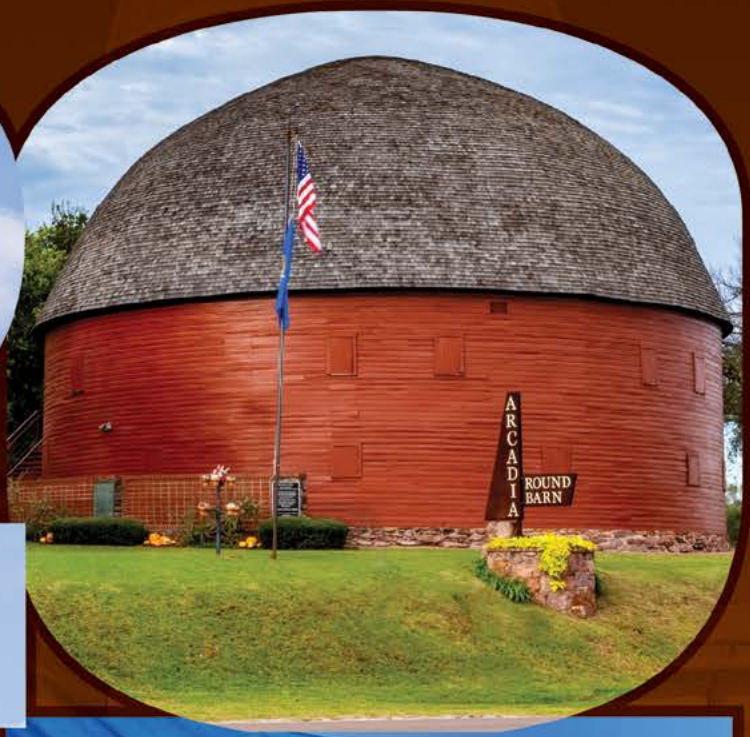
EMPLOYEE BENEFIT OPTIONS GUIDE

HEALTH
DENTAL
LIFE
VISION



JAN. 1-DEC. 31, 2027

5328

OKLAHOMA
Employees Group
Insurance Division

Monthly Premiums for Current Employees
Plan Year Jan. 1-Dec. 31, 2027

OKLAHOMA
Employees Group
Insurance Division

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
CommunityCare HMO	$ 749.36	$ 1,010.34	$ 529.98	$ 899.40
GlobalHealth HMO	$ 1,257.14	$ 1,855.64	$ 717.90	$ 1,172.36
HealthChoice High and High Alternative	$ 818.66	$ 959.80	$ 411.80	$ 698.78
HealthChoice Basic and Basic Alternative	$ 671.52	$ 788.06	$ 346.30	$ 585.78
HealthChoice High Deductible Health Plan (HDHP)	$ 588.82	$ 691.50	$ 303.74	$ 513.82

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	$ 39.28	$ 39.28	$ 31.80	$ 81.20
BCBSOK – BlueCare Dental Low Plan	$ 24.92	$ 24.92	$ 21.52	$ 52.68
Cigna Prepaid (GAOV9)	$ 13.94	$ 10.06	$ 7.32	$ 14.22
Delta Dental PPO	$ 41.30	$ 41.30	$ 35.92	$ 90.82
Delta Dental PPO – Choice	$ 18.60	$ 42.12	$ 42.44	$ 102.98
HealthChoice Dental	$ 51.60	$ 51.60	$ 41.72	$ 106.98
MetLife High Classic MAC	$ 57.46	$ 57.46	$ 49.24	$ 122.06
MetLife Low Classic MAC	$ 30.14	$ 30.14	$ 25.86	$ 63.70
Sun Life Preferred Active PPO	$ 40.48	$ 40.26	$ 30.24	$ 81.22

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
Unity Vision (formerly VCD of OK)	$ 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).

