

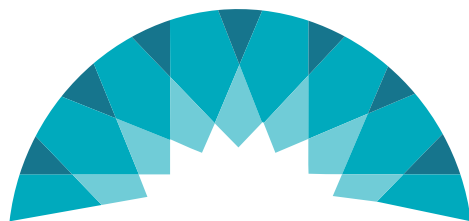


HEALTH BENEFITS PLAN

State of Oklahoma

Education, & Government Employees
January 1 - December 31, 2027

1-877-280-5600 (TTY: 711) | 9:00 AM - 5:00 PM, Monday-Friday



GlobalHealth

BENEFITS AT A GLANCE

The following is intended to be only a summary of benefits offered by GlobalHealth, plan MLGMH27-ST for State, Education, and Local Government Employees. For more information, visit www.GlobalHealth.com.

Benefit	Copay
Annual Deductible	This plan does not have a deductible.
Annual Out-of-Pocket Maximum (MOOP)	Member: \$4,000 Family: \$12,000
Primary Care Visits	\$25 copay per visit
Specialist Visits	\$50 copay per visit
Preventive Care Well Child Visits	\$0 copay per visit
X-Rays & Labs	\$0 copay per visit
Specialized Scans, Imaging, & Diagnostic Exams	\$250 copay per scan in a preferred facility \$750 copay per scan in a non-preferred facility
Inpatient Hospital Stay	\$400 copay per day \$2,000 maximum per admission
Outpatient Surgery	\$300 copay in a preferred facility \$800 copay in a non-preferred facility
Emergency Room Service	\$400 copay, waived if admitted to hospital inpatient
Urgent Care	\$25 copay per visit
Prescription Drugs (insulin copays are no more than \$30/month or \$90 for an extended supply. Oral chemotherapy is no more than \$100/month.)	30-Day Supply: Tier 1: \$20/Tier 2: \$65/Tier 3: \$90/Tier 4: \$200/\$400 90-Day Supply: Tier 1: \$40/Tier 2: \$130/Tier 3: \$180
Maternity Care	\$0 copay for prenatal care and postnatal care \$500 copay per admission for delivery
Family Planning	No copay
Allergy Care	\$0 copay per PCP visit \$50 copay per specialist visit \$30 copay/6-week supply of antigen and administration
Physical, Occupational, Speech Therapy (limited to 60 combined visits per course of therapy)	No copay for inpatient Outpatient: \$35 copay per visit Rehabilitation Outpatient Facility: \$70 copayment/day
Chiropractic Care (15 visits per year)	\$25 copay per visit
Mental Health Services, Chemical Dependency & Substance Abuse	\$0 copay per outpatient office visit \$400 copay per day / \$2,000 maximum per inpatient admission

For a complete list of plan benefits and administration visit www.GlobalHealth.com.

IMPORTANT INFORMATION

Find a Primary Care Physician fast

When you enroll, you choose a PCP from the GlobalHealth provider network. Each member of the family may choose a different PCP, including a pediatrician for children. You may change your PCP selection at any time throughout the year. Your PCP change will be effective the first day of the following month. If you need to see a PCP before you receive your new member ID cards, contact Customer Care.

To find a primary care physician near you, visit www.GlobalHealth.com and click “Find care providers.”

Always start with your PCP

\$25 copay for unlimited primary care physician visits.

Your PCP will coordinate and manage your medical care including preventive care and referral requests if specialty care is needed. Do not make your appointment with the specialist until you receive the authorization letter from GlobalHealth. The specialist may request preauthorization for procedures and follow up care after the initial visit. For urgent care needs, call your PCP if during normal office hours. A referral is not required for specific self-referral services.

Hospital visits require referrals

A preauthorization from GlobalHealth is required for scheduled stays. You may only go to a hospital in the network, except in an emergency. You do not have to obtain preauthorization for stays in connection with childbirth. If you obtain other services without an authorization, you will be responsible for the costs.

Emergency Care

Let your PCP and GlobalHealth know within 24 hours of being seen. We may arrange to transfer you to an in-network hospital if you are admitted to an out-of-network hospital from ER. You may go to any in-network emergency room and pay your regular copay.

Prescription Drug Benefits

Get details on covered drugs and pharmaceutical management procedures at www.GlobalHealth.com. We offer a four-tier system for generic medications, preferred brandname medications, non-preferred medications, and specialty medications. You may choose to obtain your prescriptions through retail or mail order with the same copays.

