

PLAN YEAR
2024

JAN. 1-DEC. 31, 2024

EMPLOYEE BENEFIT

OPTIONS GUIDE



HEALTH | DENTAL | LIFE | VISION



OKLAHOMA
Office of Management
& Enterprise Services

Monthly Premiums for Current Employees Plan Year Jan. 1-Dec. 31, 2024



OKLAHOMA
Office of Management
& Enterprise Services

| HEALTH PLANS | MEMBER | SPOUSE | CHILD | CHILDREN |
|--|-----------|------------|-----------|------------|
| Blue Cross Blue Shield of Oklahoma – BlueLincs HMO | \$ 600.78 | \$ 825.98 | \$ 556.90 | \$ 1299.08 |
| CommunityCare HMO | \$ 650.06 | \$ 762.16 | \$ 326.98 | \$ 554.88 |
| GlobalHealth HMO | \$ 979.42 | \$ 1445.72 | \$ 559.30 | \$ 913.38 |
| HealthChoice High and High Alternative | \$ 679.62 | \$ 796.80 | \$ 341.86 | \$ 580.10 |
| HealthChoice Basic and Basic Alternative | \$ 543.08 | \$ 637.32 | \$ 280.06 | \$ 473.72 |
| HealthChoice High Deductible Health Plan (HDHP) | \$ 473.68 | \$ 556.24 | \$ 244.66 | \$ 413.06 |

| TRICARE SUPPLEMENT | MEMBER | MEMBER + ONE | MEMBER + TWO OR MORE |
|--------------------|----------|--------------|----------------------|
| Selman & Company | \$ 65.50 | \$ 129.50 | \$ 181.00 |

| | |
|-----------------------------------|---|
| DISABILITY (Employee only) | \$ 10.36 (Limited city and county participation only) |
|-----------------------------------|---|

| DENTAL PLANS | MEMBER | SPOUSE | CHILD | CHILDREN |
|------------------------------------|----------|----------|----------|-----------|
| BCBSOK – BlueCare Dental High Plan | \$ 35.08 | \$ 35.08 | \$ 28.44 | \$ 72.52 |
| BCBSOK – BlueCare Dental Low Plan | \$ 23.84 | \$ 23.84 | \$ 20.60 | \$ 50.40 |
| Cigna Prepaid High (K1I09) | \$ 13.56 | \$ 10.98 | \$ 8.40 | \$ 14.44 |
| Cigna Prepaid Low (OKIV9) | \$ 10.48 | \$ 6.80 | \$ 4.62 | \$ 10.42 |
| Delta Dental PPO | \$ 39.70 | \$ 39.70 | \$ 34.54 | \$ 87.30 |
| Delta Dental PPO – Choice | \$ 17.88 | \$ 40.50 | \$ 40.80 | \$ 99.02 |
| HealthChoice Dental | \$ 48.58 | \$ 48.58 | \$ 39.28 | \$ 100.74 |
| MetLife High Classic MAC | \$ 50.90 | \$ 50.90 | \$ 43.62 | \$ 107.98 |
| MetLife Low Classic MAC | \$ 28.90 | \$ 28.90 | \$ 24.78 | \$ 60.94 |
| Sun Life Preferred Active PPO | \$ 34.98 | \$ 34.80 | \$ 26.12 | \$ 70.14 |

| VISION PLANS | MEMBER | SPOUSE | CHILD | CHILDREN |
|-------------------------------------|----------|----------|----------|----------|
| Primary Vision Care Services (PVCS) | \$ 10.40 | \$ 9.28 | \$ 9.20 | \$ 11.50 |
| Superior Vision | \$ 7.40 | \$ 7.34 | \$ 6.96 | \$ 14.30 |
| Vision Care Direct | \$ 15.48 | \$ 10.96 | \$ 10.96 | \$ 24.48 |
| VSP (Vision Service Plan) | \$ 8.62 | \$ 5.66 | \$ 5.58 | \$ 12.22 |

| | | |
|-------------|------------------------------|--|
| LIFE | Basic Life (\$20,000) \$5.20 | First \$20,000 of Supplemental Life \$5.20 |
|-------------|------------------------------|--|

| SUPPLEMENTAL LIFE – Age-rated cost per additional \$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 \$11.26 |
|------------------------------|----------------------|------------------------|------------------------|
| 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, 2024

| HEALTH | Employee | Employee & Spouse | Employee, Spouse & Child | Employee, Spouse & Children | Employee & Child | Employee & Children |
|--|-----------|-------------------|--------------------------|-----------------------------|------------------|---------------------|
| Blue Cross Blue Shield of Oklahoma – BlueLincs HMO | \$ 600.78 | \$ 1426.76 | \$ 1983.66 | \$ 2725.84 | \$ 1157.68 | \$ 1899.86 |
| CommunityCare HMO | \$ 650.06 | \$ 1412.22 | \$ 1739.20 | \$ 1967.10 | \$ 977.04 | \$ 1204.94 |
| GlobalHealth HMO | \$ 979.42 | \$ 2425.14 | \$ 2984.44 | \$ 3338.52 | \$ 1538.72 | \$ 1892.80 |
| HealthChoice High and High Alternative | \$ 679.62 | \$ 1476.42 | \$ 1818.28 | \$ 2056.52 | \$ 1021.48 | \$ 1259.72 |
| HealthChoice Basic and Basic Alternative | \$ 543.08 | \$ 1180.40 | \$ 1460.46 | \$ 1654.12 | \$ 823.14 | \$ 1016.80 |
| HealthChoice High Deductible Health Plan (HDHP) | \$ 473.68 | \$ 1029.92 | \$ 1274.58 | \$ 1442.98 | \$ 718.34 | \$ 886.74 |
| TRICARE Supplement – Selman & Company | \$ 65.50 | \$ 129.50 | \$ 181.00 | \$ 181.00 | \$ 129.50 | \$ 181.00 |

