



**Employee
Benefits Department**
Human Capital Management
Office of Management and Enterprise Services

2013 BENEFITS ENROLLMENT GUIDE

TABLE OF CONTENTS

OKHealth	1
New Opt-Out Details	2
Benefit Allowance	2
Monthly Plan Rates	3
Bi-Weekly Plan Rates	4
Health Care Reform Update	5
Dependent Eligibility	5
Benefits Enrollment Calculator	5
Online Enrollment	6
Eligibility Reminder	6
Flexible Spending Accounts	6
Health Care Account	7
Dependent Care Account	7
Life, Supplemental life, & Dependent life	10
Health Plans	12
Dental Plans	26
Vision Plans	28
Disability	30
Employee Assistance Program	30
SoonerSave	30
Benefits Details	32
Glossary	35



OKHealth

The OKHealth Program is part of the Benefits available to all state employees. It provides FREE one-on-one health coaching to strengthen our health and improve our great state. Personal health coaching empowers individuals to take healthy ACTIONS in physical fitness, nutrition, staying relaxed and being tobacco-free. All state employees may participate in health coaching appointments via the telephone, during regular business hours. There is also a program for those who would like to work on their own. This gives guidance and ideas on how to develop and maintain their own goals.

It's customized! In fact, as an active state employee or elected official, you already have your own

wellness page that can be tailored to fit your individual needs! For a free, no-obligation preview of what's available, go to **OKHealth.ok.gov**



The website resources include: Up-to-date health and wellness news, exercise database, stretching database, healthy recipe box, and wellness event calendar. YOU are the one who will decide what topics fit your lifestyle and goals. If you want, you can chart your progress with a food-intake tracker and exercise tracker using Runkeeper & Fitbit interfaces. You'll also find articles related to your wellness interests.

All of our wellness services will continue to be FREE to active state employees. All active state employees are encouraged to participate. To sign up go to the OKHealth website and select the *Total Wellness Program tab*. Then select the *Enroll* button. For more information about the exciting, new OKHealth program, (Website: **OKHealth.ok.gov**, Email: wellnessgroup@omes.ok.gov, 405-522-1190 ext. 3)

New Login Box

Your entry point for Online Enrollment in the Benefits Administration System (BAS) now looks a little different (see image at right). It is located in the upper right corner of the EBC home page, www.ebc.ok.gov. Notice the *Go To* line, followed by a drop-down menu.

This is where you will choose the Benefits Administration System, which is where you'll find Online Enrollment. Your User ID is your six-digit Employee ID. If you don't know your password, either select *Forgot Your Password* or simply select *LOGIN* and you will be directed to a screen where you can update your password.

New Opt-out details

With the approval of House Bill 2088 in May 2012, (which revised HB 1062) state employees and elected officials were given the right to opt-out of state benefits. Specifically,

*“Any active employee eligible to participate or who is a participant may opt-out of the state’s basic plan as outlined in Sections 1370 and 1371 of Title 74 of the Oklahoma Statutes, provided that the **participant is currently covered by a separate group health insurance plan or will be covered by January 1, 2013.** Any active employee eligible to participate or who is a participant opting-out of coverage pursuant to this section shall provide proof of the separate health insurance plan participation and sign an affidavit attesting that the participant is currently covered and does not require state-provided health insurance each plan year. Any active employee opting-out of coverage pursuant to this section shall receive One Hundred Fifty Dollars (\$150.00) in lieu of the flexible benefit amount the employee would be otherwise eligible to receive.”*

As the new law spells out, you may opt-out ONLY if you are currently covered by a separate group health insurance plan or will be covered by January 1, 2013. In addition, you must provide proof of the separate health insurance plan participation and sign an affidavit before the opt-out will be approved. You will need to fill out a new form which is available through your Benefits Coordinator (NOTE: Opt-outs cannot be done online).

The “basic plan” described in the new law consists of the following: health, dental, basic life and disability insurance. If you opt-out, you are no longer eligible for any of those coverage’s through the State. Because Basic Life insurance is a prerequisite for the optional Supplemental Life and Dependent Life, those are eliminated, as well. However, state employees who opt-out can still take advantage of vision insurance offered by the State, as well as Flexible Spending Accounts (FSAs). Employees

must opt-out each year because the election does not roll over.

If you are considering opting-out, please understand you are forfeiting the normal benefit allowance provided by your agency. In lieu of that benefit allowance, you will get 150 dollars per month from your agency. That \$150 can be used to pay for vision coverage, FSA contributions, and/or added to your net pay as taxable income.

Retired Military

State employees who have retired from military service and have federal TRICARE insurance benefits can



also opt out of the state’s basic plan. Those individuals will get no coverage for health, dental, life, disability, supplemental life or dependent life insurance. In lieu of the normal benefit allowance, TRICARE opt-outs will receive \$150 per month from their agencies. They can still elect vision coverage as well as flexible spending account participation. A copy of the participant’s DD 2 retired card (front and back) will be requested as proof of TRICARE coverage. Employees must opt out each year because the election does not roll over.

Benefit Allowance

Your Benefit Allowance Helps Cover Your Costs

The State provides a Benefit Allowance to help you pay for insurance premiums that would otherwise come out of your own pocket. In previous years the Benefit Allowance would increase or decrease as premiums increased or decreased. In the past legislative session, the Benefit Allowance was frozen at the Plan Year 2012 rate. The following amounts are provided based upon the Health election you choose:

For an employee electing the following coverage in their health plan election:

Health Election	Monthly	Bi-weekly
Employee Only	640.98	295.84
Employee Plus 1 Child	870.89	401.95
Employee Plus Children	1,006.19	464.40
Employee Plus Spouse	1,312.75	605.89
Employee, Spouse & Child	1,542.66	712.00
Employee, Spouse & Children	1,677.96	774.45
Opt Out	150.00	69.23

2013 PLAN RATES

Benefit Allowances

	Monthly		Biweekly
Employee	640.98	Employee	295.84
Plus Child	870.89	Plus Child	401.95
Plus Children	1,006.19	Plus Children	464.40
Plus Spouse	1,312.75	Plus Spouse	605.89
Plus Spouse & 1 Child	1,542.66	Plus Spouse & 1 Child	712.00
Plus Spouse & Children	1,677.96	Plus Spouse & Children	774.45

2013 MONTHLY PLAN RATES

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
CommunityCare HMO	543.82	1,335.96	1,612.94	1,779.12	820.80	986.98
GlobalHealth HMO	398.84	1,052.98	1,263.16	1,388.06	609.02	733.92
HealthChoice High	463.99	1,145.95	1,381.52	1,509.40	699.56	827.44
HealthChoice High Alternative	463.99	1,145.95	1,381.52	1,509.40	699.56	827.44
HealthChoice Basic	402.98	996.50	1,204.16	1,316.30	610.64	722.78
HealthChoice Basic Alternative	402.98	996.50	1,204.16	1,316.30	610.64	722.78
HealthChoice S-Account	382.56	898.00	1,088.18	1,189.90	572.74	674.46
HealthChoice USA	710.21	1,420.42	1,653.67	1,780.12	943.46	1,069.91
TRICARE Supplement	59.00	118.00	177.00	218.00	118.00	159.00
Dental	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Assurant Freedom Preferred	28.83	57.50	79.00	115.30	50.33	86.63
Assurant Heritage Plus with SBA (Prepaid)	11.74	20.60	28.20	35.80	19.34	26.94
Assurant Heritage Secure (Prepaid)	7.20	13.18	18.38	23.56	12.40	17.58
CIGNA Dental Care Plan (Prepaid)	9.26	15.32	22.40	30.64	16.34	24.58
Delta Dental PPO	33.64	67.26	96.52	141.30	62.90	107.68
Delta Dental Premier	40.66	81.32	116.72	170.86	76.06	130.20
Delta Dental PPO – Choice	15.06	49.24	83.68	132.84	49.50	98.66
HealthChoice Dental	31.38	62.76	89.66	129.72	58.28	98.34
Vision	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Humana	6.76	11.82	15.39	16.28	10.33	11.22
Primary Vision Care Services (PVCS)	9.25	17.25	25.75	28.00	17.75	20.00
Superior Vision Services	7.14	14.24	20.96	28.04	13.86	20.94
UnitedHealthcare Vision	8.18	13.97	18.56	20.95	12.77	15.16
Vision Service Plan (VSP)	8.93	14.91	20.64	27.79	14.66	21.81
Disability	9.10					
Life Insurance Options						
Life	4.00	Supplemental Life First Unit		\$4.00		
Dependent Life		Supplemental Life Age Rated (Per \$20,000)				
Low Option	2.60		< 30	0.80	55 - 59	5.60
Standard Option	4.32		30 - 34	0.80	60 - 64	6.40
Premier Option	8.64		35 - 39	0.80	65 - 69	10.40
			40 - 44	1.20	70 - 74	17.60
			45 - 49	2.00	75+	27.20
			50 - 54	3.60		

2013 PLAN RATES

Benefit Allowances			
Monthly		Biweekly	
Employee	640.98	Employee	295.84
Plus Child	870.89	Plus Child	401.95
Plus Children	1,006.19	Plus Children	464.40
Plus Spouse	1,312.75	Plus Spouse	605.89
Plus Spouse & 1 Child	1,542.66	Plus Spouse & 1 Child	712.00
Plus Spouse & Children	1,677.96	Plus Spouse & Children	774.45

2013 BIWEEKLY PLAN RATES

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
CommunityCare HMO	250.99	616.59	744.43	821.13	378.83	455.53
GlobalHealth HMO	184.08	485.99	583.00	640.64	281.09	338.76
HealthChoice High	214.15	528.90	637.62	696.65	322.87	381.90
HealthChoice High Alternative	214.15	528.90	637.62	696.65	322.87	381.90
HealthChoice Basic	185.99	459.92	555.76	607.52	281.83	333.59
HealthChoice Basic Alternative	185.99	459.92	555.76	607.52	281.83	333.59
HealthChoice S-Account	176.57	414.47	502.25	549.19	264.35	311.29
HealthChoice USA	327.79	655.58	763.23	821.60	435.44	493.81
Dental	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Assurant Freedom Preferred	13.31	26.54	36.46	53.22	23.23	39.99
Assurant Heritage Plus with SBA (Prepaid)	5.42	9.51	13.02	16.53	8.93	12.44
Assurant Heritage Secure (Prepaid)	3.32	6.08	8.48	10.87	5.72	8.11
CIGNA Dental Care Plan (Prepaid)	4.27	7.07	10.34	14.14	7.54	11.34
Delta Dental PPO	15.53	31.05	44.55	65.22	29.03	49.70
Delta Dental Premier	18.77	37.54	53.88	78.87	35.11	60.10
Delta Dental PPO – Choice	6.95	22.73	38.63	61.31	22.85	45.53
HealthChoice Dental	14.48	28.96	41.38	59.86	26.90	45.38
Vision	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Humana	3.12	5.46	7.11	7.52	4.77	5.18
Primary Vision Care Services (PVCS)	4.27	7.96	11.88	12.92	8.19	9.23
Superior Vision Services	3.30	6.58	9.68	12.95	6.40	9.67
UnitedHealthcare Vision	3.78	6.45	8.57	9.67	5.90	7.00
Vision Service Plan (VSP)	4.12	6.88	9.52	12.82	6.76	10.06
Disability	4.20					
Life Insurance Options						
Life	1.85	Supplemental Life First Unit		1.85		
Dependent Life		Supplemental Life Age Rated (Per \$20,000)				
Low Option	1.20		< 30	0.37	55 - 59	2.58
Standard Option	1.99		30 - 34	0.37	60 - 64	2.95
Premier Option	3.99		35 - 39	0.37	65 - 69	4.80
			40 - 44	0.55	70 - 74	8.12
			45 - 49	0.92	75+	12.55
			50 - 54	1.66		

Health Care Reform Update

In 2011, state employees and their families saw several changes in their health plans, thanks to the Patient Protection and Affordable Care Act passed by Congress and signed by the President.

Once again, HMO plans will cover most preventive services at 100 percent provided the services are done In-network. In 2013, HealthChoice will also cover most preventive services at 100 percent. For you, this means no-cost access to such services as:



- Blood pressure, diabetes, and cholesterol tests
- Many cancer screenings
- Counseling from your health care provider on topics including quitting smoking, losing weight, eating better, treating depression, and reducing alcohol use
- Routine vaccines for diseases such as measles, meningitis or tetanus
- Flu and pneumonia shots
- Counseling, screening and vaccines for healthy pregnancies
- Regular well-baby and well-child visits, from birth to age 21

(See the Health Plan Comparison section of this guide for details.)

CAUTION: Make Sure Your Dependents Are Eligible

Are you covering an ineligible dependent? Enrolled ineligible dependents can result in significant and unnecessary costs to the State and its employees. Even the very conservative estimates put the value in the millions of dollars.

Now is the time to make sure the dependents you claim are eligible for state coverage. Although no official action has been taken, an audit is being considered. A dependent eligibility audit is a controlled process designed to preserve the integrity of an employer's benefit plan by identifying enrolled, but ineligible participants. Examples include:

- Ineligible spouses
- Member forgets to inform employer of a divorce:



Once a divorce decree is issued, the employee's spouse is no longer an eligible dependent and does not qualify for state benefits. If the court orders the employee to provide the spouse with health (or other) insurance, that coverage cannot be through the State and will need to be obtained from another source.

