plans

Allowable Fees apply for all benefits	Delta Dental PPO In-Network and Out-of-Network	Delta Dental PPO Plus Premier In-Network and Out-of-Network	Delta Dental PPO – Choice PPO Network
Annual Deductible	$25 per person, per year, applies to Basic and Major Care only	$50 per person, per year, applies to Diagnostic, Preventive, Basic and Major Care	$100 per person, per year, applies to Major Care only (Level 4)
Diagnostic and Preventive Care Cleanings, routine oral exams	Plan pays 100% of allowable amounts No deductible applies Topical fluoride covered for children (up to age 19)	Plan pays 100% of allowable amounts after deductible Topical fluoride covered for children (up to age 19)	Schedule of covered services and copays Topical fluoride covered for children only Copay examples: Routine cleaning $5 Periodic oral evaluation $5 Topical fluoride application (up to age 19) $5
Basic Care Extractions, oral surgery	Plan pays 85% of allowable amounts after deductible	Plan pays 70% of allowable amounts after deductible	Schedule of covered services and copays Copay example: Amalgam - one surface, primary or permanent tooth $12
Major Care Dentures, bridge work	Plan pays 60% of allowable amounts after deductible	Plan pays 50% of allowable amounts after deductible	Schedule of covered services and copays Copay examples: Crown - porcelain/ceramic substrate $241 Complete denture – maxillary $320
Orthodontic Care	Plan pays 60% of allowable amounts, up to $2,000 lifetime maximum per person Orthodontic benefits are available to eligible employee, spouse and dependent children	Plan pays 60% of allowable amounts, up to $2,000 lifetime maximum per person Orthodontic benefits are available to eligible employee, spouse and dependent children	You pay charges in excess of $50 per month Lifetime maximum up to $1,800 per person Orthodontic benefits are available to eligible employee, spouse and dependent children
Plan Year Maximum	$2,500 per person/year for Diagnostic, Preventive, Basic and Major Care	$3,000 per person/year for Diagnostic, Preventive, Basic and Major Care	$2,000 per person/year for Diagnostic, Preventive, Basic and Major Care
Filing Claims	Claims are filed by participating dentists	Claims are filed by participating dentists	Claims are filed by participating dentists

Comparison of Benefits for the Dental Plans

Allowable Fees apply for all benefits	HealthChoice Dental	MetLife Classic
Annual Deductible	Network: $25 Basic and Major services combined Non-Network: $25 Preventive, Basic and Major services combined plus amounts above Allowable Fees	$25 per person $75 per family Basic and Major Care
Diagnostic and Preventive Care Cleanings, routine oral exams	You pay Network: $0 Non-Network: $0 of Allowable Fees after deductible	Network: Plan pays 100% of negotiated fee schedule Non-Network: Plan pays 100% of reasonable and customary Routine exams and cleanings: two every 12 months Fluoride: two every 12 months (up to age 16)
Basic Care Extractions, oral surgery	You pay Network: 15% Non-Network: 30% plus amounts above Allowable Fees Deductible applies	Network: Plan pays 85% of negotiated fee schedule Non-Network: Plan pays 85% of reasonable and customary Network and non-Network: Root canal: one per tooth per lifetime
Major Care Dentures, bridge work	You pay Network: 40% Non-Network: 50% plus amounts above Allowable Fees Deductible applies	Network: Plan pays 60% of negotiated fee schedule Non-Network: Plan pays 60% of reasonable and customary Network and non-Network: Dentures: one every five years Fixed bridges/inlays/onlays: one every five years Implants: one per tooth every five years
Orthodontic Care	You pay Network: 50% Non-Network: 50% plus amounts above Allowable Fees 12-month waiting period applies No lifetime maximum Covered for members under age 19 and members ages 19 and older with TMD	Network: Plan pays 60% of negotiated fee schedule Non-Network: Plan pays 60% of reasonable and customary $2,000 lifetime maximum
Plan Year Maximum	Network and non-Network: $2,500 per person, per year	$5,000, applies to Preventive, Basic and Major Care
Filing Claims	Network: No claims to file Non-Network: You file claims	Claims are filed by Network and non-Network dentists

