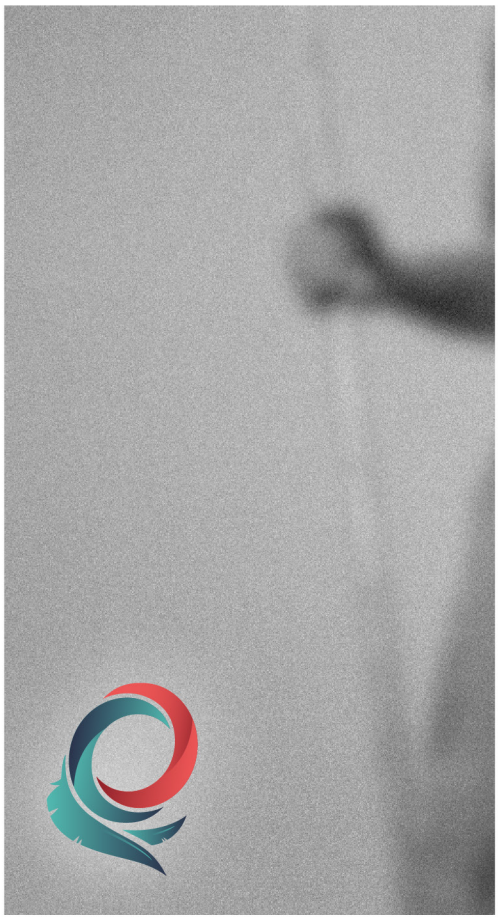
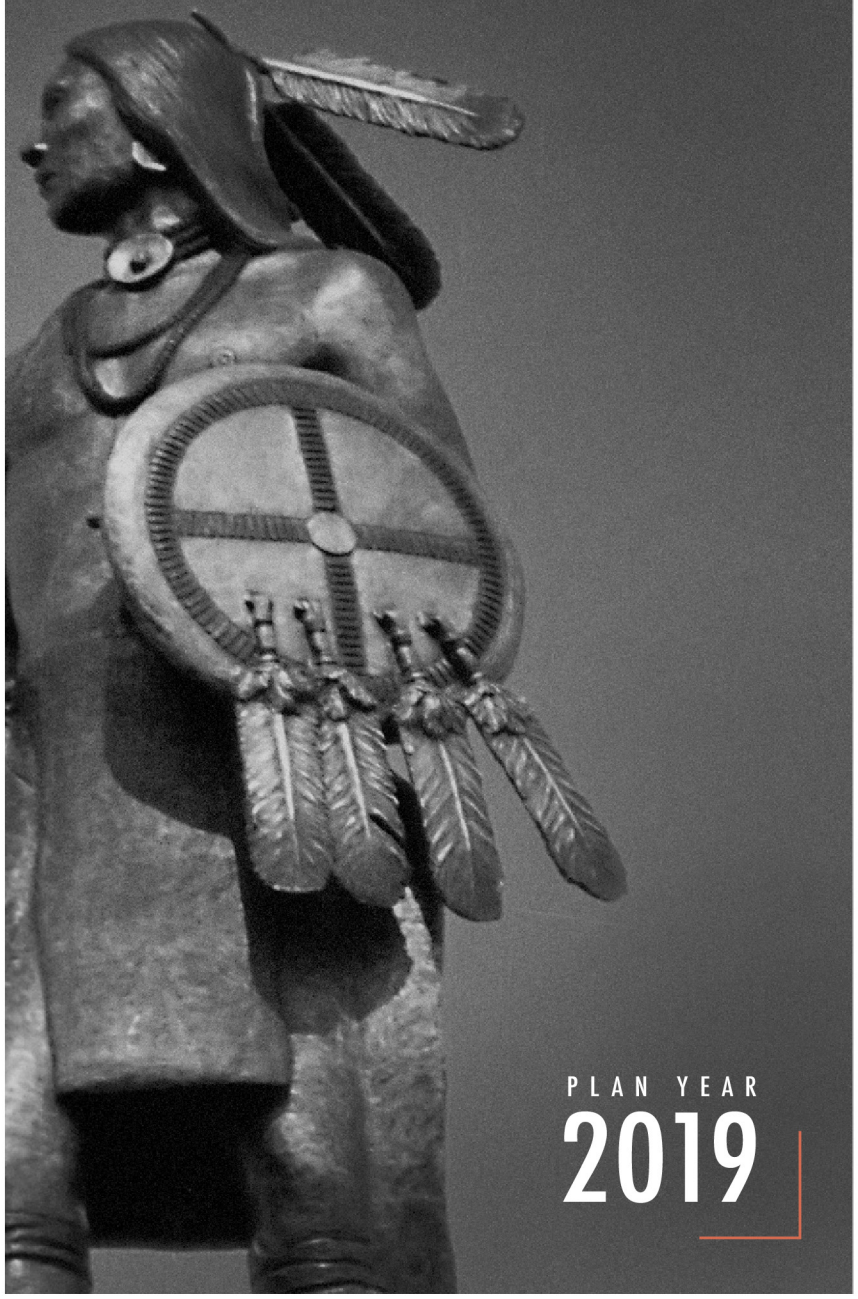
JAN. 1 - DEC. 31, 2019



HEALTH | DENTAL | LIFE | VISION

# EMPLOYEE BENEFIT

## OPTIONS GUIDE



PLAN YEAR

2019

# Monthly Premiums for Current Employees

**Plan Year Jan. 1 through Dec. 31, 2019**

| HEALTH PLANS | MEMBER | SPOUSE | CHILD | CHILDREN |
|---|---|---|---|---|
| Aetna HMO | $ 897.90 | $ 1,472.24 | $ 601.60 | $ 962.52 |
| BlueLincs HMO | $ 550.00 | $ 811.90 | $ 297.16 | $ 485.24 |
| CommunityCare HMO | $ 894.32 | $ 1,302.68 | $ 455.48 | $ 728.78 |
| GlobalHealth HMO | $ 623.18 | $ 919.88 | $ 355.88 | $ 581.16 |
| HealthChoice High and High Alternative | $ 594.90 | $ 697.50 | $ 299.24 | $ 507.80 |
| HealthChoice Basic and Basic Alternative | $ 466.42 | $ 547.38 | $ 240.54 | $ 406.88 |
| HealthChoice High Deductible Health Plan (HDHP) | $ 401.78 | $ 471.82 | $ 207.52 | $ 350.36 |
| DISABILITY (Employee only) | $9.10 (Limited city and county participation only) | | | |

| DENTAL PLANS | MEMBER | SPOUSE | CHILD | CHILDREN |
|---|---|---|---|---|
| Cigna Dental Care Plan (Prepaid) | $ 9.44 | $ 6.18 | $ 4.20 | $ 9.46 |
| Delta Dental PPO | $ 35.84 | $ 35.82 | $ 31.18 | $ 78.86 |
| Delta Dental PPO – Choice | $ 15.68 | $ 35.56 | $ 35.82 | $ 86.96 |
| HealthChoice Dental | $ 39.12 | $ 39.12 | $ 31.58 | $ 81.10 |
| MetLife High Classic MAC | $ 46.24 | $ 46.24 | $ 39.62 | $ 98.16 |
| MetLife Low Classic MAC | $ 26.64 | $ 26.64 | $ 22.82 | $ 56.16 |
| Sun Life Preferred Active PPO | $ 30.26 | $ 30.10 | $ 22.58 | $ 60.68 |

| VISION PLANS | MEMBER | SPOUSE | CHILD | CHILDREN |
|---|---|---|---|---|
| Primary Vision Care Services (PVCS) | $ 9.98 | $ 8.90 | $ 8.70 | $ 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 | |
|---|---|
| HealthChoice Basic Life ($20,000) $4.00 | First $20,000 of Supplemental Life $4.00 |

| SUPPLEMENTAL LIFE — Age Rated Cost Per $20,000 Unit | | | |
|---|---|---|---|
| < 30 ---- $ 1.20 | 30 - 34 ---- $ 1.20 | 35 - 39 ---- $ 1.20 | 40 - 44 ---- $ 1.60 |
| 45 - 49 ---- $ 2.80 | 50 - 54 ---- $ 5.20 | 55 - 59 ---- $ 8.00 | 60 - 64 ---- $ 9.20 |
| 65 - 69 ---- $ 14.80 | 70 - 74 ---- $ 25.60 | 75+ ---- $ 39.20 | |

| DEPENDENT LIFE | Low Option $2.60 | Standard Option $4.32 | Premier Option $8.64 |
|---|---|---|---|
| Spouse | $6,000 of coverage | $10,000 of coverage | $20,000 of coverage |
| Child (live birth to age 26) | $3,000 of coverage | $ 5,000 of coverage | $10,000 of coverage |

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

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

# TABLE OF CONTENTS



This information is only a brief summary of the plans. All benefits and limitations of these plans are governed in all cases by the relevant plan documents, insurance contracts, handbooks and *Administrative Rules* of the Office of Management and Enterprise Services. The rules of the Oklahoma Administrative Code, Title 260, are controlling in all aspects of plan benefits. No oral statement of any person shall modify or otherwise affect the benefits, limitations or exclusions of any plan.