| DENTAL | Employee | Employee & Spouse | Employee, Spouse & Child | Employee, Spouse & Children | Employee & Child | Employee & Children |
|------------------------------------|----------|-------------------|--------------------------|-----------------------------|------------------|---------------------|
| BCBSOK – BlueCare Dental High Plan | \$ 35.08 | \$ 70.16 | \$ 98.60 | \$ 142.68 | \$ 63.52 | \$ 107.60 |
| BCBSOK – BlueCare Dental Low Plan | \$ 23.84 | \$ 47.68 | \$ 68.28 | \$ 98.08 | \$ 44.44 | \$ 74.24 |
| Cigna Prepaid High (K1109) | \$ 13.56 | \$ 24.54 | \$ 32.94 | \$ 38.98 | \$ 21.96 | \$ 28.00 |
| Cigna Prepaid Low (OKIV9) | \$ 10.48 | \$ 17.28 | \$ 21.90 | \$ 27.70 | \$ 15.10 | \$ 20.90 |
| Delta Dental PPO | \$ 39.70 | \$ 79.40 | \$ 113.94 | \$ 166.70 | \$ 74.24 | \$ 127.00 |
| Delta Dental PPO – Choice | \$ 17.88 | \$ 58.38 | \$ 99.18 | \$ 157.40 | \$ 58.68 | \$ 116.90 |
| HealthChoice Dental | \$ 48.58 | \$ 97.16 | \$ 136.44 | \$ 197.90 | \$ 87.86 | \$ 149.32 |
| MetLife High Classic MAC | \$ 50.90 | \$ 101.80 | \$ 145.42 | \$ 209.78 | \$ 94.52 | \$ 158.88 |
| MetLife Low Classic MAC | \$ 28.90 | \$ 57.80 | \$ 82.58 | \$ 118.74 | \$ 53.68 | \$ 89.84 |
| Sun Life Preferred Active PPO | \$ 34.98 | \$ 69.78 | \$ 95.90 | \$ 139.92 | \$ 61.10 | \$ 105.12 |

| VISION | Employee | Employee & Spouse | Employee, Spouse & Child | Employee, Spouse & Children | Employee & Child | Employee & Children |
|-------------------------------------|----------|-------------------|--------------------------|-----------------------------|------------------|---------------------|
| Primary Vision Care Services (PVCS) | \$ 10.40 | \$ 19.68 | \$ 28.88 | \$ 31.18 | \$ 19.60 | \$ 21.90 |
| Superior Vision | \$ 7.40 | \$ 14.74 | \$ 21.70 | \$ 29.04 | \$ 14.36 | \$ 21.70 |
| Vision Care Direct | \$ 15.48 | \$ 26.44 | \$ 37.40 | \$ 50.92 | \$ 26.44 | \$ 39.96 |
| VSP (Vision Service Plan) | \$ 8.62 | \$ 14.28 | \$ 19.86 | \$ 26.50 | \$ 14.20 | \$ 20.84 |

Terms for understanding your insurance

Deductible: The out-of-pocket amount you pay before insurance pays expenses. Many plans provide certain coverages before deductible. Refer to plan for specifics.

Premium: The amount you pay for insurance each pay period.

Copay: A fixed out-of-pocket amount you pay for covered services.

Coinsurance: A percentage of costs you pay after your deductible is met.

Primary care physician (PCP): A physician you choose who provides both first contact and a continuing care for a variety of medical conditions. Some HMOs require a PCP referral for other services.

Out-of-pocket maximum: A predetermined amount a covered individual must reach before insurance pays 100% of eligible medical expenses.

Explanation of benefits (EOB): A statement provided by your health insurance company explaining how medical treatments and services were paid.

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This information is only a 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 [Oklahoma.gov/omes](https://oklahoma.gov/omes). Select Services, then Employees Group Insurance Division.

2024 PLAN CHANGES

Below is a summary of significant plan changes. Details of changes can be found in the comparison of benefits charts and are indicated by **bold** text.

Most plans have premium changes. Please refer to the monthly premiums at the beginning of this guide.

HEALTH PLANS

Blue Cross Blue Shield of Oklahoma

- The BlueLincs HMO drug formulary has changed to the BCBSOK Performance Drug List.

CommunityCare

- The CommunityCare HMO plan has had a significant increase in service areas.

DENTAL PLANS

Sun Life Preferred Active PPO

- The non-network orthodontic care lifetime maximum has decreased to \$1,500.
- The plan year maximum has decreased to \$1,750.

VISION PLANS

- There are no significant plan changes among the vision plans.

GENERAL INFORMATION

The benefits you select will take effect Jan. 1 — or for new employees, the effective date of your coverage — through Dec. 31, 2024, or the last day of the month of your termination date.

After enrollment, the plans you select may provide more information about your benefits. Contact each plan directly if you have questions about your benefits. Refer to Contact Information at the back of this guide.

It is your responsibility to review your benefits and know what is covered before choosing your benefits.

Enrollment in a plan does not guarantee 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.

COORDINATION OF BENEFITS

Coordination of benefits occurs when you are covered under two insurance plans, one primary and one secondary. Most insurance plans require you to annually verify if you or any of your covered dependents have other health or dental insurance. Failure to verify other insurance coverage may result in denial of claims until verification is completed. You may complete your verification by contacting the plan directly. Refer to Contact Information at the back of this guide.

HEALTH PLANS

There are several health plans available:

- BCBSOK – BlueLincs HMO.
- CommunityCare HMO.
- GlobalHealth HMO.
- HealthChoice High and High Alternative.
- HealthChoice Basic and Basic Alternative.
- HealthChoice HDHP.
- TRICARE Supplement Plan.

Refer to Comparison of Network Benefits for Health Plans on Pages 18-29 for benefit information.

- Includes standard plan provisions only. For all plan benefits and limitations, contact each plan. Refer to Contact Information at the back of this guide.
- 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 13-17** for the HMO ZIP Code Lists.
 - You must use the provider network designated by that plan for Oklahoma.

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 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 oklahoma.gov/omes/services/employees-group-insurance-division/tricare-supplement.

Note: Residents of WA, CO, UT, AK, NH, OR, ME and PR are not eligible to participate in the TRICARE Supplement Plan.

DENTAL PLANS

There are several dental plans available:

- BCBSOK – BlueCare Dental High Plan.
- BCBSOK – BlueCare Dental Low Plan.
- Cigna Prepaid High (K1I09).
- Cigna Prepaid Low (OKIV9).
- 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 30-37 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 38-42 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 non-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 REMINDERS

HEALTHCHOICE HEALTH PLANS

Tobacco-Free Attestation for HealthChoice High or Basic

If you are enrolled in the HealthChoice High or Basic plan and wish to stay enrolled in that plan, you must complete the HealthChoice Tobacco-Free Attestation for Plan Year 2024 by Nov. 10, 2023. This does not apply to members who are enrolling in the HDHP plan. However, if you are currently enrolled in the HealthChoice HDHP plan and wish to enroll in the High or Basic plan for the next year, you will need to complete the HealthChoice Tobacco-Free Attestation. The online Tobacco-Free Attestation for Plan Year 2024 is open Sept. 4 through Nov. 10, 2023. HealthChoice members who are tobacco free can update their Tobacco-Free Attestation online in just a few minutes.

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. 10:

- 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 moved to one of the alternative plans that correspond to your current plan effective Jan. 1, and your annual deductible will be higher. You also have the option of enrolling in the HDHP plan which does not require the Tobacco-Free Attestation. Refer to the Comparison of Network Benefits for Health Plans.

Health savings account information for HealthChoice HDHP

HSAs for HealthChoice HDHP members allow you to save money for HSA-eligible expenses and 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.

There is no requirement to use American Fidelity. Members may choose any HSA administrator; however, to have pretax contributions withheld from your paycheck, you must contact your insurance coordinator for more information.

