2020 PLAN YEAR
JAN. 1-DEC. 31, 2020

MEDICARE SUPPLEMENT | MAPD | DENTAL | LIFE | VISION

# BENEFITS

## OPTION PERIOD GUIDE

# Monthly Premiums for Medicare Eligible Members
# Plan Year Jan. 1 - Dec. 31, 2020

| MEDICARE SUPPLEMENT PLANS | |
|---|---|
| BCBSOK – BlueSecure℠ | $364.02 per covered person |
| HealthChoice SilverScript High Option Medicare Supplement | $395.30 per covered person |
| HealthChoice SilverScript Low Option Medicare Supplement | $320.44 per covered person |

| MEDICARE ADVANTAGE PRESCRIPTION DRUG (MAPD) PLANS | |
|---|---|
| BCBSOK – MAPD | $282.62 per covered person |
| CommunityCare Senior Health Plan | $228.70 per covered person |
| Generations by GlobalHealth | $216.00 per covered person |
| Humana National MAPD | $224.72 per covered person |

| DENTAL PLANS | MEMBER | SPOUSE | CHILD | CHILDREN |
|---|---|---|---|---|
| Cigna Dental Care Plan (Prepaid) | $ 9.44 | $ 6.18 | $ 4.20 | $ 9.46 |
| Delta Dental PPO | $ 36.92 | $ 36.92 | $ 32.12 | $ 81.24 |
| Delta Dental PPO – Choice | $ 15.68 | $ 35.56 | $ 35.82 | $ 86.96 |
| HealthChoice Dental | $ 41.72 | $ 41.72 | $ 33.72 | $ 86.50 |
| MetLife High Classic MAC | $ 48.54 | $ 48.54 | $ 41.58 | $ 103.04 |
| MetLife Low Classic MAC | $ 27.96 | $ 27.96 | $ 23.94 | $ 58.94 |
| Sun Life Preferred Active PPO | $ 31.46 | $ 31.30 | $ 23.48 | $ 63.10 |

| VISION PLANS | MEMBER | SPOUSE | CHILD | CHILDREN |
|---|---|---|---|---|
| Primary Vision Care Services (PVCS) | $ 9.98 | $ 9.28 | $ 9.20 | $ 11.50 |
| 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) | $ 8.72 | $ 5.78 | $ 5.70 | $ 12.48 |

| LIFE PLAN | | | |
|---|---|---|---|
| **From $5,000 to $40,000** | $ 2.16 Per $1,000 | | |
| **AGE RATED SUPPLEMENTAL LIFE — Cost Per $1,000 for $41,000 and Up** | | | |
| < 30 ---- $ 0.06 | 30 - 34 ---- $ 0.06 | 35 - 39 ---- $ 0.06 | 40 - 44 ---- $ 0.08 |
| 45 - 49 ---- $ 0.14 | 50 - 54 ---- $ 0.26 | 55 - 59 ---- $ 0.40 | 60 - 64 ---- $ 0.46 |
| 65 - 69 ---- $ 0.74 | 70 - 74 ---- $ 1.28 | 75+ ---- $ 1.96 | |

| DEPENDENT LIFE | $ 1.08 Per $500 Unit, Per Dependent |
|---|---|

These rates do not reflect any retirement system contribution.

# Monthly COBRA Premiums for Medicare Eligible Members
# Plan Year Jan. 1 - Dec. 31, 2020

| MEDICARE SUPPLEMENT PLANS | |
|---|---|
| BCBSOK – BlueSecure℠ | $364.02 per covered person |
| HealthChoice SilverScript High Option Medicare Supplement | $395.30 per covered person |
| HealthChoice SilverScript Low Option Medicare Supplement | $320.44 per covered person |

| MEDICARE ADVANTAGE PRESCRIPTION DRUG (MAPD) PLANS | |
|---|---|
| BCBSOK – MAPD | $282.62 per covered person |
| CommunityCare Senior Health Plan | $228.70 per covered person |
| Generations by GlobalHealth | $216.00 per covered person |
| Humana National MAPD | $224.72 per covered person |

| DENTAL PLANS | MEMBER | SPOUSE | CHILD | CHILDREN |
|---|---|---|---|---|
| Cigna Dental Care Plan (Prepaid) | $ 9.63 | $ 6.30 | $ 4.28 | $ 9.65 |
| Delta Dental PPO | $ 37.66 | $ 37.66 | $ 32.76 | $ 82.86 |
| Delta Dental PPO – Choice | $ 15.99 | $ 36.27 | $ 36.54 | $ 88.70 |
| HealthChoice Dental | $ 42.55 | $ 42.55 | $ 34.39 | $ 88.23 |
| MetLife High Classic MAC | $ 49.51 | $ 49.51 | $ 42.41 | $ 105.10 |
| MetLife Low Classic MAC | $ 28.52 | $ 28.52 | $ 24.42 | $ 60.12 |
| Sun Life Preferred Active PPO | $ 32.09 | $ 31.93 | $ 23.95 | $ 64.36 |

| VISION PLANS | MEMBER | SPOUSE | CHILD | CHILDREN |
|---|---|---|---|---|
| Primary Vision Care Services (PVCS) | $ 10.18 | $ 9.47 | $ 9.38 | $ 11.73 |
| Superior Vision | $ 7.77 | $ 7.73 | $ 7.32 | $ 15.03 |
| Vision Care Direct | $ 16.22 | $ 11.49 | $ 11.49 | $ 23.19 |
| VSP (Vision Service Plan) | $ 8.89 | $ 5.90 | $ 5.81 | $ 12.73 |

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



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# 2020 PLAN CHANGES

**Please confirm that your Medicare Advantage Prescription Drug plan is continuing next year.**

**If your plan is not an option in 2020**, Section B of your personalized Option Period form indicates the coverage end date. You then need to choose a new plan. If you do not, your health coverage through this program will end Dec. 31, 2019.

The general plan changes below are indicated by bold text, and with details if necessary, in the Comparison of Benefits charts. For complete benefits and plan changes, contact the plans directly. Contact Information is at the back of this guide.

## MAPD PPO Plans

### Aetna Medicare

- Aetna will **not** be available in 2020. If you wish to continue health coverage for 2020, you are required to select a new plan. Refer to Page 3.

### Blue Cross Blue Shield of Oklahoma

- BCBSOK is offering a new MAPD PPO plan for 2020.
- This plan is available for members living in Oklahoma and nationwide.
- Refer to the Comparison of Benefits chart beginning on Page 17.

### Humana National MAPD

- Humana National MAPD is a new MAPD PPO plan for 2020.
- This plan is available for members living in Oklahoma and nationwide.
- There is no PCP selection or referral to a specialist required.
- Refer to the Comparison of Benefits chart beginning on Page 17.

## MAPD HMO Plans

### CommunityCare Senior Health Plan

- The copay for skilled nursing facility (inpatient services) has increased to $100 per day for days 21-100.

### Generations by GlobalHealth

- The copay for days 21-100 for skilled nursing facility (inpatient services) has increased to $178.
- The copay for in- and out-of-area urgent care centers has decreased to $15 per visit.
- Pharmacy copays decreased for 31- to 90-day supplies on Tiers 1-3 for preferred or mail order. Refer to the pharmacy copay structure on Page 27.
- Pharmacy Tier 6 (Select Care) is no longer available.

# GENERAL INFORMATION

## This Benefit Guide

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

To view this guide online, visit **omes.ok.gov**. In the menu under Services, select Employees Group Insurance Division. Select the Option Period banner for the EGID Option Period page.

## Health Benefits

The health benefits provided by the Medicare supplement and Medicare Advantage Prescription Drugs plans described in this guide are designed to provide Medicare-covered benefits according to Part A and Part B guidelines.

