

JAN. 1-DEC. 31, 2019

HEALTH | DENTAL | LIFE | VISION

BENEFITS

ENROLLMENT GUIDE



PLAN YEAR
2019



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

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

2019 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	1,017.88

2019 MONTHLY PLAN RATES

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Aetna HMO	897.90	2,370.14	2,971.74	3,332.66	1,499.50	1,860.42
BlueLincs HMO	550.00	1,361.90	1,659.06	1,847.14	847.16	1,035.24
CommunityCare HMO	894.32	2,197.00	2,652.48	2,925.78	1,349.80	1,623.10
GlobalHealth HMO	623.18	1,543.06	1,898.94	2,124.22	979.06	1,204.34
HealthChoice High and High Alternative	594.90	1,292.40	1,591.64	1,800.20	894.14	1,102.70
HealthChoice Basic and Basic Alternative	466.42	1,013.80	1,254.34	1,420.68	706.96	873.30
HealthChoice High Deductible Health Plan (HDHP)	401.78	873.60	1,081.12	1,223.96	609.30	752.14

TRICARE Supplement	60.50	119.50	160.50	160.50	119.50	160.50
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DENTAL	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
CIGNA Dental Care Plan (Prepaid)	9.44	15.62	19.82	25.08	13.64	18.90
Delta Dental PPO	35.84	71.66	102.84	150.52	67.02	114.70
Delta Dental PPO – Choice	15.68	51.24	87.06	138.20	51.50	102.64
HealthChoice Dental	39.12	78.24	109.82	159.34	70.70	120.22
MetLife High Classic MAC	46.24	92.48	132.10	190.64	85.86	144.40
MetLife Low Classic MAC	26.64	53.28	76.10	109.44	49.46	82.80
Sun Life Preferred Active PPO	30.26	60.36	82.94	121.04	52.84	90.94

VISION	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Primary Vision Care Services (PVCS)	9.98	18.88	27.58	30.38	18.68	21.48
Superior Vision	7.62	15.20	22.38	29.94	14.80	22.36
Vision Care Direct	15.90	27.16	38.42	49.90	27.16	38.64
VSP (Vision Service Plan)	8.72	14.50	20.20	26.98	14.42	21.20

DISABILITY	9.10
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LIFE INSURANCE OPTIONS							
Life	4.00	Supplemental Life First Unit			4.00		
Dependent Life	Supplemental Life Age Rated (Per 20,000)						
Low Option	2.60	< 30	1.20	30 - 34	1.20	35 - 39	1.20
Standard Option	4.32	40 - 44	1.60	45 - 49	2.80	50 - 54	5.20
Premier Option	8.64	55 - 59	8.00	60 - 64	9.20	65 - 69	14.80
		70 - 74	25.60	75+	39.20		

2019 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	508.94

2019 BIWEEKLY PLAN RATES

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Aetna HMO	448.95	1,185.07	1,485.87	1,666.33	749.75	930.21
BlueLincs HMO	275.00	680.95	829.53	923.57	423.58	517.62
CommunityCare HMO	447.16	1,098.50	1,326.24	1,462.89	674.90	811.55
GlobalHealth HMO	311.59	771.53	949.47	1,062.11	489.53	602.17
HealthChoice High and High Alternative	297.45	646.20	795.82	900.10	447.07	551.35
HealthChoice Basic and Basic Alternative	233.21	506.90	627.17	710.34	353.48	436.65
HealthChoice High Deductible Health Plan (HDHP)	200.89	436.80	540.56	611.98	304.65	376.07

TRICARE Supplement	30.25	59.75	80.25	80.25	59.75	80.25
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DENTAL	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
CIGNA Dental Care Plan (Prepaid)	4.72	7.81	9.91	12.54	6.82	9.45
Delta Dental PPO	17.92	35.83	51.42	75.26	33.51	57.35
Delta Dental PPO – Choice	7.84	25.62	43.53	69.10	25.75	51.32
HealthChoice Dental	19.56	39.12	54.91	79.67	35.35	60.11
MetLife High Classic MAC	23.12	46.24	66.05	95.32	42.93	72.20
MetLife Low Classic MAC	13.32	26.64	38.05	54.72	24.73	41.40
Sun Life Preferred Active PPO	15.13	30.18	41.47	60.52	26.42	45.47

VISION	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Primary Vision Care Services (PVCS)	4.99	9.44	13.79	15.19	9.34	10.74
Superior Vision	3.81	7.60	11.19	14.97	7.40	11.18
Vision Care Direct	7.95	13.58	19.21	24.95	13.58	19.32
VSP (Vision Service Plan)	4.36	7.25	10.10	13.49	7.21	10.60

DISABILITY	4.55					
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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		

2019 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 St. John ZIP code service area has expanded.
- Calendar year out-of-pocket maximum has increased to \$5,000 for an individual and \$10,000 for a family.
- Maximum copay for inpatient stays has increased to \$1,000.
- Copays for some services have changed. Refer to the Comparison of Network Benefits for Health Plans.

Blue Cross and Blue Shield of Oklahoma BlueLincs HMO

- BlueLincs HMO is a new plan for 2019. Refer to the ZIP code service area for eligibility. Refer to the Comparison of Network Benefits for Health Plans.

