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

HEALTH | DENTAL | LIFE | VISION

EMPLOYEE BENEFIT

OPTIONS GUIDE

4024

Monthly Premiums for Current Employees
Plan Year Jan. 1 - Dec. 31, 2020

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Blue Cross Blue Shield of Oklahoma - BlueLincs HMO	$ 559.90	$ 826.50	$ 302.50	$ 493.96
CommunityCare HMO	$ 970.34	$1,413.42	$ 494.20	$ 790.74
GlobalHealth HMO	$ 710.74	$1,049.14	$ 405.88	$ 662.82
HealthChoice High and High Alternative	$ 615.90	$ 722.12	$ 309.80	$ 525.72
HealthChoice Basic and Basic Alternative	$ 487.36	$ 571.96	$ 251.34	$ 425.14
HealthChoice High Deductible Health Plan (HDHP)	$ 422.26	$ 495.86	$ 218.10	$ 368.22

TRICARE SUPPLEMENT	MEMBER	MEMBER + ONE	MEMBER + TWO OR MORE
Selman & Company	$60.50	$119.50	$160.50

DISABILITY	$ 10.36 (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	$ 36.92	$ 36.92	$ 32.12	$ 81.24
Delta Dental PPO – Choice	$ 15.68	$ 35.56	$ 35.82	$ 86.96
HealthChoice Dental	$ 41.72	$ 41.72	$ 33.72	$ 86.50
MetLife High Classic MAC	$ 48.54	$ 48.54	$ 41.58	$103.04
MetLife Low Classic MAC	$ 27.96	$ 27.96	$ 23.94	$ 58.94
Sun Life Preferred Active PPO	$ 31.46	$ 31.30	$ 23.48	$ 63.10

VISION PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Primary Vision Care Services (PVCS)	$ 9.98	$ 9.28	$ 9.20	$ 11.50
Superior Vision	$ 7.62	$ 7.58	$ 7.18	$ 14.74
Vision Care Direct	$ 15.90	$ 11.26	$ 11.26	$ 22.74
VSP (Vision Service Plan)	$ 8.72	$ 5.78	$ 5.70	$ 12.48

LIFE	HealthChoice Basic Life ($20,000) $ 4.20	First $20,000 of Supplemental Life $ 4.20

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 $9.42
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).

Monthly Cumulative Plan Premiums for Current Employees
Plan Year Jan. 1 - Dec. 31, 2020

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Blue Cross Blue Shield of Oklahoma - BlueLincs HMO	$ 559.90	$ 1,386.40	$ 1,688.90	$ 1,880.36	$ 862.40	$ 1,053.86
CommunityCare HMO	$ 970.34	$ 2,383.76	$ 2,877.96	$ 3,174.50	$ 1,464.54	$ 1,761.08
GlobalHealth HMO	$ 710.74	$ 1,759.88	$ 2,165.76	$ 2,422.70	$ 1,116.62	$ 1,373.56
HealthChoice High and High Alternative	$ 615.90	$ 1,338.02	$ 1,647.82	$ 1,863.74	$ 925.70	$ 1,141.62
HealthChoice Basic and Basic Alternative	$ 487.36	$ 1,059.32	$ 1,310.66	$ 1,484.46	$ 738.70	$ 912.50
HealthChoice High Deductible Health Plan (HDHP)	$ 422.26	$ 918.12	$ 1,136.22	$ 1,286.34	$ 640.36	$ 790.48
TRICARE Supplement	$ 60.50	$ 119.50	$ 160.50	$ 160.50	$ 119.50	$ 160.50

DENTAL	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Cigna Dental Care Plan (Prepaid)	$ 9.44	$ 15.62	$ 19.82	$ 25.08	$ 13.64	$ 18.90
Delta Dental PPO	$ 36.92	$ 73.84	$ 105.96	$ 155.08	$ 69.04	$ 118.16
Delta Dental PPO – Choice	$ 15.68	$ 51.24	$ 87.06	$ 138.20	$ 51.50	$ 102.64
HealthChoice Dental	$ 41.72	$ 83.44	$ 117.16	$ 169.94	$ 75.44	$ 128.22
MetLife High Classic MAC	$ 48.54	$ 97.08	$ 138.66	$ 200.12	$ 90.12	$ 151.58
MetLife Low Classic MAC	$ 27.96	$ 55.92	$ 79.86	$ 114.86	$ 51.90	$ 86.90
Sun Life Preferred Active PPO	$ 31.46	$ 62.76	$ 86.24	$ 125.86	$ 54.94	$ 94.56

