Comparison of Benefits

Pre-Medicare Health Plans

Plan Year 2016

Jan. 1 through Dec. 31, 2016

3390

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	Aetna INTEGRIS HMO	BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Calendar Year Deductible	No deductible	No deductible	No deductible	No deductible
Calendar Year Out-of-Pocket Maximum	$3,000 individual $4,500 family Includes all copays and coinsurance paid on covered services, prescriptions and durable medical equipment	$4,000 individual $8,000 family Includes all copays and coinsurance paid on covered services, prescriptions and durable medical equipment	$4,000 individual $8,000 family Includes all copays and coinsurance paid on covered services, prescriptions and durable medical equipment	$3,500 individual $10,500 family Includes all copays and coinsurance paid on covered services, prescriptions and durable medical equipment
Office Visit	$25 copay/PCP $50 copay/specialist	$35 copay/PCP $50 copay/specialist	$35 copay/PCP $50 copay/specialist	$0 copay/PCP $50 copay/specialist
X-Ray and Lab	$0 copay for X-ray and lab $0 copay per MRI, CAT, MRA or PET scan	$0 copay for X-ray and lab $200 copay per scan for FOCUS Procedures (MRI, CT, PET, EEG, echocardiogram, MPS, and similar imaging tests; and procedures under CPTs of cytogenetic studies, surgical pathology or transcutaneous procedures	$0 copay for X-ray and lab $200 copay per scan Specialty scans: MRI, MRA, PET, CAT and nuclear scans	$0 copay for X-ray and lab $250 copay per scan in a free-standing/low-cost facility $750 per scan in a hospital facility Specialty scans: MRI, MRA, PET, CAT and nuclear scans
Urgent Care	$50 copay per visit	$50 copay per visit	$50 copay per visit	$25 copay per visit

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High, High Alternative USA and FOCUS Plans	HealthChoice Basic and Basic Alternative Plans	HealthChoice HDHP
Calendar Year Deductible	**High and USA Plans** $500 individual $1,500 family **High Alternative Plan** $750 individual $2,250 family **FOCUS Plan** $250 individual $750 family	**Basic Plan** $1,000 individual $1,500 family Applies after Plan pays first $500 of Allowable Fees **Basic Alternative Plan** $1,250 individual $1,750 family Applies after Plan pays first $250 of Allowable Fees	$1,500 individual $3,000 family The individual deductible does not apply if two or more family members are covered The combined medical and pharmacy deductible must be met before benefits are paid
Calendar Year Out-of-Pocket Maximum **(High, High Alternative, Basic, Basic Alternative and USA Plans have a separate pharmacy out-of-pocket maximum, refer to page 23)**	**High and USA Plans*** $3,300 Network individual $8,400 Network family $3,800 non-Network individual $9,900 non-Network family, plus amounts over Allowable Fees **High Alternative Plan*** $3,550 Network individual $8,400 Network family $4,050 non-Network individual $9,900 non-Network family, plus amounts over Allowable Fees **FOCUS Plan*** $3,000 individual $7,500 family $3,800 non-Network individual $9,900 non-Network family, plus amounts over Allowable Fees	**Basic Plan** $4,000 individual $9,000 family **Basic Alternative Plan** $4,000 individual $9,000 family	$3,000 individual $6,000 family Pharmacy copays apply to the out-of-pocket maximum, but non-Network charges do not apply.
Office Visit	$30 copay/primary physician** $50 copay/specialist **FOCUS Plan** $15 copay/PCP $50 copay/specialist	Copays do not apply All covered services, exceptions, limitations and conditions are identical to the HealthChoice High Plan Refer to the HealthChoice Basic and Basic Alternative Plans on page 19 for a description of the benefits	You pay 100% of Allowable Fees until deductible is met $30/$50** office visit copay applies after deductible
X-Ray and Lab	20% of Allowable Fees after deductible		20% of Allowable Fees after deductible
Urgent Care	$30/$50** office visit copay may apply 20% of Allowable Fees after deductible		$30/$50** office visit copay may apply after deductible 20% of Allowable Fees after deductible

