Employee Benefit Options Guide

Plan Year 2016

Jan. 1 through Dec. 31, 2016

3292

Monthly Premiums for Current Employees

Plan Year Jan. 1 through Dec. 31, 2016

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Aetna INTEGRIS HMO	$ 515.82	$ 845.76	$ 271.72	$ 433.22
BlueLincs HMO	$ 595.34	$ 976.40	$ 313.76	$ 500.18
CommunityCare HMO	$ 796.14	$ 1,159.68	$ 405.48	$ 648.78
GlobalHealth HMO	$ 499.76	$ 737.68	$ 269.98	$ 440.86
HealthChoice High and High Alternative	$ 526.88	$ 661.22	$ 267.50	$ 412.72
HealthChoice Basic and Basic Alternative	$ 397.82	$ 488.38	$ 227.82	$ 351.14
HealthChoice High Deductible Health Plan (HDHP)	$ 345.86	$ 421.76	$ 197.08	$ 302.92
HealthChoice USA	$ 806.48	$ 806.48	$ 264.86	$ 408.46

DISABILITY (Employee only)	$9.10 (Limited county participation only)

DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Assurant Freedom Preferred	$ 28.82	$ 28.66	$ 21.50	$ 57.80
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)	$ 9.26	$ 6.06	$ 7.08	$ 15.32
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	$ 32.00	$ 32.00	$ 27.40	$ 68.20

VISION PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Humana Vision Care Plan	$ 7.14	$ 12.46	$ 10.90	$ 11.84
Primary Vision Care Services (PVCS)	$ 9.36	$ 8.00	$ 8.00	$ 11.00
Superior Vision	$ 7.40	$ 7.36	$ 6.96	$ 14.30
UnitedHealthcare Vision	$ 8.18	$ 5.78	$ 4.58	$ 6.98
Vision Care Direct	$ 15.90	$ 9.74	$ 9.74	$ 13.00
Vision Service Plan (VSP)	$ 9.50	$ 6.36	$ 6.12	$ 13.72

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).

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Contact Information .... inside back cover

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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INTRODUCTION

NEW LOGO

As a result of legislation passed in 2011, the Oklahoma State and Education Employees Group Insurance Board that administered insurance benefits for education, local government and other eligible employees was consolidated under the Office of State Finance, now known as the Office of Management and Enterprise Services (OMES). The former state agency is now a department of the Office of Management and Enterprise Services Human Capital Management and is known as the Employees Group Insurance Department (EGID).

In an effort to develop the consistent, cohesive identity, key to any organization's success, OMES adopted a new logo as seen below and on the front cover of this guide. The logo's dominant element, the "O", represents the agency's connectivity and collaborative spirit. The feathers on the "O" are inspired by the feathers on Oklahoma's state flag and the scissortail flycatcher, Oklahoma's state bird known – as OMES is – for its resourcefulness and tenacity. The logo's clean, modern, progressive design embodies our status as a technology-driven, forward-thinking agency. In the future, you will see the OMES logo or its slimmer sibling, the "O", on all EGID communications.

2016 PLAN CHANGES AND IMPORTANT REMINDERS

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

HEALTH PLANS

Aetna INTEGRIS HMO – New for 2016

- Aetna INTEGRIS HMO is being offered for 2016. It is not just a new medical plan, but a whole new way of looking at health care. The plan is designed to improve the quality of your care, provide a better experience for you and your family, and do it all while saving you money.

  Aetna INTEGRIS HMO offers the INTEGRIS Health Partners Network, a special group of local primary care providers, specialists, hospitals and other health professionals who share the responsibility for your health. Refer to "HMO ZIP Code List" and "Comparison of Network Benefits for Health Plans" for more information. Visit Aetna INTEGRIS HMO's website at **www.aetna.com/integris/stateofok** for participating providers.

BlueLincs HMO – New for 2016

- BlueLincs HMO is being offered for 2016. Its ZIP code service area encompasses the entire State of Oklahoma, and its network currently includes 1,266 primary care physicians, 3,252 specialists and 73 acute care hospitals.

