

Benefits Enrollment Guide

Plan Year 2016
Jan. 1 through Dec. 31, 2016



WHAT'S NEW FOR 2016?

Please take some time to review this Benefits Enrollment Guide before you make your selections. If you have questions or need further information about plan benefits, contact each plan directly. If you have questions about your benefits as a State employee, please contact your Benefits Coordinator.

We look forward to serving you in 2016.

HEALTH PLAN OFFERINGS

There will be five health plan providers for PY 2016. CommunityCare HMO, GlobalHealth HMO and HealthChoice will be joined by Aetna INTEGRIS HMO and BlueLincs HMO. Each plan is different so please review the plans in the "Comparison of Network Benefits for Health Plans on pages 22-29.

YOUR BENEFIT ALLOWANCE

There is no change to the Benefit Allowance for Plan Year 2016.

FLEXIBLE SPENDING ACCOUNT CONTRIBUTION LIMITS

Flexible Spending Account Health Care Accounts (HCA) contributions will be limited to \$2,550 for 2016. Note that this new limit is per employee, regardless of whether you cover just yourself or your family. Most people put away less than this, but if you are one of those who take full advantage of the State's current maximum, you may see a reduction in the amount you are able to save in the future.

THE STATE OF OKLAHOMA EMPLOYEE WELLNESS PROGRAM

OKHEALTH is now the State of Oklahoma Employee Wellness Program. For information on the program, refer to page 39.

NEW LOGO

As a result of legislation passed in 2011, the Employee Benefits Council that administered insurance benefits for state employees was consolidated under the Office of State Finance, now known as the Office of Management and Enterprise Services (OMES). The former state agency is now a department of the Office of Management and Enterprise Services Human Capital Management and is known as the Employee Benefits Department (EBD).

In an effort to develop the consistent, cohesive identity, key to any organization's success, OMES adopted a new logo as seen below and on the front cover of this guide. The logo's dominant element, the "O", represents the agency's connectivity and collaborative spirit. The feathers on the "O" are inspired by the feathers on Oklahoma's state flag and the scissortail flycatcher, Oklahoma's state bird known – as OMES is – for its resourcefulness and tenacity. The logo's clean, modern, progressive design embodies our status as a technology-driven, forward-thinking agency. In the future, you will see the OMES logo or its slimmer sibling, the "O", on all EGID communications.



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A fully accessible version of this guide is available at www.ebd.ok.gov.

2016 MONTHLY BENEFIT ALLOWANCES	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
	640.98	1,312.75	1,542.66	1,677.96	870.89	1,006.19

2016 MONTHLY PLAN RATES

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Aetna INTEGRIS HMO	515.82	1,361.58	1,633.30	1,794.80	787.54	949.04
BlueLincs HMO	595.34	1,571.74	1,885.50	2,071.92	909.10	1,095.52
CommunityCare HMO	796.14	1,955.52	2,361.30	2,604.60	1,201.62	1,444.92
GlobalHealth HMO	499.76	1,237.44	1,507.42	1,678.30	769.74	940.62
HealthChoice High and High Alternative	526.88	1,188.10	1,455.60	1,600.82	794.38	939.60
HealthChoice Basic and Basic Alternative	397.82	886.20	1,114.02	1,237.34	625.64	748.96
HealthChoice High Deductible Health Plan (HDHP)	345.86	767.62	964.70	1,070.54	542.94	648.78
HealthChoice USA	806.48	1,612.96	1,877.82	2,021.42	1,071.34	1,214.94
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	28.82	57.48	78.98	115.28	50.32	86.62
Assurant Heritage Plus (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 PPO Plus Premier	44.52	89.04	127.82	187.10	83.30	142.58
Delta Dental PPO – Choice	15.06	49.24	83.68	132.84	49.50	98.66
HealthChoice Dental	32.00	64.00	91.40	132.20	59.40	100.20

VISION	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Humana Vision Care Plan	7.14	19.60	30.50	31.44	18.04	18.98
Primary Vision Care Services (PVCS)	9.36	17.36	25.36	28.36	17.36	20.36
Superior Vision	7.40	14.76	21.72	29.06	14.36	21.70
UnitedHealthcare Vision	8.18	13.96	18.54	20.94	12.76	15.16
Vision Care Direct	15.90	25.64	35.38	38.64	25.64	28.90
Vision Service Plan (VSP)	9.50	15.86	21.98	29.58	15.62	23.22

DISABILITY	9.10
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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	1.20	30 - 34	1.20	35 - 39	1.20
Standard Option	4.32	40 - 44	1.60	45 - 49	2.80	50 - 54	5.20
Premier Option	8.64	55 - 59	8.00	60 - 64	9.20	65 - 69	14.80
		70 - 74	25.60	75+	39.20		

2016 BIWEEKLY BENEFIT ALLOWANCES	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
	320.49	656.38	771.33	838.98	435.45	503.10

2016 BIWEEKLY PLAN RATES

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Aetna INTEGRIS HMO	257.91	680.79	816.65	897.40	393.77	474.52
BlueLincs HMO	297.67	785.87	942.75	1,035.96	454.55	547.76
CommunityCare HMO	398.07	977.91	1,180.65	1,302.30	600.81	722.46
GlobalHealth HMO	249.88	618.72	753.71	839.15	384.87	470.31
HealthChoice High and High Alternative	263.44	594.05	727.80	800.41	397.19	469.80
HealthChoice Basic and Basic Alternative	198.91	443.10	557.10	618.67	312.82	374.48
HealthChoice High Deductible Health Plan (HDHP)	172.93	383.81	482.35	535.27	271.47	324.39
HealthChoice USA	403.24	806.48	938.91	1,010.71	535.67	607.47
TRICARE Supplement	29.50	59.00	88.50	109.00	59.00	79.50
DENTAL	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Assurant Freedom Preferred	14.41	28.74	39.49	57.64	25.16	43.31
Assurant Heritage Plus (Prepaid)	5.87	10.30	14.10	17.90	9.67	13.47
Assurant Heritage Secure (Prepaid)	3.60	6.59	9.19	11.78	6.20	8.79
CIGNA Dental Care Plan (Prepaid)	4.63	7.66	11.20	15.32	8.17	12.29
Delta Dental PPO	16.82	33.63	48.26	70.65	31.45	53.84
Delta Dental PPO Plus Premier	22.26	44.52	63.91	93.55	41.65	71.29
Delta Dental PPO – Choice	7.53	24.62	41.84	66.42	24.75	49.33
HealthChoice Dental	16.00	32.00	45.70	66.10	29.70	50.10
VISION	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Humana Vision Care Plan	3.57	9.80	15.25	15.72	9.02	9.49
Primary Vision Care Services (PVCS)	4.68	8.68	12.68	14.18	8.68	10.18
Superior Vision	3.70	7.38	10.86	14.53	7.18	10.85
UnitedHealthcare Vision	4.09	6.98	9.27	10.47	6.38	7.58
Vision Care Direct	7.95	12.82	17.69	19.32	12.82	14.45
Vision Service Plan (VSP)	4.75	7.93	10.99	14.79	7.81	11.61
DISABILITY	4.55					
LIFE INSURANCE OPTIONS						
Life	2.00	Supplemental Life First Unit		\$2.00		
Dependent Life		Supplemental Life Age Rated (Per \$20,000)				
Low Option	1.30	< 30	0.60	30 - 34	0.60	35 - 39 0.60
Standard Option	2.16	40 - 44	0.80	45 - 49	1.40	50 - 54 2.60
Premier Option	4.32	55 - 59	4.00	60 - 64	4.60	65 - 69 14.80
		70 - 74	12.80	75+	19.60	

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This information is only a brief summary of the plans. All benefits and limitations of these plans are governed in all cases by the relevant plan documents, insurance contracts, handbooks and *Administrative Rules* of the Office of Management and Enterprise Services. The rules of the Oklahoma Administrative Code, Title 260, are controlling in all aspects of plan benefits. No oral statement of any person shall modify or otherwise affect the benefits, limitations or exclusions of any plan.