Member Materials

Make the most of your benefits by going to www.GlobalHealth.com to download information including:

- Member Handbook (including Member Rights and Responsibilities & Notice of Privacy Practices)
- Drug Formulary
- Physician and Health Providers Directory
- Pharmacy Directory
- Summary of Benefits and Coverage

Printed copies are available upon request by calling Customer Care.

Membership Premium Details

2027	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Monthly Rate	\$1,257.14	\$3,112.78	\$3,830.68	\$4,285.14	\$1,975.04	\$2,429.50

SELF REFERRALS

You do not need preauthorization from GlobalHealth in order to obtain in-network care for the following services:



Obstetrical/Gynecological Services and Well-Woman Exams

from a healthcare professional who specializes in obstetrics or gynecology.



Chiropractic Care Visits for in-network care within the chiropractor's scope of license.



Physical Therapy for an evaluation only from a healthcare professional who specializes in physical therapy. You will need preauthorization for any additional treatment.



Routine Mammogram from an imaging center.



Behavioral & Mental Health/Chemical Dependency Services

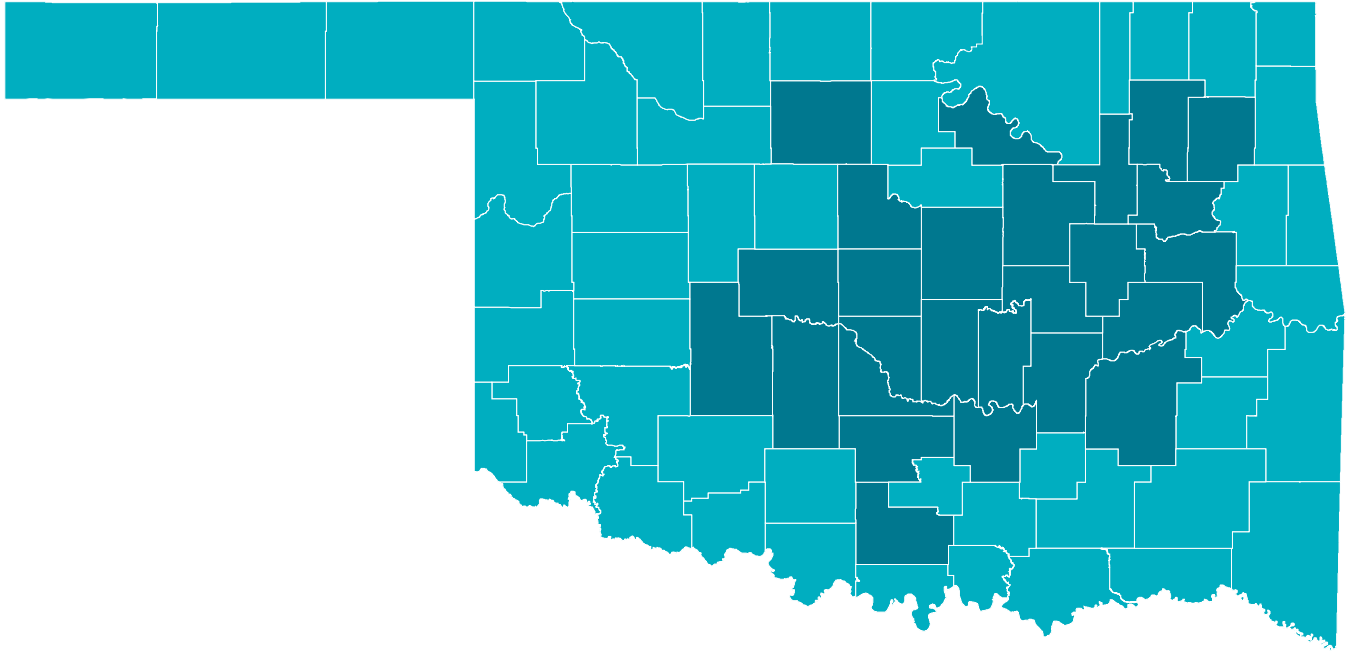
including medication management, therapy, and/or psychiatric testing from a healthcare professional who specializes in behavioral health.



After-Hours Urgent Care Visits that are in-network.

SERVICE AREA

Our plans are offered in 26 Oklahoma counties. You must live or work in the GlobalHealth service area to be eligible.



Caddo
Canadian
Carter
Cleveland
Creek
Garfield
Garvin

Grady
Hughes
Lincoln
Logan
Mayes
McClain
McIntosh

Muskogee
Okfuskee
Oklahoma
Okmulgee
Pawnee
Pittsburg
Pontotoc

Pottawatomie
Rogers
Seminole
Tulsa
Wagoner



GlobalHealth

Excluded Services and Limitations

Limitations

Bariatric Surgery

- Bariatric surgery is limited to lap-band surgery.