## Updating Life Insurance Beneficiaries

If you need to update your life insurance beneficiary information, complete and return a Beneficiary Designation Form available at **www.healthchoiceconnect.com** or from EGID at 405-717-8780 or toll-free at 800-752-9475. TTY 711.

## Health Provider Network

To find a health, dental or vision provider or to check the network status of a provider, visit the plan's website or call the plan for assistance. Refer to Contact Information at the back of this guide. Choose your health care provider carefully. If you do not select a provider who accepts Medicare assignment, your out-of-pocket costs may be higher, or your claim may be denied entirely.

## If You Currently Have Health Coverage Through Your Employer or Union

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

## Getting Help From Medicare

To get information directly from Medicare, call toll-free 800-MEDICARE (800-633-4227) or TTY 877-486-2048. You can also visit Medicare's website at **Medicare.gov**.

You can read the 2020 *Medicare & You* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits and answers the most frequently asked questions about Medicare. You can also download a copy of this booklet from Medicare's website.

# ANNUAL OPTION PERIOD

You have from Oct. 15-Dec. 7 to make changes to your coverage. Changes received after the deadline cannot be accepted. If you do not return your form by Dec. 7, you will remain in the same coverage you currently have if the plan is still available for 2020.

During Option Period, you can:

- Change your health, dental and vision plans already in place.
- Drop benefits and dependents.
- Decrease the amount of your life insurance coverage.
- Enroll in a vision plan.

If you are Medicare eligible, then you should have already received the following:

- A schedule of retiree Option Period meetings. If you did not receive a schedule, please contact EGID Member Services at 405-717-8780 to request a schedule. If you plan to attend one of these meetings, please bring this guide with you.
- Option Period Enrollment/Change Form. This is being securely mailed in a separate envelope.
    - When you receive your form, review your personalized information and current coverage listed in the upper right corner. Review the premiums and plan changes for 2020.
    - If an MAPD plan is not listed as a selection on your personalized Option Period Enrollment/Change Form, you are not eligible to enroll in that MAPD plan.

## If you DO NOT WANT to make changes and your health plan is offered for this plan year:

- Do **NOT** return your Option Period Enrollment/Change Form. Your current coverage will automatically continue Jan. 1.
- You will **NOT** receive a confirmation statement. Keep your personalized Option Period Enrollment/Change Form as proof of your coverage.
- If you live in a long-term care facility, such as a skilled nursing facility or nursing home, and want to remain enrolled in your current coverage, do not allow your facility to enroll you in another plan with Part D benefits. Enrollment in another plan with Part D benefits will end your Part D benefits through Employees Group Insurance Division.

## If you WANT to make changes or if your health plan is NOT offered this plan year:

- You must complete your Option Period Enrollment/Change Form to make changes for you and your dependents. If you are making health plan changes, you must also submit either the Application for Medicare Supplement with Prescription Drug Plan or Application for Medicare Advantage Prescription Drug (MAPD) Plan.

    - This application is available at **omes.ok.gov**. In the menu under Services, select Employees Group Insurance Division. Under Resources, select Forms and Applications.
    - You can also request an application by calling Member Services at 405-717-8780 or toll-free 800-752-9475. TTY 711.
- If you are considering an MAPD HMO plan, check the ZIP code service area beginning on Page 28 to make sure you are eligible, then check with the MAPD plans to make sure your provider participates in the plan's network. Refer to Contact Information at the end of this guide.
- Enroll in only one plan that provides Part D prescription drug benefits. (Enrolling in another plan that provides Part D benefits will end your current Part D coverage.)
- A separate Part D application is required for each Medicare eligible dependent.
- Return your forms to EGID before Dec. 7.
- Plan changes made during Option Period are reflected on the confirmation statement you receive from EGID.
- Review your confirmation statement to make sure your coverage is correct. Contact EGID right away if it is incorrect so corrections can be made as soon as possible.
- If you enroll in an MAPD plan, you will also receive a letter from your plan confirming your enrollment and effective date. Just before your effective date, you will receive your plan ID card and handbook.
- If you need additional benefit information, contact the plan directly and indicate you are with the State of Oklahoma.

# HEALTH PLAN ELIGIBILITY REQUIREMENTS

## Enrolling in a Medicare Supplement Plan

To participate in the Medicare supplement plans described in this guide, you must be entitled to benefits under Medicare Part A.

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

## Enrolling in an MAPD Plan

An MAPD plan replaces Medicare and administers your health benefits according to Medicare Part A and Part B guidelines.

You may not be eligible to enroll in an MAPD plan if you have been diagnosed with end-stage renal disease. If you are currently enrolled in an MAPD plan and develop ESRD or undergo a successful transplant, you can remain with your plan.

To participate in an MAPD plan described in this guide, you must be enrolled in both Medicare Part A (Hospital) and Part B (Medical) and continue to pay your monthly Part B premium.

### For MAPD PPOs (BCBSOK – MAPD and Humana National MAPD):

- You can receive services anywhere in the United States as long as the provider is a Medicare eligible provider and accepts your plan's payment terms and conditions.
- You do not have to designate a primary care physician to direct your care.
- Referrals and medical precertification are not required.

### For MAPD HMOs (CommunityCare Senior Health Plan and Generations by GlobalHealth):

- You must permanently reside in the MAPD plan's ZIP code service area. This is a federally qualified area where the MAPD HMO plan provides coverage. You must have a home address; a post office box number is not acceptable. Check the ZIP code lists on Pages 28-31 to see if you live within an MAPD HMO plan's service area.
- If you permanently move out of your plan's service area or are absent from the service area for more than six consecutive months, you will be disenrolled from your MAPD HMO plan, and you must select another plan that provides coverage in your new area.
- You must select and designate a PCP to coordinate all your medical and hospital services. There are exceptions in cases of out-of-network emergency or urgent care.
- If you do not use your PCP for routine care, you will be financially responsible for any charges related to those services.
- You can change doctors for any reason as long as the physician you select participates in your MAPD plan's network. To change your PCP, please contact the MAPD plan.

- If your provider leaves your plan, you must select another provider within your plan's network. You cannot change plans until the next annual Option Period.

## When a Dependent is Not Yet Eligible for Medicare

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

## Disenrolling or Changing Plans

If you are changing from from one Medicare health plan to another with EGID:

- You must complete your Option Period Enrollment/Change Form and also the appropriate Part D form, either the Application for Medicare Advantage Prescription Drug (MAPD) Plan or Application for Medicare Supplement with Prescription Drug Plan, and submit to EGID.
- Your new plan will begin Jan. 1.
- You will automatically be disenrolled from your previous plan.
- You will receive a letter from your former plan advising of the date your coverage ends.

If you are disenrolling from your Medicare health plan with EGID:

- Medicare requires you provide a signed written request or your Option Period form to EGID to advise of your disenrollment.
- You will receive a letter from your former plan advising you of the date your coverage ends.

# PRESCRIPTION DRUG BENEFIT INFORMATION

## Prescription Drug Creditable Coverage Notice

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

## Network Pharmacy Access

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

## Non-Network Pharmacy Access

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

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

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

## Plan Formularies (Lists of Covered Drugs)

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

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

- Prior authorization.
- Quantity limits.

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

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

## Drugs that Require Pharmacy Prior Authorization

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

## Quantity Limits

Pharmacy benefits generally cover up to a 30- or 90-day supply. For safety and cost reasons, plans may limit the amount of covered prescription drugs over a certain period of time. Specific therapeutic categories, drugs and dosage forms may have more restrictive quantity and duration of therapy limitations. Some drugs have a maximum quantity limitation and are not dispensed in tablet or capsule form. Be aware that quantity limitations for some drugs may have been added or removed for 2020.