A fully accessible version of this guide is available at **omes.ok.gov**. Select Services, then Employees Group Insurance Division.


This publication was printed by the Office of Management and Enterprise Services as authorized by Title 62, Section 34. 1,500 copies have been printed at a cost of $3,375.00. A copy has been submitted to Documents.OK.gov in accordance with the Oklahoma State Government Open Documents Initiative (62 O.S. 2012, § 34.11.3).

# 2019 PLAN CHANGES AND IMPORTANT REMINDERS

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

## HEALTH PLANS

### Aetna INTEGRIS and Aetna St. John HMO

- Aetna St. John ZIP code service area has expanded.
- Calendar year out-of-pocket maximum has increased to $5,000 for an individual and $10,000 for a family.
- Maximum copay for inpatient stays has increased to $1,000.
- Copays for some services have changed. Refer to the Comparison of Network Benefits for Health Plans.

### Blue Cross and Blue Shield of Oklahoma BlueLincs HMO

- BlueLincs HMO is a new plan for 2019. Refer to the ZIP code service area for eligibility. Refer to the Comparison of Network Benefits for Health Plans.

### CommunityCare HMO

- Inpatient hospital copays have increased to $350 copay per day with a $1,750 maximum.
- Outpatient hospital copay has decreased to $300 per visit.
- Copays for some services have changed. Refer to the Comparison of Network Benefits for Health Plans.
- CommunityCare is changing the Pharmacy Benefit Manager to CVS. Along with this change, the preferred/non-preferred pharmacy network arrangement will no longer be in place.
- Pharmacy benefit structure has been redesigned. Refer to the Comparison of Network Benefits for Health Plans for pharmacy plan information.

### GlobalHealth HMO

- Calendar year out-of-pocket maximum has increased to $4,000 for an individual and $12,000 for a family.
- Copays for some services have changed and some services now include an additional copay for physician charges. Refer to the Comparison of Network Benefits for Health Plans.

### HealthChoice Health Plans

- There will be some changes to the list of preferred medications. If you are a HealthChoice health plan member who is taking a medication that will no longer be covered in 2019, you will be notified by mail. For a complete list of medications that will no longer be covered, please visit **www.healthchoiceok.com**.

### HealthChoice High

- Copay for urgent care is $30.

### HealthChoice High Deductible Health Plan (HDHP)

- The HSA maximum annual contribution for an individual is increasing from $3,450 to $3,500.
- The HSA maximum annual contribution for a family is increasing from $6,900 to $7,000.

## DENTAL PLANS

If your plan is not an option in 2019, your personalized Option Period form indicates the coverage end date. You then need to choose a new plan. If you do not, your dental coverage will end Dec. 31, 2018.

### Delta Dental

- Delta Dental PPO Plus Premier will not be available in 2019.

### MetLife

- MetLife Value PDP will not be available in 2019.
- MetLife High Classic MAC was formerly known as MetLife Classic.
- MetLife Low Classic MAC was formerly known as MetLife Value MAC.
  - Deductible increased to $50 for an individual and $150 for a family.
  - Basic Care: Member network coinsurance increased to 30%.
  - Major Care: Member network coinsurance increased to 50%.
  - Orthodontic Care: Member network coinsurance increased to 50%.
  - Plan Year Maximum decreased to $1,500.

### Sun Life (formerly Assurant)

- Assurant Heritage Plus with SBA (Prepaid) and Assurant Heritage Secure will not be available in 2019.
- Sun Life Preferred Active PPO was formerly known as Assurant Freedom Preferred.

## VISION PLANS

### Vision Care Direct

- **Lenses** Network: $15 copay includes lenticular lenses; PLUS Plan offers free upgrades for high definition polycarbonate, premium anti-reflection, scratch and UV coatings, and no-line progressive lenses. Non-network: Plan reimbursement for bifocals increased to $75.

### VSP

- **Eye exams** Non-network: Plan reimbursement is after a $10 copay.
- **Lenses** Non-network: Plan reimbursement is after a $25 materials copay.
- **Frames** Non-network: Plan reimbursement is after a $25 materials copay.

## REMINDER

If you are enrolled in the HealthChoice High or Basic Plan and wish to stay enrolled in that plan, you must complete the online tobacco-free attestation for Plan Year 2019 available at **www.healthchoiceok.com** by Nov. 9, 2018.

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

If you cannot sign the tobacco-free attestation because either you or a covered dependent uses tobacco, you can still qualify for the High or Basic plan if those who use tobacco complete one of the following alternatives by Nov. 9:

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

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

# GENERAL INFORMATION

The benefits you select will be in effect Jan. 1, or for new employees, the effective date of your coverage, through Dec. 31, 2019, or the last day of the month of your termination date.

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

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

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

## HEALTH PLANS

**There are several health plans available:**

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

**Refer to Comparison of Network Benefits for Health Plans on pages 20-27 for benefit information.**

- There are no preexisting condition exclusions or limitations applied to any of the health plans.
- All health plans coordinate benefits with other group insurance plans you have in force.
- You must **live or work** within an HMO's ZIP code service area to be eligible. Post office box addresses cannot be used to determine your HMO eligibility. Refer to pages 12-19 for the HMO ZIP Code Lists.
- If you select an HMO, you must use the provider network designated by that plan for Oklahoma.
- To remain enrolled in the HealthChoice High or Basic Plan for 2019, you must complete the tobacco-free attestation located on the HealthChoice website or a reasonable alternative.
- HealthChoice contracts with American Fidelity Health Services Administration to waive fees and make establishing and keeping a health savings account easier and more convenient for HealthChoice HDHP members.

## HSA Information

Health savings accounts allow you to save money for HSA-eligible expenses, and they give you the ability to take greater control of your own health care costs. An HSA allows you to payroll deduct pre-tax HSA contributions.

### Triple Tax Savings Advantage

When coupled with your Section 125 Plan, the HSA allows you a triple tax advantage:

- Pre-tax contributions.
- Tax-free interest accumulation.
- Tax-free distributions for qualified medical expenses.

### HSA Card

Use your HSA Card to pay for eligible expenses instead of paying out-of-pocket.

- Direct access to funds.
- Eliminate distribution wait time.
- Accepted at doctor's offices, retailers and pharmacies.

### Online Account Access

Distributions can be requested online either before or after an expense has been incurred. Distributions can be received via check by mail or by direct deposit.

### Health Savings Account Form

If you choose American Fidelity for your HSA, you must complete the American Fidelity Health Savings Account Form and return it directly to American Fidelity.

For more information about HSAs, contact American Fidelity at the number located in Contact Information at the back of this guide.

## Electing a TRICARE Supplement Plan
(Military only)

**NOTE:** *If you do not currently have TRICARE coverage as a current or former military member, EGID cannot enroll you in TRICARE coverage, and you are not eligible for the TRICARE Supplement Plan.* If you currently have TRICARE coverage and are younger than age 65, you can choose to enroll in the TRICARE Supplement Plan. Electing to purchase the TRICARE Supplement Plan means that TRICARE will be primarily responsible for your medical coverage and the supplement plan will be secondarily responsible for coverage. The plan covers the cost shares and copays, including prescription drugs; a portion of the TRICARE deductible; and excess charges up to the legal limit. By your election, you submit to the eligibility rules of TRICARE and the TRICARE Supplement Plan. These rules may be different from the rules of eligibility created by the State of Oklahoma. Medicare may become the primary insurer upon attaining eligibility for Medicare. For more information on the TRICARE Supplement Plan, refer to **http://omes.ok.gov/services/employees-group-insurance-division/tricare-supplement**.

## DENTAL PLANS

**There are several dental plans available:**

- Cigna Dental Care Plan (Prepaid)
- Delta Dental PPO
- Delta Dental PPO – Choice
- HealthChoice Dental
- MetLife High Classic MAC
- MetLife Low Classic MAC
- Sun Life Preferred Active PPO

**Refer to Comparison of Benefits for Dental Plans on pages 28-31 for benefit information.**

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

## VISION PLANS

**There are several vision plans available:**

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

**Refer to Comparison of Benefits for Vision Plans on pages 32-34 for benefit information.**

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

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

## HEALTHCHOICE LIFE INSURANCE PLAN

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

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

## Basic Life Insurance. . . For You

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

## Supplemental Life Insurance . . . For You

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

## Beneficiary Designation

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

## Dependent Life Insurance . . . For Your Eligible Dependents

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

| DEPENDENT | LOW OPTION | STANDARD OPTION | PREMIER OPTION |
|---|---|---|---|
| Spouse | $ 6,000 of coverage | $ 10,000 of coverage | $ 20,000 of coverage |
| Child (live birth to age 26) | $ 3,000 of coverage | $ 5,000 of coverage | $ 10,000 of coverage |

Dependent Life does not include AD&D benefits.

