PLAN YEAR 2017

JAN. 1 - DEC. 31, 2017

HEALTH | DENTAL | LIFE | VISION

BENEFITS

ENROLLMENT GUIDE

WHAT'S NEW FOR 2017?

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 2017.

HEALTH PLAN OFFERINGS

There will be four health plan providers for PY 2017. Aetna HMO, CommunityCare HMO, GlobalHealth HMO and HealthChoice. Each plan is different so please review the plans in the "Comparison of Network Benefits for Health Plans" on pages 18-25.

Aetna is expanding its offering in 2017 to include Aetna St. John HMO network for members who live and/or work in Tulsa. Aetna will continue to offer the Aetna INTEGRIS HMO network for members who live and/or work in Oklahoma City.

YOUR BENEFIT ALLOWANCE

There is no change to the Benefit Allowance for Plan Year 2017.

THE STATE OF OKLAHOMA EMPLOYEE WELLNESS PROGRAM

Thrive is the new State of Oklahoma Employee Wellness Program. For information on the program, refer to page 36.

This publication is issued by the Office of Management and Enterprise Services as authorized by Title 62, Section 34. Copies have not been printed but are available through the agency website. This work is licensed under a Creative Attribution-NonCommercial-NoDerivs 3.0 Unported License.

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

2017 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

2017 Monthly Plan Rates

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Aetna HMO	572.56	1,511.36	1,894.96	1,894.96	956.16	956.16
CommunityCare HMO	850.52	2,089.42	2,522.60	2,782.52	1,283.70	1,543.62
GlobalHealth HMO	529.78	1,311.78	1,597.78	1,779.12	815.78	997.12
HealthChoice High and High Alternative	571.04	1,245.34	1,533.50	1,734.00	859.20	1,059.70
HealthChoice Basic and Basic Alternative	433.04	938.34	1,166.16	1,317.40	660.86	812.10
HealthChoice High Deductible Health Plan (HDHP)	372.60	807.72	1,004.80	1,133.70	569.68	698.58
TRICARE Supplement	60.50	119.50	160.50	160.50	119.50	160.50

DENTAL	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Assurant Freedom Preferred	30.26	60.36	82.94	121.04	52.84	90.94
Assurant Heritage Plus (Prepaid)	11.74	20.70	28.30	35.90	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)	9.16	15.16	19.24	24.34	13.24	18.34
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	34.30	68.60	96.00	141.24	61.70	106.94
MetLife Classic	36.98	73.96	105.64	152.74	68.66	115.76
MetLife Value MAC	27.24	54.48	77.82	112.50	50.58	85.26
MetLife Value PDP	29.48	58.96	84.20	121.76	54.72	92.28

VISION	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
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
Vision Care Direct	15.90	27.16	38.42	49.90	27.16	38.64
Vision Service Plan (VSP)	9.40	15.69	21.88	29.27	15.59	22.98

DISABILITY	9.10

LIFE INSURANCE OPTIONS							
Life	4.00	Supplemental Life First Unit		$4.00			
Dependent Life		Supplemental Life Age Rated (Per $20,000)					
Low Option	2.60	< 30	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		

2017 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

2017 Biweekly Plan Rates

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Aetna HMO	286.28	755.68	947.48	947.48	478.08	478.08
CommunityCare HMO	425.26	1,044.71	1,261.30	1,391.26	641.35	771.81
GlobalHealth HMO	264.89	655.39	798.89	889.56	407.89	498.56
HealthChoice High and High Alternative	285.52	622.67	766.75	867.00	429.60	529.85
HealthChoice Basic and Basic Alternative	211.02	469.17	583.08	658.70	330.43	406.05
HealthChoice High Deductible Health Plan (HDHP)	186.30	403.86	502.40	566.85	284.84	349.29
TRICARE Supplement	30.25	59.75	80.25	80.25	59.75	80.25

DENTAL	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Assurant Freedom Preferred	15.13	30.18	41.47	60.52	26.42	45.47
Assurant Heritage Plus (Prepaid)	5.87	10.35	14.15	17.95	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)	4.58	7.58	9.62	12.17	6.62	9.17
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	17.15	34.30	48.00	70.62	30.85	53.47
MetLife Classic	18.49	36.98	52.82	76.37	34.33	57.88
MetLife Value MAC	13.62	27.29	38.91	56.25	25.29	42.63
MetLife Value PDP	14.74	29.48	42.10	60.88	27.36	46.14

VISION	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
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
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	7.40
		70 - 74	12.80	75+	19.60		

TABLE OF CONTENTS

2017 Plan Changes and Important Reminders 2

General Information 4

Enrollment 7

Enrollment Periods 9

Eligibility 10

HMO ZIP Code Lists 13

Comparison of Network Benefits for Health Plans 18

Comparison of Benefits for Dental Plans 26

Comparison of Benefits for Vision Plans 30

Change of Address 33

Biweekly Benefits Transition 33

Flexible Spending Accounts 33

Thrive: Oklahoma Employee Well-Being 36

Sooner Save 37

Employee Assistance Program 38

Consumer Information and Annual Notices 38

Glossary 39

Contact Information . . . . . inside back cover

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.