## When Changes Affect a Drug You Currently Take

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

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

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

## Transition Supply of Drug

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

## Income-Related Monthly Adjustment Amount

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

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

## Extra Help Paying for Part D (Medicare Low-income Subsidy)

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

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

If you qualify for Extra Help, the chart below shows your maximum prescription drug costs for 2020:

| Rx Group | Your maximum prescription drug costs for 2020 |
|---|---|
| 1 | $0 deductible |
| | $0 copay |
| 2 | $0 deductible |
| | $1.30 generic and preferred brand copay |
| | $3.90 non-preferred brand and other drug copays |
| 3 | $0 deductible |
| | $3.60 generic and preferred brand copay |
| | $8.95 non-preferred brand and other drug copays |
| 4-7 | $89 deductible |
| | 15% copay |

## If You Enroll in Another Plan With Part D Benefits

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

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

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

# COMPARISON OF BENEFITS FOR THE MEDICARE SUPPLEMENT PLANS

## Medicare Part A (Hospitalization) Services

**All Benefits are Based on Medicare-Approved Amounts**

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

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.



# Medicare Part B (Medical) Services

**All Benefits are Based on Medicare-Approved Amounts**

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

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

## Coverage for Additional Medical Services

| Service | BCBSOK – BlueSecure | HealthChoice SilverScript High and Low Options |
|---|---|---|
| **Foreign Travel**<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States. | You pay the first $250 each calendar year, then 20% and all amounts over the $50,000 lifetime maximum | You pay the first $250 each calendar year, then 20% and all amounts over the $50,000 lifetime maximum |
| **Bariatric Surgery** | You pay 20% coinsurance after meeting the Part B deductible | You pay $0 after meeting the Part B deductible |
| **National Diabetes Prevention Program** | You pay $0 after meeting the Part B deductible | You pay $0 |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

## Medicare Preventive Services

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

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

For a list of preventive services and details on Medicare coverage, go to **CMS.gov** or **Medicare.gov**. You can also refer to the 2020 *Medicare & You* handbook.

# Pharmacy Copay Structure for Part D Network Benefits

| General Information | BCBSOK – Blue Cross Group MedicareRx |
|---|---|
| This plan uses a formulary<br>Some drugs require prior authorization<br>Quantity limits apply to certain drugs<br>Only copays for covered drugs purchased at network pharmacies count toward out-of-pocket maximums<br>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the *Medicare Modernization Act* of 2003<br>You will be notified before any changes are made to your plan's formulary | No deductible; no coverage gap<br>There is an annual out-of-pocket maximum<br><br>**Preferred Retail***<br>30-day Supply<br>Preferred Generic (Tier 1)<br>$0 copay<br>Non-Preferred Generic (Tier 2)<br>$2 copay<br>Preferred Brand (Tier 3)<br>$25 copay<br>Non-Preferred Brand (Tier 4)<br>$75 copay<br>Specialty (Tier 5)<br>33% coinsurance to $4,020, then 15% coinsurance to $6,350<br>60- or 90-day Supply Preferred<br>Generic (Tier 1)<br>$0 copay (60 or 90)<br>Non-Preferred Generic (Tier 2)<br>$4 copay (60) $6 copay (90)<br>Preferred Brand (Tier 3)<br>$50 copay (60) $75 copay (90)<br>Non-Preferred Brand (Tier 4)<br>$150 copay (60) $225 copay (90)<br>Specialty (Tier 5)<br>33% coinsurance to $4,020, then 15% coinsurance to $6,350 TrOOP<br>MOOP set at $6,350 for all tiers<br><br>*Preferred pharmacies: include but are not limited to Walgreens, PPOK, Access Health Independent Pharmacies<br><br>**Standard Retail**<br>30-day Supply<br>Preferred Generic (Tier 1)<br>$5 copay<br>Non-Preferred Generic (Tier 2)<br>$7 copay<br>Preferred Brand (Tier 3)<br>$40 copay<br>Non-Preferred Brand (Tier 4)<br>$95 copay<br>Specialty (Tier 5)<br>33% coinsurance to $4,020, then 15% coinsurance to $6,350<br>60- or 90-day Supply Preferred<br>Generic (Tier 1)<br>$10 copay (60) $15 copay (90)<br>Non-Preferred Generic (Tier 2)<br>$14 copay (60) $21 copay (90)<br>Preferred Brand (Tier 3)<br>$80 copay (60) $120 copay (90)<br>Non-Preferred Brand (Tier 4)<br>$190 copay (60) $285 copay (90)<br>Specialty (Tier 5)<br>33% coinsurance to $4,020, then 15% coinsurance to $6,350 TrOOP<br>MOOP set at $6,350 for all tiers<br><br>Mail order: Same retail cost sharing applies for all tiers for applicable day supply<br>Once you reach the **$6,350** out-of-pocket maximum, you pay 0% for covered prescription drugs at network pharmacies for the remainder of the calendar year |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

# Pharmacy Copay Structure for Part D Network Benefits

| General Information | HealthChoice SilverScript High Option |
|---|---|
| This plan uses a formulary<br><br>Some drugs require prior authorization<br><br>Quantity limits apply to certain drugs<br><br>Only copays for covered drugs purchased at network pharmacies count toward out-of-pocket maximums<br><br>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the *Medicare Modernization Act* of 2003<br><br>You will be notified before any changes are made to your plan's formulary | **Pharmacy Deductible**<br>You pay the first $100 in medication costs before the copays listed below apply<br><br>No coverage gap; there is an annual out-of-pocket maximum<br><br>**30-day Supply**<br><br>Generic (Tier 1) Drugs<br>Up to $10 copay<br><br>Preferred (Tier 2) Drugs<br>Up to $45 copay<br><br>Non-Preferred (Tier 3) Drugs<br>Up to $75 copay<br><br>Specialty/High Cost (Tier 4) Drugs<br>Up to $100 copay<br><br>Preferred Tobacco Cessation (Tier 5) Drugs<br>$0 copay<br><br>**31- to 90-day Supply**<br><br>Generic (Tier 1) Drugs<br>Up to $25 copay<br><br>Preferred (Tier 2) Drugs<br>Up to a $90 copay<br><br>Non-Preferred (Tier 3) Drugs<br>Up to $150 copay<br><br>Specialty/High Cost (Tier 4) Drugs<br>Specialty drugs are available in only a 30-day supply<br><br>Preferred Tobacco Cessation (Tier 5) Drugs<br>$0 copay<br><br>Once you reach the **$6,350** out-of-pocket maximum, you pay 0% for covered prescription drugs at network pharmacies for the remainder of the calendar year |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.