CommunityCare HMO

- Inpatient hospital copays have increased to \$350 copay per day with a \$1,750 maximum.
- Outpatient hospital copay has decreased to \$300 per visit.
- Copays for some services have changed. Refer to the Comparison of Network Benefits for Health Plans.
- CommunityCare is changing the Pharmacy Benefit Manager to CVS. Along with this change, the preferred/non-preferred pharmacy network arrangement will no longer be in place.
- Pharmacy benefit structure has been redesigned. Refer to the Comparison of Network Benefits for Health Plans for pharmacy plan information.

GlobalHealth HMO

- Calendar year out-of-pocket maximum has increased to \$4,000 for an individual and \$12,000 for a family.
- Copays for some services have changed and some services now include an additional copay for physician charges. Refer to the 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 2019, you will be notified by mail. For a complete list of medications that will no longer be covered, please visit www.healthchoiceok.com.

HealthChoice High

- Copay for urgent care is \$30.

HealthChoice High Deductible Health Plan (HDHP)

- The HSA maximum annual contribution for an individual is increasing from \$3,450 to \$3,500.
- The HSA maximum annual contribution for a family is increasing from \$6,900 to \$7,000.

DENTAL PLANS

If your plan is not an option in 2019, your personalized Option Period form indicates the coverage end date. You then need to choose a new plan. If you do not, your dental coverage will be defaulted to HealthChoice Dental.

Delta Dental

- Delta Dental PPO Plus Premier will not be available in 2019.

MetLife

- MetLife Value PDP will not be available in 2019.
- MetLife High Classic MAC was formerly known as MetLife Classic.
- MetLife Low Classic MAC was formerly known as MetLife Value MAC.
 - Deductible increased to \$50 for an individual and \$150 for a family.
 - Basic Care: Member network coinsurance increased to 30%.
 - Major Care: Member network coinsurance increased to 50%.
 - Orthodontic Care: Member network coinsurance increased to 50%.
 - Plan Year Maximum decreased to \$1,500.

Sun Life (formerly Assurant)

- Assurant Heritage Plus with SBA (Prepaid) and Assurant Heritage Secure will not be available in 2019.
- Sun Life Preferred Active PPO was formerly known as Assurant Freedom Preferred.

VISION PLANS

Vision Care Direct

- **Lenses** Network: \$15 copay includes lenticular lenses; PLUS Plan offers free upgrades for high definition polycarbonate, premium anti-reflection, scratch and UV coatings, and no-line progressive lenses. Non-network: Plan reimbursement for bifocals increased to \$75.

VSP

- **Eye exams** Non-network: Plan reimbursement is after a \$10 copay.
- **Lenses** Non-network: Plan reimbursement is after a \$25 materials copay.
- **Frames** Non-network: Plan reimbursement is after a \$25 materials copay.

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 2019 available at www.healthchoiceok.com by Nov. 9, 2018.

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 the High or Basic plan if those who use tobacco complete one of the following alternatives by Nov. 9:

- Show proof of an attempt to quit using tobacco by enrolling in the quit tobacco program available through the Oklahoma Tobacco Helpline (1-800-QUIT-NOW) and Optum and completing three coaching calls.
- Provide a letter from your doctor 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, 2019, or the last day of the month of 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 before you choose 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 several health plans available:

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

Refer to Comparison of Network Benefits for Health Plans on pages 24-31 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 16-23 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 2019, 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 waive fees and make establishing and keeping a health savings account easier and more convenient for HealthChoice HDHP members.

HSA Information

Health savings accounts allow you to save money for HSA-eligible expenses, and they give you the ability to take greater control of your own health care costs. An HSA allows you to payroll deduct pre-tax HSA contributions.

Triple Tax Savings Advantage

When coupled with your Section 125 Plan, the HSA allows you a triple tax advantage:

- Pre-tax contributions.
- Tax-free interest accumulation.
- Tax-free distributions for qualified medical expenses.

HSA Card

Use your HSA Card to pay for eligible expenses instead of paying out-of-pocket.

- Direct access to funds.
- Eliminate distribution wait time.
- Accepted at doctor's offices, retailers and pharmacies.

Online Account Access

Distributions can be requested online either before or after an expense has been incurred. Distributions can be received via check by mail or by direct deposit.

Health Savings Account Form

If you choose American Fidelity for your HSA, you must complete the American Fidelity Health Savings Account Form and return it directly to American Fidelity.

For more information about HSAs, contact American Fidelity at the number located in Contact Information at the back of this guide.

Electing a TRICARE Supplement Plan (Military only)

NOTE: *If you do not currently have TRICARE coverage as a current or former military member, EGID cannot enroll you in TRICARE coverage, and you are not eligible for the TRICARE Supplement Plan.* If you currently have TRICARE coverage and are younger than age 65, you can choose to enroll in the TRICARE Supplement Plan. Electing to purchase the TRICARE Supplement Plan means that TRICARE will be primarily responsible for your medical coverage and the supplement plan will be secondarily responsible for coverage. The plan covers the cost shares and copays, including prescription drugs; a portion of the TRICARE deductible; and excess charges up to the legal limit. 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. For more information on the TRICARE Supplement Plan, refer to <http://omes.ok.gov/services/employees-group-insurance-division/tricare-supplement>.

DENTAL PLANS

There are several dental plans available:

- Cigna Dental Care Plan (Prepaid)
- Delta Dental PPO
- Delta Dental PPO – Choice
- HealthChoice Dental
- MetLife High Classic MAC
- MetLife Low Classic MAC
- Sun Life Preferred Active PPO

Refer to Comparison of Benefits for Dental Plans on pages 32-35 for benefit information.