  BlueLincs HMO also offers out-of-area coverage to members when they live, work or travel outside of the HMO service area. The out-of-area coverage program consists of two components: Urgent Care and Guest Membership®. The Urgent Care component enables members to receive care for an unexpected illness or injury when they are outside of Oklahoma. Guest Membership is available to BlueLincs HMO members temporarily living outside of their home state for at least 90 consecutive days. Guest Membership coverage is helpful for covered students who are living out-of-state while attending school or for members on extended travel out-of-state. Refer to "HMO ZIP Code List" and "Comparison of Network Benefits for Health Plans" for more information. Visit BlueLincs HMO's website at **www.bcbsok.com/state** for participating providers.

CommunityCare HMO

- CommunityCare is expanding its service area. Refer to "HMO ZIP Code List" to determine if you live or work in their area.
- Some copays are increasing and others are decreasing. Changes are listed in bold text in "Comparison of Network Benefits for Health Plans."

GlobalHealth HMO

- Some copays are decreasing. Changes are listed in bold text in "Comparison of Network Benefits for Health Plans."
- Copays for select generic medications are changing to $5.

HealthChoice Health Plans

- HealthChoice has a new pharmacy benefit manager (PBM), CVS/caremark. All current and new HealthChoice health plan members will receive new pharmacy ID cards.

  With the transition to the new PBM, there will be little change to the pharmacies participating in the HealthChoice Pharmacy Network. All major chains, such as CVS, Target, Walgreens, Walmart, etc., as well as local independent pharmacies, will continue to be part of the Network.

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 2016, you will be notified by mail. For a complete list of medications that will no longer be covered, please visit **www.sib.ok.gov**.

If you currently have a prior authorization for a medication, it will transfer to the new PBM.

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

- HealthChoice is introducing the HealthChoice Bundled Select Network. This special network of facilities will provide certain services to members at one low, bundled price that will be covered at 100% with no out-of-pocket costs to members.

  Initially, only colonoscopy and sigmoidoscopy services will be offered by the HealthChoice Bundled Select Network. To encourage members to get these colorectal cancer screenings and use the Bundled Select Network, HealthChoice will provide a $100 incentive payment to members once per calendar year.

  Beginning Jan. 1, 2016, for the most current list of facilities participating in the HealthChoice Bundled Select Network and the most current list of procedures covered under bundled pricing, select “Find a Provider” in the top menu bar of the HealthChoice website at **www.sib.ok.gov**; select “Medical and Dental Providers” under “HealthChoice Provider Listings,” and then choose “Select Network” from the top menu bar.
- HealthChoice is covering two preventive services office visits per calendar year for members and dependents ages 18 and older at 100% when using a HealthChoice Network Provider.

HealthChoice High Deductible Health Plan

- The maximum annual contribution for a family is increasing from $6,650 to $6,750.

VISION PLANS

Vision Care Direct

- The allowance for frames and conventional and disposable contact lenses is decreasing to $130.

REMINDER

If you are enrolled in the HealthChoice High or Basic plan and wish to stay enrolled in that plan for 2016, you must complete the online tobacco-free Attestation for Plan Year 2016 available on the HealthChoice website at **www.sib.ok.com** by Nov. 13, 2015.

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 complete the tobacco-free Attestation because you or your covered adult dependents are not tobacco-free, you can still qualify for the HealthChoice High or Basic Plan if you can complete one of the following Reasonable 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 Nov. 13, 2015; or
- Provide a letter from your doctor by Nov. 13, 2015, 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 as defined on the previous page, you will automatically be enrolled in the HealthChoice High Alternative or Basic Alternative Plan effective Jan. 1, 2016, and your annual deductible will be $250 higher.

GENERAL INFORMATION

The benefits you select will be in effect Jan. 1, 2016, or for new employees, the effective date of your coverage, through Dec. 31, 2016, or your termination date if earlier.

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.