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. Please contact your insurance coordinator to request a form.

NOTE: A member cannot contribute to both an HSA and a Section 125 flexible spending account at the same time. Some exceptions may apply for dependent care FSAs.

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.
- Eliminates 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.

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 submit a life insurance application for approval to 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.
- The window to complete and submit a life insurance application during Option Period is Sept. 18-Oct. 31, 2023. Contact your insurance coordinator for a life insurance application. Completed applications must be submitted directly to EGID by fax or mail.

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 the 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, for a total amount of \$520,000 in life insurance coverage. 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 Life and Supplemental Life benefits, you must name your beneficiaries when you enroll. Your designation can be changed at any time. Contact your insurance coordinator for a Beneficiary Designation Form or more information. This form is also available at HealthChoiceOK.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, 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 up 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 is effective the first day of the month following your employment date or the date you become eligible with your employer. You become eligible for disability benefits once you have been actively at work for 31 consecutive days after the effective date of coverage. During that time, you must continuously perform all 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, 2024

This is 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 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 other coverage for you or your dependents ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent because 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; or a city employee; and not classified as temporary or seasonal.
- 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. Premium total does not include amounts paid by your employer.
- 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 did not make changes to your benefits, and if you completed your Tobacco-Free Attestation for Plan Year 2024 as required for HealthChoice High or Basic plan members, 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, 2024, go to oklahoma.gov/omes/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. If you or your dependents will be Medicare eligible by Jan. 1, an additional form is 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

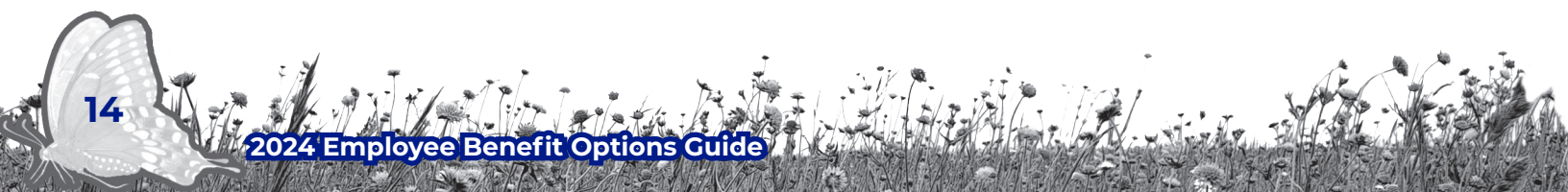
The Consolidated Omnibus Budget Reconciliation Act allows you and/or your covered dependents to continue health, dental and/or vision insurance coverage after your employment terminates or after your dependent loses eligibility. Certain time limits apply to enrollment. Contact your insurance coordinator 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.**

HMO ZIP CODE LISTS

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 | 73189 | 73190 | 73194 | 73195 |
| 73196 | 73401 | 73402 | 73403 | 73425 | 73430 | 73432 | 73433 | 73434 |
| 73435 | 73436 | 73437 | 73438 | 73439 | 73440 | 73441 | 73442 | 73443 |
| 73444 | 73446 | 73447 | 73448 | 73449 | 73450 | 73453 | 73455 | 73456 |
| 73458 | 73459 | 73460 | 73461 | 73463 | 73481 | 73487 | 73488 | 73491 |
| 73501 | 73502 | 73503 | 73505 | 73506 | 73507 | 73520 | 73521 | 73522 |
| 73523 | 73526 | 73527 | 73528 | 73529 | 73530 | 73531 | 73532 | 73533 |
| 73534 | 73536 | 73537 | 73538 | 73539 | 73540 | 73541 | 73542 | 73543 |
| 73544 | 73546 | 73547 | 73548 | 73549 | 73550 | 73551 | 73552 | 73553 |
| 73554 | 73555 | 73556 | 73557 | 73558 | 73559 | 73560 | 73561 | 73562 |
| 73564 | 73565 | 73566 | 73567 | 73568 | 73569 | 73570 | 73571 | 73572 |
| 73573 | 73601 | 73620 | 73622 | 73624 | 73625 | 73626 | 73627 | 73628 |
| 73632 | 73638 | 73639 | 73641 | 73642 | 73644 | 73645 | 73646 | 73647 |
| 73648 | 73650 | 73651 | 73654 | 73655 | 73658 | 73659 | 73660 | 73661 |
| 73662 | 73663 | 73664 | 73666 | 73667 | 73668 | 73669 | 73673 | 73701 |
| 73702 | 73703 | 73705 | 73706 | 73716 | 73717 | 73718 | 73719 | 73720 |
| 73722 | 73724 | 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 | 74186 | 74187 | 74192 | 74193 | 74301 | 74330 | 74331 | 74332 |
| 74333 | 74335 | 74337 | 74338 | 74339 | 74340 | 74342 | 74343 | 74344 |
| 74345 | 74346 | 74347 | 74349 | 74350 | 74352 | 74354 | 74355 | 74358 |
| 74359 | 74360 | 74361 | 74362 | 74363 | 74364 | 74365 | 74366 | 74367 |
| 74368 | 74369 | 74370 | 74401 | 74402 | 74403 | 74421 | 74422 | 74423 |
| 74425 | 74426 | 74427 | 74428 | 74429 | 74430 | 74431 | 74432 | 74434 |
| 74435 | 74436 | 74437 | 74438 | 74439 | 74440 | 74441 | 74442 | 74444 |
| 74445 | 74446 | 74447 | 74450 | 74451 | 74452 | 74454 | 74455 | 74456 |
| 74457 | 74458 | 74459 | 74460 | 74461 | 74462 | 74463 | 74464 | 74465 |
| 74467 | 74468 | 74469 | 74470 | 74471 | 74472 | 74477 | 74501 | 74502 |
| 74521 | 74522 | 74523 | 74525 | 74528 | 74529 | 74530 | 74531 | 74533 |
| 74534 | 74535 | 74536 | 74538 | 74540 | 74543 | 74545 | 74546 | 74547 |
| 74549 | 74552 | 74553 | 74554 | 74555 | 74556 | 74557 | 74558 | 74559 |
| 74560 | 74561 | 74562 | 74563 | 74565 | 74567 | 74569 | 74570 | 74571 |
| 74572 | 74574 | 74576 | 74577 | 74578 | 74601 | 74602 | 74604 | 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

| | | | | | | | | |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 73003 | 73007 | 73008 | 73012 | 73013 | 73014 | 73016 | 73019 | 73020 |
| 73022 | 73025 | 73026 | 73027 | 73028 | 73034 | 73036 | 73040 | 73044 |
| 73045 | 73047 | 73049 | 73050 | 73051 | 73054 | 73056 | 73058 | 73059 |
| 73063 | 73064 | 73065 | 73066 | 73068 | 73069 | 73070 | 73071 | 73072 |
| 73073 | 73078 | 73080 | 73083 | 73084 | 73085 | 73089 | 73090 | 73095 |
| 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 | 73734 | 73742 | 73750 |
| 73756 | 73762 | 73763 | 73764 | 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 |