2016 PLAN CHANGES AND IMPORTANT REMINDERS

Plan changes are indicated by **bold text** in the comparison of benefits charts.

HEALTH PLANS

Aetna INTEGRIS HMO – New for 2016

- ◆ Aetna INTEGRIS HMO is being offered for 2016. It is not just a new medical plan, but a whole new way of looking at health care. The plan is designed to improve the quality of your care, provide a better experience for you and your family, and do it all while saving you money.

Aetna INTEGRIS HMO offers the INTEGRIS Health Partners Network, a special group of local primary care providers, specialists, hospitals and other health professionals who share the responsibility for your health. Refer to “HMO ZIP Code Lists” and “Comparison of Network Benefits for Health Plans” for more information. Visit Aetna INTEGRIS HMO’s website at www.integris.aetna.com/stateofok for participating providers.

BlueLincs HMO – New for 2016

- ◆ BlueLincs HMO is being offered for 2016. Its ZIP code service area encompasses the entire State of Oklahoma, and its network currently includes 1,266 primary care physicians, 3,252 specialists and 73 acute care hospitals.

BlueLincs HMO also offers out-of-area coverage to members when they live, work or travel outside of the HMO service area. The out-of-area coverage program consists of two components: Urgent Care and Guest Membership®. The Urgent Care component enables members to receive care for an unexpected illness or injury when they are outside of Oklahoma. Guest Membership is available to BlueLincs HMO members temporarily living outside of their home state for at least 90 consecutive days. Guest Membership coverage is helpful for covered students who are living out-of-state while attending school or for members on extended travel out-of-state. Refer to “HMO ZIP Code Lists” and “Comparison of Network Benefits for Health Plans” for more information. Visit BlueLincs HMO’s website at www.bcbsok.com/state for participating providers.

CommunityCare HMO

- ◆ CommunityCare is expanding its service area. Refer to “HMO ZIP Code Lists” to determine if you live or work in their area.
- ◆ Some copays are increasing and others are decreasing. Changes are listed in **bold text** in “Comparison of Network Benefits for Health Plans.”

GlobalHealth HMO

- ◆ Some copays are decreasing. Changes are listed in **bold text** in “Comparison of Network Benefits for Health Plans.”
- ◆ Copays for select generic medications are changing to \$5.

HealthChoice Health Plans

- ◆ HealthChoice has a new pharmacy benefit manager (PBM), CVS/caremark. All current and new HealthChoice health plan members will receive new pharmacy ID cards.

With the transition to the new PBM, there will be little change to the pharmacies participating in the HealthChoice Pharmacy Network. All major chains, such as CVS, Target, Walgreens, Walmart, etc., as well as local independent pharmacies, will continue to be part of the Network.

There will be some changes to the list of Preferred medications. If you are a HealthChoice health plan member who is taking a medication that will no longer be covered in 2016, you will be notified by mail. For a complete list of medications that will no longer be covered, please visit www.sib.ok.gov.

If you currently have a prior authorization for a medication, it will transfer to the new PBM.

HealthChoice High, High Alternative, Basic, Basic Alternative Plans and High Deductible Health Plan

- ◆ HealthChoice is introducing the HealthChoice Select Provider Network. This special network of facilities will provide certain services to members at one low, bundled price that will be covered at 100% with no out-of-pocket costs to members.

Initially, only colonoscopy and sigmoidoscopy services will be offered by the HealthChoice Select Provider Network. To encourage members to get these colorectal cancer screenings and use the Select Provider Network, HealthChoice will provide a \$100 incentive payment to members once per calendar year.

Beginning Jan. 1, 2016, for the most current list of facilities participating in the HealthChoice Select Provider Network and the most current list of procedures covered under bundled pricing, select “Find a Provider” in the top menu bar of the HealthChoice website at www.sib.ok.gov; select “Medical and Dental Providers” under “HealthChoice Provider Listings,” and then choose “Select Network” from the top menu bar.

- ◆ HealthChoice is covering two preventive services office visits per calendar year for members and dependents ages 18 and older at 100% when using a HealthChoice Network Provider.

HealthChoice High Deductible Health Plan

- ◆ The maximum annual contribution for a family is increasing from \$6,650 to \$6,750.

VISION PLANS

Vision Care Direct

- ◆ The allowance for frames and conventional and disposable contact lenses is decreasing to \$130.

REMINDER

If you are enrolled in the HealthChoice High or Basic Plan and wish to stay enrolled in that plan for 2016, you must complete the online tobacco-free Attestation for Plan Year 2016 available on the HealthChoice website at www.sib.ok.gov by Nov. 13, 2015.

The Attestation is waived for the first year of enrollment in the High or Basic Plan but is required each year thereafter to remain enrolled. If you are in the process of quitting tobacco, you must be tobacco-free for 90 days prior to the deadline to attest to being tobacco-free.

If you cannot complete the tobacco-free Attestation because you or your covered adult dependents are not tobacco-free, you can still qualify for the HealthChoice High or Basic Plan if you can complete one of the following Reasonable Alternatives:

- ◆ Show proof of an attempt to quit using tobacco by enrolling in the quit tobacco program available through the Oklahoma Tobacco Helpline and Alere Wellbeing AND completing three coaching calls by Nov. 13, 2015; or
- ◆ Provide a letter from your doctor by Nov. 13, 2015, indicating it is not medically advisable for you or your covered dependents to quit tobacco.

If you do not complete the tobacco-free Attestation or complete one of the Reasonable Alternatives as defined on the previous page, you will automatically be enrolled in the HealthChoice High Alternative or Basic Alternative Plan effective Jan. 1, 2016, and your annual deductible will be \$250 higher.

GENERAL INFORMATION

The benefits you select will be in effect Jan. 1, 2016, or for new employees, the effective date of your coverage, through Dec. 31, 2016, or your termination date if earlier.

After enrollment, the plans you select will provide more information about your benefits. Contact each plan directly if you have questions about your benefits.

Once enrolled in any of the plans, it is your responsibility to review your benefits carefully so you know what is covered, as well as the plan's policies and procedures, before you use your benefits.

Enrollment in a plan does not guarantee that a provider will remain in your plan's network for the entire year. You enroll with the plan and not the provider. If your provider terminates his or her contract during the plan year, this does not allow you to change your plan carrier.

HEALTH PLANS

There are ten health plans available:

- ◆ Aetna INTEGRIS HMO
- ◆ BlueLincs HMO
- ◆ CommunityCare HMO
- ◆ GlobalHealth HMO
- ◆ HealthChoice High and High Alternative Plans
- ◆ HealthChoice Basic and Basic Alternative Plans
- ◆ HealthChoice HDHP
- ◆ HealthChoice USA Plan

Refer to “Comparison of Network Benefits for Health Plans” on pages 22-29 for benefit information.

- ◆ There are no preexisting condition exclusions or limitations applied to any of the health plans.
- ◆ All health plans coordinate benefits with other group insurance plans you have in force.
- ◆ You must **live or work** within an HMO's ZIP code service area to be eligible. Post office box addresses cannot be used to determine your HMO eligibility. Refer to pages 14-21 for the “HMO ZIP Code Lists.”
- ◆ If you select an HMO, you must use the provider network designated by that plan for Oklahoma.
- ◆ To remain enrolled in the HealthChoice High or Basic Plan for Plan Year 2016, you must complete the tobacco-free Attestation located on the HealthChoice website or a Reasonable Alternative.
- ◆ The HealthChoice USA Plan is designed for employees who receive work assignments of more than 90 consecutive days outside of Oklahoma and Arkansas. HealthChoice USA members have access to the ChoiceCare Network, one of the largest provider networks in the country.
- ◆ HealthChoice contracts with American Fidelity Health Services Administration to make establishing and keeping a health savings account (HSA) easier and more convenient for HealthChoice HDHP members. For more information about HSAs, contact American Fidelity at the number located in “Contact Information” at the back of this guide.