2027 Current Employee Monthly Cumulative Premiums

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
CommunityCare HMO	$ 749.36	$ 1,759.70	$ 2,289.68	$ 2,659.10	$ 1,279.34	$ 1,648.76
GlobalHealth HMO	$ 1,257.14	$ 3,112.78	$ 3,830.68	$ 4,285.14	$ 1,975.04	$ 2,429.50
HealthChoice High and High Alternative	$ 818.66	$ 1,778.46	$ 2,190.26	$ 2,477.24	$ 1,230.46	$ 1,517.44
HealthChoice Basic and Basic Alternative	$ 671.52	$ 1,459.58	$ 1,805.88	$ 2,045.36	$ 1,017.82	$ 1,257.30
HealthChoice High Deductible Plan (HDHP)	$ 588.82	$ 1,280.32	$ 1,584.06	$ 1,794.14	$ 892.56	$ 1,102.64
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	$ 39.28	$ 78.56	$ 110.36	$ 159.76	$ 71.08	$ 120.48
BCBSOK – BlueCare Dental Low Plan	$ 24.92	$ 49.84	$ 71.36	$ 102.52	$ 46.44	$ 77.60
Cigna Prepaid (GAOV9)	$ 13.94	$ 24.00	$ 31.32	$ 38.22	$ 21.26	$ 28.16
Delta Dental PPO	$ 41.30	$ 82.60	$ 118.52	$ 173.42	$ 77.22	$ 132.12
Delta Dental PPO – Choice	$ 18.60	$ 60.72	$ 103.16	$ 163.70	$ 61.04	$ 121.58
HealthChoice Dental	$ 51.60	$ 103.20	$ 144.92	$ 210.18	$ 93.32	$ 158.58
MetLife High Classic MAC	$ 57.46	$ 114.92	$ 164.16	$ 236.98	$ 106.70	$ 179.52
MetLife Low Classic MAC	$ 30.14	$ 60.28	$ 86.14	$ 123.98	$ 56.00	$ 93.84
Sun Life Preferred Active PPO	$ 40.48	$ 80.74	$ 110.98	$ 161.96	$ 70.72	$ 121.70

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
Unity Vision (formerly VCD of OK)	$ 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

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

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

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

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

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

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

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

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TABLE OF CONTENTS

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 Oklahoma Health Care Authority (OHCA) – Employees Group Insurance Division (EGID). The rules of the Oklahoma Administrative Code, Title 317 and 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/egid**. In the menu under Health, Dental and Vision, select Employee Benefit Options Guide.

2027 PLAN CHANGES

Below is a summary of significant plan changes.

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

- Blue Cross Blue Shield of Oklahoma (BCBSOK) is not available for Plan Year 2027; current BCBSOK members must select a new health plan.

GlobalHealth HMO

- Office visits increased to a $25 copay/PCP.
- X-rays and labs decreased to a $0 copay.
- Hospital inpatient, mental health or substance use disorder inpatient, and bariatric surgery copays increased to $400/day and a maximum of $2,000/admission.

HealthChoice High and Basic Health Plans

- Preferred and non-preferred specialty drugs changed to 30% coinsurance.
- Pharmacy out-of-pocket maximum increased to $5,000/individual, $10,000/family.

HealthChoice High Deductible Health Plan

- Combined medical and pharmacy deductible increased to $2,000/individual, $4,000 family.
- Out-of-pocket maximum increased to $6,250/individual, $12,500/family.

DENTAL PLANS

Cigna Prepaid (GAOV9)

- Previously offered plans are not available. This is a new plan. Refer to the Dental Comparison Chart for more details. Members currently enrolled in a Cigna plan must elect a new plan for 2027.

VISION PLANS

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

The benefits you elect will take effect Jan. 1 – or for new employees, the effective date of your coverage – through Dec. 31, 2027, 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 end 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 done. You may complete your verification by contacting the plan directly. Refer to Contact Information at the end of this guide.

HEALTH PLANS

There are several health plans available:

- 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 16-27 for benefit information.