## HEALTHCHOICE DISABILITY PLAN
(limited city and county participation)

The HealthChoice Disability Plan provides partial replacement income if you are unable to work due to an illness or injury. Disability coverage is not available to dependents. For 2019, there is a new disability administrator.

## Eligibility

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

# ENROLLMENT PERIODS

## Option Period Enrollment – Coverage effective Jan. 1, 2019

This is the time when eligible employees can:

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

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

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

This is the time when new employees are eligible to:

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

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

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

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

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

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

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

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

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

# ELIGIBILITY

## Members

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

## Dependents

- If one eligible dependent is covered, all eligible dependents must be covered. Exceptions apply (refer to Excluding Dependents from Coverage in this section).
- Eligible dependents include:
  - Your legal spouse (including common-law).
  - Your daughter, son, stepdaughter, stepson, eligible foster child, adopted child or child legally placed with you for adoption up to age 26, whether married or unmarried.
  - A dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26. Subject to medical review and approval.
  - Other unmarried dependent children up to age 26, upon completion and approval of an Application for Coverage for Other Dependent Children. Guardianship papers or a tax return showing dependency can be provided in lieu of the application.
- If your spouse is enrolled separately in one of the plans offered through EGID, your dependents can be covered under either parent's health, dental and/or vision plan (but not both); however, both parents can cover dependents under Dependent Life.
- Dependents who are not enrolled within 30 days of your eligibility date cannot be enrolled until the next annual Option Period, unless a qualifying event such as birth, marriage or loss of other group coverage occurs. Dependent coverage can be dropped midyear with a qualifying event.
- Dependents can be enrolled only in the same types of coverage and in the same plans you elect.
- To enroll your newborn, the appropriate form must be provided to your insurance coordinator within 30 days of the birth. This coverage is effective the first of the birth month. If you do not enroll your newborn during this 30-day period, you cannot do so until the next annual Option Period. Direct notification to a plan will not enroll your newborn or any other dependents. The newborn's Social Security number is not required at the time of initial enrollment, but must be provided once it is received from Social Security. Insurance premiums for the month the child was born must be paid.
- Without enrollment:
  - HealthChoice – A newborn is covered only for the first 48 hours following a vaginal birth or the first 96 hours following a cesarean section birth. Under the HealthChoice plans, a separate deductible and coinsurance apply.
  - Aetna, BlueLincs, CommunityCare, and GlobalHealth HMOs – A newborn is covered for 31 days without an additional premium.

## Excluding Dependents from Coverage

- You can exclude your spouse from health and/or dental coverage while covering other dependents on these benefits. Your spouse must sign the Spouse Exclusion Certification section of your enrollment or change form. Check with your insurance coordinator for more information.

- You can exclude dependents who do not reside with you, are married, are not financially dependent on you for support, have other group coverage or are eligible for Indian or military health benefits.

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

## Confirmation Statements

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

## Transfer Employee

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

## Retiring and Changing Plans

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

## Termination of Coverage

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

## COBRA – Temporary Continuation of Coverage

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

# THRIVE: OKLAHOMA EMPLOYEE WELL-BEING

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

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

## Thrive Well-Being Toolkits

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

## Aetna INTEGRIS

| | | | | | | |
|---|---|---|---|---|---|---|
| 73003 | 73007 | 73008 | 73012 | 73013 | 73014 | 73019 |
| 73020 | 73022 | 73025 | 73026 | 73034 | 73036 | 73045 |
| 73049 | 73051 | 73054 | 73064 | 73066 | 73068 | 73069 |
| 73070 | 73071 | 73072 | 73078 | 73083 | 73084 | 73085 |
| 73090 | 73097 | 73099 | 73101 | 73102 | 73103 | 73104 |
| 73105 | 73106 | 73107 | 73108 | 73109 | 73110 | 73111 |
| 73112 | 73113 | 73114 | 73115 | 73116 | 73117 | 73118 |
| 73119 | 73120 | 73121 | 73122 | 73123 | 73124 | 73125 |
| 73126 | 73127 | 73128 | 73129 | 73130 | 73131 | 73132 |
| 73134 | 73135 | 73136 | 73137 | 73139 | 73140 | 73141 |
| 73142 | 73143 | 73144 | 73145 | 73146 | 73147 | 73148 |
| 73149 | 73150 | 73151 | 73152 | 73153 | 73154 | 73155 |
| 73156 | 73157 | 73159 | 73160 | 73162 | 73163 | 73164 |
| 73165 | 73167 | 73169 | 73170 | 73172 | 73173 | 73178 |
| 73179 | 73184 | 73185 | 73189 | 73190 | 73194 | 73195 |
| 73196 | 73198 | 74857 | | | | |

## Aetna St. John

| | | | | | | |
|---|---|---|---|---|---|---|
| 74001 | 74002 | 74003 | 74004 | 74005 | 74006 | 74008 |
| 74010 | 74011 | 74012 | 74013 | 74015 | 74016 | 74017 |
| 74018 | 74019 | 74021 | 74022 | 74028 | 74029 | 74030 |
| 74031 | 74033 | 74035 | 74036 | 74037 | 74039 | 74041 |
| 74043 | 74044 | 74046 | 74047 | 74050 | 74051 | 74052 |
| 74053 | 74054 | 74055 | 74056 | 74060 | 74061 | 74063 |
| 74066 | 74067 | 74068 | 74070 | 74071 | 74073 | 74080 |
| 74082 | 74084 | 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 | 74192 | 74193 |
| 74194 | 74633 | 74637 | 74652 | | | |

# BlueLincs ZIP Code List

| | | | | | | |
|---|---|---|---|---|---|---|
| 73001 | 73002 | 73003 | 73004 | 73005 | 73006 | 73007 |
| 73008 | 73009 | 73010 | 73011 | 73012 | 73013 | 73014 |
| 73015 | 73016 | 73017 | 73018 | 73019 | 73020 | 73021 |
| 73022 | 73023 | 73024 | 73025 | 73026 | 73027 | 73028 |
| 73029 | 73030 | 73031 | 73032 | 73033 | 73034 | 73036 |
| 73038 | 73039 | 73040 | 73041 | 73042 | 73043 | 73044 |
| 73045 | 73047 | 73048 | 73049 | 73050 | 73051 | 73052 |
| 73053 | 73054 | 73055 | 73056 | 73057 | 73058 | 73059 |
| 73061 | 73062 | 73063 | 73064 | 73065 | 73066 | 73067 |
| 73068 | 73069 | 73070 | 73071 | 73072 | 73073 | 73074 |
| 73075 | 73077 | 73078 | 73079 | 73080 | 73082 | 73083 |
| 73084 | 73085 | 73086 | 73089 | 73090 | 73092 | 73093 |
| 73095 | 73096 | 73097 | 73098 | 73099 | 73101 | 73102 |
| 73103 | 73104 | 73105 | 73106 | 73107 | 73108 | 73109 |
| 73110 | 73111 | 73112 | 73113 | 73114 | 73115 | 73116 |
| 73117 | 73118 | 73119 | 73120 | 73121 | 73122 | 73123 |
| 73124 | 73125 | 73126 | 73127 | 73128 | 73129 | 73130 |
| 73131 | 73132 | 73134 | 73135 | 73136 | 73137 | 73139 |
| 73140 | 73141 | 73142 | 73143 | 73144 | 73145 | 73146 |
| 73147 | 73148 | 73149 | 73150 | 73151 | 73152 | 73153 |
| 73154 | 73155 | 73156 | 73157 | 73159 | 73160 | 73162 |
| 73163 | 73164 | 73165 | 73167 | 73169 | 73170 | 73172 |
| 73173 | 73178 | 73179 | 73184 | 73185 | 73189 | 73190 |
| 73194 | 73195 | 73196 | 73198 | 73401 | 73402 | 73403 |
| 73425 | 73430 | 73432 | 73433 | 73434 | 73435 | 73436 |
| 73437 | 73438 | 73439 | 73440 | 73441 | 73442 | 73443 |
| 73444 | 73446 | 73447 | 73448 | 73449 | 73450 | 73453 |
| 73455 | 73456 | 73458 | 73459 | 73460 | 73461 | 73463 |
| 73481 | 73487 | 73488 | 73491 | 73501 | 73502 | 73503 |
| 73505 | 73506 | 73507 | 73520 | 73521 | 73522 | 73523 |
| 73526 | 73527 | 73528 | 73529 | 73530 | 73531 | 73532 |
| 73533 | 73534 | 73536 | 73537 | 73538 | 73539 | 73540 |
| 73541 | 73542 | 73543 | 73544 | 73546 | 73547 | 73548 |
| 73549 | 73550 | 73551 | 73552 | 73553 | 73554 | 73555 |
| 73556 | 73557 | 73558 | 73559 | 73560 | 73561 | 73562 |
| 73564 | 73565 | 73566 | 73567 | 73568 | 73569 | 73570 |
| 73571 | 73572 | 73573 | 73601 | 73620 | 73622 | 73624 |
| 73625 | 73626 | 73627 | 73628 | 73632 | 73638 | 73639 |
| 73641 | 73642 | 73644 | 73645 | 73646 | 73647 | 73648 |
| 73650 | 73651 | 73654 | 73655 | 73658 | 73659 | 73660 |
| 73661 | 73662 | 73663 | 73664 | 73666 | 73667 | 73668 |
| 73669 | 73673 | 73701 | 73702 | 73703 | 73705 | 73706 |
| 73716 | 73717 | 73718 | 73719 | 73720 | 73722 | 73724 |
| 73726 | 73727 | 73728 | 73729 | 73730 | 73731 | 73733 |