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|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 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 |
| 74531 | 74536 | 74540 | 74543 | 74545 | 74546 | 74547 | 74549 | 74552 |
| 74553 | 74554 | 74557 | 74558 | 74559 | 74560 | 74561 | 74562 | 74563 |
| 74565 | 74567 | 74570 | 74571 | 74574 | 74576 | 74577 | 74578 | 74604 |
| 74633 | 74637 | 74644 | 74650 | 74652 | 74723 | 74724 | 74727 | 74735 |
| 74738 | 74743 | 74756 | 74759 | 74760 | 74761 | 74764 | 74801 | 74802 |
| 74804 | 74818 | 74824 | 74825 | 74826 | 74827 | 74829 | 74830 | 74831 |
| 74832 | 74833 | 74834 | 74837 | 74839 | 74840 | 74845 | 74848 | 74849 |
| 74850 | 74851 | 74852 | 74854 | 74855 | 74857 | 74859 | 74860 | 74864 |
| 74866 | 74867 | 74868 | 74869 | 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 | 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 | 73022 | 73023 | 73025 | 73026 | 73028 | 73029 | 73031 |
| 73033 | 73034 | 73036 | 73038 | 73042 | 73044 | 73045 | 73047 | 73048 |
| 73049 | 73050 | 73051 | 73052 | 73053 | 73054 | 73056 | 73057 | 73058 |
| 73059 | 73063 | 73064 | 73065 | 73066 | 73067 | 73068 | 73069 | 73070 |
| 73071 | 73072 | 73073 | 73074 | 73075 | 73078 | 73079 | 73080 | 73082 |
| 73083 | 73084 | 73085 | 73089 | 73090 | 73092 | 73093 | 73095 | 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 | 73189 |
| 73190 | 73194 | 73195 | 73196 | 73401 | 73402 | 73403 | 73433 | 73434 |
| 73435 | 73436 | 73437 | 73438 | 73443 | 73444 | 73458 | 73463 | 73481 |
| 73487 | 73488 | 73701 | 73702 | 73703 | 73705 | 73706 | 73720 | 73727 |
| 73730 | 73733 | 73735 | 73736 | 73738 | 73743 | 73753 | 73754 | 73773 |
| 74008 | 74010 | 74011 | 74012 | 74013 | 74014 | 74015 | 74016 | 74017 |
| 74018 | 74019 | 74020 | 74021 | 74026 | 74028 | 74030 | 74031 | 74033 |
| 74034 | 74036 | 74037 | 74038 | 74039 | 74041 | 74043 | 74044 | 74046 |
| 74047 | 74050 | 74052 | 74053 | 74055 | 74058 | 74063 | 74066 | 74067 |
| 74068 | 74071 | 74073 | 74079 | 74080 | 74081 | 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 |
| 74186 | 74187 | 74192 | 74193 | 74330 | 74337 | 74340 | 74350 | 74352 |
| 74361 | 74362 | 74365 | 74366 | 74367 | 74401 | 74402 | 74403 | 74421 |
| 74422 | 74423 | 74425 | 74426 | 74428 | 74429 | 74430 | 74431 | 74432 |
| 74434 | 74436 | 74437 | 74438 | 74439 | 74442 | 74445 | 74446 | 74447 |
| 74450 | 74454 | 74455 | 74456 | 74458 | 74459 | 74460 | 74461 | 74463 |
| 74467 | 74468 | 74469 | 74470 | 74477 | 74501 | 74502 | 74522 | 74528 |
| 74529 | 74531 | 74546 | 74547 | 74553 | 74554 | 74560 | 74561 | 74565 |
| 74570 | 74640 | 74650 | 74801 | 74802 | 74804 | 74818 | 74820 | 74821 |
| 74824 | 74825 | 74826 | 74827 | 74829 | 74830 | 74831 | 74832 | 74833 |
| 74834 | 74837 | 74839 | 74840 | 74842 | 74843 | 74844 | 74845 | 74848 |
| 74849 | 74850 | 74851 | 74852 | 74854 | 74855 | 74857 | 74859 | 74860 |
| 74864 | 74865 | 74866 | 74867 | 74868 | 74869 | 74871 | 74872 | 74873 |
| 74875 | 74878 | 74880 | 74881 | 74883 | 74884 | | | |



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 | \$4,000 individual \$12,000 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 | \$25 copay/PCP \$50 copay/specialist | \$35 copay/PCP \$50 copay/specialist (PCP referral is not required to see most specialists) | \$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, contact each plan. Refer to Contact Information at the back of this guide.

| Your Costs for Network Services | HealthChoice High and High Alternative | HealthChoice HDHP | HealthChoice Basic and Basic Alternative |
|--|--|--|--|
| Calendar Year Deductible (for pharmacy deductible, refer to Page 29) | High plan \$750 individual \$2,000 family | \$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 Plan pays first \$500 (Basic) or \$250 (Basic Alternative) per covered family member for covered expenses |
| | 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 | | 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 | \$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 |
| | High Alternative plan \$3,550 individual \$8,400 family For both plans: Deductible, coinsurance and copays apply; excludes pharmacy expenses | | 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, refer to Page 29 |
| Office Visit | \$30 copay/general physician \$50 copay/specialist | You pay 100% of allowable amounts until deductible is met \$30 copay/general physician \$50 copay/specialist | First-dollar coverage, then 50% of allowable amounts after deductible |

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

| Your Costs for Network Services | BCBSOK – BlueLincs HMO | CommunityCare HMO | GlobalHealth HMO |
|--------------------------------------|---|---|---|
| X-Ray and Lab | \$25 copay for X-ray and lab \$250 copay per scan or procedure for FOCUS Procedures (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 | \$25 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 for well-woman visit, no PCP referral required | \$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 |

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

| Your Costs for Network Services | HealthChoice High and High Alternative | HealthChoice HDHP | HealthChoice Basic and Basic Alternative |
|---|---|---|--|
| X-Ray and Lab | 20% of allowable amounts after deductible | 20% of allowable amounts after deductible | First-dollar coverage, then 50% of allowable amounts after deductible |
| 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, then 50% of allowable amounts after deductible Limit of 60 tests every 24 months |
| Preventive Services (for full list, refer to HealthChoiceOK.com) | \$0 copay; no deductible or coinsurance Includes two preventive office visits per calendar year for members and dependents ages 18 and older | \$0 copay; no deductible or coinsurance Includes two preventive office visits per calendar year for members and dependents ages 18 and older | \$0 copay; no deductible or coinsurance Includes two preventive office visits per calendar year for members and dependents ages 18 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, then 50% of allowable amounts after deductible |