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

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	Aetna INTEGRIS HMO	BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Preventive Services	$0 copay/PCP	$0 copay/PCP	$0 copay (PCP or specialist)	$0 copay/PCP/routine physical exam $50 copay male surgical procedure $0 copay well-woman exam and preventive services
Well Child Care Visit	$0 copay	$0 copay	$0 copay	$0 copay ages 0-21
Immunizations	$0 copay ages birth through age 18 years $0 copay ages 19 and over When medically necessary	$0 copay ages birth through age 18 years $0 copay ages 19 and over When medically necessary	$0 copay ages birth through age 20 years $0 copay ages 21 and over when appropriate following the recommendation of ACIP	$0 copay birth through age 18 years $0 copay ages 19 and over when appropriate following the recommendation of ACIP Office visit copay may apply
Hearing Screening and Hearing Aid	**Hearing screening** $0 copay Limit of one per year **Hearing aids** 20% coinsurance for children up to age 18	**Hearing screening** $0 copay per visit **Audiological services and hearing aids** Limited to one hearing aid per ear every 48 months up to age 18; up to four additional ear molds per benefit period up to 2 years of age	**Hearing screening** $0 copay when performed by PCP Limit of one per year **Hearing aids** 20% coinsurance for children up to age 18	**Hearing screening** $0 copay children birth – age 21 $25 copay ages 22 and over Limit of one per year **Hearing aids** 20% coinsurance For children up to age 18
Durable Medical Equipment (DME)	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Hospital Inpatient	$250 copay per day $750 maximum per admission Preauthorization required	$100 copay per day $800 maximum per admission Preauthorization required	$200 copay per day 5 day maximum ($1,000) per admission Preauthorization required	$250 copay per day $750 maximum per admission
Hospital Outpatient	$250 copay per visit	$200 copay per visit	$500 copay per visit	$250 copay in a free-standing/low-cost facility $750 copay in a hospital facility
Emergency Room	$200 copay; waived if admitted	$200 copay; waived if admitted	$200 copay; waived if admitted	$300 copay; waived if admitted

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High, High Alternative, USA and FOCUS Plans	HealthChoice Basic and Basic Alternative Plans	HealthChoice HDHP
Preventive Services	$0 copay for two preventive services office visits per calendar year for members and dependents ages 18 and older One mammogram per year at no charge for women ages 40 and older	$0 copay for two preventive services office visits per calendar year for members and dependents ages 18 and older One mammogram per year at no charge for women ages 40 and older No deductible for well child care visit Copays do not apply All covered services, exceptions, limitations and conditions are identical to the HealthChoice High Plan **Basic Plan** $0 of the first $500 of Allowable Fees 100% of the next $1,000 of Allowable Fees (deductible). Only Allowable Fees count toward the deductible. 50% of the next $6,000 of Allowable Fees **Basic Alternative Plan** $0 of the first $250 of Allowable Fees 100% of the next $1,250 of Allowable Fees (deductible). Only Allowable Fees count toward the deductible. 50% of the next $5,500 of Allowable Fees **Both Basic Plans** $0 of Allowable Fees over the individual or family out-of-pocket maximum You can use non-Network providers, but it will be more costly.	$0 copay for two preventive services office visits per calendar year for members and dependents ages 18 and older One mammogram per year at no charge for women ages 40 and older
Well Child Care Visit	$0 copay; no deductible applies		$0 copay; no deductible applies
Immunizations	No charge for well child or adult immunizations and administration $30/$50** office visit copay may apply		No charge for well child or adult immunizations and administration $30/$50** office visit copay may apply
Hearing Screening and Hearing Aid	**Hearing screening** $30/$50** copay Limit of one per year **Hearing aids** Covered as durable medical equipment for children up to age 18. Certification required		**Hearing screening** $30/$50** copay after deductible Limit of one per year **Hearing aids** Covered as durable medical equipment for children up to age 18. Certification required
Durable Medical Equipment (DME)	20% of Allowable Fees after deductible for purchase, rental, repair or replacement		20% of Allowable Fees after deductible for purchase, rental, repair or replacement
Hospital Inpatient	20% of Allowable Fees after deductible Additional $300 copay per non-Network admission (does not count toward out-of-pocket maximum)		20% of Allowable Fees after deductible Additional $300 copay per non-Network admission (does not count toward out-of-pocket maximum)
Hospital Outpatient	20% of Allowable Fees after deductible		20% of Allowable Fees after deductible
Emergency Room	20% of Allowable Fees after deductible **High, High Alternative, USA** Additional $100 ER copay* **FOCUS Plan** Additional $200 ER copay* *waived if admitted		20% of Allowable Fees after deductible Additional $100 ER copay – waived if admitted

**The $30 copay applies to general practitioners, internal medicine physicians, OB/GYNs, pediatricians, physician assistants and nurse practitioners.