Behavioral Health Services

- Applied behavioral analysis limited to the following diagnoses:
 - Autistic disorder – childhood autism, infantile psychosis, and Kanner's syndrome;
 - Childhood disintegrative disorder – Heller's syndrome;
 - Rett's syndrome; and
 - Specified pervasive developmental disorders – Asperger's disorder, atypical childhood psychosis, and borderline psychosis of childhood.
- Autism Screening and Developmental Screening limited to well-child visits.
- Psychosocial education limited to daily living and social skills education.

Cardiac Rehabilitation Services

- Limited to 36 visits per event.

Chiropractic Care

- Limited to 15 visits per year.

Cosmetic Services

- Treatment, item, supply, drug, procedure, or any portion of a procedure performed primarily to improve physical appearance limited to:
 - Breast reconstruction after a mastectomy;
 - Improve function of a malformed part of the body; and
 - Repair due to an accidental injury.

Dental Service

- Dentistry or dental processes to the teeth and surrounding tissue limited to
 - ER services to treat accidental injury to the jaw, sound natural teeth, mouth, or face
 - Surgery to improve function of the jaw, mouth, or face resulting from a birth defect. Does not include dental work.
- General anesthesia/IV sedation for dental services limited to a Member who:
 - Has a medical or emotional condition that requires Hospitalization or general anesthesia for dental care;
 - Is severely disabled;
 - In the judgment of the treating Practitioner, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia; and
 - Requires Inpatient or Outpatient services because of an underlying medical condition and clinical status or because of the severity of the dental procedure.

DME, orthotic devices, and prosthetic appliances

- Breast pumps limited to:
 - One per year for women who are pregnant or nursing,
 - Purchase or rental of breast pump and related supplies.
- Corrective lenses and fittings limited to pair of basic non-designer frames and single vision lenses or contact lenses following cataract surgery.
- Footwear limited to:
 - Shoes, shoe inserts, arch supports, and supportive devices for Members diagnosed with diabetes or a blood circulation disease.
 - Orthopedic or corrective shoes permanently attached to a Denis Browne splint for children.
- DME rentals:
 - Knee walker or kneeling crutch rentals limited to 4 months.
 - Oxygen and oxygen equipment rentals limited to 36 months and remaining Medically Necessary.
 - Other DME rentals limited to 13 months.
- Hearing aids limited to:
 - One basic hearing aid per ear every 48 months unless Medically Necessary to replace more often.
 - Four additional ear molds per year (two molds for each ear) for children less than two years of age.
- Orthotic devices limited to:
 - Braces for the leg, arm, neck, back, or shoulder;
 - Back and special surgical corsets;
 - Splints for the extremities; and
 - Hernia trusses.
- Replacements, repairs, and adjustments for orthotics and prosthetics limited to:
 - Normal wear and tear; and
 - Due to a significant change in your physical condition.
- Wigs and scalp prostheses limited to one synthetic wig or scalp prosthesis per year when required due to loss of hair resulting from chemotherapy or radiation therapy.

Foot Care

- Routine care limited to Members with diabetes or a blood circulation disease.

General Care or Hospital Services

- Hospital private room limited to isolation to prevent contagion per the
- Hospital's infection control policy.

General Limitations

- Sexual dysfunction services limited to drugs and supplies for post-prostate surgery indications.

Genetic analysis, services, or testing

- Limited to counseling and testing for women whose personal or family history or ancestry is associated with a high risk for deleterious mutations in BRCA 1 and BRCA 2 genes.
- Limited to testing for members with a cancer diagnosis for treatment plan purposes.
- Limited to biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition when the test is supported by medical and scientific evidence.

Hearing Services

- Cochlear® surgery and basic devices limited to Members at least 18 months of age or for pre-lingual Members with minimal speech perception using hearing aids.

Home Healthcare

- Limited to 100 visits per year.

Obstetrical Care

- Costs resulting from normal, full-term delivery out of our network, limited to emergencies.
- Cryopreservation or storage of sperm (sperm banking), eggs, or embryos limited to individual diagnosed with cancer who are within reproductive age when a Medically Necessary treatment may directly or indirectly cause iatrogenic infertility.