Comparison of Benefits for the Dental Plans

Allowable Fees apply for all benefits	**MetLife Value MAC**	**MetLife Value PDP**
Annual Deductible	$25 per person $75 per family Basic and Major Care	$25 per person $75 per family Basic and Major Care
Diagnostic and Preventive Care Cleanings, routine oral exams	Network: Plan pays 100% of negotiated fee schedule Non-Network: Plan pays 100% of reasonable and customary Routine exams and cleanings: two every 12 months Fluoride: two every 12 months (up to age 16)	Network: Plan pays 100% of negotiated fee schedule Non-Network: Plan pays 100% of reasonable and customary Routine exams and cleanings: two every 12 months Fluoride: two every 12 months (up to age 16)
Basic Care Extractions, oral surgery	Network: Plan pays 85% of negotiated fee schedule Non-Network: Plan pays 70% of reasonable and customary Network and non-Network: Root canal: one per tooth per lifetime	Network: Plan pays 85% of negotiated fee schedule Non-Network: Plan pays 70% of reasonable and customary Network and non-Network: Root canal: one per tooth per lifetime
Major Care Dentures, bridge work	Network: Plan pays 60% of negotiated fee schedule Non-Network: Plan pays 50% of reasonable and customary Network and non-Network: Dentures: one every 10 years Fixed bridges/inlays/onlays: one every 10 years Implants: one per tooth every 10 years	Network: Plan pays 60% of negotiated fee schedule Non-Network: Plan pays 50% of reasonable and customary Network and non-Network: Dentures: one every 10 years Fixed bridges/inlays/onlays: one every 10 years Implants: one per tooth every 10 years
Orthodontic Care	Network: Plan pays 60% of negotiated fee schedule Non-Network: Plan pays 50% of reasonable and customary $2,000 lifetime maximum	Network: Plan pays 60% of negotiated fee schedule Non-Network: Plan pays 50% of reasonable and customary $2,000 lifetime maximum
Plan Year Maximum	$2,500, applies to Preventive, Basic and Major Care	$2,500, applies to Preventive, Basic and Major Care
Filing Claims	Claims are filed by Network and non-Network dentists	Claims are filed by Network and non-Network dentists

Comparison of Benefits for Vision Plans

	Primary Vision Care Services		Superior Vision	
Covered Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Eye Exams	$0 copay No limit to frequency	Plan pays up to $40 Limit one exam	$10 copay	Plan pays: $34 ophthalmologist $26 optometrist
Lenses Each Pair	You pay wholesale cost No limit to number of pairs	You pay normal doctor's fees, reimbursed up to $60 for one set of lenses and frames per year	$25 copay Standard Progressive: $25 copay Refer to "Vision Plan Notes" after this chart	Plan pays: Single up to $26 Bifocals up to $39 Trifocals up to $49 Lenticular up to $78 Standard Progressive: Up to $49
Frames	You pay wholesale cost No limit to number of frames	You pay normal doctor's fees, reimbursed up to $60 for one set of lenses and frames per year	$25 copay then plan pays up to $125 retail	Plan pays up to $68
Contact Lenses	You pay wholesale cost for annual supply of contacts	Limit of one set annually in lieu of eyeglasses You pay normal doctor's fees reimbursed up to $60	Plan pays up to $120 all contacts Medically necessary contacts covered in full (Contact lens fit copay: Standard $25, after copay, covered in full; Specialty $25, after copay, plan pays up to $50)	Plan pays up to $100 on all contacts $210 for medically necessary (Contact lens fit copay: Standard not covered; specialty not covered)
Laser Vision Correction	Discount at nJoy Vision **Extra savings between June 1 - Sept. 30, 2017**	No benefit	5-50% discount off surgical fees	No benefit