- Ineligible children
- Grandchildren, nieces and nephews (unless employee has been granted legal custody)
- Spouses of married dependents (daughter in-law or son in-law)

While there are financial benefits to a dependent audit, it is by no means a popular move. However, an audit may become necessary as a way to reduce costs in state government, to validate insurance claims and to make sure the State is in compliance with federal laws. While the "honor system" is still in effect for Plan Year 2013, protect yourself by verifying the eligibility of all the people you are claiming as dependents. If you're unsure whether a dependent is eligible, contact your Benefits Coordinator or the Employee Benefits Department, Human Capital Management at (405) 522-1190 or 1-800-219-8115.

Mental Health Parity and Addiction Equity

Federal law, the Mental Health Parity and Addiction Equity Act of 2008, requires health insurance providers to include mental health and substance abuse coverage equal to physical health coverage in terms of the financial and treatment requirements. The law removed differences in co-pays and removed limits on visits and treatment days. Provisions of the law will be in effect in all of the state's available health plans in 2013.

Benefits Enrollment Calculator

OKLAHOMA EMPLOYEES Benefits Council Home / Benefits / Plan Year 2012 / Calculator

SEARCH

ABOUT EBC

BENEFITS

- Your Benefits
- Military Opt Outs
- Forms
- Plan Year 2012
- Calculator
- New Hire Video
- Health Plan Comparison Guide
- Plan Rates
- Plan Year 2011
- Plan Year 2010
- Provider Directory
- State Benefits Coordinators
- Helpful Links
- FAQs
- News

FLEXIBLE SPENDING

OKHEALTH

EBC Enrollment Calculator

EASY BENEFIT ELECTIONS CALCULATOR !

To compute benefit designations that appear on your payroll advice statement, follow the boxes below. Indicate your choices then select the "calculate" button. Remember that this amount is deducted from the generous **Benefit Allowance** provided by the state of Oklahoma. Any excess will be added to your salary (pre-tax) and any average will be deducted from your salary.

STEP ONE:
Indicate the Plan Year and the Pay Frequency that affects you.

STEP TWO:
Select your other options in the other available Selection areas. The calculator will automatically display and adjust to your various selections.

* Please refrain from hitting your *ENTER* key while using the calculator. Doing so will cause the page to submit and may result in calculation errors.

Plan Period Pay Frequency

Option	Carrier	Coverage	Rate
Health	<input type="text" value="HealthChoice USA"/>	<input type="text" value="Employee only"/>	\$688.82
Dental	<input type="text" value="None"/>	<input type="text" value="Employee only"/>	\$0.00
Vision	<input type="text" value="None"/>	<input type="text" value="Employee only"/>	\$0.00
Supplemental Life	<input type="text" value="None"/>	<input type="text" value="0-25"/> <input type="text" value="20000.00"/>	\$0.00
Dependent Life	<input type="text" value="None"/>	<input type="text" value=""/>	\$0.00
Invisible Bracelet	<input type="text" value="None"/>	<input type="text" value="3"/> members	\$0.00
Basic Life			\$4.00
Disability			\$9.10
Health Care Account		\$ <input type="text" value="0.00"/>	\$0.00
Dependent Care Account		\$ <input type="text" value="0.00"/>	\$0.00
Mass Trans Account		\$ <input type="text" value="0.00"/>	\$0.00
Total Benefits Cost			\$701.92
Benefits Allowance			\$640.98
Out of Pocket Cost *			\$-60.94

* This amount may vary from actual because of possible tax implications.

Your benefits costs can be easily estimated using the online Benefits Enrollment Calculator located on the web site at www.ebc.ok.gov. Be sure to choose the monthly calculator if you are paid once a month and the bi-weekly calculator if you are paid every two weeks. The Benefits Enrollment Calculator can add your benefits costs, apply your benefits allowance and provide an estimated total, showing any out-of-pocket expense or additional take-home pay you may realize in your paycheck.

Important Notes about the Enrollment Calculator:

- Print your benefits calculator results for easy reference during online enrollment.
- Use the calculator as many times as you want, but to actually enroll you must use the Benefits Administration System (BAS) link on the web site or complete your paper enrollment form.
- The online Benefits Calculator provides estimates only. Although every attempt has been made to provide accurate information, the calculator provides no guarantee of compensation, benefits or tax implications.

Online Enrollment

Enroll Online!

Remember: Online Enrollment opens October 1 and closes October 31, 2012.

Customer assistance is available October 1st through 30th from 8 a.m. – 4 p.m. and October 31st from 8 a.m. – 8 p.m. Assistance is also available by submitting a help ticket through the help desk of the website at: www.ebc.ok.gov or helpdesk@omes.ok.gov.

Last year, 82 percent of state employees went to www.ebc.ok.gov and used online enrollment to make their benefit elections. Join your co-workers and discover how easy it is to enroll online. The average enrollment takes just a few minutes and you can log on anytime, 24 hours a day, seven days a week during Option Period.

Online Enrollment allows you to:

- Print your confirmation of elections instantly
 - Update your address, telephone, and email information online
 - Change your elections and make corrections as many times as you like, until the close of Option Period (remember, your final election is the official enrollment!)
1. Go to the Employee Benefits Website at www.ebc.ok.gov. Sign on to the Benefits Administration System logon area using your 6 digit employee number and click *Forgot Password*.
 2. Follow instructions to set your personal password.
 3. Choose Online Enrollment and begin.

On the home page of www.ebc.ok.gov, the Benefits Administration System (BAS) access window is in the top right corner of the screen. Online enrollment is not

currently available for newly hired employees outside of Option Period. Your user ID will continue to be your 6 digit employee number, make sure you update your email address, home address, and phone number.

Eligibility Reminder

If you experience a qualifying life event during the year; for example, marriage, divorce, birth or adoption, you may be allowed to make certain changes to your insurance elections without waiting for Option Period. You must complete a change form within 30 days of the life event or wait until the next Option Period to make any changes.

Remember, it is a 30-day deadline! Contact your Benefit Coordinator

Flexible Spending Accounts (FSAs)

Want to Save More On Your Taxes? – Flexible Spending Accounts (FSAs) are money-saving ways to pay for qualified health and day care expenses because the accounts are funded with pre-tax dollars. Here’s how the average person, contributing just \$100 per month, can increase their take-home pay by using an FSA:

	Without FSA	With FSA
Annual Salary	\$35,000	\$35,000
Flexible Spending Account Deposit (annual)	0	1,200
Taxable Income	35,000	33,800
Estimated Taxes (30 percent)	- 10,500	-10,140
Health Care Expenses	- 1,200	0
Take Home Pay	23,300	23,660
Annual Increase in Take Home Pay		\$360

FSA Contribution Limits: Due to federal legislation, beginning in 2013, FSA contributions will be limited to \$2,500 each year with annual inflation increases.

FSAs can no longer be used to pay for some over-the-counter drugs and health products without a prescription. Check out the list of eligible items provided at www.ebc.ok.gov in the “Flexible Spending” section.

Experience the Convenience of the Free FSA Debit Card!

It’s fast, flexible and free! The optional Flexible Spending Account (FSA) debit card can be used at hundreds of merchants.

Simply present the FSA debit card to pay for medical and dependent care expenses. The money is taken directly from your FSA account, resulting in fewer paper claims to file.



When using the FSA debit card, some charges may

require proof after purchase. Save your receipts!

Please Note the Following:

- FSAs have a “Use it or Lose it” rule. Simply stated, if you have money left in your account after March 15th of the following year, that money will be forfeited. But don’t let that scare you. With a little planning, you can take advantage of this tax-reducing benefit without losing any money.
- You cannot enroll in a Flexible Spending Health Care Account if you choose the HealthChoice S-Account Plan.
- You may be restricted from enrollment in the HealthChoice S-Account if you have funds remaining in your FSA Health Care Account on January 1, 2013.
- You can continue to participate in the FSA Dependent Care Account if you elect the HealthChoice S-Account Plan.

Grace Period Extension

The IRS allows a grace period for incurring approved expenses from your FSA. You have until March 15th of the following year to use funds from your current year’s account.

So, go to the doctor, buy a prescription or incur any approved expenses such as bandages, diabetes testing supplies, and contact lens solution until March 15th, 2013 and still file for reimbursement from your remaining 2012 FSA account fund. Check out the full list of eligible products in the Flexible Spending section of www.ebc.ok.gov.

When calculating your FSA contribution for Plan Year 2013, it is important to plan conservatively. Calculate based on your plan year estimated expenses. Do not include the extended grace period in your calculations. This extension may help you reduce the risk of losing unused funds in your FSA accounts.

Add Up Your Savings with our FSA Savings Calculator

OKLAHOMA EMPLOYEES Benefits Council

Home / Flexible Spending / EBC FSA Calculator

EBC Spending Account Savings Calculator

Easy FSA Savings Calculator !

To get an estimate of your potential tax savings by utilizing a flexible spending account to

How it works:

1. Select the Pay Frequency that affects you.
2. Select your family size.
3. Select the check box next to each item to add to your savings estimate.
4. Review your savings estimate at the bottom of the page!

(Please note the spending amounts are estimates that you may incur for health exp

Pay Frequency: Monthly
Family size: Employee only

Type	Item	Yearly Cost
	Health Plan Annual Deductible	<input type="checkbox"/> \$0.00
	Dr/Copay	
	Co-payments	<input type="checkbox"/> \$0.00

- How much in taxes will I save?
- How much should I contribute annually?
- What expenses should I consider when calculating my contribution?

To see how you might benefit from enrolling in an FSA, log on to www.ebc.ok.gov and use the FSA savings calculator. It can help you estimate your qualifying annual expenses and calculate how much you can save in taxes by paying for your health care and dependent care expenses on a pre-tax basis.

Health Care Account (HCA)

By signing up for a Health Care Account, you can set aside up to \$2,500 for you and your family’s health care related expenses. Realize significant tax savings on qualified, un-reimbursed expenses by paying for the services and items pre-tax. Enroll in an HCA online or with your paper enrollment, indicating the pay period contribution you want deducted from your paycheck. Some qualifying expenses include:

- Doctors visits, deductibles and copays
- Prescription drugs
- Vision care, laser eye surgery, eyeglasses or lenses
- Dental care, orthodontic expenses
- Physical therapy

As many FSA users are already aware, restrictions on pre-tax purchases of some over-the-counter (OTC) medications like Tylenol and Claritin took effect in 2011 and will continue to be in place for 2013. In accordance with a provision of the health care reform law, OTC drugs, medicines and biologicals can be purchased with Health Care FSA funds, but only with a letter of medical necessity from a medical provider. Also, the items can no longer be purchased with the “Benny” debit card. However, products like bandages and contact lens solution will still be allowed as Benny card purchases.

Check out the list provided at www.ebc.ok.gov in the “Flexible Spending” section.

HCA Monthly Minimum: \$10

HCA Monthly Maximum: \$208.33

Dependent Care Account (DCA)

Daycare expenses can add up quickly. By contributing to a Dependent Care Account, you can pay for child or adult daycare with pre-tax dollars resulting in substantial tax savings. Monthly contributions are deducted from your paycheck before your taxes are calculated. Enroll for the DCA online or by paper, but be sure to indicate your pay period contribution.

DCA Monthly Minimum: \$50

DCA Monthly Maximum: \$416.66

Important Notes on FSA Accounts:

- You must re-enroll every year.
- Indicate your per-pay-period contribution on your

enrollment (not your annual contribution).

- View account balances and claim information online by logging onto the Benefits Administration System (BAS) via the EBC website at www.ebc.ok.gov.
- After logging in using your employee ID and password, select Flexible Spending from the left menu.
- See additional important rules and regulations for FSAs on page 6 of this Guide.

HealthChoice S-Account Plan

The HealthChoice S-Account Plan is a qualified, high deductible health plan. HealthChoice has contracted with American Fidelity Health Services Administration to make establishing and keeping an HSA easier and more convenient.

The S- Account Plan provides access to one of the largest provider networks in Oklahoma, the HealthChoice Provider Network. This is the same network that is available to HealthChoice High, High Alternative, Basic and Basic Alternative Plan members.

The \$1,500 individual/\$3,000 family deductible for the HealthChoice S-Account Plan must be met before any health or pharmacy benefits are paid by the plan. There are certain exceptions for preventive care. Refer to the *Health Plan Comparison* section for details. The individual deductible does not apply if two or more family members are covered.

Please refer to the *Benefits Enrollment Guide Plan Year 2013* for information on covered, services, claim procedures, eligibility, and Plan exclusions and limitations.

¹ Although OSEEGIB and the Health Savings Account (HSA) trustee/custodian together provide health insurance benefits, each are independent entities with separate responsibilities. OSEEGIB expressly disclaims any fiduciary obligation to manage the member's HSA funds or accounts. HSA account information concerning contributions, IRS determinations, withdrawals, or any matters regarding the HSA is the sole responsibility of the HSA trustee/custodian chosen by the member.

² Confer with your tax professional for possible eligibility questions and tax consequences of enrollment in a high deductible health plan and health savings account.

For further information about the S-Account Plan contact OSEEGIB Member Services at 405-717-8780 or toll-free 1-800-752-9475. For further information about American Fidelity Health Services Administration contact 405-523-5699 or toll-free 1-866-326-3600.

Premium Conversion

Do You Want to Save on Your Taxes?

