PLAN YEAR
2018

HEALTH | DENTAL | LIFE | VISION

EMPLOYEE BENEFIT

OPTIONS GUIDE

JAN. 1-DEC. 31, 2018

3623

Monthly Premiums for Current Employees

Plan Year Jan. 1 through Dec. 31, 2018

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Aetna HMO	$ 675.62	$ 1,107.78	$ 452.66	$ 452.66
CommunityCare HMO	$ 882.30	$ 1,285.18	$ 449.36	$ 718.98
GlobalHealth HMO	$ 593.36	$ 875.86	$ 320.54	$ 523.44
HealthChoice High and High Alternative	$ 594.90	$ 697.50	$ 299.24	$ 507.80
HealthChoice Basic and Basic Alternative	$ 466.42	$ 547.38	$ 240.54	$ 406.88
HealthChoice High Deductible Health Plan (HDHP)	$ 401.78	$ 471.82	$ 207.52	$ 350.36
DISABILITY (Employee only)	$9.10 (Limited city and county participation only)			

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	$ 39.12	$ 39.12	$ 31.58	$ 81.10
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	$ 7.62	$ 7.58	$ 7.18	$ 14.74
Vision Care Direct	$ 15.90	$ 11.26	$ 11.26	$ 22.74
VSP (Vision Service Plan)	$ 8.02	$ 5.36	$ 5.28	$ 11.58

LIFE

HealthChoice Basic Life ($20,000) $4.00	First $20,000 of Supplemental Life $4.00

SUPPLEMENTAL LIFE — Age Rated Cost Per $20,000 Unit

< 30 ---- $ 1.20	30 - 34 ---- $ 1.20	35 - 39 ---- $ 1.20	40 - 44 ---- $ 1.60
45 - 49 ---- $ 2.80	50 - 54 ---- $ 5.20	55 - 59 ---- $ 8.00	60 - 64 ---- $ 9.20
65 - 69 ---- $ 14.80	70 - 74 ---- $ 25.60	75+ ---- $ 39.20	

DEPENDENT LIFE	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

Dependent Life does not include Accidental Death and Dismemberment (AD&D).

For TRICARE Supplement Plan information for military only, refer to page 5.

TABLE OF CONTENTS

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.

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

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2018 PLAN CHANGES AND IMPORTANT REMINDERS

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

HEALTH PLANS

All HMOs

- The HMO service areas have expanded. Check each plan's ZIP code list for your area.

Aetna INTEGRIS and Aetna St. John HMO

- No copay for outpatient mental health or substance use disorder visit.

CommunityCare HMO

- Hearing aids have a 20 percent coinsurance.
- Maternity prenatal and postnatal care has $0 copay for preventive care; $35 copay for PCP and $50 copay for specialist confirmation visit.

GlobalHealth HMO

- Hearing screenings are covered with $0 copay and must conform to the U.S. Preventive Services Task Force preventive care guidelines. Hearing aids have a 20 percent coinsurance.
- Mental health or substance use disorder: Inpatient: $0 copay for office visit; inpatient copays are for residential treatment centers or medical detox facilities.
- Maternity/delivery inpatient: $500 copay per admission.
- Physical, occupational and speech therapy have a combined limit of 60 visits.

HealthChoice Health Plans

- TRICARE Supplement Plan is available for military personnel. Refer to page 5 for information.
- 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 2018, you will be notified by mail. For a complete list of medications that will no longer be covered, please visit **www.healthchoiceok.com**.

HealthChoice High and High Alternative Plans

- Deductibles are increasing.

High Plan

- $750 individual
- $2,000 family

High Alternative Plan

- $1,000 individual
- $2,750 family

HealthChoice Basic and Basic Alternative Plans

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

HealthChoice High Deductible Health Plan (HDHP)

- Deductibles are increasing.
  - $1,750 individual
  - $3,500 family

- Out-of-pocket maximum is increasing.
  - $6,000 individual
  - $12,000 family
- The HSA maximum annual contribution for an individual is increasing from $3,400 to $3,450.
- The HSA maximum annual contribution for a family is decreasing from $6,900 to $6,850.

