



PLAN
YEAR
2017

JAN. 1 - DEC. 31, 2017



HEALTH | DENTAL | LIFE | VISION

**FORMER EMPLOYEES,
SURVIVING DEPENDENTS,
COBRA PARTICIPANTS**

OPTION PERIOD GUIDE

Monthly Premiums for Former Employees and Surviving Dependents

Plan Year Jan. 1 – Dec. 31, 2017

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Aetna HMO	\$572.56	\$ 938.80	\$383.60	\$383.60
CommunityCare HMO	\$850.52	\$1,238.90	\$433.18	\$693.10
GlobalHealth HMO	\$529.78	\$ 782.00	\$286.00	\$467.34
HealthChoice High and High Alternative	\$571.04	\$ 674.30	\$288.16	\$488.66
HealthChoice Basic and Basic Alternative	\$433.04	\$ 505.30	\$227.82	\$379.06
HealthChoice High Deductible Health Plan (HDHP)	\$372.60	\$ 435.12	\$197.08	\$325.98
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 PPO 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

These rates do not reflect any retirement system contribution.

Monthly Premiums for Former Employees and Surviving Dependents

Plan Year Jan. 1 – Dec. 31, 2017

LIFE PLAN FOR PRE-MEDICARE RETIREES/VESTS		
From \$5,000 to \$40,000	\$1.88 Per \$1,000	
Age Rated Supplemental Life — Cost Per \$1,000 for \$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

MONTHLY LIFE INSURANCE PREMIUMS FOR SURVIVING DEPENDENTS

SURVIVING DEPENDENTS OF CURRENT EMPLOYEES	LOW OPTION \$2.60	STANDARD OPTION \$4.32	PREMIER OPTION \$8.64
Spouse	\$6,000 of coverage	\$10,000 of coverage	\$20,000 of coverage
Child (live birth to age 26)	\$3,000 of coverage	\$ 5,000 of coverage	\$10,000 of coverage
SURVIVING DEPENDENTS OF FORMER EMPLOYEES	\$0.94 Per \$500 Unit, Per Dependent		

By law, the premiums for current employees and pre-Medicare former employees must be the same. For information on how this reduces your premium, visit the “Frequently Asked Questions” (FAQ) section of the Employees Group Insurance Department (EGID) website and search for *blended rates*.

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.

Monthly Premiums for COBRA Participants

Plan Year Jan. 1 – Dec. 31, 2017

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Aetna HMO	\$ 584.01	\$ 957.58	\$ 391.27	\$ 391.27
CommunityCare HMO	\$ 867.53	\$ 1,263.68	\$ 441.84	\$ 706.96
GlobalHealth HMO	\$ 540.38	\$ 797.64	\$ 291.72	\$ 476.69
HealthChoice High and High Alternative	\$ 582.46	\$ 687.79	\$ 293.92	\$ 498.43
HealthChoice Basic and Basic Alternative	\$ 441.70	\$ 515.41	\$ 232.38	\$ 386.64
HealthChoice High Deductible Health Plan (HDHP)	\$ 380.05	\$ 443.82	\$ 201.02	\$ 332.50
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 primary member did not keep that benefit, one person is always billed the primary member rate.

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YOUR “OPTION PERIOD ENROLLMENT/CHANGE FORM” IS BEING MAILED.

IF YOU ARE MAKING CHANGES, YOUR FORM MUST BE POSTMARKED BY DEC. 7.

This information is only a brief summary of the plans. All benefits and limitations of these plans are governed in all cases by the relevant plan documents, insurance contracts, handbooks and *Administrative Rules* of the Office of Management and Enterprise Services. 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.

www.sib.ok.gov

INTRODUCTION

Your Option Period Guide

This Option Period guide is a summary of the plans available to the following members who are not yet eligible for Medicare:

- Former employees and their dependents;
- Surviving dependents; and
- COBRA participants.

Your “Option Period Enrollment/Change Form”

- **If you do not want to make any changes to your coverage, do NOT return your form.** Keep it as verification of your coverage.
- If you do not make changes to your coverage and are not automatically enrolled in one of the HealthChoice Alternative Plans, you will not receive a “Confirmation Statement” (CS) from EGID.
- If you do want to make changes, complete your form and return it to EGID by **Dec. 7**.
- If you are enrolled in BlueLincs, you will need to select another health plan for 2017. If you do not make a selection or terminate your health coverage, EGID will move you to an alternative health plan to ensure your health coverage does not lapse. If you are enrolled in Humana Vision Care Plan or UnitedHealthcare Vision, you can select a vision plan or your vision coverage will end Jan. 1.
- Review your CS when you receive it in the mail to verify your coverage is correct. Contact EGID Member Services right away if it is incorrect.

It is your responsibility to review your benefits carefully so you know what is covered, as well as the plan’s policies and procedures, before you use your benefits.

Don’t Miss Out on Important Mailings

Keep your email and mailing address information current. To update a new temporary or permanent address, send written notice of the new address, including the date of the change, your daytime phone number, member ID number and signature to Attention: Member Accounts, 3545 N.W. 58th St., Ste. 110, Oklahoma City, OK 73112; or via fax at 405-717-8939.

2017 PLAN CHANGES AND IMPORTANT REMINDERS

Plan changes are indicated by **bold text** in the comparison of benefits charts.

HEALTH PLANS

Aetna INTEGRIS and Aetna St. John HMO

- Aetna is expanding its offering in 2017 to include Aetna St. John HMO network for members who live in Tulsa. Aetna will continue to offer the Aetna INTEGRIS HMO network for members who live in Oklahoma City; however, the service area has changed. When you enroll with Aetna, your network of providers is determined by the ZIP code in which you live. Refer to “HMO ZIP Code Lists” to determine if you live in their area.

BlueLincs HMO

- BlueLincs is not available for 2017. If you have BlueLincs, you must choose another health plan. If you do not choose another plan or terminate health coverage, EGID will enroll you in an alternate plan.

CommunityCare HMO

- The pharmacy program is being redesigned. Changes are listed in bold text in “Comparison of Network Benefits for Health Plans.”