Premium Conversion is an optional, IRS approved election chosen by more than 97 percent of state employees, allowing you to save by paying NO TAX on your eligible insurance premiums. By paying insurance premiums for

health, dental, vision, flexible spending accounts and a portion of supplemental life pre-tax, you have more take-home pay than you would if you paid the same premiums with after-tax dollars.

The premium conversion option is automatic. You will be enrolled in premium conversion unless you elect to opt out. You can opt out of premium conversion in two ways.

- Select "No" to premium conversion during online enrollment
- Check the "No" box under the Premium Conversion section of the paper enrollment form

If you have questions about your premium conversion options, be sure to ask your Benefits Coordinator.

✓ **Yes = tax savings!**

HealthChoice Health Plans

Each year, tobacco use costs the HealthChoice health plans and its members approximately \$50 million dollars. Because these costs affect the premiums of all health plan members, HealthChoice is encouraging members to stay or become tobacco-free by offering the deductible and out-of-pocket limits of the HealthChoice High and Basic Plans at 2012 amounts for non-tobacco users. The HealthChoice High Alternative and HealthChoice Basic Alternative Plans are continuing at the same increased deductible and out-of-pocket limits for tobacco users. The individual deductibles and out-of-pocket limits for these two plans are \$250 higher than the High and Basic Plans.

To enroll or remain enrolled in the HealthChoice High or Basic Plan for Plan Year 2013, you must attest that you and your covered dependents are tobacco-free by completing the HealthChoice High and Basic Plans Tobacco-Free Attestation. The attestation is available to you:

- Online at www.sib.ok.gov or www.healthchoiceok.com under the *Be Tobacco Free or HealthConnect* tab.
- By calling HealthChoice Member Services at 1-405-717-8780 or toll-free 1-800-752-9475. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

If you cannot complete the tobacco-free attestation because you and/or your covered dependents are not tobacco-free, you can still qualify for the HealthChoice High or HealthChoice Basic plan if you can show proof of an attempt to quit using tobacco or provide a letter from your doctor. To qualify for the tobacco-free plans, you must provide one of the following:

- Register yourself and/or your covered dependents in the quit tobacco program available through the Oklahoma Tobacco Settlement Endowment Trust and Alere Wellbeing and complete three counseling calls within the previous 90 days
- A letter from your doctor indicating it is not medically advisable for you or your covered

dependents to quit tobacco.

The letter from your doctor must be provided to HealthChoice at 3545 N.W. 58 St., Ste. 110, Oklahoma City, OK 73112. If you do not or cannot complete the tobacco-free attestation, be certified by Alere Wellbeing as completing three counseling calls, or provide the letter from your physician, you and your covered dependents will be enrolled in the HealthChoice High Alternative Plan or HealthChoice Basic Alternative Plan.

HealthChoice High, High Alternative, Basic, Basic Alternative, S-Account, and USA Plans

- Non-Network emergency room visits will be covered at the Network benefit level; however, you can still be billed for non-covered services and amounts over Allowed Charges.
- Preventive Procedures Covered at 100% of Allowed Charges. As an enhanced benefit for HealthChoice members, preventive procedures and many other services will be covered at 100% of Allowed Charges with no out-of-pocket costs when using a Network Provider. This means no-cost access to such services as:
 - Blood pressure, diabetes, and cholesterol tests
 - Breast, cervical, prostate, and colorectal cancer screenings
 - Osteoporosis screening
 - Counseling from your health care provider on topics including quitting tobacco, losing weight, eating healthy, treating depression, and reducing alcohol use
 - Prescription tobacco cessation products
 - Vaccines for children and adults
 - Flu and pneumonia shots
 - Screening for obesity and counseling from your doctor and other health professionals to promote sustained weight loss, including dietary counseling from your doctor
 - Screening for conditions that can harm pregnant women or their babies, including iron deficiency, hepatitis B, a pregnancy related immune condition called Rh incompatibility, and a bacterial infection called bacteriuria
 - Special, pregnancy-tailored counseling from a doctor to help pregnant women quit smoking and avoid alcohol use
 - Counseling to support breast-feeding and help nursing mothers
 - Well-woman visits

- Gestational diabetes screening that helps protect pregnant women from one of the most serious pregnancy-related diseases
- Domestic and interpersonal violence screening and counseling
- FDA-approved contraceptive methods and contraceptive education and counseling
- Breastfeeding support, supplies, and counseling
- HPV DNA testing for women 30 or older
- Sexually transmitted infections counseling for sexually-active women
- HIV screening and counseling for sexually-active women

See the HealthChoice website at www.sib.ok.gov or www.healthchoicework.com for more details.

HealthChoice High, High Alternative, and USA Plans

- HealthChoice has a family out-of-pocket limit for the HealthChoice High and High Alternative Plans. The family out-of-pocket limit for the High Plan is \$8,400 when using a Network Provider and \$9,900 when using a non-Network Provider. The family out-of-pocket limit for the High Alternative Plan is \$9,150 when using a Network Provider and \$10,650 when using a non-Network provider.

HealthChoice S-Account Plan

- The out-of-pocket limits are \$3,000/individual and \$6,000/family. The individual deductible does not apply if two or more family members are covered.
- HealthChoice has again contracted with American Fidelity Health Services Administration to make establishing and keeping a Health Savings Account easier and more convenient for S-Account members. See the Health Savings Accounts information page in the back pocket of this guide.

HealthChoice Pharmacy Benefit

- Two 90-day courses of prescription tobacco cessation products will be covered at 100% with no cost to members.
- HealthChoice has a 30-day or 90-day supply of medication covered when purchased at retail pharmacies for one copay. See the Health Plan Comparison for copay amounts.



What is the Oklahoma Tobacco Helpline?

The Helpline is a highly effective service that provides a series of one-on-one tobacco cessation coaching sessions over the telephone. Once enrolled in the program, most participants also receive nicotine replacement products such as patches, gum, or lozenges. The Helpline has been proven to work for Oklahomans, and similar Helplines have been proven to work for people all over the country.

How does telephone coaching work?

When you call the Helpline at 1-800-QUIT-NOW you'll speak with a helpful registration assistant who will ask a few questions to gather your phone number and other contact information, insurance provider, and basic information about your reason for calling. Then, a Helpline Quit Coach™ will work with you to determine your readiness to quit, discuss your options for using nicotine replacement products or other cessation aids, and assist you in developing a quit plan that is right for you. The Quit Coach will also schedule up to four follow-up sessions throughout your quitting process and you may call in to speak with a coach as needed between scheduled calls.

Once enrolled, you may also participate in Web Coach, an online resource with helpful quitting tips and tools and an online community for additional support. Your Quit Coach will discuss this feature with you.

Who is eligible to receive Helpline services?

Anyone living in Oklahoma ages 13 and older may call the Helpline and receive services at no charge up to twice per year. Helpline specialists assist tobacco users, health care professionals, and concerned family members and friends.

What are the Oklahoma Tobacco Helpline hours?

The Helpline is available 24 hours a day, 7 days a week.

Additional HealthChoice Insurance Helpline Benefits

HealthChoice members enrolled in the Helpline program may receive up to twelve weeks of nicotine replacement products up to twice per year with no copay or deductible. The products are mailed directly to your home.

Employee Life Insurance

All eligible current state employees are covered by the HealthChoice Life Insurance Plan which provides a \$20,000 basic term life insurance policy called Basic Life. An additional term life policy, called Supplemental Life, is available in \$20,000 units for employees who need more coverage.

Basic Life Coverage

As a state employee, you are **automatically** enrolled in Basic Life. This also includes Accidental Death and Dismemberment (AD&D) coverage.

Supplemental Life Coverage

You can elect to increase your life insurance coverage in \$20,000 units up to a maximum of \$500,000. To increase your coverage, a Life Insurance Application must be submitted and approved. Your application must be approved before coverage can take effect. The postmark deadline for submitting the Life Insurance Application is **Friday, November 16, 2012**.

AD&D Coverage

Basic Life (\$20,000) and the first unit (\$20,000) of Supplemental Life include Accidental Death and Dismemberment coverage. AD&D coverage pays additional benefits for the loss of life, loss of limb or limbs, or the loss of sight. See the HealthChoice Life Insurance Handbook for more information. The handbook is available online at www.sib.ok.gov or www.healthchoiceok.com.

Guaranteed Issue (New employees only)

You may enroll in life insurance coverage in an amount up to two times your base annual salary without completing a Life Insurance Application. See your Benefits Coordinator for details.

How to Increase Your Life Insurance Coverage

During Option Period, all increases to the employee life insurance amount require salary verification and the Coordinator's signature. To increase your life insurance coverage, please complete a Life Insurance Application and obtain your Coordinator's signature. Mail directly to the Oklahoma State and Education Employees Group Insurance Board (OSEEGIB). The address is located on the back of the form.

For a complete description of life insurance coverage, eligibility and benefits; please refer to the HealthChoice Life Insurance Handbook. The handbook is available online at www.sib.ok.gov or www.healthchoiceok.com.

Dependent Life Insurance

You have three options to choose from when purchasing dependent life insurance coverage:



Dependent Life Premier Option

- \$20,000 term life policy for spouse
- \$10,000 term life policy for each child
- \$1,000 term life policy for newborns to 6 months

Dependent Life Standard Option

- \$10,000 term life policy for spouse
- \$5,000 term life policy for each child
- \$1,000 term life policy for newborns to 6 months

Dependent Life Low Option

- \$6,000 term life policy for spouse
- \$3,000 term life policy for each child
- \$1,000 term life policy for newborns to 6 months

To apply, complete the back of your enrollment form or select this option during your online enrollment.

Basic Life (\$20,000)

Includes AD&D \$4.00

First \$20,000 Supplemental Life

Includes AD&D \$4.00

Additional Units of Supplemental Life

Age-Rated (Per \$20,000)

Under 30 years	\$0.80
30-34 years	\$0.80
35-39 years	\$0.80
40-44 years	\$1.20
45-49 years	\$2.00
50-54 years	\$3.60
55-59 years	\$5.60
60-64 years	\$6.40
65-69 years	\$10.40
70-74 years	\$17.60
75+ years	\$27.20

Dependent Life

Low Option	\$2.60
Standard Option	\$4.32
Premier Option	\$8.64

Disability \$9.10

Turn the page for your Health Plan, Dental Plan, and Vision Plan Comparison Charts



2013 Health Plans
See the Health Plan Monthly Rates
on page 3

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<p>Choice of Provider</p>	<p>Contact your PCP for all medical care (New Hires & New Enrollees must indicate PCP on Enrollment Form) Members may self-refer to most specialists for initial visit.</p>	<p>Contact your PCP for all medical care (New Hires & New Enrollees must indicate PCP on Enrollment Form) PCP referral & HMO authorization required for all care received outside PCP office, You may self-refer to an in-network OB/GYN. For children, you may designate a pediatrician as the primary care provider</p>
<p>Calendar Year Deductible</p>	<p>None</p>	<p>None</p>
<p>Annual Out-of-Pocket Maximum</p>	<p>Individual: \$3,000 Family: \$6,000</p>	<p>Individual: \$3,000 Family: \$5,000</p>
<p>Office visits (Professional services)</p>	<p>Copays \$35 PCP copay per visit \$50 Specialist copay per visit</p>	<p>Copayments \$25 PCP \$50 Specialist</p>

HealthChoice High & High Alternative Network A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider www.healthchoiceok.com	HealthChoice High & High Alternative Non-Network A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider www.healthchoiceok.com	HealthChoice Basic & Basic Alternative Additional out-of-pocket costs apply when using a non-Network provider www.healthchoiceok.com	HealthChoice S-Account Network A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider www.healthchoiceok.com
Choice of Network Provider for medically necessary services	Choice of any Provider, Allowed Charges for medically necessary Services. Member responsible for amount that exceeds the Allowed Charges when using a non-Network provider and all ineligible expenses.	Choice of any Provider, Allowed Charges for medically necessary services. Member responsible for amount that exceeds the Allowed Charges when using a non-Network provider and all ineligible expenses.	Choice of Provider for medically necessary services
High Individual: \$500 Family: \$1,500 High Alternative Individual: \$750 Family: \$2,250 See Emergency Health Care and Hospital Inpatient for additional per service copay.	High Individual: \$500 Family: \$1,500 High Alternative Individual: \$750 Family: \$2,250 plus \$300 per confinement hospital copay. See Emergency Health Care and Hospital Inpatient for additional per service copay.	Basic Individual: \$500 Family: \$1,000 Deductible applies after Plan pays first \$500 of Allowed Charges. Basic Alternative Individual: \$750 Family: \$1,500 Deductible applies after Plan pays first \$250 of Allowed Charges.	Individual: \$1,500 Family: \$3,000 The combined medical and pharmacy deductible must be met before benefits are paid. The individual deductible does not apply if two or more family members are covered
High Individual: \$2,800 Family: \$8,400 (includes deductible) High Alternative Individual: \$3,050 Family: \$9,150 (includes deductible) Non-covered services, copays & ER copay do not apply	High Individual: \$3,300 Family: \$9,900 (includes deductible) High Alternative Individual: \$3,550 Family: \$10,650 (includes deductible) plus Member is responsible for amount that exceeds the Allowed Charges, inpatient copay, ER copay & charges over maximum benefit limitations	Basic Individual: \$5,500 Family: \$11,000 Basic Alternative Individual: \$5,750 Family: \$11,500	Individual: \$3,000 Family: \$6,000 Non-Network charges do not count toward out-of-pocket limit
\$30 Physician copay; \$50 Specialist copay per office visit; for other professional services, the calendar year deductible applies first; member pays 20% of Allowed Charges	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses	See <i>Hospital Inpatient</i> for a description of benefits	After the calendar year deductible, \$50 copay

