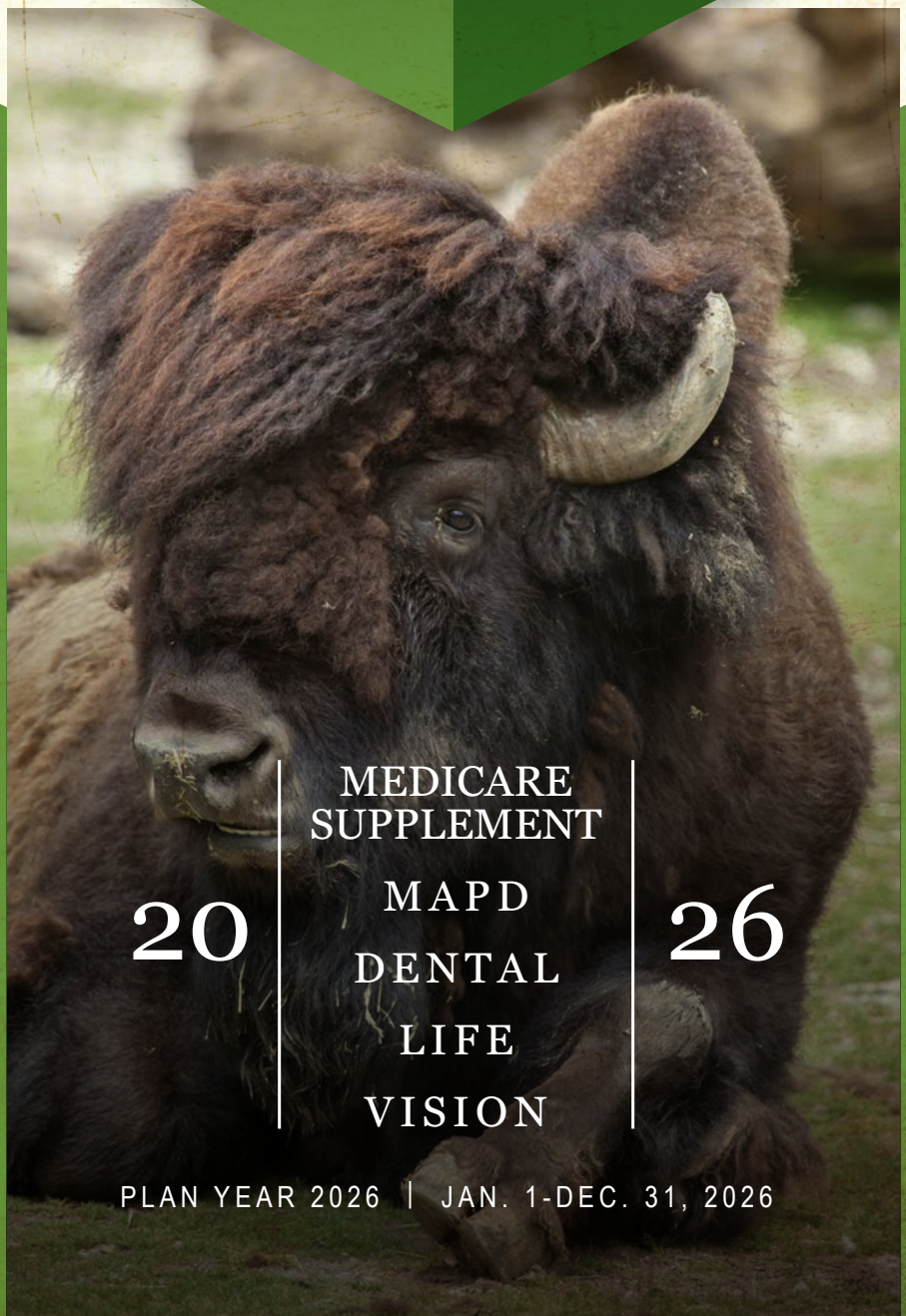
OKLAHOMA
Employees Group
Insurance Division

BENEFITS

OPTION PERIOD GUIDE



20 | 26

MEDICARE SUPPLEMENT

MAPD

DENTAL

LIFE

VISION

PLAN YEAR 2026 | JAN. 1-DEC. 31, 2026

5252

Monthly Premiums for Medicare Eligible Members Plan Year Jan. 1-Dec. 31, 2026

OKLAHOMA
Employees Group
Insurance Division

MEDICARE SUPPLEMENT PLANS	
BCBSOK – BlueSecure℠	$ 568.78 per covered person
HealthChoice SilverScript High Option Medicare Supplement	$ 437.00 per covered person
HealthChoice SilverScript Low Option Medicare Supplement	$ 356.06 per covered person

MEDICARE ADVANTAGE PRESCRIPTION DRUG (MAPD) PLANS	
BCBSOK – MAPD	$ 268.10 per covered person
CommunityCare Senior Health Plan	$ 217.00 per covered person
Generations by GlobalHealth	$ 220.00 per covered person
Humana MAPD PPO	$ 273.42 per covered person

DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
BCBSOK – BlueCare Dental High Plan	$ 37.40	$ 37.40	$ 30.30	$ 77.30
BCBSOK – BlueCare Dental Low Plan	$ 23.72	$ 23.72	$ 20.50	$ 50.16
Cigna Prepaid High K1I09	$ 14.24	$ 11.54	$ 8.82	$ 15.16
Cigna Prepaid Low OKIV9	$ 11.00	$ 7.14	$ 4.86	$ 10.94
Delta Dental PPO	$ 39.98	$ 39.98	$ 34.78	$ 87.92
Delta Dental PPO – Choice	$ 18.60	$ 42.12	$ 42.44	$ 102.98
HealthChoice Dental	$ 48.58	$ 48.58	$ 39.28	$ 100.74
MetLife High Classic MAC	$ 54.28	$ 54.28	$ 46.50	$ 115.20
MetLife Low Classic MAC	$ 30.20	$ 30.20	$ 25.90	$ 63.74
Sun Life Preferred Active PPO	$ 39.30	$ 39.10	$ 29.36	$ 78.82

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

LIFE PLAN			
From $5,000 to $40,000	$3.12 Per $1,000 unit		
AGE-RATED SUPPLEMENTAL LIFE – Cost per $1,000 unit for $41,000 and up			
<30 – $0.06	30-34 – $0.06	35-39 – $0.06	40-44 – $0.08
45-49 – $0.14	50-54 – $0.26	55-59 – $0.40	60-64 – $0.46
65-69 – $0.74	70-74 – $1.28	75+ – $1.96	

DEPENDENT LIFE	$1.56 per $500 unit, per dependent

These rates do not reflect any contribution from your retirement system.