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 ten health plans available:

- Aetna INTEGRIS HMO
- BlueLincs HMO
- CommunityCare HMO
- GlobalHealth HMO
- HealthChoice High and High Alternative Plans
- HealthChoice Basic and Basic Alternative Plans
- HealthChoice HDHP
- HealthChoice USA Plan

Refer to "Comparison of Network Benefits for Health Plans" on pages 18-25 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 10-17 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 2016, you must complete the tobacco-free Attestation located on the HealthChoice website or a Reasonable Alternative.
- The HealthChoice USA Plan is designed for employees who receive work assignments of more than 90 consecutive days outside of Oklahoma and Arkansas. HealthChoice USA members have access to the ChoiceCare Network, one of the largest provider networks in the country.
- 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 eight 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

Refer to "Comparison of Benefits for Dental Plans" on pages 26-27 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.

VISION PLANS

There are six vision plans available:

- Humana Vision Care Plan
- Primary Vision Care Services (PVCS)
- Superior Vision
- UnitedHealthcare Vision
- Vision Care Direct
- Vision Service Plan (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 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.sib.ok.gov**. 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 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, 2016

This is the time when eligible employees can:

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

♦ You can enroll in health, dental, life and/or vision coverage for yourself and/or your dependent(s) 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; and
- 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.
- 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; and
  - 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:
  - BlueLincs and 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 INTEGRIS, 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, 2016, go to **www.sib.ok.gov** 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 and/or your dependent(s) will be Medicare eligible by Jan. 1, an additional form will be required to enroll in Medicare Part D. You can also call EGID Member Services 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; or
  - 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.**

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

BlueLincs ZIP Code List

73001	73002	73003	73004	73005	73006	73007
73008	73009	73010	73011	73012	73013	73014
73015	73016	73017	73018	73019	73020	73021
73023	73024	73025	73026	73027	73028	73029
73030	73031	73032	73033	73034	73036	73038
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	73076
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	73152	73165
73167	73169	73170	73172	73173	73179	73189
73195	73196	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	73537	73538	73539	73540	73541	73542
73543	73544	73546	73547	73548	73549	73550
73551	73552	73553	73554	73555	73556	73557
73559	73560	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	73716	73717	73718	73719	73720
73722	73724	73726	73727	73728	73729	73730
73731	73733	73734	73735	73736	73737	73738

BlueLincs ZIP Code List

73739	73741	73742	73743	73744	73747	73749
73750	73753	73754	73755	73756	73757	73758
73759	73760	73761	73762	73763	73764	73766
73768	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
74005	74006	74008	74010	74011	74012	74013
74014	74015	74016	74017	74018	74019	74020
74021	74022	74023	74026	74027	74028	71029
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
74119	74120	74126	74127	74128	74129	74130
74131	74132	74133	74134	74135	74136	74137
74145	74146	74147	74148	74149	74150	74152
74153	74155	74156	74157	74158	74159	74169
74170	74182	74301	74330	74331	74332	74333
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	74369	74370	74401
74402	74403	74421	74422	74423	74425	74426
74427	74428	74429	74430	74431	74432	74434
74435	74436	74437	74438	74441	74442	74444
74445	74446	74447	74450	74451	74452	74454
74455	74456	74457	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
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

BlueLincs ZIP Code List

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						

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	74033	74034
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74043	74044	74045	74046	74047	74048	74050
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74060	74061	74063	74066	74067	74068	74070
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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	74521	74522
74523	74526	74528	74529	74536	74543	74545
74546	74547	74548	74549	74552	74553	74554
74557	74558	74559	74560	74561	74562	74563
74565	74567	74571	74574	74577	74578	74604
74633	74637	74650	74652	74722	74724	74727
74728	74734	74735	74736	74737	74738	74740
74743	74745	74750	74752	74754	74755	74756
74759	74760	74761	74764	74766	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				

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
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73037	73038	73040	73041	73042	73043	73044
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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	73177	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

GlobalHealth ZIP Code List

73726	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	74014	74015	74016	74017	74018	74019
74020	74021	74022	74023	74026	74027	74028
74029	74030	74031	74032	74033	74034	74035
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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	74150	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	74477	74501	74521	74522	74523
74525	74528	74529	74530	74531	74533	74534
74535	74536	74538	74540	74543	74545	74546