2017 PLAN CHANGES AND IMPORTANT REMINDERS

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

HEALTH PLANS

Aetna INTEGRIS and Aetna St. John HMO

- Aetna is expanding its offering in 2017 to include Aetna St. John HMO network for members who live and/or work in Tulsa. Aetna will continue to offer the Aetna INTEGRIS HMO network for members who live and/or work in Oklahoma City; however, the service area has changed. When you enroll with Aetna, your network of providers is determined by the ZIP code in which you live or work. Refer to "HMO ZIP Code Lists" to determine if you live or work in their area.

CommunityCare HMO

- The pharmacy program is being redesigned. Changes are listed in bold text in "Comparison of Network Benefits for Health Plans."

HealthChoice Health Plans

- 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 2017, you will be notified by mail. For a complete list of medications that will no longer be covered, please visit **www.healthchoiceok.com**.
- The mental health or substance abuse outpatient treatment benefit is increasing to 20 vists per year without certification.
- HealthChoice HelpCheck program and HealthChoice USA Plan are not available for 2017.

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

- HealthChoice is expanding the HealthChoice Select Program. These select facilities provide certain services to members that are covered at 100 percent with no out-of-pocket costs to members.*

  For the most current list of facilities participating in the HealthChoice Select Program and the most current list of procedures covered, select "Find a Provider" in the top menu bar of the HealthChoice website at **www.healthchoiceok.com**; select "Medical and Dental Providers" under "HealthChoice Provider Listings," and then choose "Select Network" from the top menu bar.

  *HDHP members must meet their deductible before benefits are paid at 100 percent, except for preventive services.

HealthChoice High and High Alternative Plans

- A new $100 per person pharmacy deductible, with a $300 maximum deductible per family.

HealthChoice High and High Alternative Plans and High Deductible Health Plan

- Emergency room copay is increasing to $200.
- The “HealthChoice Preventive Medication List” is being implemented for Plan Year 2017. This is a list of frequently prescribed generic medications and the charges for these medications will not be subject to the High and High Alternative pharmacy deductible and HDHP combined medical and pharmacy deductible.

HealthChoice High Deductible Health Plan (HDHP)

- The maximum annual contribution for an individual is increasing from $3,350 to $3,400.

DENTAL PLANS

MetLife – New for 2017

- MetLife is offering three dental plans for 2017. For benefit information, refer to the “Comparison of Benefits for Dental Plans” or visit their website at the address listed in “Contact Information.”

VISION PLANS

Primary Vision Care Services

- Primary Vision Care Services is offering additional discounts on laser vision correction surgery. Changes are listed in bold text in “Comparison of Benefits for Vision Plans.”

Vision Service Plan

- Vision Service Plan is increasing the allowance for frames. Changes are listed in bold text in “Comparison of Benefits for Vision Plans.”

REMINDER

If you are enrolled in the HealthChoice High or Basic Plan and wish to stay enrolled in that plan, you must complete the online tobacco-free attestation for Plan Year 2017 available at **www.healthchoiceok.com** by Nov. 14, 2016.

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 sign the tobacco-free attestation because either you or a covered dependent uses tobacco, you can still qualify for HealthChoice High or HealthChoice Basic plans if those that use tobacco complete one of the following 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. 14.
- Provide a letter from your doctor by Nov. 14, 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, you will automatically be enrolled in the HealthChoice High Alternative or Basic Alternative Plan effective Jan. 1, and your annual deductible will be $250 higher.

GENERAL INFORMATION

The benefits you select will be in effect Jan. 1, or for new employees, the effective date of your coverage, through Dec. 31, 2017, or your termination date.

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

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 eight health plans available:

- Aetna INTEGRIS and Aetna St. John HMO
- CommunityCare HMO
- GlobalHealth HMO
- HealthChoice High and High Alternative Plans
- HealthChoice Basic and Basic Alternative Plans
- HealthChoice HDHP

Refer to "Comparison of Network Benefits for Health Plans" on pages 18-25 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 13-17 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 2017, you must complete the tobacco-free attestation located on the HealthChoice website or a reasonable alternative.
- 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. You can use any financial institution to establish an HSA, but to qualify for your contributions being deducted pre-tax from your paycheck, you must enroll in an American Fidelity HSA. For more information about HSAs, you can contact American Fidelity at the number or website located in "Contact Information" at the back of this guide.