Monthly COBRA Premiums for Medicare Eligible Members
Plan Year Jan. 1-Dec. 31, 2026

OKLAHOMA
Employees Group
Insurance Division

MEDICARE SUPPLEMENT PLANS	
BCBSOK – BlueSecure℠	$ 568.78 per covered person
HealthChoice SilverScript High Option Medicare Supplement	$ 437.00 per covered person
HealthChoice SilverScript Low Option Medicare Supplement	$ 356.06 per covered person

MEDICARE ADVANTAGE PRESCRIPTION DRUG (MAPD) PLANS	
BCBSOK – MAPD	$ 268.10 per covered person
CommunityCare Senior Health Plan	$ 217.00 per covered person
Generations by GlobalHealth	$ 220.00 per covered person
Humana MAPD PPO	$ 273.42 per covered person

DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
BCBSOK – BlueCare Dental High Plan	$ 38.15	$ 38.15	$ 30.91	$ 78.85
BCBSOK – BlueCare Dental Low Plan	$ 24.19	$ 24.19	$ 20.91	$ 51.16
Cigna Prepaid High (K1I09)	$ 14.52	$ 11.77	$ 9.00	$ 15.46
Cigna Prepaid Low (OKIV9)	$ 11.22	$ 7.28	$ 4.96	$ 11.16
Delta Dental PPO	$ 40.78	$ 40.78	$ 35.48	$ 89.68
Delta Dental PPO – Choice	$ 18.97	$ 42.96	$ 43.29	$ 105.04
HealthChoice Dental	$ 49.55	$ 49.55	$ 40.07	$ 102.75
MetLife High Classic MAC	$ 55.37	$ 55.37	$ 47.43	$ 117.50
MetLife Low Classic MAC	$ 30.80	$ 30.80	$ 26.42	$ 65.01
Sun Life Preferred Active PPO	$ 40.09	$ 39.88	$ 29.95	$ 80.40

VISION PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Primary Vision Care Services (PVCS)	$ 10.61	$ 9.47	$ 9.38	$ 11.73
Superior Vision	$ 7.55	$ 7.49	$ 7.10	$ 14.59
Vision Care Direct	$ 15.79	$ 11.18	$ 11.18	$ 24.97
VSP (Vision Service Plan)	$ 8.79	$ 5.77	$ 5.69	$ 12.46

This publication, printed by OMES Central Printing, is issued by the Oklahoma Health Care Authority as authorized by Title VI and Title VII of the 1964 Civil Rights Act and the Rehabilitation Act of 1973. 34,500 copies have been prepared and distributed at a cost of $29,796. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries. [74 O.S. 2001 § 3105 (C)]

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.

2026 PLAN CHANGES

Below is a summary of significant plan changes. Details of changes can be found in the comparison of benefits charts and are indicated in **bold text**. These charts include standard plan provisions only. For all plan benefits and limitations, contact each plan. Refer to Contact Information at the end of this guide.

Each year, the Centers for Medicare & Medicaid Services sets the Part D pharmacy initial deductible, initial coverage limit and out-of-pocket maximum for Medicare plans. These changes are noted in **bold** on the pages with each plan's Pharmacy copay structure for Part D network benefits.

MEDICARE SUPPLEMENT PLANS

- There are no significant plan changes among the Medicare supplement plans.

MAPD PPO PLANS

BCBSOK - MAPD

- A $150 Part A & B deductible has been added.

Humana MAPD PPO

- A $250 copay per hospitalization and for inpatient mental health care has been added.
- A $50 copay for emergency services has been added.

MAPD HMO PLANS

CommunityCare Senior Health Plan

- Canadian, Comanche, Latimer, LeFlore, Pushmataha, Sequoyah and Stephens counties have been added to the service area.

DENTAL PLANS

Sun Life

- Preventive rewards have been added.

VISION PLANS

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

GENERAL INFORMATION

This benefit guide

The information provided in this guide is only a summary of each plan's benefits. If you need additional information to help you make a coverage decision, contact the individual plan. Refer to Contact Information at the end of this guide.

Health benefits

The health benefits provided by the Medicare supplement and Medicare Advantage Prescription Drug plans described in this guide are designed to provide Medicare-covered benefits according to Part A and Part B guidelines.

Updating life insurance beneficiaries

If you need to update your life insurance beneficiary information, complete and return a Beneficiary Designation Form, available at **HealthChoiceOK.com** or from EGID by calling 405-717-8780 or toll-free 800-752-9475. TTY 711.

Health provider network

To find a health, dental or vision provider, or to check the network status of a provider, visit the plan's website or call the plan for assistance. Refer to Contact Information at the end of this guide. Choose your health care provider carefully. If you do not select a provider who accepts Medicare assignment, your out-of-pocket costs may be higher or your claim may be denied entirely. **Note:** Provider networks apply only to MAPDs. Networks do not apply to the Medicare supplement plans offered through EGID.

Getting help from Medicare

To get information directly from Medicare, call toll-free 800-MEDICARE (800-633-4227) or TTY 877-486-2048. You can also visit Medicare's website at **Medicare.gov**.

You can read the 2026 Medicare & You handbook. Every year in the fall, this booklet is mailed to people with Medicare. It summarizes Medicare benefits and answers the most frequently asked questions about Medicare. You can also download a copy of this booklet from Medicare's website.

ANNUAL OPTION PERIOD OCT. 15-DEC. 7, 2025

You have from Oct. 15 until Dec. 7 to make changes to your coverage. Changes received after the deadline cannot be accepted. If your form is not postmarked by Dec. 7, you will remain in the same coverage you currently have for 2025.

During Option Period, you can:

- Change your health, dental and vision plans already in place.
- Drop benefits and dependents.
- Decrease the amount of your life insurance coverage.
- Enroll in a vision plan.

If you are eligible for Medicare, you should have already received the following:

- **A retiree Option Period schedule of virtual webinar meetings and benefit fairs. If you did not receive this schedule, please call EGID Member Services at 405-717-8780 or 800-752-9475** so a schedule can be sent to you. If you plan to attend one of the optional benefit fairs, please bring this guide with you.
- Option Period Enrollment/Change Form. This is being securely mailed in a separate envelope.
  - **When you receive your form, review your personalized information and current coverage listed in the upper right corner.** Review the premiums and plan changes for 2026.
  - **If the HMO MAPD plans are not listed as selections on your personalized Option Period Enrollment/Change Form, you are not eligible for those MAPD plan options.** Check the service area lists beginning on **Page 28** to determine eligibility for a specific HMO MAPD.

If you DO NOT WANT to make changes:

- Do **NOT** return your Option Period Enrollment/Change Form. Your current coverage will automatically continue Jan. 1.
- You will **NOT** receive a Confirmation Statement. Keep your personalized Option Period Enrollment/Change Form as proof of your coverage.
- If you live in a long-term care facility, such as a skilled nursing facility or nursing home, and want to remain enrolled in your current coverage, do not allow your facility to enroll you in another plan with Part D benefits. Enrollment in another plan with Part D benefits will end your Part D benefits through the Employees Group Insurance Division.

If you WANT to make changes:

- You must complete your Option Period Enrollment/Change Form to make changes for you and your dependents. If you are changing your health plan, you must also submit either the Application for Medicare Supplement with Prescription Drug Plan or Application for Medicare Advantage Prescription Drug (MAPD) Plan.
  - This application is available at **Oklahoma.gov/egid**. In the menu under Retirement, select Retirement Insurance Checklist.

- You can also request an application by calling EGID Member Services at 405-717-8780 or toll-free 800-752-9475. TTY 711.

- If you are considering an MAPD HMO plan, check the service area lists beginning on **Page 28** to make sure you are eligible, and then check with the MAPD plans to make sure your provider participates in the plan's network. Refer to Contact Information at the end of this guide.
- Enroll in only one plan that provides Part D prescription drug benefits. (Enrolling in another plan that provides Part D benefits will end your current Part D coverage.)
- A separate Part D application is required for each Medicare-eligible dependent.
- Form(s) must be postmarked no later than Dec. 7.
- Plan changes made during Option Period are reflected on the Confirmation Statement you receive from EGID.
  - Review your Confirmation Statement to make sure your coverage is correct. Contact EGID right away so any corrections can be made as soon as possible.
- If you enroll in an MAPD plan, you will also receive a letter from your plan confirming your enrollment and effective date. Just before your effective date, you will receive your plan ID card and handbook.
- If you need additional benefit information, contact the plan directly and indicate you are with the State of Oklahoma.