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



| Your Costs for Network Services | BCBSOK – BlueLincs HMO | CommunityCare HMO | GlobalHealth HMO |
|--|--|--|--|
| 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 screening \$0 copay Limit of one per year |
| | Hearing aids 20% coinsurance | Hearing aids 20% coinsurance | Hearing aids 20% coinsurance |
| Hospital Inpatient | \$1,000 copay per day \$3,000 maximum per admission | \$350 copay per day \$1,750 maximum per admission (May be subject to prior authorization) | \$300 copay per day \$900 maximum per admission |
| Hospital Outpatient | \$750 copay per day | \$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 | \$50 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 \$2,000 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 (May be subject to prior authorization) | \$0 copay for prenatal and postnatal care \$500 per hospital admission |

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

| Your Costs for Network Services | HealthChoice High and High Alternative | HealthChoice HDHP | HealthChoice Basic and Basic Alternative |
|--|---|--|---|
| Hearing Screening and Hearing Aid | <p>Hearing screening \$30/\$50 copay unless preventive Limit of one per year</p> <p>Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required</p> | <p>Hearing screening \$30/\$50 copay after deductible unless preventive Limit of one per year</p> <p>Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required</p> | <p>Hearing screening Limit of one per year</p> <p>Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required First-dollar coverage, then 50% of allowable amounts after deductible</p> |
| Hospital Inpatient | 20% of allowable amounts after deductible | 20% of allowable amounts after deductible | First-dollar coverage, then 50% of allowable amounts after deductible |
| Hospital Outpatient | 20% of allowable amounts after deductible | 20% of allowable amounts after deductible. | First-dollar coverage, then 50% of allowable amounts after deductible |
| 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, then 50% of allowable amounts after deductible |
| 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, then 50% of allowable amounts after deductible |
| 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, then 50% 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) |

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



| Your Costs for Network Services | BCBSOK – BlueLincs HMO | CommunityCare HMO | GlobalHealth HMO |
|---|--|--|--|
| Durable Medical Equipment | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| Mental Health or Substance Use Disorder Inpatient | \$1,000 copay per day \$3,000 maximum per admission | \$350 copay per day \$1,750 maximum per admission (May be subject to prior authorization) | Residential treatment center or medical detox \$300 copay per day \$900 maximum per admission |
| Mental Health or Substance Use Disorder Outpatient | \$25 copay/PCP \$50 copay/specialist | \$35 copay/PCP \$0 copay/facility \$0 copay/Applied Behavioral Analysis | \$0 copay per visit |
| 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 (May be subject to prior authorization) \$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 | | | |

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

| Your Costs for Network Services | HealthChoice High and High Alternative | HealthChoice HDHP | HealthChoice Basic and Basic Alternative |
|---|---|---|---|
| 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, then 50% of allowable amounts after deductible |
| Mental Health or Substance Use Disorder Inpatient | 20% of allowable amounts after deductible | 20% of allowable amounts after deductible | First-dollar coverage, then 50% of allowable amounts after deductible |
| 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, then 50% of allowable amounts after deductible Limit: 20 services/year without certification |
| 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, then 50% 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 |
| 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, then 50% of allowable amounts after deductible Limits: 20 visits/year without certification; 60 visits/year maximum |

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

| Your Costs for Network Services | BCBSOK – BlueLincs HMO | CommunityCare HMO | GlobalHealth HMO |
|--|--|---|--|
| Chiropractic and Manipulative Therapy Visit | \$50 copay Included under physical and occupational therapy, no separate visit limit per year | \$50 copay No visit limits | \$25 copay Limit 15 visits per year |
| Bariatric Surgery | \$1,000 copay per day \$3,000 maximum per admission | \$350 copay per day \$1,750 maximum per admission (May be subject to prior authorization) | \$300 per day \$900 maximum per admission |
| National Diabetes Prevention Program | Covered at 100% | Covered at 100% | Covered at 100% |
| Telehealth/ Telemedicine | Covered services are covered at regular plan provisions MDLIVE covered at 100% | \$35 copay/PCP \$50 copay/Specialist \$0 copay/Preventive | Covered same as office visit if provider offers telehealth/telemedicine services |

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

| Your Costs for Network Services | HealthChoice High and High Alternative | HealthChoice HDHP | HealthChoice Basic and Basic Alternative |
|--|--|---|--|
| 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 | 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 | Chiropractic therapy First-dollar coverage, then 50% of allowable amounts after deductible Limits: 20 visits/year without certification; 60 visits/year maximum |
| | Manipulative therapy Included within physical or chiropractic therapy limits | Manipulative therapy Included within physical or chiropractic therapy limits | 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, then 50% of allowable amounts after deductible; some limitations and exclusions apply |
| National Diabetes Prevention Program | \$0 copay for preventive service | \$0 copay for preventive service | \$0 copay for preventive service |
| Telehealth/ Telemedicine | 20% of allowable amounts after deductible; some limitations and exclusions apply \$30/\$50 office visit copay may apply SwiftMD: \$0 fee and no coinsurance | 20% of allowable amounts after deductible; some limitations and exclusions apply. \$30/\$50 office visit copay may apply SwiftMD: \$45 fee until deductible is met. \$0 fee and no coinsurance after meeting deductible | First-dollar coverage, then 50% of allowable amounts after deductible; some limitations and exclusions apply SwiftMD: \$0 fee and no coinsurance |

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



| Your Costs for Network Services | BCBSOK – BlueLincs HMO | CommunityCare HMO | GlobalHealth HMO |
|---|---|---|---|
| <p style="text-align: center;">Pharmacy Benefits</p> | <p>Retail or Mail Order (30-day supply) Preferred generic: \$5 Non-preferred generic: \$15 Preferred brand: \$40 Non-preferred brand: \$80 Insulin*: No more than \$30</p> <p>(90-day supply) Preferred generic: \$10 Non-preferred generic: \$30 Preferred brand: \$80 Non-preferred brand: \$160 Insulin*: No more than \$90</p> <p>Specialty Preferred: \$100 Non-preferred: \$200</p> <p>Drug formulary has changed to the BCBSOK Performance Drug List.</p> <p>*Only insulin included on current drug list.</p> | <p>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* Member cost share will not exceed \$30 for a 30-day supply of insulin.</p> <p>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*</p> <p>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.</p> | <p>Retail or Mail Order (30-day supply) Tier 1 generic: \$20 Preferred brand: \$65 Non-preferred drugs: \$90 Insulin: No more than \$30</p> <p>(90-day supply) Tier 1 generic: \$40 Preferred brand: \$130 Non-preferred drugs: \$180 Insulin: No more than \$90</p> <p>Specialty (30-day supply) Preferred: \$200 Non-preferred: \$400</p> |