GlobalHealth ZIP Code List

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	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 HMO	BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Calendar Year Deductible	No 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	$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	$35 copay/PCP $50 copay/ specialist	**$0** copay/PCP $50 copay/specialist
X-Ray and Lab	$0 copay for X-ray and lab $0 copay per MRI, CAT, MRA or PET scan	$0 copay for X-ray and lab; $200 copay per scan for FOCUS Procedures (MRI, CT, PET, EEG, echocardiogram, MPS, and similar imaging tests; and procedures under CPTs of cytogenetic studies, surgical pathology or transcutaneous procedures	$0 copay for X-ray and lab $200 copay per scan Specialty scans: MRI, MRA, PET, CAT and nuclear scans	$0 copay for X-ray and lab $250 copay per scan in a free-standing/ low-cost facility $750 copay per scan in a hospital 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 copay for allergy serum and shots (once every 6 weeks)	$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, High Alternative and USA Plans	HealthChoice Basic and Basic Alternative Plans	HealthChoice HDHP
Calendar Year Deductible	**High and USA Plans** $500 individual $1,500 family **High Alternative Plan** $750 individual $2,250 family	**Basic Plan** $1,000 individual $1,500 family Applies after Plan pays first $500 of Allowable Fees **Basic Alternative Plan** $1,250 individual $1,750 family Applies after Plan pays first $250 of Allowable Fees	$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
Calendar Year Out-of-Pocket Maximum **(High, High Alternative, Basic, Basic Alternative and USA Plans have a separate pharmacy out-of-pocket maximum, refer to page 25)**	**High and USA Plans*** 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	$3,000 individual $6,000 family 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	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 **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 You can use non-Network providers, but it will be more costly	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

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

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	Aetna INTEGRIS HMO	BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Preventive Services	$0 copay/PCP	$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	$0 copay ages 0-21
Immunizations	$0 copay ages birth through age 18 years $0 copay ages 19 and over When medically necessary	$0 copay ages birth through age 18 years $0 copay ages 19 and over When medically necessary	$0 copay birth through age **20** years $0 copay ages **21** and over when appropriate following the recommendation of ACIP	$0 copay birth through age 18 years $0 copay ages 19 and over 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 per visit **Audiological services and hearing aids** Limited to one hearing aid per ear every 48 months up to age 18; up to four additional ear molds per benefit period up to 2 years of age	**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 birth – age 21 $25 copay ages 22 and over 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	$100 copay per day $800 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	$200 copay per visit	**$500** copay per visit	$250 copay in a free-standing/low-cost facility $750 copay in a hospital facility
Emergency Room	$200 copay; waived if admitted	$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	$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, High Alternative and USA 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 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 **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 You can use non-Network providers, but it will be more costly.	$0 copay for **two** preventive services office visits per calendar year for members and dependents ages 20 and older One mammogram per year at no charge for women ages 40 and older
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 admission (does not count toward out-of-pocket maximum)		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 $100 ER copay – waived if admitted		20% of Allowable Fees after deductible Additional $100 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

**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

<table>
<tr><th>Your Costs for Network Services</th><th>Aetna INTEGRIS HMO</th><th>BlueLincs HMO</th><th>CommunityCare HMO</th><th>GlobalHealth HMO</th></tr>
<tr><td>Maternity Pre and Post Natal Care</td><td>$25 copay for initial visit
$250 copay per day
$750 maximum per admission</td><td>$35 copay for initial visit
$100 copay per day
$800 maximum per inpatient hospital admission</td><td>$0 copay for prenatal and postnatal care
$35 copay initial visit
$200 per day, 5 day maximum ($1,000) per hospital admission
Preauthorization required</td><td>$0 copay for prenatal care
$25 copay for delivery and all postnatal care
$500 per hospital admission</td></tr>
<tr><td>Durable Medical Equipment (DME)</td><td>20% coinsurance</td><td>20% coinsurance</td><td>20% coinsurance</td><td>20% coinsurance</td></tr>
<tr><td>Mental Health or Substance Abuse Inpatient</td><td>$250 copay per day
$750 maximum per admission
Preauthorization required</td><td>$100 copay per day
$800 maximum per admission
Preauthorization required</td><td>$200 per day
5 day maximum ($1,000) per hospital admission
Preauthorization required</td><td>$250 per day
$750 maximum per admission
Must be preauthorized by MHNet</td></tr>
<tr><td>Mental Health or Substance Abuse Outpatient</td><td>$50 copay/specialist</td><td>$35 copay/PCP/ specialist</td><td>$35 copay</td><td>$0 copay
Must be preauthorized by MHNet</td></tr>
<tr><td>Occupational or Speech Therapy Visit</td><td>No copay inpatient
$50 copay outpatient therapy
Limit of 60 days per illness</td><td rowspan="2">No copay inpatient
$35 copay outpatient therapy
Limit of 60 outpatient visits combined per year for physical, occupational, speech and chiropractic therapy visits</td><td rowspan="2">$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)</td><td rowspan="2">No copay inpatient
$50 copay per outpatient therapy