HEALTH PLAN ELIGIBILITY REQUIREMENTS

Enrolling in a Medicare supplement plan

A Medicare supplement plan helps pay for some of the remaining out-of-pocket costs that Original Medicare doesn't pay, such as copayments, coinsurance and deductibles. A Medicare supplement plan is in addition to Medicare. There are no provider networks for Medicare supplement plans. If the provider accepts Medicare assignment, the services will be covered.

- To participate in the BCBSOK Medicare supplement plan, you must be enrolled in both Medicare Part A (hospital) and Part B (medical) and continue to pay your monthly Part B premium.
- To participate in the HealthChoice Medicare supplement plans, you must be entitled to benefits under Medicare Part A. You are not required to be enrolled in Part B, but the plan pays benefits as if you are. To maximize your benefits, you need to be enrolled in Medicare Part B.

Enrolling in an MAPD plan

An MAPD plan replaces Original Medicare and administers your health benefits according to Medicare Part A and Part B guidelines.

To participate in the MAPD plans, you must be enrolled in both Medicare Part A (hospital) and Part B (medical) and continue to pay your monthly Part B premium.

For MAPD PPOs (BCBSOK – MAPD and Humana MAPD PPO)

- You can receive services anywhere in the United States as long as the provider is a Medicare-eligible provider and accepts your plan's payment terms and conditions.
- You do not have to designate a primary care physician to direct your care.
- No referrals are required.

For MAPD HMOs (CommunityCare Senior Health Plan and Generations by GlobalHealth)

- You must permanently reside in the MAPD plan's service area. This is a federally qualified area where the MAPD HMO plan provides coverage. You must have a street address. A Post Office Box number is not acceptable. Check the service area lists on **Pages 28-29** to see if you live within an MAPD HMO plan's service area.
- If you permanently move out of your plan's service area or are absent from the service area for more than six consecutive months, you must disenroll from your MAPD HMO plan and select another plan that provides coverage in your new area.
- You must select and designate a PCP to coordinate all your medical and hospital services. There are exceptions in cases of out-of-network emergency or urgent care.
- If you do not use your PCP for routine care, you will be financially responsible for any charges related to those services.
- You can change doctors for any reason as long as the physician you select participates in your MAPD plan's network. To change your PCP, please contact the MAPD plan.
- If your provider leaves your plan, you must select another provider within your plan's network. You will not be able to change plans until the next annual Option Period.

When a dependent is not yet eligible for Medicare

All covered dependents must enroll in the same plan. For example, if you are enrolled in an MAPD or MSP plan, your pre-Medicare dependents must enroll in the corresponding HMO option of that plan. If your current MAPD or MSP plan election does not have a corresponding HMO plan for your dependents to enroll in, you must elect an MAPD or MSP plan that does. As the primary member, you must indicate that you have elected an MAPD or MSP plan and complete all the required information regarding your dependents on your Option Period Enrollment/Change Form.

Disenrolling or changing plans

If you are changing from an MAPD plan to another Medicare health plan with EGID:

- You must complete your Option Period Enrollment/Change Form and the appropriate Part D form (either the Application for Medicare Advantage Prescription Drug (MAPD) Plan or Application for Medicare Supplement With Prescription Drug Plan) and submit them to EGID.
- Your new plan will begin Jan. 1.
- You will automatically be disenrolled from your previous plan.
- You will receive a letter from your former plan confirming the date your coverage ends.

If you are disenrolling from your Medicare health plan with EGID:

- Medicare requires you to provide a signed written request or your Option Period form to EGID to advise of your disenrollment.
- You will receive a letter from your former plan confirming the date your coverage ends.

PRESCRIPTION DRUG BENEFIT INFORMATION

Prescription drug creditable coverage notice

The Medicare supplement and MAPD plans available through EGID include Part D coverage and provide creditable coverage. If you drop your health coverage with EGID and do not get other Part D coverage or coverage as good as Medicare's (creditable coverage) in the future, you may have to pay Medicare's late enrollment penalty in addition to your premium for Part D prescription drug coverage.

Network pharmacy access

Network pharmacies file electronic claims; there are no paper claims to file. Sometimes a pharmacy leaves the network. When this occurs, you will have to get your prescriptions filled at another network pharmacy.

Non-network pharmacy access

In most cases, your prescriptions are covered only if they are filled at a network pharmacy. In certain Part D emergency or urgent situations, your prescriptions can be covered as if you filled them at a network pharmacy. Non-network pharmacies cannot file claims electronically, so you must pay the full cost for your drugs up front and then file a paper claim for your plan to reimburse you for its share of the cost.

An exception can be made if you cannot access a network pharmacy due to one of the following circumstances:

- You travel outside the service area and run out of your prescription or become ill and need a Part D drug.
- You cannot fill a Part D specialty drug timely because it is not in stock.
- There is no network pharmacy with 24/7 service within reasonable driving distance.
- You receive a Part D drug while in an emergency, observation or other outpatient setting.
- You are evacuated or displaced from your residence due to a federal disaster or other public health emergency declaration.

Plan formularies (lists of covered drugs)

The Medicare supplement and MAPD plans each have a formulary, or a list of drugs covered by the plan. Medicare has reviewed and approved these lists of covered drugs. To find out how your drugs are covered, contact the plan or visit their website.

Be aware of restrictions on certain drugs as noted in the plan's formulary, such as:

- Prior authorization
- Step therapy
- Quantity limits

All plans cover both brand-name and generic drugs, which are sorted into five tiers.

Drugs not listed in the plan's formulary are not covered.

Drugs that require pharmacy prior authorization

Drugs that require prior authorization are covered by your plan if the prescribed use meets approved guidelines. Prior authorization requests must be submitted by your physician. The plans may have added or removed certain medications from their lists of drugs that require prior authorization.

Quantity limits

Pharmacy benefits generally cover up to a 30- or 90-day supply. For safety and cost reasons, plans may limit the amount of covered prescription drugs over a certain period. Some drugs have quantity limits, which is a set maximum supply of tablets, capsules, liquids or other units of measure that can be received, as part of the covered benefit, and within a certain time limit. Specific therapeutic categories, drugs and dosage forms may have more restrictive quantity and duration of therapy limitations. Be aware that quantity limitations for some drugs may have been added or removed for 2026.

When changes affect a drug you currently take

If you take a drug that is not listed in your plan's formulary, or if coverage for your drug has changed (e.g., your drug is a brand-name drug that has been replaced by a new generic, has moved to a higher cost-sharing tier or has new restrictions), you have a few options:

- In some situations, your plan covers a one-time, temporary supply of your drug when your current supply runs out. This temporary supply is for up to 30 days. Refer to Transition supply of drug below.
- You and your doctor can find a covered drug that treats your medical condition.
- Your doctor can ask for an exception/prior authorization for your current drug.

If coverage for a drug you are taking changes, you will be notified 60 days before the change so you can review your options. If a drug is immediately removed from your plan's formulary because it was recalled by the FDA for being found unsafe or for other reasons, you will be notified at that time. Your pharmacy provider will also be aware of this change and can work with you to find another formulary drug for your condition.

Transition supply of drug

During the first 90 days of your transition to a new Medicare supplement plan with Part D coverage or to a Part D formulary drug, you can be authorized to purchase a one-time supply of your current drug that is nonformulary under your new plan. This total temporary supply is for up to a maximum 30-day supply of the drug and is available either prior to initiating or completing the plan review process for a drug requiring prior authorization, or if your provider is requesting a medically necessary exception on a drug. Please note that the temporary supply period may be extended under certain circumstances, such as if you reside in a long-term care facility.