HealthChoice Health Plans

- There will be some changes to the list of Preferred medications. If you are a HealthChoice health plan member who is taking a medication that will no longer be covered in 2017, you will be notified by mail. For a complete list of medications that will no longer be covered, visit www.healthchoiceok.com.
- HealthChoice FOCUS and HealthChoice USA Plans are not available for 2017. If you have either HealthChoice FOCUS or HealthChoice USA, you must choose another health plan. If you do not choose another plan or terminate health coverage, EGID will enroll you in an alternate plan.

HealthChoice High, High Alternative, Basic, Basic Alternative Plans and High Deductible Health Plan

- HealthChoice is expanding the HealthChoice Select Program. These select facilities provide certain services to members that are covered at 100 percent with no out-of-pocket costs to members.*
For the most current list of facilities participating in the HealthChoice Select Program and the most current list of procedures covered, select “Find a Provider” in the top menu bar of the HealthChoice website at www.healthchoiceok.com; select “Medical and Dental Providers” under “HealthChoice Provider Listings,” and then choose “Select Network” from the top menu bar.

*HDHP members must meet their deductible before benefits are paid at 100 percent.

HealthChoice High and High Alternative Plans

- A new \$100 per person pharmacy deductible, with a \$300 maximum deductible per family.

HealthChoice High and High Alternative Plans and High Deductible Health Plan

- Emergency room copay is increasing to \$200.
- The “HealthChoice Preventive Medication List” is being implemented for Plan Year 2017. This is a list of frequently prescribed generic medications and the charges for these medications will not be subject to the High and High Alternative pharmacy deductible and HDHP combined medical/pharmacy deductible.

HealthChoice High Deductible Health Plan

- The maximum annual contribution for an individual is increasing from \$3,350 to \$3,400.

DENTAL PLANS

MetLife – New for 2017

- MetLife is offering three dental plans for 2017. For benefit information, refer to the “Comparison of Benefits for Dental Plans” or visit their website at the address listed in “Contact Information.”

VISION PLANS

Humana Vision Care Plan

- Humana Vision Care Plan is not available for 2017. If you had Humana Vision Care Plan for 2016, you must choose another vision plan or your vision coverage will end Jan. 1.

Primary Vision Care Services

- Primary Vision Care Services is offering additional discounts on laser vision correction surgery. Changes are listed in bold text in “Comparison of Benefits for Vision Plans.”

UnitedHealthcare Vision

- UnitedHealthcare Vision is not available for 2017. If you had UnitedHealthcare Vision for 2016, you must choose another vision plan or your vision coverage will end Jan. 1.

Vision Service Plan

- Vision Service Plan is increasing the allowance for frames. Changes are listed in bold text in “Comparison of Benefits for Vision Plans.”

REMINDER

If you are enrolled in the HealthChoice High or Basic Plan and wish to stay enrolled in that plan for 2017, you must complete the online tobacco-free attestation for Plan Year 2017 available on the HealthChoice website at www.healthchoiceok.com by Dec. 7, 2016.

The attestation is waived for the first year of enrollment in the High or Basic Plan but is required each year thereafter to remain enrolled. If you are in the process of quitting tobacco, you must be tobacco-free for 90 days prior to the deadline to attest to being tobacco-free.

If you cannot sign the tobacco-free attestation because either you or a covered dependent uses tobacco, you can still qualify for HealthChoice High or HealthChoice Basic plans if those that use tobacco complete one of the following alternatives:

- Show proof of an attempt to quit using tobacco by enrolling in the quit tobacco program available through the Oklahoma Tobacco Helpline and Alere Wellbeing AND completing three coaching calls by Dec. 7; or
- Provide a letter from your doctor by Dec. 7, indicating it is not medically advisable for you or your covered dependents to quit tobacco.

If you do not complete the attestation or complete one of the reasonable alternatives as defined above, you will automatically be enrolled in the HealthChoice High Alternative or Basic Alternative Plan effective Jan. 1, 2017, and your annual deductible will be \$250 higher.

GENERAL INFORMATION

The benefits you select will be in effect Jan. 1, 2017, through Dec. 31, 2017.

After enrollment, the plans you select will provide more information about your benefits. Contact each plan directly if you have questions about your benefits.

Once enrolled in any of the plans, it is your responsibility to review your benefits carefully so you know what is covered, as well as the plan’s policies and procedures, before you use your benefits.

HEALTH PLANS

There are eight health plans available:

- Aetna INTEGRIS and Aetna St. John HMO
- HealthChoice High and High Alternative Plans
- CommunityCare HMO
- HealthChoice Basic and Basic Alternative Plans
- GlobalHealth HMO
- HealthChoice HDHP

Refer to “Comparison of Network Benefits for Health Plans” on pages 14-21 for benefit information.

- There are no preexisting condition exclusions or limitations applied to any of the health plans.
- All health plans coordinate benefits with other group insurance plans you have in force.
- You must live within an HMO’s ZIP code service area to be eligible. Post office box addresses cannot be used to determine your HMO eligibility. Refer to pages 9-13 for the “HMO ZIP Code Lists.”
- If you select an HMO, you must use the provider network designated by that plan for Oklahoma.
- To remain enrolled in the HealthChoice High or Basic Plan for Plan Year 2017, you must complete the tobacco-free attestation located on the HealthChoice website or a reasonable alternative.
- HealthChoice contracts with American Fidelity Health Services Administration to make establishing and keeping a health savings account (HSA) easier and more convenient for HealthChoice HDHP members. For more information about HSAs, contact American Fidelity at the number located in “Contact Information” at the back of this guide.

DENTAL PLANS

There are 11 dental plans available:

- Assurant Freedom Preferred
- Assurant Heritage Plus with SBA (Prepaid)
- Assurant Heritage Secure (Prepaid)
- CIGNA Dental Care Plan (Prepaid)
- Delta Dental PPO
- Delta Dental PPO Plus Premier
- Delta Dental PPO – Choice
- HealthChoice Dental
- MetLife Classic
- MetLife Value MAC
- MetLife Value PDP

Refer to “Comparison of Benefits for Dental Plans” on pages 22-25 for benefit information.