VISION PLANS

Superior Vision

- Eye exams and glasses are limited to one per year.
- Frames allowance increased: Network: $150; Non-network: $81.
- Standard contact lenses are covered in full, specialty contacts $50 retail allowance.

Vision Care Direct

- Eye exams: Non-network copay increased to $50.
- Lenses: Network: $40 upgrade fee for anti-reflective, UV and scratch coating on polycarbonate lenses; Non-network: plan allowance increases for single, bifocal, trifocal and progressive no-line lenses.
- Frames: Network: VCD Frame Collection – lens upgrade fee waived; Any frame option – $130 allowance each year, lens upgrade fee optional.
- Laser vision correction: Network: Up to $1,000 off at nJoy facilities in Oklahoma City and Tulsa.

VSP

- Eye exams: Non-network: reimbursed up to $45.
- Lenses: Non-network: plan allowance increases for single, bifocal, trifocal and progressive lenses.
- Frames allowance increased: Network: up to $170 with 20 percent discount on overage; Non-network: up to $70.
- Contact lenses reimbursed up to: Network: $120; Non-network: $105.
- Laser vision correction: Network: average discount of 15 percent.

REMINDER

If you are enrolled in the HealthChoice High or Basic Plan and wish to stay enrolled in that plan, you must complete the online tobacco-free attestation for Plan Year 2018 available at **www.healthchoiceok.com** by Nov. 13, 2017.

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 the High or Basic plan if those that use tobacco complete one of the following alternatives by Nov. 13:

- Show proof of an attempt to quit using tobacco by enrolling in the quit tobacco program available through the Oklahoma Tobacco Helpline (1-800-QUIT-NOW) and Alere Wellbeing and completing three coaching calls.
- Provide a letter from your doctor indicating it is not medically advisable for you or your covered dependents to quit tobacco.

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

IMPORTANT INFORMATION

Beginning Jan. 1, 2018, HealthChoice will have a new claims and certification administrator, HealthSCOPE, for services beginning Jan. 1. You will receive a new HealthChoice ID card for medical and dental services that will include the new contact information.

The current claims administrator will continue to process claims and answer questions until June 30, 2018, when related to services received prior to Jan. 1, 2018.

GENERAL INFORMATION

The benefits you select will be in effect Jan. 1, or for new employees, the effective date of your coverage, through Dec. 31, 2018, or the last day of the month following your termination date.

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

It is your responsibility to review your benefits carefully so you know what is covered before you choose your benefits.

Enrollment in a plan does not guarantee that a provider will remain in your plan's network for the entire year. You enroll with the plan and not the provider. If your provider terminates his or her contract during the plan year, this does not allow you to change your plan carrier.

HEALTH PLANS

There are several health plans available:

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

Refer to Comparison of Network Benefits for Health Plans on pages 16-23 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 or work** 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 11-15 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 2018, 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.

Electing a TRICARE Supplement Plan
(Military only)

NOTE: *If you do not currently have TRICARE coverage as a current or former military member, EGID cannot enroll you in TRICARE coverage, and you are not eligible for the TRICARE Supplement Plan.*
If you currently have TRICARE coverage, you can choose to enroll in the TRICARE Supplement Plan. Electing to purchase the TRICARE Supplement Plan means that TRICARE will be primarily responsible for your medical coverage and the supplement plan will be secondarily responsible for coverage. The plan covers the cost shares and copays, including prescription drugs; a portion of the TRICARE deductible; and excess charges up to the legal limit. By your election, you submit to the eligibility rules of TRICARE and the TRICARE Supplement plan. These rules may be different from the rules of eligibility created by the State of Oklahoma. Medicare may become the primary insurer upon attaining eligibility for Medicare. For more information on the TRICARE Supplement Plan, refer to **https://www.ok.gov/sib/Member/TRICARE_Supplement/index.html**.