Plan changes are indicated by **bold text**.
This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

Comparison of Benefits For Vision Plan

	Vision Care Direct		Vision Service Plan (VSP)	
Covered Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Eye Exams	$15 copay for full comprehensive exam including dilation	Plan pays up to $40	$10 copay	$10 copay then plan pays up to $35
Lenses Each Pair	$15 copay Single, bifocals, trifocals and no-line progressive lenses covered in full Anti-reflective, **UV** and polycarbonate lenses are covered in full	Plan pays up to: $30 single $45 bifocals $55 trifocals $75 lenticular	$25 copay applies to lenses or frame Single vision, lined bifocal and trifocal lenses covered in full Average 35-40% discount on lens options	$25 copay then plan pays: Single up to $25 Bifocals up to $40 Trifocals up to $55 Lenticular up to $80
Frames	$0 copay $130 frame allowance each year	Plan pays up to $35	$25 copay then plan pays up to **$150**	$25 copay, then plan pays up to $45
Contact Lenses	$130 for conventional and disposable lenses $250 allowance for medically necessary contacts	$80 allowance for conventional, disposable and medically necessary lenses	Plan pays up to $120 for conventional or disposable Medically necessary contacts covered in full	Plan pays up to $105 for conventional or disposable $210 for medically necessary contacts
Laser Vision Correction	**Up to $1,000 off**	No benefit	15% average off usual and customary price or 5% off the laser center's promotional price	No benefit

Plan changes are indicated by **bold text**.
This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

Vision Plan Notes

PVCS: The only Oklahoma owned and operated vision care plan with unlimited in-network services. Member must select either in-network or out-of-network for entire year. In-network services are unlimited. Out-of-network services (one eye exam, one set of eyeglasses or contacts) are limited to once annually. A $50 service fee applies to soft contact lens fittings; a $75 service fee applies to rigid or gas permeable contact lens fittings; and a $150 service fee applies to hybrid contact lens fittings. Simple replacements are not assessed with these fees. Limitations/ exclusions include the following: 1) Medical eye care, 2) Vision therapy, 3) Non-routine vision services and tests, 4) Luxury frames 5) Premium prescription lenses, and 6) Nonprescription eyewear. For more information or detail, call 1-888-357-6912.

Superior Vision: Materials copay applies to lenses and/or frames. Discounts for lens add-ons will be given by contracted providers with a “DP” in their listing. Online, in-network contact lens materials available at www.svcontacts.com. Exams, lenses and frames are provided once per calendar year. Progressive lenses (no-line bifocals) – you pay the difference between the retail price of the selected progressive lens and the retail price of the lined trifocal. The difference may also be subject to a discount. Standard contact lens fitting applies to an existing contact lens user who wears disposable, daily wear or extended wear lenses only. The specialty contact lens fitting applies to new contact lens wearers and/or members who wear toric, gas permeable or multifocal lenses.

Vision Care Direct: A plan that will cost you less money overall. With the VCD plan, you can get your exam, frames and lenses (upgraded to polycarbonate, premium anti-reflective coatings and UV coatings) for $30, even if you wear progressive no-line lenses. We are not an insurance company and our focus is on delivering the very best patient care with quality materials at a very affordable price. Other plans may offer discounts for extra services, but we include the extras the doctor wants you to have, like polycarbonate lenses that are thinner, lighter and safer. We also include premium anti-reflection and UV coatings on our lenses because it’s better for you and the doctor wants you to have it. Choose one of our 79 private line frames and you’ll pay no more out of pocket than $30 for single vision lenses or no-line progressives. If you want a brand-name frame, no problem; you simply pay a small $40 unbundling fee and can choose any frame you want up to $130. What would normally cost you over $300 for progressive lenses will cost you much less with VCD. Visit www.visioncaredirect.com/oklahoma for more information, inclusions and limitations. For our provider list, visit www.visioncaredirect.com and enter your ZIP code, be sure to look for the VCD Plus logo. For more information, call 1-855-918-2020 or text 918-695-3080.