- You must select a primary care dentist for yourself and each covered dependent when enrolling in a prepaid dental plan.
- Assurant Freedom Preferred and HealthChoice have a 12-month waiting period for orthodontic benefits.
- Some plans may not be available in all areas.

VISION PLANS

There are four vision plans available:

- Primary Vision Care Services (PVCS)
- Superior Vision
- Vision Care Direct
- Vision Service Plan (VSP)

Refer to “Comparison of Benefits for Vision Plans” on pages 26-28 for benefit information.

- Verify your vision provider participates in a vision plan’s network by contacting the plan, visiting the plan’s website or calling your provider.
- All vision plans have limited coverage for services provided by out-of-network providers.

If your provider leaves your health, dental or vision plan, you cannot change plans until the next annual Option Period; however, you can change providers within your plan’s network as needed.

HEALTHCHOICE LIFE INSURANCE PLAN

Please take time this Option Period to consider your life insurance needs. Former employees and surviving dependents have the following life insurance options:

- Keep your current amount of life insurance;
- Reduce your amount of life insurance; and
- Reduce your amount of Dependent Life insurance.

Your “Option Period Enrollment/Change Form” indicates the amounts and types of life insurance you currently carry. Please take time to evaluate your coverage. Keep in mind that as a former employee or surviving dependent, you cannot reinstate any life insurance that you decrease or terminate.

Beneficiary Designation

Your beneficiary designation can be changed at any time. For a “Beneficiary Designation Form” or more information, contact HealthChoice Member Services. Refer to “Contact Information” at the back of this guide. This form is also available at www.healthchoiceok.com. For Dependent Life insurance, the member is the beneficiary, so no beneficiary designation is needed.

ELIGIBILITY

Former employees (retired, vested and non-vested), COBRA participants and surviving dependents can make certain changes during Option Period:

Former employees and surviving dependents can:

- Change health and/or dental plans currently in place;
- Drop coverage and/or dependents;
- Decrease life insurance coverage; and
- Enroll in or change vision plans.

COBRA participants can:

- Add eligible dependents up to age 26;
- Add or change coverage (health, dental and/or vision) as long as your former employer participates in those benefits; and
- Drop benefits and/or dependents.

Dependents

- If one eligible dependent is covered, all eligible dependents must be covered. Exceptions apply (refer to "Excluding Dependents from Coverage" on the next page). Eligible dependents include:
 - Your legal spouse (including common-law).
 - Your daughter, son, stepdaughter, stepson, eligible foster child, adopted child or child legally placed with you for adoption up to age 26, whether married or unmarried.
 - A dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26. Subject to medical review and approval.
 - Other unmarried dependent children up to age 26, upon completion of an "Application for Coverage for Other Dependent Children." Guardianship papers or a tax return showing dependency can be provided in lieu of the application.
- If your spouse is enrolled separately in one of the plans offered through EGID, your dependents can be covered under either parent's health, dental and/or vision plan (but not both); however, both parents can cover dependents under Dependent Life insurance.
- Dependents can be enrolled only in the same types of coverage and in the same plans you elect. For COBRA members, exceptions apply.
- To enroll your newborn, a letter requesting coverage for the newborn must be sent to EGID within 30 days of the birth. If you are a former employee or surviving spouse and do not enroll your newborn during this 30-day period, you cannot do so at a later date. If you are a COBRA participant and do not enroll your newborn during this 30-day period, you will not be able to do so until the next annual Option Period. Direct notification to a plan will not enroll your newborn or any other dependents. The newborn's Social Security number is not required at the time of initial enrollment, but must be provided once it is received from Social Security. Insurance premiums for the month the child was born must be paid.

- Without enrollment:
 - HealthChoice – A newborn is covered only for the first 48 hours following a vaginal birth or the first 96 hours following a C-section birth. Under the HealthChoice Plans, a separate deductible and coinsurance apply.
 - Aetna, CommunityCare and GlobalHealth HMOs – A newborn is covered for 31 days without an additional premium.

Excluding Dependents From Coverage

- You can exclude your spouse from health and/or dental coverage while covering other dependents on these benefits. Your spouse must sign the “Spouse Exclusion Certification” section of your “Option Period Enrollment/Change Form.”
- You can exclude dependents who do not reside with you, are married, are not financially dependent on you for support, have other group coverage or are eligible for Indian or military health benefits.

Note: Your spouse cannot be excluded from vision coverage if your other dependents are covered unless your spouse has proof of other group vision coverage. You must always provide proof of other group coverage to EGID when excluding a dependent for that reason.

COBRA – Temporary Continuation of Coverage

COBRA coverage may be available to dependents who become ineligible due to qualifying events, such as:

- Reaching age 26 (applies only to dependent children);
- Divorce of a spouse; and
- Death of the covered employee.

Important Information About Becoming Eligible for Medicare

Eligible for Medicare Prior to Turning 65

If you are under age 65 and become eligible for Medicare, you must notify EGID to begin the enrollment process into a Medicare supplement or Medicare Advantage Prescription Drug (MA-PD) plan. You will be asked to provide your Medicare ID number as it appears on your Medicare card. Depending on the plan you are enrolled in, you may have different options for your Medicare supplement or MA-PD coverage. Your Medicare supplement or MA-PD coverage will become effective the date you become eligible for Medicare or the first of the month after you complete the enrollment process, whichever is later.

Aging into Medicare

Approximately two months before you or one of your eligible dependents turn 65, EGID will send you a letter that explains the Medicare plan options available to you. The letter will also provide instructions on how to enroll with a Medicare supplement or MA-PD plan.

If you are enrolled in HealthChoice, you can enroll in a HealthChoice Silverscript Medicare Supplement Plan. If you are enrolled in an HMO, you can enroll in its MA-PD Plan (if available in your area). If you are enrolled in Aetna, you can enroll in Aetna Medicare. If you or one of your dependents will soon become Medicare eligible, watch your mail for this important enrollment information.

All Medicare Eligible Members

OMES's *Administrative Rules* state that all covered individuals who are eligible for Medicare, except current employees, must be enrolled in a Medicare supplement or MA-PD plan offered through EGID, regardless of age. **To maximize your benefits, you need to enroll in Medicare Part B.** The HealthChoice Medicare supplement plans do not require you to be enrolled in Part B, but pay benefits as if you are. All MA-PD plans offered through EGID **require** you to have both Medicare Part A and Part B.