VISION	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Primary Vision Care Services (PVCS)	$ 9.98	$ 19.26	$ 28.46	$ 30.76	$ 19.18	$ 21.48
Superior Vision	$ 7.62	$ 15.20	$ 22.38	$ 29.94	$ 14.80	$ 22.36
Vision Care Direct	$ 15.90	$ 27.16	$ 38.42	$ 49.90	$ 27.16	$ 38.64
VSP (Vision Service Plan)	$ 8.72	$ 14.50	$ 20.20	$ 26.98	$ 14.42	$ 21.20

DISABILITY	$ 10.36 (Limited city and county participation only)

LIFE	HealthChoice Basic Life ($20,000) $ 4.20	First $20,000 of Supplemental Life $ 4.20

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 $ 9.42

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 $4,175.00. 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).

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.

2020 PLAN CHANGES AND IMPORTANT REMINDERS

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

HEALTH PLANS

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

Aetna INTEGRIS and Aetna St. John HMO

- Aetna will **not** be available in 2020.

Blue Cross and Blue Shield of Oklahoma – BlueLincs HMO

- Bariatric surgery is now a covered benefit with a $250 copay per day with a $750 maximum per admission.
- CDC-recognized Diabetes Prevention Program is now a covered benefit with a $0 copay for Omada Health.

GlobalHealth HMO

- There is no longer a separate physician cost-share for inpatient, outpatient and emergency room stays.
- Hospital inpatient and mental health and substance abuse inpatient have increased to a $300 copay per day with a $900 maximum per admission.
- Hospital outpatient has increased to a $300 copay in a preferred facility and an $800 copay in a non-preferred facility.
- The emergency room copay has increased to $400 for the facility charge.
- There is no longer a copay for maternity postnatal care.
- A 30-day supply of preferred specialty drugs has increased to $200 and $400 for non-preferred specialty drugs.
- Bariatric surgery is now a covered benefit with a $300 copay per day with a $900 maximum per admission.
- CDC-recognized Diabetes Prevention Program is a covered benefit with a $0 copay.

HealthChoice Health Plans

- CDC-recognized Diabetes Prevention Program is a covered benefit with a $0 copay.

REMINDER

The online attestation for Plan Year 2020 is open Sept. 1-Nov. 8, 2019. HealthChoice members who are tobacco free can update their annual Verification of Other Insurance Coverage and their Tobacco-Free Attestation online in just a few minutes.

Tobacco-Free Attestation

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 2020 available at **www.healthchoiceconnect.com** by Nov. 8, 2019.

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. 8:

- Show proof of an attempt to quit using tobacco by enrolling in the quit tobacco program available through the Oklahoma Tobacco Helpline (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 and you are not in the first year grace period, 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.

Coordination of Benefits

You are required to annually verify if you or any of your covered dependents have other health or dental insurance. Failure to verify other insurance coverage will result in denial of claims until verification is completed. You may complete your verification by logging in at **www.healthchoiceconnect.com** or by calling HealthChoice customer care at 800-323-4314.

Coordination of benefits is an industry standard process that occurs when two insurance plans must work together to pay claims for the same person. Coordinating benefits establishes which plan is primary and which plan is secondary and helps avoid duplicate payments by making sure the two plans do not pay more than the total amount of the claim. The primary plan pays first and the secondary plan pays any remaining balance after your share of the costs is deducted. This process also helps reduce the cost of insurance premiums.

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, 2020, 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. The contact information is provided at the end of this guidebook.

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 their contract during the plan year, this does not allow you to change your plan carrier.

HEALTH PLANS

There are several health plans available:

- BCBSOK – 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 20-29 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.
- If you select an HMO:
  - 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 13-19** for the HMO ZIP Code Lists.
  - You must use the provider network designated by that plan for Oklahoma.
- If you select HealthChoice:
  - To remain enrolled in the HealthChoice High or Basic Plan for 2020, you must complete the Tobacco-Free Attestation located on the HealthChoice website or one of the two listed reasonable alternatives.

HSA Information for HealthChoice HDHP

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 have pretax HSA contributions withheld from your paycheck.