- You must select a primary care dentist for yourself and each covered dependent when enrolling in a prepaid dental plan.
- HealthChoice has a 12-month waiting period for orthodontic benefits.
- Some plans may not be available in all areas.

VISION PLANS

There are several vision plans available:

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

Refer to Comparison of Benefits for Vision Plans on pages 36-38 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 in life coverage when first eligible, you can enroll:
 - During the annual Option Period (enroll in or increase life coverage).
 - 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

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. For 2019, there is a new disability administrator.

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 ebd.ok.gov. Be sure to choose the monthly or biweekly calculator, depending on your pay frequency. 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. 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, 2018.

Customer assistance is available Oct. 1 through 31 from 8 a.m. – 4 p.m. Assistance is also available by submitting a help ticket at servicedesk@omes.ok.gov.

Last year, 80 percent of state employees went to 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.

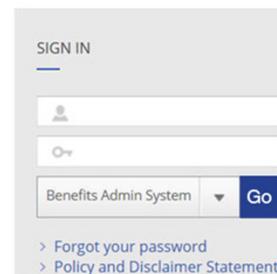
Online enrollment allows you to:

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

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

On the home page of ebd.ok.gov, the Benefits Administration System (BAS) access window is on the right of the screen. For online enrollment in the BAS, refer to image at right. It is located at 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.



The image shows a 'SIGN IN' form with a header 'SIGN IN' and a blue underline. Below the header is a text input field with a person icon, followed by a password input field with a key icon. A dropdown menu is set to 'Benefits Admin System' with a blue 'Go' button to its right. At the bottom, there are two links: '> Forgot your password' and '> Policy and Disclaimer Statement'.

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).
- 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 HCM and EGID rules and regulations.

ENROLLMENT PERIODS

Option Period Enrollment – Coverage effective Jan. 1, 2019

This is the time when eligible employees can:

- Enroll in coverage.
- Change plans or drop coverage.
- Increase or decrease life coverage.
- 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.
- 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. You have 30 days following your eligibility date to make changes to your original enrollment. Check with your benefits coordinator for more information.

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.

Midyear Changes – Coverage generally effective the first of the month following a qualifying event

Midyear plan changes are allowed only when a qualifying event, such as birth, marriage or loss of other group coverage, occurs. You must complete the appropriate form within 30 days of the event. Contact your benefits coordinator for more information.

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.
- 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 eligibility begin 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, HCM 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.
 - 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.
- 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, BlueLincs, 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, 2019. 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 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, select Confirmation of Benefits (COB) to save your enrollment confirmation for future reference.

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. If the coverage listed on the COB is incorrect, it is your responsibility to immediately notify your benefits coordinator.

Retiring and Changing Plans

If you are retiring on or before Jan. 1, 2019, go to omes.ok.gov for the appropriate Option Period materials. Select the Option Period banner, then select according to your status as of Jan. 1, 2019 – 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, 2019, an additional form will be required to enroll in one of the Medicare supplement or Medicare Advantage Prescription Drug (MA-PD) plans. You can also call EGID 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.
 - 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 ZIP Code List

Aetna INTEGRIS

73003	73007	73008	73012	73013	73014	73019
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Aetna St. John