Physical, occupational, and speech therapy

- Rehabilitation Services limited to 60 Outpatient visits, combination of therapies. Outpatient visits include office visits and/or rehabilitation Outpatient Facility visits.
- Habilitation Services limited to:
 - ASD treatment – Physical, occupational, and/or speech therapy services for the following diagnoses:
 - Autistic disorder – childhood autism, infantile psychosis, and Kanner's syndrome;
 - Childhood disintegrative disorder – Heller's syndrome;
 - Rett's syndrome; and

All services described below are excluded or limited under this Plan for all types of services. We cover some benefits only as follows. You pay for additional services

- Specified pervasive developmental disorders – Asperger's disorder, atypical childhood psychosis, and borderline psychosis of childhood.
- Cleft lip and cleft palate treatment – Otologic, audiologic, and speech therapy.

Prescription Drugs

- Drugs prescribed or given to you by Out-of-network doctors in nonemergencies limited to those prescribed by dentists.
- Contraceptive drugs limited to:
 - A three-month supply the first time you obtain the drug.
 - A six-month supply at each subsequent time you obtain the same drug, regardless of whether you were enrolled in this plan at the first time the drug was obtained.
 - One six-month supply of a covered prescription drug during each six-month period.
- Epinephrine autoinjectors limited to four per year.
- Glucometers limited to two per year.
- Inhaler extender devices and peak flow meters limited to three per year.
- Medication prescribed for parenteral use or administration, allergy sera, immunizing agents, and immunizing injectable drugs limited to immunizations covered under Preventive Care guidelines and given to you at a Network pharmacy.
- Non-prescription contraceptive jellies, ointments, foams, or devices limited to those that are FDA-approved and prescribed by a Network doctor for a woman.
- Prescription Drugs for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasm, hyporgasm, or decreased libido limited to post-prostate surgery indications.
- Prescription diaphragms limited to two per year.
- The Pharmacy and Therapeutics Committee's standard quantity limits, prior authorization criteria, and step therapies apply.
- Smoking cessation products limited to:
 - Two full 90-day courses of FDA-approved tobacco cessation products per year; if prescribed by your PCP.
 - Members who are at least 18 years old.
- Specialty Drugs limited to a one-month supply.

Preventive Care

- DEXA scans for bone density screening limited to one every 24 months.
- Limited to USPSTF, HRSA, and CDC guidelines.
- Routine exam for adults limited to one per year.
- Routine exam for children and well-child care limited to the American Academy of Pediatrics (AAP) schedule.
- Tobacco cessation limited to two attempts per year.

Pulmonary rehabilitation services

- Limited to 36 visits per event

Skilled Nursing Facility care

- Limited to 100 days per year.

Temporomandibular joint dysfunction

- Non-surgical treatment limited to a lifetime maximum of \$1,500.

Vision

- Diabetic eye exam limited to one per year.
- Glaucoma test limited to one per year.
- Routine services limited to one check-up, including eye refraction, per year.
- Treatment for orthoptics or visual training limited to a diagnosis of mild strabismus.

Excluded Services

We do not cover the following benefits. We may pay for care while deciding whether or not the care falls within the Excluded Services listed below. If it is later determined that the care is excluded from your coverage, we will recover the amount we have allowed for benefits. You must give us all documents needed to enforce our rights.

Behavioral Health Services

- Education, tutoring, and services offered through a school/academic institution for the purpose of diagnosing or treating a learning disability, disruptive, impulse-control, or conduct disorder.
- Wilderness therapy.

Dental Services

- Correction of occlusive jaw defects, dental implants, or grafting of alveolar ridges.
- General or preventive dentistry.
- Non-emergency procedures that involve the teeth or their supporting structures.
- Replacement, re-implantation, and follow-up care of teeth, even if the teeth are not saved by emergency stabilization.
- Treatment of soft tissue to prepare for dental procedures or dentures.

DME, orthotic devices, and prosthetic appliances

- Accessories.
- Additional warranties.
- Bandages, pads, or diapers.
- Bionic and myoelectric prosthetics.
- Changes to your home or vehicle.
- Clothing and devices available OTC.
- Continuous passive motion devices.
- Equipment that serves as comfort or convenience.
 - For example, portable oxygen concentrators.
- Equipment or devices not medical in nature such as:
 - Braces worn for athletic or recreational use
 - Ear plugs
 - Elastic stockings and supports
 - Garter belts
- Jacuzzi/whirlpools.
- Mattresses and other bedding or bed-wetting alarms.
- Multiple DME items for the same or like purposes.
- Power-operated vehicles that may be used as wheelchairs.
- Purchase or rental of equipment or supplies for common household use such as:
 - Air-cleaning machines or filtration devices
 - Air conditioners
 - Beds and chairs
 - Cervical or lumbar pillows
 - Grab bars
 - Physical fitness equipment
 - Raised toilet seats
 - Shower benches
 - Traction tables
 - Water purifiers
- Upgrade features to enhance basic equipment.