DENTAL PLANS

There are several 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 24-27 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 several vision plans available:

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

Refer to Comparison of Benefits for Vision Plans on pages 28-30 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

- As a **new employee**, you can elect life insurance coverage within 30 days of your employment or initial eligibility date. You can enroll in Guaranteed Issue, in addition to Basic Life, without a Life Insurance Application. Guaranteed Issue is two times your annual salary rounded up to the nearest $20,000. All requests for supplemental coverage above Guaranteed Issue require you to submit a Life Insurance Application for approval.
- As a **current employee**, if you did not enroll in life coverage when first eligible, you can enroll:
  - During the annual Option Period (enroll in or increase life coverage); or
  - Within 30 days of a midyear qualifying event, such as birth of a child or marriage by submitting a Life Insurance Application for approval. A Life Insurance Application is available from your insurance coordinator.

As a current employee, you can also enroll in life insurance coverage within 30 days of the loss of other group life coverage. You are eligible to enroll in the amount of coverage you lost rounded up to the next $20,000 unit without submitting a Life Insurance Application for approval. Proof of the loss of other coverage is required.

Basic Life Insurance. . . For You

- Basic Life pays a benefit of $20,000 to your beneficiary in the event of your death.
- Basic Life includes Accidental Death and Dismemberment (AD&D) benefits, which pays an additional $20,000 to your beneficiary if your death is due to an accident. It also pays benefits if you lose your sight or a limb due to an accident.

Supplemental Life Insurance . . . For You

- You can enroll in Supplemental Life in units of $20,000. The maximum amount of Supplemental Life coverage available is $500,000. You must complete and submit a Life Insurance Application, which must be approved before coverage begins.
- The first $20,000 of Supplemental Life provides an additional $20,000 of AD&D benefits.

Beneficiary Designation

For Basic and Supplemental Life benefits, you must name your beneficiary(ies) when you enroll. Your designation can be changed at any time. For a Beneficiary Designation Form or more information, contact your insurance coordinator. This form is also available at **www.healthchoiceok.com**. Life insurance benefits are paid according to the information on file.

Dependent Life Insurance . . . For Your Eligible Dependents

- If you are enrolled in Basic Life insurance, you can elect Dependent Life for your spouse and other eligible dependents during your initial enrollment, the annual Option Period, within 30 days of the loss of other group life insurance or other midyear qualifying event without a Life Insurance Application.
- Each eligible dependent must be enrolled in Dependent Life. Regardless of the number of dependents covered, the monthly premium is a flat amount. Benefits are paid only to the member. Below are the three levels of coverage:

DEPENDENT	LOW OPTION	STANDARD OPTION	PREMIER OPTION
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

Dependent Life does not include AD&D benefits.

HEALTHCHOICE DISABILITY PLAN
(limited city and county participation)

The HealthChoice Disability Plan provides partial replacement income if you are unable to work due to an illness or injury. Disability coverage is not available to dependents.

Eligibility

Enrollment in the disability plan begins the first day of the month following your employment date or the date you become eligible. You become eligible for disability benefits after 31 consecutive days of employment. During that time, you must continuously perform all of the material duties of your regular occupation. Any claim for disability benefits must be filed within one year of the date your disability began. Contact your insurance coordinator for more information.

ENROLLMENT PERIODS

Option Period Enrollment – Coverage effective Jan. 1, 2018

This is the time when eligible employees can:

- Enroll in coverage.
- Change plans or drop coverage.
- Increase or decrease life coverage.
- Add or drop eligible dependents from coverage.

You can enroll in health, dental, life and/or vision coverage for yourself and/or your dependents during the annual Option Period, as long as you have not dropped that coverage within the past 12 months. If you have dropped coverage within the past 12 months without a midyear qualifying event, you cannot reinstate that coverage for at least 12 months.

Initial Enrollment – Coverage effective the first of the month following your employment date or the date set by your employer

This is the time when new employees are eligible to:

- Enroll in coverage.
- Enroll eligible dependents.
- Apply for life insurance coverage above Guaranteed Issue by submitting a Life Insurance Application for review and approval.

As a new employee, you have 30 days from your employment or eligibility date to enroll in coverage. If you do not enroll within 30 days, you cannot enroll until the next annual Option Period, unless you experience a qualifying event. Check with your insurance coordinator for more information.

You have 30 days following your eligibility date to make changes to your original enrollment.