DENTAL PLANS

There are eight dental plans available:

- ◆ Assurant Freedom Preferred
- ◆ Assurant Heritage Plus (Prepaid)
- ◆ Assurant Heritage Secure (Prepaid)
- ◆ CIGNA Dental Care Plan (Prepaid)
- ◆ Delta Dental PPO
- ◆ Delta Dental PPO Plus Premier
- ◆ Delta Dental PPO – Choice
- ◆ HealthChoice Dental

Refer to “Comparison of Benefits for Dental Plans” on pages 30-31 for benefit information.

- ◆ You must select a primary care dentist for yourself and each covered dependent when enrolling in a prepaid dental plan.
- ◆ Out-of-network benefits may allow dentists to balance bill. Balance billing is the practice of a provider charging full fees and billing the member for the portion of the bill insurance doesn't cover.
- ◆ 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 copay schedule for Assurant Secure plan specialist services. Assurant Secure plan specialists reduce their charges as follows:
 - 15 percent discount off normal retail charges for endodontist; and
 - 25 percent discount for any other plan specialist, including orthodontist.
- ◆ Assurant Freedom Preferred and HealthChoice have a 12-month waiting period for orthodontic benefits.
- ◆ Visit each plan's website for a list of participating providers.

VISION PLANS

There are six vision plans available:

- ◆ Humana Vision Care Plan
- ◆ Primary Vision Care Services (PVCS)
- ◆ Superior Vision
- ◆ UnitedHealthcare Vision
- ◆ Vision Care Direct
- ◆ Vision Service Plan (VSP)

Refer to “Comparison of Benefits for Vision Plans” on pages 32-34 for benefit information.

- ◆ Verify your vision provider participates in a vision plan's network by contacting the plan, visiting the plan's website or calling your provider.
- ◆ All vision plans have limited coverage for services provided by out-of-network providers.

If your provider leaves your health, dental or vision plan, you cannot change plans until the next annual Option Period; however, you can change providers within your plan's network as needed.

HEALTHCHOICE LIFE INSURANCE PLAN

- ◆ As a **new employee**, you can elect life insurance coverage within 30 days of your employment or initial eligibility date. You can enroll in Guaranteed Issue, in addition to Basic Life, without a “Life Insurance Application.” Guaranteed Issue is two times your annual salary rounded up to the nearest \$20,000. All requests for supplemental coverage above Guaranteed Issue require you to submit a “Life Insurance Application” for approval.
- ◆ As a **current employee**, if you did not enroll when first eligible, you can enroll:
 - During the annual Option Period (enroll in or increase life coverage); or
 - Within 30 days of a midyear qualifying event, such as birth of a child or marriage by submitting a “Life Insurance Application” for approval. A “Life Insurance Application” is available from your insurance coordinator.

As a current employee, you can also enroll in life insurance coverage within 30 days of the loss of other group life coverage. You are eligible to enroll in the amount of coverage you lost rounded up to the next \$20,000 unit without submitting a “Life Insurance Application” for approval. Proof of the loss of other coverage is required.

Basic Life Insurance . . . For You

- ◆ Basic Life pays a benefit of \$20,000 to your beneficiary in the event of your death.
- ◆ Basic Life includes Accidental Death and Dismemberment (AD&D) benefits, which pays an additional \$20,000 to your beneficiary if your death is due to an accident. It also pays benefits if you lose your sight or a limb due to an accident.

Supplemental Life Insurance . . . For You

- ◆ You can enroll in Supplemental Life in units of \$20,000. The maximum amount of Supplemental Life coverage available is \$500,000. You must complete and submit a “Life Insurance Application” which must be approved before coverage begins.
- ◆ The first \$20,000 of Supplemental Life provides an additional \$20,000 of AD&D benefits.

Beneficiary Designation

For Basic and Supplemental Life benefits, you must name your beneficiary(ies) when you enroll. Your designation can be changed at any time. For a “Beneficiary Designation Form” or more information, contact your benefits coordinator. This form is also available at www.sib.ok.gov. Life insurance benefits are paid according to the information on file.

Dependent Life Insurance . . . For Your Eligible Dependents

- ◆ If you are enrolled in Basic Life insurance, you can elect Dependent Life for your spouse and other eligible dependents during your initial enrollment, the annual Option Period, or within 30 days of the loss of other group life insurance or other midyear qualifying event without a “Life Insurance Application.”

- ◆ Each eligible dependent must be enrolled in Dependent Life. Regardless of the number of dependents covered, the monthly premium is a flat amount. Benefits are paid only to the member. Below are the three levels of coverage:

DEPENDENT	LOW OPTION	STANDARD OPTION	PREMIER OPTION
Spouse	\$ 6,000 of coverage	\$ 10,000 of coverage	\$ 20,000 of coverage
Child (live birth to age 26)	\$ 3,000 of coverage	\$ 5,000 of coverage	\$ 10,000 of coverage

Dependent Life does not include AD&D benefits.

HEALTHCHOICE DISABILITY PLAN

The HealthChoice Disability Plan provides partial replacement income if you are unable to work due to an illness or injury. Disability coverage is not available to dependents.

Eligibility

Enrollment in the Disability Plan begins the first day of the month following your employment date or the date you become eligible. You become eligible for disability benefits after 31 consecutive days of employment. During that time, you must continuously perform all of the material duties of your regular occupation. Any claim for disability benefits must be filed within one year of the date your disability began. Contact your benefits coordinator for more information.

ENROLLMENT

Benefits Enrollment Calculator

Your benefits costs can be easily estimated using the online “Benefits Enrollment Calculator” located on the website at www.ebd.ok.gov. Be sure to choose the monthly calculator if you are paid once a month or the biweekly 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 Benefits 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 BAS link on the website 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.

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. The benefit allowance was frozen at the Plan Year 2012 rate and remains at that level for 2016. Refer to the benefit allowances at the top of the plan rates charts at the beginning of this guide. The amounts are provided based upon the health election you choose.

Online Enrollment

Enroll Online!

Remember: Online enrollment opens Oct. 1 and closes Oct. 30, 2015.

Customer assistance is available Oct. 1 through 30 from 8 a.m. – 4 p.m. Assistance is also available by submitting a help ticket through the help desk of the website at: helpdesk@omes.ok.gov.

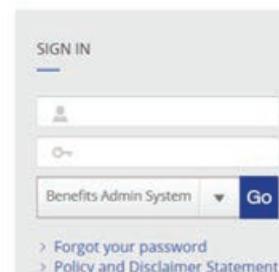
Last year, 93 percent of state employees went to www.ebd.ok.gov and used online enrollment to make their benefit elections. Join your co-workers and discover how easy it is to enroll online. The average enrollment takes just a few minutes and you can log on anytime, 24 hours a day, seven days a week during Option Period.

Online enrollment allows you to:

- ◆ Print your confirmation of benefits (COB) 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.ebd.ok.gov. Sign in to the Benefits Administration System Sign-In area using your six digit employee number and password. If you have forgotten your password, select “Forgot Password.”
2. Follow instructions to set your personal password.
3. Choose “Online Enrollment” and begin.
4. Be sure to **“Submit”** at the end of the enrollment process.

On the home page of www.ebd.ok.gov, the BAS access window is on the right 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 six digit employee number, make sure you update your email address, home address and phone number.



Login Box

For online enrollment in the Benefits Administration System (BAS) (refer to image at right). It is located on the EBD home page, www.ebd.ok.gov. Notice the “SIGN IN” 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, and need to reset it, select “Forgot Your Password” and you will be directed to a screen where you can update your password.

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 IRS 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.

Midyear Changes

Life events that qualify you to change your benefit elections midyear 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 DCA using unrelated care provider);
- ◆ Changes in coverage of spouse or dependent under other employer's plan (except HCA); and
- ◆ 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 IRS Code regulations promulgated under, and in accordance with EBD and EGID rules and regulations.