HealthChoice contracts with American Fidelity Health Services Administration to waive fees and make establishing and keeping an HSA easier and more convenient. For more information about HSAs, contact American Fidelity at the number listed in Contact Information at the back of this guide.

Note: A member cannot contribute to both an HSA and a Section 125 flexible spending account at the same time.

Triple Tax Savings Advantage

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

- Pretax 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.

Electing a TRICARE Supplement Plan (Military only)

NOTE: If you do not currently have TRICARE coverage as a current or former military member, 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 30-35 for benefit information.

- You must select a primary care dentist for yourself and each covered dependent when enrolling in a prepaid dental plan.
- Some plans may not be available in all areas.

VISION PLANS

There are several vision plans available:

- Primary Vision Care Services.
- Superior Vision.
- Vision Care Direct.
- VSP.

Refer to Comparison of Benefits for Vision Plans on Pages 36-38 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).

- Within 30 days of a midyear qualifying event, such as birth of a child or marriage.
- A life insurance application must be submitted 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 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 beneficiaries 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.healthchoiceconnect.com** under Member Forms. 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. There is no beneficiary designation for dependent life. Any dependent life proceeds are paid directly to the member.
- 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
Per covered child (live birth to age 26)	$ 3,000 of coverage	$ 5,000 of coverage	$ 10,000 of coverage

Dependent Life does not include AD&D benefits.

HEALTHCHOICE DISABILITY PLAN (limited city and county participation)

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

Eligibility

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

For further details, refer to the HealthChoice Disability Handbook.

ENROLLMENT PERIODS

Option Period Enrollment – Coverage effective Jan. 1, 2020

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.
- Submit a life insurance application for review and approval for life insurance coverage above Guaranteed Issue.

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 qualified 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 occurs, such as birth, marriage or loss of other group coverage. 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; 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 or other qualified health insurance 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 for yourself.
- 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 the Social Security Administration. Insurance premiums for the month the child was born must be paid.
- Without newborn enrollment:
  - HealthChoice: A newborn has limited coverage without an additional premium 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.
  - BCBSOK – 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, dental and/or vision 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.

Confirmation Statements

- You are mailed a confirmation statement when you enroll or make changes to your coverage. Your statement lists the coverage you are enrolled in, the effective date of your coverage and the premium amounts.
- Always review your statement 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 confirmation statement 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 **https://omes.ok.gov/services/employees-group-insurance-division** 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 Coverage. If you or your dependents will be Medicare eligible by Jan. 1, an additional form will be required to enroll in one of the Medicare supplement plans or Medicare Advantage Prescription Drug plans. 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 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 Employee Well-Being Program's mission is to empower employees to be valued, engaged and productive. Our approach is based on six essential elements of well-being: career and purpose, social, financial, physical, community and emotional. We work with wellness coordinators to provide information, activities and opportunities that enable employees to improve and enhance their overall well-being. We create wellness initiatives that include challenges, programs, coordination of employee recreational leagues and many educational opportunities such as monthly toolkits, lunch and learn presentations, and classes through our training department.

In 2020, we will be providing new programs, challenges and more educational opportunities including two new training classes.

Thrive's website and social media house all of this information. We invite employees and their families to visit our website, **thrive.ok.gov**, and sign up for our monthly newsletter and blog updates.

BCBSOK – 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

ZIP codes are subject to change by plan.

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BCBSOK – BlueLincs 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	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

ZIP codes are subject to change by plan.

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BCBSOK – BlueLincs ZIP Code List

74547	74549	74552	74553	74554	74555	74556	74557
74558	74559	74560	74561	74562	74563	74565	74567
74569	74570	74571	74572	74574	74576	74577	74578
74601	74602	74604	74630	74631	74632	74633	74636
74637	74640	74641	74643	74644	74646	74647	74650
74651	74652	74653	74701	74702	74720	74721	74722
74723	74724	74726	74727	74728	74729	74730	74731
74733	74734	74735	74736	74737	74738	74740	74741
74743	74745	74747	74748	74750	74752	74753	74754
74755	74756	74759	74760	74761	74764	74766	74801
74802	74804	74818	74820	74821	74824	74825	74826
74827	74829	74830	74831	74832	74833	74834	74836
74837	74839	74840	74842	74843	74844	74845	74848
74849	74850	74851	74852	74854	74855	74856	74857
74859	74860	74864	74865	74866	74867	74868	74869
74871	74872	74873	74875	74878	74880	74881	74883
74884	74901	74902	74930	74931	74932	74935	74936
74937	74939	74940	74941	74942	74943	74944	74945
74946	74947	74948	74949	74951	74953	74954	74955
74956	74957	74959	74960	74962	74963	74964	74965
74966							

ZIP codes are subject to change by plan.