- Includes standard plan provisions only. For all plan benefits and limitations, contact each plan. Refer to Contact Information at the end 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 13-15** for the HMO ZIP Code Lists.

- You must use the provider network designated by that plan for Oklahoma.
- You must select a primary care physician for yourself and each covered dependent.

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 65, you can choose to enroll in the TRICARE Supplement Plan. Electing the TRICARE Supplement Plan means TRICARE will be your primary medical coverage and the supplement plan will be secondary. 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, visit **oklahoma.gov/egid/health-dental-vision/health-insurance/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 (GAOV9).
- Delta Dental PPO.
- Delta Dental PPO – Choice.
- HealthChoice Dental.
- MetLife High Classic MAC.
- MetLife Low Classic MAC.
- Sun Life Preferred Active PPO.

Refer to Comparison of Benefits for Dental Plans on Pages 28-35 for benefit information.

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

VISION PLANS

There are several vision plans available:

- Primary Vision Care Services.
- Superior Vision.
- Unity Vision (formerly VCD of OK).
- VSP.

Refer to Comparison of Benefits for Vision Plans on Pages 36-40 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

You must complete the HealthChoice Tobacco-Free Attestation for Plan Year 2027 if:

- You are enrolled in the HealthChoice High or Basic plan and wish to stay enrolled in that plan.
- You are currently enrolled in the HealthChoice HDHP plan and wish to enroll in the High or Basic plan for the next year.

The online Tobacco-Free Attestation for Plan Year 2027 at **https://gateway.sib.ok.gov/Attestation/** is open Sept. 1 through Nov. 14, 2026. HealthChoice members who are tobacco free can complete the attestation in just a few minutes.

The attestation is waived for members who are new to a HealthChoice plan for the first year of enrollment in the High or Basic plan, but it 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 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 provide a letter from your doctor indicating it is not medically advisable for you or your covered dependents to quit tobacco, by **Nov. 14, 2026**.

If you do not complete the attestation or the reasonable alternative, and you are not in the first-year grace period, you will automatically be moved to the corresponding alternative plans 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

A health savings account (HSA) for HealthChoice HDHP members lets you save money for HSA-eligible expenses and take greater control of your own healthcare costs. With an HSA, you can 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 end 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. For additional information, visit **afhsa.com**.

Note: You 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. 21-Oct. 31, 2026. Contact your insurance coordinator for a life insurance application. Completed applications must be submitted directly to EGID.

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. 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 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. You can change your designation at any time. Life insurance benefits are paid according to the information on file. For a Beneficiary Designation Form or more information, contact your insurance coordinator. This form is also available at **HealthChoiceOK.com** under Frequently Used Forms.

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, or 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 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 as soon as reasonably possible but no later than 60 days of the date you become disabled. 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, 2027

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 (or the employer stops contributing toward) that other coverage. However, you must request enrollment within 30 days after the 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 that qualifying event. 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.
- HMOs (CommunityCare and GlobalHealth): Newborn coverage without an additional premium is provided for the first 48 hours following a vaginal birth or the first 96 hours following a cesarean section birth. Coverage without an additional premium may extend for up to the first 31 days of life. Refer to each HMO plan handbook for specific coverage details and limitations.

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. The 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 2027 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 continue your current coverage 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, 2027, go to **oklahoma.gov/egid** for the appropriate Option Period materials. Select the Option Period banner, then select Pre-Medicare or Medicare (according to your status as of Jan. 1). 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 end 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.
  - Nonpayment 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.**