# Pharmacy Copay Structure for Part D Network Benefits

| General Information | HealthChoice SilverScript Low Option |
|---|---|
| This plan uses a formulary<br>Some drugs require prior authorization<br>Quantity limits apply to certain drugs<br>Only copays for covered drugs purchased at network pharmacies count toward the out-of-pocket maximums<br>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003<br>You will be notified before any changes are made to your plan's formulary | **Pharmacy Deductible**<br>You pay the first **$435** in medication costs<br>**Initial Coverage Limit**<br>After the deductible, you and HealthChoice share prescription drug costs<br>You pay 25% (**$896.25**) and HealthChoice pays 75% (**$2,688.75**) until total drug spending reaches **$4,020**<br>**Coverage Gap**<br>You pay 100% of your prescription drug costs at discounted rates – **25%** of the cost of generic drugs and 25% of the cost of brand-name drugs<br>What you pay for brand-name drugs plus the 70% manufacturer discount applies to your out-of-pocket to get out of the coverage gap<br>For generic drugs, only what you pay applies<br>**Catastrophic Coverage**<br>Once you reach the **$6,350** out-of-pocket maximum, you pay $0 for covered prescription drugs purchased at network pharmacies for the remainder of the calendar year |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

# COMPARISON OF BENEFITS FOR THE MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS

## MAPD PPO Plans

**All Benefits are Based on Medicare-Covered Services**

| Services | BCBSOK – MAPD | Humana National MAPD |
|---|---|---|
| **Hospitalization**<br>Semiprivate room (private room if medically necessary)<br>Nursing services, medications and all meals<br>Laboratory tests, X-rays and other radiology services<br>Inpatient physician and surgical services, including anesthesia<br>Necessary medical supplies and appliances<br>Blood and its administration<br>Operating room, special care units and rehabilitation services | You pay $0 per stay after $175 plan deductible | You pay $0 for Part A services |
| **Organ Transplants**<br>Must be performed in a Medicare-approved transplant facility | You pay $0 per stay after $175 plan deductible | You pay $0 |
| **Skilled Nursing Facility (Inpatient Services)**<br>Semi-private room, regular nursing services and all meals<br>Physical, occupational and speech therapy<br>Drugs and necessary medical equipment and supplies furnished by the facility<br>Blood and its administration<br>Inpatient radiology and pathology<br>Use of appliances such as wheelchairs | You pay $0 per stay after $175 plan deductible | You pay $0 for Part A services |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

| Services | BCBSOK – MAPD | Humana National MAPD |
|---|---|---|
| **Outpatient Hospital Services**<br>Outpatient surgical services in an ambulatory surgical center or outpatient hospital facility | You pay $0 after $175 plan deductible | You pay $0 after $185 deductible for Part B services |
| **Urgent Care Services**<br>Urgently needed services worldwide | You pay $0 after $175 plan deductible | You pay $0<br>If you have lab services, you pay $0 after $185 deductible<br>This would not apply to worldwide services. |
| **Emergency Services**<br>Emergency services needed worldwide | You pay $0 after $175 plan deductible | You pay $0 |
| **Ambulance Services**<br>When medically necessary | You pay $0 after $175 plan deductible | You pay $0 after $185 deductible for Part B services |
| **Professional Services**<br>Office visit<br>Consultation, diagnosis and treatment by a specialist<br>Medical and surgical care<br>Allergy tests and treatment (serum)<br>Diagnostic tests and treatment<br>Medical supplies including casts, dressings and splints | You pay $0 after $175 plan deductible | You pay $0 after $185 deductible for Part B services |
| **Physical, Occupational and Speech Therapy Services** | You pay $0 after $175 plan deductible | You pay $0 after $185 deductible for Part B services |
| **Laboratory Services** | You pay $0 after $175 plan deductible | You pay $0 after $185 deductible for Part B services |
| **X-Ray/Diagnostic Radiology** | You pay $0 after $175 plan deductible | You pay $0 after $185 deductible for Part B services |
| **Hearing Examinations** | You pay $0 after $175 plan deductible | You pay $0 for Medicare covered services after $185 deductible for Part B services |
| **Chiropractic**<br>Limited to manual manipulation of the spine as medically necessary | You pay $0 after $175 plan deductible | You pay $0 for Medicare covered services after $185 deductible for Part B services |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

| Services | BCBSOK - MAPD | Humana National MAPD |
|---|---|---|
| **Part-Time or Intermittent Skilled Nursing Care**<br>Home health aide in conjunction with skilled care<br>Physical, speech and occupational therapy<br>Medical supplies and equipment (excluding medications) provided by the agency | You pay $0 after $175 plan deductible | You pay $0 for Part A services and $0 after $185 deductible for Part B services |
| **Durable Medical Equipment**<br>DME and supplies<br>Prosthetic devices<br>Therapeutic shoes/inserts for severe diabetes | You pay $0 after $175 plan deductible | You pay $0 after $185 deductible for Part B services |
| **Bariatric Surgery** | You pay $0 after $175 plan deductible | You pay $0 |
| **National Diabetes Prevention Program** | You pay $0 after $175 plan deductible | You pay $0 |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

## Medicare Preventive Services

The MAPD PPO plans cover many Part B preventive services, such as your annual flu vaccination, wellness visit and screening mammogram, at 100% when you use a doctor or other health care provider who is a Medicare eligible provider.

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

For a list of preventive services as governed by Medicare, go to **CMS.gov** or **Medicare.gov**. You can also refer to the 2020 *Medicare & You* handbook.

# Pharmacy Copay Structure for Part D Network Benefits

| General Information | BCBSOK – MAPD | |
|---|---|---|
| This plan uses a formulary<br>Some drugs require prior authorization<br>Quantity limits apply to certain drugs<br>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the *Medicare Modernization Act* of 2003<br>You will be notified before changes are made to your plan's formulary | **Preferred Pharmacy**<br>30-day Supply<br>$0 copay Tier 1<br>$2 copay Tier 2<br>$25 copay Tier 3<br>$75 copay Tier 4<br>33% coinsurance to $4,020, then 15% coinsurance to $6,350 Tier 5<br>31- to 90-day Supply<br>$0 copay Tier 1 (60-, 90-day)<br>$4 copay Tier 2 (60-day)<br>$6 copay Tier 2 (90-day)<br>$50 copay Tier 3 (60-day)<br>$75 copay Tier 3 (90-day)<br>$150 copay Tier 4 (60-day)<br>$225 copay Tier 4 (90-day)<br>33% coinsurance to $4,020, then 15% coinsurance to $6,350 TrOOP Tier 5<br>Coinsurance applies at both preferred and standard pharmacy<br>Pharmacy MOOP $6,350 | **Standard Pharmacy**<br>30-day Supply<br>$5 copay Tier 1<br>$7 copay Tier 2<br>$40 copay Tier 3<br>$95 copay Tier 4<br>33% coinsurance to $4,020, then 15% coinsurance to $6,350 Tier 5<br>31- to 90-day Supply<br>$0 copay Tier 1 (60-day)<br>$15 copay Tier 1 (90-day)<br>$14 copay Tier 2 (60-day)<br>$21 copay Tier 2 (90-day)<br>$80 copay Tier 3 (60-day)<br>$120 copay Tier 3 (90-day)<br>$190 copay Tier 4 (60-day)<br>$285 copay Tier 4 (90-day)<br>33% coinsurance to $4,020, then 15% coinsurance to $6,350 TrOOP Tier 5 |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

# Pharmacy Copay Structure for Part D Network Benefits

| General Information | Humana National MAPD |
|---|---|
| This plan uses a formulary<br>Some drugs require prior authorization<br>Quantity limits apply to certain drugs<br>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the *Medicare Modernization Act* of 2003<br>You will be notified before changes are made to your plan's formulary | **Pharmacy Deductible**<br>You pay the first $100 in medication costs before the member benefit copays listed below begin to apply<br>**30-day Supply**<br>$10 copay Tier 1 generic or preferred generic<br>$45 copay Tier 2 preferred brand<br>$75 copay Tier 3 non-preferred brand<br>$100 copay Tier 4 specialty<br>N/A Tier 5<br>**31- to 90-day Supply**<br>$25 copay Tier 1<br>$90 copay Tier 2<br>$150 copay Tier 3<br>N/A Tier 4 no specialty drugs for 90-day supply<br>N/A Tier 5<br>**Catastrophic Coverage**<br>Once you reach the $6,350 out-of-pocket maximum, you pay the greater of $3.60 for generic/preferred multi-source drugs and $8.95 for all other drugs OR 5% coinsurance<br>($100 maximum out-of-pocket per prescription for 30-day supply and $150 maximum out-of-pocket per prescription for 90-day supply)<br>Maximum out-of-pocket $6,350 |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