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			

ZIP codes are subject to change by plan.

GlobalHealth ZIP Code List

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

ZIP codes are subject to change by plan.

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GlobalHealth ZIP Code List

73724	73726	73727	73728	73729	73730	73731	73733
73734	73735	73736	73737	73738	73739	73741	73742
73743	73744	73746	73747	73749	73750	73753	73754
73755	73756	73757	73758	73759	73760	73761	73762
73763	73764	73766	73768	73770	73771	73772	73773
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

ZIP codes are subject to change by plan.

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GlobalHealth ZIP Code List

74529	74530	74531	74533	74534	74535	74536	74538
74540	74542	74543	74545	74546	74547	74549	74552
74553	74554	74555	74556	74557	74558	74559	74560
74561	74562	74563	74565	74567	74569	74570	74571
74572	74574	74576	74577	74578	74601	74602	74604
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		

ZIP codes are subject to change by plan.

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Calendar Year Deductible	No deductible	No deductible	No deductible
Calendar Year Out-of-Pocket Maximum	$3,500 individual $10,500 family Includes medical and pharmacy	$4,000 individual $8,000 family Includes medical and pharmacy	$4,000 individual $12,000 family Includes medical and pharmacy
Office Visit	$0 copay/PCP $50 copay/specialist	$35 copay/PCP $50 copay/specialist	$0 copay/PCP $50 copay/specialist

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, refer to the plan's handbook or contact each plan (see Contact Information at the back of this guide).

Your Costs for Network Services	HealthChoice High and High Alternative Plans	HealthChoice HDHP	HealthChoice Basic and Basic Alternative Plans
Calendar Year Deductible **(For pharmacy deductible, refer to Page 29)**	High Plan $750 individual $2,000 family High Alternative Plan $1,000 individual $2,750 family Copays do not apply to deductible Separate pharmacy deductible A family is three or more covered individuals	$1,750 individual $3,500 family One member may be responsible for up to the full family deductible The combined medical and pharmacy deductible must be met before benefits are paid A family is two or more covered individuals	Medical First-Dollar Coverage Applies to each covered family member Plan pays first $500 (Basic) or $250 (Basic Alternative) for covered expenses Medical Deductible After first-dollar coverage, you pay the deductible for covered expenses Basic: $1,000 individual or $1,500 family Basic Alternative: $1,250 individual or $1,750 family A family is two or more covered individuals
Calendar Year Out-of-Pocket Maximum	High Plan $3,300 individual $8,400 family High Alternative Plan $3,550 individual $8,400 family For both plans: deductible, coinsurance and copays apply; excludes pharmacy expenses For pharmacy out-of-pocket maximum refer to Page 29	$6,000 individual $12,000 family Deductible, coinsurance and copays apply; includes pharmacy expenses	Medical Coinsurance (Basic and Basic Alternative) After medical deductible, you pay 50% and plan pays 50% for covered expenses until your out-of-pocket maximum is reached Medical Calendar Year Out-of-Pocket Maximum (Basic and Basic Alternative) $4,000 maximum per member, no more than $9,000 per family Deductible and coinsurance apply to maximums. Once your maximum limit is met, the plan pays 100% of allowable amounts for covered services For pharmacy deductible and maximums, refer to Page 29
Office Visit	$30 copay/general physician $50 copay/specialist	You pay 100% of allowable amounts until deductible is met $30/$50 copay applies after deductible	First-dollar coverage, deductibles and coinsurance apply

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, refer to the plan's handbook or contact each plan (see Contact Information at the back of this guide).