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BlueLincs ZIP Code List

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BlueLincs ZIP Code List

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BlueLincs ZIP Code List

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CommunityCare ZIP Code List

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GlobalHealth ZIP Code List

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GlobalHealth ZIP Code List

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GlobalHealth ZIP Code List

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

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	Aetna INTEGRIS and Aetna St. John HMO	BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Calendar Year Deductible	No deductible	No deductible	No deductible	No deductible
Calendar Year Out-of-Pocket Maximum	\$5,000 individual \$10,000 family Includes medical and pharmacy	\$3,500 individual \$10,500 family Includes medical and pharmacy	\$4,000 individual \$8,000 family Includes medical and pharmacy	\$4,000 individual \$12,000 family Includes medical and pharmacy
Office Visit	\$35 copay/PCP \$50 copay/specialist	\$0 copay/PCP \$50 copay/specialist	\$35 copay/PCP \$50 copay/specialist	\$0 copay/PCP \$50 copay/specialist
X-Ray and Lab	\$0 copay for routine X-ray and lab \$0 copay per MRI, CAT, MRA or PET scan	\$0 copay for X-ray and lab \$250 copay per scan/procedure (MRI, CT, PET, EEG, ECG, MPS and similar); and pathology and lab under CPT codes of cytogenetic studies, surgical pathology, or transcutaneous procedures	\$0 copay for routine X-ray and lab \$200 copay per scan Specialty scans: MRI, CT, MRA and PET scans	\$10 copay for X-ray and lab For MRI, MRA, PET, CAT and nuclear scans: \$250 copay per scan in a preferred facility \$750 copay per scan in a non-preferred facility
Allergy Testing and Treatment	\$35 copay/PCP \$50 copay/specialist Testing covered at 100% per 6-week supply of antigen and administration	\$0 copay/PCP \$50 copay/specialist \$30 copay for allergy serum (once every 6 weeks, including shots)	\$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 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 (Separate pharmacy deductible, refer to page 31)	<p>High Plan \$750 individual \$2,000 family (3 or more)</p> <p>High Alternative Plan \$1,000 individual \$2,750 family (3 or more)</p> <p>Copays do not apply to deductible</p>	<p>Basic Plan \$1,000 individual \$1,500 family (2 or more) Applies after plan pays first \$500 of allowable fees</p> <p>Basic Alternative Plan \$1,250 individual \$1,750 family (2 or more) Applies after plan pays first \$250 of allowable fees</p>	<p>\$1,750 individual \$3,500 family (2 or more) Deductible can be met by one or more family members The combined medical and pharmacy deductible must be met before benefits are paid</p>
Calendar Year Out-of-Pocket Maximum (Medical copays and deductibles apply to out-of-pocket maximum; separate pharmacy out-of-pocket maximum, refer to page 31)	<p>High Plan* \$3,300 network individual \$8,400 network family \$3,800 non-network individual \$9,900 non-network family, plus amounts over allowable fees</p> <p>High Alternative Plan* \$3,550 network individual \$8,400 network family \$4,050 non-network individual \$9,900 non-network family, plus amounts over allowable fees</p>	<p>Basic Plan \$4,000 individual \$9,000 family</p> <p>Basic Alternative Plan \$4,000 individual \$9,000 family</p> <p>Network and non-network coinsurance, copays and deductibles apply to medical out-of-pocket maximum</p>	<p>\$6,000 individual \$12,000 family (2 or more) The individual out-of-pocket does not apply if two or more family members are covered Pharmacy copays apply to the out-of-pocket maximum but non-network charges do not apply</p>
Office Visit	<p>\$30 copay/physician office visit** \$50 copay/specialist office visit</p>	<p>Basic Plan \$0 of the first \$500 of allowable fees 100% of the next \$1,000 of allowable fees (deductible). Only allowable fees count toward the deductible; 50% of the next \$6,000 of allowable fees</p> <p>Basic Alternative Plan \$0 of the first \$250 of allowable fees 100% of the next \$1,250 of allowable fees (deductible). Only allowable fees count toward the deductible; 50% of the next \$5,500 of allowable fees</p> <p>Both Basic Plans \$0 of allowable fees over the individual or family out-of-pocket maximum If using non-network providers, you pay costs above allowable fees</p>	<p>You pay 100% of allowable fees until deductible is met \$30/\$50** office visit copay applies after deductible</p>
X-Ray and Lab	<p>20% of allowable fees after deductible</p>	<p>20% of allowable fees after deductible</p>	<p>20% of allowable fees after deductible</p>
Allergy Testing and Treatment	<p>20% of allowable fees after deductible Limit of 60 tests every 24 months</p>	<p>Copays do not apply All covered services, limitations and conditions are identical to the HealthChoice High Plan</p>	<p>20% of allowable fees after deductible Limit of 60 tests every 24 months</p>

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.

