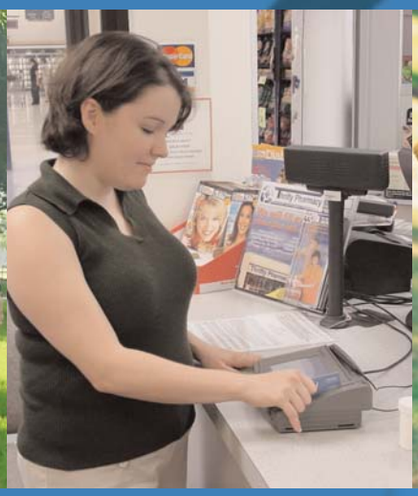
BIWEEKLY

2006

BENEFITS ENROLLMENT GUIDE

Active and New Employees of the State of Oklahoma



New Opportunities

- OK Health
- More Choices
- FSA Debit Cards
- Improved Online Enrollment

EMPLOYEES
Benefits Council

NEW FOR 2006!

Enroll in the OK Health Program

Left: *Before joining the OK Health Program, Danny White, an employee with the Department of Human Services, was struggling with high triglicerides and high blood pressure. After losing 35 lbs., Danny enjoys golfing, playing basketball and walking in the park with his family.*

Above: *Kari Lockwood, Department of Human Services employee, made lifestyle changes to avoid a genetic predisposition to diabetes, stroke and cardiovascular disease. By adding exercise to her daily activities and watching what she eats, Kari is on her way to better health.*

OK Health

It's about living well. . .
The OK Health Program

- **ENROLLMENT AVAILABLE FOR ALL** *active State employees,* **FREE OF CHARGE**
- **PERSONAL COACHING** *sessions with professionally trained mentors*
- **NO COPAY OR DEDUCTIBLE** *for initial doctor's visit and lab work*
- **FINANCIAL INCENTIVES AVAILABLE**
  (check with your agency for details)
- **TO ENROLL** *return attached postcard, enroll during option period, or logon to www.ebc.state.ok.us*

For more information on the OK Health Program, turn to page 24

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It's about making choices…

This is about you. It's about choosing your benefits and so much more. This Enrollment Guide will help you understand your choices and guide you through the enrollment process. In this Guide you will find benefit descriptions and plan comparisons and additional information in the back pocket.

To see a quick reference of this year's benefit allowance and the plan choices available, turn to the following pages:

Benefit Allowance PAGE 6

Health Plan Choices PAGE 9

Dental Plan Choices PAGES 10 & 11

Vision Plan Choices PAGES 12 & 13

It's about new opportunities…

This year you have some exciting additional choices available to you:

- ***Choose to Live Well:*** Join the OK Health Program available free of charge to all State employees beginning January 1, 2006. For information about this innovative health and wellness effort based on a successful pilot program with the Department of Human Services, see page 24 in this guide.
- ***Choose from an expanded list of HMO carriers:*** There are more HMO health plan choices available for 2006, including Aetna, CommunityCare, GlobalHealth and PacifiCare. Review the HMO plan designs carefully as the benefits have changed for the HMO Standard Plan and the HMO Alternative Plan. Each Alternative Plan has a different design set by each individual carrier.
- ***Choose to participate in the Flexible Spending Accounts (FSA):*** Flexible Spending Accounts will offer a virtually paperless option for 2006! Pre-loaded debit cards you can use at participating doctor's offices, pharmacies or day care providers will make filing most claims a thing of the past. Be sure to try the new FSA calculator at **www.ebc.state.ok.us** and see how much you can save in taxes by choosing to enroll in an FSA.
- ***Choose to enroll online:*** It takes just a few minutes to complete your enrollment and receive a confirmation of your selections. Log on to **www.ebc.state.ok.us** and choose the easy route to enrollment today.

Option Period is October 10 – November 4, 2005.
Benefits will be effective January 1, 2006.

Your agency may have earlier deadlines. Check with your Benefits Coordinator.

Health Plan Design Changes:

There will be changes to several health plan designs this year. Please refer to the Health Plan Comparison Chart (Gold Booklet) for detailed information about each plan design.

- ***Initial OK Health visit to be covered:*** OK Health Program enrollment will include an initial physician visit, biometric measurements, and labwork as needed for the OK Health Program evaluation. All health plans will include the initial visit with no copay or out-of-pocket expense. ***This benefit applies to employees choosing to participate in the OK Health Program. Dependents do not qualify for participation in the OK Health Program.***

- ***The HMO Plan designs have changed:*** The HMO Plan designs have changed for Plan Year 2006. There are two HMO plan designs available, a Standard and an Alternative, as opposed to the three HMO options which were available during Plan Year 2005. Carefully review the Gold Health Plan Comparison Booklet before making your HMO selections for Plan Year 2006.

- ***HMO Low Plan no longer available:*** The HMO Low Plan will not be available in 2006. If you participated in the HMO Low Plan in 2005 and do not choose a new plan for 2006, you will be defaulted to the same carrier's HMO Standard Plan for your 2006 health plan coverage.

- ***No Change to HealthChoice health benefit designs:*** There will be no changes to the HealthChoice High or HealthChoice Basic benefit designs for 2006, with the exception of the additional benefit for OK Health participants mentioned above.

Don't Be Caught By Surprise!

HMO members should be careful when making their choices in 2006. Don't rely on your plan being the same as last year. Plan designs have changed. If you do not complete your enrollment online or on paper, your health plan election will default and you may not get the coverage you want. So, be sure to review the new plan designs and complete your enrollment during Option Period.

NO ELECTION →	DEFAULT ELECTION
2005 selection	**2006 default**
CommunityCare HMO High	CommunityCare HMO Standard
GlobalHealth HMO High	GlobalHealth HMO Standard
CommunityCare HMO Low	CommunityCare HMO Standard
GlobalHealth HMO Low	GlobalHealth HMO Standard
CommunityCare HMO Alternative	CommunityCare HMO Alternative
GlobalHealth HMO Alternative	GlobalHealth HMO Alternative
HealthChoice High	HealthChoice High
HealthChoice Basic	HealthChoice Basic

Illustrative example

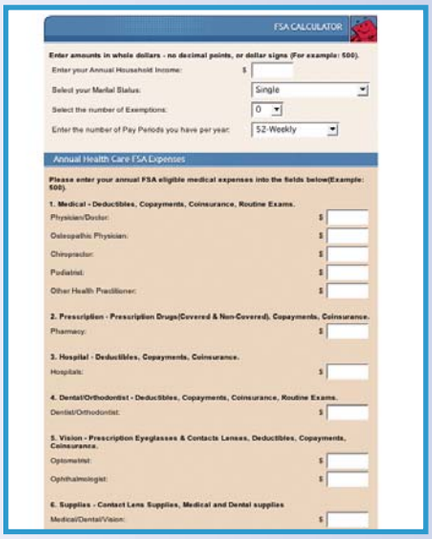
Flexible Spending Accounts Debit Card

If you've never used a Health Care Reimbursement Account, this year is the time to start. New debit cards will be introduced in 2006, allowing employees to pay for most doctor visits and pharmacy copays with the swipe of the card.* Using the debit card will result in filing fewer paper claims and less time waiting for reimbursements. The card will be pre-loaded with your allocated funds. If you contribute to the Dependent Care Reimbursement Account, and you have a participating provider, you can use the new debit card to pay for Dependent Care expenses as well. The debit card is optional and paper claims will still be accepted.

*Small annual activation fee estimated at $14.40 per year will apply for debit card usage. See your Benefits Coordinator to verify the annual activation fee amount. Some prescriptions, over-the-counter medications, and other charges may still require filing a paper claim for reimbursement.