# MAPD HMO Plans

## All Benefits are Based on Medicare-Covered Services

| Services | CommunityCare Senior Health Plan | Generations by GlobalHealth |
|---|---|---|
| **Hospitalization**<br>Semiprivate room (private room if medically necessary)<br>Nursing services and medications<br>Laboratory tests, X-rays and other radiology services<br>Inpatient physician and surgical services, including anesthesia<br>Necessary medical supplies and appliances<br>Blood and its administration<br>Operating room, special care units and rehabilitation services | $50 copay each day for days 1-5<br>$0 copay each day for days 6 and beyond for a Medicare-covered stay in a network hospital<br>Prior authorization required, except in an emergency<br>You are covered for unlimited days each benefit period<br>A benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received hospital or skilled nursing care for 60 days in a row<br>Copays apply for each admission | $250 copay per admission<br>You are covered for unlimited days each benefit period<br>Prior authorization required, except in an emergency |
| **Organ Transplants**<br>Cornea, heart, heart-lung, kidney, liver, lung, bone marrow, intestinal and multivisceral, pancreas and stem cell<br>Must be performed in a Medicare-approved transplant facility | $50 copay each day for days 1-5<br>$0 copay each day for days 6 and beyond | $250 copay per admission<br>You are covered for unlimited days each benefit period<br>Prior authorization required except in the case of an emergency |
| **Outpatient Hospital Services**<br>Outpatient surgical services in an ambulatory surgical center or outpatient hospital facility. | $0 copay for each visit<br>Prior authorization required | $0 copay per surgery in an ambulatory surgery center<br>$200 copay per surgery in an outpatient hospital |
| Radiation therapy | $0 copay | $40 copay |
| Blood | $0 copay | $0 copay |

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

| Services | CommunityCare Senior Health Plan | Generations by GlobalHealth |
|---|---|---|
| **In-Area Urgent Care Services** | $10 copay for each visit | **$15 copay for each visit** |
| **Out-of-Area Urgent Care Services**<br>During a temporary absence from service area | $10 copay for each visit worldwide | **$15 copay for each visit within the U.S.** |
| **Emergency Services** | $90 copay for each Medicare-covered visit worldwide<br>Waived if admitted inpatient to hospital within 48 hours for same condition | $75 copay for each visit nationwide; all-inclusive<br>Waived if admitted inpatient to hospital or for outpatient surgery within 24 hours for same condition |
| **Ambulance Services**<br>Medically necessary services as covered by Medicare | $50 copay<br>Waived if admitted inpatient to hospital | $50 copay<br>Waived if admitted inpatient to hospital |
| **Skilled Nursing Facility (Inpatient Services)**<br>Semi-private room and regular nursing services<br>Physical, occupational and speech therapy<br>Drugs and necessary medical equipment and supplies furnished by facility<br>Blood and its administration<br>Inpatient radiology and pathology<br>Use of appliances such as wheelchairs | $0 copay for days 1-20<br>**$100 copay for days 21-100 for each benefit period**<br>No prior hospital stay required<br>Prior authorization required<br>All services listed at left are inclusively covered under the skilled nursing facility copayment | $0 copay per day for days 1-20<br>**$178 copay per day for days 21-100**<br>No prior hospital stay required<br>Prior authorization required<br>All services listed at left are inclusively covered under the skilled nursing facility copayment |

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

| Services | CommunityCare Senior Health Plan | Generations by GlobalHealth |
|---|---|---|
| **Professional Services**<br>Office visit<br>Consultation, diagnosis and treatment by a specialist<br>Medical and surgical care<br>Allergy tests and treatment (serum)<br>Diagnostic tests and treatment<br>Medical supplies including casts, dressings and splints | $0 copay for each PCP visit<br>$10 copay for each specialist visit | $0 copay for each PCP visit<br>$20 copay for each specialist visit |
| **X-Ray/Diagnostic Radiology Services** | $0 copay | $0 copay |
| **Laboratory Services** | $0 copay for each diagnostic procedure and test<br>Prior authorization may apply | $0 copay |
| **Physical, Occupational and Speech Therapy Services** | $0 copay for each visit<br>Prior authorization required | $20 copay for each visit<br>Prior authorization required |
| **Hearing Examinations** | $0 copay for routine hearing tests<br>$0 copay for diagnostic hearing exams<br>You pay 100% for hearing aids | $0 copay for each PCP diagnostic evaluation<br>$20 copay for each specialist exam to diagnose and treat hearing and balance issues |
| **Chiropractic**<br>Limited to manual manipulation of the spine as medically necessary | $10 copay each visit<br>Prior authorization required | $20 copay each visit<br>No prior authorization required |

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

| Services | CommunityCare Senior Health Plan | Generations by GlobalHealth |
|---|---|---|
| **Part-Time or Intermittent Skilled Nursing Care**<br>Home health aide in conjunction with skilled care<br>Physical, speech and occupational therapy<br>Medical supplies and equipment (excluding medications) provided by the agency | $0 copay for Medicare-covered home health visits<br>Prior authorization required | $0 copay for home health visits<br>Prior authorization required |
| **Durable Medical Equipment**<br>Durable medical equipment and supplies | $0 to $50 copay or 20% coinsurance for each item<br>Prior authorization required | 20% coinsurance for each item<br>Prior authorization required |
| Prosthetic devices | $0 copay for each device<br>Prior authorization required | $0 if surgically implanted<br>20% coinsurance per external device<br>Prior authorization required |
| Therapeutic shoes/inserts for severe diabetes | $0 copay for each orthotic Prior authorization required | $0 for each orthotic<br>Prior authorization required |
| **Bariatric Surgery** | Inpatient: $50 copay each day for days 1-5 and $0 copay each day 6 and beyond<br>Outpatient: $0 copay<br>Prior authorization required | $250 inpatient copay<br>You are covered for unlimited days each benefit period<br>Prior authorization required |
| **National Diabetes Prevention Program** | 0% coinsurance/$0 copay | 0% coinsurance/$0 copay |

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

## Medicare Preventive Services

The MAPD HMO plans cover many Part B preventive services, such as your annual flu vaccination, wellness visit and screening mammogram, at 100% when you use a network provider.

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

For a list of these preventive services as governed by Medicare, go to **CMS.gov** or **Medicare.gov**. You can also refer to the 2020 *Medicare & You handbook.*



# Pharmacy Copay Structure for Part D Network Benefits

| General Information | CommunityCare Senior Health Plan |
|---|---|
| This plan uses a formulary<br>Some drugs require prior authorization<br>Quantity limits apply to certain drugs<br>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003<br>You will be notified before changes are made to your plan's formulary | 30-day supply<br>$0 copay – Tier 1 preferred generic drugs<br>Up to $10 copay – Tier 2 generic drugs<br>Up to $30 copay – Tier 3 preferred brand drugs<br>Up to $60 copay – Tier 4 non-preferred drugs (including tobacco cessation)<br>33% coinsurance – Tier 5 specialty drugs and certain injectables<br><br>90-day supply<br>$0 copay – Tier 1 preferred generic drugs<br>Up to $20 copay – Tier 2 generic drugs<br>Up to $60 copay – Tier 3 preferred brand drugs<br>Up to $120 copay – Tier 4 non-preferred drugs (including tobacco cessation)<br>33% coinsurance – Tier 5 specialty drugs and certain injectables<br><br>Mail order is available for up to a 90-day supply<br><br>Once you reach the **$6,350** out-of-pocket maximum, you pay the greater of 5% of the cost or **$3.60** for generic drugs and preferred multi-source brand drugs or **$8.95** for all other drugs for the remainder of the calendar year. |