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
73061	73063	73064	73065	73066	73068	73069	73070	73071
73072	73073	73077	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	73175	73178
73179	73184	73185	73189	73190	73194	73195	73196	73198
73701	73702	73703	73705	73706	73718	73720	73727	73730
73733	73734	73735	73736	73738	73739	73742	73743	73750
73753	73754	73756	73757	73761	73762	73763	73764	73773
74001	74002	74003	74004	74005	74006	74008	74010	74011
74012	74013	74014	74015	74016	74017	74018	74019	74020
74021	74022	74023	74026	74027	74028	74029	74030	74031
74032	74033	74034	74035	74036	74037	74038	74039	74041
74042	74043	74044	74045	74046	74047	74048	74050	74051
74052	74053	74054	74055	74056	74058	74059	74060	74061
74062	74063	74066	74067	74068	74070	74071	74072	74073
74074	74075	74076	74077	74078	74079	74080	74081	74082
74083	74084	74085	74101	74102	74103	74104	74105	74106
74107	74108	74110	74112	74114	74115	74116	74117	74119
74120	74121	74126	74127	74128	74129	74130	74131	74132
74133	74134	74135	74136	74137	74141	74145	74146	74147
74148	74149	74150	74152	74153	74155	74156	74157	74158
74159	74169	74170	74171	74172	74182	74183	74184	74186
74187	74192	74193	74194	74301	74330	74331	74332	74333
74335	74337	74338	74339	74340	74342	74343	74344	74345
74346	74347	74349	74350	74352	74354	74355	74358	74359
74360	74361	74362	74363	74364	74365	74366	74367	74368

74369	74370	74401	74402	74403	74421	74422	74423	74425
74426	74427	74428	74429	74430	74431	74432	74434	74435
74436	74437	74438	74439	74440	74441	74442	74444	74445
74446	74447	74450	74451	74452	74454	74455	74456	74457
74458	74459	74460	74461	74462	74463	74464	74465	74467
74468	74469	74470	74471	74472	74477	74501	74502	74521
74522	74523	74525	74528	74529	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	74601	74604	74630	74633	74637
74640	74644	74650	74651	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	73017	73018	73019
73020	73022	73023	73025	73026	73027	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	73094	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
73185	73189	73190	73193	73194	73195	73196	73197	73198
73199	73401	73402	73403	73433	73435	73436	73437	73438
73443	73444	73451	73454	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	74045	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	74183
74184	74186	74187	74189	74192	74193	74194	74330	74332
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	74452	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	CommunityCare HMO	GlobalHealth HMO
Calendar Year Deductible	No deductible	No deductible
Calendar Year Out-of-Pocket Maximum	$4,000 individual $10,000 family Includes medical and pharmacy	$4,000 individual $12,000 family Includes medical and pharmacy
Office Visit	$25 copay/PCP $50 copay/specialist	**$25 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 end 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 27)	High plan $750 individual $2,000 family High Alternative plan $1,000 individual $2,750 family Copays do not apply to deductible Separate pharmacy deductible A family is three or more covered individuals	**$2,000 individual** **$4,000 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 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 Medical Coinsurance (Basic and Basic Alternative) After medical deductible, you pay 50% and plan pays 50% for covered expenses until your out-of-pocket maximum is reached Medical Calendar Year Out-of-Pocket Maximum (Basic and Basic Alternative) $4,000 maximum per member, no more than $9,000 per family Deductible and coinsurance apply to maximums. Once your maximum limit is met, the plan pays 100% of allowable amounts for covered services For pharmacy deductible, refer to Page 27
Calendar Year Out-of-Pocket Maximum	High plan $3,300 individual $8,400 family High Alternative plan $3,550 individual $8,400 family For both plans: Deductible, coinsurance and copays apply; excludes pharmacy expenses	**$6,250 individual** **$12,500 family** Deductible, coinsurance and copays apply; includes pharmacy expenses	
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 end of this guide.

Your Costs for Network Services	CommunityCare HMO	GlobalHealth HMO
X-Ray and Lab	$0 copay for routine X-rays and labs $200 copay per scan Specialty scans: MRI, CT, MRA and PET scans (May be subject to prior authorization)	**$0 copay for X-rays and labs** 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 $30 serum and shots including a six-week supply of antigen	$0 copay/PCP $50 copay/specialist $30 serum and shots including a six-week supply of antigen and administration
Preventive 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 per well-child visit
Immunizations	$0 copay birth through age 20 $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 end 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 end of this guide.