Try the New Flexible Spending Account Calculator

Tax savings are what Flexible Spending Accounts are all about. Try the new Flexible Spending Account calculator to see how contributing to a Health Care Reimbursement or Dependent Care Reimbursement Account can allow you to pay for qualifying expenses with pre-tax dollars. Log onto **www.ebc.state.ok.us** and look for the new Flexible Spending Account calculator.


FSA CALCULATOR

Enter amounts in whole dollars - no decimal points, or dollar signs (For example: 500).

Enter your Annual Household Income: $

Select your Marital Status: Single

Select the number of Exemptions: 0

Enter the number of Pay Periods you have per year: 52-Weekly

Annual Health Care FSA Expenses

Please enter your annual FSA eligible medical expenses into the fields below(Example: 500).

1. Medical - Deductibles, Copayments, Coinsurance, Routine Exams.
Physician/Doctor: $
Osteopathic Physician: $
Chiropractor: $
Podiatrist: $
Other Health Practitioner: $

2. Prescription - Prescription Drugs(Covered & Non-Covered), Copayments, Coinsurance.
Pharmacy: $

3. Hospital - Deductibles, Copayments, Coinsurance.
Hospitals: $

4. Dental/Orthodontist - Deductibles, Copayments, Coinsurance, Routine Exams.
Dentist/Orthodontist: $

5. Vision - Prescription Eyeglasses & Contacts Lenses, Deductibles, Copayments, Coinsurance.
Optometrist: $
Ophthalmologist: $

6. Supplies - Contact Lens Supplies, Medical and Dental supplies
Medical/Dental/Vision: $

Retired Military Employees Have New Choices

State employees who retired from military service and have federal TRICARE insurance benefits may elect any of the following:

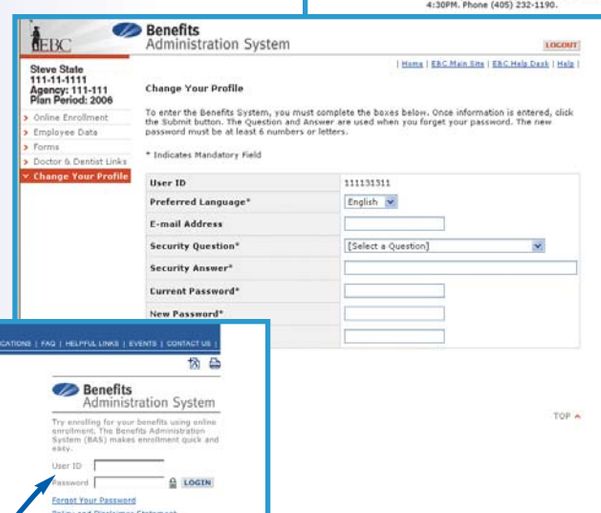
- Retain all State employee coverage and receive the regular benefit allowance.
- Opt out of State health, dental, life and disability coverage and ***receive no benefit allowance.*** You may still choose premium conversion, vision coverage and flexible spending account participation.
- Opt out of health insurance coverage only. ***Employee must purchase TRICARE Supplement Insurance plan.*** Your benefit allowance will be calculated using the cost of your TRICARE Supplement plan, average dental costs, life and disability costs. An employee electing the TRICARE Supplement retains dental, supplemental and dependent life and disability coverage, and may elect premium conversion, vision, and flexible spending account participation.

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. Differences may include, but are not limited to, the following: 1) Coverage for dependents who are full-time students may end at age 23, and 2) Medicare may become the primary insurer upon attaining eligibility for Medicare.

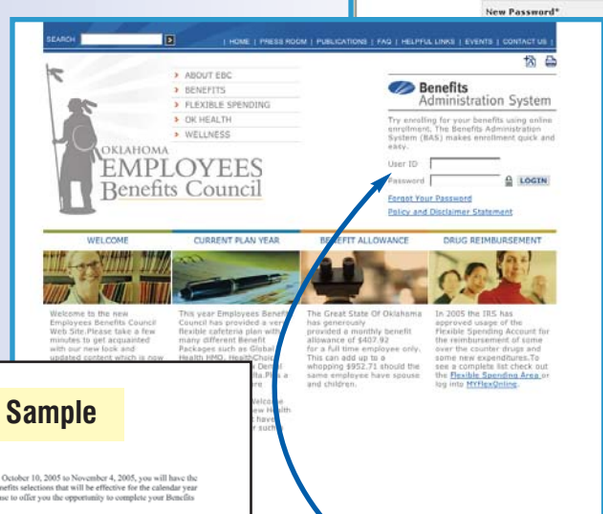
For information about the TRICARE Supplemental plan designs, contact the Association and Society Insurance Corporation toll free at (800) 638-2610 ext. 255 or log onto www.asitrisuppOK.com. If you choose to opt out or purchase TRICARE Supplement coverage, see your Benefits Coordinator for the required forms.

Online Enrollment Has a New Look

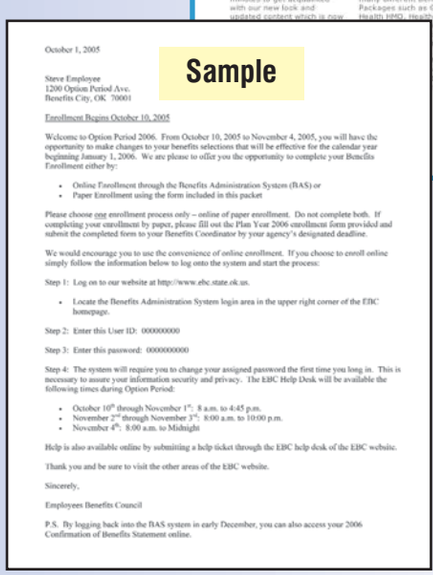
Last year, online benefits enrollment increased by more than 300 percent! Isn't it time you tried this quick and convenient enrollment process? This year, the Benefits Administration System (BAS) has a new look and online enrollment is even easier, with drop down menus and an improved confirmation process. To enroll online, log on to our website and look for the online enrollment screen at: **www.ebc.state.ok.us**.



4 *Choose Online Enrollment and begin.*



3 *Change password: Follow instructions to set your personal password.*



2 *Logon to EBC website: Sign onto Benefits Administration System using instructions found in your Welcome Letter.*

1 *Look for: The Welcome Letter in your enrollment materials. Find your User ID and password for Step 2.*

HELP IS AVAILABLE BY PHONE AT THE EMPLOYEES BENEFITS COUNCIL: (405) 232-1190 OR 1-800-219-8115

October 10 – November 1 (Monday – Friday) . . . . . 8:00 a.m. – 4:45 p.m.

November 2 – November 3 . . . . . 8:00 a.m. – 10:00 p.m.

November 4 . . . . . 8:00 a.m. – Midnight

Help is also available online by submitting a help ticket through the help desk of the EBC website.

How do my benefits really help me?

It's a question we hear often. Medical expenses are rising and insurance premiums are costly. So, what benefit am I realizing from my employer-paid health care insurance? Here's a snapshot of the value in having health insurance:

	Typical HMO Copay	Typical Indemnity Plan	No Insurance
Sample Costs:			
PCP office visit for common illness	$ 20.00	$ 25.00	$ 75.00
Inpatient hospital stay for 2 days	200.00	1,980.00	7,300.00
Lipitor prescription	25.00	25.00	120.00
TOTAL COST	$245.00	$2,030.00	$7,495.00
How much you pay:			
Total cost without insurance	$7,495.00	$7,495.00	$7,495.00
Your out-of-pocket expense	- 245.00	- 2,030.00	- 7,495.00
YOUR SAVINGS	$7,250.00	$5,465.00	$ 0.00

Note: This information is only provided for illustrative purposes using average costs and financial sharing arrangement information. It is intended only to provide a general statement about the value of health insurance. Do not rely on this information when making decisions about your actual health care. Actual copayment and coinsurance amounts are established by the plan in which you enroll. Actual medical costs will vary by provider and location.