ENROLLMENT PERIODS

Option Period Enrollment – Coverage effective Jan. 1, 2016

This is the time when eligible employees can:

- Enroll in coverage;
 - Change plans or drop coverage;
 - Increase or decrease life coverage; and/or
 - Add or drop eligible dependents from coverage.
- ◆ You can enroll in health, dental, life and/or vision coverage for yourself and/or your dependent(s) during the annual Option Period, as long as you have not dropped that coverage within the past 12 months. If you have dropped coverage within the past 12 months without a midyear qualifying event, you cannot reinstate that coverage for at least 12 months.

Initial Enrollment – Coverage effective the first of the month following your employment date

This is the time when new employees are eligible to:

- Enroll in coverage;
- Enroll eligible dependents; and
- Apply for life insurance coverage above Guaranteed Issue by submitting a “Life Insurance Application” for review and approval.

As a new employee, you have 30 days from your employment or enter-on-duty date to enroll in coverage. If you do not enroll within 30 days, you will be enrolled in the default plans (HealthChoice High, HealthChoice Dental, Disability and HealthChoice Basic Life). Check with your benefits coordinator for more information.

You have 30 days following your enter-on-duty date to make changes to your original enrollment.

HIPAA Special Enrollment Rights – Coverage generally effective the first of the month following a qualifying event

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your benefits coordinator.

ELIGIBILITY

Members

- ◆ You must be a current state employee regularly scheduled to work at least 1,000 hours a year, and not classified as temporary or seasonal.
- ◆ Effective Jan. 1, 2015, any current state employee regularly scheduled to work 30 hours per week shall be eligible for and offered insurance coverage under the provisions of the *Patient Protection and Affordable Care Act*.
- ◆ 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.
- ◆ You must be enrolled in a group health plan to enroll in dental and/or life insurance.

Dependents

The *Working Families Tax Relief Act* of 2004 changed the definition of dependent for federal income tax purposes, effective Jan. 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.

- ◆ If one eligible dependent is covered, all eligible dependents must be covered. Exceptions apply (refer to “Excluding Dependents from Coverage” in this section).
- ◆ Eligible dependents include:
 - Your legal spouse (including common-law);
 - Your daughter, son, stepdaughter, stepson, eligible foster child, adopted child or child legally placed with you for adoption up to age 26, whether married or unmarried;
 - A dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26. Subject to medical review and approval; and
 - Other unmarried dependent children up to age 26, upon completion and approval of an “Application for Coverage for Other Dependent Children.” Guardianship papers or a tax return showing dependency can be provided in lieu of the application.
- ◆ If your spouse is enrolled separately in one of the plans offered through EGID, your dependents can be covered under either parent’s health, dental and/or vision plan (but not both); however, both parents can cover dependents under Dependent Life.
- ◆ Dependents who are not enrolled within 30 days of your eligibility date cannot be enrolled until the next annual Option Period, unless a qualifying event such as birth, marriage or loss of other group coverage occurs. Dependent coverage can be dropped midyear with a qualifying event. If you drop dependent coverage due to leave without pay or workers compensation, you cannot reinstate coverage for at least 12 months.
- ◆ Dependents can be enrolled only in the same types of coverage and in the same plans you elect.
- ◆ To enroll your newborn, the appropriate form must be provided to your benefits coordinator within 30 days of the birth. This coverage is effective the first of the birth month. If you do not enroll your newborn during this 30-day period, you cannot do so until the next annual Option Period. Direct notification to a plan will not enroll your newborn or any other dependents. The newborn’s Social Security number is not required at the time of initial enrollment, but must be provided once it is received from Social Security. Insurance premiums for the month the child was born must be paid.

- ◆ Without enrollment:
 - BlueLincs and HealthChoice – A newborn is covered only for the first 48 hours following a vaginal birth or the first 96 hours following a C-section birth. Under the HealthChoice Plans, a separate deductible and coinsurance apply.
 - Aetna INTEGRIS, CommunityCare and GlobalHealth HMOs – A newborn is covered for 31 days without an additional premium.

Opt Out Details

With the approval of House Bill (HB) 1107 in May 2013 (which revised HB 2088), 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 this title, or may opt out of the health and dental basic plan options only and retain the life and disability plan benefits, provided that the participant is currently covered by a separate group health insurance plan or will be covered by a separate group health insurance plan at or before the beginning of the next plan year. 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 the state’s basic plan or the health and dental basic plan options 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 law spells out, you may opt out of the “basic plan” (all benefits) or you may opt out of health and dental benefits only, if you are currently covered by a separate group health insurance plan, or will be covered by Jan. 1, 2016. In addition, you must provide proof of the separate group 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 and must be renewed each year. It will not rollover.

The “basic plan” described in the law consists of the following: health, dental, basic life and disability insurance. If you opt out of the “basic plan,” 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, if you opt out of health and dental only, you may retain both life and disability insurance. 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 rollover.

If you are considering opting out of the “basic plan,” please understand you are forfeiting the normal benefit allowance provided by your agency. In lieu of that benefit allowance, you will get \$150 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. If you are considering opting out of health and dental only, the \$150 per month can be used to purchase additional life insurance, vision insurance, FSA contributions and/or added to your net pay as taxable income.

Note: You must renew your opt-out each year. It will not rollover.

Excluding Dependents from Coverage

- ◆ You can exclude your spouse from health, dental and/or vision coverage while covering other dependents on these benefits. Your spouse must sign the appropriate spouse exclusion form. Check with your benefits coordinator for more information.
- ◆ You can exclude dependents who do not reside with you, are married, are not financially dependent on you for support, have other group coverage or are eligible for Indian or military health benefits.

Confirming Your Benefits

Once you enroll in and/or make changes to your benefits,

- ◆ The Employee Benefits Department provides “Confirmation of Benefits” (COB) to state employees.

Your COB lists the coverage you are enrolled in, the effective date of your coverage, and the premium amounts. Always review your COB to verify your coverage is correct.

Retiring and Changing Plans

If you are retiring on or before Jan. 1, 2016, go to www.sib.ok.gov for the appropriate Option Period materials. Select the Option Period banner, then select according to your status as of Jan. 1 – Pre-Medicare or Medicare. Your benefits coordinator can assist you and must also provide you the required “Application for Retiree/Vested/Non-Vested/Defer Insurance.” If you and/or your dependent(s) will be Medicare eligible by Jan. 1, an additional form will be required to enroll in Medicare Part D. You can also call EGID Member Services for assistance. Refer to “Contact Information” at the back of this guide.

Termination of Coverage

- ◆ Coverage will end the last day of the month in which a termination event occurs, such as:
 - Loss of employment;
 - Reduction in hours;
 - Loss of dependent eligibility;
 - Non-payment of premiums; or
 - Death.