HIPAA Special Enrollment Rights – Coverage generally effective the first of the month following a qualifying event

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your insurance coordinator.

Midyear Changes – Coverage generally effective the first of the month following a qualifying event

Midyear plan changes are allowed only when a qualifying event, such as birth, marriage or loss of other group coverage, occurs. You must complete the appropriate form within 30 days of the event. Contact your insurance coordinator for more information.

ELIGIBILITY

Members

- Your employer must participate in the plans offered through EGID.
- You must be a current education employee eligible to participate in the Oklahoma Teachers Retirement System working a minimum of four hours per day or 20 hours per week, or a current local government or other eligible employee regularly scheduled to work at least 1,000 hours a year, and not classified as temporary or seasonal, or a city employee.
- You must be enrolled in a group health plan to enroll in dental and/or life insurance.

Dependents

- If one eligible dependent is covered, all eligible dependents must be covered. Exceptions apply (refer to Excluding Dependents from Coverage in this section).
- 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 and approval 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.

- Dependents who are not enrolled within 30 days of your eligibility date cannot be enrolled until the next annual Option Period, unless a qualifying event such as birth, marriage or loss of other group coverage occurs. Dependent coverage can be dropped midyear with a qualifying event. If you drop dependent coverage without a qualifying event, you cannot reinstate coverage for at least 12 months.
- Dependents can be enrolled only in the same types of coverage and in the same plans you elect.
- To enroll your newborn, the appropriate form must be provided to your insurance coordinator within 30 days of the birth. This coverage is effective the first of the birth month. If you do not enroll your newborn during this 30-day period, you cannot 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 cesarean 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 enrollment or change form. Check with your insurance coordinator for more information.
- 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 your insurance coordinator when excluding a dependent for that reason.

Confirmation Statements

- You are mailed a Confirmation Statement (CS) when you enroll or make changes to your coverage. Your CS lists the coverage you are enrolled in, the effective date of your coverage and the premium amounts.
- Always review your CS to verify your coverage is correct. Corrections to your coverage must be submitted to your insurance coordinator within 60 days of your election. Corrections reported after 60 days are effective the first of the month following notification.
- **Section B of your Option Period Enrollment/Change Form lists your most current coverage.** If you don't make changes and you are not automatically enrolled in one of the HealthChoice Alternative Plans, you will not receive a CS from EGID. Keep a copy of your Option Period Enrollment/Change Form as verification of your coverage.

Transfer Employee

- You can keep your coverage continuous when you move from one participating employer to another as long as there is no break in coverage that lasts longer than 30 days. Premiums must be paid upon reporting to work.
- Benefit options vary from employer to employer. Changes to your coverage must be made within the first 30 days of your transfer. Contact your insurance coordinator for more information.

Retiring and Changing Plans

If you are retiring on or before Jan. 1, go to **www.healthchoiceok.com** for the appropriate Option Period materials. Select the Option Period banner, then select according to your status as of Jan. 1 – Pre-Medicare or Medicare. Your insurance coordinator can assist you and must also provide you the required Application for Retiree/Vested/Non-Vested/Defer Insurance. If you or your dependents will be Medicare eligible by Jan. 1, an additional form will be required to enroll in one of the HealthChoice Medicare Supplement plans or a Medicare Advantage Part D (MA-PD) plan. You can also call EGID for assistance. Refer to Contact Information at the back of this guide.

Termination of Coverage

- Coverage will end the last day of the month in which a termination event occurs, such as:
  - Loss of employment.
  - Reduction in hours.
  - Loss of dependent eligibility.
  - Non-payment of premiums.
  - Death.

COBRA – Temporary Continuation of Coverage

- The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows you and/or your covered dependents to continue health, dental and/or vision insurance coverage after your employment terminates or after your dependent loses eligibility. Certain time limits apply to enrollment. Contact your insurance coordinator immediately upon termination of your employment, or when changes to your family status occur, to find out more about your COBRA rights. **Be aware, dropping dependent coverage during Option Period is not a COBRA qualifying event.**

THRIVE: OKLAHOMA EMPLOYEE WELL-BEING

Thrive is the name and inspiration behind the well-being program. Our vision is for every member's well-being to be valued and to empower members to be fearless, valued, and engaged. Thrive does this by standing behind our core pillars of purpose, social, financial, physical, community and emotional well-being.