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

# Pharmacy Copay Structure for Part D Network Benefits

| General Information | Generations by GlobalHealth | |
|---|---|---|
| Mandatory generic and brand formulary medications you get at a network pharmacy<br>Some drugs require prior authorization<br>Quantity limits apply to certain drugs<br>Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003<br>You will be notified before changes are made to your plan's formulary | **Preferred Retail**<br>30-day Supply<br>$5 copay – Tier 1<br>$15 copay – Tier 2<br>$42 copay – Tier 3<br>40% coinsurance – Tier 4<br>33% coinsurance – Tier 5<br>**Not covered – Tier 6**<br>31- to 90-day Supply<br>**$0 copay – Tier 1**<br>**$0 copay – Tier 2**<br>**$84 copay – Tier 3**<br>40% coinsurance – Tier 4<br>Not covered – Tier 5<br>**Not covered – Tier 6** | **Standard Retail**<br>30-day Supply<br>$10 copay – Tier 1<br>$20 copay – Tier 2<br>$47 copay – Tier 3<br>50% coinsurance – Tier 4<br>33% coinsurance – Tier 5<br>**Not covered – Tier 6**<br>31- to 90-day Supply<br>$30 copay – Tier 1<br>$60 copay – Tier 2<br>$141 copay – Tier 3<br>50% coinsurance – Tier 4<br>Not covered – Tier 5<br>**Not covered – Tier 6** |
| | **Preferred Mail Order**<br>30-day Supply<br>$5 copay – Tier 1<br>$15 copay – Tier 2<br>$42 copay – Tier 3<br>40% coinsurance – Tier 4<br>33% coinsurance – Tier 5<br>**Not covered – Tier 6**<br>31- to 90-day Supply<br>**$0** copay – Tier 1<br>**$0** copay – Tier 2<br>**$84** copay – Tier 3<br>40% coinsurance – Tier 4<br>Not covered – Tier 5<br>**Not covered – Tier 6** | **Standard Mail Order**<br>30-day Supply<br>$10 copay – Tier 1<br>$20 copay – Tier 2<br>$47 copay – Tier 3<br>50% coinsurance – Tier 4<br>33% coinsurance – Tier 5<br>**Not covered – Tier 6**<br>31- to 90-day Supply<br>$30 copay – Tier 1<br>$60 copay – Tier 2<br>$141 copay – Tier 3<br>50% coinsurance – Tier 4<br>Not covered – Tier 5<br>**Not covered – Tier 6** |
| | Once you reach the **$6,350** out-of-pocket maximum, you pay Medicare-defined amounts for covered generic and brand prescription drugs purchased at network pharmacies for the remainder of the year | |

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

# ZIP CODE SERVICE AREAS FOR MAPD PLANS

## BCBSOK – MAPD

You can receive services anywhere within the United States as long as the provider is a Medicare-eligible provider, accepts Medicare assignment and is willing to accept BCBSOK's Blue Cross Group Medicare Advantage (PPO) | MAPD Plan.

## CommunityCare Senior Health Plan

### Craig

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 74016 | 74072 | 74301 | 74330 | 74331 | 74332 | 74333 | 74349 |
| 74354 | 74369 | | | | | | |

### Creek

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 74010 | 74028 | 74030 | 74033 | 74037 | 74038 | 74039 | 74041 |
| 74044 | 74046 | 74047 | 74052 | 74063 | 74066 | 74067 | 74068 |
| 74071 | 74079 | 74131 | 74132 | | | | |

### McIntosh

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 74426 | 74428 | 74432 | 74437 | 74438 | 74450 | 74455 | 74459 |
| 74461 | 74469 | 74839 | 74845 | | | | |

### Muskogee

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 74401 | 74402 | 74403 | 74422 | 74423 | 74426 | 74428 | 74434 |
| 74435 | 74436 | 74439 | 74450 | 74455 | 74463 | 74468 | 74469 |
| 74470 | | | | | | | |

### Nowata

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|---|---|---|---|---|---|---|---|
| 74006 | 74016 | 74027 | 74042 | 74048 | 74072 | 74083 | 74301 |

### Osage

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 74001 | 74002 | 74003 | 74004 | 74009 | 74022 | 74035 | 74054 |
| 74056 | 74060 | 74063 | 74070 | 74073 | 74084 | 74106 | 74126 |
| 74127 | 74604 | 74633 | 74637 | 74650 | 74652 | | |

### Tulsa

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 74008 | 74011 | 74012 | 74013 | 74014 | 74015 | 74021 | 74033 |
| 74037 | 74043 | 74047 | 74050 | 74055 | 74063 | 74066 | 74070 |
| 74073 | 74100 | 74101 | 74102 | 74103 | 74104 | 74105 | 74106 |
| 74107 | 74108 | 74110 | 74112 | 74114 | 74115 | 74116 | 74117 |
| 74119 | 74120 | 74121 | 74126 | 74127 | 74128 | 74129 | 74130 |
| 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 | | | | | | |

### Wagoner

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 74008 | 74014 | 74015 | 74036 | 74108 | 74337 | 74352 | 74403 |
| 74429 | 74434 | 74436 | 74446 | 74454 | 74458 | 74466 | 74467 |
| 74477 | | | | | | | |

### Washington

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 74003 | 74004 | 74005 | 74006 | 74021 | 74022 | 74029 | 74048 |
| 74051 | 74061 | 74070 | 74080 | 74082 | 74083 | | |

## Generations by 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 | 73025 |
| 73026 | 73027 | 73028 | 73029 | 73030 | 73031 | 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 | 73077 | 73078 | 73079 | 73080 |
| 73082 | 73083 | 73084 | 73085 | 73089 | 73090 | 73092 | 73093 |
| 73094 | 73095 | 73097 | 73098 | 73099 | 73101 | 73102 | 73103 |
| 73104 | 73105 | 73106 | 73107 | 73108 | 73109 | 73110 | 73111 |
| 73112 | 73113 | 73114 | 73115 | 73116 | 73117 | 73118 | 73119 |

ZIP codes are subject to change by plan.

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## Generations by GlobalHealth ZIP Code List

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 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 | 73433 | 73434 | 73442 | 73456 |
| 73481 | 73520 | 73528 | 73529 | 73530 | 73531 | 73533 | 73540 |
| 73542 | 73543 | 73546 | 73548 | 73551 | 73553 | 73555 | 73559 |
| 73561 | 73562 | 73564 | 73565 | 73566 | 73568 | 73569 | 73570 |
| 73572 | 73573 | 73644 | 73646 | 73651 | 73654 | 73655 | 73658 |
| 73659 | 73663 | 73667 | 73701 | 73702 | 73703 | 73705 | 73706 |
| 73716 | 73717 | 73718 | 73719 | 73720 | 73722 | 73724 | 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 | 73835 | 73838 |
| 73842 | 73859 | 73860 | 74001 | 74002 | 74003 | 74008 | 74010 |
| 74011 | 74012 | 74014 | 74015 | 74016 | 74017 | 74018 | 74019 |
| 74020 | 74021 | 74022 | 74023 | 74026 | 74027 | 74028 | 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 | 74063 | 74066 | 74067 | 74068 | 74070 |
| 74071 | 74072 | 74073 | 74075 | 74079 | 74080 | 74081 | 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 | 74337 |
| 74340 | 74347 | 74349 | 74350 | 74352 | 74354 | 74361 | 74362 |
| 74364 | 74365 | 74366 | 74367 | 74369 | 74401 | 74402 | 74403 |
| 74421 | 74422 | 74423 | 74425 | 74426 | 74427 | 74428 | 74429 |

ZIP codes are subject to change by plan.