Notice of Creditable Coverage

If you are a former employee who is already eligible or will soon become eligible for Medicare, you may be hearing a lot about Medicare prescription drug benefits (Part D) and Creditable Coverage.

The term Creditable Coverage, as it applies to Medicare Part D, simply means that the prescription drug benefits of an insurance plan meet certain standards that have been set by the Centers for Medicare & Medicaid Services (CMS). All health plans offered through EGID provide Creditable Coverage.

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

Aetna INTEGRIS ZIP Code List

73003	73007	73008	73012	73013	73019	73020
73022	73025	73026	73034	73036	73045	73049
73051	73054	73064	73066	73068	73069	73070
73071	73072	73078	73083	73084	73085	73090
73097	73099	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	73153	73154	73155	73156
73157	73159	73160	73162	73163	73164	73165
73167	73169	73170	73172	73173	73178	73179
73184	73185	73189	73190	73193	73194	73195
73196	73197	73198	73199			

Aetna St. John ZIP Code List

74008	74011	74012	74013	74021	74033	74037
74043	74050	74055	74063	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	74857	

ZIP codes are subject to change by plan

CommunityCare ZIP Code List

2
0
1
7

H
M
O

Z
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P

C
O
D
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L
I
S
T
S

74001	74002	74003	74004	74005	74006	74008
74009	74010	74011	74012	74013	74014	74015
74016	74017	74018	74019	74020	74021	74022
74027	74028	74029	74030	74031	74033	74034
74035	74036	74037	74038	74039	74041	74042
74043	74044	74045	74046	74047	74048	74050
74051	74052	74053	74054	74055	74056	74058
74060	74061	74063	74066	74067	74068	74070
74071	74072	74073	74080	74081	74082	74083
74084	74100	74101	74102	74103	74104	74105
74106	74107	74108	74110	74112	74114	74115
74116	74117	74119	74120	74121	74126	74127
74128	74129	74130	74131	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	74301	74330	74331	74332	74333
74335	74337	74338	74339	74340	74342	74343
74344	74345	74346	74347	74349	74350	74352
74353	74354	74355	74358	74359	74360	74361
74362	74363	74364	74365	74366	74367	74368
74369	74370	74401	74402	74403	74421	74422
74423	74425	74426	74427	74428	74429	74430
74431	74432	74434	74435	74436	74437	74438
74439	74440	74441	74442	74444	74445	74446
74447	74450	74451	74452	74454	74455	74456
74457	74458	74459	74460	74461	74462	74463
74464	74465	74466	74467	74468	74469	74470
74471	74472	74477	74501	74502	74522	74526
74529	74552	74554	74564	74578	74604	74633
74637	74650	74652	74845	74930	74931	74936
74941	74943	74944	74945	74948	74955	74960
74962	74964	74965				

ZIP codes are subject to change by plan

GlobalHealth ZIP Code List

73001	73002	73003	73004	73005	73006	73007
73008	73009	73010	73011	73012	73013	73014
73015	73016	73017	73018	73019	73020	73021
73022	73023	73024	73025	73026	73027	73028
73029	73030	73031	73032	73033	73034	73036
73038	73039	73040	73041	73042	73043	73044
73045	73047	73048	73049	73050	73051	73052
73053	73054	73055	73056	73057	73058	73059
73061	73062	73063	73064	73065	73066	73067
73068	73069	73070	73071	73072	73073	73074
73075	73077	73078	73079	73080	73082	73083
73084	73085	73086	73089	73090	73092	73093
73095	73096	73097	73098	73099	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	73153
73154	73155	73156	73157	73159	73160	73162
73163	73164	73165	73167	73169	73170	73172
73173	73178	73179	73184	73185	73189	73190
73194	73195	73196	73401	73402	73403	73425
73430	73432	73433	73434	73435	73436	73437
73438	73439	73440	73441	73442	73443	73444
73446	73447	73448	73449	73450	73453	73455
73456	73458	73459	73460	73461	73463	73481
73487	73488	73491	73501	73502	73503	73505
73506	73507	73520	73521	73522	73523	73526
73527	73528	73529	73530	73531	73532	73533
73534	73536	73537	73538	73539	73540	73541
73542	73543	73544	73546	73547	73548	73549
73550	73551	73552	73553	73554	73555	73556
73557	73558	73559	73560	73561	73562	73564
73565	73566	73567	73568	73569	73570	73571
73572	73573	73601	73620	73622	73624	73625
73626	73627	73628	73632	73638	73639	73641
73642	73644	73645	73646	73647	73648	73650
73651	73654	73655	73658	73659	73660	73661
73662	73663	73664	73666	73667	73668	73669
73673	73701	73702	73703	73705	73706	73716
73717	73718	73719	73720	73722	73724	73726

ZIP codes are subject to change by plan

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GlobalHealth ZIP Code List

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73727	73728	73729	73730	73731	73733	73734
73735	73736	73737	73738	73739	73741	73742
73743	73744	73746	73747	73749	73750	73753
73754	73755	73756	73757	73758	73759	73760
73761	73762	73763	73764	73766	73768	73770
73771	73772	73773	73801	73802	73832	73834
73835	73838	73840	73841	73842	73843	73844
73848	73851	73852	73853	73855	73857	73858
73859	73860	73901	73931	73932	73933	73937
73938	73939	73942	73944	73945	73946	73947
73949	73950	73951	74001	74002	74003	74004
74005	74006	74008	74010	74011	74012	74013
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74061	74062	74063	74066	74067	74068	74070
74071	74072	74073	74074	74075	74076	74077
74078	74079	74080	74081	74082	74083	74084
74085	74101	74102	74103	74104	74105	74106
74107	74108	74110	74112	74114	74115	74116
74117	74119	74120	74121	74126	74127	74128
74129	74130	74131	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
74186	74187	74192	74193	74301	74330	74331
74332	74333	74335	74337	74338	74339	74340
74342	74343	74344	74345	74346	74347	74349
74350	74352	74354	74355	74358	74359	74360
74361	74362	74363	74364	74365	74366	74367
74368	74369	74370	74401	74402	74403	74421
74422	74423	74425	74426	74427	74428	74429
74430	74431	74432	74434	74435	74436	74437
74438	74439	74440	74441	74442	74444	74445
74446	74447	74450	74451	74452	74454	74455
74456	74457	74458	74459	74460	74461	74462
74463	74464	74465	74467	74468	74469	74470
74471	74472	74477	74501	74502	74521	74522
74523	74525	74528	74529	74530	74531	74533
74534	74535	74536	74538	74540	74543	74545