COBRA – Temporary Continuation of Coverage

- ◆ The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows you and/or your covered dependents to continue health, dental and/or vision insurance coverage after your employment terminates or after your dependent loses eligibility. Certain time limits apply to enrollment. Contact your benefits coordinator immediately upon termination of your employment, or when changes to your family status occur, to find out more about your COBRA rights. **Be aware, dropping dependent coverage during Option Period is not a COBRA qualifying event.**

Aetna INTEGRIS ZIP Code List

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BlueLincs ZIP Code List

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BlueLincs ZIP Code List

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BlueLincs ZIP Code List

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CommunityCare ZIP Code List

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GlobalHealth ZIP Code List

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GlobalHealth ZIP Code List

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73947	73949	73950	73951	74001	74002	74003
74004	74005	74006	74008	74010	74011	74012
74013	74014	74015	74016	74017	74018	74019
74020	74021	74022	74023	74026	74027	74028
74029	74030	74031	74032	74033	74034	74035
74036	74037	74038	74039	74041	74042	74043
74044	74045	74046	74047	74048	74050	74051
74052	74053	74054	74055	74056	74058	74059
74060	74061	74062	74063	74066	74067	74068
74070	74071	74072	74073	74074	74075	74076
74077	74078	74079	74080	74081	74082	74083
74084	74085	74101	74102	74103	74104	74105
74106	74107	74108	74110	74112	74114	74115
74116	74117	74119	74120	74121	74126	74127
74128	74129	74130	74131	74132	74133	74134
74135	74136	74137	74141	74145	74146	74147
74148	74149	74150	74150	74153	74155	74156
74157	74158	74159	74169	74170	74171	74172
74182	74186	74187	74192	74193	74301	74330
74331	74332	74333	74335	74337	74338	74339
74340	74342	74343	74344	74345	74346	74347
74349	74350	74352	74354	74355	74358	74359
74360	74361	74362	74363	74364	74365	74366
74367	74368	74369	74370	74401	74402	74403
74421	74422	74423	74425	74426	74427	74428
74429	74430	74431	74432	74434	74435	74436
74437	74438	74439	74440	74441	74442	74444
74445	74446	74447	74450	74451	74452	74454
74455	74456	74457	74458	74459	74460	74461
74462	74463	74464	74465	74467	74468	74469
74470	74471	74477	74501	74521	74522	74523
74525	74528	74529	74530	74531	74533	74534
74535	74536	74538	74540	74543	74545	74546

GlobalHealth ZIP Code List

74547	74549	74552	74553	74554	74555	74556
74557	74558	74559	74560	74561	74562	74563
74565	74567	74569	74570	74571	74572	74574
74576	74577	74578	74601	74602	74604	74630
74631	74632	74633	74636	74637	74640	74641
74643	74644	74646	74647	74650	74651	74652
74653	74701	74702	74720	74721	74722	74723
74724	74726	74727	74728	74729	74730	74731
74733	74734	74735	74736	74737	74738	74740
74741	74743	74745	74747	74748	74750	74752
74753	74754	74755	74756	74759	74760	74761
74764	74766	74801	74802	74804	74818	74820
74821	74824	74825	74826	74827	74829	74830
74831	74832	74833	74834	74836	74837	74839
74840	74842	74843	74844	74845	74848	74849
74850	74851	74852	74854	74855	74856	74857
74859	74860	74864	74865	74866	74867	74868
74869	74871	74872	74873	74875	74878	74880
74881	74883	74884	74901	74902	74930	74931
74932	74935	74936	74937	74939	74940	74941
74942	74943	74944	74945	74946	74947	74948
74949	74951	74953	74954	74955	74956	74957
74959	74960	74962	74963	74964	74965	74966

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	Aetna INTEGRIS HMO	BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Calendar Year Deductible	No deductible	No deductible	No deductible	No deductible
Calendar Year Out-of-Pocket Maximum	\$3,000 individual \$4,500 family Includes all copays and coinsurance paid on covered services, prescriptions and durable medical equipment	\$4,000 individual \$8,000 family Includes all copays and coinsurance paid on covered services, prescriptions and durable medical equipment	\$4,000 individual \$8,000 family Includes all copays and coinsurance paid on covered services, prescriptions and durable medical equipment	\$3,500 individual \$10,500 family Includes all copays and coinsurance paid on covered services, prescriptions and durable medical equipment
Office Visit	\$25 copay/PCP \$50 copay/specialist	\$35 copay/PCP \$50 copay/specialist	\$35 copay/PCP \$50 copay/specialist	\$0 copay/PCP \$50 copay/specialist
X-Ray and Lab	\$0 copay for X-ray and lab \$0 copay per MRI, CAT, MRA or PET scan	\$0 copay for X-ray and lab; \$200 copay per scan for FOCUS Procedures (MRI, CT, PET, EEG, echocardiogram, MPS, and similar imaging tests; and procedures under CPTs of cytogenetic studies, surgical pathology or transcutaneous procedures	\$0 copay for X-ray and lab \$200 copay per scan Specialty scans: MRI, MRA, PET, CAT and nuclear scans	\$0 copay for X-ray and lab \$250 copay per scan in a free-standing/low-cost facility \$750 copay per scan in a hospital facility Specialty scans: MRI, MRA, PET, CAT and nuclear scans
Allergy Testing and Treatment	\$25 copay/PCP \$50 copay/specialist	\$35 copay/PCP \$50 copay/specialist \$30 copay for allergy serum and shots (once every 6 weeks)	\$35 copay/PCP \$50 copay/specialist \$30 serum and shots including a 6-week supply of antigen	\$0 copay/PCP \$50 copay/specialist \$30 serum and shots including a 6-week supply of antigen and administration

Plan changes are indicated by **bold text**.

This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact each plan. Refer to "Contact Information" at the back of this guide.

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	HealthChoice High, High Alternative and USA Plans	HealthChoice Basic and Basic Alternative Plans	HealthChoice HDHP
Calendar Year Deductible	<p>High and USA Plans \$500 individual \$1,500 family</p> <p>High Alternative Plan \$750 individual \$2,250 family</p>	<p>Basic Plan \$1,000 individual \$1,500 family Applies after Plan pays first \$500 of Allowable Fees</p> <p>Basic Alternative Plan \$1,250 individual \$1,750 family Applies after Plan pays first \$250 of Allowable Fees</p>	<p>\$1,500 individual \$3,000 family The individual deductible does not apply if two or more family members are covered The combined medical and pharmacy deductible must be met before benefits are paid</p>
Calendar Year Out-of-Pocket Maximum (High, High Alternative, Basic, Basic Alternative and USA Plans have a separate pharmacy out-of-pocket maximum, refer to page 29)	<p>High and USA Plans* Copays apply \$3,300 Network individual \$8,400 Network family \$3,800 non-Network individual \$9,900 non-Network family, plus amounts over Allowable Fees</p> <p>High Alternative Plan* Copays apply \$3,550 Network individual \$8,400 Network family \$4,050 non-Network individual \$9,900 non-Network family, plus amounts over Allowable Fees</p>	<p>Basic Plan \$4,000 individual \$9,000 family</p> <p>Basic Alternative Plan \$4,000 individual \$9,000 family</p>	<p>\$3,000 individual \$6,000 family Pharmacy copays apply to the out-of-pocket maximum but non-Network charges do not apply</p>
Office Visit	<p>\$30 copay/physician office visit** \$50 copay/specialist office visit</p>	<p>Copays do not apply All covered services, exceptions, limitations and conditions are identical to the HealthChoice High Plan</p> <p>Basic Plan \$0 of the first \$500 of Allowable Fees 100% of the next \$1,000 of Allowable Fees (deductible). Only Allowable Fees count toward the deductible; 50% of the next \$6,000 of Allowable Fees</p> <p>Basic Alternative Plan \$0 of the first \$250 of Allowable Fees 100% of the next \$1,250 of Allowable Fees (deductible). Only Allowable Fees count toward the deductible; 50% of the next \$5,500 of Allowable Fees</p> <p>Both Basic Plans \$0 of Allowable Fees over the individual or family out-of-pocket maximum You can use non-Network providers, but it will be more costly</p>	<p>You pay 100% of Allowable Fees until deductible is met \$30/\$50** office visit copay applies after deductible</p>
X-Ray and Lab	<p>20% of Allowable Fees after deductible</p>	<p>20% of Allowable Fees after deductible</p>	<p>20% of Allowable Fees after deductible</p>
Allergy Testing and Treatment	<p>20% of Allowable Fees after deductible Limit of 60 tests every 24 months</p>	<p>20% of Allowable Fees after deductible Limit of 60 tests every 24 months</p>	<p>20% of Allowable Fees after deductible Limit of 60 tests every 24 months</p>

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

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

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

Plan changes are indicated by **bold text**.

This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact each plan. Refer to "Contact Information" at the back of this guide.

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

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

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

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

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

Plan changes are indicated by **bold text**.

This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact each plan. Refer to "Contact Information" at the back of this guide.

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

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

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

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

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

Plan changes are indicated by **bold text**.