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## Generations by GlobalHealth ZIP Code List

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 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 | 74528 | 74529 | 74531 | 74536 | 74540 |
| 74543 | 74546 | 74547 | 74549 | 74552 | 74553 | 74554 | 74557 |
| 74558 | 74560 | 74561 | 74562 | 74565 | 74567 | 74570 | 74571 |
| 74572 | 74574 | 74576 | 74601 | 74604 | 74630 | 74633 | 74636 |
| 74637 | 74640 | 74643 | 74644 | 74646 | 74650 | 74651 | 74652 |
| 74653 | 74735 | 74760 | 74801 | 74802 | 74804 | 74818 | 74820 |
| 74821 | 74824 | 74825 | 74826 | 74827 | 74829 | 74830 | 74831 |
| 74832 | 74833 | 74834 | 74837 | 74839 | 74840 | 74842 | 74843 |
| 74844 | 74845 | 74848 | 74849 | 74850 | 74851 | 74852 | 74854 |
| 74855 | 74857 | 74859 | 74860 | 74864 | 74865 | 74866 | 74867 |
| 74868 | 74869 | 74871 | 74872 | 74873 | 74875 | 74878 | 74880 |
| 74881 | 74883 | 74884 | 74931 | 74941 | 74943 | 74944 | 74960 |
| 74964 | 74965 | | | | | | |

## Humana National MAPD PPO ZIP Code List

You are eligible for Humana National MAPD PPO if you live in the United States.

You can receive services anywhere within the United States as long as the provider is a Medicare-eligible provider and is willing to accept the Humana National MAPD and agrees to Humana payment terms and conditions. The Humana National MAPD PPO plan has an extended service area network beyond the network within their ZIP code service area.

# COMPARISON OF BENEFITS FOR DENTAL PLANS

| Allowable amounts apply for all benefits | Cigna Dental Care Plan (Prepaid) | Delta Dental PPO Network and Non-Network | Delta Dental PPO – Choice |
|---|---|---|---|
| **Annual Deductible** | No deductible<br>$5 office copay applies | $25 per person<br>Basic and major care combined | $100 per person<br>Major care only (Level 4) |
| **Diagnostic and Preventive Care (Cleanings, routine oral exams)** | Sealant per tooth: $17 copay<br>No charge for:<br>Routine cleaning (limit two per calendar year)<br>Topical fluoride application (up to age 18)<br>Periodic oral evaluations | Plan pays 100% of allowable amounts | Schedule of covered services and copays<br>Topical fluoride covered for children only<br>Copay examples:<br>Routine cleaning $5<br>Periodic oral evaluation $5<br>Topical fluoride application (up to age 19) $5 |
| **Basic Care (Extractions, oral surgery)** | Amalgam (one surface, permanent teeth): $23 copay | Plan pays 85% of allowable amounts after deductible | Schedule of covered services and copays<br>Copay example:<br>Amalgam – one surface, primary or permanent tooth $12 |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

| Allowable amounts apply for all benefits | HealthChoice Dental | MetLife High Classic MAC | MetLife Low Classic MAC | Sun Life Preferred Active PPO |
|---|---|---|---|---|
| **Annual Deductible** | Network:<br>$25 individual<br>$75 family<br>Basic and major services combined<br>Non-network:<br>$25 individual<br>$75 family<br>Preventive, basic and major services combined<br><br>Separate network and non-network deductibles<br>A family is 3 or more covered individuals. | Network and non-network:<br>$25 individual/$75 family<br>Basic and major care combined | Network and non-network:<br>$50 individual/$150 family<br>Basic and major care combined | $25 per person, waived for network preventive services |
| **Diagnostic and Preventive Care (Cleanings, routine oral exams)** | Network:<br>You pay $0<br>Non-network:<br>You pay $0 after deductible plus charges above the allowable amounts | You pay<br>Network: $0<br>Non-network: Amounts above maximum allowed charge | You pay<br>Network: $0<br>Non-network: Amounts above maximum allowed charge | Network: Plan pays 100% of allowable amounts<br>Non-network: Plan pays 100% of usual and customary after deductible |
| **Basic Care (Extractions, oral surgery)** | Network:<br>You pay 15% after deductible<br><br>Non-network:<br>You pay 30% after deductible plus charges above the allowable amounts | You pay<br>Network: 15%<br>Non-network: 15% plus amounts above maximum allowed charge<br>Deductible applies | You pay<br>Network: 30%<br>Non-network: 30% plus amounts above maximum allowed charge<br>Deductible applies | Network: Plan pays 85% of allowable amounts after deductible<br>Non-network: Plan pays 70% of usual and customary after deductible |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.



| Allowable amounts apply for all benefits | Cigna Dental Care Plan (Prepaid) | Delta Dental PPO Network and Non-Network | Delta Dental PPO – Choice |
|---|---|---|---|
| **Major Care (Dentures, bridge work)** | Root canal (anterior): $375 copay<br>Periodontal scaling/root planing 1-3 teeth (per quadrant): $75 copay | Plan pays 60% of allowable amounts after deductible | Schedule of covered services and copays<br>Copay examples:<br>Crown – porcelain/ceramic substrate $241<br>Complete denture – maxillary $320 |
| **Orthodontic Care** | $2,472 out-of-pocket child<br>$3,384 out-of-pocket adult (24-month treatment)<br>Excludes orthodontic treatment plan and banding<br>No waiting period for orthodontic benefits | Plan pays 60% of allowable amounts, up to $2,000 lifetime maximum per person<br>Orthodontic benefits are available to eligible employee, spouse and dependent children<br>No waiting period for orthodontic benefits | You pay charges in excess of $50 per month<br>Lifetime maximum up to $1,800 per person<br>Orthodontic benefits are available to eligible employee, spouse and dependent children<br>No waiting period for orthodontic benefits |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

| Allowable amounts apply for all benefits | HealthChoice Dental | MetLife High Classic MAC | MetLife Low Classic MAC | Sun Life Preferred Active PPO |
|---|---|---|---|---|
| **Major Care (Dentures, bridge work)** | Network:<br>You pay 40% after deductible<br><br>Non-network:<br>You pay 50% after deductible plus charges above the allowable amounts | You pay<br>Network: 40%<br>Non-network: 40% plus amounts above maximum allowed charge<br>Deductible applies | You pay<br>Network: 50%<br>Non-network: 50% plus amounts above maximum allowed charge<br>Deductible applies | Network: Plan pays 60% of allowable amounts after deductible<br>Non-network: Plan pays 50% of usual and customary after deductible |
| **Orthodontic Care** | Network:<br>You pay 50% of allowable amounts; no deductible applies<br><br>Non-network:<br>You pay 50% of the allowable amounts, plus charges above the allowable amounts; no deductible applies<br><br>Covered for members age 18 and under<br>Covered for treatment of TMD at any age<br><br>No lifetime maximum<br><br>12-month waiting period for orthodontic benefits (some exceptions apply). | You pay<br>Network: 40%<br>Non-network: 40% plus amounts above maximum allowed charge<br>$2,000 lifetime maximum per person<br><br>No waiting period for orthodontic benefits | You pay<br>Network: 50%<br>Non-network: 50% plus amounts above maximum allowed charge<br>$2,000 lifetime maximum per person<br><br>No waiting period for orthodontic benefits | Network: Plan pays 60%<br>Non-network: Plan pays 50% up to lifetime maximum of $2,000 for dependents under age 19<br><br>12-month waiting period applies |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.