Thrive provides members and their families with information and opportunities to learn, grow and enrich their lives. It's our journey and our promise to help members cultivate excellence and, in short, Thrive.

Thrive Well-Being Toolkits

Thrive toolkits are monthly well-being initiatives filled with information, suggested activities and promotional materials centered on well-being topics that support Thrive's six elements. The toolkits are available on our website at **thrive.ok.gov**. You can also contact us with questions at thrive@omes.ok.gov.

Aetna INTEGRIS ZIP Code List

73003	73007	73008	73012	73013	73014	73019
73020	73022	73025	73026	73034	73036	73037
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	74857

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		

CommunityCare ZIP Code List

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	74032	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	74079	74080	74081
74082	74083	74084	74085	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	74521	74522	74523	74526	74528	74529
74536	74540	74543	74545	74546	74547	74548
74549	74552	74553	74554	74557	74558	74559
74560	74561	74562	74563	74565	74567	74570
74571	74574	74576	74577	74578	74604	74633
74637	74650	74651	74652	74722	74724	74727
74728	74734	74735	74736	74737	74738	74740
74743	74745	74750	74752	74754	74755	74756
74759	74760	74761	74764	74766	74839	74845
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	74966			

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
73094	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	73193	73194	73195	73196	73197	73198
73199	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	73727	73728

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GlobalHealth ZIP Code List

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	74014	74015
74016	74017	74018	74019	74020	74021	74022
74023	74026	74027	74028	74029	74030	74031
74032	74033	74034	74035	74036	74037	74038
74039	74041	74042	74043	74044	74045	74046
74047	74048	74050	74051	74052	74053	74054
74055	74056	74058	74059	74060	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	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	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
74542	74543	74545	74546	74547	74549	74552

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GlobalHealth ZIP Code List

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	74820	74821	74824	74825
74826	74827	74829	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	74966			

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 Testing covered at 100% per series	$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	**High Plan** **$750 individual** **$2,000 family** (3 or more) **High Alternative Plan** **$1,000 individual** **$2,750 family** (3 or more)	**Basic Plan** $1,000 individual $1,500 family (2 or more) Applies after plan pays first $500 of allowable fees **Basic Alternative Plan** $1,250 individual $1,750 family (2 or more) Applies after plan pays first $250 of allowable fees	**$1,750 individual** **$3,500 family** (2 or more) 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
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)**	**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 **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	**Basic Plan** $4,000 individual $9,000 family **Basic Alternative Plan** $4,000 individual $9,000 family	**$6,000 individual** **$12,000 family** (2 or more) The individual out-of-pocket does not apply if two or more family members are covered Pharmacy copays apply to the out-of-pocket maximum but non-network charges do not apply
Office Visit	$30 copay/physician office visit** $50 copay/specialist office visit	**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 **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 **Both Basic Plans** $0 of allowable fees over the individual or family out-of-pocket maximum If using non-network providers, you pay costs above allowable fees Copays do not apply All covered services, limitations and conditions are identical to the HealthChoice High Plan	You pay 100% of allowable fees until deductible is met $30/$50** office visit copay applies after deductible
X-Ray and Lab	20% of allowable fees after deductible		20% of allowable fees after deductible
Allergy Testing and Treatment	20% of allowable fees after deductible Limit of 60 tests every 24 months		20% of allowable fees after deductible Limit of 60 tests every 24 months