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to 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 or, for HDHP, combined deductible must be met before pharmacy copays apply. | |
|---|---|--|
| Pharmacy Deductible | HealthChoice High, High Alternative, Basic and Basic Alternative \$100 for individual \$300 for family | HealthChoice HDHP Medical and pharmacy combined \$1,750 for individual \$3,500 for family |
| Prescription Medications | 30-Day Supply | 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 | 30-day copays apply to each additional 30-day supply |
| Insulin | No more than \$30 | No more than \$90 |
| Note: Only FDA approved drugs and drugs with FDA Emergency Use Authorizations are covered. Experimental treatments and unapproved drugs and drugs not approved or not authorized for emergency use by the FDA are not covered under this plan. | | |

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 [HealthChoice Be Tobacco Free page](#) 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 | BCBSOK – BlueCare Dental High Plan | BCBSOK – BlueCare Dental Low Plan |
|--|--|--|
| <p>Annual Deductible</p> | <p>Network: \$25 individual/\$75 family Basic and Major services combined Non-network: \$25 individual/\$75 family Preventive, basic and major services combined plus amounts above allowable fees</p> | <p>Network: \$50 individual/\$150 family Basic and Major services combined Non-network: \$50 individual/\$150 family Preventive, basic and major services combined plus amounts above allowable fees</p> |
| <p>Diagnostic and Preventive Care (cleanings, routine oral exams)</p> | <p>Network: 0% Non-network 0% after charges above the allowable amounts</p> | <p>Network: 0% Non-network 0% after maximum allowed charge</p> |
| <p>Basic Care (extractions, oral surgery)</p> | <p>Network: 15% in-network after deductible Non-network: 30% after deductible and charges above the allowable amounts</p> | <p>Network: 15% in-network after deductible Non-network: 30% after deductible and maximum allowed charge</p> |

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 the Contact Information at the back of this guide.

| Allowable Amounts Apply for All Benefits | Cigna Prepaid High (K1109) | Cigna Prepaid Low (OKIV9) |
|---|---|---|
| Annual Deductible | No deductible \$0 office copay | No deductible \$5 office copay |
| Diagnostic and Preventive Care (cleanings, routine oral exams) | <p>There is a \$0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1109)</p> <p>Example services/copays: Sealant per tooth: \$12 copay Routine cleaning (once every 6 months): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge</p> | <p>There is a \$5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9)</p> <p>Example services/copays: Sealant per tooth: \$17 copay Routine cleaning (once every 6 months): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge</p> |
| Basic Care (extractions, oral surgery) | <p>There is a \$0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1109)</p> <p>Example service/copay: Amalgam – one surface, permanent teeth: \$0 copay</p> | <p>There is a \$5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9)</p> <p>Example service/copay: Amalgam – one surface, permanent teeth: \$23 copay</p> |

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 the Contact Information at the back of this guide.



| Allowable Amounts Apply for All Benefits | Delta Dental PPO | Delta Dental PPO – Choice | HealthChoice Dental |
|--|---|---|--|
| <p>Annual Deductible</p> | <p>Network and non-network: \$25 per person, per year. Applies to Basic and Major services only.</p> | <p>Network and non-network: \$100 per person per year. Applies to only Major Restorative (Level 4) services.</p> | <p>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.</p> |
| <p>Diagnostic and Preventive Care (cleanings, routine oral exams)</p> | <p>Network and non-network: Member pays 0% of allowable amounts. No deductible or copayments. Routine Cleanings, Oral Evaluations and X-rays are considered Diagnostic and Preventive (Level 1) services. No waiting periods.</p> | <p>Network and non-network: Member pays copayments for all tiers of service (Levels 1-5) based on a fee table. No deductible. Routine Cleanings, Oral Evaluations and X-rays are considered Diagnostic and Preventive (Level 1) services. No waiting periods.</p> | <p>Network: You pay \$0 Non-network: You pay \$0 after deductible plus charges above the allowable amounts</p> |
| <p>Basic Care (extractions, oral surgery)</p> | <p>Network and non-network: Member pays 15% of allowable amounts. Deductible applies. Endodontics, Periodontics and Oral Surgery are considered Basic services. No waiting periods.</p> | <p>Network and non-network: Member pays copayments for Basic (Levels 2 and 3) services as outlined in the fee table. No deductible. Endodontics, Periodontics and Oral Surgery are considered Basic services. No waiting periods.</p> | <p>Network: You pay 15% after deductible Non-network: You pay 30% after deductible plus charges above the allowable amounts</p> |

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 the Contact Information at the back of this guide.

| Allowable Amounts Apply for All Benefits | MetLife High Classic MAC | MetLife Low Classic MAC | Sun Life Preferred Active PPO |
|---|---|---|---|
| Annual Deductible | Member pays Network and non-network: \$25 individual/\$75 family Basic and Major Care combined | Member pays Network and non-network: \$50 individual/\$150 family Basic and Major Care combined | \$30 per person, waived for network preventive services |
| Diagnostic and Preventive Care (cleanings, routine oral exams) | Member pays Network: \$0 Non-network: Amounts above maximum allowed charge | Member pays Network: \$0 Non-network: Amounts above maximum allowed charge | Network: Plan pays 100% of allowable amounts. No deductible. Non-network: Plan pays 100% of usual and customary after deductible |
| Basic Care (extractions, oral surgery) | Member pays Network: 15% Non-network: 15% plus amounts above maximum allowed charge Deductible applies | Member pays 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 the Contact Information at the back of this guide.



| Allowable Amounts Apply for All Benefits | BCBSOK – BlueCare Dental High Plan | BCBSOK – BlueCare Dental Low Plan |
|---|--|---|
| Major Care (dentures, bridge work) | Network: 40% after deductible Non-network: 50% after deductible and charges above the allowable amounts | Network: 50% after deductible Non-network: 50% after deductible and maximum allowed charge |
| Orthodontic Care | Network: 50%. Deductible waived Non-network: 50% after charges above the allowable amounts \$5,000 Lifetime maximum Dependents covered up to age 19 No waiting period for orthodontic benefits | Network: 50%. Deductible waived Non-network: 50% after maximum allowed charge \$1,500 Lifetime maximum Dependents covered up to age 19 No waiting period for orthodontic benefits |
| Plan Year Maximum | \$2,500 | \$1,500 |
| Filing Claims | Network: No claims to file Non-network: You may file claims; provider may file claims. | Network: No claims to file Non-network: You may file claims; provider may 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 the Contact Information at the back of this guide.