How to be a Smart Health Care Consumer

It's important to take an active role in managing your own care. Becoming a smart health care consumer means taking responsibility for your health care choices. Understanding your health care coverage can result in better use of benefits and lower out-of-pocket costs for you. Following are a few tips for becoming a smart health care consumer:

- **Know your plan:** ***Before choosing a health or dental plan, pay special attention to***
  - Participating physicians
  - Premiums, copayments, deductibles
  - Plan availability within your home or work zip code

- **Talk to your Doctor:**
  - Tell your doctor about all the medications you take. Some medications may interfere with each other and shouldn't be taken together.
  - Find out why a test or treatment is necessary

- **Organize your health care information:**
  - Make a list of questions to ask your doctor at your next appointment
  - Keep your medical records in one file, for easy access
  - Make a list of the medications you are taking and important facts about your medical history (surgeries, treatments received, etc). Make a copy of the list and bring it to doctor visits for easy reference.

- **Make smart prescription medication choices:**
  - Use generic prescription drugs when possible

Your Benefit Allowance Has Increased Again!

After you've considered your benefit choices, the State gives you an "allowance" to help pay for your selections. The Benefit Allowance helps you pay for insurance premiums that would otherwise come out of your own pocket. This year's employee benefit allowance has increased from last year, helping meet the rising costs of your benefits. And for employees electing to cover dependents on the health option, an allowance is provided to cover 75% of the average of all high option premium dependent costs.

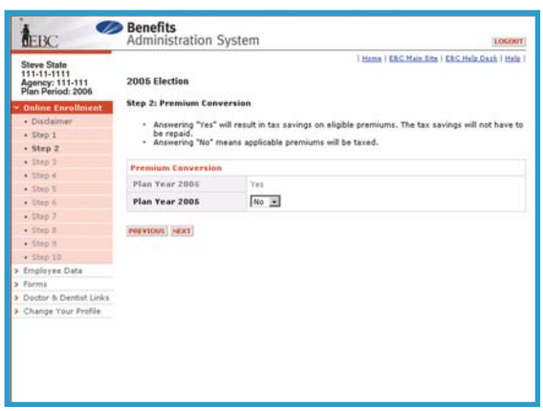
Biweekly Allowance

			Biweekly		Yearly
Employee-Only			**$200.10**		**$ 5,202.60**
Child	$88.83	=	$288.93	=	$ 7,512.18
Children	$120.39	=	$320.49	=	$ 8,332.74
Spouse	$186.37	=	$386.47	=	$10,048.22
Spouse/Child	$275.20	=	$475.30	=	$12,357.80
Spouse/Children	$306.76	=	$506.86	=	$13,178.36

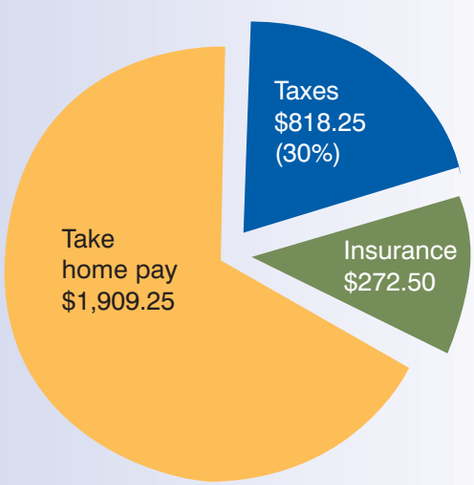
Premium Conversion It's About Saving Taxes…

Premium Conversion is an optional election chosen by over 91% of State employees, allowing them to save by paying NO TAX on their eligible insurance premiums. By paying insurance premiums for health, dental, vision, supplemental life and flexible spending accounts pre-tax, you have more take home pay than you would if you paid the same premiums with after-tax dollars. To choose premium conversion, you must check "Yes" on the premium conversion box during online enrollment or when completing your paper enrollment form.

Online Enrollment: Step 2

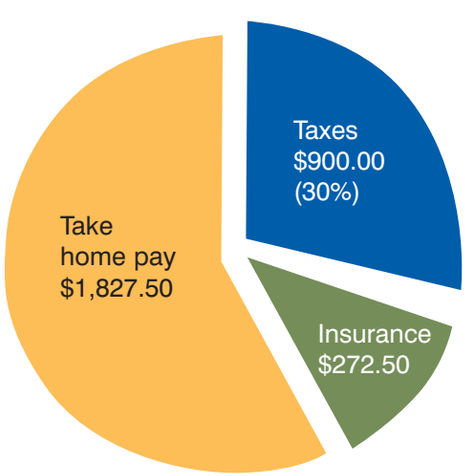


Yes to Premium Conversion*

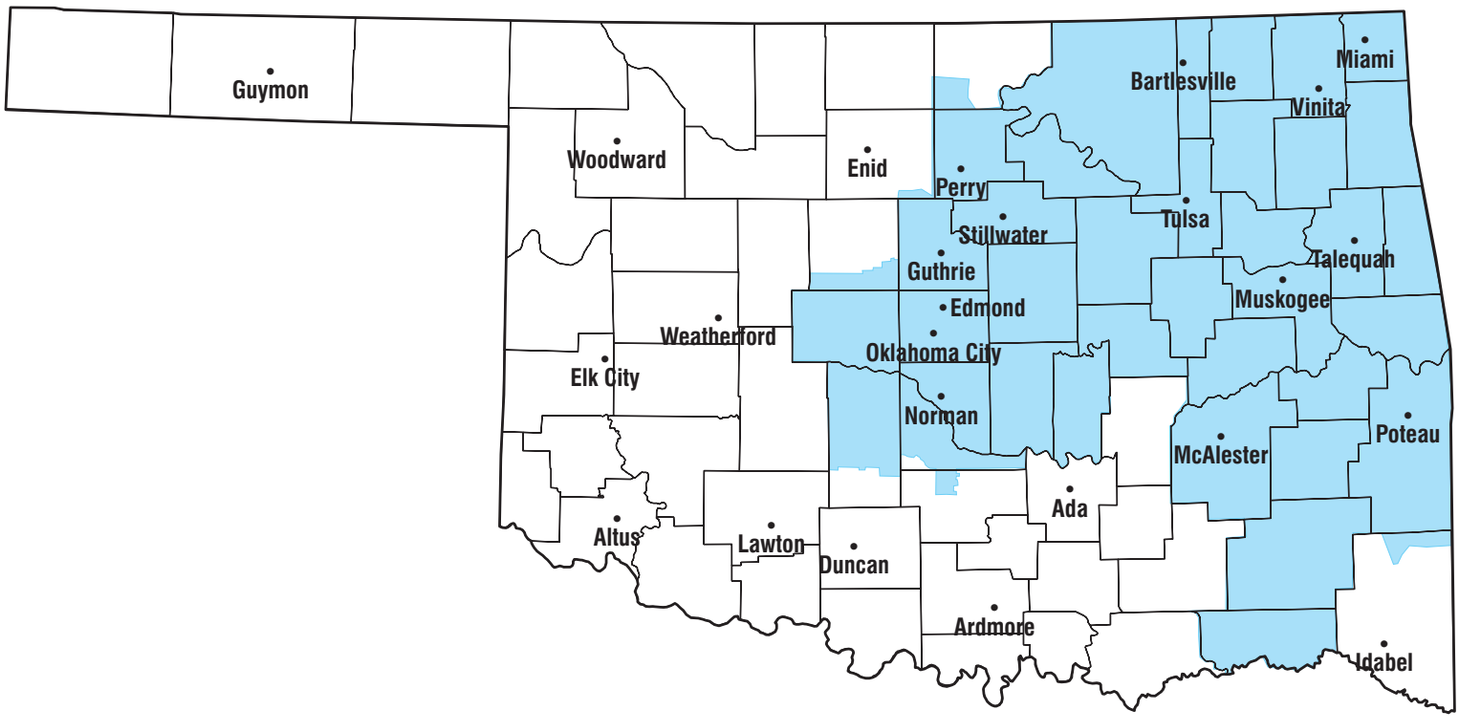


*Assumes 30% tax bracket and gross monthly income of $3,000

No to Premium Conversion*



*Assumes 30% tax bracket and gross monthly income of $3,000



HealthChoice Only
HMO and HealthChoice Coverage

Note: The HMO coverage area is determined by zip code. Please look at the Provider Guide, included in your enrollment material, for a list of HMOs available by zip code.