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	Aetna INTEGRIS and Aetna St. John HMO	BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Preventive Services	\$0 copay/PCP	\$0 copay (PCP or specialist) \$0 copay per OB/GYN visit, no referral required for annual routine services	\$0 copay (PCP or specialist)	\$0 copay PCP/routine physical exam \$0 copay well-woman exam and preventive services
Well Child Care	\$0 copay	\$0 copay	\$0 copay	\$0 copay per well-child visit
Immunizations	\$0 copay ages birth through 18 years \$0 copay ages 19 and older when medically necessary	\$0 copay	\$0 copay birth through age 20 years \$0 copay ages 21 and older when following the recommendation of ACIP	\$0 copay when following the recommendation of ACIP
Hearing Screening and Hearing Aid	Hearing screening \$0 copay Limit of one per year	Hearing screening \$0 copay Limit of one per year	Hearing screening \$0 copay when performed by PCP Limit of one per year Hearing aids 20% coinsurance	Hearing screening \$0 copay Limit of one per year Hearing aids 20% coinsurance
Hospital Inpatient	\$250 copay per day \$1,000 maximum per admission Preauthorization required	\$250 copay per day \$750 maximum per admission	\$350 copay per day \$1,750 maximum per admission Preauthorization required	\$250 copay per day \$750 maximum per admission Plus \$150 copay for physician charges
Hospital Outpatient	\$500 copay per visit	\$250 copay per visit	\$300 copay per visit	\$250 copay in a preferred facility \$750 copay in a non-preferred facility Plus \$50 copay for physician charges
Emergency Room	\$250 copay ; waived if admitted	\$300 copay; waived if admitted	\$200 copay; waived if admitted	\$350 copay for facility charge ; waived if admitted Plus \$50 copay for physician charges
Urgent Care	\$50 copay per visit	\$25 copay for outpatient or professional urgent care facility 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 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	\$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	No deductible for well child care visit	\$0 copay; no deductible applies
Immunizations	No charge for well child and adult immunizations and administration \$30/\$50** office visit copay may apply	Basic Plan \$0 of the first \$500 of allowable fees 100% of the next \$1,000 of allowable fees (deductible). Only allowable fees count toward the deductible; 50% of the next \$6,000 of allowable fees	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	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	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, non-emergency admission (does not count toward out-of-pocket)	Both Basic Plans \$0 of allowable fees over the individual or family out-of-pocket maximum If using non-network providers, you pay costs above allowable fees	20% of allowable fees after deductible Additional \$300 copay per non-network, non-emergency admission (does not count toward out-of-pocket)
Hospital Outpatient	20% of allowable fees after deductible	Copays do not apply All covered services, limitations and conditions are identical to the HealthChoice High Plan	20% of allowable fees after deductible
Emergency Room	20% of allowable fees after deductible \$200 ER copay – waived if admitted		20% of allowable fees after deductible \$200 ER copay – waived if admitted
Urgent Care	\$30 office visit copay may apply 20% of allowable fees after deductible		\$30 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	BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Maternity Pre and Post Natal Care	\$35 copay for initial visit \$250 copay per day \$1,000 maximum per admission	\$0 copay for prenatal and postnatal care \$500 copay per admission	\$0 copay for preventive prenatal and postnatal care \$35 copay/PCP \$50 copay/specialist for confirmation visit \$350 copay per day \$1,750 maximum per admission Preauthorization required	\$0 copay for prenatal care \$25 copay for delivery and all postnatal care \$500 per hospital admission
Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance
Mental Health or Substance Use Disorder Inpatient	\$250 copay per day \$1,000 maximum per admission Preauthorization required	\$250 copay per day \$750 maximum per admission	\$350 copay per day \$1,750 maximum per admission Preauthorization required	Residential Treatment Center or medical detox \$250 copay per day \$750 maximum per admission Plus \$150 copay for physician charges
Mental Health or Substance Use Disorder Outpatient	\$35 copay for office visit	\$0 copay/PCP \$50 copay/specialist	\$35 copay	\$0 copay per visit
Occupational or Speech Therapy Visit	\$0 copay inpatient, included in inpatient hospital cost \$50 copay outpatient therapy Limit of 60 days per condition	\$0 copay inpatient \$50 copay per outpatient therapy Limit of 60 visits combined for all therapies per year	Inpatient \$350 copay per day \$1,750 maximum per admission Preauthorization required \$50 copay per outpatient therapy visit Up to 60 days treatment per disability	\$0 copay inpatient \$35 copay per outpatient visit Limit of 60 treatment days per course of therapy
Physical Therapy or Physical Medicine Visit				
Chiropractic and Manipulative Therapy Visit	\$50 copay Limit 15 visits per year	\$50 copay Included under physical and occupational therapy, no separate visit limit per year	\$50 copay	\$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 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	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	20% of allowable fees after deductible Includes one postpartum home visit – criteria must be met
Durable Medical Equipment	20% of allowable fees after deductible for purchase, rental, repair or replacement	Both Basic Plans \$0 of allowable fees over the individual or family out-of-pocket maximum If using non-network providers, you pay costs above allowable fees Copays do not apply All covered services, limitations and conditions are identical to the HealthChoice High Plan	20% of allowable fees after deductible for purchase, rental, repair or replacement
Mental Health or Substance Use Disorder 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 Use Disorder Outpatient	20% of allowable fees after deductible Limit of 20 services per calendar year without certification	Both Basic Plans \$0 of allowable fees over the individual or family out-of-pocket maximum If using non-network providers, you pay costs above allowable fees Copays do not apply All covered services, limitations and conditions are identical to the HealthChoice High Plan	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	BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Pharmacy Benefits	<p>Retail Select generic: \$4 Generic: \$10 Preferred brand: \$30 Non-preferred brand: \$60</p> <p>Mail-order Select generic: \$8 Generic: \$20 Preferred brand: \$60 Non-preferred brand: \$120</p> <p>Specialty Preferred: \$100 Non-preferred: \$200</p>	<p>Retail Preferred generic: \$0 Non-preferred generic: \$10 Preferred brand: \$40 Non-preferred brand: \$80</p> <p>Mail-order Preferred generic: \$0 Non-preferred generic: \$25 Preferred brand: \$100 Non-preferred brand: \$200</p> <p>Specialty Preferred: \$100 Non-preferred: \$200</p>	<p>Retail (30-day supply) Select generic: \$0 Preferred generic/Tier 1: \$15 Preferred brand/Tier 2: \$40* Non-preferred brand or generic/Tier 3: \$70* Specialty/Tier 4: \$160*</p> <p>Mail-order (90-day supply) Select generic: \$0 Preferred generic/Tier 1: \$45 Preferred brand/Tier 2: \$120* Non-preferred brand or generic/Tier 3: \$210*</p> <p>Mail-Order (30-day supply) Specialty/Tier 4: \$160*</p> <p>*If you choose to obtain a brand name drug when a generic is available, you 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.</p>	<p>Retail 30-day supply Tier 1 generics: \$10 Preferred brand: \$65 Non-preferred drugs: \$90</p> <p>90-day supply Tier 1 generics: \$20 Preferred brand: \$130 Non-preferred drugs: \$180</p> <p>Specialty Preferred: \$100 Non-preferred: \$200</p>

Plan changes are indicated by **bold text**. This is only a sample of the services covered by each plan. For services 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 The applicable pharmacy deductible must be met before pharmacy copays apply. Refer to the bottom of the page for more details.	
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, HIGH ALTERNATIVE, BASIC, AND BASIC ALTERNATIVE PLANS

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

Pharmacy out-of-pocket maximum – \$2,500 for individual (\$4,000 for family), then you pay \$0 for preferred products at network pharmacies for the rest of the calendar year.

HEALTHCHOICE HDHP

Pharmacy benefits are available only after the combined medical and pharmacy deductible (\$1,750 individual/\$3,500 family) has been met.

ALL HEALTHCHOICE PLANS

HealthChoice Preventive Medication List – These medications are not subject to pharmacy deductible.

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 **up to a 168-day supply** 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-recommended 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.

Amounts paid by Copay Assistance programs, Manufacturer Copay Cards, or other third parties do not apply toward deductibles or out-of-pocket maximums.