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
X-Ray and Lab	$0 copay for X-ray and lab $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 $200 copay per scan Specialty scans: MRI, CT, MRA and PET scans	$10 copay for X-ray and lab For MRI, MRA, PET, CAT and nuclear scans: $250 copay per scan in a preferred facility $750 copay per scan in a non-preferred facility
Allergy Testing and Treatment	$0 copay/PCP $50 copay/specialist Serum and shots including a 6-week supply of antigen	$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
Preventive Services	$0 copay (PCP or specialist) $0 copay per OB/GYN visit, no referral required for annual routine services	$0 copay (PCP or specialist)	$0 copay PCP/routine physical exam $0 copay well-woman exam and preventive services
Well-Child Care	$0 copay	$0 copay	$0 copay per well-child visit
Immunizations	$0 copay	$0 copay birth through age 20 years $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 $0 copay Limit of one per year	Hearing screening $0 copay when performed by PCP Limit of one per year Hearing aids 20% coinsurance	Hearing screening $0 copay Limit of one per year Hearing aids 20% coinsurance

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, refer to the plan's handbook or contact each plan (see Contact Information at the back of this guide).

Your Costs for Network Services	HealthChoice High and High Alternative Plans	HealthChoice HDHP	HealthChoice Basic and Basic Alternative Plans
X-Ray and Lab	20% of allowable amounts after deductible	20% of allowable amounts after deductible	First-dollar coverage, deductibles and coinsurance apply
Allergy Testing and Treatment	20% of allowable amounts after deductible Limit of 60 tests every 24 months	20% of allowable amounts after deductible Limit of 60 tests every 24 months	First-dollar coverage, deductibles and coinsurance apply Limit of 60 tests every 24 months
Preventive Services (not an all-inclusive list)	$0 copay; no deductible or coinsurance Includes two preventive services office visits per calendar year for members and dependents ages 18 and older; one mammogram per year for women ages 40 and older	$0 copay; no deductible or coinsurance Includes two preventive services office visits per calendar year for members and dependents ages 18 and older; one mammogram per year for women ages 40 and older	$0 copay; no deductible or coinsurance Includes two preventive services office visits per calendar year for members and dependents ages 18 and older; one mammogram per year for women ages 40 and older
Well-Child Care	$0 copay; no deductible or coinsurance	$0 copay; no deductible or coinsurance	$0 copay; no deductible or coinsurance
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	No charge for well-child and adult immunizations and administration Office visit: first-dollar coverage, deductibles and coinsurance 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 ages 17 and younger Certification required	Hearing screening $30/$50 copay after deductible Limit of one per year Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required	First-dollar coverage, deductibles and coinsurance apply Hearing screening Limit of one per year Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, refer to the plan's handbook or contact each plan (see Contact Information at the back of this guide).

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Hospital Inpatient	$250 copay per day $750 maximum per admission	$350 copay per day $1,750 maximum per admission Preauthorization required	**$300 copay per day** **$900 maximum per admission**
Hospital Outpatient	$250 copay per visit	$300 copay per visit	**$300 copay in a preferred facility** **$800 copay in a non-preferred facility**
Emergency Room	$300 copay; waived if admitted	$200 copay; waived if admitted	**$400 copay for facility charge**; waived if admitted
Urgent Care	$25 copay for outpatient or professional urgent care facility per visit	$50 copay per visit	$25 copay per visit
Maternity Prenatal and Postnatal Care	$0 copay for prenatal and postnatal care $500 copay per admission	$0 copay for preventive prenatal and postnatal care $35 copay/PCP $50 copay/ specialist for confirmation visit $350 copay per day $1,750 maximum per admission Preauthorization required	**$0** copay for prenatal and **postnatal** care $500 per hospital admission
Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance
Mental Health or Substance Use Disorder Inpatient	$250 copay per day $750 maximum per admission	$350 copay per day $1,750 maximum per admission Preauthorization required	Residential treatment center or medical detox **$300 copay per day** **$900 maximum per admission**
Mental Health or Substance Use Disorder Outpatient	$0 copay/PCP $50 copay/specialist	$35 copay/PCP $0 copay outpatient/other	$0 copay per visit

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, refer to the plan's handbook or contact each plan (see Contact Information at the back of this guide).