# BlueLincs ZIP Code List

| 73734 | 73735 | 73736 | 73737 | 73738 | 73739 | 73741 |
|---|---|---|---|---|---|---|
| 73742 | 73743 | 73744 | 73746 | 73747 | 73749 | 73750 |
| 73753 | 73754 | 73755 | 73756 | 73757 | 73758 | 73759 |
| 73760 | 73761 | 73762 | 73763 | 73764 | 73766 | 73768 |
| 73770 | 73771 | 73772 | 73773 | 73801 | 73802 | 73832 |
| 73834 | 73835 | 73838 | 73840 | 73841 | 73842 | 73843 |
| 73844 | 73848 | 73851 | 73852 | 73853 | 73855 | 73857 |
| 73858 | 73859 | 73860 | 73901 | 73931 | 73932 | 73933 |
| 73937 | 73938 | 73939 | 73942 | 73944 | 73945 | 73946 |
| 73947 | 73949 | 73950 | 73951 | 74001 | 74002 | 74003 |
| 74004 | 74005 | 74006 | 74008 | 74010 | 74011 | 74012 |
| 74013 | 74014 | 74015 | 74016 | 74017 | 74018 | 74019 |
| 74020 | 74021 | 74022 | 74023 | 74026 | 74027 | 74028 |
| 74029 | 74030 | 74031 | 74032 | 74033 | 74034 | 74035 |
| 74036 | 74037 | 74038 | 74039 | 74041 | 74042 | 74043 |
| 74044 | 74045 | 74046 | 74047 | 74048 | 74050 | 74051 |
| 74052 | 74053 | 74054 | 74055 | 74056 | 74058 | 74059 |
| 74060 | 74061 | 74062 | 74063 | 74066 | 74067 | 74068 |
| 74070 | 74071 | 74072 | 74073 | 74074 | 74075 | 74076 |
| 74077 | 74078 | 74079 | 74080 | 74081 | 74082 | 74083 |
| 74084 | 74085 | 74101 | 74102 | 74103 | 74104 | 74105 |
| 74106 | 74107 | 74108 | 74110 | 74112 | 74114 | 74115 |
| 74116 | 74117 | 74119 | 74120 | 74121 | 74126 | 74127 |
| 74128 | 74129 | 74130 | 74131 | 74132 | 74133 | 74134 |
| 74135 | 74136 | 74137 | 74141 | 74145 | 74146 | 74147 |
| 74148 | 74149 | 74150 | 74152 | 74153 | 74155 | 74156 |
| 74157 | 74158 | 74159 | 74169 | 74170 | 74171 | 74172 |
| 74182 | 74183 | 74184 | 74186 | 74187 | 74192 | 74193 |
| 74194 | 74301 | 74330 | 74331 | 74332 | 74333 | 74335 |
| 74337 | 74338 | 74339 | 74340 | 74342 | 74343 | 74344 |
| 74345 | 74346 | 74347 | 74349 | 74350 | 74352 | 74354 |
| 74355 | 74358 | 74359 | 74360 | 74361 | 74362 | 74363 |
| 74364 | 74365 | 74366 | 74367 | 74368 | 74369 | 74370 |
| 74401 | 74402 | 74403 | 74421 | 74422 | 74423 | 74425 |
| 74426 | 74427 | 74428 | 74429 | 74430 | 74431 | 74432 |
| 74434 | 74435 | 74436 | 74437 | 74438 | 74439 | 74440 |
| 74441 | 74442 | 74444 | 74445 | 74446 | 74447 | 74450 |
| 74451 | 74452 | 74454 | 74455 | 74456 | 74457 | 74458 |
| 74459 | 74460 | 74461 | 74462 | 74463 | 74464 | 74465 |
| 74467 | 74468 | 74469 | 74470 | 74471 | 74472 | 74477 |
| 74501 | 74502 | 74521 | 74522 | 74523 | 74525 | 74528 |
| 74529 | 74530 | 74531 | 74533 | 74534 | 74535 | 74536 |
| 74538 | 74540 | 74542 | 74543 | 74545 | 74546 | 74547 |
| 74549 | 74552 | 74553 | 74554 | 74555 | 74556 | 74557 |

# BlueLincs ZIP Code List

| | | | | | | |
|---|---|---|---|---|---|---|
| 74558 | 74559 | 74560 | 74561 | 74562 | 74563 | 74565 |
| 74567 | 74569 | 74570 | 74571 | 74572 | 74574 | 74576 |
| 74577 | 74578 | 74601 | 74602 | 74604 | 74630 | 74631 |
| 74632 | 74633 | 74636 | 74637 | 74640 | 74641 | 74643 |
| 74644 | 74646 | 74647 | 74650 | 74651 | 74652 | 74653 |
| 74701 | 74702 | 74720 | 74721 | 74722 | 74723 | 74724 |
| 74726 | 74727 | 74728 | 74729 | 74730 | 74731 | 74733 |
| 74734 | 74735 | 74736 | 74737 | 74738 | 74740 | 74741 |
| 74743 | 74745 | 74747 | 74748 | 74750 | 74752 | 74753 |
| 74754 | 74755 | 74756 | 74759 | 74760 | 74761 | 74764 |
| 74766 | 74801 | 74802 | 74804 | 74818 | 74820 | 74821 |
| 74824 | 74825 | 74826 | 74827 | 74829 | 74830 | 74831 |
| 74832 | 74833 | 74834 | 74836 | 74837 | 74839 | 74840 |
| 74842 | 74843 | 74844 | 74845 | 74848 | 74849 | 74850 |
| 74851 | 74852 | 74854 | 74855 | 74856 | 74857 | 74859 |
| 74860 | 74864 | 74865 | 74866 | 74867 | 74868 | 74869 |
| 74871 | 74872 | 74873 | 74875 | 74878 | 74880 | 74881 |
| 74883 | 74884 | 74901 | 74902 | 74930 | 74931 | 74932 |
| 74935 | 74936 | 74937 | 74939 | 74940 | 74941 | 74942 |
| 74943 | 74944 | 74945 | 74946 | 74947 | 74948 | 74949 |
| 74951 | 74953 | 74954 | 74955 | 74956 | 74957 | 74959 |
| 74960 | 74962 | 74963 | 74964 | 74965 | 74966 | |