DENTAL PLANS

There are 11 dental plans available:

- Assurant Freedom Preferred
- Assurant Heritage Plus with SBA (Prepaid)
- Assurant Heritage Secure (Prepaid)
- CIGNA Dental Care Plan (Prepaid)
- Delta Dental PPO
- Delta Dental PPO Plus Premier
- Delta Dental PPO – Choice
- HealthChoice Dental
- MetLife Classic
- MetLife Value MAC
- MetLife Value PDP

Refer to "Comparison of Benefits for Dental Plans" on pages 26-29 for benefit information.

- You must select a primary care dentist for yourself and each covered dependent when enrolling in a prepaid dental plan.
- Assurant Freedom Preferred and HealthChoice have a 12-month waiting period for orthodontic benefits.

VISION PLANS

There are four vision plans available:

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

Refer to "Comparison of Benefits for Vision Plans" on pages 30-32 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 benefits 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.healthchoiceok.com**. 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, 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

(limited city and county participation)

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 2017. 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. 31, 2016.

Customer assistance is available Oct. 1 through 31 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!)

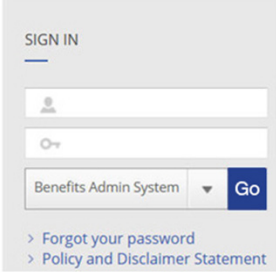
1. Go to the Employee Benefits website at **www.ebd.ok.gov**. Sign in to the Benefits Administration System Sign-In area using your six digit employee number and password. If you have forgotten your password, select "Forgot Password."
2. Follow instructions to set your personal password.

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 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, 2017

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 dependents during the annual Option Period, as long as you have not dropped that coverage within the past 12 months. If you have dropped coverage within the past 12 months without a midyear qualifying event, you cannot reinstate that coverage for at least 12 months.

Initial Enrollment – Coverage effective the first of the month following your employment date or the date set by your employer

This is 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 eligibility date to enroll in coverage. If you do not enroll within 30 days, you will be enrolled in default coverage (HealthChoice High, HealthChoice Dental, Disability and Life) and will not be able to enroll until the next annual Option Period, unless you experience a qualifying event. Check with your benefits coordinator for more information.

You have 30 days following your eligibility date to make changes to your original enrollment.

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

If you are declining enrollment for yourself or your dependents (including your spouse) because of other 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.

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:
  - HealthChoice – A newborn is covered only for the first 48 hours following a vaginal birth or the first 96 hours following a cesarean section birth. Under the HealthChoice Plans, a separate deductible and coinsurance apply.
  - Aetna, 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, 2017. 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, go to **www.healthchoiceok.com** 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 or your dependents 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

73003	73007	73008	73012	73013	73019	73020
73022	73025	73026	73034	73036	73045	73049
73051	73054	73064	73066	73068	73069	73070
73071	73072	73078	73083	73084	73085	73090
73097	73099	73101	73102	73103	73104	73105
73106	73107	73108	73109	73110	73111	73112
73113	73114	73115	73116	73117	73118	73119
73120	73121	73122	73123	73124	73125	73126
73127	73128	73129	73130	73131	73132	73134
73135	73136	73137	73139	73140	73141	73142
73143	73144	73145	73146	73147	73148	73149
73150	73151	73152	73153	73154	73155	73156
73157	73159	73160	73162	73163	73164	73165
73167	73169	73170	73172	73173	73178	73179
73184	73185	73189	73190	73193	73194	73195
73196	73197	73198	73199			

Aetna St. John ZIP Code List

74008	74011	74012	74013	74021	74033	74037
74043	74050	74055	74063	74070	74073	74101
74102	74103	74104	74105	74106	74107	74108
74110	74112	74114	74115	74116	74117	74119
74120	74121	74126	74127	74128	74129	74130
74132	74133	74134	74135	74136	74137	74141
74145	74146	74147	74148	74149	74150	74152
74153	74155	74156	74157	74158	74159	74169
74170	74171	74172	74182	74183	74184	74186
74187	74189	74192	74193	74194	74857	

