COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

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

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

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High and High Alternative Plans	HealthChoice Basic and Basic Alternative Plans	HealthChoice HDHP
Calendar Year Deductible	**High Plan** $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, and Basic Alternative Plans have a separate pharmacy out-of-pocket maximum, refer to page 23)**	**High Plan*** Copays apply $3,300 Network individual $8,400 Network family $3,800 non-Network individual $9,900 non-Network family, plus amounts over Allowable Fees **High Alternative Plan*** Copays apply $3,550 Network individual $8,400 Network family $4,050 non-Network individual $9,900 non-Network family, plus amounts over Allowable Fees	**Basic Plan** $4,000 individual $9,000 family **Basic Alternative Plan** $4,000 individual $9,000 family	$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

Plan changes are indicated by **bold text**.
*Emergency room and office visit copays apply. Coinsurance applies until the out-of-pocket maximum is met.
**The $30 copay applies to general practitioners, internal medicine physicians, OB/GYNs, pediatricians, physician assistants and nurse practitioners.

2017 HEALTH PLAN COMPARISON

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

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

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

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High and High Alternative Plans	HealthChoice Basic and Basic Alternative Plans	HealthChoice HDHP
Preventive Services	$0 copay for two preventive services office visits per calendar year for members and dependents ages 18 and older One mammogram per year at no charge for women ages 40 and older	$0 copay for two preventive services office visits per calendar year for members and dependents ages 18 and older One mammogram per year at no charge for women ages 40 and older No deductible for well child care visit 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 18 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 **$200** ER copay – waived if admitted		20% of Allowable Fees after deductible Additional **$200** ER copay – waived if admitted
Urgent Care	$30/$50** office visit copay may apply 20% of Allowable Fees after deductible		$30/$50** office visit copay may apply after deductible 20% of Allowable Fees after deductible

Plan changes are indicated by **bold text**.
**The $30 copay applies to general practitioners, internal medicine physicians, OB/GYNs, pediatricians, physician assistants and nurse practitioners.

2017 HEALTH PLAN COMPARISON

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

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

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

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High and High Alternative Plans	HealthChoice Basic and Basic Alternative Plans	HealthChoice HDHP
Maternity Pre and Post Natal Care	20% of Allowable Fees after deductible Includes one postpartum home visit – criteria must be met	Copays do not apply All covered services, exceptions, limitations and conditions are identical to the HealthChoice High Plan **Basic Plan** $0 of the first $500 of Allowable Fees 100% of the next $1,000 of Allowable Fees (deductible). Only Allowable Fees count toward the deductible; 50% of the next $6,000 of Allowable Fees **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 **20** services per calendar year without certification		20% of Allowable Fees after deductible Limit of **20** services per calendar year without certification
Occupational or Speech Therapy Visit	20% of Allowable Fees after deductible **Occupational therapy*** Limit of 20 visits per year without certification **Speech therapy*** For ages 17 and younger, certification required For ages 18 and older, certification not required *Maximum of 60 visits per year		20% of Allowable Fees after deductible **Occupational therapy*** Limit of 20 visits per year without certification **Speech therapy*** For ages 17 and younger, certification required For ages 18 and older, certification not required *Maximum of 60 visits per year
Physical Therapy or Physical Medicine Visit	20% of Allowable Fees after deductible Limit of 20 visits per year without certification Maximum of 60 visits per year		20% of Allowable Fees after deductible Limit of 20 visits per year without certification Maximum of 60 visits per year
Chiropractic and Manipulative Therapy Visit	**Chiropractic therapy** 20% of Allowable Fees after deductible Limit of 20 visits per year without certification Maximum of 60 visits per year **Manipulative therapy** Refer to “Physical Therapy/ Physical Medicine” above		**Chiropractic therapy** 20% of Allowable Fees after deductible Limit of 20 visits per year without certification Maximum of 60 visits per year **Manipulative therapy** Refer to “Physical Therapy/ Physical Medicine” above

Plan changes are indicated by **bold text**.
*The $30 copay applies to general practitioners, internal medicine physicians, OB/GYNs, pediatricians, physician assistants and nurse practitioners.

2017 HEALTH PLAN COMPARISON

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

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

Plan changes are indicated by **bold text**.
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COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

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

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

HEALTHCHOICE HIGH AND HIGH ALTERNATIVE PLANS

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

HEALTHCHOICE HIGH AND HIGH ALTERNATIVE PLANS AND HIGH DEDUCTIBLE HEALTH PLAN

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

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

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

HEALTHCHOICE HDHP

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

ALL HEALTHCHOICE PLANS

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

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

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

2017 HEALTH PLAN COMPARISON