# CommunityCare ZIP Code List

| | | | | | | |
|---|---|---|---|---|---|---|
| 74001 | 74002 | 74003 | 74004 | 74005 | 74006 | 74008 |
| 74009 | 74010 | 74011 | 74012 | 74013 | 74014 | 74015 |
| 74016 | 74017 | 74018 | 74019 | 74020 | 74021 | 74022 |
| 74027 | 74028 | 74029 | 74030 | 74031 | 74032 | 74033 |
| 74034 | 74035 | 74036 | 74037 | 74038 | 74039 | 74041 |
| 74042 | 74043 | 74044 | 74045 | 74046 | 74047 | 74048 |
| 74050 | 74051 | 74052 | 74053 | 74054 | 74055 | 74056 |
| 74058 | 74060 | 74061 | 74063 | 74066 | 74067 | 74068 |
| 74070 | 74071 | 74072 | 74073 | 74079 | 74080 | 74081 |
| 74082 | 74083 | 74084 | 74085 | 74100 | 74101 | 74102 |
| 74103 | 74104 | 74105 | 74106 | 74107 | 74108 | 74110 |
| 74112 | 74114 | 74115 | 74116 | 74117 | 74119 | 74120 |
| 74121 | 74126 | 74127 | 74128 | 74129 | 74130 | 74131 |
| 74132 | 74133 | 74134 | 74135 | 74136 | 74137 | 74141 |
| 74145 | 74146 | 74147 | 74148 | 74149 | 74150 | 74152 |
| 74153 | 74155 | 74156 | 74157 | 74158 | 74159 | 74169 |
| 74170 | 74171 | 74172 | 74182 | 74183 | 74184 | 74186 |
| 74187 | 74189 | 74192 | 74193 | 74194 | 74301 | 74330 |
| 74331 | 74332 | 74333 | 74335 | 74337 | 74338 | 74339 |
| 74340 | 74342 | 74343 | 74344 | 74345 | 74346 | 74347 |
| 74349 | 74350 | 74352 | 74353 | 74354 | 74355 | 74358 |
| 74359 | 74360 | 74361 | 74362 | 74363 | 74364 | 74365 |
| 74366 | 74367 | 74368 | 74369 | 74370 | 74401 | 74402 |
| 74403 | 74421 | 74422 | 74423 | 74425 | 74426 | 74427 |
| 74428 | 74429 | 74430 | 74431 | 74432 | 74434 | 74435 |
| 74436 | 74437 | 74438 | 74439 | 74440 | 74441 | 74442 |
| 74444 | 74445 | 74446 | 74447 | 74450 | 74451 | 74452 |
| 74454 | 74455 | 74456 | 74457 | 74458 | 74459 | 74460 |
| 74461 | 74462 | 74463 | 74464 | 74465 | 74466 | 74467 |
| 74468 | 74469 | 74470 | 74471 | 74472 | 74477 | 74501 |
| 74502 | 74521 | 74522 | 74523 | 74526 | 74528 | 74529 |
| 74536 | 74540 | 74543 | 74545 | 74546 | 74547 | 74548 |
| 74549 | 74552 | 74553 | 74554 | 74557 | 74558 | 74559 |
| 74560 | 74561 | 74562 | 74563 | 74565 | 74567 | 74570 |
| 74571 | 74574 | 74576 | 74577 | 74578 | 74604 | 74633 |
| 74637 | 74650 | 74651 | 74652 | 74727 | 74728 | 74735 |
| 74738 | 74743 | 74754 | 74756 | 74759 | 74760 | 74761 |
| 74764 | 74839 | 74845 | 74901 | 74902 | 74930 | 74931 |
| 74932 | 74935 | 74936 | 74937 | 74939 | 74940 | 74941 |
| 74942 | 74943 | 74944 | 74945 | 74946 | 74947 | 74948 |
| 74949 | 74951 | 74953 | 74954 | 74955 | 74956 | 74957 |
| 74959 | 74960 | 74962 | 74964 | 74965 | 74966 | |

# GlobalHealth ZIP Code List

| 73001 | 73002 | 73003 | 73004 | 73005 | 73006 | 73007 |
|---|---|---|---|---|---|---|
| 73008 | 73009 | 73010 | 73011 | 73012 | 73013 | 73014 |
| 73015 | 73016 | 73017 | 73018 | 73019 | 73020 | 73021 |
| 73022 | 73023 | 73024 | 73025 | 73026 | 73027 | 73028 |
| 73029 | 73030 | 73031 | 73032 | 73033 | 73034 | 73036 |
| 73038 | 73039 | 73040 | 73041 | 73042 | 73043 | 73044 |
| 73045 | 73047 | 73048 | 73049 | 73050 | 73051 | 73052 |
| 73053 | 73054 | 73055 | 73056 | 73057 | 73058 | 73059 |
| 73061 | 73062 | 73063 | 73064 | 73065 | 73066 | 73067 |
| 73068 | 73069 | 73070 | 73071 | 73072 | 73073 | 73074 |
| 73075 | 73077 | 73078 | 73079 | 73080 | 73082 | 73083 |
| 73084 | 73085 | 73086 | 73089 | 73090 | 73092 | 73093 |
| 73094 | 73095 | 73096 | 73097 | 73098 | 73099 | 73101 |
| 73102 | 73103 | 73104 | 73105 | 73106 | 73107 | 73108 |
| 73109 | 73110 | 73111 | 73112 | 73113 | 73114 | 73115 |
| 73116 | 73117 | 73118 | 73119 | 73120 | 73121 | 73122 |
| 73123 | 73124 | 73125 | 73126 | 73127 | 73128 | 73129 |
| 73130 | 73131 | 73132 | 73134 | 73135 | 73136 | 73137 |
| 73139 | 73140 | 73141 | 73142 | 73143 | 73144 | 73145 |
| 73146 | 73147 | 73148 | 73149 | 73150 | 73151 | 73152 |
| 73153 | 73154 | 73155 | 73156 | 73157 | 73159 | 73160 |
| 73162 | 73163 | 73164 | 73165 | 73167 | 73169 | 73170 |
| 73172 | 73173 | 73178 | 73179 | 73184 | 73185 | 73189 |
| 73190 | 73193 | 73194 | 73195 | 73196 | 73197 | 73198 |
| 73199 | 73401 | 73402 | 73403 | 73425 | 73430 | 73432 |
| 73433 | 73434 | 73435 | 73436 | 73437 | 73438 | 73439 |
| 73440 | 73441 | 73442 | 73443 | 73444 | 73446 | 73447 |
| 73448 | 73449 | 73450 | 73453 | 73455 | 73456 | 73458 |
| 73459 | 73460 | 73461 | 73463 | 73481 | 73487 | 73488 |
| 73491 | 73501 | 73502 | 73503 | 73505 | 73506 | 73507 |
| 73520 | 73521 | 73522 | 73523 | 73526 | 73527 | 73528 |
| 73529 | 73530 | 73531 | 73532 | 73533 | 73534 | 73536 |
| 73537 | 73538 | 73539 | 73540 | 73541 | 73542 | 73543 |
| 73544 | 73546 | 73547 | 73548 | 73549 | 73550 | 73551 |
| 73552 | 73553 | 73554 | 73555 | 73556 | 73557 | 73558 |
| 73559 | 73560 | 73561 | 73562 | 73564 | 73565 | 73566 |
| 73567 | 73568 | 73569 | 73570 | 73571 | 73572 | 73573 |
| 73601 | 73620 | 73622 | 73624 | 73625 | 73626 | 73627 |
| 73628 | 73632 | 73638 | 73639 | 73641 | 73642 | 73644 |
| 73645 | 73646 | 73647 | 73648 | 73650 | 73651 | 73654 |
| 73655 | 73658 | 73659 | 73660 | 73661 | 73662 | 73663 |
| 73664 | 73666 | 73667 | 73668 | 73669 | 73673 | 73701 |
| 73702 | 73703 | 73705 | 73706 | 73716 | 73717 | 73718 |
| 73719 | 73720 | 73722 | 73724 | 73726 | 73727 | 73728 |

# GlobalHealth ZIP Code List

| 73729 | 73730 | 73731 | 73733 | 73734 | 73735 | 73736 |
|---|---|---|---|---|---|---|
| 73737 | 73738 | 73739 | 73741 | 73742 | 73743 | 73744 |
| 73746 | 73747 | 73749 | 73750 | 73753 | 73754 | 73755 |
| 73756 | 73757 | 73758 | 73759 | 73760 | 73761 | 73762 |
| 73763 | 73764 | 73766 | 73768 | 73770 | 73771 | 73772 |
| 73773 | 73801 | 73802 | 73832 | 73834 | 73835 | 73838 |
| 73840 | 73841 | 73842 | 73843 | 73844 | 73848 | 73851 |
| 73852 | 73853 | 73855 | 73857 | 73858 | 73859 | 73860 |
| 73901 | 73931 | 73932 | 73933 | 73937 | 73938 | 73939 |
| 73942 | 73944 | 73945 | 73946 | 73947 | 73949 | 73950 |
| 73951 | 74001 | 74002 | 74003 | 74004 | 74005 | 74006 |
| 74008 | 74010 | 74011 | 74012 | 74013 | 74014 | 74015 |
| 74016 | 74017 | 74018 | 74019 | 74020 | 74021 | 74022 |
| 74023 | 74026 | 74027 | 74028 | 74029 | 74030 | 74031 |
| 74032 | 74033 | 74034 | 74035 | 74036 | 74037 | 74038 |
| 74039 | 74041 | 74042 | 74043 | 74044 | 74045 | 74046 |
| 74047 | 74048 | 74050 | 74051 | 74052 | 74053 | 74054 |
| 74055 | 74056 | 74058 | 74059 | 74060 | 74061 | 74062 |
| 74063 | 74066 | 74067 | 74068 | 74070 | 74071 | 74072 |
| 74073 | 74074 | 74075 | 74076 | 74077 | 74078 | 74079 |
| 74080 | 74081 | 74082 | 74083 | 74084 | 74085 | 74101 |
| 74102 | 74103 | 74104 | 74105 | 74106 | 74107 | 74108 |
| 74110 | 74112 | 74114 | 74115 | 74116 | 74117 | 74119 |
| 74120 | 74121 | 74126 | 74127 | 74128 | 74129 | 74130 |
| 74131 | 74132 | 74133 | 74134 | 74135 | 74136 | 74137 |
| 74141 | 74145 | 74146 | 74147 | 74148 | 74149 | 74150 |
| 74152 | 74153 | 74155 | 74156 | 74157 | 74158 | 74159 |
| 74169 | 74170 | 74171 | 74172 | 74182 | 74183 | 74184 |
| 74186 | 74187 | 74189 | 74192 | 74193 | 74194 | 74301 |
| 74330 | 74331 | 74332 | 74333 | 74335 | 74337 | 74338 |
| 74339 | 74340 | 74342 | 74343 | 74344 | 74345 | 74346 |
| 74347 | 74349 | 74350 | 74352 | 74354 | 74355 | 74358 |
| 74359 | 74360 | 74361 | 74362 | 74363 | 74364 | 74365 |
| 74366 | 74367 | 74368 | 74369 | 74370 | 74401 | 74402 |
| 74403 | 74421 | 74422 | 74423 | 74425 | 74426 | 74427 |
| 74428 | 74429 | 74430 | 74431 | 74432 | 74434 | 74435 |
| 74436 | 74437 | 74438 | 74439 | 74440 | 74441 | 74442 |
| 74444 | 74445 | 74446 | 74447 | 74450 | 74451 | 74452 |
| 74454 | 74455 | 74456 | 74457 | 74458 | 74459 | 74460 |
| 74461 | 74462 | 74463 | 74464 | 74465 | 74467 | 74468 |
| 74469 | 74470 | 74471 | 74472 | 74477 | 74501 | 74502 |
| 74521 | 74522 | 74523 | 74525 | 74528 | 74529 | 74530 |
| 74531 | 74533 | 74534 | 74535 | 74536 | 74538 | 74540 |
| 74542 | 74543 | 74545 | 74546 | 74547 | 74549 | 74552 |