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	Aetna INTEGRIS HMO	BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Maternity Pre and Post Natal Care	$25 copay initial visit $250 copay per day $750 maximum per admission	$35 copay initial visit $100 copay per day $800 maximum per inpatient hospital admission	$0 copay for prenatal and postnatal care $35 copay initial visit $200 copay per day 5 day maximum ($1000) per hospital admission Preauthorization required	$0 copay for prenatal care $25 copay for delivery and all postnatal care $500 per hospital admission
Allergy Testing and Treatment	$25 copay/PCP $50 copay/specialist	$35 copay/PCP $50 copay/specialist $30 copay for allergy serum and shots (once every 6 weeks)	$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
Mental Health or Substance Abuse Inpatient	$250 copay per day $750 maximum per admission Preauthorization required	$100 copay per day $800 maximum per admission Preauthorization required	$200 per day 5 day maximum ($1,000) per hospital admission Preauthorization required	$250 per day $750 maximum per admission Must be preauthorized by MHNet
Mental Health or Substance Abuse Outpatient	$50 copay/specialist	$35 copay/PCP/ specialist	$35 copay	$0 copay Must be preauthorized by MHNet
Occupational or Speech Therapy Visit	No copay inpatient $50 copay outpatient therapy Limit of 60 days per illness	No copay inpatient $35 copay outpatient therapy Limit of 60 outpatient visits combined per year for physical, occupational, speech and chiropractic therapy visits	$200 copay per day 5 day maximum ($1,000) per hospital admission Preauthorization required $50 copay per outpatient therapy visit (up to 60 days treatment per disability)	No copay inpatient $50 copay per outpatient therapy Limit of 60 visits
Physical Therapy or Physical Medicine Visit	No copay inpatient $50 copay outpatient therapy Limit of 60 days per illness			
Chiropractic and Manipulative Therapy Visit	$20 copay Limit of 15 visits per year	$35 copay Limit of 60 outpatient visits combined per year for physical, occupational, speech and chiropractic therapy visits	$50 copay Limit of 15 visits per year	$25 copay Limit of 15 visits per year

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High, High Alternative, USA and FOCUS Plans	HealthChoice Basic and Basic Alternative Plans	HealthChoice HDHP
Maternity Pre and Post Natal Care	20% of Allowable Fees after deductible Includes one postpartum home visit – criteria must be met	Copays do not apply All covered services, exceptions, limitations and conditions are identical to the HealthChoice High Plan **Basic Plan** $0 of the first $500 of Allowable Fees 100% of the next $1,000 of Allowable Fees (deductible). Only Allowable Fees count toward the deductible. 50% of the next $6,000 of Allowable Fees **Basic Alternative Plan** $0 of the first $250 of Allowable Fees 100% of the next $1,250 of Allowable Fees (deductible). Only Allowable Fees count toward the deductible. 50% of the next $5,500 in Allowable Fees **Both Basic Plans** $0 of Allowable Fees over the individual or family out-of-pocket maximum You can use non-Network providers, but it will be more costly.	20% of Allowable Fees after deductible Includes one postpartum home visit – criteria must be met
Allergy Testing and Treatment	20% of Allowable Fees after deductible Limit of 60 tests every 24 months		20% of Allowable Fees after deductible Limit of 60 tests every 24 months
Mental Health or Substance Abuse Inpatient	20% of Allowable Fees after deductible No limit on the number of days per year		20% of Allowable Fees after deductible No limit on the number of days per year
Mental Health or Substance Abuse Outpatient	20% of Allowable Fees after deductible Limit of 15 services per calendar year without certification		20% of Allowable Fees after deductible Limit of 15 services per calendar year without certification
Occupational or Speech Therapy Visit	20% of Allowable Fees after deductible **Occupational therapy*** Limit of 20 visits per year without certification **Speech therapy*** For ages 17 and younger, certification required For ages 18 and older, certification not required *Maximum of 60 visits per year		20% of Allowable Fees after deductible **Occupational therapy*** Limit of 20 visits per year without certification **Speech therapy*** For ages 17 and younger, certification required For ages 18 and older, certification not required *Maximum of 60 visits per year
Physical Therapy or Physical Medicine Visit	20% of Allowable Fees after deductible Limit of 20 visits per year without certification Maximum of 60 visits per year		20% of Allowable Fees after deductible Limit of 20 visits per year without certification Maximum of 60 visits per year
Chiropractic and Manipulative Therapy Visit	**Chiropractic therapy** 20% of Allowable Fees after deductible Limit of 20 visits per year without certification Maximum of 60 visits per year **Manipulative therapy** Refer to "Physical Therapy/ Physical Medicine" below		**Chiropractic therapy** 20% of Allowable Fees after deductible Limit of 20 visits per year without certification Maximum of 60 visits per year **Manipulative therapy** Refer to "Physical Therapy/ Physical Medicine" below