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 $0 copay well-woman exam and preventive services
Well Child Care	$0 copay	$0 copay	$0 copay per well-child visit
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 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**	**Hearing screening** **$0 copay** Limit of one per year **Must conform to the USPSTF preventive care guidelines** **Hearing aids** **20% coinsurance**
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 **$500 copay per admission for maternity/delivery**
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; excludes 3D mammogram	$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; excludes 3D mammogram No deductible for well child care visit **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 **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 **Both Basic Plans** $0 of allowable fees over the individual or family out-of-pocket maximum If using non-network providers, you pay costs above allowable fees Copays do not apply All covered services, limitations and conditions are identical to the HealthChoice High Plan	$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; excludes 3D mammogram
Well Child Care	$0 copay; no deductible applies		$0 copay; no deductible applies
Immunizations	No charge for well child and adult immunizations and administration $30/$50** office visit copay may apply		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		**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, non-emergency admission (does not count toward out-of-pocket)		20% of allowable fees after deductible Additional $300 copay per non-network, non-emergency admission (does not count toward out-of-pocket)
Hospital Outpatient	20% of allowable fees after deductible		20% of allowable fees after deductible
Emergency Room	20% of allowable fees after deductible $200 ER copay – waived if admitted		20% of allowable fees after deductible $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 **preventive** prenatal and postnatal care **$35 copay/PCP or $50 copay/specialist for confirmation 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 Use Disorder Inpatient	$250 copay per day $750 maximum per admission Preauthorization required	$200 per day 5 day maximum ($1,000) per hospital admission Preauthorization required	**$0 copay/office visit** **Residential Treatment Center or medical detox** $250 per day $750 maximum per admission
Mental Health or Substance Use Disorder Outpatient	**$0 copay**	$35 copay	$0 copay per visit
Occupational or Speech Therapy Visit	No copay inpatient, included in inpatient hospital cost $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 combined physical therapy, occupational therapy and speech therapy visits**
Physical Therapy or Physical Medicine Visit	No copay inpatient, included in inpatient hospital cost $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	$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	**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 **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 **Both Basic Plans** $0 of allowable fees over the individual or family out-of-pocket maximum If using non-network providers, you pay costs above allowable fees Copays do not apply All covered services, limitations and conditions are identical to the HealthChoice High Plan	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 Use Disorder Inpatient	20% of allowable fees after deductible No limit on the number of days per year		20% of allowable fees after deductible No limit on the number of days per year
Mental Health or Substance Use Disorder Outpatient	20% of allowable fees after deductible Limit of 20 services per calendar year without certification		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	**Retail** Select generic: $4 Generic: $10 Brand: $30 Non-preferred brand: $60 **Mail-order** Select generic: $8 Generic: $20 Brand: $60 Non-preferred brand: $120 **Specialty** Preferred: $100 Non-preferred: $200	**Retail** **(30-day supply)** 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* **Mail-order** (90-day supply) Select generic: $0 Preferred generic: $45 Preferred brand: $120* Non-preferred brand or generic: $210* **Mail-Order Specialty** (30-day supply) BriovaRx: $160* Preferred pharmacy copays will apply to prescriptions filled through our mail order service using Walgreens or Optum or through BriovaRx for specialty medicines. *If you choose to obtain a brand name drug when a generic is available, you 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. The difference in cost between the brand name drug and its generic equivalent will not count toward your annual out-of-pocket maximum.	**Retail** Select generic: $5 Generic: $10 Brand: $50 Non-preferred brand: $75 **Mail-order** Select generic: $10 Generic: $20 Brand: $100 Non-preferred brand: $150 **Specialty** Preferred: $100 Non-preferred: $200

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 The applicable pharmacy deductible must be met before pharmacy copays apply. Refer to the bottom of the page for more details.	
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, HIGH ALTERNATIVE, BASIC, AND BASIC ALTERNATIVE PLANS

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

Pharmacy out-of-pocket maximum – $2,500 for individual ($4,000 for family), then you pay $0 for preferred products at network pharmacies for the rest of the calendar year.

HEALTHCHOICE HDHP

Pharmacy benefits are available only after the combined medical and pharmacy deductible ($1,750 individual/$3,500 family) has been met.

ALL HEALTHCHOICE PLANS

HealthChoice Preventive Medication List – These medications are not subject to pharmacy deductible.

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.

Amounts paid by Copay Assistance programs, Manufacturer Copay Cards, or other third parties do not apply toward deductibles or out-of-pocket maximums.

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.

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 individual/$75 family, Basic and Major services combined Non-network: $25 individual/$75 family, 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.

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.

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 Copay 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.