| Allowable amounts apply for all benefits | Cigna Dental Care Plan (Prepaid) | Delta Dental PPO Network and Non-Network | Delta Dental PPO – Choice |
|---|---|---|---|
| **Plan Year Maximum** | No plan year maximum | $2,500 per person for diagnostic, preventive, basic and major care | $2,000 per person for diagnostic, preventive, basic and major care |
| **Filing Claims** | No claims to file | Network: No claims to file<br>Non-network: You file claims | Network: No claims to file<br>Non-network: You file claims |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

| Allowable amounts apply for all benefits | HealthChoice Dental | MetLife High Classic MAC | MetLife Low Classic MAC | Sun Life Preferred Active PPO |
|---|---|---|---|---|
| **Plan Year Maximum** | Network and non-network: $2,500 per person<br><br>You are responsible for all charges billed by provider after plan year maximum is met | Network and non-network: $5,000 per person | Network and non-network: $1,500 per person | $2,000 per person |
| **Filing Claims** | Network: No claims to file<br>Non-network: You file claims | Claims are filed by network and non-network dentists | Claims are filed by network and non-network dentists | Claims must be filed by either the member or the provider |

This is only a sample of the services covered by each plan. For services 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** | **Network** | **Non-Network** | **Network** | **Non-Network** |
| **Eye Exams** | $0 copay<br>No limit to frequency | Plan reimburses up to $40<br>Limit one exam | $10 copay<br>Limit one exam per calendar year | Plan pays up to:<br>$34 M.D.<br>$26 O.D. |
| **Lenses Per Pair** | You pay wholesale cost<br>No limit to number of pairs | You pay normal doctor's fees, reimbursed up to $60 for one set of lenses and frames per year | $25 copay for replacement lenses<br>Lenses copay is waived if one set of lenses is purchased simultaneously with frames<br>Limit one pair per calendar year<br>Single focal, lined bifocal, lined trifocal covered in full | Plan pays up to:<br>$26 single<br>$39 bifocal<br>$49 trifocal<br>$49 standard progressive<br>$78 lenticular |
| **Frames** | You pay wholesale cost<br>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 for new frames, then plan pays up to $150 retail<br>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<br>You pay normal doctor's fees reimbursed up to $60 | $25 copay for lens fitting exam, one per calendar year<br>Plan pays up to $120 retail allowance, in lieu of glasses<br>After exam copay, medically necessary contacts covered in full<br>Standard contacts covered in full; Specialty contacts $50 retail allowance | Plan pays up to $100 all contacts<br>In lieu of glasses: Plan pays up to $210 medically necessary contact lenses<br>Contact lens fitting exam not covered (standard not covered; specialty not covered) |
| **Laser Vision Correction** | Through nJoy Vision in Oklahoma City and Tulsa<br>Discount up to $1,000 off Lasik | No benefit | Discount available | Discount available |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

| | Vision Care Direct | | VSP | |
|---|---|---|---|---|
| **Covered Services** | **Network** | **Non-Network** | **Network** | **Non-Network** |
| **Eye Exams** | $15 copay for full comprehensive exam including dilation | Reimbursed up to $50 | Covered in full after $10 copay | Reimbursed up to $45 after $10 copay |
| **Lenses Per Pair** | $15 copay<br>Single vision, bifocal, trifocal, lenticular lenses<br>At a PLUS PLAN Provider, you receive free upgrades for HD polycarbonate, no-line progressive lenses with high quality anti-reflection, scratch and UV coatings (refer to Vision Notes for details) | Reimbursed up to:<br>$50 single<br>$75 bifocal<br>$100 trifocal<br>$100 progressive | Covered in full after $25 materials copay<br>Polycarbonate lenses covered in full for dependent children<br>Standard progressives covered in full | Reimbursed up to:<br>$30 single<br>$50 bifocal<br>$65 trifocal<br>$50 progressive<br>After $25 materials copay |
| **Frames** | Covered in full up to $130 for any frame | Reimbursed up to $60 | Covered in full up to $170 or $220 for featured frame brands<br>20% discount on any overage | Reimbursed up to $70 after $25 materials copay |
| **Contact Lenses** | No copay for fitting fee<br>$130 allowance, in lieu of glasses<br>$250 allowance for medically necessary contacts | $80 allowance, in lieu of glasses | $120 allowance, in lieu of glasses<br>Up to $60 copay for contact lens exam (fitting and evaluation)<br>Medically necessary contacts are covered in full after the $25 material copay | Reimbursed up to $105, in lieu of glasses<br>Medically necessary contacts are covered up to $210 after the $25 copay |
| **Laser Vision Correction** | Up to $1,000 discount at nJoy facilities in Oklahoma City and Tulsa | No benefit | Average discount of 15% off regular price or 5% off promotional price | No benefit |

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to Contact Information at the back of this guide.

# VISION PLAN NOTES

***PVCS:*** The only Oklahoma owned and operated vision care plan with unlimited network services. Member must select either network or non-network for entire year. Network services are unlimited. Non-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 or refittings; and a $150 service fee applies to hybrid contact lens fittings or refittings. 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, network contact lens materials available at **www.contactsdirect.com/superiorvision**. 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 with provider offices that accept our discount plans. 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, which means customer service is here in the state to help you anytime you need help. It also means that you support your local community when you buy a plan based in Oklahoma! When you compare the total cost of your premium and what you spend in the doctor's office, you will see in most cases 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 any frame up to $130 and simply pay the difference if you go over. No more Frame Kit or Unbundling Fees, we have simplified the process to improve your experience. What would normally cost you over $300 for progressive lenses will cost you much less with VCD. Visit **www.okstate.vision** for more information and inclusions/limitations, as well as a provider search. For our provider list, be sure to look for the VCD Plus logo to receive all the free options mentioned above. For more information, call 855-918-2020 or email oklahoma@visioncaredirect.com.

***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 choosing a frame valued at more than the allowance, member saves 20 percent on out-of-pocket costs when using a VSP doctor. Member receives an extra $50 toward frame allowance when selecting a Marchon frame. Contact lenses are in lieu of spectacle lenses and frame. The $120 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 non-network allowance applies to the contacts and contact lens exam. 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 – member receives an extra 20 percent off additional complete pairs of glasses, sunglasses or lens options at any VSP provider within last 12 months from 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

## Medicare Supplement Plans

**Blue Cross Blue Shield of Oklahoma**
**Member Services**
855-609-5684
TTY 711
**www.bcbsok.com/state**

**HealthChoice**

**Medical**
800-323-4314
TTY 711

**Pharmacy**
866-275-5253
TTY 711
**www.healthchoiceconnect.com**

## MAPD Plans

**Blue Cross Blue Shield of Oklahoma**
**Member Services**
855-609-5684
TTY 711
**www.bcbsok.com/state**

**CommunityCare Senior Health Plan**
800-642-8065
TDD/TTY 800-722-0353
**www.ccok.com**

**Generations by GlobalHealth**

**Prospective Members**
844-322-8422
TTY 711

**Current Members**
405-280-5555 or 844-280-5555
TTY 711
**www.globalhealth.com/medicare**

**Humana**
866-396-8810
TTY 711
9 a.m. to 10 p.m. (CT)
**www.humana.com**

## Eligibility and Enrollment Program Administrator

**Employees Group Insurance Division**
3545 N.W. 58th St., Ste. 600
Oklahoma City, OK 73112
405-717-8780 or toll-free 800-752-9475
TTY 711
**omes.ok.gov**

## Dental Plans

**Cigna Prepaid Dental**
800-244-6224
Hearing-impaired relay 800-654-5988
**www.cigna.com**

**Delta Dental**
405-607-2100 or 800-522-0188
**DeltaDentalOK.org/client/OK**

**HealthChoice**
800-323-4314
TTY 711
**www.healthchoiceconnect.com**

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

**Sun Life**
800-442-7742
**www.sunlife.com**

## 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 TTY 711
**www.okstate.vision**

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


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