**The $30 copay applies to general practitioners, internal medicine physicians, OB/GYNs, pediatricians, physician assistants and nurse practitioners.

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	Aetna INTEGRIS HMO	BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Pharmacy Benefits	**Retail** Select generic: $4 Generic: $10 Brand: $30 Non-preferred brand: $60 **Mail-order** Select generic: $8 Generic: $20 Brand: $60 Non-preferred brand: $120 **Specialty** Preferred: $100 Non-preferred: $200	**Retail** Preferred generic: $0 Non-preferred generic: $10 Preferred brand: $40 Non-preferred brand: $80 **Mail-order** Preferred generic: $0 Non-preferred generic: $25 Preferred brand: $100 Non-preferred brand: $200 **Specialty** Preferred or Non-preferred: $100	**Retail** Select generic: $0 Generic: $10 Brand: $40 Non-preferred brand: $65 **Mail-order** Select generic: $0 Generic: $30 Brand: $120 Non-preferred brand: $195 **Specialty** Preferred or Non-preferred: $100	**Retail** Select generic: $5 Generic: $10 Brand: $50 Non-preferred brand: $75 **Mail-order** Select generic: $10 Generic: $20 Brand: $100 Non-preferred brand: $150 **Specialty** Preferred: $100 Non-preferred: $200

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

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

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

HEALTHCHOICE HIGH, HIGH ALTERNATIVE, BASIC, BASIC ALTERNATIVE, USA AND FOCUS PLANS

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

HEALTHCHOICE HDHP

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

ALL HEALTHCHOICE PLANS

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

HealthChoice covers two 90-day courses of tobacco cessation medications at 100% when filled at a Network Pharmacy. Visit the "Be Tobacco-Free" page at **www.sib.ok.gov** for details.

CDC 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.

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	73023	73024	73025	73026	73027	73028
73029	73030	73031	73032	73033	73034	73036	73038	73040
73041	73042	73043	73044	73045	73047	73048	73049	73050
73051	73052	73053	73054	73055	73056	73057	73058	73059
73061	73062	73063	73064	73065	73066	73067	73068	73069
73070	73071	73072	73073	73074	73075	73076	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	73165	73167	73169	73170	73172	73173	73179
73189	73195	73196	73199	73401	73402	73403	73425	73430
73432	73433	73434	73435	73436	73437	73438	73439	73440
73441	73442	73443	73444	73446	73447	73448	73449	73450
73453	73455	73456	73458	73459	73460	73461	73463	73481
73487	73488	73491	73501	73502	73503	73505	73506	73507
73520	73521	73522	73523	73526	73527	73528	73529	73530
73531	73532	73533	73534	73537	73538	73539	73540	73541
73542	73543	73544	73546	73547	73548	73549	73550	73551
73552	73553	73554	73555	73556	73557	73559	73560	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	73716	73717	73718	73719	73720	73722
73724	73726	73727	73728	73729	73730	73731	73733	73734
73735	73736	73737	73738	73739	73741	73742	73743	73744
73747	73749	73750	73753	73754	73755	73756	73757	73758
73759	73760	73761	73762	73763	73764	73766	73768	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	74005	74006	74008	74010	74011

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BlueLincs ZIP Code List

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	74119	74120
74126	74127	74128	74129	74130	74131	74132	74133	74134
74135	74136	74137	74145	74146	74147	74148	74149	74150
74152	74153	74155	74156	74157	74158	74159	74169	74170
74182	74301	74330	74331	74332	74333	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	74369	74370	74401	74402	74403
74421	74422	74423	74425	74426	74427	74428	74429	74430
74431	74432	74434	74435	74436	74437	74438	74441	74442
74444	74445	74446	74447	74450	74451	74452	74454	74455
74456	74457	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