ZIP codes are subject to change by plan

CommunityCare ZIP Code List

74001	74002	74003	74004	74005	74006	74008
74009	74010	74011	74012	74013	74014	74015
74016	74017	74018	74019	74020	74021	74022
74027	74028	74029	74030	74031	74033	74034
74035	74036	74037	74038	74039	74041	74042
74043	74044	74045	74046	74047	74048	74050
74051	74052	74053	74054	74055	74056	74058
74060	74061	74063	74066	74067	74068	74070
74071	74072	74073	74080	74081	74082	74083
74084	74100	74101	74102	74103	74104	74105
74106	74107	74108	74110	74112	74114	74115
74116	74117	74119	74120	74121	74126	74127
74128	74129	74130	74131	74132	74133	74134
74135	74136	74137	74141	74145	74146	74147
74148	74149	74150	74152	74153	74155	74156
74157	74158	74159	74169	74170	74171	74172
74182	74183	74184	74186	74187	74189	74192
74193	74194	74301	74330	74331	74332	74333
74335	74337	74338	74339	74340	74342	74343
74344	74345	74346	74347	74349	74350	74352
74353	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	74466	74467	74468	74469	74470
74471	74472	74477	74501	74502	74522	74526
74529	74552	74554	74564	74578	74604	74633
74637	74650	74652	74845	74930	74931	74936
74941	74943	74944	74945	74948	74955	74960
74962	74964	74965				

ZIP codes are subject to change by plan

GlobalHealth ZIP Code List

73001	73002	73003	73004	73005	73006	73007
73008	73009	73010	73011	73012	73013	73014
73015	73016	73017	73018	73019	73020	73021
73022	73023	73024	73025	73026	73027	73028
73029	73030	73031	73032	73033	73034	73036
73038	73039	73040	73041	73042	73043	73044
73045	73047	73048	73049	73050	73051	73052
73053	73054	73055	73056	73057	73058	73059
73061	73062	73063	73064	73065	73066	73067
73068	73069	73070	73071	73072	73073	73074
73075	73077	73078	73079	73080	73082	73083
73084	73085	73086	73089	73090	73092	73093
73095	73096	73097	73098	73099	73101	73102
73103	73104	73105	73106	73107	73108	73109
73110	73111	73112	73113	73114	73115	73116
73117	73118	73119	73120	73121	73122	73123
73124	73125	73126	73127	73128	73129	73130
73131	73132	73134	73135	73136	73137	73139
73140	73141	73142	73143	73144	73145	73146
73147	73148	73149	73150	73151	73152	73153
73154	73155	73156	73157	73159	73160	73162
73163	73164	73165	73167	73169	73170	73172
73173	73178	73179	73184	73185	73189	73190
73194	73195	73196	73401	73402	73403	73425
73430	73432	73433	73434	73435	73436	73437
73438	73439	73440	73441	73442	73443	73444
73446	73447	73448	73449	73450	73453	73455
73456	73458	73459	73460	73461	73463	73481
73487	73488	73491	73501	73502	73503	73505
73506	73507	73520	73521	73522	73523	73526
73527	73528	73529	73530	73531	73532	73533
73534	73536	73537	73538	73539	73540	73541
73542	73543	73544	73546	73547	73548	73549
73550	73551	73552	73553	73554	73555	73556
73557	73558	73559	73560	73561	73562	73564
73565	73566	73567	73568	73569	73570	73571
73572	73573	73601	73620	73622	73624	73625
73626	73627	73628	73632	73638	73639	73641
73642	73644	73645	73646	73647	73648	73650
73651	73654	73655	73658	73659	73660	73661
73662	73663	73664	73666	73667	73668	73669
73673	73701	73702	73703	73705	73706	73716
73717	73718	73719	73720	73722	73724	73726

ZIP codes are subject to change by plan

continued on next page

GlobalHealth ZIP Code List

73727	73728	73729	73730	73731	73733	73734
73735	73736	73737	73738	73739	73741	73742
73743	73744	73746	73747	73749	73750	73753
73754	73755	73756	73757	73758	73759	73760
73761	73762	73763	73764	73766	73768	73770
73771	73772	73773	73801	73802	73832	73834
73835	73838	73840	73841	73842	73843	73844
73848	73851	73852	73853	73855	73857	73858
73859	73860	73901	73931	73932	73933	73937
73938	73939	73942	73944	73945	73946	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	74152	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	74472	74477	74501	74502	74521	74522
74523	74525	74528	74529	74530	74531	74533
74534	74535	74536	74538	74540	74543	74545