VSP: Exam, lenses and frame benefit provided annually. The $25 materials copay applies to lenses or frames, but not to both. Copays/prices listed are for standard lens options. Premium lens options will vary. If you choose a frame valued at more than your allowance, you’ll save 20 percent on your out-of-pocket costs when you use a VSP doctor. Member’s receive an extra $20 towards their frame allowance when selecting a Marchon frame. Contact lenses are in lieu of spectacle lenses and frame. The $120 in-network allowance applies to the contact lenses. With a VSP provider, the contact lens exam (fitting and evaluation) is covered in full after a copay up to $60. The $105 out-of-network allowance applies to the contacts and contact lens exam. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts. Prescription glasses – 30 percent off additional complete pairs of glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam, or get 20 percent off from any VSP doctor within 12 months from your last WellVision Exam. Contact VSP or visit vsp.com to learn more.

Contact Information

Medicare Supplement Plans

HealthChoice

Health, Dental and Life Claims, Benefits, Eligibility and ID Cards
405-416-1800 or 1-800-782-5218
TDD 405-416-1525 or 1-800-941-2160

Pharmacy Claims, Formulary and ID Cards
1-866-275-5253
TTY 711

Member Services
405-717-8780 or 1-800-752-9475
TDD 405-949-2281 or 1-866-447-0436

www.healthchoiceok.com

MA-PD Plans

Aetna MA-PD

Prospective Members
1-800-307-4830 or TTY 711

Member Services
1-888-267-2637 or TTY 711

www.aetnamedicare.com/en/for-members/group-plans.html

CommunityCare Senior Health Plan

1-800-642-8065
TDD 1-800-722-0353
www.ccok.com

Generations by GlobalHealth

Current Members
405-280-5555 or 1-844-280-5555
TTY 711

Prospective Members
1-844-322-8422 or TTY 711

www.globalhealth.com/medicare

If a TDD or TTY number is not listed for a plan, hearing impaired members should use a relay service to contact the plan.

Contact Information

Dental Plans

Assurant Inc. Dental
PPO Freedom Preferred 1-800-442-7742
Prepaid Heritage Plans 1-800-443-2995
www.assurantemployeebenefits.com

CIGNA Prepaid Dental
1-800-244-6224
Hearing Impaired Relay 1-800-654-5988
www.cigna.com

Delta Dental
405-607-2100 or 1-800-522-0188
www.DeltaDentalOK.org

MetLife
1-800-942-0584
www.metlife.com

Vision Plans

Primary Vision Care Services (PVCS)
1-888-357-6912 or TDD 1-800-722-0353
www.pvcs-usa.com

Superior Vision
1-800-507-3800 or TDD 1-916-852-2382
www.superiorvision.com

Vision Care Direct
1-877-488-8900 or TDD 1-877-488-8900
visioncaredirect.com

Vision Service Plan (VSP)
1-800-877-7195 or TDD 1-800-428-4833
www.vsp.com

If a TDD or TTY number is not listed for a plan, hearing impaired members should use a relay service to contact the plan.

A fully accessible version of this guide is available on the EGID website at **www.sib.ok.gov**.

The information contained in this guide is only a brief summary of the listed options. All benefits and limitations of these plans are governed in all cases by the relevant plan documents, insurance contracts, handbooks, *Administrative Rules* and the regulations governing the *Medicare Prescription Drug Benefit, Improvement, and Modernization Act*. The federal regulation at 42 CFR, 2011 § 423, et seq. and the rules of the *Oklahoma Administrative Code*, Title 260, are controlling in all aspects of Plan benefits. No oral statement of any person shall modify or otherwise affect the benefits, limitations or exclusions of any plan.

Cover image: Wichita Mountains

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IMPORTANT PLAN INFORMATION