This is only a sample of the services covered by each plan. For services that are not listed in this comparison chart, contact each plan. Refer to "Contact Information" at the back of this guide.

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

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

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

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

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

HEALTHCHOICE HDHP

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

ALL HEALTHCHOICE PLANS

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

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

CDC vaccinations, such as for shingles, are covered at 100% when using a Network Pharmacy.

Note: These can also be covered under the health benefit if provided by a recognized Network health provider, such as a physician or health department.

COMPARISON OF BENEFITS FOR DENTAL PLANS

	Assurant Employee Benefits Freedom Preferred	Assurant Employee Benefits Heritage Plus and Heritage Secure	CIGNA Dental Care Plan (Prepaid)
Annual Deductible	\$25 per person, per policy year, waived for in-Network preventive services	No deductibles	No deductible or plan maximum \$5 office copay applies
Diagnostic and Preventive Care (cleanings, routine oral exams) Allowable Fees Apply	Network: \$0 Plan pays 100% of negotiated fee No deductible Non-Network: \$0 Plan pays 100% of usual and customary Deductible applies	No charge for routine cleaning (once every 6 months) No charge for topical fluoride application (up to age 18) No charge for periodic oral evaluations	Sealant: \$17 per tooth No charge for routine cleaning once every 6 months No charge for topical fluoride application (through age 18) No charge for periodic oral evaluations
Basic Care (extractions, oral surgery) Allowable Fees Apply	Network: 15% Plan pays 85% of usual and customary Non-Network: 30% Plan pays 70% of usual and customary Deductible applies	Fillings Minor oral surgery Refer to the copay schedule for each plan	Amalgam: One surface, permanent teeth \$23
Major Care (dentures, bridge work) Allowable Fees Apply	Network: 40% Plan pays 60% of usual and customary Deductible applies Non-Network: 50% Plan pays 50% of usual and customary Deductible applies	Root canal Periodontal Crowns Refer to the copay schedule for each plan	Root canal, anterior: \$375 Periodontal/scaling/root planing 1-3 teeth (per quadrant): \$75
Orthodontic Care Allowable Fees Apply	Network: 40% Plan pays 60% of negotiated fee Non-Network: 50% Plan pays 50% of usual and customary – deductible applies Network and Non-Network: \$2,000 lifetime maximum Coverage only for dependent children under age 19 12-month waiting period may apply	25% discount Adults and children	\$2,472 out-of-pocket for children through age 18 \$3,384 out-of-pocket for adults 24-month treatment excludes orthodontic treatment plan and banding
Plan Year Maximum	\$2,000 per person, per policy year	No annual maximum for general dentist	No maximum
Filing Claims	Member/provider must file claims	No claims to file	No claims to file

Plan changes are indicated by **bold text**.
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COMPARISON OF BENEFITS FOR DENTAL PLANS

	Delta Dental PPO In-Network and Out-of-Network	Delta Dental PPO Plus Premier In-Network and Out-of-Network	Delta Dental PPO – Choice PPO Network	HealthChoice Dental
Annual Deductible	\$25 per person, per year, applies to Basic and Major Care only	\$50 per person, per year, applies to Diagnostic, Preventive, Basic and Major Care	\$100 per person, per year, applies to Major Care only (Level 4)	Network: \$25 Basic and Major services combined Non-Network: \$25 Preventive, Basic and Major services combined plus amounts above Allowable Fees
Diagnostic and Preventive Care (cleanings, routine oral exams) Allowable Fees Apply	\$0 of allowable amounts No deductible applies	\$0 of allowable amounts after deductible	Schedule of covered services and copays Copay examples: Routine cleaning \$5 Periodic oral evaluation \$5 Topical fluoride application (up to age 19) \$5	Network: \$0 Non-Network: \$0 of Allowable Fees after deductible
Basic Care (extractions, oral surgery) Allowable Fees Apply	15% of allowable amounts after deductible	30% of allowable amounts after deductible	Schedule of covered services and copays Copay example: Amalgam - one surface, primary or permanent tooth \$12	Network: 15% Non-Network: 30% plus amounts above Allowable Fees Deductible applies
Major Care (dentures, bridge work) Allowable Fees Apply	40% of allowable amounts after deductible	50% of allowable amounts after deductible	Schedule of covered services and copays Copay examples: Crown - porcelain/ceramic substrate \$241 Complete denture – maxillary \$320	Network: 40% Non-Network: 50% plus amounts above Allowable Fees Deductible applies
Orthodontic Care Allowable Fees Apply	40% of allowable amounts, up to lifetime maximum of \$2,000 No deductible No waiting period Orthodontic benefits are available to the employee, their lawful spouse and eligible dependent children	40% of allowable amounts, up to lifetime maximum of \$2,000 No deductible No waiting period Orthodontic benefits are available to the employee, their lawful spouse and eligible dependent children	You pay amounts in excess of \$50 per month Lifetime maximum up to \$1,800 No deductible No waiting period Orthodontic benefits are available to the employee, their lawful spouse and eligible dependent children	Network: 50% Non-Network: 50% plus amounts above Allowable Fees 12-month waiting period applies No lifetime maximum Covered for members under age 19 and members ages 19 and older with TMD
Plan Year Maximum	\$2,500 per person, per year	\$3,000 per person, per year	\$2,000 per person, per year	Network and non-Network: \$2,500 per person, per year
Filing Claims	Claims are filed by participating dentists	Claims are filed by participating dentists	Claims are filed by participating dentists	Network: No claims to file Non-Network: You file claims

Plan changes are indicated by **bold text**.

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COMPARISON OF BENEFITS FOR VISION PLANS

	Humana Vision Care Plan		Primary Vision Care Services		Superior Vision	
Covered Services	In-Network	Out-of-Network	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	\$0 copay No limit to frequency	Plan pays up to \$40 Limit one exam	\$10 copay	Plan pays: \$34 Ophthalmologist \$26 Optometrist
Lenses Per Pair	\$25 copay for single/multi-focal lenses Discounts apply to lens options	Plan pays up to: \$25 single \$40 bifocals \$60 trifocals \$100 lenticular	You pay wholesale cost No limit to number of pairs	You pay normal doctor's fees, reimbursed up to \$60, for one set of lenses and frames annually	\$25 copay Standard Progressive: \$25 copay Refer to "Vision Plan Notes" after this chart	Plan pays: Single up to \$26 Bifocals up to \$39 Trifocals up to \$49 Lenticular up to \$78 Standard Progressive: Up to \$49
Frames	\$25 copay, up to plan limits One frame every calendar year	Plan pays up to \$45	You pay wholesale cost No limit to number of frames	You pay normal doctor's fees, reimbursed up to \$60 for one set of lenses and frames per year	\$25 copay then plan pays up to \$125 retail	Plan pays up to \$68
Contact Lenses	\$130 allowance for conventional or disposable lenses and fitting fee in lieu of all other benefits every calendar year Medically necessary, plan pays 100%	\$130 allowance for contacts and fitting fee in lieu of all other benefits Medically necessary, plan pays up to \$210	You pay wholesale cost for annual supply of contacts	Limit of one set annually in lieu of eyeglasses You pay normal doctor's fees reimbursed up to \$60	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)	Plan pays up to \$100 all contacts; \$210 medically necessary (Contact lens fit copay: Standard not covered; specialty not covered)
Laser Vision Correction	Members can access information on providers through the website or by calling customer service Refer to "Vision Plan Notes" after this chart	No benefit	Discount at nJoy Vision (formerly TLC, The Laser Center)	No benefit	5-50% discount off surgical fees	No benefit

For more information or details, contact each vision plan directly.