Limit of 60 visits</td></tr>
<tr><td>Physical Therapy or Physical Medicine Visit</td><td>No copay inpatient
$50 copay outpatient therapy
Limit of 60 days per illness</td></tr>
<tr><td>Chiropractic and Manipulative Therapy Visit</td><td>$20 copay
Limit of 15 visits per year</td><td>$35 copay
Limit of 60 outpatient visits per year for physical, occupational or speech therapy, and chiropractic visits</td><td>$50 copay
Limit 15 visits per year</td><td>$25 copay
Limit 15 visits per year</td></tr>
</table>

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 and USA 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 **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 You can use non-Network providers but it will be more costly.	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		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 15 services per calendar year without certification		20% of Allowable Fees after deductible Limit of 15 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

**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 HMO	BlueLincs 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** Preferred generic: $0 Non-preferred generic: $10 Preferred brand: $40 Non-preferred brand: $80 **Mail-order** Prefered generic: $0 Non-preferred generic: $25 Preferred brand: $100 Non-preferred brand: $200 **Specialty** Preferred or Non-preferred: $100	**Retail** Select generic: $0 Generic: $10 Brand: $40 Non-preferred brand: $65 **Mail-order** Select generic: $0 Generic: $30 Brand: $120 Non-preferred brand: $195 **Specialty** Preferred or Non-preferred: $100	**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, HDHP and USA 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*	Preferred drugs – $100 copay Non-Preferred drugs – $200 copay	Copays are up to a 30-day supply

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

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

Pharmacy out-of-pocket maximum – $2,500 per person ($4,000 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% when filled at a Network Pharmacy. Visit the “Be Tobacco-Free” page at **www.sib.ok.gov** for details.

CDC vaccinations, such as for shingles, are covered at 100% 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)
Annual Deductible	$25 per person, per policy year, waived for in-Network preventive services	No deductibles	No deductible or plan maximum $5 office copay applies
Diagnostic and Preventive Care (cleanings, routine oral exams) Allowable Fees Apply	Network: $0 Plan pays 100% of negotiated fee No deductible Non-Network: $0 Plan pays 100% of usual and customary Deductible applies	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	Sealant: $17 per tooth No charge for routine cleaning once every 6 months No charge for topical fluoride application (through age 18) No charge for periodic oral evaluations
Basic Care (extractions, oral surgery) Allowable Fees Apply	Network: 15% Plan pays 85% of usual and customary Non-Network: 30% Plan pays 70% of usual and customary Deductible applies	Fillings Minor oral surgery Refer to the copay schedule for each plan	Amalgam: One surface, permanent teeth $23
Major Care (dentures, bridge work) Allowable Fees Apply	Network: 40% Plan pays 60% of usual and customary Deductible applies Non-Network: 50% Plan pays 50% of usual and customary Deductible applies	Root canal Periodontal Crowns Refer to the copay schedule for each plan	Root canal, anterior: $375 Periodontal/scaling/root planing 1-3 teeth (per quadrant): $75
Orthodontic Care **Allowable Fees Apply**	Network: 40% Plan pays 60% of negotiated fee Non-Network: 50% Plan pays 50% of usual and customary – deductible applies Network and Non-Network: $2,000 lifetime maximum Coverage only for dependent children under age 19 12-month waiting period may apply	25% discount Adults and children	$2,472 out-of-pocket for children through age 18 $3,384 out-of-pocket for adults 24-month treatment excludes orthodontic treatment plan and banding
Plan Year Maximum	$2,000 per person, per policy year	No annual maximum for general dentist	No maximum
Filing Claims	Member/provider must file claims	No claims to file	No claims to file