# GlobalHealth ZIP Code List

| | | | | | | |
|---|---|---|---|---|---|---|
| 74553 | 74554 | 74555 | 74556 | 74557 | 74558 | 74559 |
| 74560 | 74561 | 74562 | 74563 | 74565 | 74567 | 74569 |
| 74570 | 74571 | 74572 | 74574 | 74576 | 74577 | 74578 |
| 74601 | 74602 | 74604 | 74630 | 74631 | 74632 | 74633 |
| 74636 | 74637 | 74640 | 74641 | 74643 | 74644 | 74646 |
| 74647 | 74650 | 74651 | 74652 | 74653 | 74701 | 74702 |
| 74720 | 74721 | 74722 | 74723 | 74724 | 74726 | 74727 |
| 74728 | 74729 | 74730 | 74731 | 74733 | 74734 | 74735 |
| 74736 | 74737 | 74738 | 74740 | 74741 | 74743 | 74745 |
| 74747 | 74748 | 74750 | 74752 | 74753 | 74754 | 74755 |
| 74756 | 74759 | 74760 | 74761 | 74764 | 74766 | 74801 |
| 74802 | 74804 | 74818 | 74820 | 74821 | 74824 | 74825 |
| 74826 | 74827 | 74829 | 74830 | 74831 | 74832 | 74833 |
| 74834 | 74836 | 74837 | 74839 | 74840 | 74842 | 74843 |
| 74844 | 74845 | 74848 | 74849 | 74850 | 74851 | 74852 |
| 74854 | 74855 | 74856 | 74857 | 74859 | 74860 | 74864 |
| 74865 | 74866 | 74867 | 74868 | 74869 | 74871 | 74872 |
| 74873 | 74875 | 74878 | 74880 | 74881 | 74883 | 74884 |
| 74901 | 74902 | 74930 | 74931 | 74932 | 74935 | 74936 |
| 74937 | 74939 | 74940 | 74941 | 74942 | 74943 | 74944 |
| 74945 | 74946 | 74947 | 74948 | 74949 | 74951 | 74953 |
| 74954 | 74955 | 74956 | 74957 | 74959 | 74960 | 74962 |
| 74963 | 74964 | 74965 | 74966 | | | |

# COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

| Your Costs for Network Services | Aetna INTEGRIS and Aetna St. John HMO | BlueLincs HMO | CommunityCare HMO | GlobalHealth HMO |
|---|---|---|---|---|
| **Calendar Year Deductible** | No deductible | No deductible | No deductible | No deductible |
| **Calendar Year Out-of-Pocket Maximum** | **$5,000** individual<br>**$10,000** family<br>Includes medical and pharmacy | $3,500 individual<br>$10,500 family<br>Includes medical and pharmacy | $4,000 individual<br>$8,000 family<br>Includes medical and pharmacy | **$4,000** individual<br>**$12,000** family<br>Includes medical and pharmacy |
| **Office Visit** | **$35 copay/PCP**<br>$50 copay/specialist | $0 copay/PCP<br>$50 copay/specialist | $35 copay/PCP<br>$50 copay/specialist | $0 copay/PCP<br>$50 copay/specialist |
| **X-Ray and Lab** | $0 copay for routine X-ray and lab<br>**$0 copay** per MRI, CAT, MRA or PET scan | $0 copay for X-ray and lab<br>$250 copay per scan/ procedure (MRI, CT, PET, EEG, ECG, MPS and similar); and pathology and lab under CPT codes of cytogenetic studies, surgical pathology, or transcutaneous procedures | $0 copay for routine X-ray and lab<br>$200 copay per scan<br>Specialty scans: MRI, CT, MRA and PET scans | **$10 copay** for X-ray and lab<br>For MRI, MRA, PET, CAT and nuclear scans:<br>$250 copay per scan in a preferred facility<br>$750 copay per scan in a non-preferred facility |
| **Allergy Testing and Treatment** | **$35 copay/PCP**<br>$50 copay/specialist<br>Testing covered at 100% per 6-week supply of antigen and administration | $0 copay/PCP<br>$50 copay/specialist<br>$30 copay for allergy serum (once every 6 weeks, including shots) | $35 copay/PCP<br>$50 copay/specialist<br>$30 serum and shots including a 6-week supply of antigen | $0 copay/PCP<br>$50 copay/specialist<br>$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 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**<br><br>**(Separate pharmacy deductible, refer to page 27)** | **High Plan**<br>$750 individual<br>$2,000 family (3 or more)<br><br>**High Alternative Plan**<br>$1,000 individual<br>$2,750 family (3 or more)<br><br>Copays do not apply to deductible | **Basic Plan**<br>$1,000 individual<br>$1,500 family (2 or more)<br>Applies after plan pays first $500 of allowable fees<br>**Basic Alternative Plan**<br>$1,250 individual<br>$1,750 family (2 or more)<br>Applies after plan pays first $250 of allowable fees | $1,750 individual<br>$3,500 family (2 or more)<br>Deductible can be met by one or more family members<br>The combined medical and pharmacy deductible must be met before benefits are paid |
| **Calendar Year Out-of-Pocket Maximum**<br><br>**(Medical copays and deductibles apply to out-of-pocket maximum; separate pharmacy out-of-pocket maximum, refer to page 27)** | **High Plan***<br>$3,300 network individual<br>$8,400 network family<br>$3,800 non-network individual<br>$9,900 non-network family, plus amounts over allowable fees<br>**High Alternative Plan***<br>$3,550 network individual<br>$8,400 network family<br>$4,050 non-network individual<br>$9,900 non-network family, plus amounts over allowable fees | **Basic Plan**<br>$4,000 individual<br>$9,000 family<br><br>**Basic Alternative Plan**<br>$4,000 individual<br>$9,000 family<br><br>Network and non-network coinsurance, copays and deductibles apply to medical out-of-pocket maximum | $6,000 individual<br>$12,000 family (2 or more)<br>The individual out-of-pocket does not apply if two or more family members are covered<br>Pharmacy copays apply to the out-of-pocket maximum but non-network charges do not apply |
| **Office Visit** | $30 copay/physician office visit**<br>$50 copay/specialist office visit | **Basic Plan**<br>$0 of the first $500 of allowable fees<br>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<br>**Basic Alternative Plan**<br>$0 of the first $250 of allowable fees<br>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<br>**Both Basic Plans**<br>$0 of allowable fees over the individual or family out-of-pocket maximum<br>If using non-network providers, you pay costs above allowable fees<br><br>Copays do not apply<br>All covered services, limitations and conditions are identical to the HealthChoice High Plan | You pay 100% of allowable fees until deductible is met<br>$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<br>Limit of 60 tests every 24 months | | 20% of allowable fees after deductible<br>Limit of 60 tests every 24 months |