COMPARISON OF BENEFITS FOR DENTAL PLANS

Allowable fees apply for all benefits	Cigna Dental Care Plan (Prepaid)	Delta Dental PPO Network and Non-Network	Delta Dental PPO – Choice
Annual Deductible	No deductible \$5 office copay applies	\$25 per person Basic and Major Care combined	\$100 per person Major Care only (Level 4)
Diagnostic and Preventive Care Cleanings, routine oral exams	Sealant per tooth: \$17 copay No charge for: Routine cleaning (limit two per calendar year) Topical fluoride application (up to age 18) Periodic oral evaluations	Plan pays 100% of allowable amounts	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
Basic Care Extractions, oral surgery	Amalgam (one surface, permanent teeth): \$23 copay	Plan pays 85% of allowable amounts after deductible	Schedule of covered services and copays Copay example: Amalgam – one surface, primary or permanent tooth \$12
Major Care Dentures, bridge work	Root canal (anterior): \$375 copay Periodontal scaling/root planing 1-3 teeth (per quadrant): \$75 copay	Plan pays 60% of allowable amounts after deductible	Schedule of covered services and copays Copay examples: Crown – porcelain/ceramic substrate \$241 Complete denture – maxillary \$320

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

COMPARISON OF BENEFITS FOR DENTAL PLANS

Allowable fees apply for all benefits	HealthChoice Dental	MetLife High Classic MAC	MetLife Low Classic MAC	Sun Life Preferred Active PPO
Annual Deductible	Network: \$25 individual/\$75 family Basic and Major services combined Non-network: \$25 individual/\$75 family Preventive, Basic and Major services combined	Network and Non-Network: \$25 individual/\$75 family Basic and Major Care combined	Network and Non-Network: \$50 individual/ \$150 family Basic and Major Care combined	\$25 per person, waived for Network preventive services
Diagnostic and Preventive Care Cleanings, routine oral exams	You pay Network: \$0 Non-network: Amounts above allowable fees after deductible	You pay Network: \$0 Non-network: Amounts above maximum allowed charge	You pay Network: \$0 Non-network: Amounts above maximum allowed charge	Network: Plan pays 100% of allowable amounts Non-network: Plan pays 100% of usual and customary after deductible
Basic Care Extractions, oral surgery	You pay Network: 15% Non-network: 30% plus amounts above allowable fees Deductible applies	You pay Network: 15% Non-network: 15% plus amounts above maximum allowed charge Deductible applies	You pay Network: 30% Non-network: 30% plus amounts above maximum allowed charge Deductible applies	Network: Plan pays 85% of allowable amounts after deductible Non-network: Plan pays 70% of usual and customary after deductible
Major Care Dentures, bridge work	You pay Network: 40% Non-network: 50% plus amounts above allowable fees Deductible applies	You pay Network: 40% Non-network: 40% plus amounts above maximum allowed charge Deductible applies	You pay Network: 50% Non-network: 50% plus amounts above maximum allowed charge Deductible applies	Network: Plan pays 60% of allowable amounts after deductible Non-network: Plan pays 50% of usual and customary after deductible

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

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

COMPARISON OF BENEFITS FOR DENTAL PLANS

Allowable fees apply for all benefits	Cigna Dental Care Plan (Prepaid)	Delta Dental PPO Network and Non-Network	Delta Dental PPO – Choice
Orthodontic Care	<p>\$2,472 out-of-pocket child \$3,384 out-of-pocket adult (24-month treatment)</p> <p>Excludes orthodontic treatment plan and banding</p>	<p>Plan pays 60% of allowable amounts, up to \$2,000 lifetime maximum per person</p> <p>Orthodontic benefits are available to eligible employee, spouse and dependent children</p>	<p>You pay charges in excess of \$50 per month Lifetime maximum up to \$1,800 per person</p> <p>Orthodontic benefits are available to eligible employee, spouse and dependent children</p>
Plan Year Maximum	No plan year maximum	\$2,500 per person for Diagnostic, Preventive, Basic and Major Care	\$2,000 per person for Diagnostic, Preventive, Basic and Major Care
Filing Claims	No claims to file	Network: No claims to file Non-network: You file claims	Network: No claims to file Non-network: You file claims

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

COMPARISON OF BENEFITS FOR DENTAL PLANS

Allowable fees apply for all benefits	HealthChoice Dental	MetLife High Classic MAC	MetLife Low Classic MAC	Sun Life Preferred Active PPO
Orthodontic Care	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	You pay Network: 40% Non-network: 40% plus amounts above maximum allowed charge \$2,000 lifetime maximum per person	You pay Network: 50% Non-network: 50% plus amounts above maximum allowed charge \$2,000 lifetime maximum per person	Network: Plan pays 60% Non-network: Plan pays 50% up to lifetime maximum of \$2,000 for dependents under age 19
Plan Year Maximum	Network and Non-network: \$2,500 per person	Network and Non-network: \$5,000 per person	Network and Non-network: \$1,500 per person	\$2,000 per person
Filing Claims	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	Member/provider must file claims