2013 Health Plans
See the Health Plan Monthly Rates
on page 3

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**Prescription
Drugs**

Up to \$0 select generic formulary
 Up to \$10 generic formulary
 Up to \$40 brand formulary
 (when no generic is available)
 Up to \$65 brand formulary
 (when generic is available)
 Up to \$65 non formulary

30-day supply
 Selected medications may have restricted
 quantities

Convenience Mail Order Pharmacy
 Up to 90-day supply
 for 3 copays

\$10/\$50/\$75

\$4 copay for selected generics
 30-day supply
 Certain medications may have restricted
 quantities
 These copays do not apply to the
 maximum out-of-pocket
 Home Delivery up to 90-day supply for 2
 copays



<p>HealthChoice High & High Alternative Network A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider www.healthchoiceok.com</p>	<p>HealthChoice High & High Alternative Non-Network A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider www.healthchoiceok.com</p>	<p>HealthChoice Basic & Basic Alternative Additional out-of-pocket costs apply when using a non-Network provider www.healthchoiceok.com</p>	<p>HealthChoice S-Account Network A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider www.healthchoiceok.com</p>
<p>30-day supply: Generic medication – You pay cost of medication up to a maximum copay of \$10; Preferred brand – If cost of medication is \$60 or less, you pay maximum copay of \$15 or cost of medication, if less; if cost of medication is more than \$60, you pay 25% of cost up to maximum copay of \$30 Non-Preferred brand – if cost of medication is \$60 or less, you pay maximum copay of \$30 or cost of medication if less; if cost of medication is more than \$60, you pay 50% up to a maximum copay of \$60 90-day supply: Generic medication – You pay cost of medication up to a maximum copay of \$25 Preferred brand – If cost of medication is \$120 or less, you pay maximum copay of \$30 or cost of medication, if less. If cost of medication is more than \$120, you pay 25% of cost up to a maximum copay of \$60 Non-Preferred brand – If cost of medication is \$120 or less, you pay maximum copay of \$60 or cost of medication, if less. If cost of medication is more than \$120, you pay 50% of cost up to a maximum copay of \$120 Specialty Medications Copay: Preferred - \$60 per 30-day supply Non-Preferred - \$120 per 30-day supply Brand/Generic difference: Member is responsible for the difference in the brand and generic if a brand is purchased when a generic is available. For more details, visit www.healthchoiceok.com or www.sib.ok.gov</p>	<p>Preferred medications – If cost of medication is \$90 or less, you pay maximum copay of \$45 or cost of medication, if less, plus dispensing fee. If cost of medication is more than \$90, you pay 50% of cost, plus dispensing fee (no maximum) Non-Preferred medication – If cost of medication is \$160 or less, you pay maximum copay of \$120 or cost of medication, if less, plus dispensing fee. If cost of medication is more than \$160, you pay 75% of cost, plus dispensing fee (no maximum) Brand/Generic difference: Member is responsible for the difference in the brand and generic if a brand is purchased when a generic is available. For more details visit www.healthchoiceok.com or www.sib.ok.gov</p>	<p>30-day supply: Generic medication – You pay cost of medication up to a maximum copay of \$10; Preferred brand-name medication – If cost of medication is \$60 or less, you pay maximum copay of \$15 or cost of medication, if less. If cost of medication is more than \$60, you pay 25% of cost up to a maximum copay of \$30 Non-Preferred brand-name medication – If cost of medication is \$60 or less, you pay maximum copay of \$30 or cost of medication, if less. If cost of medication is more than \$60, you pay 50% of cost up to a maximum copay of \$60 90-day supply: Generic medication – You pay cost of medication up to a maximum copay of \$25 Preferred brand – If cost of medication is \$120 or less, you pay maximum copay of \$30 or cost of medication, if less. If cost of medication is more than \$120, you pay 25% of cost up to a maximum copay of \$60 Non-Preferred brand – If cost of medication is \$120 or less, you pay maximum copay of \$60 or cost of medication, if less. If cost of medication is more than \$120, you pay 50% of cost up to a maximum copay of \$120 Specialty Medication Copay: Preferred - \$60 per 30-day supply Non-Preferred - \$120 per 30-day supply Brand/Generic difference: Member is responsible for the difference in the brand and generic if a brand is purchased when a generic is available. For more details, visit www.healthchoiceok.com or www.sib.ok.gov</p>	<p>After the \$1,500 individual or \$3,000 family deductible has been met, the pharmacy benefits are: 30-day supply: Generic medication – You pay cost of medication up to a maximum copay of \$10; Preferred Brand – If cost of medication is \$60 or less, you pay maximum copay of \$15 or cost of medication, if less. If cost of medication is more than \$60, you pay 25% of cost up to a maximum copay of \$30. Non-Preferred Brands – If cost of medication is \$60 or less, you pay maximum copay of \$30 or cost of medication, if less. If cost of medication is more than \$60, you pay 50% of cost up to a maximum copay of \$60. 90-day supply: Generic – You pay cost of medication up to a maximum copay of \$25. Preferred Brand – If cost of medication is \$120 or less, you pay maximum copay of \$30 or cost of medication, if less. If cost of medication is more than \$120, you pay 25% of cost up to a maximum copay of \$60 Non-Preferred Brand – If cost of medication is \$120 or less, you pay maximum copay of \$60 or cost of medication, if less. If cost of medication is more than \$120, you pay 50% of cost up to a maximum copay of \$120 Specialty Medications Copay: Preferred - \$60 per 30-day supply Non-Preferred - \$120 per 30-day supply Brand/Generic difference: Member is responsible for the difference in the brand and generic if a brand is purchased when a generic is available. For more details, visit www.healthchoiceok.com or www.sib.ok.gov</p>

2013 Health Plans

See the Health Plan Monthly Rates on page 3

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Hospital Inpatient	\$500 copay per admission (prior authorization from PCP required)	\$250 copayment per inpatient day \$750 max. per admission Preauthorization required
Hospital Outpatient	\$300 copay per visit outpatient surgical facility	\$250 copayment per visit Preauthorization required
Emergency Health Care	\$200 per visit copay (waived if admitted)	\$150 per visit copay (waived if admitted)
After Hours Urgent Care	\$50 copay per visit (prior authorization required)	\$50 copay per visit NOTE: Must use in-network facilities
Diagnostic X-ray and Lab	No additional copay for laboratory services or outpatient radiology. \$200 copay per scan for MRI, CT, MRA and PET Scan	No additional copay for laboratory services or outpatient radiology. \$250 copay per scan for MRI, CT, MRA, PET and Nuclear Scan
Allergy Treatment and Testing	\$35 copay per visit to PCP \$50 copay per visit to Specialist \$30 copay for allergy serum (six week supply - including shots)	\$25 PCP /\$50 Specialist \$30 copayment per 6 weeks antigen and shots
Well-Child Care	No copay	No Copayment up to age 21

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<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible and \$300 per confinement hospital copay, plus amount that exceeds the Allowed Charges and all ineligible expenses. Certification required</p>	<ul style="list-style-type: none"> •Copays do not apply •All covered services, exceptions, limitations, and conditions are identical to the HealthChoice High Plan <p>Basic Plan Member pays: •\$0 the first \$500 of Allowed Charges</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible and \$300 per confinement hospital copay when using a non-Network provider plus amount that exceeds the Allowed Charges and all ineligible expenses Certification required</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required for certain outpatient surgeries</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses. Certification required for certain outpatient surgeries</p>	<ul style="list-style-type: none"> •100% of the next \$500 of Allowed Charges (deductible) <p>Only Allowed Charges count toward the deductible</p> <p>Basic Alternative Plan Member pays: •\$0 the first \$250 of Allowed Charges</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required for certain outpatient surgeries</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. \$100 ER copay; waived if hospitalized</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible, plus amount that exceeds the allowed charges. \$100 ER copay; waived if hospitalized</p>	<ul style="list-style-type: none"> •100% of the next \$750 of Allowed Charges (deductible) <p>Only Allowed Charges count toward the deductible</p> <p>Both Basic Plans Member pays: •50% of the next \$10,000 of Allowed Charges •\$0 of Allowed Charges over the individual or family out-of-pocket limit</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible. \$100 ER copay; waived if hospitalized</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses</p>	<ul style="list-style-type: none"> •No deductible for well child care visit. •You can use non-Network providers, but it will be more costly 	<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. Limit: Battery of 60 tests every 24 months</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses Limit: Battery of 60 tests every 24 months</p>		<p>Member pays 20% of Allowed Charges after the calendar year deductible Limit: Battery of 60 tests every 24 months</p>
<p>\$0 copay for preventive well baby exam</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses</p>	<p>\$0 Copay for preventive well-baby exam</p>	<p>\$0 copay for preventive well baby exam</p>

2013 Health Plans
See the Health Plan Monthly Rates
on page 3

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<p>Immunizations</p>	<p>No copay for childhood immunizations up to 18 No copay for medically necessary immunizations 19 and over</p>	<p>\$0 copay birth through age 18 years \$0 copay ages 19 and over When appropriate following the recommendation of ACIP Office copayments may apply</p>
<p>Maternity</p>	<p>\$35 copay for initial visit only (includes prenatal and postnatal care) No copay for Prenatal Classes Amniocentesis (medically necessary; outpatient surgical facility copay may apply) \$500 per admission</p>	<p>\$0 copay for prenatal care \$25 one-time copay for delivery and all post natal care \$250 per day, \$750 Maximum per hospital admission</p>
<p>Contraceptive Services</p>	<p>\$35 PCP/\$50 Specialist copay per visit for consultation \$35 PCP/\$50 Specialist copay for surgical procedure (in office)</p>	<p>No copayment for women on FDA approved contraceptive services, not including abortifacient drugs \$50 copayment for men if services performed in an office setting</p>
<p>Contraceptive Drugs</p>	<p>See <i>Outpatient Prescription Drug Benefits</i></p> <p>Up to \$0 select generic formulary Up to \$10 generic formulary Up to \$40 brand formulary (when no generic is available) Up to \$65 brand formulary (when generic is available) Up to \$65 non formulary</p> <p>30-day supply Selected medications may have restricted quantities. One copay per injectable contraceptive.</p>	<p>Selected FDA approved contraceptive prescriptions provided for no copayment.</p> <p>All others are subject to prescription copays and possible prior authorization Tier 1: \$4/\$10 Tier 2: \$50 Tier 3: \$75 See Drug Formulary Over the counter contraceptives not covered</p>
<p>Infertility Services</p>	<p>\$35 PCP copay per visit \$50 Specialist copay per visit Office visit copays apply Infertility Services 50% Copay Infertility Medications (require prior authorization) are subject to a 50% copay</p>	<p>50% coinsurance, office visit copayments apply</p>

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<p>Well-baby and adult immunizations covered at 100%, Office visit subject to copay Administration charge may apply and is subject to deductible and coinsurance \$30 Physician office visit copay \$50 Specialist office visit copay Physicians include: General Practitioners Internal Medicine Physicians OB/GYN Pediatricians Physicians Assistants Nurse Practitioners</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses</p>	<p>Well-baby & Adult immunizations covered at 100%</p> <ul style="list-style-type: none"> •Copays do not apply •All covered services, exceptions, limitations, and conditions are identical to the HealthChoice High Plan <p>Basic Plan Member pays: •\$0 the first \$500 of Allowed Charges •100% of the next \$500 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible</p>	<p>Well-baby and adult immunizations covered at 100%. Office visit is subject to \$50 copay. Administration charge is subject to deductible and coinsurance</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible Includes one postpartum home visit (must meet criteria) Also see <i>Hospital Inpatient Benefits</i></p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible and \$300 per confinement hospital copay, plus amount that exceeds the Allowed Charges and all ineligible expenses. Includes one postpartum home visit (must meet criteria) Also see <i>Hospital Inpatient Benefits</i></p>	<p>Basic Alternative Plan Member pays: •\$0 the first \$250 of Allowed Charges •100% of the next \$750 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible</p> <p>Both Basic Plans Member pays: •50% of the next \$10,000 of Allowed Charges •\$0 of Allowed Charges over the individual or family out-of-pocket limit •No deductible for well child care visit. •You can use non-Network providers, but it will be more costly</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible. Includes one postpartum home visit (must meet criteria) Also see <i>Hospital Inpatient Benefits</i></p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses</p>	<p>Member pays: •50% of the next \$10,000 of Allowed Charges •\$0 of Allowed Charges over the individual or family out-of-pocket limit •No deductible for well child care visit. •You can use non-Network providers, but it will be more costly</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>
<p>See <i>Prescription Drugs</i></p>	<p>See <i>Prescription Drugs</i></p>	<p>See <i>Prescription Drugs</i></p>	<p>After the \$1,500 individual or \$3,000 family deductible has been met, all Pharmacy copays apply. See <i>Prescription Drugs</i></p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible Benefits available for diagnosis and some treatment. See exclusions in member materials</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds Allowed Charges and all ineligible expenses Benefits available for diagnosis and some treatment. See exclusions in member materials</p>	<p>See <i>Hospital Inpatient</i> for benefit details</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible Benefits available for diagnosis and some treatment. See exclusions in member materials</p>