Your Costs for Network Services	HealthChoice High and High Alternative Plans	HealthChoice HDHP	HealthChoice Basic and Basic Alternative Plans
Hospital Inpatient	20% of allowable amounts after deductible	20% of allowable amounts after deductible	First-dollar coverage, deductibles and coinsurance apply
Hospital Outpatient	20% of allowable amounts after deductible	20% of allowable amounts after deductible	First-dollar coverage, deductibles and coinsurance apply
Emergency Room	$200 copay – waived if admitted 20% of allowable amounts after deductible	$200 copay – waived if admitted 20% of allowable amounts after deductible	First-dollar coverage, deductibles and coinsurance apply
Urgent Care	$30 office visit copay 20% of allowable amounts after deductible	$30 office visit copay after deductible 20% of allowable amounts after deductible	First-dollar coverage, deductibles and coinsurance apply
Maternity Prenatal and Postnatal Care	Prenatal: $0 copay Postnatal: 20% of allowable amounts after deductible Labor and delivery: based on location and type of service as applicable (such as hospital inpatient or hospital outpatient benefits)	Prenatal: $0 copay Postnatal: 20% of allowable amounts after deductible Labor and delivery: based on location and type of service as applicable (such as hospital inpatient or hospital outpatient benefits)	Prenatal: $0 copay Postnatal: first-dollar coverage, deductibles and coinsurance apply Labor and delivery: based on location and type of service as applicable (such as hospital inpatient or hospital outpatient benefits)
Durable Medical Equipment	20% of allowable amounts after deductible for purchase, rental, repair or replacement	20% of allowable amounts after deductible for purchase, rental, repair or replacement	First-dollar coverage, deductibles and coinsurance apply for purchase, rental, repair or replacement
Mental Health or Substance Use Disorder Inpatient	20% of allowable amounts after deductible	20% of allowable amounts after deductible	First-dollar coverage, deductibles and coinsurance apply
Mental Health or Substance Use Disorder Outpatient	20% of allowable amounts after deductible Limit: 20 services/year without certification	20% of allowable amounts after deductible Limit: 20 services/year without certification	First-dollar coverage, deductibles and coinsurance apply Limit: 20 services/year without certification

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, refer to the plan's handbook or contact each plan (see Contact Information at the back of this guide).

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Occupational or Speech Therapy Visit	$0 copay inpatient $50 copay per outpatient therapy Limit of 60 visits combined for all therapies per year	Inpatient $350 copay per day $1,750 maximum per admission Preauthorization required $50 copay per outpatient therapy visit Up to 60 days treatment per disability	$0 copay inpatient $35 copay per outpatient visit Limit of 60 treatment days per course of therapy
Physical Therapy or Physical Medicine Visit			
Chiropractic and Manipulative Therapy Visit	$50 copay Included under physical and occupational therapy, no separate visit limit per year	$50 copay	$25 copay Limit 15 visits per year
Bariatric Surgery	$250 per day $750 maximum per admission	Not covered	**$300 per day** **$900 maximum per admission**
National Diabetes Prevention Program	Covered at 100%	Not covered	Covered at 100%

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, refer to the plan's handbook or contact each plan (see Contact Information at the back of this guide).

Your Costs for Network Services	HealthChoice High and High Alternative Plans	HealthChoice HDHP	HealthChoice Basic and Basic Alternative Plans
Occupational or Speech Therapy Visit	20% of allowable amounts after deductible; 60 visits/ year maximum Occupational therapy Limit: 20 visits/year without certification Speech therapy For ages 17 and younger, certification required	20% of allowable amounts after deductible; 60 visits/ year maximum Occupational therapy Limit: 20 visits/year without certification Speech therapy For ages 17 and younger, certification required	First-dollar coverage, deductibles and coinsurance apply; 60 visits/ year maximum Occupational therapy Limit: 20 visits/year without certification Speech therapy For ages 17 and younger, certification required
Physical Therapy or Physical Medicine Visit	20% of allowable amounts after deductible Limits: 20 visits/year without certification; 60 visits/year maximum	20% of allowable amounts after deductible Limits: 20 visits/year without certification; 60 visits/year maximum	First-dollar coverage, deductibles and coinsurance apply Limits: 20 visits/year without certification; 60 visits/year maximum
Chiropractic and Manipulative Therapy Visit	Chiropractic therapy 20% of allowable amounts after deductible $50 specialist office visit copay may apply Limits: 20 visits/year without certification; 60 visits/year maximum Manipulative therapy Included within physical or chiropractic therapy limits	Chiropractic therapy 20% of allowable amounts after deductible $50 specialist office visit copay may apply Limits: 20 visits/year without certification; 60 visits/year maximum Manipulative therapy Included within physical or chiropractic therapy limits	Chiropractic therapy First-dollar coverage, deductibles and coinsurance apply Limits: 20 visits/year without certification; 60 visits/year maximum Manipulative therapy Included within physical or chiropractic therapy limits
Bariatric Surgery	20% of allowable amounts after deductible; some limitations and exclusions apply	20% of allowable amounts after deductible; some limitations and exclusions apply	First-dollar coverage, deductibles and coinsurance apply; some limitations and exclusions apply
National Diabetes Prevention Program	**$0 copay for preventive service**	**$0 copay for preventive service**	**$0 copay for preventive service**

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, refer to the plan's handbook or contact each plan (see Contact Information at the back of this guide).