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

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

COMPARISON OF BENEFITS FOR VISION PLANS

	Primary Vision Care Services		Superior Vision	
Covered Services	Network	Non-Network	Network	Non-Network
Eye Exams	\$0 copay No limit to frequency	Plan reimburses up to \$40 Limit one exam	\$10 copay Limit one exam per calendar year	Plan pays up to: \$34 MD \$26 OD
Lenses Per Pair	You pay wholesale cost No limit to number of pairs	You pay normal doctor's fees, reimbursed up to \$60 for one set of lenses and frames per year	\$25 copay Limit one pair per calendar year Single focal, lined bifocal, lined trifocal covered in full	Plan pays up to: \$26 single \$39 bifocal \$49 trifocal \$49 standard progressive \$78 lenticular
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 \$150 retail Limit one per calendar year	Plan pays up to \$81
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	\$25 copay for lens fitting exam, one per calendar year Plan pays up to \$120 retail allowance After exam copay, medically necessary contacts covered in full Standard contacts covered in full; Specialty contacts \$50 retail allowance	Plan pays up to \$100 all contacts Plan pays up to \$210 medically necessary contact lenses Contact lens fitting exam not covered (Standard not covered; specialty not covered)
Laser Vision Correction	Through nJoy Vision in Oklahoma City and Tulsa Discount up to \$1,000 off Lasik	No benefit	Discount available	Discount available

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		VSP	
Covered Services	Network	Non-Network	Network	Non-Network
Eye Exams	\$15 copay for full comprehensive exam including dilation	Reimbursed up to \$50	Covered in full after \$10 copay	Reimbursed up to \$45 after \$10 copay
Lenses Per Pair	\$15 copay Single vision, bifocal, trifocal, lenticular lenses; PLUS free upgrades for high definition polycarbonate, premium anti-reflection, scratch and UV coatings, and no-line progressive lenses at any Plus Plan provider	Reimbursed up to: \$50 single \$75 bifocal \$100 trifocal \$100 progressive	Covered in full after \$25 materials copay Polycarbonate lenses covered in full for dependent children Standard progressives covered in full	Reimbursed up to: \$30 single \$50 bifocal \$65 trifocal \$50 progressive After \$25 materials copay
Frames	Covered in full up to \$130 for any frame	Reimbursed up to \$60	Covered in full up to \$170 or \$220 for featured frame brands 20% discount on any overage	Reimbursed up to \$70 after \$25 materials copay
Contact Lenses	No copay for fitting fee \$130 allowance, in lieu of glasses \$250 allowance for medically necessary contacts	\$80 allowance, in lieu of glasses	\$120 allowance, in lieu of glasses Up to \$60 copay for contact lens exam (fitting and evaluation)	Reimbursed up to \$105
Laser Vision Correction	Up to \$1,000 discount at nJoy facilities in Oklahoma City and Tulsa	No benefit	Average discount of 15% off regular price or 5% off 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 network services. Member must select either network or non-network for entire year. Network services are unlimited. Non-network services (one eye exam, one set of eyeglasses or contacts) are limited to once annually. A \$50 service fee applies to soft contact lens fittings; a \$75 service fee applies to rigid or gas permeable contact lens fittings or refittings; and a \$150 service fee applies to hybrid contact lens fittings or refittings. Simple replacements are not assessed with these fees. Limitations/exclusions include the following: 1) Medical eye care, 2) Vision therapy, 3) Non-routine vision services and tests, 4) Luxury frames, 5) Premium prescription lenses, and 6) Nonprescription eyewear. For more information or detail, call 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, 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 with provider offices that accept our discount plans. Standard contact lens fitting applies to an existing contact lens user who wears disposable, daily wear or extended wear lenses only. The specialty contact lens fitting applies to new contact lens wearers and/or members who wear toric, gas permeable or multifocal lenses.

Vision Care Direct: We are an Oklahoma-owned and operated company, which means customer service is here in the state to help you anytime you need help. It also means that you support your local community when you buy a plan based in Oklahoma! When you compare the total cost of your premium and what you spend in the doctor's office, you will see in most cases we offer 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 any frame up to \$130 and simply pay the difference if you go over. No more Frame Kit or Unbundling Fees, we have simplified the process to improve your experience. What would normally cost you over \$300 for progressive lenses will cost you much less with VCD. Visit www.okstate.vision for more information and inclusions/limitations, as well as a provider search. For our provider list, be sure to look for the VCD Plus logo to receive all the free options mentioned above. For more information, call 855-918-2020 or email oklahoma@visioncaredirect.com.

VSP: Exam, lenses and frame benefit provided annually. The \$25 materials copay applies to lenses or frames, but not to both. Copays/prices listed are for standard lens options. Premium lens options will vary. If choosing a frame valued at more than the allowance, member saves 20 percent on out-of-pocket costs when using a VSP doctor. Member receives an extra \$50 toward frame allowance when selecting a Marchon frame. Contact lenses are in lieu of spectacle lenses and frame. The \$120 network allowance applies to the contact lenses. With a VSP provider, the contact lens exam (fitting and evaluation) is covered in full after a copay up to \$60. The \$105 non-network allowance applies to the contacts and contact lens exam. Contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts. Prescription glasses – member receives an extra 20 percent off additional complete pairs of glasses, sunglasses or lens options at any VSP provider within last 12 months from exam. The 30 percent discount is not applicable. Contact VSP or visit vsp.com to learn more. VSP members can now use and integrate their benefits online, via eyeconic.com. Oklahoma enrollees can virtually try on each pair in the extensive catalog of glasses and sunglasses. Members can order glasses and contacts while using their VSP benefit. In addition to your VSP vision insurance, any additional savings will automatically be applied at the time of purchase. Frames can be sent directly to your door, or your provider's office for a final fitting, adjustment, and confirmation you are completely satisfied.

FLEXIBLE SPENDING ACCOUNTS

The health care account (HCA) and dependent care account (DCA) allow you to set aside money from your paycheck, pretax, to pay for after-insurance, qualified medical expenses, deductibles, copays, qualified over-the-counter (OTC) items, and planned dependent care charges. Updated lists of eligible and non-eligible expenses are available at ebd.ok.gov in the Flexible Spending section.