| Allowable Amounts Apply for All Benefits | Cigna Prepaid High (K1109) | Cigna Prepaid Low (OKIV9) |
|---|--|--|
| Major Care (dentures, bridge work) | <p>There is a \$0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1109)</p> <p>Example Services/Copays: Root Canal, Anterior: \$210 copay Periodontal Scaling/Root planning 1-3 teeth (per quadrant): \$42 copay</p> | <p>There is a \$5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9)</p> <p>Example Services/Copays: Root Canal, Anterior: \$375 copay Periodontal Scaling/Root planning 1-3 teeth (per quadrant): \$75 copay</p> |
| Orthodontic Care | <p>There is a \$0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1109)</p> <p>\$2,040 out-of-pocket child \$2,376 out-of-pocket adult (24-month treatment)</p> <p>Excludes orthodontic treatment plan and banding No waiting period for orthodontic benefits</p> | <p>There is a \$5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9)</p> <p>\$2,472 out-of-pocket child \$3,384 out-of-pocket adult (24-month treatment)</p> <p>Excludes orthodontic treatment plan and banding No waiting period for orthodontic benefits</p> |
| Plan Year Maximum | <p>Plan year maximum is unlimited No plan year dollar maximum</p> | <p>Plan year maximum is unlimited No plan year dollar maximum</p> |
| Filing Claims | <p>There is no applicable copayment schedule for the Cigna Dental Prepaid K1109 plan. The plan is based on a fee schedule. If you receive care from a Network Specialty Dentist, you are responsible to pay for that care. You are entitled to pay at the Contract Fees negotiated by Cigna Dental rather than the Network Specialty Dentists' usual fees. No claim filing is necessary, the network provider will bill you based on the agreed upon fee schedule.</p> | <p>There is no applicable copayment schedule for the Cigna Dental Prepaid OKIV9 plan. The plan is based on a fee schedule. If you receive care from a Network Specialty Dentist, you are responsible to pay for that care. You are entitled to pay at the Contract Fees negotiated by Cigna Dental rather than the Network Specialty Dentists' usual fees. No claim filing is necessary, the network provider will bill you based on the agreed upon fee schedule.</p> |

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 the Contact Information at the back of this guide.

| Allowable Amounts Apply for All Benefits | Delta Dental PPO | Delta Dental PPO – Choice | HealthChoice Dental |
|---|---|---|---|
| Major Care (dentures, bridge work) | <p>Network and non-network: Member pays 40% of allowable amounts. Deductible applies.</p> <p>Restorations, Prosthodontics, and Implants are considered Major services.</p> <p>No waiting periods.</p> | <p>Network and non-network: Member pays on a service-by-service basis with copayments for all tiers of service (Levels 1-5) as outlined in the fee table. Deductible applies.</p> <p>Restorations, Prosthodontics, and Implants are considered Major services.</p> <p>No waiting periods.</p> | <p>Network: You pay 40% after deductible</p> <p>Non-network: You pay 50% after deductible plus charges above the allowable amounts.</p> |
| Orthodontic Care | <p>Network and non-network: Plan pays 60% of allowable amounts up to \$2,000 lifetime maximum per person.</p> <p>Orthodontic benefits are available to eligible employees, spouses and dependent children and are paid in periodic or monthly intervals.</p> <p>No deductible.</p> <p>No waiting periods.</p> | <p>Network and non-network: Plan pays up to the \$1,800 lifetime maximum per person.</p> <p>Orthodontic (Level 5) services are paid in periodic or monthly intervals and copayments are based on a fee table.</p> <p>Orthodontic benefits are available to eligible employees, spouses and dependent children.</p> <p>No deductible.</p> <p>No waiting periods.</p> | <p>Network: You pay 50% of allowable amounts; no deductible applies</p> <p>Non-network: You pay 50% of the allowable amounts, plus charges above the allowable amounts; no deductible applies</p> <p>Covered for members under age 19</p> <p>Covered for treatment of TMD at any age</p> <p>No lifetime maximum</p> <p>12-month waiting period for orthodontic benefits (some exceptions apply)</p> |
| Plan Year Maximum | <p>Network and non-network: \$2,500 per person per year for Diagnostic, Preventive, Basic and Major (Levels 1, 2, 3 and 4) services.</p> | <p>Network and non-network: \$2,000 per person per year for Diagnostic, Preventive, Basic and Major (Levels 1, 2, 3 and 4) services.</p> | <p>Network and non-network: \$2,500 per person</p> <p>You are responsible for all charges billed by provider after plan year maximum is met.</p> |
| Filing Claims | <p>Network dentists are required to submit claims on behalf of the member.</p> <p>Non-network: Members must submit claims to receive reimbursement for treatment if the dentist does not submit the claims on their behalf.</p> | <p>Network dentists are required to submit claims on behalf of the member.</p> <p>Non-network: Members must submit claims to receive reimbursement for treatment if the dentist does not submit the claims on their behalf.</p> | <p>Network: No claims to file.</p> <p>Non-network: You file claims.</p> |

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 the Contact Information at the back of this guide.

| Allowable Amounts Apply for All Benefits | MetLife High Classic MAC | MetLife Low Classic MAC | Sun Life Preferred Active PPO |
|---|---|---|--|
| Major Care (dentures, bridge work) | Member pays Network: 40% Non-network: 40% plus amounts above maximum allowed charge Deductible applies | Member pays 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 | Member pays Network: 40% Non-network: 40% plus amounts above maximum allowed charge \$5,000 lifetime maximum per person | Member pays Network: 50% Non-network: 50% plus amounts above maximum allowed charge \$2,000 lifetime maximum per person | Network: Plan pays 60% Non-network: Plan pays 50% up to lifetime maximum of \$1,500 for dependents under age 19 12-month waiting period applies |
| Plan Year Maximum | Network and non-network: \$5,000 per person, per year | Network and non-network: \$1,500 per person, per year | \$1,750 per person, per policy year |
| Filing Claims | Network and non-network: Claims are filed for all services performed. Most claims are submitted by dentists on behalf of the member. | Network and non-network: Claims are filed for all services performed. Most claims are submitted by dentists on behalf of the member. | Network and non-network: Member or provider must file claims, depending on 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 the Contact Information at the back of this guide.

COMPARISON OF BENEFITS FOR VISION PLANS

| Covered Services | Primary Vision Care Services | | Superior Vision | |
|------------------------|---|---|--|--|
| | Network | Non-Network | Network | Non-Network |
| Eye Exams | \$0 copay No limit to frequency | Plan reimburses up to \$40 Limit one exam | Covered in full after \$10 copay 1 per Calendar Year | \$10 copay Up to \$34 (MD) Up to \$26 (OD) 1 per Calendar Year |
| 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 1 pair per Calendar Year Standard Lenses: Single-covered in full Bifocal-covered in full Trifocal-covered in full Standard Progressives-Covered in full | \$25 copay 1 pair per Calendar Year Standard lenses: Single-up to \$26 Bifocal-up to \$39 Trifocal-up to \$49 Standard Progressives-up to \$39 |

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 the Contact Information at the back of this guide.