2013 Health Plans
See the Health Plan Monthly Rates
on page 3

CommunityCare HMO
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GlobalHealth HMO
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Mental Health Inpatient	\$500 copay per admission (requires prior authorization through CCOK Behavioral Health Services)	\$25 per inpatient day copayment \$750 max. per admission Must be preauthorized
Mental Health Outpatient <i>Including Gambling Addiction</i>	\$35 PCP/specialist copay per visit (requires prior authorization through CCOK Behavioral Health Services)	\$25 per inpatient day copayment Must be preauthorized
Substance Abuse Inpatient	\$500 copay per admission (requires prior authorization through CCOK Behavioral Health Services)	\$250 per inpatient day copayment \$750 max. per admission Must be preauthorized
Substance Abuse Outpatient	\$35 PCP/specialist copay per visit (requires prior authorization through CCOK Behavioral Health Services)	\$25 copayment per visit Must be preauthorized
Hearing Screening	\$0 copay per visit(covered under preventive care services and limited to one per year)	No copayment per visit up to age 21 \$25 copayment per visit age 22 and over limited to 1 per year
Hearing Aids	20% copay for children up to age 18. Coverage shall only apply to hearing aids that are prescribed, filled and dispensed by a licensed audiologist, and may limit the hearing aid benefit payable for each hearing-impaired ear to every forty-eight (48) months; provided, however, such coverage may provide for up to four (4) additional ear molds per year for children up to two (2) years of age	Covered for children up to age 18 only 20% coinsurance
Physical, Occupational, or Speech Therapy	No copay for Inpatient Rehabilitation \$50 copay for Outpatient Physical, Occupational or Speech Therapy (up to 60 treatment days per disability)	No copayment for inpatient rehabilitation \$50 Specialist copayment per visit for outpatient Limited to 60 consecutive days per illness or injury

HealthChoice High & High Alternative Network A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider www.healthchoicework.com	HealthChoice High & High Alternative Non-Network A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider www.healthchoicework.com	HealthChoice Basic & Basic Alternative Additional out-of-pocket costs apply when using a non-Network provider www.healthchoicework.com	HealthChoice S-Account Network A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider www.healthchoicework.com
Member pays 20% of Allowed Charges after the calendar year deductible Certification required	Member pays 50% of Allowed Charges after the calendar year deductible plus \$300 per confinement copay, plus amount that exceeds Allowed Charges and all ineligible expenses. Certification required	<ul style="list-style-type: none"> •Copays do not apply •All covered services, exceptions, limitations, and conditions are identical to the HealthChoice High Plan Basic Plan Member pays:	Member pays 20% of Allowed Charges after the calendar year deductible. Certification required
Member pays 20% of Allowed Charges after calendar year deductible. Requires certification after 15 visits or penalty applies	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses. Requires certification after 15 visits or penalty applies	<ul style="list-style-type: none"> •\$0 the first \$500 of Allowed Charges •100% of the next \$500 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible Basic Alternative Plan Member pays:	Member pays 20% of Allowed Charges after the calendar year deductible. Requires certification after 15 visits or penalty applies
Member pays 20% of Allowed Charges after the calendar year deductible Certification required	Member pays 50% of Allowed Charges after the calendar year deductible and \$300 per confinement copay, plus amount above the Allowed Charges and all ineligible expenses Certification required	<ul style="list-style-type: none"> •\$0 the first \$250 of Allowed Charges •100% of the next \$750 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible Both Basic Plans Member pays:	Member pays 20% of Allowed Charges after the calendar year deductible Certification required
Member pays 20% of Allowed Charges after the calendar year deductible. Requires certification after 15 visits or penalty applies	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges & all ineligible expenses. Requires certification after 15 visits or penalty applies	<ul style="list-style-type: none"> •50% of the next \$10,000 of Allowed Charges •\$0 of Allowed Charges over the individual or family out-of-pocket limit •No deductible for well child care visit. 	Member pays 20% of Allowed Charges after the calendar year deductible. Requires certification after 15 visits or penalty applies
\$30 Physician copay, \$50 Specialist copay per office visit for a basic hearing screening only (does not include a comprehensive hearing exam) One per calendar year	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses. Basic hearing screening only One per calendar year	<ul style="list-style-type: none"> •You can use non-Network providers, but it will be more costly 	\$50 copay per visit after the calendar year deductible for a basic hearing screening (does not include a comprehensive hearing exam) One per calendar year
Benefit limited to children up to age 18; audiological services and hearing aids are covered as Durable Medical Equipment. No benefits for ages 18 and over; certification required	Benefit limited to children up to age 18; audiological services and hearing aids are covered as Durable Medical Equipment. No benefits for ages 18 and over; certification required		Benefit limited to children up to age 18; audiological services and hearing aids are covered as Durable Medical Equipment. No benefits for ages 18 and over; certification required
Member pays 20% of Allowed Charges after calendar year deductible. Certification required after 20 visits. Each service limited to 60 visits per year	Member pays 50% of Allowed Charges after calendar year deductible plus amount that exceeds the Allowed Charges and all ineligible expenses. Certification required after 20 visits. Each service limited to 60 visits per year		Member pays 20% of Allowed Charges after the calendar year deductible. Certification required after 20 visits. Each service limited to 60 visits per year

2013 Health Plans
See the Health Plan Monthly Rates
on page 3

CommunityCare HMO
www.ccok.com

GlobalHealth HMO
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Chiropractic and Manipulative Therapy	\$50 copay per visit (15 visits per year) (PCP prior authorization required)	\$20 copayment per visit Must be preauthorized
Durable Medical Equipment (DME)	20% copay (prior authorization required)	20% coinsurance Must be preauthorized and obtained from a contracted network provider
Blood and Blood Products	No copay	No copayment
Skilled Nursing Facility	No copay (Limit: Max 100 days per year)	Limit: 100 days per Plan Year \$250/day copayment \$750 max. per admission
Periodic Health Exams	\$0 copay Routine Physicals	No copayment per PCP limited to 1 per year
Temporo-mandibular Joint Dysfunction	\$100 copay per treatment plan (lifetime non-surgical maximum of \$1,500)	\$100 copayment per treatment plan NOTE: Lifetime non-surgical maximum of \$1,500. Surgical is under medical

<p>HealthChoice High & High Alternative Network A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider www.healthchoiceok.com</p>	<p>HealthChoice High & High Alternative Non-Network A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider www.healthchoiceok.com</p>	<p>HealthChoice Basic & Basic Alternative Additional out-of-pocket costs apply when using a non-Network provider www.healthchoiceok.com</p>	<p>HealthChoice S-Account Network A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider www.healthchoiceok.com</p>
<p>Member pays 20% of Allowed Charges after calendar year deductible Certification required after 20 visits. Each service limited to 60 visits per year</p>	<p>Member pays 50% of Allowed Charges after calendar year deductible plus amount that exceeds the Allowed Charges and all ineligible expenses. Certification required after 20 visits. Each service limited to 60 visits per year</p>	<ul style="list-style-type: none"> •Copays do not apply •All covered services, benefits, exceptions, limitations, and conditions are identical to the HealthChoice High Plan <p>Basic Plan Member pays: •\$0 the first \$500 of Allowed Charges •100% of the next \$500 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible Certification required after 20 visits. Each service limited to 60 visits per year</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible for covered items. Purchase, rental, repair, or replacement must be certified</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. Purchase, rental, repair, or replacement must be certified</p>	<p>Basic Alternative Plan Member pays •\$0 the first \$250 of Allowed Charges •100% of the next \$750 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible for covered items. Purchase, rental, repair, or replacement must be certified</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses</p>	<p>Both Basic Plans Member pays: •50% of the next \$10,000 of Allowed Charges •\$0 of Allowed Charges over the individual or family out-of-pocket limit</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required Limit: 100 days per year</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. Certification required Limit: 100 days per year</p>	<ul style="list-style-type: none"> •No deductible for well child care visit. •You can use non-Network providers, but it will be more costly 	<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required Limit: 100 days per year</p>
<p>\$0 copay for one preventive services visit per calendar year for members and dependents age 20 and older. H.E.L.P. Check program pays primary member \$200 for completing preventive services visit, metabolic and lipid panels, and health risk assessment. One mammogram per year at no charge for woman age 40 and older. For woman under age 40, \$30 Physician copay or \$50 Specialist copay per office visit. Some guidelines apply</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. No copay or deductible for one mammogram per calendar year for women age 40 and over, member pays charges over \$115. Some guidelines apply</p>	<p>One preventive services visit covered at 100% of Allowed Charges for members and dependents age 20 and older. H.E.L.P. Check program pays primary member \$200 for completing preventive services visit, metabolic and lipid panels, and health risk assessment. One mammogram per year at no charge for woman age 40 and older. For woman under age 40, normal plan benefits apply. Some guidelines apply</p>	<p>\$0 copay for one preventive services visit per calendar year for members and dependents age 20 and older. H.E.L.P. Check program pays primary member \$200 for completing preventive services visit, metabolic and lipid panels, and health risk assessment. One mammogram per year at no charge for woman age 40 and older. For woman under age 40, \$30 Physician copay or \$50 Specialist copay per office visit. Some guidelines apply</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. Certification required</p>	<p>See <i>Hospital Inpatient</i> for benefit details</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required</p>

2013 Health Plans
See the Health Plan Monthly Rates
on page 3

CommunityCare HMO
www.ccok.com

GlobalHealth HMO
www.globalhealth.com



Home Health Services	No copay (prior authorization required)	\$25 copayment per visit Must be prescribed by PCP
Medical Transportation	Ambulance No copay (must have prior authorization except for emergencies)	\$100 copayment
Transplants	No copay (all transplant services, including evaluations must be preauthorized)	Inpatient copayment applies Preapproval and precertification required
Hospice	No copay	No copayment for terminal illness of six months or less Preapproval required
Preventive Services		
Eye Care	\$0 copay Vision Screening and Refraction (one every 365 days) Contact Members Services for a contracted provider	



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<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required Limit: 100 visits per calendar year</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. Certification required Limit: 100 visits per calendar year</p>	<p>Copays do not apply •All covered services, benefits, exceptions, limitations, and conditions are identical to the HealthChoice High Plan Basic Plan Member pays: •\$0 the first \$500 of Allowed Charges</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required Limit: 100 visits per calendar year</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. If not an emergency, medically necessary services require certification</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. If not an emergency, medically necessary services require certification</p>	<p>•100% of the next \$500 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible Basic Alternative Plan Member pays: •\$0 the first \$250 of Allowed Charges •100% of the next \$750 of Allowed Charges (deductible)</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible. If not an emergency, medically necessary services require certification</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. Certification required</p>	<p>Only Allowed Charges count toward the deductible Both Basic Plans Member pays: •50% of the next \$10,000 of Allowed Charges •\$0 of Allowed Charges over the individual or family out-of-pocket limit</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible. Certification required</p>
<p>Member pays 20% of Allowed Charges after the calendar year deductible. For life expectancy of six months or less Certification is required</p>	<p>Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. For life expectancy of six months or less Certification is required</p>	<p>•No deductible for well child care visit. •You can use non-Network providers, but it will be more costly</p>	<p>Member pays 20% of Allowed Charges after the calendar year deductible. For life expectancy of six months or less Certification is required</p>
<p>Age 20 and older, no charge one time per calendar year for preventative service visit, metabolic panel, and comprehensive lipid panel H.E.L.P. Check program pays primary member \$200 for completing preventive services visit, metabolic and lipid panels, and health risk assessment</p>	<p>Member pays 50% of Allowed Charges after the individual calendar year deductible, plus amount above Allowed Charges and all ineligible expenses</p>	<p>Age 20 and older, no charge one time per calendar year for preventive service visit, metabolic panel, and comprehensive lipid panel H.E.L.P. Check program pays primary member \$200 for completing preventive services visit, metabolic and lipid panels, and health risk assessment</p>	<p>Age 20 and older, no charge one time per calendar year for preventive service visit, metabolic panel, and comprehensive lipid panel H.E.L.P. Check program pays primary member \$200 for completing preventive services visit, metabolic and lipid panels, and health risk assessment</p>

2013 Dental Plans
See the Dental Plan Monthly Rates on page 3

**Assurant Employee Benefits
Freedom Preferred Plan**
www.assurantemployeebenefits.com

Assurant Employee Benefits *Heritage**
www.assurantemployeebenefits.com

**SECURE
Prepaid Plan**
(Requires choosing a primary care dentist)

**PLUS
Prepaid Plan**
(Requires choosing a primary care dentist)



	In-Network	Out-of-Network	SECURE Prepaid Plan <i>(Requires choosing a primary care dentist)</i>	PLUS Prepaid Plan <i>(Requires choosing a primary care dentist)</i>
Deductibles	\$25 per person (Waived for Class A Services)	\$25 per person	None	None
Diagnostic & Preventive Care (Class A) Includes routine cleanings, check-ups, X-rays for adults and children, fluoride treatments	100% of allowable amounts Topical fluoride application for children up to age 16	100% of allowable amounts Topical fluoride application for children up to age 16	Example Services Copays Sealant per tooth: \$22 copay Routine Cleaning (once every 6 months): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge	Example Services Copays Sealant per tooth: \$15 copay Routine Cleaning (once every 6 months): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge
Basic Care (Class B) Includes fillings, some X-rays, extractions, periodontal care, and some root canal oral surgery	85% of allowable amounts after deductible.	70% of allowable amounts after deductible.	Example Services/ Copays Amalgam – one surface, permanent teeth \$32	Example Services/ Copays Amalgam – one surface, permanent teeth \$25
Major Care (Class C) Includes crowns, bridges and dentures	60% of allowable amounts after deductible	50% of allowable amounts after deductible	Example Services/ Copays Root Canal Anterior \$175 Periodontal/Scaling/Root planning 1-3 teeth (per quadrant) \$54 Endodontist: 15 percent discount	Example Services/ Copays Root Canal Anterior \$165 Periodontal/Scaling/Root planning 1-3 teeth (per quadrant) \$36 Specialty rider Pays specialist at set Copays
Orthodontic Care (Class D)	No deductible, plan pays 60% up to lifetime maximum of \$2,000 Dependents under age 19	No deductible, plan pays 50% up to lifetime maximum of \$2,000 Dependents under age 19	25% discount for Adults and Children	25% discount for Adults and Children
Annual Maximum Benefit	\$2,000 per person per policy year	\$2,000 per person per policy year	No plan year dollar maximum	No plan year dollar maximum

NOTES:

Out-of-network benefits may allow dentist to balance bill.