COMPARISON OF BENEFITS FOR VISION PLANS

	UnitedHealthcare Vision		Vision Care Direct		Vision Service Plan (VSP)	
Covered Services	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Eye Exams	\$10 copay	Reimbursed up to \$40	\$15 copay for full comprehensive exam including dilation	Plan pays up to \$40	\$10 copay	\$10 copay then plan pays up to \$35
Lenses Per Pair	\$25 copay UV coating, tint, scratch resistant coating, and polycarbonate lens options are covered in full Discounts apply to other lens options	Single up to \$40 Bifocals up to \$60 Trifocals up to \$80 Lenticular up to \$80	\$15 copay Single, bifocals, trifocals and no-line progressive lenses covered in full Anti-reflective and polycarbonate lenses are covered in full	Plan pays up to: \$30 single \$45 bifocals \$55 trifocals \$75 lenticular	\$25 copay applies to lenses or frame Single vision, lined bifocal and trifocal lenses covered in full Average 35-40% 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
Frames	\$25 copay	Reimbursed up to \$45	\$0 copay \$130 frame allowance each year	Plan pays up to \$35	\$25 copay then plan pays up to \$120	\$25 copay then plan pays up to \$45
Contact Lenses	\$25 copay on covered-in-full qualifying lenses Refer to "Vison Plan Notes" after this chart	Reimbursed up to \$150 elective contact lenses \$210 medically necessary contact lenses	\$130 allowance for conventional and disposable lenses \$250 allowance for medically necessary contacts	\$80 allowance for conventional, disposable and medically necessary contacts	Plan pays up to \$120 conventional or disposable; Medically necessary contacts covered in full	Plan pays up to \$105 conventional or disposable; \$210 medically necessary contacts
Laser Vision Correction	15% discount off the usual and customary price, 5% off promotional price	No benefit	15% discount Contact the plan prior to procedure	No benefit	15% average off usual and customary price or 5% off the laser center's promotional price	No benefit

For more information or details, contact each vision plan directly.

Vision Plan Notes

Humana Vision Care Plan: 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. Traditional Intralase (bladeless) with a lifetime plan with insurance discount is \$1,395 per eye. CustomVue Intralase (bladeless) with lifetime plan with insurance discount is \$1,784.15 per eye. Other Lasik locations include QualSight in Tulsa, Muskogee and Oklahoma City.

PVCS: The only Oklahoma owned and operated vision care plan with unlimited in-network services. Member selects either in-network or out-of-network for entire year. Out-of-network services are limited (one eye exam, one set of eyeglasses or contacts) 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-prescriptive eye wear. For more information or detail, call 1-888-357-6912 or go to www.pvcs-usa.com

Superior Vision: 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 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 new contact lens wearers and/or members who wear toric, gas permeable or multifocal lenses.

UHC Vision: For either glasses or contact lenses, there is a one-time \$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.

Vision Care Direct: A plan that will cost you less money overall. With the VCD plan, you can get your exam, frames and lenses (upgraded to polycarbonate, premium anti-reflective coatings and UV coatings) for \$30, even if you wear progressive no-line lenses. We are not an insurance company, and our focus is on delivering the very best patient care with quality materials at a very affordable price. Other plans may offer discounts for extra services, but we include the extras the doctor wants you to have, like polycarbonate lenses that are thinner, lighter and safer. We also include premium anti-reflection and UV coatings on our lenses because it's better for you and the doctor wants you to have it. Choose one of our 79 private line frames and you'll pay no more out of pocket than \$30 for single vision lenses and no-line progressives. If you want a brand-name frame, no problem; you simply pay a small \$40 unbundling fee and can choose any frame you want up to \$130. What would normally cost you over \$300 for progressive lenses will cost you much less with VCD. To see our private line of frames, visit <http://vcdlabs.biz/complete-eyewear-frame-kit/>. For our provider list, visit www.visioncaredirect.com/oklahoma and enter your ZIP code. For more information, visit www.visioncaredirect.com/oklahoma or call 1-855-918-2020 or text 918-695-3080.

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.

CHANGE OF ADDRESS

In the event of a change of address, contact your agency's benefits coordinator or make your address change online in BAS under the "Basic Information" screen.

BIWEEKLY BENEFITS TRANSITION

As a reminder, House Bill 1107, of the 1st session of the 54th Legislature, 2013, mandated the payment of the flexible benefit allowance for employees on biweekly payroll to be credited annually over 24 pay periods. In addition, benefit deductions for employees on biweekly payroll now occur over the same 24 pay periods.

The invoices for insurance benefits are 12 equal monthly payments for each enrolled employee. Because of the current 26 pay period arrangement, often there are not enough premiums collected from each employee to cover these invoices. On 'three-payday months,' there is usually too much collected. Payments deducted from the first two paychecks of each month correct this imbalance. The twice-monthly payments for benefits will equal the amount of the invoices.

FLEXIBLE SPENDING ACCOUNTS

The health care account (HCA) and dependent care account (DCA) let you set aside money from your paycheck, pretax, to pay for after-insurance, qualified medical expenses, deductibles, copays and certain over-the-counter (OTC) items and planned dependent care charges. You must enroll each Option Period or you lose the account.

Important Notes on FSA Accounts:

- ◆ You must enroll every year.
- ◆ Indicate your per-pay-period contribution when you enroll (not your annual contribution).
- ◆ View account balances and claim information online by logging into the BAS via the EBD website at www.ebd.ok.gov. Log in with your employee ID and password then select "Flexible Spending" from the left menu. If you are a Benny Card holder, you can check your balance at www.mybenny.com.
- ◆ If you are not on active payroll (on some type of leave) it is your responsibility to mail in your FSA (HCA/DCA) contribution.
- ◆ Reimbursement can also be made for expenses incurred by any participant during the "grace period."
- ◆ FSAs have a "use it or lose it" rule. Simply stated, if you have money left in your account after March 15 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 an HCA if you enroll in the HealthChoice HDHP.
- ◆ You may be restricted from enrolling in the HealthChoice HDHP if you have funds remaining in your HCA on Jan. 1, 2016.
- ◆ You can continue to participate in the DCA if you elect the HealthChoice HDHP.

Updated lists of eligible and non-eligible expenses are available on our website at www.ebd.ok.gov in the "Flexible Spending" section.

Health Care Account

By enrolling in the HCA, you can set aside up to \$2,550 for you and your family's health care related expenses. You can realize significant tax savings on qualified, un-reimbursed expenses by paying for the services and items pretax. Enroll in the 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 and lenses
- ◆ Dental care, including orthodontic expenses
- ◆ Physical therapy

As many FSA users are already aware, restrictions on pretax purchases of some over-the-counter (OTC) medications like Tylenol® and Claritin® took effect in 2011 and will continue to be in place for 2016. In accordance with a provision of the health care reform law, OTC drugs and biologicals can be purchased with HCA funds, but only with a letter of medical necessity from a medical provider. This letter of medical necessity must be updated every 12 months. Also, these items can no longer be purchased with the Benny Card; however, products like bandages and contact lens solution are still allowed as Benny Card purchases.

For further information on allowable expenses, including OTC items, visit the EBD website at www.ebd.ok.gov.

- ◆ HCA monthly minimum: \$10
- ◆ HCA monthly maximum: \$212.50
- ◆ HCA biweekly minimum: \$5
- ◆ HCA biweekly maximum: \$106.24

Dependent Care Account

By enrolling in the DCA, you can set aside up to \$5,000 for your day care* related expenses. Day care expenses can add up quickly. By contributing to the DCA, you can use pretax dollars to pay for day care for:

- ◆ Children ages 12 and younger who are claimed as a dependent on your income tax return; or
- ◆ Other dependents who are physically or mentally incapable of self-care;

Monthly contributions are deducted from your paycheck before your taxes are calculated. Enroll in the DCA online or by paper, but be sure to indicate your pay period contribution.

*Day care providers cannot also be your tax dependent.

- ◆ DCA monthly minimum: \$50
- ◆ DCA monthly maximum: \$416.66
- ◆ DCA biweekly minimum: \$25
- ◆ DCA biweekly maximum: \$208.33

Add Up Your Savings with our FSA Savings Calculator

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

To find out how you might benefit from enrolling in an FSA, log on to www.ebd.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 pretax basis.