General Excluded Services

- Care or services provided outside the GlobalHealth Service Area if the need for such care or services could have been foreseen before leaving the Service Area.
- Charges for injuries resulting from war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.
- Custodial care, respite care, homemaker services, or domiciliary care.

- Drugs, therapies, and technologies:
 - Before the long-term effect is known or proven; or
 - That are not more effective than standard treatment.
- Drugs, eyewear, devices, appliances, equipment, dental work, or other items that are lost, missing, sold, or stolen.
- Drugs or other items that have been damaged or rendered unusable due to improper handling or abuse.
- Elective enhancement procedures, services, supplies, or medications, including but not limited to:
 - Anti-aging
 - Athletic performance
 - Cosmetic purposes
 - Hair growth
 - Sexual performance
- Lodging and meals.
- New procedures, services, supplies, and drugs that have not been reviewed and approved by GlobalHealth.
- Personal or comfort items.
- Private duty nursing.
- Screening services requested solely by you, such as commercially advertised heart or lung scans.
- Separate charges for missed or canceled appointments, penalty or finance charges, maintenance and/or record-keeping, record copying, or Case Management services.
- Services for travel, insurance, licensing, employment, school, camp, sports, premarital, or pre-adoption purposes.
- Services, other than Hospital Services for behavioral health, for which you do not allow the release of information to GlobalHealth.
- Services received while outside of the U.S. (50 states and territories).
- Services received without an authorization when one is required.
- Complications arising from those services.
- Services resulting in whole or in part from an excluded condition, item, or service.
- Services that are provided as a result of Workers' Compensation laws or similar laws.
- Treatment of any kind which is excessive or not Medically Necessary.
- Treatment of any kind received before your start date of coverage or after the time coverage ends, even if authorized.
- Treatment, supplies, drugs, and devices for which no charge was made.
- Treatment, supplies, drugs, and devices for which no payment would be requested if you did not have this coverage.
- Treatment for injury resulting from extreme activities including, but not limited to:
 - Base jumping
 - Bungee jumping
 - Bull riding
 - Car racing
 - Skydiving
 - Motorcycle/BMX racing and/or stunts
- Treatment for disabilities connected to military service for which you are legally entitled and to which you have reasonable accessibility (that is, services through a federal governmental agency).
- Treatment for which the cost is recoverable under any other coverage, including Workers' Compensation, Occupational Disease law, school/academic institution, or any state or government agency.

Genetic Analysis, Services, or Testing

- Genetic counseling and testing for family planning or disease identification purposes.

Immunizations

- Unless also a Preventive Service, shots you must have for:
 - Employment;
 - The military;
 - Travel; or
 - A vocational school or institute of higher education.

Obstetrical and Infertility Services

- Alternative programs for delivery such as home delivery and use of midwives.
- Cost of donor sperm or donor egg.
- Elective abortions.
- Expenses related to surrogate parenthood.
- Genetic counseling and genetic Screening.
- Home uterine monitoring.
- Hysterectomies for the purpose of contraception.
- Insemination procedures and all services related to insemination.
 - Gamete Intrafallopian Transfer (GIFT)
 - In Vitro Fertilization (IVF)
 - Intracervical Insemination (ICI)
 - Zygote Intrafallopian Transfer (ZIFT)
- Reversal of a sterilization procedures.
- Services associated with these procedures.

Physical, Occupational, and Speech Therapy

- Acupuncture/acupressure.
- Kinesiology or movement therapy.
- Massage therapy.
- Recreational therapy including, but not limited to:
 - Animal-facilitated therapy
 - Music therapy
 - Rolf technique.

Prescription Drugs

- Drugs prescribed for a non-FDA approved indication, dosage, or length of therapy.
- Products available without a prescription (OTC). Including but not limited to:
 - Dietary supplements
 - Foods
 - Formulas
 - Medications for irrigation
 - Non-preventive care drugs
 - Saline
- Compounded drugs

Transplants

- Artificial or non-human organ transplants.

Transportation

- Commercial or public transportation.
- Gurney van services.
- Wheelchair van services.

Vision

- Computer programs of any type, including but not limited to, those to assist with vision therapy.
- Insurance for contact lenses.
- LASIK, INTACS, radial keratotomy, and other refractive surgery.
- Lens upgrades.
- Non-prescription lenses.
- Special multifocal ocular implant lenses.

Weight Loss

- Commercial weight loss programs or OTC weight loss products.
- Bariatric surgery when related to weight loss alone.