ZIP codes are subject to change by plan

continued on next page

GlobalHealth ZIP Code List

74546	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						

ZIP codes are subject to change by plan

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	Aetna INTEGRIS and Aetna St. John HMO	CommunityCare HMO	GlobalHealth HMO
Calendar Year 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	$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	$0 copay/PCP $50 copay/specialist
X-Ray and Lab	$0 copay for X-ray and lab **$250** copay per MRI, CAT, MRA or PET scan	$0 copay for X-ray and lab $200 copay per scan Specialty scans: MRI, CT, MRA and PET scans	$0 copay for X-ray and lab $250 copay per scan **in a preferred facility** $750 copay per scan **in a non-preferred 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 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 and High Alternative Plans	HealthChoice Basic and Basic Alternative Plans	HealthChoice HDHP
Calendar Year Deductible	**High Plan** $500 individual $1,500 family **High Alternative Plan** $750 individual $2,250 family	**Basic Plan** $1,000 individual $1,500 family Applies after Plan pays first $500 of Allowable Fees **Basic Alternative Plan** $1,250 individual $1,750 family Applies after Plan pays first $250 of Allowable Fees	$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
Calendar Year Out-of-Pocket Maximum **(High, High Alternative, Basic, and Basic Alternative Plans have a separate pharmacy out-of-pocket maximum, refer to page 25)**	**High Plan*** 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 **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	**Basic Plan** $4,000 individual $9,000 family **Basic Alternative Plan** $4,000 individual $9,000 family	$3,000 individual $6,000 family Pharmacy copays apply to the out-of-pocket maximum but non-Network charges do not apply
Office Visit	$30 copay/physician office visit** $50 copay/specialist office visit	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** $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 You can use non-Network providers, but it will be more costly	You pay 100% of Allowable Fees until deductible is met $30/$50** office visit copay applies after deductible
X-Ray and Lab	20% of Allowable Fees after deductible		20% of Allowable Fees after deductible
Allergy Testing and Treatment	20% of Allowable Fees after deductible Limit of 60 tests every 24 months		20% of Allowable Fees after deductible Limit of 60 tests every 24 months

Plan changes are indicated by **bold text**.
*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 and Aetna St. John HMO	CommunityCare HMO	GlobalHealth HMO
Preventive Services	$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
Immunizations	$0 copay ages birth through 18 years $0 copay ages 19 and older When medically necessary	$0 copay birth through age 20 years $0 copay ages 21 and older when appropriate following the recommendation of ACIP	$0 copay birth through age 18 years $0 copay ages 19 and older 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 when performed by PCP Limit of one per year **Hearing aids** 20% coinsurance for children up to age 18	**Hearing screening** $0 copay children 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	$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	$500 copay per visit	$250 copay **in a preferred facility** $750 copay **in a non-preferred facility**
Emergency Room	$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	$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 and High Alternative 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 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** $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 You can use non-Network providers, but it will be more costly.	$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		$0 copay; no deductible applies
Immunizations	No charge for well child and adult immunizations and administration $30/$50** office visit copay may apply		No charge for well child and adult immunizations and administration $30/$50** office visit copay may apply
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		**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)		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 **$200** ER copay – waived if admitted		20% of Allowable Fees after deductible Additional **$200** 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

Plan changes are indicated by **bold text**.
**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 and Aetna St. John HMO	CommunityCare HMO	GlobalHealth HMO
Maternity Pre and Post Natal Care	$25 copay for initial visit $250 copay per day $750 maximum per 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
Mental Health or Substance Abuse Inpatient	$250 copay per day $750 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
Mental Health or Substance Abuse Outpatient	$50 copay/specialist	$35 copay	$0 copay
Occupational or Speech Therapy Visit	No copay inpatient $50 copay outpatient therapy Limit of 60 days per illness	$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	$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 and High Alternative 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** $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 You can use non-Network providers but it will be more costly.	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		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		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 **20** services per calendar year without certification		20% of Allowable Fees after deductible Limit of **20** 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

Plan changes are indicated by **bold text**.
*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 and Aetna St. John HMO	CommunityCare HMO	GlobalHealth HMO
Pharmacy Benefits	**Retail** Select generic: $4 Generic: $10 Brand: $30 Non-preferred brand: $60 **Mail-order** Select generic: $8 Generic: $20 Brand: $60 Non-preferred brand: $120 **Specialty** Preferred: $100 Non-preferred: $200	**Retail** **Preferred Pharmacies (Walgreens and Walmart)** **Select generic: $0** **Preferred generic: $15** **Preferred brand: $40*** **Non-preferred brand or generic: $70*** **Specialty: $160*** **Non-Preferred Pharmacies (All other network pharmacies)** **Select generic: $5** **Preferred generic: $20** **Preferred brand: $50*** **Non-preferred brand or generic: $90*** **Specialty: $200*** **Mail-order (90-day supply)** **Select generic: $0** **Preferred generic: $45** **Preferred brand: $120*** **Non-preferred brand or generic: $210*** **Mail-Order Specialty (30-day supply)** **BriovaRx: $160*** **Preferred pharmacy copays *will apply* to prescriptions filled through our mail order service using (Walgreens or Optum) or through BriovaRx for specialty medicines.** ***If you choose to obtain a brand name drug when a generic equivalent is available, you will pay the applicable copay or coinsurance for the brand name drug, plus the difference in cost between the brand name drug and its generic equivalent.** **The difference in cost between the brand name drug and its generic equivalent will not count toward your annual out-of-pocket maximum.**	**Retail** Select generic: $5 Generic: $10 Brand: $50 Non-preferred brand: $75 **Mail-order** Select generic: $10 Generic: $20 Brand: $100 Non-preferred brand: $150 **Specialty** Preferred: $100 Non-preferred: $200