Balance Billing – the practice of a provider charging full fees and billing the member for the portion of the bill insurance doesn't cover.

Orthodontic benefits on the PPO options are typically only available for dependents under the age of 19 or anyone with TMD. Contact the plan to determine limits on Orthodontic benefits prior to enrollment. If new hires and/or new enrollees did not have continuous group dental coverage in effect prior to becoming covered under HealthChoice Dental and Assurant Freedom PPO, a 12-month waiting period is applied for orthodontic services. *No waiting period applies for orthodontic benefits under the Delta Dental plans.

See each dental plan's website for a list of the dentists participating in each plan's network.

Delta Dental and Assurant Freedom Preferred both have statewide and nationwide networks and will

have the same benefits if treatment is provided out of state.

**There is no applicable copayment schedule for Assurant Secure Plan Specialist services. Assurant Secure Plan Specialists reduce their charges as follows: a 15 percent discount off normal retail charges for Endodontist and a 25 percent discount for

any other Plan Specialist including Orthodontist.

Assurant Employee Benefits is the brand name for dental products provided by Union Security Insurance Company.



IMPORTANT:

This Dental Plan Comparison Chart provides a brief summary. Please review the detailed dental enrollment materials for all plan features, including all plan limitations, exclusions, and restrictions before enrolling and selecting a dental product.

CIGNA Dental <i>www.cigna.com</i>	Delta Dental <i>www.DentaDentalOK.org</i>	Delta Dental <i>www.DentaDentalOK.org</i>	Delta Dental <i>www.DentaDentalOK.org</i>	HealthChoice Dental <i>www.healthchoiceok.com</i>	
Prepaid Plan <i>(Requires choosing a primary care dentist)</i>	PPO In-Network and Out-of-Network	Premier In-Network and Out-of-Network	PPO-Choice Delta Dental PPO Network	Network Provider	Non-Network Provider
None \$5 office copay applies	\$25 per person per calendar year- Classes B & C only	\$50 per person per calendar year- Classes A, B and C only	\$100 deductible per person on Major Services only (level 4)	\$25 per person Basic Care and Major Care combined	\$25 per person Preventive, Basic, and Major Care combined
Example Services Copays Sealant per tooth: \$15 copay Routine cleaning (once every 6 months): no charge Topical Fluoride Application	100% of allowable amounts No deductible applies	100% of allowable amounts after deductible	Schedule of Covered Services and Enrollee Copayments: Example Services/Copays Routine Cleaning: \$5 copay; Periodic oral evaluations:\$5 copay; Topical fluoride application (up to age 19): \$5 copay	100% of Allowed Charges	100% of Allowed Charges after the deductible
Example Services/ Copays Amalgam – one surface, permanent teeth \$21	85% of allowable amounts after deductible	70% of allowable amounts after deductible	Schedule of Covered Services and Enrollee Copayments: Example Services/Copays Amalgam one surface, primary or permanent tooth \$12 copay	85% of Allowed Charges after deductible	70% of Allowed Charges after deductible
Example Services/ Copays Root Canal, Anterior \$355 copay Periodontal Scaling/ Root planning 1-3 teeth (per quadrant) \$71 copay	60% of allowable amounts after deductible	50% of allowable amounts after deductible	Schedule of Covered Services and Enrollee Copayments: Example Services/Copays Crown-porcelain/ceramic substrate: \$241 copay; Complete denture-maxillary \$320 copay	60% of Allowed Charges after deductible	50% of Allowed Charges after deductible
\$2,280 out-of-pocket child; 3,120 out-of-pocket adult (24 month treatment); excludes orthodontic treatment plan and banding.	60% of allowable amounts up to \$2,000 lifetime maximum per person (eligible employee, spouse, and dependent children) See Notes	60% of allowable amounts up to \$2,000 lifetime maximum per person (eligible employee, spouse, and dependent children) See Notes	You pay charges in excess of \$50 per month. Lifetime maximum up to \$1,800 per person (eligible employee, spouse, and dependent children) See Notes	50% of allowed charges 12-month waiting period may apply* No lifetime maximum for Network or Non-Network	
No plan year dollar maximum	\$2,500 per person per calendar year	\$3,000 per person per calendar year	\$2,000 per person per calendar year	\$2,500 per person per calendar year Preventive, Basic, and Major Care combined	

IMPORTANT DETAILS ABOUT DENTAL COVERAGE:

- Pay special attention to the plans’ participating dentist. Call to confirm your dentist accepts your selected plan. Be specific in your questions. For example, ask if the dentist participates as a Delta Dental PPO network provider, not just if they accept Delta Dental.
- If you choose a dentist out-of-network, you will receive lower benefits and may be subject to additional costs.
- Dental prescriptions are covered under health plan benefits.

2013 Vision Plans
See the Vision Plan Monthly Rates on page 3

Humana
www.visioncare.com

PVCS
www.pvcs-usa.com

	In-Network	Out-of-Network	In-Network	Out-of-Network
Eye Exams	\$10 copay One exam for eyeglasses or contacts every calendar year	Plan pays up to \$35; One exam every calendar year	No Copay No Limit to frequency	Plan pays up to \$40 Limit 1 exam
Lenses Per Pair	\$25 Copay for single/multi-focal lenses	Plan pays up to: Single \$25 Bifocals \$40 Trifocals \$60 Lenticular \$100	Member pays wholesale cost. No limit to number of pairs	Member pays normal doctor fees, reimbursed up to \$60 for one set of lenses & frames annually
Frames	\$25 Copay, up to plan limits. One set of frames every calendar year	Plan pays up to \$45	Member pays wholesale cost. No limit to number of frames	Member pays normal doctor fee, reimbursed up to \$60 for one set of lenses & frames annually
Contact Lenses	\$130 allowance for conventional or disposable lenses and fitting fee in lieu of all other benefits every calendar year Medically necessary contacts, plan pays 100%	**\$130 allowance for contacts, and fitting fee in lieu of all other benefits Medically necessary contacts, plan pays up to \$210	Member pays wholesale cost for annual supply of contacts	Limit of one set annually in lieu of eyeglasses Member pays normal doctor fees reimbursed up to \$60
Laser Vision Correction	Discount thru TLC, member will pay no more than \$895 per eye for conventional Lasik, \$1,295 Custom plus bladeless when services are rendered by a TLC network provider	No Benefit	Discount nationwide at The Laser Center (TLC)	No Benefit
Lens Options				
UV Coating	Substantial discount \$15 member cost	No Benefit	\$14 Copay No limit	Member pays normal doctor fees
Tint	Substantial discount \$13 member cost	No Benefit	\$14 Copay and up No limit	Member pays normal doctor fees
Standard Scratch Resist	Substantial discount \$16 member cost	No Benefit	\$13 Copay and up No limit	Member pays normal doctor fees
Standard Polycarbonate	Substantial discount \$30 member cost	No Benefit	Wholesale cost No limit	Member pays normal doctor fees
Standard Progressive	Substantial discount \$82 member cost	No Benefit	Wholesale cost, No limit	Member pays normal doctor fees
Anti-Reflective	Substantial discount \$46 member cost	No Benefit	\$45 Copay and up: No limit	Member pays normal doctor fees



NOTES:

Humana: The contact lens benefit provides a \$130 yearly allowance for the annual vision exam to evaluate eye health, contact lens exam for fitting and evaluation, and the purchase of either conventional or disposable contacts. If a member prefers contact lenses, the plan provides the contact lens allowance in lieu of all other benefits. Instead if a member opts for lenses and frames during the plan year; a \$25 copay applies for these two material items. More than 23,000 frames are covered in full by the \$25 copay with in-network providers. Exams, lenses and frame benefits are provided once every 12 months. Oklahoma City LasikPlus Traditional Intralase (bladeless) with a one year plan with insurance discount is \$695 per eye equals \$1,390

Traditional Intralase (bladeless) with a lifetime plan with insurance discount is 1395 per eye equals \$2,790
CustomVue Intralase (bladeless) with lifetime plan with insurance discount is \$1,784.15 per eye equals \$3,568.30.

PVCS: Member must select either in-network or out-of-network for entire plan year. In-network services are unlimited. Out-of-network services (one eye exam, one set of eyeglasses or contacts) are limited to once annually. A \$50 service fee applies to soft contact lens fittings; a \$75 service fee applies to rigid or gas permeable contact lens fittings; and a \$150 service fee applies to hybrid contact lens fittings. 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 (wholesale cost of frame exceeds \$100, 5) Premium prescription lenses, and 6) Non prescription eye wear. For more information, call 1-888-357-6912.

***Superior:** Materials copay applies to lenses and/or frames. Discounts for lens add-ons will be given by contracted providers with a "DP" in their listing. Online, in-network contact lens materials available at www.svcontacts.com. 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 provider's lined trifocal. The difference may also be subject to a discount. Standard

Superior www.superiorvision.com		UnitedHealthcare Vision www.myuhcvision.com		VSP www.vsp.com	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
\$10 Copay	Plan pays: \$34 Ophthalmologist, \$26 Optometrist	\$10 Copay	Reimbursement up to \$40	\$10 Copay	\$10 Copay then plan pays up to \$35
\$25 Copay Standard Progressive: \$25 Copay *See notes below	\$Plan pays: Single up to \$26 Bifocals up to \$39 Trifocals up to \$49 Lenticular up to \$78 Standard Progressive: Up to \$49 *See notes below	\$25 Copay	Single up to \$40 Bifocals up to \$60 Trifocals up to \$80 Lenticular up to \$80	\$25 Copay applies to lenses or frame. Single vision, lined bifocal and trifocal lenses covered in full. Average 35% to 40% discount on lens options	\$25 Copay then plan pays: Single up to \$25 Bifocals up to \$40 Trifocals up to \$55 Lenticular up to \$80
\$25 Copay then plan pays up to \$125 retail	Plan pays up to \$68	\$25 Copay	Reimbursement up to \$45	\$25 Copay then plan pays up to \$120	\$25 Copay, then plan pays up to \$45
No Copay Plan pays up to \$120 all contacts Medically necessary contacts covered in full (Contact lens fit copay: Standard \$25, after copay, covered in full; specialty \$25, after copay, plan pays up to \$50)	No Copay Plan pays up to \$100 all contacts; \$210 medically necessary contacts (Contact lens fit copay: Standard not covered; specialty not covered)	\$25 Copay on covered-in-full qualifying lenses (covers fittings and evaluation fees, contact lenses and up to 2 follow-up visits) *See notes below	Reimbursement up to \$150 elective contact lenses; \$210 medically necessary contact lenses	No Copay Plan pays up to \$120 conventional or disposable Medically necessary contacts covered in full	No Copay Plan pays up to \$105 conventional or disposable \$210 medically necessary contacts
5% - 50% Discount off surgical fees	No Benefit	15% Discount off the usual & customary price, 5% off promotional price	No Benefit	15% average off usual and customary price or 5% off the laser center's promotional price	No Benefit
20% Discount	No Benefit	Covered in full	No Benefit	\$14 copay	No Benefit
20% Discount	No Benefit	Covered in full	No Benefit	\$13-\$15 copay	No Benefit
20% Discount	No Benefit	Covered in full	No Benefit	\$15 copay	No Benefit
20% Discount	No Benefit	Covered in full	No Benefit	Covered in full for dependent children \$23-\$28 copay for all other members	No Benefit
*See notes below	*See notes below	Available 20-40% discount	No Benefit	\$50 copay	No Benefit
20% Discount	No Benefit	Available 20-40% discount	No Benefit	\$37 copay	No Benefit

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 a member who wears toric, gas permeable, or multifocal lenses.

UHC Vision: For either glasses or contact lenses, there is one \$25 materials copay. In lieu of lenses and frames, you may select contact lenses. Covered contact lens benefit includes the fitting/evaluation fee, contact lenses, and up to two follow-up visits. If covered disposable contact lenses are chosen, up to six boxes (depending on prescription) are included when obtained from a network provider. It is important to note that UHC covered contact lenses may vary by provider. Should you choose contact lenses outside the

covered selection, a \$150 allowance will be applied toward the fitting/evaluation fees and purchase of contact lenses (material copay does not apply). Toric and gas permeable contact lenses are examples of contact lenses that are outside of our covered contacts. Necessary contacts are covered-in-full after applicable copay. Exams, lenses, and frame benefits provided once every calendar year.