Income-related monthly adjustment amount

If you are a member of one of the Medicare supplement or MAPD plans offered through EGID, your premium for Part D prescription drug coverage is included in your regular monthly premium. Part B premiums are paid through Social Security; however, if your income is above a certain level, the law requires that your Part B and Part D premiums be adjusted (income-related monthly adjustment amount). If you must pay extra, Social Security will notify you. For more information, call Social Security at toll-free 800-772-1213. TTY users call toll-free 800-325-0778.

Note: If you fail to pay any Part D IRMAA as a HealthChoice SilverScript member, HealthChoice must move you to a plan without Part D.

Extra Help with Medicare prescription drug costs

People with limited incomes may get Extra Help paying for prescription drug costs. To learn more or apply, call Social Security at toll-free 800-772-1213. TTY users call toll-free 800-325-0778. More information is also available at **SSA.gov**. You can also call Medicare at toll-free 800-MEDICARE (800-633-4227). TTY users call toll-free 877-486-2048.

If you already get help paying for your prescription drugs, the premium and drug cost information in this guide is not correct for you; the amounts of your monthly premiums and pharmacy costs will be less than listed herein. EGID may request a copy of your letter from Social Security confirming you are qualified. Once you enroll in a Part D plan with Part D benefits, Medicare or your plan will tell us the amount of assistance you will receive. We will then send you information about the amount you will pay.

If you qualify for Extra Help, this chart shows your maximum prescription drug costs for 2026:

Rx group	Your maximum prescription drug costs for 2026
1	$0 deductible
	$0 copay
2	$0 deductible
	$5.10 generic copay
	$12.65 brand copay
3	$0 deductible
	$1.60 generic copay
	$4.90 brand copay
4-5	$0 deductible
	$0 copay

If you enroll in another plan with Part D benefits

Your Medicare Part D benefits through your Medicare supplement plan or MAPD plan provide Part D prescription drug coverage. If you enroll in another plan with Part D benefits, Medicare must disenroll you from your current plan. EGID will change your coverage to a plan without Part D benefits. Your coverage will be similar and include prescription drug coverage but not Part D benefits. You must continue in the plan without Part D benefits and pay the higher premium for that plan until the next Option Period. Since you have other Part D (prescription) coverage, you can drop your health and prescription coverage through EGID or drop your other Part D coverage, whichever you decide. If you drop your health plan through EGID, you cannot regain coverage through EGID in the future, and you will lose any premium contribution made by your retirement system. Exceptions may apply to members who qualify for Extra Help through Social Security.

Replacing medications lost or damaged in a declared disaster or public health emergency

You can also replace medications that were stolen, lost or damaged due to a federally declared disaster or other public health emergency. Your pharmacy must contact your plan's pharmacy helpline to provide early refills or override the maximum supply per fill. You must still pay the applicable copay per fill.

COMPARISON OF BENEFITS FOR THE MEDICARE SUPPLEMENT PLANS

Medicare Part A (hospitalization) services

All benefits are based on Medicare-approved amounts.

Part A Network Services	BCBSOK – BlueSecure℠	HealthChoice SilverScript High and Low Options
Hospitalization Includes semiprivate room, meals, drugs as part of your inpatient treatment, and other hospital services and supplies		
First 60 days	You pay $0	You pay $0
Days 61 through 90	You pay $0	You pay $0
Days 91 and after while using Medicare's 60 lifetime reserve days	You pay $0	You pay $0
The plan's additional lifetime reserve days	You pay $0 for additional lifetime reserve days limited to 365 days	You pay $0 for additional lifetime reserve days limited to 365 days
Beyond the plan's lifetime reserve days	You pay 100%	You pay 100%
Skilled Nursing Facility Care Must meet Medicare requirements, including inpatient hospitalization for at least three days and entering a Medicare-approved facility within 30 days of leaving the hospital; limited to 100 days per calendar year		
First 20 days	You pay $0	You pay $0
Days 21 through 100	You pay $0	You pay $0
Days 101 and after	You pay 100%	You pay 100%
Hospice Care Your doctor and hospice provider must certify you are terminally ill and you elect hospice Includes physical care, counseling, equipment, supplies, respite care, inpatient care and drugs for pain and symptom control	You pay $0	You pay up to $5 per prescription for palliative drugs or biologicals You also pay 5% of Medicare amounts for inpatient respite care
Blood Limited to the first three pints unless you or someone else donates blood to replace what you use	You pay $0	You pay $0

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.

Medicare Part B (medical) services

All benefits are based on Medicare-approved amounts

Part B Network Services	BCBSOK – BlueSecure℠	HealthChoice SilverScript High and Low Options
Medical Expenses Medically necessary outpatient services and supplies Includes doctor's visits, outpatient hospital treatment, surgical services, physical and speech therapy and diagnostic tests	You pay the Part B deductible	You pay $0 after meeting the Part B deductible
Clinical Diagnostic Laboratory Services Blood tests, urinalysis and tissue pathology	You pay $0	You pay $0
Home Health Care Intermittent skilled care and medical supplies	You pay $0	You pay $0
Durable Medical Equipment Items such as nebulizers, wheelchairs and walkers	You pay the Part B deductible	You pay $0 after meeting the Part B deductible
Diabetes Monitoring Supplies Glucose monitors, test strips and lancets for those with diabetes Must be requested by your doctor	You pay the Part B deductible	You pay $0 after meeting the Part B deductible
Ostomy Supplies Includes ostomy bags, wafers and other ostomy supplies for those with a need based on their condition	You pay the Part B deductible	You pay $0 after meeting the Part B deductible
Blood Includes amounts in addition to the coverage under Part A unless you or someone else donates blood to replace what you use	You pay the Part B deductible after the first 3 pints	You pay $0 after meeting the Part B deductible
Outpatient Prescriptions Includes infused, oral end-stage renal disease drugs and some cancer and transplant drugs	You pay the Part B deductible	You pay $0 after meeting the Part B deductible

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.

Coverage for additional medical services

Service	BCBSOK – BlueSecure℠	HealthChoice SilverScript High and Low Options
Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.	You pay the first $250 each calendar year, then 20% and all amounts over the $50,000 lifetime maximum	You pay the first $250 each calendar year, then 20% and all amounts over the $50,000 lifetime maximum
Bariatric Surgery	You pay the Part B deductible	You pay $0 after meeting the Part B deductible
National Diabetes Prevention Program	You pay $0	You pay $0

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.

Medicare preventive services

Medicare Part B covers many preventive services, such as your annual flu vaccination, wellness visit and screening mammogram, at 100% when you use a doctor or other health care provider who accepts Medicare assignment; however, certain preventive services may still require the Part B deductible or coinsurance. Coinsurance can apply depending on where you receive certain services.

For Medicare to cover preventive services, you must follow their guidelines for each service. Guidelines can include criteria for age, frequency and disease risk.

For a list of preventive services and details on Medicare coverage, go to **CMS.gov** or **Medicare.gov**. You can also refer to the 2026 Medicare & You handbook.