When calculating your FSA contribution for Plan Year 2016, 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 reduce your risk of losing unused funds in your FSA accounts.

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.

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

Experience the Convenience of the Free FSA Benny Card

The FSA “Benny Card” debit card, is fast, flexible and free! The optional Benny Card can be used at hundreds of merchants.

After you activate your Benny Card, simply use it to pay for eligible medical and dependent care expenses. The money is taken directly from your FSA account, resulting in fewer paper claims to file.

When using the Benny Card, some charges may require proof after purchase, so it is important to save your itemized receipts. Occasionally, we may have to request documents to substantiate your debit card purchase. If we request documents and you do not respond timely, your card will temporarily be suspended. Once suspended, the card remains suspended until the issue is resolved, even if it involves the previous plan year. Please send in all requested documents as soon as possible to avoid suspension.

The rules of eligibility for HCAs and DCAs apply to participants using the Benny Card. EBD will reimburse an HCA and/or DCA participant for eligible expenses incurred through the use of the participant's Benny Card after the participant properly activates the card, properly substantiates the claim for expenses, and abides by the terms of use of the card. EBD reserves the right to set the fee charged to participants for use of the card, waive the annual fee, discontinue use of the card, or require paper substantiation of expenses. Upon demand, a participant shall immediately refund any overpayment made by the plan administrator. Likewise, items charged to a Benny Card that are unacceptable to the plan administrator require the participant to immediately refund the overpayment to the plan administrator.

Amounts remaining in a participant's HCA and/or DCA 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.

Filing a Paper Claim

To submit a paper claim:

- ◆ Complete, sign and date the “EBD Expense Reimbursement Voucher” (claim form).
- ◆ Attach the service documentation, such as
 - The itemized bill and/or the insurance explanation of benefits (HealthChoice health plans or dental indemnity plans).
 - The printed pharmacy receipt or an itemized print-out provided by the pharmacy for prescription medications.
 - The computerized receipt, including the name of the item, date of purchase, and amount paid for OTC medications and eligible items. Pharmacy labels need to include the printed name of the drug.

The date of service/purchase is the date you incur the expense, i.e., date you receive the medical care or the date you drop off the prescription at the pharmacy. 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). Funds will be disbursed for the amount requested within ten days of receipt if you submit all required documentation.

Run Out Period

The final payment of benefits for any plan year can 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 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.

Grace Period

The IRS allows a grace period extension for incurring approved expenses that are reimbursable from your FSA. You have until March 15 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 15, 2017, and still file for reimbursement from your remaining 2016 FSA account fund.

Premium Conversion Saves on Your Taxes

Premium conversion is an optional, IRS-approved election chosen by more than 97% of state employees. It allows you to save money by not paying taxes on your eligible insurance premiums and FSA contributions. By paying eligible insurance premiums and contributions to FSAs with pretax dollars, you have more take-home pay than 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; or
- ◆ 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!**

STATE OF OKLAHOMA EMPLOYEE WELLNESS PROGRAM

Formerly OKHEALTH

The State of Oklahoma employee wellness program, formerly OKHealth, is restructuring! The wellness team is under new leadership, has grown in size, and is expanding its vision to focus on all areas of wellbeing: career, social, financial, physical and community wellbeing. The employee wellness team's mission is to lead agencies to provide the foundation for a culture that supports wellbeing for all. This will be accomplished through one-on-one consultations with agencies to improve organizational health and by providing innovative programs that fit with the needs of the employees and agencies.

Additionally, the program will be rebranded for 2016 with a new name and logo to match the new vision. Stay tuned for exciting things to come for employee wellbeing!

At each agency, your volunteer wellness coordinator will be the best resource for information on the new program. If you do not know your wellness coordinator, or you would like to volunteer for this role at your agency, please contact the employee wellness team at WellnessGroup@omes.ok.gov.

“Choose Well, Oklahoma!”



Password: savenow

Take control of your retirement savings with SoonerSave. SoonerSave is a voluntary long-term retirement savings plan available to state employees. 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 (\$11.54 for biweekly payrolls) 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 EBD online 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 contribution each pay period from your employer just for participating in SoonerSave (up to \$300 annually).

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.



Enroll in SoonerSave. Select the link at the end of your online benefits enrollment and enter the password **“savenow.”**

EMPLOYEE ASSISTANCE PROGRAM

The employee assistance program (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 EBD's website at www.ebd.ok.gov, select "Benefits" then "State Programs."

CONSUMER INFORMATION AND ANNUAL NOTICES

EBD and EGID comply with the *Health Insurance Portability and Accountability Act* of 1996 known as HIPAA. EBD, EGID 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 EBD. 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 EGID 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. Refer to "General Eligibility Information" for more details.

The *Mental Health Parity and Addiction Equity Act*, a federal law, 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 copays 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 2016.

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 *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.

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 EBD and EGID 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.

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 EBD or EGID.

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. Refer to your agency for more information.

GLOSSARY

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

Coinsurance – 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 copay, plus 20 percent of covered charges, while the plan pays the other 80 percent.

Copay – 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.

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 – Six-digit number assigned by the Office of Management and Enterprise Services 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 – Jan. 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.

Health Maintenance Organization (HMO) – Out-of-pocket expenses for members are limited to set copays. All have defined coverage areas, based on ZIP codes.

Health Savings Account (HSA) – An account that allows you to contribute pretax 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 (PPACA) 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 visit 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 copays, deductibles and coinsurance.

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 15 of the following year, otherwise the remaining funds will be forfeited. For example, if participants did not use all of their Plan Year 2015 FSA funds by March 15, 2016, they would lose those funds.

Contact Information

HMO Plans

Aetna INTEGRIS

1-800-459-7791

www.integris.aetna.com/stateofok

BlueLincs

1-855-609-5684

www.bcbsok.com/state

CommunityCare

1-800-777-4890 or TDD 1-800-722-0353

state.ccok.com

GlobalHealth Inc.

1-405-280-5600 or 1-877-280-5600

TDD 1-800-522-8506

www.globalhealth.com

HealthChoice

Member Services/Provider Directory

1-405-717-8780 or 1-800-752-9475

TDD 1-405-949-2281 or 1-866-447-0436

www.sib.ok.gov

Health, Dental and Life Claims, Benefits, Eligibility and ID Cards

1-405-416-1800 or 1-800-782-5218

TDD 1-405-416-1525 or 1-800-941-2160

Pharmacy Claims, Formulary and ID Cards

1-877-720-9375 or TDD 711

HealthChoice USA Provider Directory

1-877-877-0715 or TDD 1-800-941-2160

www.choicecarenetwork.com

American Fidelity Health Services Administration

1-405-523-5699 or 1-866-326-3600

www.afhsa.com

Dental Plans

Assurant Inc. Dental

PPO Freedom Preferred 1-800-442-7742

Prepaid Heritage Plans 1-800-443-2995

www.assurantemployeebenefits.com

CIGNA Prepaid Dental

1-800-244-6224

Hearing Impaired Relay 1-800-654-5988

www.cigna.com

Delta Dental

1-405-607-2100 or 1-800-522-0188

www.DeltaDentalOK.org

Vision Plans

Humana VisionCare Plan

1-800-865-3676 or TDD 1-877-553-4327

www.compbenefits.com/custom/stateofoklahoma

Primary Vision Care Services (PVCS)

1-888-357-6912 or TDD 1-800-722-0353

www.pvcs-usa.com

Superior Vision

1-800-507-3800 or TDD 1-916-852-2382

www.superiorvision.com

UnitedHealthcare Vision

1-800-638-3120 or TDD 1-800-524-3157

www.myuhcvision.com

Vision Care Direct

1-877-488-8900 or TDD 1-877-488-8900

www.visioncaredirect.com/oklahoma

Vision Service Plan (VSP)

1-800-877-7195 or TDD 1-800-428-4833

www.vsp.com