ZIP codes are subject to change by plan

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GlobalHealth ZIP Code List

74546	74547	74549	74552	74553	74554	74555
74556	74557	74558	74559	74560	74561	74562
74563	74565	74567	74569	74570	74571	74572
74574	74576	74577	74578	74601	74602	74604
74630	74631	74632	74633	74636	74637	74640
74641	74643	74644	74646	74647	74650	74651
74652	74653	74701	74702	74720	74721	74722
74723	74724	74726	74727	74728	74729	74730
74731	74733	74734	74735	74736	74737	74738
74740	74741	74743	74745	74747	74748	74750
74752	74753	74754	74755	74756	74759	74760
74761	74764	74766	74801	74802	74804	74818
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74830	74831	74832	74833	74834	74836	74837
74839	74840	74842	74843	74844	74845	74848
74849	74850	74851	74852	74854	74855	74856
74857	74859	74860	74864	74865	74866	74867
74868	74869	74871	74872	74873	74875	74878
74880	74881	74883	74884	74901	74902	74930
74931	74932	74935	74936	74937	74939	74940
74941	74942	74943	74944	74945	74946	74947
74948	74949	74951	74953	74954	74955	74956
74957	74959	74960	74962	74963	74964	74965
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ZIP codes are subject to change by plan

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	Aetna INTEGRIS and Aetna St. John HMO	CommunityCare HMO	GlobalHealth HMO
Calendar Year Deductible	No deductible	No deductible	No deductible
Calendar Year Out-of-Pocket Maximum	\$3,000 individual \$4,500 family Includes all copays and coinsurance paid on covered services, prescriptions and durable medical equipment	\$4,000 individual \$8,000 family Includes all copays and coinsurance paid on covered services, prescriptions and durable medical equipment	\$3,500 individual \$10,500 family Includes all copays and coinsurance paid on covered services, prescriptions and durable medical equipment
Office Visit	\$25 copay/PCP \$50 copay/specialist	\$35 copay/PCP \$50 copay/specialist	\$0 copay/PCP \$50 copay/specialist
X-Ray and Lab	\$0 copay for X-ray and lab \$250 copay per MRI, CAT, MRA or PET scan	\$0 copay for X-ray and lab \$200 copay per scan Specialty scans: MRI, CT, MRA and PET scans	\$0 copay for X-ray and lab \$250 copay per scan in a preferred facility \$750 copay per scan in a non-preferred facility Specialty scans: MRI, MRA, PET, CAT and nuclear scans
Allergy Testing and Treatment	\$25 copay/PCP \$50 copay/specialist	\$35 copay/PCP \$50 copay/specialist \$30 serum and shots including a 6-week supply of antigen	\$0 copay/PCP \$50 copay/specialist \$30 serum and shots including a 6-week supply of antigen and administration

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 NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High and High Alternative Plans	HealthChoice Basic and Basic Alternative Plans	HealthChoice HDHP
Calendar Year Deductible	<p>High Plan \$500 individual \$1,500 family</p> <p>High Alternative Plan \$750 individual \$2,250 family</p>	<p>Basic Plan \$1,000 individual \$1,500 family Applies after Plan pays first \$500 of Allowable Fees</p> <p>Basic Alternative Plan \$1,250 individual \$1,750 family Applies after Plan pays first \$250 of Allowable Fees</p>	<p>\$1,500 individual \$3,000 family The individual deductible does not apply if two or more family members are covered The combined medical and pharmacy deductible must be met before benefits are paid</p>
Calendar Year Out-of-Pocket Maximum (High, High Alternative, Basic, and Basic Alternative Plans have a separate pharmacy out-of-pocket maximum, refer to page 23)	<p>High Plan* Copays apply \$3,300 Network individual \$8,400 Network family \$3,800 non-Network individual \$9,900 non-Network family, plus amounts over Allowable Fees</p> <p>High Alternative Plan* Copays apply \$3,550 Network individual \$8,400 Network family \$4,050 non-Network individual \$9,900 non-Network family, plus amounts over Allowable Fees</p>	<p>Basic Plan \$4,000 individual \$9,000 family</p> <p>Basic Alternative Plan \$4,000 individual \$9,000 family</p>	<p>\$3,000 individual \$6,000 family Pharmacy copays apply to the out-of-pocket maximum but non-Network charges do not apply</p>
Office Visit	<p>\$30 copay/physician office visit** \$50 copay/specialist office visit</p>	<p>Copays do not apply All covered services, exceptions, limitations and conditions are identical to the HealthChoice High Plan</p> <p>Basic Plan \$0 of the first \$500 of Allowable Fees 100% of the next \$1,000 of Allowable Fees (deductible). Only Allowable Fees count toward the deductible; 50% of the next \$6,000 of Allowable Fees</p> <p>Basic Alternative Plan \$0 of the first \$250 of Allowable Fees 100% of the next \$1,250 of Allowable Fees (deductible). Only Allowable Fees count toward the deductible; 50% of the next \$5,500 of Allowable Fees</p> <p>Both Basic Plans \$0 of Allowable Fees over the individual or family out-of-pocket maximum You can use non-Network providers, but it will be more costly</p>	<p>You pay 100% of Allowable Fees until deductible is met \$30/\$50** office visit copay applies after deductible</p>
X-Ray and Lab	<p>20% of Allowable Fees after deductible</p>	<p>20% of Allowable Fees after deductible</p>	<p>20% of Allowable Fees after deductible</p>
Allergy Testing and Treatment	<p>20% of Allowable Fees after deductible Limit of 60 tests every 24 months</p>	<p>20% of Allowable Fees after deductible Limit of 60 tests every 24 months You can use non-Network providers, but it will be more costly</p>	<p>20% of Allowable Fees after deductible Limit of 60 tests every 24 months</p>

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

*Emergency room and office visit copays apply. Coinsurance applies until the out-of-pocket maximum is met.