Pharmacy copay structure for Part D network benefits

General information	BCBSOK – Blue Cross Group MedicareRx℠	
This plan uses a formulary Some drugs require prior authorization Quantity limits apply to certain drugs Only copays for covered drugs purchased at network pharmacies count toward out-of-pocket maximums Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003 You will be notified before any changes are made to your plan's formulary	No deductible No Coverage Gap There is an annual out-of-pocket maximum	
	Preferred Retail*	**Standard Retail**
	30-Day Supply	30-Day Supply
	Preferred Generic Tier 1 $0 copay Non-Preferred Generic Tier 2 $2 copay Preferred Brand Tier 3 $25 copay Non-Preferred Brand Tier 4 $75 copay Specialty Tier 5 33% coinsurance to **$2,100** TrOOP Insulin – No more than $35 copay	Preferred Generic Tier 1 $5 copay Non-Preferred Generic Tier 2 $7 copay Preferred Brand Tier 3 $40 copay Non-Preferred Brand Tier 4 $95 copay Specialty Tier 5 33% coinsurance to **$2,100** TrOOP Insulin – No more than $35 copay
	60- or 90-Day Supply	60- or 90-Day Supply
	Preferred Generic Tier 1 $0 copay (60 or 90) Non-Preferred Generic Tier 2 $4 copay (60) $6 copay (90) Preferred Brand Tier 3 $50 copay (60) $75 copay (90) Non-Preferred Brand Tier 4 $150 copay (60) $225 copay (90) Specialty Tier 5 33% coinsurance to **$2,100** TrOOP MOOP set at **$2,100** for all tiers *Preferred pharmacies include but are not limited to Walgreens, Walmart and other independent pharmacies as indicated in the provider directory	Standard Tier 1 $10 copay (60) $15 copay (90) Non-Preferred Generic Tier 2 $14 copay (60) $21 copay (90) Preferred Brand Tier 3 $80 copay (60) $120 copay (90) Non-Preferred Brand Tier 4 $190 copay (60) $285 copay (90) Specialty Tier 5 33% coinsurance to **$2,100** TrOOP MOOP set at **$2,100** for all tiers
	Mail order: Same retail cost sharing applies for all tiers for applicable day supply Once you reach the **$2,100** out-of-pocket maximum, you pay 0% for covered prescription drugs at network pharmacies for the remainder of the calendar year	

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.

Pharmacy copay structure for Part D network benefits

General information	HealthChoice SilverScript High Option
This plan uses a formulary Some drugs require prior authorization Quantity limits and step therapy apply to certain drugs Only copays for covered drugs purchased at network pharmacies count toward out-of-pocket maximum Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003 You will be notified before any changes are made to your plan's formulary	**Pharmacy Deductible** You pay the first $100 in medication costs before the copays listed below apply No Coverage Gap. There is an annual out-of-pocket maximum **30-Day Supply** Generic Tier 1 Drugs Up to $10 copay Preferred Tier 2 Drugs Up to $45 copay Non-Preferred Tier 3 Drugs Up to $75 copay Specialty Tier 4 Drugs Up to $100 copay Preferred Tobacco Cessation $0 copay Insulin No more than $35 copay **31- to 90-Day Supply** Generic Tier 1 Drugs Up to $25 copay Preferred Tier 2 Drugs Up to a $90 copay Non-Preferred Tier 3 Drugs Up to $150 copay Specialty Tier 4 Drugs 30-day copay applies to additional 30-day supply Preferred Tobacco Cessation $0 copay Once you reach the **$2,100** out-of-pocket maximum, you pay $0 for covered prescription drugs at network pharmacies for the remainder of the calendar year Non-network pharmacy will reimburse at an allowed amount

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.

Pharmacy copay structure for Part D network benefits

General information	HealthChoice SilverScript Low Option
This plan uses a formulary Some drugs require prior authorization Quantity limits and step therapy apply to certain drugs Only the coinsurance amount for covered drugs purchased at network pharmacies counts toward the out-of-pocket maximum Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003 You will be notified before any changes are made to your plan's formulary	**Pharmacy Deductible** You pay the first **$615** in medication costs No Coverage Gap. There is an annual out-of-pocket maximum **Initial Coverage** After the deductible, you and HealthChoice share prescription drug costs You pay 25% and HealthChoice is responsible for 75%* until you reach the **$2,100** annual out-of-pocket maximum (includes the deductible) ***HealthChoice pays 65% and manufacturer pays 10%** **Catastrophic Coverage** Once you reach the **$2,100** out-of-pocket maximum, you pay $0 for covered prescription drugs purchased at network pharmacies for the remainder of the calendar year

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.

COMPARISON OF BENEFITS FOR THE MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS

MAPD PPO plans

All benefits are based on Medicare-covered services

Services	BCBSOK – MAPD	Humana MAPD PPO
Hospitalization Semiprivate room (private room if medically necessary) Nursing services, medications and all meals Laboratory tests, X-rays and other radiology services Inpatient physician and surgical services, including anesthesia Necessary medical supplies and appliances Blood and its administration Operating room, special care units and rehabilitation services	You pay $0 after **$150 deductible**	You pay $0 after $250 deductible and **$250 copay per admission**
Organ Transplants Must be performed in a Medicare-approved transplant facility	You pay $0 after **$150 deductible**	You pay $0 after $250 deductible
Skilled Nursing Facility (Inpatient Services) Semiprivate room, regular nursing services and all meals Physical, occupational and speech therapy Drugs and necessary medical equipment and supplies furnished by the facility Blood and its administration Inpatient radiology and pathology Use of appliances such as wheelchairs	You pay $0 after **$150 deductible**	You pay $0 after $250 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.

Services	BCBSOK – MAPD	Humana MAPD PPO
Outpatient Hospital Services Outpatient surgical services in an ambulatory surgical center or outpatient hospital facility	You pay $0 after **$150 deductible**	You pay $0 after $250 deductible
Urgent Care Services Urgently needed services worldwide	You pay $0 after **$150 deductible**	You pay $0 If you have lab services, you pay $0 after $250 deductible This would not apply to worldwide services
Emergency Services Emergency services needed worldwide	You pay $0 after **$150 deductible**	You pay **$50 copay** Copay applies to emergency services in U.S. This would not apply to worldwide services
Ambulance Services When medically necessary	You pay $0 after **$150 deductible**	You pay $0 after $250 deductible
Professional Services Office visit Consultation, diagnosis and treatment by a specialist Medical and surgical care Allergy tests and treatment (serum) Diagnostic tests and treatment Medical supplies including casts, dressings and splints	You pay $0 after **$150 deductible**	You pay $0 after $250 deductible
Physical, Occupational and Speech Therapy Services	You pay $0 after **$150 deductible**	You pay $0 after $250 deductible
Laboratory Services	You pay $0 after **$150 deductible**	You pay $0 after $250 deductible
X-Ray/Diagnostic Radiology	You pay $0 after **$150 deductible**	You pay $0 after $250 deductible
Hearing Examinations	You pay $0 after **$150 deductible**	You pay $0 for Medicare covered services after $250 deductible
Chiropractic Limited to manual manipulation of the spine as medically necessary	You pay $0 after **$150 deductible**	You pay $0 for Medicare covered services after $250 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.

Services	BCBSOK – MAPD	Humana MAPD PPO
Part-Time or Intermittent Skilled Nursing Care Home health aide in conjunction with skilled care, physical, speech and occupational therapy Medical supplies and equipment (excluding medications) provided by the agency	You pay $0 after **$150 deductible**	You pay $0 after $250 deductible
Durable Medical Equipment Durable medical equipment and supplies Prosthetic devices Therapeutic shoes/inserts for severe diabetes	You pay $0 after **$150 deductible**	You pay $0 for Medicare covered services after $250 deductible
Bariatric Surgery	You pay $0 after **$150 deductible**	You pay $0 after $250 deductible
National Diabetes Prevention Program	You pay $0 after **$150 deductible**	You pay $0
Telehealth/Telemedicine	You pay $0 after **$150 deductible**	In-Network: PCP, Specialist, Behavioral Health & Substance Abuse, Urgently Needed Care You pay $0 Out-of-Network: N/A

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.

Medicare preventive services

The MAPD PPO plans cover many Part B preventive services, such as your annual flu vaccination, wellness visit and screening mammogram, at 100% when you use a doctor or other health care provider who is a Medicare-eligible provider.