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 In-Network and Out-of-Network	Delta Dental PPO Plus Premier In-Network and Out-of-Network	Delta Dental PPO – Choice PPO Network	HealthChoice Dental
Annual Deductible	$25 per person, per year, applies to Basic and Major Care only	$50 per person, per year, applies to Diagnostic, Preventive, Basic and Major Care	$100 per person, per year, applies to Major Care only (Level 4)	Network: $25 Basic and Major services combined Non-Network: $25 Preventive, Basic and Major services combined plus amounts above Allowable Fees
Diagnostic and Preventive Care (cleanings, routine oral exams) Allowable Fees Apply	$0 of allowable amounts No deductible applies	$0 of allowable amounts after deductible	Schedule of covered services and copays Copay examples: Routine cleaning $5 Periodic oral evaluation $5 Topical fluoride application (up to age 19) $5	Network: $0 Non-Network: $0 of Allowable Fees after deductible
Basic Care (extractions, oral surgery) Allowable Fees Apply	15% of allowable amounts after deductible	30% of allowable amounts after deductible	Schedule of covered services and copays Copay example: Amalgam - one surface, primary or permanent tooth $12	Network: 15% Non-Network: 30% plus amounts above Allowable Fees Deductible applies
Major Care (dentures, bridge work) Allowable Fees Apply	40% of allowable amounts after deductible	50% of allowable amounts after deductible	Schedule of covered services and copays Copay examples: Crown - porcelain/ ceramic substrate $241 Complete denture – maxillary $320	Network: 40% Non-Network: 50% plus amounts above Allowable Fees Deductible applies
Orthodontic Care Allowable Fees Apply	40% of allowable amounts, up to lifetime maximum of $2,000 No deductible No waiting period Orthodontic benefits are available to the employee, their lawful spouse and eligible dependent children	40% of allowable amounts, up to lifetime maximum of $2,000 No deductible No waiting period Orthodontic benefits are available to the employee, their lawful spouse and eligible dependent children	You pay amounts in excess of $50 per month Lifetime maximum up to $1,800 No deductible No waiting period Orthodontic benefits are available to the employee, their lawful spouse and eligible dependent children	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
Plan Year Maximum	$2,500 per person, per year	$3,000 per person, per year	$2,000 per person, per year	Network and non-Network: $2,500 per person, per year
Filing Claims	Claims are filed by participating dentists	Claims are filed by participating dentists	Claims are filed by participating dentists	Network: No claims to file Non-Network: You file claims

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

	Humana Vision Care Plan		Primary Vision Care Services		Superior Vision	
Covered Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Eye Exams	$10 copay One exam for eyeglasses or contacts every calendar year	Plan pays up to $35; one exam every calendar year	$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	$25 copay for single/multi-focal lenses Discounts apply to lens options	Plan pays up to: $25 single $40 bifocals $60 trifocals $100 lenticular	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	$25 copay, up to plan limits One frame every calendar year	Plan pays up to $45	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	$130 allowance for conventional or disposable lenses and fitting fee in lieu of all other benefits every calendar year Medically necessary, plan pays 100%	$130 allowance for contacts and fitting fee in lieu of all other benefits Medically necessary, plan pays up to $210	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	Members can access information on providers through the website or by calling customer service Refer to "Vision Plan Notes" after this chart	No benefit	Discount at nJoy Vision (formerly TLC, The Laser Center)	No benefit	5-50% discount off surgical fees	No benefit

For more information or details, contact each vision plan directly.