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 and HDHP 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*	Generic – $10 copay Preferred drugs – $100 copay Non-Preferred drugs – $200 copay	Copays are for up to a 30-day supply

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

HEALTHCHOICE HIGH AND HIGH ALTERNATIVE PLANS

Pharmacy deductible – $100 for individual ($300 for family).

HEALTHCHOICE HIGH AND HIGH ALTERNATIVE PLANS AND HIGH DEDUCTIBLE HEALTH PLAN

HealthChoice Preventive Medication List – Medications not subject to pharmacy deductible.

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

Pharmacy out-of-pocket maximum – $2,500 for individual ($4,000 for 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 percent when filled at a Network Pharmacy. Visit the “Be Tobacco-Free” page at **www.healthchoiceok.com** for details.

CDC vaccinations, such as for shingles, are covered at 100 percent 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)	Delta Dental PPO In-Network and Out-of-Network	Delta Dental PPO Plus Premier In-Network and Out-of-Network
Annual Deductible	$25 per person, waived for in-Network preventive services	No deductibles	No deductible or plan maximum $5 office copay applies	$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
Diagnostic and Preventive Care (cleanings, routine oral exams) Allowable Fees Apply	Network: Plan pays 100% of allowable amounts No deductible Non-Network: Plan pays 100% of usual and customary after deductible	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 Heritage Plus: Sealant per tooth: $15 copay Heritage Secure: Sealant per tooth: $22 copay	Sealant per tooth: $17 copay Routine cleaning (once every 6 months): no charge Topical fluoride application (up to age 18): no charge Periodic oral evaluations: no charge	Plan pays 100% of allowable amounts No deductible applies Topical fluoride covered for children (up to age 19)	Plan pays 100% of allowable amounts after deductible Topical fluoride covered for children (up to age 19)
Basic Care (extractions, oral surgery) Allowable Fees Apply	Network: Plan pays 85% of allowable amounts after deductible Non-Network: Plan pays 70% of usual and customary after deductible	Fillings Minor oral surgery Heritage Plus: Amalgam, one surface, permanent teeth: $25 copay Heritage Secure: Amalgam, one surface, permanent teeth: $32 copay	Amalgam: One surface, permanent teeth $23 copay	Plan pays 85% of allowable amounts after deductible	Plan pays 70% of allowable amounts after deductible

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 BENEFITS FOR DENTAL PLANS

	Delta Dental PPO – Choice PPO Network	HealthChoice Dental	MetLife Classic	MetLife Value MAC	MetLife Value PDP
Annual Deductible	$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	$25 per person $75 per family Basic and Major Care	$25 per person $75 per family Basic and Major Care	$25 per person $75 per family Basic and Major Care
Diagnostic and Preventive Care (cleanings, routine oral exams) Allowable Fees Apply	Schedule of covered services and copays Topical fluoride covered for children only Copay examples: Routine cleaning $5 Periodic oral evaluation $5 Topical fluoride application (up to age 19) $5	You pay Network: $0 Non-Network: $0 of Allowable Fees after deductible	Network: Plan pays 100% of negotiated fee schedule Non-Network: Plan pays 100% of reasonable and customary Routine exams and cleanings: two every 12 months Fluoride: two every 12 months (up to age 16)	Network: Plan pays 100% of negotiated fee schedule Non-Network: Plan pays 100% of reasonable and customary Routine exams and cleanings: two every 12 months Fluoride: two every 12 months (up to age 16)	Network: Plan pays 100% of negotiated fee schedule Non-Network: Plan pays 100% of reasonable and customary Routine exams and cleanings: two every 12 months Fluoride: two every 12 months (up to age 16)
Basic Care (extractions, oral surgery) Allowable Fees Apply	Schedule of covered services and copays Copay example: Amalgam - one surface, primary or permanent tooth $12	You pay Network: 15% Non-Network: 30% plus amounts above Allowable Fees Deductible applies	Network: Plan pays 85% of negotiated fee schedule Non-Network: Plan pays 85% of reasonable and customary Network and non-Network: Root canal: one per tooth per lifetime	Network: Plan pays 85% of negotiated fee schedule Non-Network: Plan pays 70% of reasonable and customary Network and non-Network: Root canal: one per tooth per lifetime	Network: Plan pays 85% of negotiated fee schedule Non-Network: Plan pays 70% of reasonable and customary Network and non-Network: Root canal: one per tooth per lifetime