More choices available in 2006

Great news for State employees…there are more health plan choices available in the coming year, with the addition of two new HMO carriers. For plan year 2006, choose among the following carriers: HealthChoice, Aetna, CommunityCare, GlobalHealth and PacifiCare.

HealthChoice offers state-wide coverage. Aetna and PacifiCare are available in the Oklahoma City and Tulsa metropolitan areas, while CommunityCare is available in the Oklahoma City metropolitan area, the Tulsa metropolitan area and eastern Oklahoma. GlobalHealth has extended their service area and now offers coverage for those who live or work in both the Oklahoma City and Tulsa metropolitan areas.

In 2006, State employees may choose among the following dental carriers: HealthChoice Dental, Assurant Dental, CIGNA Dental and Delta Dental. You may also choose between five vision plan providers including: CompBenefits, PVCS, Spectera, Superior and VSP.

See the health, dental and vision pages in this Guide for plan comparisons and premium rates.

Out of state assignments of more than 90 days may qualify you for enrollment in the HealthChoice USA Plan, a national network healthcare option. Call EBC or HealthChoice for additional information.

Which Plan is Right for Me?

The health plan choice that is right for you and your family depends on your own situation. An HMO may be perfect if you want easily budgeted medical expenses and low out-of-pocket costs. On the other hand, if you want to see a particular doctor, the HealthChoice plans offer access to a larger list of physicians with access in-network and out-of-network. Look at the lists below for some things to consider when deciding which plan may best meet your health care needs in 2006. Premium costs are also important, so be sure to look at the medical premium chart on page 9.

HMO Standard Plans

- No deductibles
- Affordable copays
- Low out-of-pocket costs
- Easily budgeted medical expenses
- No paperwork
- Medical care managed by primary care physician
- Plan approval generally needed for outside specialists

HealthChoice High

- Available statewide
- Choose any doctor
- Deductibles apply
- Copays apply
- Out-of-network benefits available

HMO Alternative Plans

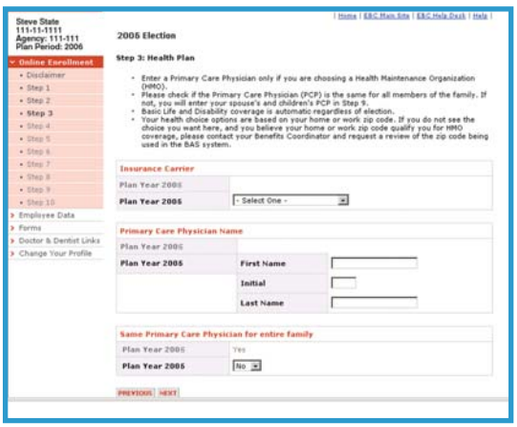
- Copays apply
- Easily budgeted medical expenses
- No paperwork
- Medical care managed by primary care physician
- Plan approval generally needed for outside specialists

HealthChoice Basic

- Available statewide
- Choose any doctor
- First $500 in eligible medical costs covered 100%, then deductible applies (see Health Plan Comparison Chart for details)
- Out-of-network benefits available
- Coinsurance applies and should be considered when budgeting for annual medical costs

See the Gold Health Plan Comparison Booklet for more information about the health plan benefit designs prior to making your Plan Year 2006 choices.

Online Enrollment: Step 3



Health Plan Choices

Health care protection brings peace of mind when everyday and unexpected medical expenses occur. For 2006, you have the following health plan choices:

HMO Options

(availability based on zip code)
Aetna HMO Standard Plan
Aetna HMO Alternative Plan
CommunityCare HMO Standard Plan
CommunityCare HMO Alternative Plan
GlobalHealth HMO Standard Plan
GlobalHealth HMO Alternative Plan
PacifiCare HMO Standard Plan
PacifiCare HMO Alternative Plan

HealthChoice Options

(available state-wide)
HealthChoice High Plan
HealthChoice Basic Plan

TRICARE Supplement

(retired military employees only)

Plan designs have changed for 2006

Be sure to review the HMO Standard and Alternative plan designs. Copays and other important benefits have changed. For more details about each health plan's benefit design, see the enclosed Health Plan Comparison Chart.

Plan Year 2006 Biweekly Rates	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & One Child	Employee & Two or More Children
HealthChoice High	$143.29	$351.08	$423.59	$466.65	$215.80	$258.86
HealthChoice Basic	124.26	303.42	365.81	402.86	186.65	223.70
Aetna Standard	176.08	410.24	582.79	582.79	348.63	348.63
Aetna Alternative	159.10	370.69	526.60	526.60	315.01	315.01
CommunityCare Std.	237.80	484.19	633.52	683.29	387.13	436.90
CommunityCare Alt.	159.24	316.89	412.44	444.28	254.79	286.63
GlobalHealth Standard	151.03	377.42	460.63	509.48	234.24	283.09
GlobalHealth Alternative	134.78	336.82	411.08	454.67	209.04	252.63
PacifiCare Standard	229.16	556.86	671.44	740.18	343.74	412.48
PacifiCare Alternative	140.77	342.08	412.47	454.70	211.16	253.39
Tricare Supplement	27.23	54.46	81.69	100.61	54.46	73.38
Plan Year 2006 Benefit Allowance	$200.10	$386.47	$475.30	$506.86	$288.93	$320.49

Benefits Calculator

Your benefit costs can be easily calculated using the online Benefits Calculator located on the EBC website at **www.ebc.state.ok.us**. Be sure to choose the monthly calculator if you are paid once a month and the biweekly calculator if you are paid every two weeks. The Benefits Calculator can calculate 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 Calculator:

- 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.

For Benefits Calculator, logon to www.ebc.state.ok.us

Dental

Biweekly Rates

HealthChoice Dental

Employee Only $12.37
Employee & Spouse 24.74
Employee, Spouse & Child . . . 35.05
Employee, Spouse & Children 51.50
Employee & One Child 22.68
Employee & Two or more Children 39.13

Assurant Heritage Plus Prepaid

Employee Only $5.42
Employee & Spouse 9.51
Employee, Spouse & Child . . . 13.02
Employee, Spouse & Children 16.53
Employee & One Child 8.93
Employee & Two or more Children 12.44

Assurant Freedom Preferred

Employee Only $10.51
Employee & Spouse 20.97
Employee, Spouse & Child 28.82
Employee, Spouse & Children 42.06
Employee & One Child 18.36
Employee & Two or more Children 31.60

Cigna Dental Prepaid

Employee Only $4.15
Employee & Spouse 6.86
Employee, Spouse & Child 10.04
Employee, Spouse & Children 13.73
Employee & One Child 7.33
Employee & Two or more Children 11.02

Delta Dental PPO - Point of Service

Employee Only $11.00
Employee & Spouse 22.00
Employee, Spouse & Child 31.07
Employee, Spouse & Children 45.74
Employee & One Child 20.07
Employee & Two or more Children 34.74