Your Costs for Network Services	CommunityCare HMO	GlobalHealth HMO
Hearing Screening and Hearing Aid	Hearing screening $0 copay when performed by PCP Limit of one per year Hearing aids 20% coinsurance	Hearing screening $0 copay Limit of one per year Hearing aids 20% coinsurance
Hospital Inpatient	$400 copay per day $2,000 maximum per admission (May be subject to prior authorization)	**$400 copay per day** **$2,000 maximum per admission**
Hospital Outpatient	$350 copay per visit	$300 copay in a preferred facility $800 copay in a non- preferred facility
Emergency Room	$300 copay; waived if admitted	$400 copay for facility charge; waived if admitted
Urgent Care	$50 copay per visit	$25 copay per visit
Maternity Prenatal and Postnatal Care	$0 copay for preventive prenatal and postnatal care $25 copay/PCP $50 copay/specialist for confirmation visit $400 copay per day $2,000 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 end 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	Hearing screening $30/$50 copay unless preventive Limit of one per year Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required	Hearing screening $30/$50 copay after deductible unless preventive Limit of one per year Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required	Hearing screening Limit of one per year 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
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 end of this guide.

Your Costs for Network Services	CommunityCare HMO	GlobalHealth HMO
Durable Medical Equipment	20% coinsurance	20% coinsurance
Mental Health or Substance Use Disorder Inpatient	$400 copay per day $2,000 maximum per admission (May be subject to prior authorization)	Residential Treatment Center or medical detox **$400 copay per day** **$2,000 maximum per admission**
Mental Health or Substance Use Disorder Outpatient	$25 copay/physician office $0 copay/facility $0 copay/Applied Behavioral Analysis	$0 copay per visit
Occupational or Speech Therapy Visit	Inpatient $400 copay per day $2,000 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 end 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 end of this guide.

Your Costs for Network Services	CommunityCare HMO	GlobalHealth HMO
Chiropractic and Manipulative Therapy Visit	$50 copay No visit limits	$25 copay Limit 15 visits per year
Bariatric Surgery	$400 copay per day $2,000 maximum per admission	**$400 per day** **$2,000 maximum per admission**
National Diabetes Prevention Program	Covered at 100%	Covered at 100%
Telehealth/ Telemedicine	$25 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 end 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 Manipulative therapy Included within physical or chiropractic therapy limits	Chiropractic therapy 20% of allowable amounts after deductible $50 specialist office visit copay may apply Limits: 20 visits/year without certification; 60 visits/year maximum Manipulative therapy Included within physical or chiropractic therapy limits	Chiropractic therapy First-dollar coverage, 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
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 Revive: $0 fee and no coinsurance	20% of allowable amounts after deductible; some limitations and exclusions apply. $30/$50 office visit copay may apply Revive: $0 fee and no coinsurance	First-dollar coverage, then 50% of allowable amounts after deductible; some limitations and exclusions apply Revive: $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 end of this guide.

Your Costs for Network Services	CommunityCare HMO	GlobalHealth HMO
Pharmacy Benefits	Retail or Mail Order (30-day supply) Select generic: $0 Preferred generic: $15 Preferred brand: $40* Non-preferred brand or generic: $70* Insulin: No more than $30 (90-day supply) Select generic: $0 Preferred generic: $30 Preferred brand: $80* Non-preferred brand or generic: $140* Insulin: No more than $90 Specialty (30-day supply) $300 *If you choose to obtain a brand-name drug when a generic is available, you pay the applicable copay or coinsurance for the brand-name drug, plus the difference in cost between the brand-name drug and its generic equivalent. The difference in cost between the brand-name drug and its generic equivalent will not count toward your annual out-of- pocket maximum.	Retail or Mail Order (30-day supply) Tier 1 generic: $20 Preferred brand: $65 Non-preferred drugs: $90 Insulin: No more than $30 (90-day supply) Tier 1 generic: $40 Preferred brand: $130 Non-preferred drugs: $180 Insulin: No more than $90 Specialty (30-day supply) Preferred: $200 Non-preferred: $400