For your plan to cover preventive services, you must follow the guidelines for each service. Guidelines can include criteria for age, frequency and disease risk.

For a list of preventive services as governed by Medicare go to **CMS.gov** or **Medicare.gov**. You can also refer to the 2026 Medicare & You handbook.

Pharmacy copay structure for Part D network benefits

General information	BCBSOK – MAPD	
This plan uses a formulary Some drugs require prior authorization Quantity limits and step therapy apply to certain drugs Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003 You will be notified before changes are made to your plan's formulary	Preferred Pharmacy*	Standard Pharmacy
	30-Day Supply	30-Day Supply
	$5 copay Tier 1	$12 copay Tier 1
	$15 copay Tier 2	$22 copay Tier 2
	$40 copay Tier 3	$47 copay Tier 3
	$90 copay Tier 4	$97 copay Tier 4
	Insulin - No more than $35 copay	Insulin - No more than $35 copay
	Specialty Tier 5	Specialty Tier 5
	33% coinsurance to **$2,100** TrOOP	33% coinsurance to **$2,100** TrOOP
	60- or 90-Day Supply	60- or 90-Day Supply
	$10 copay Tier 1 (60 day)	$24 copay Tier 1 (60 day)
	$15 copay Tier 1 (90 day)	$36 copay Tier 1 (90 day)
	$30 copay Tier 2 (60 day)	$44 copay Tier 2 (60 day)
	$45 copay Tier 2 (90 day)	$66 copay Tier 2 (90 day)
	$80 copay Tier 3 (60 day)	$94 copay Tier 3 (60 day)
	$120 copay Tier 3 (90 day)	$141 copay Tier 3 (90 day)
	$180 copay Tier 4 (60 day)	$194 copay Tier 4 (60 day)
	$270 copay Tier 4 (90 day)	$291 copay Tier 4 (90 day)
	Tier 5	Tier 5
	33% coinsurance to **$2,100** TrOOP	33% coinsurance to **$2,100** TrOOP
	Coinsurance applies at both Preferred and Standard pharmacy	Coinsurance applies at both Preferred and Standard pharmacy
	Pharmacy MOOP – **$2,100**	Pharmacy MOOP – **$2,100**
	*Preferred pharmacies include but are not limited to Walgreens, Walmart and other independent pharmacies as indicated in the provider directory	

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.

Pharmacy copay structure for Part D network benefits

General information	Humana MAPD PPO
This plan uses a formulary Some drugs require prior authorization Quantity limits and step therapy apply to certain drugs Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003 You will be notified before changes are made to your plan's formulary	**Pharmacy Deductible** $250 deductible* **30-Day Supply** $5 copay Tier 1 Generic or Preferred Generic $45 copay Tier 2 Preferred Brand $75 copay Tier 3 Non-Preferred Brand $100 copay Tier 4 Specialty $0 copay Buproban, Nicotrol, Chantix and generic statins (deductible does not apply) Insulin – Lesser of 25% coinsurance or $35 copay **90-Day Supply** $10 copay Tier 1 $90 copay Tier 2 $150 copay Tier 3 N/A Tier 4 (30-Day Only) $0 copay Buproban, Nicotrol, Chantix and generic statins (deductible does not apply) Insulin – Lesser of 25% coinsurance or $105 copay **Catastrophic Coverage** Maximum out-of-pocket **$2,100** Once your maximum out-of-pocket is reached, you pay $0 for covered Part D drugs for the remainder of the calendar year. *The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus and travel vaccines.

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.

MAPD HMO plans

All benefits are based on Medicare-covered services

Services	CommunityCare Senior Health Plan	Generations by GlobalHealth
Hospitalization Semiprivate room (private room if medically necessary) Nursing services and medications Laboratory tests, X-rays and other radiology services Inpatient physician and surgical services, including anesthesia Necessary medical supplies and appliances Blood and its administration Operating room, special care units and rehabilitation services	$50 copay each day for days 1-5 $0 copay each day for days 6 and beyond for a Medicare-covered stay in a network hospital Prior authorization required, except in an emergency You are covered for unlimited days each benefit period. A benefit period begins the day you go to a hospital or skilled nursing facility and ends when you have not received hospital or skilled nursing care for 60 days in a row Copays apply for each admission	$50/day – days 1-5 $0 – days 6-90 per admission You are covered for unlimited days each benefit period Prior authorization required, except in an emergency
Organ Transplants Cornea, heart, heart-lung, kidney, liver, lung, bone marrow, intestinal and multivisceral, pancreas, and stem cell Must be performed in a Medicare-approved transplant facility	$50 copay each day for days 1-5 $0 copay each day for days 6 and beyond Prior authorization required	$50/day – days 1-5 $0 – days 6-90 per admission You are covered for unlimited days each benefit period Prior authorization required, except in an emergency
Outpatient Hospital Services Outpatient surgical services in an ambulatory surgical center or outpatient hospital facility	$0 copay for each visit Prior authorization required	$0 copay per surgery in an ambulatory surgery center $200 copay per surgery in an outpatient hospital
Radiation therapy	$0 copay Prior authorization required	$40 copay
Blood	$0 copay	$0 copay

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.

Services	CommunityCare Senior Health Plan	Generations by GlobalHealth
In-Area Urgent Care Services	$10 copay for each visit	$15 copay for each visit
Out-of-Area Urgent Care Services During a temporary absence from service area	$10 copay for each visit worldwide	$15 copay for each visit within the U.S.
Emergency Services	$90 copay for each Medicare-covered visit worldwide Waived if admitted inpatient to hospital within 48 hours for same condition	$75 copay for each visit nationwide; all-inclusive Waived if admitted inpatient to hospital or for outpatient surgery within 24 hours for same condition
Ambulance Services Medically necessary services as covered by Medicare	$50 copay Waived if admitted inpatient to hospital	$50 copay Waived if admitted inpatient to hospital
Skilled Nursing Facility (Inpatient Services) Semiprivate room and regular nursing services Physical, occupational and speech therapy Drugs and necessary medical equipment and supplies furnished by facility Blood and its administration Inpatient radiology and pathology Use of appliances such as wheelchairs	$0 copay for days 1-20 $100 copay for days 21-100 for each benefit period No prior hospital stay required Prior authorization required All services listed at left are inclusively covered under the skilled nursing facility copayment	$0 copay per day for days 1-20 $184 copay for days 21-100 No prior hospital stay required Prior authorization required All services listed at left are inclusively covered under the skilled nursing facility copayment

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.

Services	CommunityCare Senior Health Plan	Generations by GlobalHealth
Professional Services Office visit Consultation, diagnosis and treatment by a specialist Medical and surgical care Allergy tests and treatment (serum) Diagnostic tests and treatment Medical supplies including casts, dressings and splints	$0 copay for each PCP visit $10 copay for each specialist visit	$0 copay for each PCP visit $20 copay for each specialist visit
X-Ray/Diagnostic Radiology Services	$0 copay	$0 copay
Laboratory Services	$0 copay for each diagnostic procedure and test Prior authorization may apply	$0 copay
Physical, Occupational and Speech Therapy Services	$0 copay for each visit Prior authorization required	$20 copay for each visit Prior authorization required
Hearing Examinations	$0 copay for routine hearing tests $0 copay for diagnostic hearing exams You may be reimbursed for hearing aids using your Wallet Benefit. Annual limits apply	$0 copay for each PCP diagnostic evaluation $20 copay for each specialist exam to diagnose and treat hearing and balance issues $500 per year allowance for hearing aids
Chiropractic Limited to manual manipulation of the spine as medically necessary	$10 copay each visit	$20 copay each visit No prior authorization required

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.