Delta's Choice - PPO

Employee Only $4.11
Employee & Spouse 13.80
Employee, Spouse & Child 23.03
Employee, Spouse & Children 35.03
Employee & One Child 13.34
Employee & Two or more Children 25.34

	HealthChoice Dental Plan www.healthchoiceok.com		Assurant Heritage Plus www.assurantemployeebenefits.com
	In Network	Out of Network	Prepaid Plan (Requires choosing a primary care dentist)
Deductibles	$25 per person for Basic and/or Major Combined; $50 Deductible for Orthodontia	$25 per person for Preventive, Basic and or Major Combined; $150 for Orthodontia	None
Preventive Care (Class A) Includes routine cleanings, check-ups and X-rays for adults and children, and fluoride treatments	100% of allowable amounts	100% of allowable amounts after deductible	Example Services/Copays Sealant per tooth: $15 copay Routine Cleaning (once every 6 months): No Charge Topical Fluoride Application (up to age 18): No Charge Periodic Oral Evaluations: No Charge
Basic Care (Class B) Includes fillings, extractions, root canals, periodontal care, and some oral surgery	85% of allowable amounts after deductible	70% of allowable amounts after deductible	Example Services/Copays Amalgam - one surface, permanent teeth $25
Major Care (Class C) Includes crowns, bridges, and dentures	60% of allowable amounts after deductible	50% of allowable amounts after deductible	Example Services/Copays Root Canal, Anterior $165 Periodontal/Scaling/ Root Planing 1-3 teeth (per quadrant) $36
Orthodontic Care (Class D)	Separate $50 deductible, plan pays 60% of allowable amounts up to lifetime maximum of $1,800	Separate $150 deductible, plan pays 50% of allowable amounts up to lifetime maximum of $1,800	25% discount
Annual Maximum Benefit	$1,500 per person per calendar year	$1,500 per person per calendar year	No plan year dollar maximum

Dental Coverage is something to smile about!

There are two types of dental plans available and the features are as follows:

Traditional Plans:

- *Freedom to choose any dentist*
- *Deductibles apply*
- *Coverage offered throughout the State*
- *Higher benefit paid for staying in-network*

Prepaid Plans:

- *No deductibles (see chart for exceptions)*
- *Copays apply*
- *Must choose a participating Primary Care Dentist*

Important Details on Dental Coverage:

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

Assurant Freedom Preferred Plan www.assurantemployeebenefits.com		CIGNA Dental www.cigna.com	Delta Dental PPO - Point of Service www.deltadentalok.org		Delta's Choice - PPO www.deltadentalok.org
In Network	**Out of Network**	**Prepaid Plan** *(Requires choosing a primary care dentist)*	**Delta Dental PPO Network**	**Delta Dental Premier Network & Out of Network**	**Delta Dental - PPO Network**
$25 per person (Waived for Class A services)	$25 per person	None $5 office copay applies	$25 per person per calendar year - Classes B & C only	$100 per person per calendar year - Classes A, B and C only	No deductible on Class A, B & D; $100 deductible per person on Class C Services only
100% of allowable amounts	100% of allowable amounts after deductible	Example Services/Copays Sealant per tooth: $15 copay Routine Cleaning (once every 6 months): $0 copay Topical Fluoride Application (up to age 18): $0 copay Periodic Oral Evaluations: $0 copay	100% of allowable amounts	100% of allowable amounts after deductible	Example Services/Copays Routine Cleaning: $5 copay Periodic Oral Evaluations: $5 copay Topical Fluoride Application (up to age 19): $5 copay
80% of allowable amounts after deductible	70% of allowable amounts after deductible	Example Services/Copays Amalgam - one surface, permanent teeth: $19 copay	85% of allowable amounts after deductible	70% of allowable amounts after deductible	Example Services/Copays Amalgam - one surface, permanent teeth: $12 copay
60% of allowable amounts after deductible	50% of allowable amounts after deductible	Example Services/Copays Root Canal, Anterior: $295 copay Periodontal Scaling/Root Planing 1-3 teeth (per quadrant): $55	60% of allowable amounts after deductible	50% of allowable amounts after deductible	Example Services/Copays Crown-porcelain/ceramic substrate: $241 copay Complete denture-maxillary: $320 copay
No deductible, plan pays 60% up to lifetime maximum of $1,500	No deductible, plan pays 50% up to lifetime maximum of $1,500	$2,000 out-of-pocket child; $2,700 out-of- pocket adult (24 month treatment); excludes orthodontic treatment plan and banding.	No deductible, plan pays 60% of allowable amounts, up to lifetime maximum of $1,500	No deductible, plan pays 60% of allowable amounts, up to lifetime maximum of $1,500	You pay charges in excess of $50 per month. Lifetime maximum of $1,500
$1,500 per person per calendar year	$1,500 per person per calendar year	No plan year dollar maximum	$1,500 per person per calendar year	$1,500 per person per calendar year	$1,500 per person per calendar year

NOTES:

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

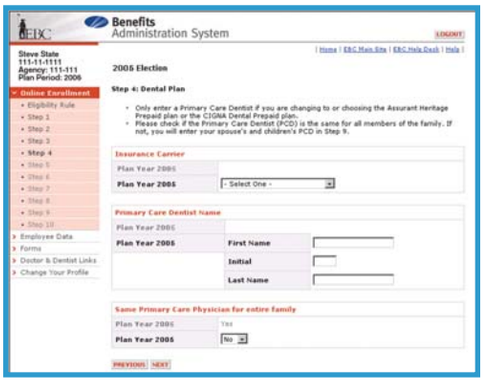
Balance Billing – the practice of a provider charging full fees and billing the member for the portion of the bill insurance doesn't cover.

Orthodontic benefits are typically only available for dependents under the age of 19 or anyone with TMD. Contact the plan to determine limits on Orthodontic benefits prior to enrollment. If new hires and/or new enrollees did not have group dental coverage in effect prior to becoming covered under HealthChoice Dental, a 12-month waiting period is applied for orthodontic services.

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

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

Online Enrollment: Step 4



Vision

Biweekly Rates

CompBenefits

Employee Only $3.12
Employee & Spouse 5.46
Employee, Spouse & Child 7.11
Employee, Spouse & Children 7.52
Employee & One Child 4.77
Employee & Two or more Children 5.18

PVCS

Employee Only $4.27
Employee & Spouse 7.85
Employee, Spouse & Child 11.66
Employee, Spouse & Children 12.58
Employee & One Child 8.08
Employee & Two or more Children 9.00

Spectera

Employee Only $3.60
Employee & Spouse 6.14
Employee, Spouse & Child 8.16
Employee, Spouse & Children 9.21
Employee & One Child 5.62
Employee & Two or more Children 6.67

Superior

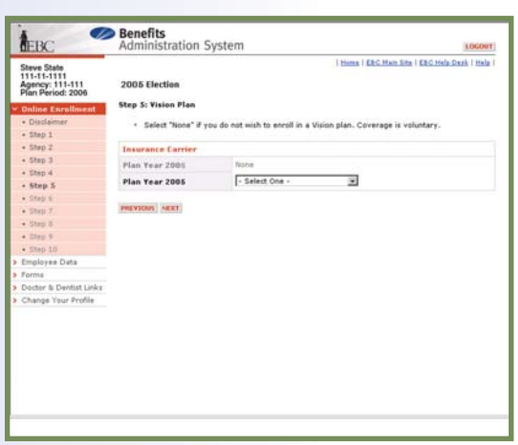
Employee Only $3.22
Employee & Spouse 6.41
Employee, Spouse & Child 9.45
Employee, Spouse & Children 9.45
Employee & One Child 6.26
Employee & Two or more Children 6.26

VSP

Employee Only $4.22
Employee & Spouse 6.75
Employee, Spouse & Child 9.42
Employee, Spouse & Children 11.95
Employee & One Child 6.89
Employee & Two or more Children 9.42