Important Notes on FSA Accounts:

- You must enroll every year.
- Indicate your **per-pay-period** contribution when you enroll.
- Reimbursement can also be made for expenses incurred by any participant during the grace period (Jan. 1 – March 15 of the following plan year).
- 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. It is important to forecast your expected expenses when enrolling in an FSA.
- You cannot enroll in a FSA if you enroll in the HealthChoice HDHP.
- You may be restricted from enrolling in the HealthChoice HDHP if you have funds remaining in your FSA on Jan. 1, 2019.
- You can continue to participate in the DCA if you elect the HealthChoice HDHP.
- Distributions from a health FSA must be paid only to reimburse you for qualified medical expenses you incurred during the period of coverage.

When calculating your FSA contribution for the upcoming plan year, it is important to plan conservatively. Calculate based on your plan year estimated expenses such as monthly prescription costs, copays for expected office visits, dependent care costs, and other planned qualifying expenses. The grace period may help reduce your risk of losing unused funds in your FSA accounts, but this time should not be used when calculating potential expenses.

If you terminate employment with the state, any daycare or medical services must be incurred prior to the last day of your termination month. Paper claims can be filed for such expenses incurred through March 30th of the following plan year. If you are not on active payroll (some type of leave), it is your responsibility to mail in your pledged contribution.

Health Care Account/Flexible Spending Account

By enrolling in the HCA, you can set aside up to \$2,700 for you and your dependent’s health care related expenses. You can realize significant tax savings on qualified, unreimbursed expenses by paying for the services and items pretax. 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

HCA Pre-tax Withdrawal Limits

- HCA monthly minimum: \$10
- HCA monthly maximum: \$225
- HCA biweekly minimum: \$5
- HCA biweekly maximum: \$112.50

Dependent Care Account

By enrolling in the DCA, you can set aside up to \$5,000 (combined total per household) for your qualified day care related expenses. By contributing to the DCA, you can use pretax dollars to pay for day care for:

- Your qualifying child who is your dependent and who was under age 13 when the care was provided.
- Your spouse who wasn't physically or mentally able to care for himself or herself and lived with you for more than half the year.
- A person who wasn't physically or mentally able to care for himself or herself, lived with you for more than half the year, and either
 - Was your dependent, or
 - Would have been your dependent, except that:
 - He or she received gross income of \$4,050 or more.
 - He or she filed a joint tax return.
 - You, or your spouse if filing jointly, could be claimed as a dependent on someone else's previous year's tax return.

DCA Pre-tax Withdrawal Limits

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

Below is an example of how an 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

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.

Premium Conversion Saves on Your Taxes

Premium conversion is an optional, IRS-approved election that 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.

You will be enrolled in premium conversion unless you elect to opt out.

If you have questions about your premium conversion options, be sure to ask your benefits coordinator.

✓ **Yes = tax savings!**

ADDITIONAL BENEFITS

Employees may be eligible to receive additional benefits, including:

- Retirement Plans
- Leave Benefits
- Longevity
- Paid Holidays
- Unemployment and Workers Compensation
- Voluntary payroll deductions
- Employee Assistance Program

CONSUMER INFORMATION AND ANNUAL NOTICES

HCM and EGID comply with the *Health Insurance Portability and Accountability Act* of 1996 known as HIPAA. HCM, 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 HCM. 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 use disorder 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 2019.

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 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 HCM 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 HCM 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.

CONTACT INFORMATION

Health Plans

Aetna INTEGRIS and Aetna St. John

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

BlueLincs

855-609-5684
www.bcbsok.com/state
www.bcbsok.com

CommunityCare

800-777-4890 or TDD 800-722-0353
state.ccok.com

GlobalHealth, Inc.

405-280-5600 or 877-280-5600
TDD 711
www.globalhealth.com

HealthChoice

Medical

800-323-4314
TTY 711 or 800-545-8279

Pharmacy

877-720-9375
TDD 711
www.healthchoiceok.com

Additional

EGID

405-717-8780 or 800-752-9475
TDD 405-949-2281 or 866-447-0436
omes.ok.gov

HealthSCOPE Benefits

877-385-8775
email CDHAdmin@healthscopebenefits.com
www.healthscopebenefits.com

American Fidelity Health Services Administration

405-523-5699 or 866-326-3600
www.afhsa.com

TRICARE

Selman & Company
800-638-2610, Option 1
Email: memberservices@selmanco.com

Dental Plans

Cigna Prepaid Dental

800-244-6224
Hearing Impaired Relay 800-654-5988
www.cigna.com

Delta Dental

405-607-2100 or 800-522-0188
DeltaDentalOK.org/client/OK

HealthChoice

800-323-4314
TTY 711 or 800-545-8279
www.healthchoiceok.com

MetLife

855-676-9443
www.metlife.com/oklahoma
www.metlife.com/mybenefits

Sun Life

800-442-7742
www.sunlife.com

Life Insurance

HealthChoice

800-323-4314
TTY 711 or 800-545-8279
www.healthchoiceok.com

Vision Plans

Primary Vision Care Services (PVCS)

888-357-6912 or TDD 800-722-0353
www.pvcs-usa.com

Superior Vision

800-507-3800 or TDD 916-852-2382
www.superiorvision.com

Vision Care Direct

877-488-8900 or TDD 711
www.okstate.vision

VSP

800-877-7195 or TDD 800-428-4833
www.vsp.com