| Covered Services | Vision Care Direct | | VSP | |
|------------------------|---|--|---|--|
| | Network | Non-Network | Network | Non-Network |
| Eye Exams | <p>\$15 copay for full comprehensive exam including dilation</p> <p>Retinal Fundus Image, no more than a \$39 fee</p> | Reimbursed up to \$50 | <p>Covered in full after \$10 copay</p> <p>Limit one exam per calendar year</p> | <p>Reimbursed up to \$45 after \$10 copay</p> <p>Limit one exam per calendar year</p> |
| Lenses Per Pair | <p>\$15 copay</p> <p>Single vision, bifocal, trifocal, lenticular lenses</p> <p>At a PLUS PLAN Provider, you receive free upgrades for no-line progressive lenses with high quality antireflection, scratch and UV coatings (refer to Vision Notes for details)</p> | <p>Reimbursed up to:</p> <p>\$50 single</p> <p>\$75 bifocal</p> <p>\$100 trifocal</p> <p>\$100 progressive</p> | <p>Standard lenses covered in full after \$25 material copay</p> <p>Polycarbonate lenses covered in full for dependent children</p> <p>Standard Progressives and UV protection covered in full</p> <p>Up to 30% savings on popular lens options</p> | <p>Reimbursed up to:</p> <p>\$30 Single</p> <p>\$50 Bifocal</p> <p>\$65 Trifocal</p> <p>\$100 Lenticular</p> <p>\$50 Progressive</p> <p>\$25 materials copay applies</p> |

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 the Contact Information at the back of this guide.



| | Primary Vision Care Services | | Superior Vision | |
|--------------------------------|---|---|---|---|
| Covered Services | Network | Non-Network | Network | Non-Network |
| 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 \$150 retail allowance 1 per Calendar Year | \$25 copay Up to \$81 1 per Calendar Year |
| Contact Lenses | You pay wholesale cost for annual supply of contacts Members are eligible for prescription glasses and contact lenses in the same year | Limit of one set annually in lieu of eyeglasses You pay normal doctor's fees reimbursed up to \$60 | \$25 CL Fit copay 1 Allowance per Calendar Year \$150 Retail Allowance (Contact lenses are in lieu of eyeglass lenses and frames.) | CL Fit Not Covered Up to \$100 1 Allowance per Calendar Year (Contact lenses are in lieu of eyeglass lenses and frames.) |
| Laser Vision Correction | Through nJoy Vision in Oklahoma City and OMEG in Tulsa Discount up to \$1,000 off Lasik | No benefit | Discount available | N/A |

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 the Contact Information at the back of this guide.

| Covered Services | Vision Care Direct | | VSP | |
|--------------------------------|---|------------------------------------|--|---|
| | Network | Non-Network | Network | Non-Network |
| Frames | Covered in full up to \$150 | Reimbursed up to \$80 | Covered in full up to \$170 or \$220 for featured frame brands and 20% discount on any overage. \$95 frame allowance at Walmart/Sam's Club and Costco | Reimbursed up to \$70 \$25 materials copay applies |
| Contact Lenses | \$150 allowance, in lieu of glasses. Contact Fitting Fees: Standard: \$65 Max Specialty: \$200 Max \$750 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 any of our Lasik providers. In addition to the discount, \$200 LASIK Reimbursement in lieu of glasses or contacts. Go to: ok.vision/lasik-discount-network | 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 the 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 copay applies to soft contact lens fittings; a \$75 copay applies to rigid or gas permeable contact lens fittings or refittings; and a \$150 copay 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 and details, call 888-357-6912 or visit our website at pvcs-usa.com/okstate.

Superior: Vision Plan information/detail is available at <https://microsite.versanthealth.com/stateofoklahoma/>. Materials copay applies to lenses and/or frames. Discounts for lens add-ons will be given by contracted providers with DP in their listing. 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 of Oklahoma: Oklahoma Owned and Operated by Optometrists. With VCD of OK, you get your exam, frames, and lenses with free enhancements (progressive lenses with premium anti-reflective and UV coatings) for \$30. Our Frame/Contact Lens Allowance to \$150 and we raised our Medically Necessary Contact Allowance to \$750. We created limits on what you pay for Contact Fitting Fees. For Standard Contact Fitting pay no more than \$65 and Specialty Fittings no more than \$200. With our plan we allow you to use your Contact Lenses Allowance to pay for your Fitting Fee and/or to purchase contacts. This allows you to use your allowance to pay for your fitting and potentially a portion of your contacts, whichever makes the best financial sense for you. Other plans offer discounts for materials such as UV, Scratch, UV Coatings, and Progressive lenses but VCD of OK takes a different approach and includes these extras at NO ADDITIONAL COST! When you compare the total cost of your premiums and what you spend in the doctor's office, in most cases, we offer a plan that will save you money. Choosing an OK company means your customer service is in state to help you. It also means that you support your local community and schools when you buy a plan based in Oklahoma! VCD of OK is not an insurance company so our focus is on delivering the very best patient care with quality materials at a very affordable price because we want you to SEE THE DIFFERENCE. Visit okstate.vision for more information and to search for providers in your area. (To get the free upgrades mentioned above simply look for the "VCD Plus" logo when searching for a provider.)

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% on out-of-pocket costs when using a VSP doctor. Member receives an extra \$50 toward frame allowance when selecting a Marchon or Altair frame brand. 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% 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 that you are completely satisfied.

CONTACT INFORMATION

HEALTH PLANS

BCBSOK – BlueLincs

855-609-5684

bcbsok.com/state

CommunityCare

918-594-5242 or 800-777-4890

TDD 800-722-0353

state.ccok.com

GlobalHealth Inc.

405-280-5600 or 877-280-5600

TTY 711

GlobalHealth.com/oklahoma/mystateplan

HealthChoice

Medical

800-323-4314

TTY 711

HealthChoiceOK.com

Pharmacy

877-720-9375

TTY 711

Caremark.com

LIFE INSURANCE

HealthChoice

800-323-4314

TTY 711

HealthChoiceOK.com

ADDITIONAL

EGID

405-717-8780 or 800-752-9475

TTY 711

Oklahoma.gov/omes

American Fidelity Health Services Administration

800-662-1113

afhsa.com

DENTAL PLANS

BCBSOK – BlueCare

855-609-5684

bcbsok.com/state/dental

Cigna Prepaid Dental

800-244-6224

Hearing-impaired relay 800-654-5988

view.ceros.com/cigna/ok-ins-benefits

Delta Dental

405-607-2100 or 800-522-0188

DeltaDentalOK.org/client/OK

HealthChoice

800-323-4314

TTY 711

HealthChoiceOK.com

MetLife

855-676-9443

metlife.com/oklahoma

Sun Life

800-442-7742

onboard.sunlifeconnect.com

VISION PLANS

Primary Vision Care Services (PVCS)

888-357-6912 or TDD 800-722-0353

pvcs-usa.com/okstate

Superior Vision

844-549-2603 or TDD 916-852-2382

superiorvision.com/stateofoklahoma/benefits

Vision Care Direct

855-918-2020 or TTY 711

okstate.vision

VSP

800-877-7195 or TDD 800-428-4833

stateofok.vspforme.com



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