COVERED SERVICES	CompBenefits www.visioncare.com		PVCS www.pvcs-usa.com	
	In Network	Out of Network	In Network	Out of Network
Eye Exams	$10 Copay	$10 Copay then plan pays up to $35	No Copay No limit to frequency	Plan pays up to $40 Limit 1 exam
Lenses Per Pair	$25 Copay for single/multi-focal lenses	Single up to $25 Bifocals up to $40 Trifocals up to $60 Lenticular up to $100	Member pays wholesale cost No limit to number of pairs	Member pays Normal Doctor Fees, reimbursed up to $40-60 for one set of lens & frame
Frames	$25 Copay, up to plan limits	$25 Copay then plan pays up to $45	Wholesale Cost No limit to number of frames	One frame annually, member pays normal doctor fees.
Contact Lenses	Plan pays up to $130 Conventional $130 Disposable Medically Necessary Covered in full	Plan pays up to $130 Conventional $130 Disposable $210 Medically Necessary	Wholesale Cost No limit to amount of lenses	Limit of one set annually in lieu of eyeglasses. Member pays Normal Doctor Fees reimbursed up to $60
Laser Vision Correction	Discount thru TLC, member will pay no more than $1800 per eye for conventional Lasik	No Benefit	Discount at multiple state locations: TLC; Wells Laser Center; Omni Eye Center	No Benefit

Online Enrollment: Step 5



IMPORTANT DETAILS

ABOUT VISION COVERAGE:

- **Each plan offers statewide coverage.**
- **Vision coverage is optional.**
- **Vision coverage does not roll over. You must re-enroll yourself and your family members each year.**

— Employees and all eligible family members may enroll, but if one dependent is covered, then all eligible dependents must be covered.

— Family members must enroll in the same vision plan as the employee.

Spectera www.spectera.com		Superior www.superiorvision.com		VSP www.vsp.com	
In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
$10 Copay	Plan pays up to $40	$10 Copay	$10 Copay then plan pays up to $34 - Opthamologist $26 - Optometrist	$10 Copay	$10 Copay then plan pays up to $35
$25 Copay	Single up to $40 Bifocals up to $60 Trifocals up to $80 Lenticular up to $80	$25 Copay	$25 Copay then plan pays up to Single up to $26 Bifocals up to $39 Trifocals up to $49 Lenticular up to $78	$25 Copay	$25 Copay, then plan pays: Single up to $25 Bifocals up to $40 Trifocals up to $55 Lenticular up to $80
$25 Copay	Plan pays up to $45	$25 Copay, then plan pays up to $125 retail	Plan pays up to $68	$25 Copay, then plan pays up to $105	$25 Copay, then plan pays up to $45
$25 Copay On covered-in-full qualifying lenses (covers fitting and evaluation fees, contact lenses and up to 2 follow-up visits) (See Notes)	$25 Copay, then plan pays up to $105 Conventional $105 Disposable $210 Medically necessary contact lenses	No Copay Plan pays up to $120 Conventional $120 Disposable Medically necessary contacts covered in full	No Copay Plan pays up to $100 Conventional $100 Disposable $210 Medically necessary	No Copay Plan pays up to $120 Conventional $120 Disposable Medically necessary contacts covered in full	No Copay Plan pays up to: $105 Conventional $105 Disposable $210 Medically necessary
Discount 15% off the usual & customary price 5% off promotional price	No Benefit	20% Discount off surgical fees	No Benefit	15% to 20% off usual and customary price or 5% off the laser center promotional price	No Benefit

NOTES: Exam, Lenses, and Frame benefits listed above are provided once every 12 months by all providers except PVCS In-Network benefits.

PVCS Note: Member must select either In Network or Out-of-Network for entire plan year. All In Network services are unlimited. Non-Network services (one eye exam, one set of eyeglasses or contacts) are limited to once annually. $50.00 service fee applies to all soft contact lens fittings; a $75.00 service fee applies to rigid or gas permeable contact lens fittings. Simple replacements are not assessed these fees. Limitations/Exclusions include the following: 1) Medical eye care, 2) Vision Therapy, 3) Nonroutine vision services and tests, 4) Nonprescription eye wear, and 5) Luxury frames (wholesale cost of frame is $100 or more).

CompBenefits Note: If frames and lenses are purchased at the same time, only one $25 copayment applies. All additional lenses (progressive lenses, scratch coating, anti-reflection, etc.) covered at wholesale copay. Contact lens benefit provides $130 annual allowance toward exam & purchase of lenses, in place of all other benefits. Over 23,000 frames on the market today are covered in full by In-Network providers. For Lasik benefit: Plan members must first contact CompBenefits for a list of providers and to receive a Refractive Care ID card.

Spectera Note:
Covered-in-full elective contact lenses:

- The fitting/evaluation fees, contacts (including disposables), and up to two follow-up visits are covered in full (after applicable copay) for the most popular brands. If covered disposable contact lenses are chosen, up to 4 boxes (depending on prescription) are included when obtained from a network provider. It is important to note that Spectera's covered-in-full contact lenses may vary by provider.
- All other elective contacts: The $105 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30, you will have $75 towards the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.

Superior Note: Comprehensive Exam does not include Contact Lens Exam. Only one $25 materials copay for frame and/or eyeglass lenses.

VSP Note: Lens/Frame benefits: The annual $25 material copayment applies to lenses or frames. If frames and lens are purchased at same time, only one $25 copayment applies. Your contact lens allowance applies to the cost of your contact lens exam (fitting and evaluation) and your contact lenses. A 15% discount applies to the cost of a contact lens exam from a VSP doctor. A contact lens exam is performed in addition to routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts.

Biweekly Rates

Basic Life ($20,000) $1.80
Includes AD&D

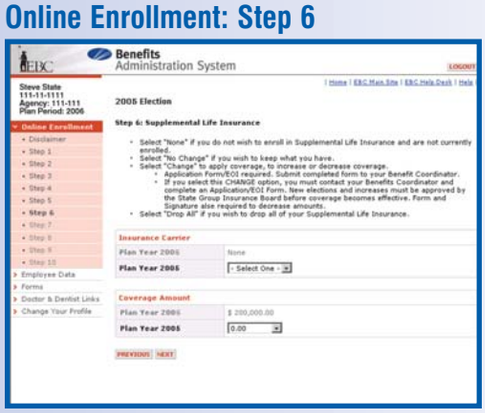
First $20,000 Supplemental Life $1.80
Includes AD&D

Additional Units of Supplemental Life
Age-Rated (Per $20,000)

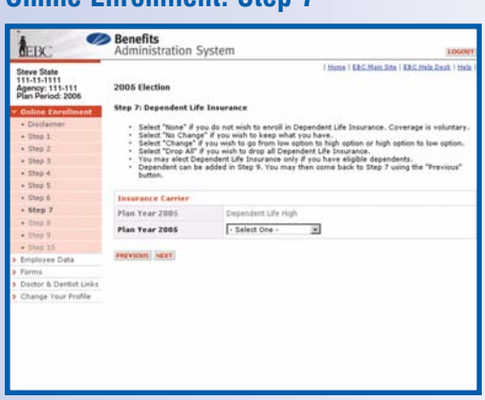
under 30 years	$ .55
30-34 years	.55
35-39 years	.83
40-44 years	1.20
45-49 years	1.94
50-54 years	3.23
55-59 years	5.35
60-64 years	6.18
65-69 years	10.15
70-74 years	17.17
75+ years	26.68

Dependent Life
Low Option $1.00
High Option $1.66

Online Enrollment: Step 6



Online Enrollment: Step 7



Employee Life Insurance

All eligible current State employees are offered a basic term life policy of $20,000 and an additional supplemental term life policy that allows flexibility in tailoring coverage to meet individual life insurance needs.