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 you choose a frame valued at more than your allowance, you'll save 20% on your out-of-pocket costs when you use a VSP doctor. Contact lenses are in lieu

of spectacle lenses and frame. The \$120 in-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 out-of-network allowance applies to the contacts and contact lens exam. Your 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 - 30% off additional complete pairs of glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months from your last WellVision Exam. Contact VSP or visit vsp.com to learn about retail chain Affiliate Providers.



Disability Insurance

No one expects to become disabled, but the financial burden can be eased by your coverage under the HealthChoice Disability Plan. Disability coverage pays an amount equal to 60 percent of your base salary up to a maximum dollar limit based on your age, salary, and years of service from the onset of your disability.



Eligibility

Disability benefits are available to all employees who have completed at least one month of continuous employment. No benefits are payable for any disability caused by a pre-existing condition.* Claims must be filed within one year of the date you first became disabled.

Definition of Disability

Disability is defined as the inability to perform the major duties of your job. After two years of disability, it is defined as the inability to perform the duties of any job for which you are or may become reasonably qualified by training, education or experience.*

What the Plan Pays

The disability plan will pay a monthly income equal to 60 percent of your base pay up to a maximum (minus offsets).

Monthly Maximum Disability Income

- Short-Term: \$2,500
- Long-Term: \$3,000

Benefits paid will be offset by any other income you may receive such as Social Security Disability, Workers' Compensation, Leave, or Disability Retirement.

When the Plan Pays

Payments begin after you have been disabled for 30 days. Short-term disability pays a benefit for the first 150 days. Generally, long-term disability pays a benefit after 180 days of disability and continues to age 65 or recovery, whichever is first, based on age, salary, and years of service at the onset of your disability. Other limitations may apply.

*For a complete description of the disability plan's eligibility and benefits, please refer to the HealthChoice Disability Insurance Handbook. The handbook is available online at www.sib.ok.gov or www.healthchoiceok.com.

Employee Assistance Program (EAP)

The EAP is a cooperative effort between employees and administration, offering employees and their families an opportunity to seek and receive free assistance in resolving personal issues. Some of these issues include family, financial, emotional, alcohol/drug abuse, addiction, trauma, and work relationships, which adversely affect safe and efficient performance on the job. The EAP is available to help employees deal with personal issues before they result in deterioration of health, family life, or job performance. EAP specialists provide confidential

assistance, information and referrals for employees/family members in using their behavioral health benefit and/or finding a community resource. EAP specialists also consult with supervisors/managers on how employees can be referred for assistance. For more information, contact your agency's Human Resource Office, review Merit Rule 530:10-21-1 through 9, or go to the Benefit web site, www.ebc.ok.gov, click on *OKHealth*, then *Wellness*, then *Programs*.

SoonerSave



Password: savenow

SoonerSave – Prepare for Retirement Wisely

SoonerSave is a voluntary long-term retirement savings plan available to State employees only. It is a division of the Oklahoma Public Employees Retirement System (OPERS) and is designed to supplement the benefit you receive from your State retirement system. SoonerSave is comprised of two defined contribution plans: The Deferred Compensation 457 Plan and the Deferred Savings Incentive 401(a) Plan. When you contribute money to SoonerSave, your contribution is deposited in the Deferred Compensation 457 Plan. As an incentive to contribute to SoonerSave, the State will contribute \$25 per month to the Deferred Savings Incentive 401(a) Plan.

A few reasons to join SoonerSave today include:

- **Easy Enrollment and Savings**—You can now enroll in SoonerSave using the same Online Enrollment process that you use to make your other benefit elections. Just follow the directions at the end of the Benefit on-line enrollment and enter the password *savenow* when you are redirected to the SoonerSave Enrollment page. Decide how much you want to contribute and how you want it invested—then you are on your way to investing for your retirement through convenient payroll deduction. Your contributions to SoonerSave will begin in January.
- **Tax Savings**—Your contributions are deducted from your paycheck before federal and state income taxes are calculated—lowering your taxable income. Plus, your contributions and any earnings grow on a tax-deferred basis.
- **Money from the State of Oklahoma**—You will receive a \$25 state contribution each month just for participating in SoonerSave.



Are you already participating in SoonerSave? Great! You've taken the first step to preparing yourself for retirement. Now, you may want to take the next step and increase your contribution amount using the Online Enrollment process. Increasing your contributions to SoonerSave by even a small amount could make a big

difference in your long-term retirement savings plan. The table below illustrates the impact an increased:

Employee Contribution Amount	Employer Contribution Amount	Total Contribution Amount	SoonerSave Balance After 20 Years*	Monthly Benefit for 20 Years (Before Tax Withholding)*
\$50/month	\$25/month	\$75/month	\$44,177	\$279.48
\$100/month	\$25/month	\$125/month	\$73,628	\$465.81
\$150/month	\$25/month	\$175/month	\$103,079	\$652.13
\$200/month	\$25/month	\$225/month	\$132,530	\$838.45

*FOR ILLUSTRATIVE PURPOSES ONLY. This hypothetical illustration does not represent the performance of any investment options. The accumulation stage assumes an 8% rate of return, reinvestment of earnings and no withdrawals. The payout stage assumes 12 monthly payments per year with a 4.5% rate of return. Withdrawals of tax-deferred accumulations are subject to ordinary income tax. This illustration does not reflect any charges, expenses or fees that may be associated with your Plan. The tax-deferred accumulations shown above would be reduced if these fees had been deducted. In order to properly plan for your retirement years, OPERS strongly encourages you to consider participating in SoonerSave (if you are eligible) as a way to supplement the income you will receive from your defined benefit plan and Social Security. For more information about SoonerSave or to update your beneficiary information, call 1-800-733-9008 or (405) 858-6781. You can also obtain information, change your contribution amount or find enrollment forms by visiting www.soonersave.com. SoonerSave is a division of the Oklahoma Public Employees Retirement System.

Benefits Details

General

Enrollment in a medical or dental plan does not guarantee that a particular doctor, dentist, clinic, or hospital will remain in your plan's network for the entire year. You enroll with the PLAN and not the provider. If your provider terminates his or her contract during the Plan Year, this does not allow you to change medical or dental plan carriers. These benefits are effective January 1, 2013. Keep this book as a reference throughout the year. This booklet is only intended to be a brief summary of certain provisions of the State of Oklahoma Employee benefit plans. In the event of a conflict between the booklet and the laws of the State of Oklahoma or administrative rules of the Employee Benefits Department and the Oklahoma State & Education Employees Group Insurance Board (Insurance Board), the laws and administrative rules shall govern in all cases.

Dental

Out-of-network benefits may allow dentist to balance bill.

Balance Billing – the practice of a provider charging full fees and billing the member for the portion of the bill insurance doesn't cover.

Orthodontic benefits on the PPO options are typically only available for dependents under the age of 19 or anyone with TMD. Contact the plan to determine limits on Orthodontic benefits prior to enrollment.

If new hires and/or new enrollees did not have group dental coverage in effect prior to becoming covered under HealthChoice Dental; and Assurant Freedom PPO a 12-month waiting period is applied for orthodontic services.

*No waiting period applies for orthodontic benefits under the Delta Dental plans.

See each dental plan's website for a list of the dentists participating in each plan's network.

Delta Dental and Assurant Freedom Preferred both have statewide and nationwide networks and will have the same benefits if treatment is provided out of state.

**There is no applicable copayment schedule for Assurant Secure Plan Specialist services. Assurant Secure Plan Specialists reduce their charges as follows: a 15 percent discount off normal retail charges for Endodontist and a 25 percent discount for any other Plan Specialist including Orthodontist.

HealthChoice Dental Notes:

You are responsible for non-Network amounts that exceed the Allowed Charges and for all non-covered services. Age limits and restrictions may apply, please consult each plan.

Orthodontic benefits are only available to dependents under the age of 19 with certification required for members greater than 19 years of age. Contact the plan to determine limits on orthodontic benefits prior to enrollment.

*If you are a new hire and/or a new enrollee and you did not have group dental coverage in effect prior to becoming covered under HealthChoice Dental; a 12-month waiting period will be applied to orthodontic services.

See each dental plan's website for a list of the dentists participating in each plan's network.

Vision

Humana/CompBenefits: If a member prefers contact lenses the plan provides an allowance for the exam and contacts, in lieu of all other benefits.

**Contact lens benefit provides a \$130 yearly allowance towards the exam and purchase of either conventional or disposable contacts. If lenses and frames are purchased at the same time only one \$25 copay applies. Over 23,000 frames are covered in full with in-network providers. Exams, lenses, frame benefits provided once every 12 months.

PVCS: Member must select either in-network or out-of-network for entire plan year. In-network services are unlimited. Out-of-network services (one eye exam, one set of eyeglasses or contacts) are limited to once annually. A \$50.00 service fee applies to all soft contact lens fittings; a \$75.00 service fee applies to rigid or gas permeable contact lens fittings; and a \$150.00 service fee applies to hybrid

contact lens fittings. 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 (wholesale cost of frame exceeds \$100), 5) Premium prescription lenses, and 6) Non prescription eye wear. For more information, call (888) 357-6912.

UnitedHealthcare (formerly Spectera): For either glasses or contact lenses there is one \$25 materials copay. In lieu of lenses and frames, you may select contact lenses. Covered contact lens benefit includes the fitting/evaluation fee, contact lenses, and up to two follow-up visits. If covered disposable contact lenses are chosen, up to six boxes (depending on prescription) are included when obtained from a network provider. It is important to note that UHC covered contact lenses may vary by provider. Should you choose contact lenses outside the covered selection, a \$150 allowance will be applied toward the fitting/evaluation fees and purchase of contact lenses (material copay does not apply). Toric, gas permeable, and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts. Necessary contacts are covered in-full after applicable copay. Exams, lenses, frame benefits provided once every calendar year.

Superior: Superior: *Materials copay applies to lenses and/or frames. Discounts for lens add-ons will be given by contracted providers with a "DP" in their listing. Online, in-network contact lens materials available at www.svcontacts.com. Exams, lenses and frames are provided once per calendar year. *Progressive Lenses (no-line bifocals) – you will 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. 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 a new contact lens wearer and/or a member who wears toric, gas permeable or multifocal lenses.

VSP: Exam, lenses and frame benefit provided annually. The \$25 materials copay applies to lenses or frames, but not to both. Copays/price on premium lens options will vary. If you choose a frame valued at more than your allowance, you'll save 20% on your out-of-pocket costs when you use a VSP doctor. Contact lenses are in lieu of spectacle lenses and frames. The \$120 in-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 out-of-network allowance applies to the contacts and contact lens exam. Your 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 - 30% off additional complete pairs of glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months from your last WellVision Exam.

Consumer Information & Annual Notices

The Benefits Department and the Insurance Board comply with the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996 known as HIPAA. The Council, the Insurance Board and each HMO, dental, and vision plan offered to State employees has a Privacy Notice which describes the organization protections and acceptable uses of information. To obtain a Privacy Notice from a particular plan, contact the plan directly or contact the Benefits Department. HIPAA also provides you and your dependents certain rights to enroll if you lose your group health plan coverage. HIPAA also prohibits a group health plan from keeping you (or your dependents) out of the plan based on anything related to your health. Finally, HIPAA also gives you the right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without pre-existing condition exclusions. The HealthChoice medical products offered by the Insurance Board are exempt from most of the portability provisions of HIPAA including, but not limited to, the following: limitations on pre-existing conditions, special enrollment rights, discrimination based upon a health factor, standards for mothers and newborns, mental health parity, and reconstructive mastectomies. See the section on General Eligibility Information for more details. The WOMEN'S HEALTH & CANCER RIGHTS ACT of 1998, a Federal Law, provides benefits for mastectomy related services including reconstruction and surgery to achieve symmetry

between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). The 1998 Guidance, Questions and Answers, and Notice Requirements under WHCRA (November 1998), can be obtained by calling 1-866-444-3272. The BREAST CANCER PATIENT PROTECTION ACT, an Oklahoma State Law, provides for at least 48 hours of inpatient care following a mastectomy and not fewer than 24 hours following a lymph node dissection. The NEWBORNS & MOTHERS ACT of 1996, a Federal Law, requires the availability of a hospital stay of at least 48 hours in connection with a vaginal delivery and not less than 96 hours with a cesarean delivery. The PROSTATE CANCER PROTECTION ACT, an Oklahoma State Law, provides for an annual screening for early detection of prostate cancer in men age 50 and over and in men from age 40-50 who are in high-risk categories. The Oklahoma Prostate Surgery Side Effects Law provides that all health benefit plans offered by OSEEGIB & EBD shall provide coverage for side effects that are commonly associated with radical retropubic prostatectomy surgery, including, but not limited to impotence and incontinence, and for other prostate related conditions. THE MANDATED BENEFIT FOR OB/GYN COVERAGE LAW requires any health benefit plan offered in the state of Oklahoma which provides medical and surgical benefits to also provide coverage for routine annual obstetrical/gynecological examinations. The law does not diminish already allowed health benefit diagnostics. In addition the law also specifies that obstetrical/gynecological examinations do not have to be performed by an obstetrician, gynecologist, or obstetrician/gynecologist. If you have a problem which cannot be resolved through your benefit plan's grievance process, you may have remedies with the Oklahoma State Department of Health, Oklahoma Department of Insurance, or a remedy of law. Once you become covered under a group health plan, you have certain rights under the CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you can contact the Benefit Department or the Insurance Board. You may also have rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA). USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service. The law also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services. See your agency for more information.