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

# COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

| Your Costs for Network Services | Aetna INTEGRIS and Aetna St. John HMO | BlueLincs HMO | CommunityCare HMO | GlobalHealth HMO |
|---|---|---|---|---|
| **Preventive Services** | $0 copay/PCP | $0 copay (PCP or specialist)<br>$0 copay per OB/GYN visit, no referral required for annual routine services | $0 copay (PCP or specialist) | $0 copay PCP/routine physical exam<br>$0 copay well-woman exam and preventive services |
| **Well Child Care** | $0 copay | $0 copay | $0 copay | $0 copay per well-child visit |
| **Immunizations** | $0 copay ages birth through 18 years<br>$0 copay ages 19 and older when medically necessary | $0 copay | $0 copay birth through age 20 years<br>$0 copay ages 21 and older when following the recommendation of ACIP | $0 copay when following the recommendation of ACIP |
| **Hearing Screening and Hearing Aid** | **Hearing screening**<br>$0 copay<br>Limit of one per year | **Hearing screening**<br>$0 copay<br>Limit of one per year | **Hearing screening**<br>$0 copay when performed by PCP<br>Limit of one per year<br><br>**Hearing aids**<br>20% coinsurance | **Hearing screening**<br>$0 copay<br>Limit of one per year<br><br>**Hearing aids**<br>20% coinsurance |
| **Hospital Inpatient** | $250 copay per day<br>**$1,000 maximum** per admission<br>Preauthorization required | $250 copay per day<br>$750 maximum per admission | **$350 copay** per day<br>**$1,750 maximum** per admission<br>Preauthorization required | $250 copay per day<br>$750 maximum per admission<br>**Plus $150 copay for physician charges** |
| **Hospital Outpatient** | **$500** copay per visit | $250 copay per visit | **$300 copay** per visit | $250 copay in a preferred facility<br>$750 copay in a non-preferred facility<br>**Plus $50 copay for physician charges** |
| **Emergency Room** | **$250 copay**; waived if admitted | $300 copay; waived if admitted | $200 copay; waived if admitted | **$350 copay for facility charge**; waived if admitted<br>**Plus $50 copay for physician charges** |
| **Urgent Care** | $50 copay per visit | $25 copay for outpatient or professional urgent care facility 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 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<br>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<br>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<br>One mammogram per year at no charge for women ages 40 and older |
| **Well Child Care** | $0 copay; no deductible applies | No deductible for well child care visit | $0 copay; no deductible applies |
| **Immunizations** | No charge for well child and adult immunizations and administration<br>$30/$50** office visit copay may apply | **Basic Plan**<br>$0 of the first $500 of allowable fees<br>100% of the next $1,000 of allowable fees (deductible).<br>Only allowable fees count toward the deductible; 50% of the next $6,000 of allowable fees | No charge for well child and adult immunizations and administration<br>$30/$50** office visit copay may apply |
| **Hearing Screening and Hearing Aid** | **Hearing screening**<br>$30/$50** copay<br>Limit of one per year<br><br>**Hearing aids**<br>Covered as durable medical equipment for children up to age 18<br>Certification required | **Basic Alternative Plan**<br>$0 of the first $250 of allowable fees<br>100% of the next $1,250 of allowable fees (deductible).<br>Only allowable fees count toward the deductible; 50% of the next $5,500 of allowable fees | **Hearing screening**<br>$30/$50** copay after deductible<br>Limit of one per year<br><br>**Hearing aids**<br>Covered as durable medical equipment for children up to age 18<br>Certification required |
| **Hospital Inpatient** | 20% of allowable fees after deductible<br>Additional $300 copay per non-network, non-emergency admission (does not count toward out-of-pocket) | **Both Basic Plans**<br>$0 of allowable fees over the individual or family out-of-pocket maximum<br>If using non-network providers, you pay costs above allowable fees | 20% of allowable fees after deductible<br>Additional $300 copay per non-network, non-emergency admission (does not count toward out-of-pocket) |
| **Hospital Outpatient** | 20% of allowable fees after deductible | Copays do not apply<br>All covered services, limitations and conditions are identical to the HealthChoice High Plan | 20% of allowable fees after deductible |
| **Emergency Room** | 20% of allowable fees after deductible<br>$200 ER copay – waived if admitted | | 20% of allowable fees after deductible<br>$200 ER copay – waived if admitted |
| **Urgent Care** | **$30** office visit copay may apply<br>20% of allowable fees after deductible | | **$30** office visit copay may apply after deductible<br>20% of allowable fees after deductible |

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

# COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

| Your Costs for Network Services | Aetna INTEGRIS and Aetna St. John HMO | BlueLincs HMO | CommunityCare HMO | GlobalHealth HMO |
|---|---|---|---|---|
| **Maternity Pre and Post Natal Care** | **$35 copay** for initial visit<br><br>$250 copay per day **$1,000 maximum** per admission | $0 copay for prenatal and postnatal care<br><br>$500 copay per admission | $0 copay for preventive prenatal and postnatal care<br>$35 copay/PCP $50 copay/specialist for confirmation visit<br>**$350 copay** per day **$1,750 maximum** per admission<br>Preauthorization required | $0 copay for prenatal care<br>$25 copay for delivery and all postnatal care<br>$500 per hospital admission |
| **Durable Medical Equipment** | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| **Mental Health or Substance Use Disorder Inpatient** | $250 copay per day **$1,000 maximum** per admission<br>Preauthorization required | $250 copay per day $750 maximum per admission | **$350 copay** per day **$1,750 maximum** per admission<br>Preauthorization required | Residential Treatment Center or medical detox<br>$250 copay per day $750 maximum per admission<br>**Plus $150 copay for physician charges** |
| **Mental Health or Substance Use Disorder Outpatient** | **$35 copay for office visit** | $0 copay/PCP<br>$50 copay/specialist | $35 copay | $0 copay per visit |
| **Occupational or Speech Therapy Visit**<br><br>**Physical Therapy or Physical Medicine Visit** | $0 copay inpatient, included in inpatient hospital cost<br>$50 copay outpatient therapy<br><br>Limit of 60 days per condition | $0 copay inpatient<br>$50 copay per outpatient therapy<br><br>Limit of 60 visits combined for all therapies per year | Inpatient **$350 copay** per day **$1,750 maximum** per admission<br>Preauthorization required<br><br>$50 copay per outpatient therapy visit<br><br>Up to 60 days treatment per disability | $0 copay inpatient **$35 copay per outpatient visit**<br><br>Limit of 60 treatment days per course of therapy |
| **Chiropractic and Manipulative Therapy Visit** | **$50 copay**<br><br>Limit 15 visits per year | $50 copay<br><br>Included under physical and occupational therapy, no separate visit limit per year | $50 copay | $25 copay<br><br>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 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<br>Includes one postpartum home visit – criteria must be met | **Basic Plan**<br>$0 of the first $500 of allowable fees<br>100% of the next $1,000 of allowable fees (deductible).<br>Only allowable fees count toward the deductible; 50% of the next $6,000 of allowable fees<br><br>**Basic Alternative Plan**<br>$0 of the first $250 of allowable fees<br>100% of the next $1,250 of allowable fees (deductible).<br>Only allowable fees count toward the deductible; 50% of the next $5,500 of allowable fees<br><br>**Both Basic Plans**<br>$0 of allowable fees over the individual or family out-of-pocket maximum<br>If using non-network providers, you pay costs above allowable fees<br><br>Copays do not apply<br>All covered services, limitations and conditions are identical to the HealthChoice High Plan | 20% of allowable fees after deductible<br>Includes one postpartum home visit – criteria must be met |
| **Durable Medical Equipment** | 20% of allowable fees after deductible for purchase, rental, repair or replacement | | 20% of allowable fees after deductible for purchase, rental, repair or replacement |
| **Mental Health or Substance Use Disorder Inpatient** | 20% of allowable fees after deductible<br><br>No limit on the number of days per year | | 20% of allowable fees after deductible<br><br>No limit on the number of days per year |
| **Mental Health or Substance Use Disorder Outpatient** | 20% of allowable fees after deductible<br>Limit of 20 services per calendar year without certification | | 20% of allowable fees after deductible<br>Limit of 20 services per calendar year without certification |
| **Occupational or Speech Therapy Visit** | 20% of allowable fees after deductible<br>**Occupational therapy***<br>Limit of 20 visits per year without certification<br>**Speech therapy***<br>For ages 17 and younger, certification required<br>For ages 18 and older, certification not required<br>*Maximum of 60 visits per year | | 20% of allowable fees after deductible<br>**Occupational therapy***<br>Limit of 20 visits per year without certification<br>**Speech therapy***<br>For ages 17 and younger, certification required<br>For ages 18 and older, certification not required<br>*Maximum of 60 visits per year |
| **Physical Therapy or Physical Medicine Visit** | 20% of allowable fees after deductible<br>Limit of 20 visits per year without certification<br>Maximum of 60 visits per year | | 20% of allowable fees after deductible<br>Limit of 20 visits per year without certification<br>Maximum of 60 visits per year |
| **Chiropractic and Manipulative Therapy Visit** | **Chiropractic therapy**<br>20% of allowable fees after deductible<br>Limit of 20 visits per year without certification<br>Maximum of 60 visits per year<br>**Manipulative therapy**<br>Refer to Physical Therapy/ Physical Medicine above | | **Chiropractic therapy**<br>20% of allowable fees after deductible<br>Limit of 20 visits per year without certification<br>Maximum of 60 visits per year<br>**Manipulative therapy**<br>Refer to Physical Therapy/ Physical Medicine above |