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Pharmacy Benefits	Retail or Mail order (30-day supply) Preferred generic: $0 Non-preferred generic: $10 Preferred brand: $40 Non-preferred brand: $80 (90-day supply) Preferred generic: $0 Non-preferred generic: $25 Preferred brand: $100 Non-preferred brand: $200 Specialty Preferred: $100 Non-preferred: $200	Retail (30-day supply) Select generic: $0 Preferred generic/Tier 1: $15 Preferred brand/Tier 2: $40* Non-preferred brand or generic/Tier 3: $70* Specialty/Tier 4: $160* Mail order (90-day supply) Select generic: $0 Preferred generic/Tier 1: $45 Preferred brand/Tier 2: $120* Non-preferred brand or generic/Tier 3: $210* Mail order (30-day supply) Specialty/Tier 4: $160* *If you choose to obtain a brand-name drug when a generic is available, you pay the applicable copay or coinsurance for the brand name drug, plus the difference in cost between the brand name drug and its generic equivalent. The difference in cost between the brand name drug and its generic equivalent will not count toward your annual out-of-pocket maximum.	Retail or Mail order (30-day supply) Tier 1 generic: $10 Preferred brand: $65 Non-preferred drugs: $90 (90-day supply) Tier 1 generic: $20 Preferred brand: $130 Non-preferred drugs: $180 Specialty Preferred: **$200** Non-preferred: **$400**

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, refer to the plan's handbook or contact each plan (see Contact Information at the back of this guide).

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

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 on the High, High Alternative, Basic or Basic Alternative Plans, or the combined medical/pharmacy deductible on the HDHP.

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% when filled at a network pharmacy. Visit the Be Tobacco Free page at **www.healthchoiceconnect.com** for details.

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

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

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

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

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

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

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

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

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

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

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

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

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

COMPARISON OF BENEFITS FOR VISION PLANS

	Primary Vision Care Services		Superior Vision	
Covered Services	**Network**	**Non-Network**	**Network**	**Non-Network**
Eye Exams	$0 copay No limit to frequency	Plan reimburses up to $40 Limit one exam	$10 copay Limit one exam per calendar year	Plan pays up to: $34 M.D. $26 O.D.
Lenses Per Pair	You pay wholesale cost No limit to number of pairs	You pay normal doctor's fees, reimbursed up to $60 for one set of lenses and frames per year	$25 copay for replacement lenses Lenses copay is waived if one set of lenses is purchased simultaneously with frames Limit one pair per calendar year Single focal, lined bifocal, lined trifocal covered in full	Plan pays up to: $26 single $39 bifocal $49 trifocal $49 standard progressive $78 lenticular
Frames	You pay wholesale cost No limit to number of frames	You pay normal doctor's fees, reimbursed up to $60 for one set of lenses and frames per year	$25 copay for new frames, then plan pays up to $150 retail Limit one per calendar year	Plan pays up to $81
Contact Lenses	You pay wholesale cost for annual supply of contacts	Limit of one set annually in lieu of eyeglasses You pay normal doctor's fees reimbursed up to $60	$25 copay for lens fitting exam, one per calendar year Plan pays up to $120 retail allowance, in lieu of glasses After exam copay, medically necessary contacts covered in full Standard contacts covered in full; Specialty contacts $50 retail allowance	Plan pays up to $100 all contacts In lieu of glasses: Plan pays up to $210 medically necessary contact lenses Contact lens fitting exam not covered (standard not covered; specialty not covered)
Laser Vision Correction	Through nJoy Vision in Oklahoma City and Tulsa Discount up to $1,000 off Lasik	No benefit	Discount available	Discount available

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

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

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

VISION PLAN NOTES

PVCS: The only Oklahoma owned and operated vision care plan with unlimited network services. Member must select either network or non-network for entire year. Network services are unlimited. Non-network services (one eye exam, one set of eyeglasses or contacts) are limited to once annually. A $50 service fee applies to soft contact lens fittings; a $75 service fee applies to rigid or gas permeable contact lens fittings or refittings; and a $150 service fee applies to hybrid contact lens fittings or refittings. Simple replacements are not assessed with these fees. Limitations/exclusions include the following: 1) Medical eye care, 2) Vision therapy, 3) Non-routine vision services and tests, 4) Luxury frames, 5) Premium prescription lenses, and 6) Nonprescription eyewear. For more information or detail, call 888-357-6912.