Basic Coverage

As a State employee, you are automatically enrolled in the basic level of life insurance coverage of $20,000. This also includes coverage for accidental death or dismemberment.

AD&D Coverage

Only the Basic Life Insurance ($20,000) and the first unit ($20,000) of Supplemental Life Insurance include Accidental Death and Dismemberment coverage. For details regarding loss of life or loss of limb benefits, see the HealthChoice Life Insurance Handbook. The handbook is available online at **www.healthchoiceok.com** or **www.sib.ok.gov.**

Supplemental Coverage

You may elect to increase your coverage in $20,000 units up to a maximum of $300,000 or five times your salary, whichever is LESS. The total amount issued depends on successful submission and approval of required Evidence of Insurability (EOI) including requested medical records. The postmark deadline for submitting an EOI is November 10, 2005.

Guaranteed Issue (New employees only)

New employees within their first 30 days of employment may enroll in life insurance coverage of two times their base annual salary without completing an EOI Form.

How to Apply

Complete a Supplemental Life Insurance Application and obtain your Coordinator's signature. Also complete an Evidence of Insurability Form and **mail directly to OSEEGIB's address** on the back of the form.

Dependent Life Insurance

You have two options when purchasing life insurance coverage for your dependents:

Dependent Life High Option

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

Dependent Life Low Option

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

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

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

Disability Insurance

Disability

No one expects to become disabled, but the financial burden can be reduced by your coverage under the State Disability Plan. The basic disability coverage under the program is 60% of your base pay up to a maximum dollar limit for which you may qualify based on age, salary and years of service.

Eligibility

Disability benefits are available to all employees who have completed at least one month of continuous employment. No benefits are payable for any disability caused by a pre-existing condition.*

Definition of Disability

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

What the Plan Pays

The disability plan will pay a monthly income of 60% of your base pay up to a maximum.

Monthly Maximum Disability Income

- Short-Term: $1,800
- Long-Term: $3,000

Any benefits paid will be offset by any other disability income you may receive such as Social Security or Worker's Compensation.

When the Plan Pays

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

Biweekly Rate

Disability $2.90

*For a complete description of the disability plans, eligibility facts and benefits please reference the HealthChoice Disability Insurance Handbook. The handbook is available online at **www.healthchoiceok.com** or **www.sib.ok.gov.**

Flexible Spending Accounts (FSAs) allow you to take money from your paycheck before taxes and set it aside for medical and child care expenses.

Fast and Flexible – the New Flex Debit Card

New for 2006! Employees participating in FSA accounts will have the ***optional*** convenience of a Flexible Spending Account debit card. The FSA debit card can be used nationwide, at participating locations. Participants simply present the FSA debit card to pay for qualified health care and dependent care expenses. The money is taken directly from your FSA, resulting in fewer claims to file and fewer forms to complete. A small annual activation fee estimated at $14.40 per year will apply for debit card usage. See your Benefits Coordinator to verify the annual activation fee amount. Some prescriptions, over-the-counter medications and other charges may still require filing a paper claim for reimbursement.

Illustrative example

Good News on Use It or Lose It – Grace Period Extended

Here's some more good news on FSA accounts. The IRS has extended the grace period for incurring qualified expenses. Now, you have until March 15 of the following year to use funds from your current year's healthcare reimbursement account.

So, go to the doctor, buy prescription medications, or incur any other qualified expenses until March 15, 2007 and still file for reimbursement from your remaining 2006 FSA account funds.

Some employees decide against participating in an FSA account because the IRS says if you don't use all of the money in your FSA by year-end, the unused amount is forfeited. This extended grace period should help you avoid losing any unused balance in your account by year-end.

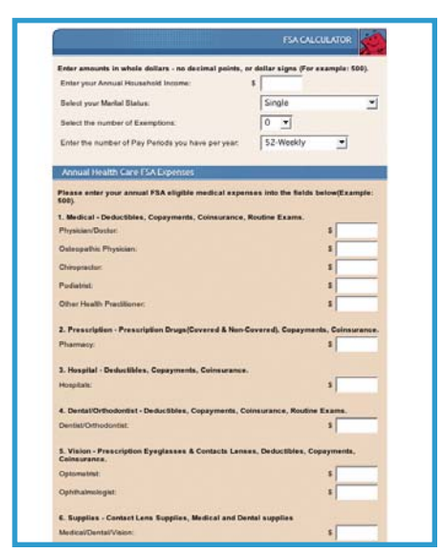
The extended grace period applies to 2005 funds as well. Ask your Benefits Coordinator for details. When calculating your FSA contributions for the Plan Year, it is important to plan conservatively. Calculate based on your Plan Year estimated expenses (and the debit card activation fee, if applicable). Do not include the extended grace period in your calculations. The extension should only be used for unexpected eligible expenses and aid in reducing your exposure to losing unused funds in your FSA account.

Calculate Your Savings with the New FSA Calculator

Some common questions asked by employees considering participation in an FSA account include:

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

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


FSA CALCULATOR

Enter amounts in whole dollars - no decimal points, or dollar signs (For example: 500).

Enter your Annual Household Income: $

Select your Marital Status: Single

Select the number of Exemptions: 0

Enter the number of Pay Periods you have per year: 52-Weekly

Annual Health Care FSA Expenses

Please enter your annual FSA eligible medical expenses into the fields below(Example: 500).

1. Medical - Deductibles, Copayments, Coinsurance, Routine Exams.

Physician/Doctor: $

Osteopathic Physician: $

Chiropractor: $

Podiatrist: $

Other Health Practitioner: $

2. Prescription - Prescription Drugs(Covered & Non-Covered), Copayments, Coinsurance.

Pharmacy: $

3. Hospital - Deductibles, Copayments, Coinsurance.

Hospitals: $

4. Dental/Orthodontist - Deductibles, Copayments, Coinsurance, Routine Exams.

Dentist/Orthodontist: $

5. Vision - Prescription Eyeglasses & Contacts Lenses, Deductibles, Copayments, Coinsurance.

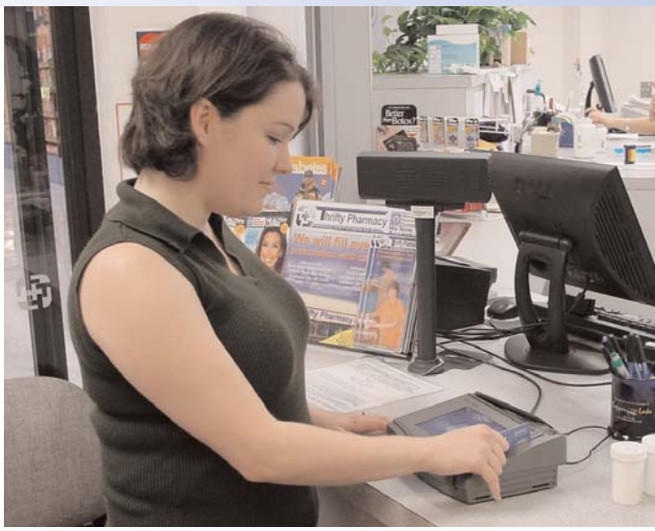
Optometrist: $

Ophthalmologist: $

6. Supplies - Contact Lens Supplies, Medical and Dental supplies

Medical/Dental/Vision: $

There are two types of FSA accounts, the Health Care Reimbursement Account and the Dependent Care Reimbursement Account. This page details both types of accounts.