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 BENEFITS FOR DENTAL PLANS

	Assurant Employee Benefits Freedom Preferred	Assurant Employee Benefits Heritage Plus and Heritage Secure	CIGNA Dental Care Plan (Prepaid)	Delta Dental PPO In-Network and Out-of-Network	Delta Dental PPO Plus Premier In-Network and Out-of-Network
Major Care (dentures, bridge work) Allowable Fees Apply	Network: Plan pays 60% of allowable amounts after deductible Non-Network: Plan pays 50% of usual and customary after deductible	Heritage Plus: Root canal anterior: $165 copay Periodontal/ Scaling/Root planing 1-3 teeth, per quadrant: $36 copay Specialty rider pays specialist at set copays Heritage Secure: Root canal anterior: $175 copay Periodontal/ Scaling/Root planing 1-3 teeth, per quadrant: $54 copay Endodontist: 15% discount	Root canal, anterior: $375 copay Periodontal: Scaling/root planing 1-3 teeth (per quadrant): $75 copay	Plan pays 60% of allowable amounts after deductible	Plan pays 50% of allowable amounts after deductible
Orthodontic Care **Allowable Fees Apply**	Network: Plan pays 60% Non-Network: Plan pays 50% Up to lifetime maximum of $2,000 for dependents under age 19	25% discount Adults and children	$2,472 out-of-pocket for children $3,384 out-of-pocket for adults 24-month treatment excludes orthodontic treatment plan and banding	Plan pays 60% of allowable amounts, up to $2,000 lifetime maximum per person Orthodontic benefits are available to eligible employee, spouse and dependent children	Plan pays 60% of allowable amounts, up to $2,000 lifetime maximum per person Orthodontic benefits are available to eligible employee, spouse and dependent children
Plan Year Maximum	$2,000 per person, per policy year	No annual maximum, per policy year	No plan year dollar maximum	$2,500 per person/year for Diagnostic, Preventive, Basic and Major Care	$3,000 per person/year for Diagnostic, Preventive, Basic and Major Care
Filing Claims	Member/provider must file claims	No claims to file	No claims to file	Claims are filed by participating dentists	Claims are filed by participating dentists

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 BENEFITS FOR DENTAL PLANS

	Delta Dental PPO – Choice PPO Network	HealthChoice Dental	MetLife Classic	MetLife Value MAC	MetLife Value PDP
Major Care (dentures, bridge work) Allowable Fees Apply	Schedule of covered services and copays Copay examples: Crown - porcelain/ceramic substrate $241 Complete denture – maxillary $320	You pay Network: 40% Non-Network: You pay 50% plus amounts above Allowable Fees Deductible applies	Network: Plan pays 60% of negotiated fee schedule Non-Network: Plan pays 60% of reasonable and customary Network and non-Network: Dentures: one every five years Fixed bridges/ inlays/onlays: one every five years Implants: one per tooth every five years	Network: Plan pays 60% of negotiated fee schedule Non-Network: Plan pays 50% of reasonable and customary Network and non-Network: Dentures: one every 10 years Fixed bridges/ inlays/onlays: one every 10 years Implants: one per tooth every 10 years	Network: Plan pays 60% of negotiated fee schedule Non-Network: Plan pays 50% of reasonable and customary Network and non-Network: Dentures: one every 10 years Fixed bridges/ inlays/onlays: one every 10 years Implants: one per tooth every 10 years
Orthodontic Care **Allowable Fees Apply**	You pay charges in excess of $50 per month Lifetime maximum up to $1,800 per person Orthodontic benefits are available to eligible employee, spouse and dependent children	You pay 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	Network: Plan pays 60% of negotiated fee schedule Non-Network: Plan pays 60% of reasonable and customary $2,000 lifetime maximum	Network: Plan pays 60% of negotiated fee schedule Non-Network: Plan pays 50% of reasonable and customary $2,000 lifetime maximum	Network: Plan pays 60% of negotiated fee schedule Non-Network: Plan pays 50% of reasonable and customary $2,000 lifetime maximum
Plan Year Maximum	$2,000 per person/year for Diagnostic, Preventive, Basic and Major Care	Network and non-Network: $2,500 per person, per year	$5,000, applies to Preventive, Basic and Major Care	$2,500, applies to Preventive, Basic and Major Care	$2,500, applies to Preventive, Basic and Major Care
Filing Claims	Claims are filed by participating dentists	Network: No claims to file Non-Network: You file claims	Claims are filed by Network and non-Network dentists	Claims are filed by Network and non-Network dentists	Claims are filed by Network and non-Network dentists

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 BENEFITS FOR VISION PLANS

	Primary Vision Care Services		Superior Vision	
Covered Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Eye Exams	$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	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	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	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	Discount at nJoy Vision **Extra savings between June 1 - Sept. 30, 2017**	No benefit	5-50% discount off surgical fees	No benefit

Plan changes are indicated by **bold text**.
For more information or details, contact each vision plan directly.