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the end 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 **$2,000 for individual** **$4,000 for family**
Prescription Medications	**30-Day Supply**	**90-Day Supply**
Generic Drugs	All HealthChoice Plans Up to $10	All HealthChoice Plans Up to $25
Preferred Drugs	All HealthChoice Plans Up to $45	All HealthChoice Plans Up to $90
Non-Preferred Drugs	All HealthChoice Plans Up to $75	All HealthChoice Plans Up to $150
Specialty Drugs	HealthChoice High, High Alternative, Basic and Basic Alternative (30-day supply) Generic – $10 copay Preferred – **30% coinsurance** Non-preferred – **30% coinsurance** 30-day copays or coinsurances apply to each additional 30-day supply	HealthChoice HDHP (30-day supply) Generic – $10 copay Preferred – $100 copay Non-preferred – $200 copay 30-day copays apply to each additional 30-day supply
Insulin	All HealthChoice Plans No more than $30	All HealthChoice Plans No more than $90

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 end of this guide.

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
Annual Deductible	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	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
Diagnostic and Preventive Care (cleanings, routine oral exams)	Network: 0% Non-network: 0% after charges above the allowable amounts	Network: 0% Non-network: 0% after maximum allowed charge
Basic Care (extractions, oral surgery)	Network: 15% in-network after deductible Non-network: 30% after deductible and charges above the allowable amounts	Network: 15% in-network after deductible Non-network: 30% after deductible and maximum allowed charge

Bold text indicates significant plan changes. 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 end of this guide.

Allowable Amounts Apply for All Benefits	Cigna Prepaid (GAOV9)	HealthChoice Dental
Annual Deductible	No deductible $5 office copay applies	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 three or more covered individuals
Diagnostic and Preventive Care (cleanings, routine oral exams)	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 GAOV9) Example services/copays: Sealant per tooth: $17 copay Routine cleaning (two per calendar year): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge **Note**: You may select a Network Pediatric Dentist for your child under the age of 7 by calling Customer Services at 1.800. Cigna24 to get a list of Network Pediatric Dentists in your area. Coverage for treatment by a Pediatric Dentist ends on your child's 7th birthday.	Network: You pay $0 Non-network: You pay $0 after deductible plus charges above the allowable amounts
Basic Care (extractions, oral surgery)	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 GAOV9) Example service/copay: Amalgam – one surface, permanent teeth: $23 copay	Network: You pay 15% after deductible Non-network: You pay 30% after deductible plus charges above the allowable amounts

Bold text indicates significant plan changes. 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 end of this guide.

Allowable Amounts Apply for All Benefits	Delta Dental PPO	Delta Dental PPO – Choice
Annual Deductible	Network and non-network: $25 per person, per year. Applies to Basic and Major services only	Network and non-network: $100 per person per year. Applies to only Major Restorative (Level 4) services
Diagnostic and Preventive Care (cleanings, routine oral exams)	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	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
Basic Care (extractions, oral surgery)	Network and non-network: Member pays 15% of allowable amounts. Deductible applies Endodontics, Periodontics and Oral Surgery are considered Basic services No waiting periods	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

Bold text indicates significant plan changes. 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 end 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 Preventive Rewards: Earn rollover dollars toward your future annual maximum by receiving preventive care Refer to *Plan Year Maximum* section for details
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

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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

Bold text indicates significant plan changes. 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 end of this guide.