74001	74002	74003	74004	74005	74006	74008	74009
74010	74011	74012	74013	74014	74015	74016	74017
74018	74019	74020	74021	74022	74027	74028	74029
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74038	74039	74041	74042	74043	74044	74045	74046
74047	74048	74050	74051	74052	74053	74054	74055
74056	74058	74060	74061	74063	74066	74067	74068
74070	74071	74072	74073	74080	74081	74082	74083
74084	74100	74101	74102	74103	74104	74105	74106
74107	74108	74110	74112	74114	74115	74116	74117
74119	74120	74121	74126	74127	74128	74129	74130
74131	74132	74133	74134	74135	74136	74137	74141
74145	74146	74147	74148	74149	74150	74152	74153
74155	74156	74157	74158	74159	74169	74170	74171
74172	74182	74183	74184	74186	74187	74189	74192
74193	74194	74301	74330	74331	74332	74333	74335
74337	74338	74339	74340	74342	74343	74344	74345
74346	74347	74349	74350	74352	74353	74354	74355
74358	74359	74360	74361	74362	74363	74364	74365
74366	74367	74368	74369	74370	74401	74402	74403
74421	74422	74423	74425	74426	74427	74428	74429
74430	74431	74432	74434	74435	74436	74437	74438
74439	74440	74441	74442	74444	74445	74446	74447
74450	74451	74452	74454	74455	74456	74457	74458
74459	74460	74461	74462	74463	74464	74465	74466
74467	74468	74469	74470	74471	74472	74477	74501
74502	74521	74522	74523	74526	74528	74529	74536
74543	74545	74546	74547	74548	74549	74552	74553
74554	74557	74558	74559	74560	74561	74562	74563
74565	74567	74571	74574	74577	74578	74604	74633
74637	74650	74652	74722	74724	74727	74728	72734
72735	72736	72737	74738	74740	74743	74745	74750
74752	74754	74855	74756	74759	74760	74761	74764
74766	74845						

GlobalHealth ZIP Code List

73001	73002	73003	73004	73005	73006	73007	73008	73009	73010
73011	73012	73013	73014	73015	73016	73017	73018	73019	73020
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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	73177	73178	73179	73184
73185	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
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73547	73548	73549	73550	73551	73552	73553	73554	73555	73556
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73625	73626	73627	73628	73632	73638	73639	73641	73642	73644
73645	73646	73647	73648	73650	73651	73654	73655	73658	73659
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73701	73702	73703	73705	73706	73716	73717	73718	73719	73720
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73773	73801	73802	73832	73834	73835	73840	73841	73842	73843
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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

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74030	74031	74032	74033	74034	74035	74036	74037	74038	74039
74041	74042	74043	74044	74045	74046	74047	74048	74050	74051
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74063	74066	74067	74068	74070	74071	74072	74073	74074	74075
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74157	74158	74159	74169	74170	74171	74172	74182	74186	74187
74192	74193	74301	74330	74331	74332	74333	74335	74337	74338
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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
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74469	74470	74471	74472	74477	74501	74502	74521	74522	74523
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74556	74557	74558	74559	74560	74561	74562	74563	74565	74567
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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
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74747	74748	74750	74752	74753	74754	74755	74756	74759	74760
74761	74764	74766	74801	74802	74804	74818	74820	74821	74824
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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
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74948	74949	74951	74953	74954	74955	74956	74957	74959	74960
74962	74963	74964	74965	74966					

HealthChoice FOCUS ZIP Code List

73003	73008	73010	73012	73013	73014	73019
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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	73193	73194
73195	73196	73197	73198	73199	73425	73442
73491	73501	73502	73503	73505	73506	73507
73527	73529	73533	73534	73536	73538	73540
73541	73543	73552	73557	73558	73567	73701
73702	73703	73705	73706	73720	73727	73730
73733	73735	73736	73737	73738	73743	73753
73754	73758	73759	73761	73766	73771	73773
74023	74032	74059	74062	74074	74075	74076
74077	74078	74085	74636	74640	74643	74831
74857						

Eligible ZIP codes listed above are within the counties of Canadian, Cleveland, Comanche, Garfield, Grant, Logan, McClain, Oklahoma, Payne and Stephens.

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