COMPARISON OF BENEFITS FOR VISION PLANS

	Vision Care Direct		Vision Service Plan (VSP)	
Covered Services	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Eye Exams	$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	$15 copay Single, bifocals, trifocals and no-line progressive lenses covered in full Anti-reflective, **UV** and poly-carbonate 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	$0 copay $130 frame allowance each year	Plan pays up to $35	$25 copay then plan pays up to **$150**	$25 copay then plan pays up to $45
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	**Up to $1,000 off**	No benefit	15% average off usual and customary price or 5% off the laser center's promotional price	No benefit

Plan changes are indicated by **bold text**.
For more information or details, contact each vision plan directly.

Vision Plan Notes

PVCS: The only Oklahoma owned and operated vision care plan with unlimited in-network services. Member must select either in-network or out-of-network for entire year. In-network services are unlimited. Out-of-network services (one eye exam, one set of eyeglasses or contacts) are limited to once annually. A $50 service fee applies to soft contact lens fittings; a $75 service fee applies to rigid or gas permeable contact lens fittings; and a $150 service fee applies to hybrid contact lens fittings. Simple replacements are not assessed with these fees. Limitations/exclusions include the following: 1) Medical eye care, 2) Vision therapy, 3) Non-routine vision services and tests, 4) Luxury frames 5) Premium prescription lenses, and 6) Nonprescription eyewear. For more information or detail, call 1-888-357-6912.

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.

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 or 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. Visit www.visioncaredirect.com/oklahoma for more information, inclusions and limitations. For our provider list, visit www.visioncaredirect.com and enter your ZIP code, be sure to look for the VCD Plus logo. For more information, 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 percent on your out-of-pocket costs when you use a VSP doctor. Member's receive an extra $20 towards their frame allowance when selecting a Marchon frame. 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 percent 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 percent off from any VSP doctor within 12 months from your last WellVision Exam. Contact VSP or visit vsp.com to learn more.

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, 2017.
- 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 2017. 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 2017, 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 temporally 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, 2018, and still file for reimbursement from your remaining 2017 FSA account fund.

Premium Conversion Saves on Your Taxes

Premium conversion is an optional, IRS-approved election chosen by more than 97 percent 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!

THRIVE: OKLAHOMA EMPLOYEE WELL-BEING

The well-being program for State of Oklahoma employees has evolved! As of January 2016, we are no longer OKHealth. We have rebranded ourselves to better reflect our values, goals, vision and programs. We are now Thrive.

Thrive is the name and inspiration behind the well-being program. Our vision is for every member's well-

being to be valued and to empower members to be fearless, valued, and engaged. Thrive does this by standing behind our core pillars of purpose, social, financial, physical, community and emotional well-being.

Thrive provides members and their families with information and opportunities to learn, grow and enrich their lives for the better. It's our journey and our promise to help members cultivate excellence and, in short, Thrive.

Thrive Well-Being Toolkits

Thrive toolkits are monthly well-being initiatives filled with information, suggested activities and promotional materials centered on well-being topics that support Thrive's six elements. The toolkits are available on our website at **https://thrive.ok.gov**. You can also contact us with questions at thrive@omes.ok.gov.

Coming in 2017 – New Classes

Thrive has partnered with several organizations to develop well-being classes that will be made available to members and their dependents. Visit our website at **https://thrive.ok.gov** for the most up-to-date details.

Take control of your retirement savings with SoonerSave. SoonerSave is a voluntary long-term retirement savings plan available to state employees who were hired before Nov. 1, 2015*. 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 – Select the link at the end of the EBD online enrollment and download the "SoonerSave Enrollment Form." Decide how much you want to contribute and how you want it invested. Give the completed form to your benefits coordinator. You are now 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.

*Certain employee groups hired after Nov. 1, 2015, qualify. Check with your benefits coordinator.

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 260:25-21-1 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 2017.

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 2017 FSA funds by March 15, 2018, they would lose those funds.

Contact Information

HMO Plans

Aetna INTEGRIS and Aetna St. John

1-800-459-7791
www.stateofok.aetna.com

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 711
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.healthchoiceok.com

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

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

MetLife

1-800-942-0854
www.metlife.com

Vision Plans

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

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

Cover image: Wichita Mountains