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 **Limit one exam**	Plan pays up to: $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 **Limit one pair per calendar year**	Plan pays up to: $26 Single $39 Bifocals $49 Trifocals $49 Standard Progressive $78 Lenticular
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 **$150** retail Limit one per calendar year	Plan pays up to **$81**
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	$25 copay for lens fitting Plan pays up to $120 retail allowance After exam copay, medically necessary contacts covered in full **Standard contacts covered in full; Specialty contacts $50 retail allowance**	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, 2018	No benefit	Discount available	**Discount available**

Plan changes are indicated by **bold text**.
For more information or details, contact each vision plan directly.

COMPARISON OF BENEFITS FOR VISION PLANS

	Vision Care Direct		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 **$50**	$10 copay	**Reimbursed up to $45**
Lenses Per Pair	$15 copay Single vision, bifocals, trifocals and progressive no-line lenses covered in full; **Look for PLUS plan providers** **Optional $40 upgrade fee for anti-reflective, UV and scratch coating on polycarbonate lenses**	Plan pays up to: **$50 single** **$60 bifocals** **$100 trifocals** **$100 progressive no-line**	Covered in full after $25 materials copay	**Reimbursed up to:** **Single $30** **Bifocals up to $50** **Trifocals up to $65** **Progressive $50**
Frames	$0 copay for frames **VCD Frame Collection - lens upgrade fee waived** **Any Frame Option - $130 allowance each year, lens upgrade fee optional**	Plan pays up to **$60**	**Covered in full up to $170** **20% discount on any overage**	**Reimbursed up to $70**
Contact Lenses	$130 allowance for conventional and disposable lenses $250 allowance for medically necessary contacts	$80 allowance for conventional, disposable and medically necessary contacts	**$120 allowance, in lieu of glasses**	**Reimbursed up to $105**
Laser Vision Correction	**Up to $1,000 off at nJoy facilities in Oklahoma City and Tulsa**	No benefit	**Average discount of 15%**	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 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: We are an Oklahoma-owned and operated company. We offer 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 lens upgrade 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 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. VSP members can now use and integrate their benefits online, via eyeconic.com. Oklahoma enrollees can virtually try on each pair in the extensive catalog of glasses and sunglasses. Members can order glasses and contacts while using their VSP benefit. In addition to your VSP vision insurance, any additional savings will automatically be applied at the time of purchase. Frames can be sent directly to your door, or your provider's office for a final fitting, adjustment, and confirmation you are completely satisfied.

Contact Information

Health Plans

Aetna INTEGRIS and Aetna St. John

800-459-7791
www.stateofok.aetna.com

CommunityCare

800-777-4890 or TDD 800-722-0353
state.ccok.com

GlobalHealth, Inc.

405-280-5600 or 877-280-5600
TDD 711
www.globalhealth.com

HealthChoice

Medical

405-416-1800 or 800-782-5218
TDD 405-416-1525 or 800-941-2160

Pharmacy

877-720-9375
TDD 711
www.healthchoiceok.com

Life Insurance

HealthChoice

405-416-1800 or 800-782-5218
TDD 405-416-1525 or 800-941-2160
www.healthchoiceok.com

Additional

EGID

405-717-8780 or 800-752-9475
TDD 405-949-2281 or 866-447-0436
www.sib.ok.gov

American Fidelity Health Services Administration

405-523-5699 or 866-326-3600
www.afhsa.com

Dental Plans

Assurant Inc. Dental

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

CIGNA Prepaid Dental

800-244-6224
Hearing Impaired Relay 800-654-5988
www.cigna.com

Delta Dental

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

HealthChoice

405-416-1800 or 800-782-5218
TDD 405-416-1525 or 800-941-2160
www.healthchoiceok.com

MetLife

855-676-9443
www.metlife.com/oklahoma
www.metlife.com/mybenefits

Vision Plans

Primary Vision Care Services (PVCS)

888-357-6912 or TDD 800-722-0353
www.pvcs-usa.com

Superior Vision

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

Vision Care Direct

877-488-8900 or TDD 877-488-8900
www.visioncaredirect.com/oklahoma

VSP

800-877-7195 or TDD 800-428-4833
www.vsp.com

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