COMPARISON OF BENEFITS FOR VISION PLANS

	UnitedHealthcare Vision		Vision Care Direct		Vision Service Plan (VSP)	
Covered Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Eye Exams	$10 copay	Reimbursed up to $40	$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	$25 copay UV coating, tint, scratch resistant coating, and polycarbonate lens options are covered in full Discounts apply to other lens options	Single up to $40 Bifocals up to $60 Trifocals up to $80 Lenticular up to $80	$15 copay Single, bifocals, trifocals and no-line progressive lenses covered in full Anti-reflective 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	$25 copay	Reimbursed up to $45	$0 copay **$130** frame allowance each year	Plan pays up to $35	$25 copay then plan pays up to $120	$25 copay then plan pays up to $45
Contact Lenses	$25 copay on covered-in-full qualifying lenses Refer to "Vison Plan Notes" after this chart	Reimbursed up to $150 elective contact lenses $210 medically necessary 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	15% discount off the usual and customary price, 5% off promotional price	No benefit	15% discount Contact the plan prior to procedure	No benefit	15% average off usual and customary price or 5% off the laser center's promotional price	No benefit

For more information or details, contact each vision plan directly.

Vision Plan Notes

Humana Vision Care Plan: The contact lens benefit provides a $130 yearly allowance for the annual vision exam to evaluate eye health, contact lens exam for fitting and evaluation, and the purchase of either conventional or disposable contacts. If a member prefers contact lenses, the plan provides the contact lens allowance in lieu of all other benefits. Instead, if a member opts for lenses and frames during the plan year, a $25 copay applies for these two material items. More than 23,000 frames are covered in full by the $25 copay with in-network providers. Exams, lenses and frame benefits are provided once every 12 months. Oklahoma City LasikPlus Traditional Intralase (bladeless) with a one-year plan with insurance discount is $695 per eye. Traditional Intralase (bladeless) with a lifetime plan with insurance discount is $1,395 per eye. CustomVue Intralase (bladeless) with lifetime plan with insurance discount is $1,784.15 per eye. Other Lasik locations include QualSight in Tulsa, Muskogee and Oklahoma City.

PVCS: The only Oklahoma owned and operated vision care plan with unlimited in-network services. Member selects either in-network or out-of-network for entire year. Out-of-network services are limited (one eye exam, one set of eyeglasses or contacts) 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 (wholesale cost of frame exceeds $100), 5) Premium prescription lenses, and 6) Non-prescriptive eye wear. For more information or detail, call 1-888-357-6912 or go to www.pvcs-usa.com

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.

UHC Vision: For either glasses or contact lenses, there is a one-time $25 materials copay. In lieu of lenses and frames, you may select contact lenses. Covered contact lens benefit includes the fitting/evaluation fee, contact lenses and up to two follow-up visits. If covered disposable contact lenses are chosen, up to six boxes (depending on prescription) are included when obtained from a network provider. It is important to note that UHC covered contact lenses may vary by provider. Should you choose contact lenses outside the covered selection, a $150 allowance will be applied toward the fitting/evaluation fees and purchase of contact lenses (material copay does not apply). Toric and gas permeable contact lenses are examples of contact lenses that are outside of our covered contacts. Necessary contacts are covered-in-full after applicable copay. Exams, lenses and frame benefits provided once every calendar year.

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 and 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. To see our private line of frames, visit http://vcdlabs.biz/complete-eyewear-frame-kit/. For our provider list, visit www.visioncaredirect.com/oklahoma and enter your ZIP code. For more information, visit www.visioncaredirect.com/oklahoma or 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% on your out-of-pocket costs when you use a VSP doctor. 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% 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% off from any VSP doctor within 12 months from your last WellVision Exam. Contact VSP or visit vsp.com to learn about retail chain Affiliate Providers.

Contact Information

HMO Plans

Aetna INTEGRIS

1-800-459-7791
www.aetna.com/integris/stateofok

BlueLincs

1-855-609-5684
www.bcbsok.com/state

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 1-800-522-8506
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.sib.ok.gov

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

HealthChoice USA Provider Directory

1-877-877-0715 or TDD 1-800-941-2160
www.choicecarenetwork.com

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

Vision Plans

Humana VisionCare Plan

1-800-865-3676 or TDD 1-877-553-4327
www.compbenefits.com/custom/stateofoklahoma

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

UnitedHealthcare Vision

1-800-638-3120 or TDD 1-800-524-3157
www.myuhcvision.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