Allowable Amounts Apply for All Benefits	Cigna Prepaid (GAOV9)	HealthChoice Dental
Major Care (dentures, bridge work)	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 GAOV9) Example services/copays: Root Canal, Anterior: $375 copay Periodontal Scaling/Root planning 1-3 teeth (per quadrant): $75 copay	Network: You pay 40% after deductible Non-network: You pay 50% after deductible plus charges above the allowable amounts.
Orthodontic Care	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 GAOV9) $2,472 out-of-pocket child $3,384 out-of-pocket adult (24-month treatment) Excludes orthodontic treatment plan and banding No waiting period for orthodontic benefits	Network: You pay 50% of allowable amounts; no deductible applies Non-network: You pay 50% of the allowable amounts, plus charges above the allowable amounts; no deductible applies Covered for members under age 19 Covered for treatment of TMD at any age No lifetime maximum 12-month waiting period for orthodontic benefits (some exceptions apply)
Plan Year Maximum	Plan year maximum is unlimited No plan year dollar maximum	Network and non-network: $2,500 per person per calendar year You are responsible for all charges billed by provider after plan year maximum is met.
Filing Claims	There is no applicable copayment schedule for the Cigna Dental Prepaid GAOV9 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	Network: No claims to file. Non-network: You file claims. (Timely filing limitations apply.)

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Allowable Amounts Apply for All Benefits	Delta Dental PPO	Delta Dental PPO – Choice
Major Care (dentures, bridge work)	Network and non-network: Member pays 40% of allowable amounts. Deductible applies. Restorations, Prosthodontics, and Implants are considered Major services. No waiting periods.	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. Restorations, Prosthodontics, and Implants are considered Major services. No waiting periods.
Orthodontic Care	Network and non-network: Plan pays 60% of allowable amounts up to $2,000 lifetime maximum per person. Orthodontic benefits are available to eligible employees, spouses and dependent children. No deductible. No waiting periods.	Network and non-network: Plan pays up to the $1,800 lifetime maximum per person. Member pays copayments for Orthodontic (Level 5) services as outlined in the fee table. Orthodontic benefits are available to eligible employees, spouses and dependent children. No deductible. No waiting periods.
Plan Year Maximum	Network and non-network: $2,500 per person per year for Diagnostic, Preventive, Basic and Major (Levels 1, 2, 3 and 4) services.	Network and non-network: $2,000 per person per year for Diagnostic, Preventive, Basic and Major (Levels 1, 2, 3 and 4) services.
Filing Claims	Network: Network dentists are required to submit claims on behalf of the member. Non-network: Members must submit claims to receive reimbursement for treatment if the dentist does not submit the claims on their behalf.	Network: Network dentists are required to submit claims on behalf of the member. Non-network: Members must submit claims to receive reimbursement for treatment if the dentist does not submit the claims on their behalf.

Bold text indicates significant plan changes. 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 end 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 Network and non-network: $5,000 lifetime maximum per person No waiting period	Member pays Network: 50% Non-network: 50% plus amounts above maximum allowed charge Network and non-network: $2,000 lifetime maximum per person No waiting period	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 Preventive Rewards: Rewards members for getting annual preventive care while increasing their annual maximum dollars for future services. The additional maximum dollars can be spent on any covered services, not just preventive (excluding orthodontic) care. Current plan has $1,750 annual maximum. With Preventive Rewards, you can roll over the amount of preventive services claims you have paid in a year, up to $3,000, for future years, and get additional rewards each year until you hit $3,000
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

Bold text indicates significant plan changes. 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 end of this guide.

COMPARISON OF BENEFITS FOR VISION PLANS

	Primary Vision Care Services		Superior Vision	
Covered Services	Network	Non-Network	Network	Non-Network
Eye Exams	$0 copay No limit to frequency	Plan reimburses up to $40 Limit one exam	Covered in full after $10 copay One per Calendar Year	$10 copay Up to $34 (MD) Up to $26 (OD) One 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 One 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 One 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 end of this guide.