Superior Vision: Materials copay applies to lenses and/or frames. Discounts for lens add-ons will be given by contracted providers with a "DP" in their listing. Online, network contact lens materials available at **www.contactsdirect.com/superiorvision**. Exams, lenses and frames are provided once per calendar year. Progressive lenses (no-line bifocals) – you pay the difference between the retail price of the selected progressive lens and the retail price of the lined trifocal. The difference may also be subject to a discount with provider offices that accept our discount plans. Standard contact lens fitting applies to an existing contact lens user who wears disposable, daily wear or extended wear lenses only. The specialty contact lens fitting applies to new contact lens wearers and/or members who wear toric, gas permeable or multifocal lenses.

Vision Care Direct: We are an Oklahoma-owned and operated company, which means customer service is here in the state to help you anytime you need help. It also means that you support your local community when you buy a plan based in Oklahoma! When you compare the total cost of your premium and what you spend in the doctor's office, you will see in most cases we offer a plan that will cost you less money overall. With the VCD plan, you can get your exam, frames and lenses (upgraded to polycarbonate, premium anti-reflective coatings and UV coatings) for $30, even if you wear progressive no-line lenses. We are not an insurance company and our focus is on delivering the very best patient care with quality materials at a very affordable price. Other plans may offer discounts for extra services, but we include the extras the doctor wants you to have, like polycarbonate lenses that are thinner, lighter and safer. We also include premium anti-reflection and UV coatings on our lenses because it's better for you and the doctor wants you to have it. Choose any frame up to $130 and simply pay the difference if you go over. No more Frame Kit or Unbundling Fees, we have simplified the process to improve your experience. What would normally cost you over $300 for progressive lenses will cost you much less with VCD. Visit **www.okstate.vision** for more information and inclusions/limitations, as well as a provider search. For our provider list, be sure to look for the VCD Plus logo to receive all the free options mentioned above. For more information, call 855-918-2020 or email oklahoma@visioncaredirect.com.

VSP: Exam, lenses and frame benefit provided annually. The $25 materials copay applies to lenses or frames, but not to both. Copays/prices listed are for standard lens options. Premium lens options will vary. If choosing a frame valued at more than the allowance, member saves 20 percent on out-of-pocket costs when using a VSP doctor. Member receives an extra $50 toward frame allowance when selecting a Marchon frame. Contact lenses are in lieu of spectacle lenses and frame. The $120 network allowance applies to the contact lenses. With a VSP provider, the contact lens exam (fitting and evaluation) is covered in full after a copay up to $60. The $105 non-network allowance applies to the contacts and contact lens exam. Contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts. Prescription glasses – member receives an extra 20 percent off additional complete pairs of glasses, sunglasses or lens options at any VSP provider within last 12 months from exam. Contact VSP or visit **vsp.com** to learn more. VSP members can now use and integrate their benefits online, via **eyeconic.com**. Oklahoma enrollees can virtually try on each pair in the extensive catalog of glasses and sunglasses. Members can order glasses and contacts while using their VSP benefit. In addition to your VSP vision insurance, any additional savings will automatically be applied at the time of purchase. Frames can be sent directly to your door, or your provider's office for a final fitting, adjustment, and confirmation you are completely satisfied.

CONTACT INFORMATION

Health Plans

BCBSOK – BlueLincs
855-609-5684
www.bcbsok.com/state
www.bcbsok.com

CommunityCare
918-594-5242 or 800-777-4890
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

Pharmacy
877-720-9375
TTY 711
www.healthchoiceconnect.com

Life Insurance

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

Additional

EGID
405-717-8780 or 800-752-9475
TTY 711
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
www.healthchoiceconnect.com

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

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

Vision Plans

Primary Vision Care Services (PVCS)
888-357-6912 or TDD 800-722-0353
www.pvcs-usa.com

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

Vision Care Direct
877-488-8900 or TTY 711
www.okstate.vision

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


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