Services	CommunityCare Senior Health Plan	Generations by GlobalHealth
Part-Time or Intermittent Skilled Nursing Care Home health aide in conjunction with skilled care Physical, speech and occupational therapy Medical supplies and equipment (excluding medications) provided by the agency	$0 copay for Medicare-covered home health visits Prior authorization required	$0 copay for home health visits Prior authorization required
Durable Medical Equipment Durable medical equipment and supplies	$0 to $50 copay or 20% coinsurance for each item Prior authorization required	20% coinsurance for each item Prior authorization required
Prosthetic devices	$0 copay for each device Prior authorization required	$0 if surgically implanted 20% coinsurance per external device Prior authorization required
Therapeutic shoes/inserts for severe diabetes	$0 copay for each orthotic Prior authorization required	$0 for each orthotic Prior authorization required
Bariatric Surgery	Inpatient: $50 copay each day for days 1-5 and $0 copay each day 6 and beyond Outpatient: $0 copay Prior authorization required	$50/day – days 1-5 $0 – days 6-90 inpatient copay You are covered for unlimited days each benefit period Prior authorization required
National Diabetes Prevention Program	0% coinsurance/$0 copay	0% coinsurance/$0 copay
Telehealth/Telemedicine	$0 copay for each PCP visit $10 copay for each specialist visit	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.

Medicare preventive services

The MAPD HMO plans cover many Part B preventive services, such as your annual flu vaccination, wellness visit and screening mammogram, at 100% when you use a network provider.

For your plan to cover preventive services, you must follow the guidelines for each service. Guidelines can include criteria for age, frequency and disease risk.

For a list of these preventive services as governed by Medicare go to **CMS.gov** or **Medicare.gov**. You can also refer to the 2026 Medicare & You handbook.

Pharmacy copay structure for Part D network benefits

General information	CommunityCare Senior Health Plan
This plan uses a formulary Some drugs require prior authorization Quantity limits and step therapy apply to certain drugs Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003 You will be notified before changes are made to your plan's formulary	30-Day Supply $0 copay Tier 1 preferred generic drugs Up to $10 copay Tier 2 generic drugs Up to $30 copay Tier 3 preferred brand drugs Up to $60 copay Tier 4 non-preferred drugs (including tobacco cessation) 33% coinsurance Tier 5 specialty drugs and certain injectables Insulin – No more than $35 copay Maximum out-of-pocket: **$2,100.** 90-Day Supply $0 copay Tier 1 preferred generic drugs Up to $20 copay Tier 2 generic drugs Up to $60 copay Tier 3 preferred brand drugs Up to $120 copay Tier 4 non-preferred drugs (including tobacco cessation) 33% coinsurance Tier 5 specialty drugs and certain injectables Insulin – No more than $70 copay Mail order is available for up to a 90-day supply Maximum out-of-pocket **$2,100**.

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.

Pharmacy copay structure for Part D network benefits

General information	Generations by GlobalHealth
Mandatory generic and brand formulary medications you get at a network pharmacy Some drugs require prior authorization Quantity limits and step therapy apply to certain drugs Pharmacy benefits must meet the minimum requirements for benefits as outlined in the Medicare Modernization Act of 2003 You will be notified before changes are made to your plan's formulary	30-Day Supply $0 copay Tier 1 $15 copay Tier 2 $42 copay Tier 3 $95 copay Tier 4 33% coinsurance Tier 5 Insulin – No more than $35 copay 30- to 90-Day Supply $0 copay Tier 1 $0 copay Tier 2 $84 copay Tier 3 $190 copay Tier 4 Not covered Tier 5 Insulin – No more than $84 copay (Tier 3) or $105 copay (Tier 4) Mail Order 30-Day Supply $0 copay Tier 1 $15 copay Tier 2 $42 copay Tier 3 $95 copay Tier 4 33% coinsurance Tier 5 Insulin – No more than $35 copay 30- to 90-Day Supply $0 copay Tier 1 $0 copay Tier 2 $84 copay Tier 3 $190 copay Tier 4 Not covered Tier 5 Insulin – No more than $84 copay (Tier 3) or $105 copay (Tier 4)
	Maximum out-of-pocket **$2,100**

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.

BCBSOK – MAPD

You can receive services anywhere within the United States as long as the provider is a Medicare-eligible provider, accepts Medicare assignment and is willing to accept BCBSOK's Blue Cross Group Medicare Advantage (PPO)SM | MAPD Plan.

CommunityCare Senior Health Plan

Adair	Canadian	Cherokee	Cleveland	Comanche	Craig
Creek	Delaware	Garvin	Grady	Haskell	Hughes
Kingfisher	Latimer	LeFlore	Lincoln	Logan	Mayes
McClain	McIntosh	Muskogee	Nowata	Okfuskee	Oklahoma
Okmulgee	Osage	Ottawa	Pawnee	Pittsburg	Pottawatomie
Pushmataha	Rogers	Seminole	Sequoyah	Stephens	Tulsa
Wagoner	Washington				

Generations by GlobalHealth

73001	73002	73003	73004	73005	73006	73007	73008
73009	73010	73011	73012	73013	73014	73015	73016
73017	73018	73019	73020	73022	73023	73025	73026
73028	73029	73031	73033	73034	73036	73038	73042
73044	73045	73047	73048	73049	73050	73051	73052
73053	73054	73056	73057	73058	73059	73063	73064
73065	73066	73067	73068	73069	73070	73071	73072
73073	73074	73075	73078	73079	73080	73082	73083
73084	73085	73089	73090	73092	73093	73095	73097
73098	73099	73101	73102	73103	73104	73105	73106
73107	73108	73109	73110	73111	73112	73113	73114
73115	73116	73117	73118	73119	73120	73121	73122
73123	73124	73125	73126	73127	73128	73129	73130
73131	73132	73134	73135	73136	73137	73139	73140
73141	73142	73143	73144	73145	73146	73147	73148
73149	73150	73151	73152	73153	73154	73155	73156
73157	73159	73160	73162	73163	73164	73165	73167
73169	73170	73172	73173	73178	73179	73184	73189
73190	73194	73195	73196	73401	73402	73403	73433
73434	73435	73436	73437	73438	73443	73444	73458
73463	73481	73487	73488	73701	73702	73703	73705

73706	73720	73727	73730	73733	73735	73736	73738
73743	73753	73754	73773	74008	74010	74011	74012
74013	74014	74015	74016	74017	74018	74019	74020
74021	74026	74028	74030	74031	74033	74034	74036
74037	74038	74039	74041	74043	74044	74046	74047
74050	74052	74053	74055	74058	74063	74066	74067
74068	74071	74073	74079	74080	74081	74101	74102
74103	74104	74105	74106	74107	74108	74110	74112
74114	74115	74116	74117	74119	74120	74121	74126
74127	74128	74129	74130	74131	74132	74133	74134
74135	74136	74137	74141	74145	74146	74147	74148
74149	74150	74152	74153	74155	74156	74157	74158
74159	74169	74170	74171	74172	74182	74186	74187
74192	74193	74330	74337	74340	74350	74352	74361
74362	74365	74366	74367	74401	74402	74403	74421
74422	74423	74425	74426	74428	74429	74430	74431
74432	74434	74436	74437	74438	74439	74442	74445
74446	74447	74450	74454	74455	74456	74458	74459
74460	74461	74463	74467	74468	74469	74470	74477
74501	74502	74522	74528	74529	74531	74546	74547
74553	74554	74560	74561	74565	74570	74640	74650
74801	74802	74804	74818	74820	74821	74824	74825
74826	74827	74829	74830	74831	74832	74833	74834
74837	74839	74840	74842	74843	74844	74845	74848
74849	74850	74851	74852	74854	74855	74857	74859
74860	74864	74865	74866	74867	74868	74869	74871
74872	74873	74875	74878	74880	74881	74883	74884

Humana MAPD PPO

You are eligible for Humana MAPD PPO if you live in the United States.