	Unity Vision (formerly VCD of OK)		VSP	
Covered Services	Network	Non-Network	Network	Non-Network
Eye Exams	$15 copay Includes: Comprehensive exam, including dilation if necessary	Reimbursed up to $50	Covered in full after $10 copay Limit one exam per calendar year	Reimbursed up to $45 after $10 copay Limit one exam per calendar year
Lenses Per Pair	$15 copay Single vision, bifocal, trifocal, lenticular lenses At a Unity Vision Premium Network provider, you receive free upgrades for no-line progressive lenses with high quality anti-reflection, scratch and UV coatings Refer to Vision Notes at the end of this guide for more details	Reimbursed up to: $50 Single $75 Bifocal $100 Trifocal $100 Progressive	Standard lenses covered in full after $25 material copay Polycarbonate lenses covered in full for dependent children Standard Progressives and UV protection covered in full Up to 30% savings on popular lens options	Reimbursed up to: $30 Single $50 Bifocal $65 Trifocal $100 Lenticular $50 Progressive $25 materials copay applies

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to the Contact Information at the end 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 One per Calendar Year	$25 copay Up to $81 One 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 One allowance per Calendar Year $150 Retail Allowance (Contact lenses are in lieu of eyeglass lenses and frames)	CL Fit Not Covered Up to $100 One 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 end of this guide.

	Unity Vision (formerly VCD of OK)		VSP	
Covered Services	Network	Non-Network	Network	Non-Network
Frames	Covered in full up to $150 Choose from any frame at your provider's office No restrictions on brands	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 Medically necessary contacts covered up to $750 Contact lens allowance can be used to purchase contacts, pay for contact-fitting fee or the balance on either Refer to Vision Plan Notes at the end of this guide for more details	$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: unityvision.care/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 end 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 **superiorvision.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.

Unity Vision (formerly VCD of OK): Unity Vision is Oklahoma-owned and operated, delivering quality eye care from Oklahoma physicians with real value and choice built in. At a Unity Vision Premium Network provider, members receive a comprehensive eye exam and lenses — with free upgrades to no-line progressive lenses, premium anti-reflective coating, scratch resistance, UV protection — for as little as $30 in total copays. Unlike traditional plans that charge extra for these upgrades, Unity Vision includes them at no additional cost. The plan includes a $150 Frame Allowance, a $150 Contact Lens Allowance (in lieu of frames and lenses), and a $750 Medically Necessary Contact Lens Allowance — one of the strongest contact lens benefits available. Your contact lens allowance can be applied toward fitting fees, the contacts themselves, or both, so you can use your benefit the way that makes the most financial sense for you. As a locally based company, Unity Vision reinvests in excellent customer support while helping strengthen Oklahoma communities. Learn more and find a provider at **okstate.vision.**

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, you save 20% on out-of-pocket costs when using a VSP doctor. You receive 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 – you receive an extra 20% off additional complete pairs of glasses, sunglasses or lens options at any VSP provider within last 12 months from your exam. Contact VSP or visit **stateofok.vspforme.com** to learn more. VSP members can now use and integrate their benefits online via **eyeconic.com.** You can virtually try on each pair in the extensive catalog of glasses and sunglasses. You can order glasses and contacts while using your 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

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

Employees Group Insurance Division
405-717-8780 or 800-752-9475
TTY 711

Oklahoma.gov/egid

American Fidelity Health Services Administration
800-662-1113
afhsa.com

DENTAL PLANS

BCBSOK – BlueCare
855-609-5684
bcbsok.com/state

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/clients/ok

HealthChoice
800-323-4314
TTY 711
HealthChoiceOK.com

MetLife
855-676-9443
Metlife.com/info/oklahoma

Sun Life
800-442-7742
Sunlife.co/StateofOKPY2027

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

Unity Vision (formerly VCD of OK)
855-918-2020 or TTY 711
okstate.vision

VSP
800-877-7195 or TDD/TTY: 711
stateofok.vspforme.com

NOTES

OKLAHOMA
Employees Group
Insurance Division