**The \$30 copay applies to general practitioners, internal medicine physicians, OB/GYNs, pediatricians, physician assistants and nurse practitioners.

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	Aetna INTEGRIS and Aetna St. John HMO	CommunityCare HMO	GlobalHealth HMO
Preventive Services	\$0 copay/PCP	\$0 copay (PCP or specialist)	\$0 copay/PCP/routine physical exam \$50 copay male surgical procedure \$0 copay well-woman exam and preventive services
Well Child Care	\$0 copay	\$0 copay	\$0 copay
Immunizations	\$0 copay ages birth through 18 years \$0 copay ages 19 and older When medically necessary	\$0 copay birth through age 20 years \$0 copay ages 21 and older when appropriate following the recommendation of ACIP	\$0 copay birth through age 18 years \$0 copay ages 19 and older when appropriate following the recommendation of ACIP Office visit copay may apply
Hearing Screening and Hearing Aid	Hearing screening \$0 copay Limit of one per year Hearing aids 20% coinsurance for children up to age 18	Hearing screening \$0 copay when performed by PCP Limit of one per year Hearing aids 20% coinsurance for children up to age 18	Hearing screening \$0 copay children Limit of one per year Hearing aids 20% coinsurance For children up to age 18
Hospital Inpatient	\$250 copay per day \$750 maximum per admission Preauthorization required	\$200 copay per day 5 day maximum (\$1,000) per admission Preauthorization required	\$250 copay per day \$750 maximum per admission
Hospital Outpatient	\$250 copay per visit	\$500 copay per visit	\$250 copay in a preferred facility \$750 copay in a non-preferred facility
Emergency Room	\$200 copay; waived if admitted	\$200 copay; waived if admitted	\$300 copay; waived if admitted
Urgent Care	\$50 copay per visit	\$50 copay per visit	\$25 copay per 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.

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High and High Alternative Plans	HealthChoice Basic and Basic Alternative Plans	HealthChoice HDHP
Preventive Services	\$0 copay for two preventive services office visits per calendar year for members and dependents ages 18 and older One mammogram per year at no charge for women ages 40 and older	\$0 copay for two preventive services office visits per calendar year for members and dependents ages 18 and older One mammogram per year at no charge for women ages 40 and older No deductible for well child care visit	\$0 copay for two preventive services office visits per calendar year for members and dependents ages 18 and older One mammogram per year at no charge for women ages 40 and older
Well Child Care	\$0 copay; no deductible applies	Copays do not apply All covered services, exceptions, limitations and conditions are identical to the HealthChoice High Plan	\$0 copay; no deductible applies
Immunizations	No charge for well child and adult immunizations and administration \$30/\$50** office visit copay may apply	Basic Plan \$0 of the first \$500 of Allowable Fees 100% of the next \$1,000 of Allowable Fees (deductible). Only Allowable Fees count toward the deductible;	No charge for well child and adult immunizations and administration \$30/\$50** office visit copay may apply
Hearing Screening and Hearing Aid	Hearing screening \$30/\$50** copay Limit of one per year Hearing aids Covered as durable medical equipment for children up to age 18 Certification required	50% of the next \$6,000 of Allowable Fees Basic Alternative Plan \$0 of the first \$250 of Allowable Fees 100% of the next \$1,250 of Allowable Fees (deductible). Only Allowable Fees count toward the deductible; 50% of the next \$5,500 of Allowable Fees	Hearing screening \$30/\$50** copay after deductible Limit of one per year Hearing aids Covered as durable medical equipment for children up to age 18 Certification required
Hospital Inpatient	20% of Allowable Fees after deductible Additional \$300 copay per non-Network admission (does not count toward out-of-pocket maximum)	Both Basic Plans \$0 of Allowable Fees over the individual or family out-of-pocket maximum You can use non-Network providers, but it will be more costly.	20% of Allowable Fees after deductible Additional \$300 copay per non-Network admission (does not count toward out-of-pocket maximum)
Hospital Outpatient	20% of Allowable Fees after deductible		20% of Allowable Fees after deductible
Emergency Room	20% of Allowable Fees after deductible Additional \$200 ER copay – waived if admitted		20% of Allowable Fees after deductible Additional \$200 ER copay – waived if admitted
Urgent Care	\$30/\$50** office visit copay may apply 20% of Allowable Fees after deductible		\$30/\$50** office visit copay may apply after deductible 20% of Allowable Fees after deductible

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

**The \$30 copay applies to general practitioners, internal medicine physicians, OB/GYNs, pediatricians, physician assistants and nurse practitioners.

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	Aetna INTEGRIS and Aetna St. John HMO	CommunityCare HMO	GlobalHealth HMO
Maternity Pre and Post Natal Care	\$25 copay for initial visit \$250 copay per day \$750 maximum per admission	\$0 copay for prenatal and postnatal care \$35 copay initial visit \$200 per day, 5 day maximum (\$1,000) per hospital admission Preauthorization required	\$0 copay for prenatal care \$25 copay for delivery and all postnatal care \$500 per hospital admission
Durable Medical Equipment (DME)	20% coinsurance	20% coinsurance	20% coinsurance
Mental Health or Substance Abuse Inpatient	\$250 copay per day \$750 maximum per admission Preauthorization required	\$200 per day 5 day maximum (\$1,000) per hospital admission Preauthorization required	\$250 per day \$750 maximum per admission
Mental Health or Substance Abuse Outpatient	\$50 copay/specialist	\$35 copay	\$0 copay
Occupational or Speech Therapy Visit	No copay inpatient \$50 copay outpatient therapy Limit of 60 days per illness	\$200 copay per day 5 day maximum (\$1,000) per hospital admission Preauthorization required \$50 copay per outpatient therapy visit (up to 60 days treatment per disability)	No copay inpatient \$50 copay per outpatient therapy Limit of 60 visits
Physical Therapy or Physical Medicine Visit	No copay inpatient \$50 copay outpatient therapy Limit of 60 days per illness		
Chiropractic and Manipulative Therapy Visit	\$20 copay Limit of 15 visits per year	\$50 copay Limit 15 visits per year	\$25 copay Limit 15 visits per year