General Eligibility Information

The following are rules of eligibility that apply to commonly occurring situations. The rules are listed in no particular order. This is not an exhaustive list. Any active state of Oklahoma employee scheduled to work at least 1,000 hours per year is eligible for benefits coverage if he/she is not a temporary or seasonal employee. New Hire coverage is effective on the first day of the month following the entry-on-duty date. Coverage ends on the last day of the termination month. All eligible dependents must be covered when one dependent is covered under health, dental, or vision insurance unless proof of other group coverage is provided. Eligible dependents can include a spouse, married and unmarried children up to the age of 26 and incapacitated or totally disabled children of any age if their incapacity occurred and was verified prior to age 26. Two State employees cannot claim coverage for the same dependents for health, dental, and vision benefits. The Working Families Tax Relief Act of 2004 changed the definition of dependent for federal income tax purposes, effective January 1, 2005. The IRS indicates that the change is not intended to affect the coverage of dependents under employer sponsored medical plans. However if you cover dependents, EBD suggests you obtain professional tax advice when completing your income tax return(s). Thirty-day written notice is required to reinstate coverage.

Electing a TRICARE Supplement Plan

Electing to purchase a TRICARE supplement plan means that TRICARE will be primarily responsible for your medical coverage and the supplement plan will be secondarily responsible for coverage. By your election, you submit to the eligibility rules of TRICARE and the

TRICARE Supplement plan. These rules may be different from the rules of eligibility created by the State of Oklahoma. Medicare may become the primary insurer upon attaining eligibility for Medicare.

Changes to Benefit Plan Elections

Benefit elections made during the Option Period are generally irrevocable. Changes can be made to Option Period elections only if the change is authorized and consistent with Internal Revenue Service regulations. If you experience an event which you believe qualifies you to change your benefit elections, contact your Benefits Coordinator within 30 days of the event. Life events that qualify you to change your benefit elections include: marriage, birth, adoption or placement of an adopted child, loss of other coverage, change in marital status, change in the number of dependents, change in employment status of employee, spouse or dependent that affects eligibility, event causing employee's dependent to satisfy or cease to satisfy eligibility requirements, change in place of residence of employee, spouse or dependent (HMO coverage), commencement of or termination of adoption proceedings, judgments, decrees or orders, Medicare or Medicaid, significant cost increases (limited to Dependent Care Account using unrelated care provider), changes in coverage of spouse or dependent under other Employer's plan (except HCA), FMLA Leave, or other such events, which may permit such modification of election under the IRS consistency rule as found in Treasury Regulations 1.125-4 and in accordance with other applicable and prevailing Internal Revenue Code regulations promulgated under, and in accordance with EBD and OSEEGIB rules and regulations.

Flexible Spending Accounts Information

These accounts let you set aside money from your paycheck, pre-tax, to pay for planned dependent care charges and expected out-of-pocket healthcare expenses. You must enroll each Option Period or you lose the account. Plan carefully when deciding your contributions. Direct deposit of your reimbursements into the same account as your payroll deposit is required by state law. If you terminate employment with the state, any daycare or medical services must be incurred prior to the last day of your termination month. If you are not on active payroll (on some type of leave) it is your responsibility to mail in your pledged contribution. Viewing your account information is easy using the Benefits website. For further information on allowable expenses see the Benefits website at www.ebc.ok.gov. Reimbursement can also be made for expenses incurred by any participant during the Grace Period. The "Grace Period" is the period from the end of the Plan Year through March 15th of the subsequent Plan Year during which reimbursable expenses can be incurred and attributable to the previous Plan Year's account balance. The final payment of benefits for any Plan Year may be made following the close of such Plan Year based on accepted claims filed with the Plan Administrator no later than the end of the Run Out Period. The "Run Out Period" means the ninety (90) day period following a Plan Year in which claims can be made for reimbursable expenses incurred during the Plan Year. You cannot pay for prior year expenses from current year account funds. All expenses use the date of service, not the date they are paid for eligibility purposes.

Debit Cards

The Benefits Department will reimburse an FSA participant for eligible expenses incurred through use of the participant's debit card provided the participant properly activates the debit card, properly substantiates the claim for expenses, and abides by the terms of use of the debit card. The Council reserves the right to set the fee charged to participants for use of the card, waive the annual fee, discontinue use of the debit card, or require paper substantiation of expenses. The rules of eligibility for Dependent Care Accounts and Health Care Accounts apply to participants using the debit card. Upon demand a participant shall immediately refund any overpayment made by the Plan Administrator. Likewise, items charged to a debit card that are unacceptable to the Plan Administrator will require a participant to immediately refund such an overpayment to the Plan Administrator. Amounts remaining in a participant's healthcare and/or dependent care accounts following final payment of all healthcare and/or dependent care expenses incurred during the periods described in OAC 87:10-25-9(b) shall be forfeited to pay administrative expenses of the Flexible Benefits Plan.

FSA Health Care (Medical) Account Information

The annual maximum for FSA Health Care (Medical) is being lowered for Plan Year 2013 to \$2,500. You spend your own money for after-insurance, qualified medical expenses, deductibles, copays and certain over-the-counter items. These expenses may be eligible for reimbursement according to the IRS Code, enabling you to submit a claim voucher with the appropriate documentation and receive reimbursement from your own tax-free account. Attach the itemized bill and/or the Insurance Explanation of Benefits (HealthChoice State Plan or Dental Indemnity Plan EOB) to your signed Benefit Expense Reimbursement Voucher (claim form) and mail to the address on the form. Funds will be disbursed for the amount requested within ten days of receipt if you submit all required documentation. Check out the list of approved over-the-counter items on the Benefits website. Documentation required for approved OTC items is the computerized receipt, name of item, date of purchase, and amount paid. Pharmacy labels need to include the printed name of the drug. The date of service is the date you incur the expense (i.e. date you drop off the prescription at the pharmacy, date you receive the medical care). This date must be during the plan year and while actively participating in the program (making monthly contributions). Claim deadlines are Fridays, at 1:00 p.m. (Subject to change during holidays).

FSA Dependent Care Account Information

If you have an eligible dependent (children 12 or younger who have been included on your income tax return or any other eligible dependent person physically or mentally incapable of self-care) who spends at least eight hours a day in your home, you may want to participate in the Dependent Care Flexible Spending Account. This account pays daycare provider expenses while you and your spouse work up to a combined calendar year total of \$5,000. The daycare provider cannot also be your tax dependent.

The individual calendar year limit is \$2,500. Form 2441 must still be filed with your taxes. You can receive reimbursement for the amount you have currently deposited in your Dependent Care Account. With proof of payment and the dates of service your daycare provider is no longer required to sign the Dependent Care acknowledgement form.

Termination of Employment

If your employment terminates, you have certain rights under federal law. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows you to receive a Certificate of Creditable Prior Coverage from the State that you can present to a future employer. This certificate can verify up to 18 months of your prior insurance coverage in order to allow a reduction in your new employer's pre-existing condition limitation. If your employment terminates, contact your Benefits Coordinator or EBD immediately to determine your rights under HIPAA. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows you to continue insurance coverage after your employment terminates in most situations. Certain time limits apply to be eligible to continue coverage and an additional fee is added to your insurance premiums. Contact your Benefits Coordinator or OSEEGIB immediately upon termination of your employment to determine your COBRA rights. The Insurance Board administers the COBRA program for state employees.

Change of Address

The Employee Benefits Department must be notified immediately of any change of address for the employee and/or dependents. In the event of the change of address, contact your agency's Benefits Coordinator to complete a Change Request Form, or make your address change online in the Benefits Administration System (BAS) under the Basic Information screen.

Prescription Drug Plan Creditable Coverage Statement

The Employee Benefits Department has determined that the

prescription drug coverage with the State of Oklahoma Employee Benefits Department Health Plans is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Because your coverage through your health plan offered through the Council is on average at least as good as standard Medicare prescription drug coverage, you can keep your coverage and not pay extra if you later decide to enroll in Medicare coverage. If you decide to enroll in a Medicare prescription drug plan and drop your State of Oklahoma Employee Benefits Department prescription drug coverage, be aware that you may not be able to get this coverage back. A notice of creditable coverage is provided in the back pocket of this Guide and can also be obtained by contacting the Employee Benefits Department at (405) 522-1190 or downloading a copy from the Benefits website at www.ebc.ok.gov

Automatic Premium Conversion Election:

A "negative" or "automatic" enrollment into Premium Conversion has been instituted by the Employee Benefits Department effective January 1, 2007. The employee is automatically enrolled in the cafeteria (pre-tax premium) program unless he or she explicitly elects not to enroll. The employee can decline coverage under premium conversion resulting in not having his or her salary reduced. During new hire enrollment, an employee can decline coverage by checking the "No" box in the Premium Conversion section of the paper enrollment form. During Option Period, the employee can decline coverage by electing "No" to premium conversion during online enrollment, or checking the "No" box in the Premium Conversion section of the paper enrollment form. An election made will be effective for the entire plan year and is subject to the Internal Revenue Service irrevocability rules for benefit elections. Changes can be made to Option Period elections only if the change is authorized and consistent with Internal Revenue Service regulations. If near or contemplating retirement, employees are advised to consult a tax professional to discuss participation in the cafeteria plan on a pre-tax basis and determine the impact, if any, on their future retirement benefits.

Glossary

BAS – Benefits Administration System – Benefits system for all active state employees. You can sign on from www.ebc.ok.gov (upper right corner).

Co-insurance – A percentage of each health insurance claim above the deductible paid by the member. For a 20-percent health coinsurance clause, the policyholder pays for the deductible and co-pay, plus 20 percent of covered charges, while the plan pays the other 80 percent.

Co-pay – A predetermined, flat fee an individual pays for health, dental or vision care services, in addition to what insurance covers.

“Cover One, Cover All” – All eligible dependents must be covered when one dependent is covered under health, dental, or vision insurance unless proof of other group coverage is provided.

Coverage – The scope of protection provided under an insurance policy.

Date of Service – The date the medical care is provided to the participant (date of prescription, order date of glasses, dentures, hearing aids, etc.), not when formally billed, charged for, or paid. For terminated employees: date of medical care must be prior to the end of the month of the termination month.

Deductible – Amount of loss that the insured pays before the insurance kicks in.

Dependent – A family member or other person who is supported financially by another, especially one living in the same house. This typically includes the spouse and/or eligible children of the state employee.

Employee ID – 6-digit number assigned by the Office of State Finance for all employees. The Employee ID appears on your payroll stub. The Employee ID is used to access the Benefits Administration System (BAS).

Explanation of Benefits (EOB) – A report from your insurance carrier that shows what recent treatment was allowed as covered under your plan, what they have paid, what the provider must write off, and what the employee owes for particular dates of service.

Flexible Spending Account (FSA) – An account in which an employee can deposit payroll deductions for future medical or childcare expenses and in so doing, reduce taxable income.

Grace Period – January 1 to March 15. This is the period of time when you can use previous year funds from your spending account for current year services. This period of time allows employees with a previous years balance to continue to spend funds that would otherwise have been forfeited. Our system is programmed to use these funds first whenever claims are processed during the grace period.

HMO – Health Maintenance Organization. Available HMOs feature Standard (higher levels of coverage) and Alternative options. Out-of-pocket expenses for members

are limited to set co-pays. All have defined coverage areas, based on zip codes.

Health Savings Account (HSA) – An account that allows you to contribute pre-tax money to be used for qualified medical expenses. HSAs, which are portable, must be linked to a high-deductible health insurance policy.

Itemized Statement – Itemized Invoice from the person providing services showing NATURE OF the expense, FOR WHOM it was incurred, AMOUNT CHARGED for the services, and DATES OF SERVICES including insurance payment and any write off (or denies to pay). Cancelled checks and charge receipts do not include the necessary information.

OTC Rule – The health care reform legislation signed into law by the President impacts over-the-counter (OTC) purchases with Health Care Flexible Spending Accounts beginning in January of 2011. OTC drugs, medicines and biologicals remain eligible, but only with a letter of medical necessity from a medical provider. NOTE: Because these items now require a doctor's directive, these items can no longer be purchased by the debit card program; however, they could be reimbursed by filing a paper claim with a doctor's letter of medical necessity.

PCP – Primary Care Physician. This is the doctor you typically see first for medical problems and routine care. Naming a PCP is required for state employees and their families who choose an HMO.

PPO – Preferred Provider Organization. The only PPO like options for state employees and their families come from HealthChoice's plans, which operate as PPOs and self-insured indemnity plans. The plans are available statewide and out-of-pocket expenses include co-pays, deductibles and co-insurance.

Premium Audit – A review of an employee's benefits account that seeks to reconcile premiums paid with premiums due, according to enrolled options.

Accounts are periodically audited to assure accuracy. A notification may be sent to the employee and their agency if insurance premiums or flexible spending accounts are found to have been overpaid or underpaid.

Premium Conversion – A program based on federal tax rules that let employees deduct their share of insurance premiums from their taxable income, thereby reducing their taxes.

“Use It or Lose It” – FSA participants must spend their total annual election amount by March 15th of the following year, otherwise the remaining funds will be forfeited. For example, if participants did not use all of their Plan Year 2013 FSA funds by March 15, 2014, they would lose those funds.