You can receive services anywhere within the United States as long as the provider is a Medicare-eligible provider and is willing to see you and bill Humana.

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 High (K1I09)	Cigna Prepaid Low (OKIV9)
Annual Deductible	No deductible $0 office copay applies	No deductible $5 office copay applies
Diagnostic and Preventive Care (cleanings, routine oral exams)	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) Example services/copays: Sealant per tooth: $12 copay Routine cleaning (two per calendar year): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) 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
Basic Care (extractions, oral surgery)	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) Example service/copay: Amalgam – one surface, permanent teeth: $0 copay	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) Example service/copay: Amalgam – one surface, permanent teeth: $23 copay

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	HealthChoice Dental
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	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)	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	Network: You pay $0 Non-network: You pay $0 after deductible plus charges above the allowable amounts
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	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	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

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	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 High (K1I09)	Cigna Prepaid Low (OKIV9)
Major Care (dentures, bridge work)	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) Example Services/Copays: Root Canal, Anterior: $210 copay Periodontal Scaling/Root planning One to three teeth (per quadrant): $42 copay	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) Example Services/Copays: Root Canal, Anterior: $375 copay Periodontal Scaling/Root planning One to three teeth (per quadrant): $75 copay
Orthodontic Care	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) $2,040 out-of-pocket child $2,376 out-of-pocket adult (24-month treatment) Excludes orthodontic treatment plan and banding No waiting period for orthodontic benefits	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) $2,472 out-of-pocket child $3,384 out-of-pocket adult (24-month treatment) Excludes orthodontic treatment plan and banding No waiting period for orthodontic benefits
Plan Year Maximum	Plan year maximum is unlimited No plan year dollar maximum	Plan year maximum is unlimited No plan year dollar maximum
Filing Claims	There is no applicable copayment schedule for the Cigna Dental Prepaid K1I09 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	There is no applicable copayment schedule for the Cigna Dental Prepaid OKIV9 plan. The plan is based on a fee schedule. If you receive care from a Network Specialty Dentist, you are responsible to pay for that care. You are entitled to pay at the Contract Fees negotiated by Cigna Dental rather than the Network Specialty Dentists' usual fees. No claim filing is necessary; the network provider will bill you based on the agreed-upon fee schedule

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	HealthChoice Dental
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.	Network: You pay 40% after deductible Non-network: You pay 50% after deductible plus charges above the allowable amounts.
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.	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	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.	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	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.	Network: No claims to file. Non-network: You file claims. (Timely filing limitations apply.)

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: Members can earn up to $1,250 in additional benefits for future years by receiving preventive dental care. The amount paid for preventive services each year (up to $1,250) rolls over and adds to the annual maximum. These additional dollars may be used for any covered services (excluding orthodontia)**
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.

	Vision Care Direct		VSP	
Covered Services	Network	Non-Network	Network	Non-Network
Eye Exams	$15 copay Includes: Comprehensive exam, including dilation if necessary Retinal Fundus Image, no more than a $39 fee	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 PLUS PLAN 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.

	Vision Care Direct		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 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: **ok.vision/lasik-discount-network**	No benefit	Average discount of 15% off regular price or 5% off promotional price	No benefit

This is only a sample of the services covered by each plan. For services not listed in this comparison chart, contact each plan. Refer to the Contact Information at the 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/benefits**. Materials copay applies to lenses and/or frames. Discounts for lens add-ons will be given by contracted providers with DP in their listing. Exams, lenses and frames are provided once per calendar year. Progressive lenses (no-line bifocals) – you pay the difference between the retail price of the selected progressive lens and the retail price of the lined trifocal. The difference may also be subject to a discount with provider offices that accept our discount plans. Standard contact lens fitting applies to an existing contact lens user who wears disposable, daily wear or extended wear lenses only. The specialty contact lens fitting applies to new contact lens wearers and/or members who wear toric, gas permeable or multifocal lenses.

Vision Care Direct of Oklahoma: Oklahoma-owned and -operated by optometrists. With VCD of OK, you get your exam, frames and lenses with free enhancements (progressive lenses with premium anti-reflective and UV coatings) for as little as $30. Our Frames/Contact Lenses Allowance is $150, and our Medically Necessary Contact Lenses Allowance is $750. With our plan, you can use your Contact Lenses Allowance to pay for your Fitting Fee and/or to purchase contacts. This allows you to use your allowance to pay for your fitting and potentially a portion of your contacts, whichever makes the best financial sense for you. Other plans offer discounts for materials, such as UV, Scratch, UV Coatings and Progressive lenses, but VCD of OK takes a different approach and includes these extras at NO ADDITIONAL COST! When you compare the total cost of your premiums and what you spend in the doctor's office, in most cases, we offer a plan that will save you money. Choosing an OK company means your customer service is in state to help you. It also means that you support your local community and schools when you buy a plan based in Oklahoma! VCD of OK is not an insurance company, so our focus is on delivering the very best patient care with quality materials at a very affordable price because we want you to SEE THE DIFFERENCE. Visit **okstate.vision** for more information and to search for providers in your area. (To get the free upgrades mentioned above, look for the VCD Plus logo when searching for a provider.)

VSP: Exam, lenses and frame benefit provided annually. The $25 materials copay applies to lenses or frames but not to both. Copays/prices listed are for standard lens options. Premium lens options will vary. If choosing a frame valued at more than the allowance, 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.

MEDICARE SUPPLEMENT PLANS

BCBSOK Member Services
833-418-0443
TTY 711
bcbsok.com/retiree-medicare-state

HealthChoice

Medical
800-323-4314
TTY 711
HealthChoiceOK.com

Pharmacy
866-275-5253
TTY 711
Caremark.com

MAPD PLANS

BCBSOK Member Services
833-418-0443
TTY 711
bcbsok.com/retiree-medicare-state

CommunityCare Senior Health Plan
918-594-5323 or 800-642-8065
TDD/TTY 800-722-0353
stateshp.ccok.com

Generations by GlobalHealth

Prospective members
855-620-5388
TTY 711
GlobalHealth.com/oklahoma/osr

Current members
405-280-5555 or 844-280-5555
TTY 711
GlobalHealth.com/oklahoma/osr

Humana Group Medicare Customer Care
Identify yourself as a retiree with the State of Oklahoma/EGID when calling as a prospective member.
866-396-8810
TTY 711
7 a.m. to 8 p.m. CT
your.humana.com/ok-medicare

ELIGIBILITY AND ENROLLMENT PROGRAM ADMINISTRATOR

Employees Group Insurance Division
P.O. Box 11137
Oklahoma City, OK 73136-9998
405-717-8780 or toll-free 800-752-9475
TTY 711
Oklahoma.gov/egid

DENTAL PLANS

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

Cigna Prepaid Dental
800-244-6224
Hearing Impaired Relay 800-654-5988
view.ceros.com/cigna/ok-ins-benefits

Delta Dental
405-607-2100 or 800-522-0188
deltadentalok.org/clients/ok

HealthChoice
800-323-4314
TTY 711
HealthChoiceOK.com

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

Sun Life
800-442-7742
sunlifeconnect.co/StateofOKPY2026

VISION PLANS

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

Superior Vision
844-549-2603 or TDD 916-852-2382
superiorvision.com/stateofoklahoma/benefits

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

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

OKLAHOMA
Employees Group
Insurance Division