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 NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High and High Alternative Plans	HealthChoice Basic and Basic Alternative Plans	HealthChoice HDHP
Maternity Pre and Post Natal Care	20% of Allowable Fees after deductible Includes one postpartum home visit – criteria must be met	Copays do not apply All covered services, exceptions, limitations and conditions are identical to the HealthChoice High Plan Basic Plan \$0 of the first \$500 of Allowable Fees 100% of the next \$1,000 of Allowable Fees (deductible). Only Allowable Fees count toward the deductible; 50% of the next \$6,000 of Allowable Fees	20% of Allowable Fees after deductible Includes one postpartum home visit – criteria must be met
Durable Medical Equipment (DME)	20% of Allowable Fees after deductible for purchase, rental, repair or replacement		20% of Allowable Fees after deductible for purchase, rental, repair or replacement
Mental Health or Substance Abuse Inpatient	20% of Allowable Fees after deductible No limit on the number of days per year	Basic Alternative Plan \$0 of the first \$250 of Allowable Fees 100% of the next \$1,250 of Allowable Fees (deductible). Only Allowable Fees count toward the deductible; 50% of the next \$5,500 of Allowable Fees	20% of Allowable Fees after deductible No limit on the number of days per year
Mental Health or Substance Abuse Outpatient	20% of Allowable Fees after deductible Limit of 20 services per calendar year without certification	Both Basic Plans \$0 of Allowable Fees over the individual or family out-of-pocket maximum You can use non-Network providers but it will be more costly.	20% of Allowable Fees after deductible Limit of 20 services per calendar year without certification
Occupational or Speech Therapy Visit	20% of Allowable Fees after deductible Occupational therapy* Limit of 20 visits per year without certification Speech therapy* For ages 17 and younger, certification required For ages 18 and older, certification not required *Maximum of 60 visits per year		20% of Allowable Fees after deductible Occupational therapy* Limit of 20 visits per year without certification Speech therapy* For ages 17 and younger, certification required For ages 18 and older, certification not required *Maximum of 60 visits per year
Physical Therapy or Physical Medicine Visit	20% of Allowable Fees after deductible Limit of 20 visits per year without certification Maximum of 60 visits per year		20% of Allowable Fees after deductible Limit of 20 visits per year without certification Maximum of 60 visits per year
Chiropractic and Manipulative Therapy Visit	Chiropractic therapy 20% of Allowable Fees after deductible Limit of 20 visits per year without certification Maximum of 60 visits per year Manipulative therapy Refer to “Physical Therapy/ Physical Medicine” above		Chiropractic therapy 20% of Allowable Fees after deductible Limit of 20 visits per year without certification Maximum of 60 visits per year Manipulative therapy Refer to “Physical Therapy/ Physical Medicine” above

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

*The \$30 copay applies to general practitioners, internal medicine physicians, OB/GYNs, pediatricians, physician assistants and nurse practitioners.

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	Aetna INTEGRIS and Aetna St. John HMO	CommunityCare HMO	GlobalHealth HMO
Pharmacy Benefits	<p>Retail Select generic: \$4 Generic: \$10 Brand: \$30 Non-preferred brand: \$60</p> <p>Mail-order Select generic: \$8 Generic: \$20 Brand: \$60 Non-preferred brand: \$120</p> <p>Specialty Preferred: \$100 Non-preferred: \$200</p>	<p>Retail Preferred Pharmacies (Walgreens and Walmart) Select generic: \$0 Preferred generic: \$15 Preferred brand: \$40* Non-preferred brand or generic: \$70* Specialty: \$160* Non-Preferred Pharmacies (All other network pharmacies) Select generic: \$5 Preferred generic: \$20 Preferred brand: \$50* Non-preferred brand or generic: \$90* Specialty: \$200*</p> <p>Mail-order (90-day supply) Select generic: \$0 Preferred generic: \$45 Preferred brand: \$120* Non-preferred brand or generic: \$210*</p> <p>Mail-Order Specialty (30-day supply) BriovaRx: \$160* Preferred pharmacy copays <i>will apply</i> to prescriptions filled through our mail order service using (Walgreens or Optum) or through BriovaRx for specialty medicines.</p> <p>*If you choose to obtain a brand name drug when a generic equivalent is available, you will pay the applicable copay or coinsurance for the brand name drug, plus the difference in cost between the brand name drug and its generic equivalent.</p> <p>The difference in cost between the brand name drug and its generic equivalent will not count toward your annual out-of-pocket maximum.</p>	<p>Retail Select generic: \$5 Generic: \$10 Brand: \$50 Non-preferred brand: \$75</p> <p>Mail-order Select generic: \$10 Generic: \$20 Brand: \$100 Non-preferred brand: \$150</p> <p>Specialty Preferred: \$100 Non-preferred: \$200</p>

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 NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High, High Alternative, Basic, Basic Alternative and HDHP Plans	
Prescription Medications	30-Day Supply	31- to 90-Day Supply
Generic Drugs	Up to \$10	Up to \$25
Preferred Drugs	Up to \$45	Up to \$90
Non-Preferred Drugs	Up to \$75	Up to \$150
Specialty Drugs*	Generic – \$10 copay Preferred drugs – \$100 copay Non-Preferred drugs – \$200 copay	Copays are for up to a 30-day supply

*Specialty medications are covered only when ordered through the CVS/caremark specialty pharmacy.

HEALTHCHOICE HIGH AND HIGH ALTERNATIVE PLANS

Pharmacy deductible – \$100 for individual (\$300 for family).

HEALTHCHOICE HIGH AND HIGH ALTERNATIVE PLANS AND HIGH DEDUCTIBLE HEALTH PLAN

HealthChoice Preventive Medication List – Medications not subject to pharmacy deductible.

HEALTHCHOICE HIGH, HIGH ALTERNATIVE, BASIC, AND BASIC ALTERNATIVE PLANS

Pharmacy out-of-pocket maximum – \$2,500 for individual (\$4,000 for family) using Preferred products at Network Pharmacies, then you pay \$0 for the rest of the calendar year.