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

# COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

| Your Costs for Network Services | Aetna INTEGRIS and Aetna St. John HMO | BlueLincs HMO | CommunityCare HMO | GlobalHealth HMO |
|---|---|---|---|---|
| **Pharmacy Benefits** | **Retail**<br>Select generic: $4<br>Generic: $10<br>Preferred brand: $30<br>Non-preferred brand: $60<br><br>**Mail-order**<br>Select generic: $8<br>Generic: $20<br>Preferred brand: $60<br>Non-preferred brand: $120<br><br>**Specialty**<br>Preferred: $100<br>Non-preferred: $200 | **Retail**<br>Preferred generic: $0<br>Non-preferred generic: $10<br>Preferred brand: $40<br>Non-preferred brand: $80<br><br>**Mail-order**<br>Preferred generic: $0<br>Non-preferred generic: $25<br>Preferred brand: $100<br>Non-preferred brand: $200<br><br>**Specialty**<br>Preferred: $100<br>Non-preferred: $200 | **Retail**<br>(30-day supply)<br>Select generic: $0<br>Preferred generic/ Tier 1: $15<br>Preferred brand/Tier 2: $40*<br>Non-preferred brand or generic/Tier 3: $70*<br>Specialty/Tier 4: $160*<br><br>**Mail-order**<br>(90-day supply)<br>Select generic: $0<br>Preferred generic/ Tier 1: $45<br>Preferred brand/Tier 2: $120*<br>Non-preferred brand or generic/Tier 3: $210*<br><br>**Mail-Order**<br>(30-day supply)<br>Specialty/Tier 4: $160*<br><br>*If you choose to obtain a brand name drug when a generic is available, you pay the applicable copay or coinsurance for the brand name drug, plus the difference in cost between the brand name drug and its generic equivalent.<br>The difference in cost between the brand name drug and its generic equivalent will not count toward your annual out-of-pocket maximum. | **Retail**<br>30-day supply<br>**Tier 1 generics: $10**<br>**Preferred brand: $65**<br>**Non-preferred drugs: $90**<br><br>90-day supply<br>**Tier 1 generics: $20**<br>**Preferred brand: $130**<br>**Non-preferred drugs: $180**<br><br>**Specialty**<br>Preferred: $100<br>Non-preferred: $200 |

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

| Your Costs for Network Services | HealthChoice High, High Alternative, Basic, Basic Alternative and HDHP Plans<br>**The applicable pharmacy deductible must be met before pharmacy copays apply. Refer to the bottom of the page for more details.** | |
|---|---|---|
| **Prescription Medications** | **30-Day Supply** | **31- to 90-Day Supply** |
| **Generic Drugs** | Up to $10 | Up to $25 |
| **Preferred Drugs** | Up to $45 | Up to $90 |
| **Non-Preferred Drugs** | Up to $75 | Up to $150 |
| **Specialty Drugs*** | Generic – $10 copay<br>Preferred drugs – $100 copay<br>Non-preferred drugs – $200 copay | Copays are for up to a 30-day supply |

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

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

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

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

## HEALTHCHOICE HDHP

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

## ALL HEALTHCHOICE PLANS

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

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

HealthChoice covers **up to a 168-day supply** 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-recommended vaccinations, such as for shingles, are covered at 100 percent when using a network pharmacy. **Note:** These can also be covered under the health benefit if provided by a recognized network health provider, such as a physician or health department.

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

# COMPARISON OF BENEFITS FOR DENTAL PLANS

| Allowable fees 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**<br>Cleanings, routine oral exams | Sealant per tooth: $17 copay<br><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**<br>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 |
| **Major Care**<br>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 |

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 DENTAL PLANS

| Allowable fees apply for all benefits | HealthChoice Dental | MetLife High Classic MAC | MetLife Low Classic MAC | Sun Life Preferred Active PPO |
|---|---|---|---|---|
| **Annual Deductible** | Network: $25 individual/$75 family Basic and Major services combined<br>Non-network: $25 individual/$75 family Preventive, Basic and Major services combined | 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**<br>Cleanings, routine oral exams | You pay<br>Network: $0<br>Non-network: Amounts above allowable fees after deductible | 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**<br>Extractions, oral surgery | You pay<br>Network: 15%<br>Non-network: 30% plus amounts above allowable fees<br>Deductible applies | 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 |
| **Major Care**<br>Dentures, bridge work | You pay<br>Network: 40%<br>Non-network: 50% plus amounts above allowable fees<br>Deductible applies | 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 |

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

| Allowable fees apply for all benefits | Cigna Dental Care Plan (Prepaid) | Delta Dental PPO Network and Non-Network | Delta Dental PPO – Choice |
|---|---|---|---|
| **Orthodontic Care** | $2,472 out-of-pocket child<br>$3,384 out-of-pocket adult<br>(24-month treatment)<br><br>Excludes orthodontic treatment plan and banding | Plan pays 60% of allowable amounts, up to $2,000 lifetime maximum per person<br><br>Orthodontic benefits are available to eligible employee, spouse and dependent children | You pay charges in excess of $50 per month<br>Lifetime maximum up to $1,800 per person<br><br>Orthodontic benefits are available to eligible employee, spouse and dependent children |
| **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.

# COMPARISON OF BENEFITS FOR DENTAL PLANS

| Allowable fees apply for all benefits | HealthChoice Dental | MetLife High Classic MAC | MetLife Low Classic MAC | Sun Life Preferred Active PPO |
|---|---|---|---|---|
| **Orthodontic Care** | You pay<br>Network: 50%<br>Non-network: 50% plus amounts above allowable fees<br>12-month waiting period applies<br>No lifetime maximum<br>Covered for members under age 19 and members ages 19 and older with TMD | You pay<br>Network: 40%<br>Non-network: 40% **plus amounts above maximum allowed charge**<br><br>$2,000 lifetime maximum per person | You pay<br>Network: **50%**<br>Non-network: 50% **plus amounts above maximum allowed charge**<br><br>$2,000 lifetime maximum per person | Network: Plan pays 60%<br>Non-network: Plan pays 50% up to lifetime maximum of $2,000 for dependents under age 19 |
| **Plan Year Maximum** | Network and Non-network: $2,500 per person | 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 | Member/provider must file claims |

Plan changes are indicated by **bold text**.
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 calender year | Plan pays up to:<br>$34 MD<br>$26 OD |
| **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<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 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<br>After exam copay, medically necessary contacts covered in full<br>Standard contacts covered in full;<br>Specialty contacts $50 retail allowance | Plan pays up to $100 all contacts<br>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 |

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

# COMPARISON OF BENEFITS FOR VISION PLANS

| | Vision Care Direct | | VSP | |
|---|---|---|---|---|
| **Covered Services** | **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>**PLUS free upgrades for high definition polycarbonate, premium anti-reflection, scratch and UV coatings, and no-line progressive lenses at any Plus Plan provider** | Reimbursed up to:<br>$50 single<br>**$75 bifocal**<br>$100 trifocal<br>$100 progressive | Covered in full after $25 materials copay<br><br>Polycarbonate lenses covered in full for dependent children<br><br>Standard progressives covered in full | Reimbursed up to:<br>$30 single<br>$50 bifocal<br>$65 trifocal<br>$50 progressive<br><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><br>$130 allowance, in lieu of glasses<br><br>$250 allowance for medically necessary contacts | $80 allowance, in lieu of glasses | $120 allowance, in lieu of glasses<br><br>**Up to $60 copay for contact lens exam (fitting and evaluation)** | Reimbursed up to $105 |
| **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 |

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

# VISION PLAN NOTES

***PVCS:*** The only Oklahoma owned and operated vision care plan with unlimited 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.svcontacts.com. Exams, lenses and frames are provided once per calendar year. Progressive lenses (no-line bifocals) – you pay the difference between the retail price of the selected progressive lens and the retail price of the lined trifocal. The difference may also be subject to a discount 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 doctors 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. The 30 percent discount is not applicable. Contact VSP or visit vsp.com to learn more. VSP members can now use and integrate their benefits online, via eyeconic.com. Oklahoma enrollees can virtually try on each pair in the extensive catalog of glasses and sunglasses. Members can order glasses and contacts while using their VSP benefit. In addition to your VSP vision insurance, any additional savings will automatically be applied at the time of purchase. Frames can be sent directly to your door, or your provider's office for a final fitting, adjustment, and confirmation you are completely satisfied.

# CONTACT INFORMATION

## Health Plans

### Aetna INTEGRIS and Aetna St. John

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

### BlueLincs

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

### CommunityCare

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

### GlobalHealth, Inc.

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

### HealthChoice

**Medical**

800-323-4314
TTY 711 or 800-545-8279

**Pharmacy**

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

## Life Insurance

### HealthChoice

800-323-4314
TTY 711 or 800-545-8279
www.healthchoiceok.com

## Additional

### EGID

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

### American Fidelity Health Services Administration

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

## 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 or 800-545-8279
www.healthchoiceok.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 TDD 711
www.okstate.vision

### VSP

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

# NOTES