HEALTHCHOICE HDHP

Pharmacy benefits are available only after the combined medical and pharmacy deductible (\$1,500 individual/\$3,000 family) has been met.

ALL HEALTHCHOICE PLANS

All Plan provisions apply. Some medications are subject to prior authorization and/or quantity limits. If you choose a brand-name medication when a generic is available, you are responsible for the difference in the cost in addition to the copay.

HealthChoice covers two 90-day courses of tobacco cessation medications at 100 percent when filled at a Network Pharmacy. Visit the “Be Tobacco-Free” page at www.healthchoiceok.com for details.

CDC vaccinations, such as for shingles, are covered at 100 percent when using a Network Pharmacy. **Note:** These can also be covered under the health benefit if provided by a recognized Network health provider, such as a physician or health department.

COMPARISON OF BENEFITS FOR DENTAL PLANS

	Assurant Employee Benefits Freedom Preferred	Assurant Employee Benefits Heritage Plus and Heritage Secure	CIGNA Dental Care Plan (Prepaid)	Delta Dental PPO In-Network and Out-of-Network	Delta Dental PPO Plus Premier In-Network and Out-of-Network
Annual Deductible	\$25 per person, waived for in-Network preventive services	No deductibles	No deductible or plan maximum \$5 office copay applies	\$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
Diagnostic and Preventive Care (cleanings, routine oral exams) Allowable Fees Apply	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): no charge Periodic oral evaluations: no charge	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)
Basic Care (extractions, oral surgery) Allowable Fees Apply	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	Plan pays 85% of allowable amounts after deductible	Plan pays 70% of allowable amounts after deductible

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.

Some plans may not be available in all areas.

COMPARISON OF BENEFITS FOR DENTAL PLANS

	Delta Dental PPO – Choice PPO Network	HealthChoice Dental	MetLife Classic	MetLife Value MAC	MetLife Value PDP
Annual Deductible	\$100 per person, per year, applies to Major Care only (Level 4)	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	\$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) Allowable Fees Apply	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	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)	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) Allowable Fees Apply	Schedule of covered services and copays Copay example: Amalgam - one surface, primary or permanent tooth \$12	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	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

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. Some plans may not be available in all areas.

COMPARISON OF BENEFITS FOR DENTAL PLANS

	Assurant Employee Benefits Freedom Preferred	Assurant Employee Benefits Heritage Plus and Heritage Secure	CIGNA Dental Care Plan (Prepaid)	Delta Dental PPO In-Network and Out-of-Network	Delta Dental PPO Plus Premier In-Network and Out-of-Network
Major Care (dentures, bridge work) Allowable Fees Apply	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	Plan pays 60% of allowable amounts after deductible	Plan pays 50% of allowable amounts after deductible
Orthodontic Care Allowable Fees Apply	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 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
Plan Year Maximum	\$2,000 per person, per policy year	No annual maximum, per policy year	No plan year dollar 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
Filing Claims	Member/provider must file claims	No claims to file	No claims to file	Claims are filed by participating dentists	Claims are filed by participating dentists

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.

Some plans may not be available in all areas.

COMPARISON OF BENEFITS FOR DENTAL PLANS

	Delta Dental PPO – Choice PPO Network	HealthChoice Dental	MetLife Classic	MetLife Value MAC	MetLife Value PDP
Major Care (dentures, bridge work) Allowable Fees Apply	Schedule of covered services and copays Copoly examples: Crown - porcelain/ceramic substrate \$241 Complete denture – maxillary \$320	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	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 Allowable Fees Apply	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	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	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	\$2,000 per person/year for Diagnostic, Preventive, Basic and Major Care	Network and non-Network: \$2,500 per person, per year	\$5,000, applies to Preventive, Basic and Major Care	\$2,500, applies to Preventive, Basic and Major Care	\$2,500, applies to Preventive, Basic and Major Care
Filing Claims	Claims are filed by participating dentists	Network: No claims to file Non-Network: You file claims	Claims are filed by Network and non-Network dentists	Claims are filed by Network and non-Network dentists	Claims are filed by Network and non-Network dentists

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.

Some plans may not be available in all areas.

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 Per 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 annually	\$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 all contacts; \$210 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**.
For more information or details, contact each vision plan directly.

COMPARISON OF BENEFITS FOR VISION PLANS

Covered Services	Vision Care Direct		Vision Service Plan (VSP)	
	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 Per Pair	\$15 copay Single, bifocals, trifocals and no-line progressive lenses covered in full Anti-reflective, UV and poly-carbonate 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 allowance for conventional and disposable lenses \$250 allowance for medically necessary contacts	\$80 allowance for conventional, disposable and medically necessary contacts	Plan pays up to \$120 conventional or disposable; Medically necessary contacts covered in full	Plan pays up to \$105 conventional or disposable; \$210 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**.
For more information or details, contact each vision plan directly.

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

HMO Plans

Aetna INTEGRIS and Aetna St. John

1-800-459-7791

www.stateofok.aetna.com

CommunityCare

1-800-777-4890 or TDD 1-800-722-0353

state.ccok.com

GlobalHealth, Inc.

1-405-280-5600 or 1-877-280-5600

TDD 711

www.globalhealth.com

HealthChoice

Member Services/Provider Directory

1-405-717-8780 or 1-800-752-9475

TDD 1-405-949-2281 or 1-866-447-0436

www.healthchoiceok.com

Health, Dental and Life Claims, Benefits, Eligibility and ID Cards

1-405-416-1800 or 1-800-782-5218

TDD 1-405-416-1525 or 1-800-941-2160

Pharmacy Claims, Formulary and ID Cards

1-877-720-9375 or TDD 711

American Fidelity Health Services Administration

1-405-523-5699 or 1-866-326-3600

www.afhsa.com

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

1-405-607-2100 or 1-800-522-0188

www.DeltaDentalOK.org

MetLife

1-800-942-0854

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

www.visioncaredirect.com/oklahoma

Vision Service Plan (VSP)

1-800-877-7195 or TDD 1-800-428-4833

www.vsp.com

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