Health Care Reimbursement Accounts (HCRA)

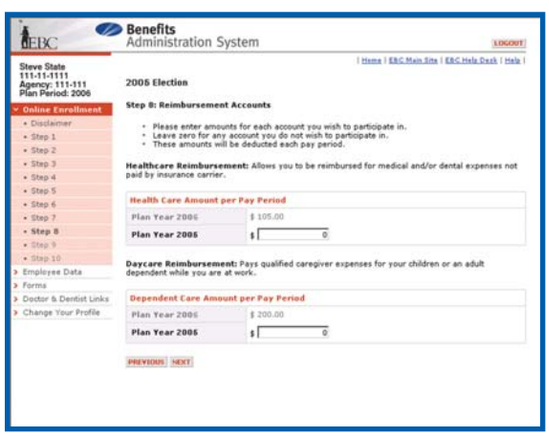
By signing up for a Health Care Reimbursement Account, you can set aside up to $4,200 annually for you and your family's health care related expenses. Realize significant tax savings on qualified, un-reimbursed expenses by paying for the items pre-tax. Enroll for an HCRA account on line or with your paper enrollment, indicating the monthly contribution you want deducted from your paycheck. Some qualifying expenses include:

- Doctors visits, deductibles and copays
- Prescription Drugs
- Tylenol®, Claritin® and other over-the-counter medications
- Vision care, laser eye surgery, eyeglasses or lenses
- Dental care, orthodontic expenses
- Physical therapy

A list of expenses eligible for reimbursement is available at www.ebc.state.ok.us.

HCRA Monthly Minimum: $10 **HCRA Monthly Maximum: $350**

Online Enrollment: Step 8



Here's how the average person can increase their take home pay by using an FSA:

	Without FSA	With FSA
Annual Salary	$25,000	$25,000
Flexible Spending Account Deposit (annual)	0	-1200
Taxable Income	$25,000	$23,800
Estimated Taxes (30%)	- 7,500	-7140
Health Care Expenses	- 1,200	0
Take Home Pay	$16,300	$16,660
Annual Increase in Take Home Pay	$360	

Dependent Care Reimbursement Account (DCRA)

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

DCRA Monthly Minimum: $50 **DCRA Monthly Maximum: $416.66**

Important Notes on FSA Accounts:

- You must re-enroll every year.
- Indicate your monthly contribution on your enrollment (not your annual contribution).
- View account balances and claim information on line by logging onto **www.ebc.state.ok.us** and choosing Flexible Spending.
- See additional important rules and regulations for FSA accounts on page 21 of this Guide.

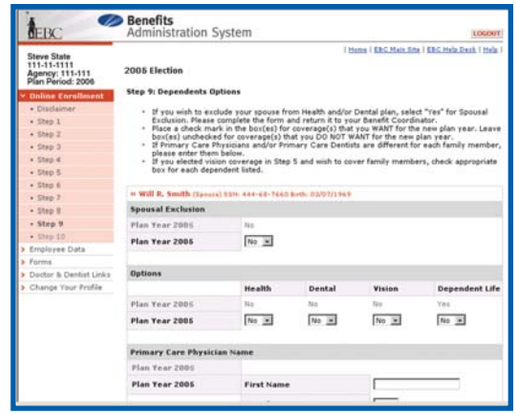
DEPENDENT COVERAGE

As a State employee, insurance coverage is available for both you and your dependents. You can choose from the following insurance options for your eligible spouse and children:

HEALTH
DENTAL
VISION

You can also elect dependent life insurance coverage (see page 14 in this Enrollment Guide for details).

Online Enrollment: Step 9



Important Notes on Dependent Coverage:

- You must first be enrolled in the plan, before your dependents can be enrolled.
- If one dependent is covered, all dependents must be covered (for example, if you choose dental coverage on one child, all of your children must be covered on dental). Certain exceptions apply if other group coverage is in place. See your Benefits Coordinator for details.
- Eligible dependents are defined by the Federal and State law and include a spouse, unmarried children up to age 19, unmarried children who are full time students up to age 25, and incapacitated or totally disabled children of any age if their incapacity occurred and was verified prior to age 19.
- A 19-year-old dependent, still in school, can be covered until age 25 if enrolled as a full-time student at an accredited university or institution of higher learning. A signed "Certification of Student Status" form must be on file with your Benefits Coordinator and EBC.
- The Working Families Tax Relief Act of 2004, changed the definition of dependent for federal income tax purposes, effective January 1, 2005. The IRS indicates that the change is not intended to affect the coverage of dependents under employer-sponsored medical plans. However if you cover dependents, EBC suggests you obtain professional tax advice when completing your income tax return(s).

Getting Married, Having a Baby or Experiencing a Life Event? Don't miss the 30 day Deadline!

Each year, State employees can change their insurance elections during the Option Period. If you experience a "qualifying life event" during the year, you might also be allowed to make certain changes to insurance elections without waiting for the next Option Period. Some of the most frequent qualifying life events include:

- Marriage, divorce, legal separation
- Birth, adoption, custody or legal guardianship
- Gain or loss of other coverage
- See page 21 for a complete listing of qualifying life events

You must complete a Change Form and return it to your Benefits Coordinator within 30 days of your life event. If you don't make the 30 day deadline, you'll have to wait until the next Option Period to make any changes.

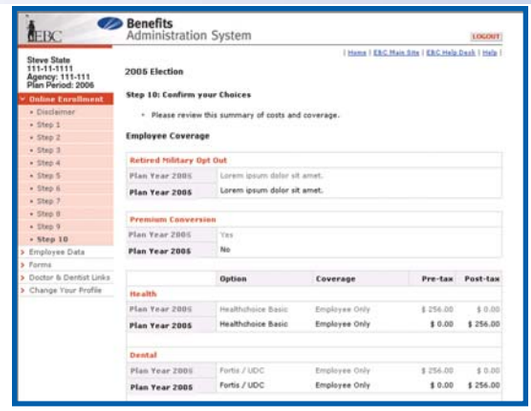
So don't delay, send in the form within 30 days!

Eligibility is Important:
EBC periodically reviews covered dependents, seeking documentation of eligibility. Failure to confirm dependent coverage will result in termination of that dependent's coverage.

ONLINE ENROLLMENT USERS:

Reviewing your benefit elections is easy with the Online Enrollment process. When the "Confirm Your Choices" menu appears, simply review the options you have selected. Changes can be made by choosing the "previous" button. If you are finished, choose the "submit" button and a copy of your selections will be made available to print. Any forms needed will automatically print as well.

Online Enrollment: Step 10

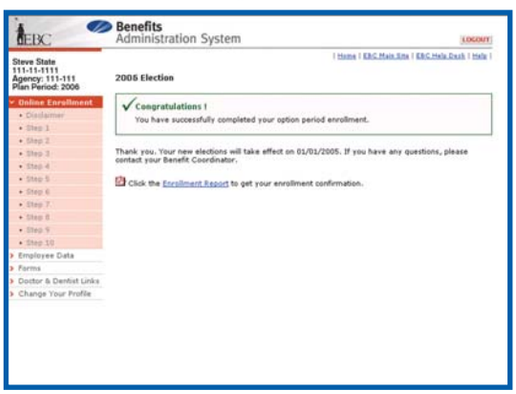


PAPER FORM USERS:

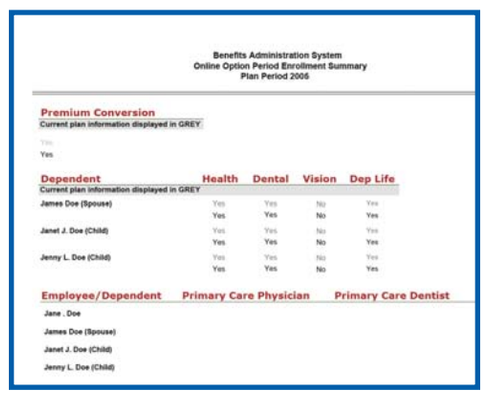
Be sure to review your benefit selections prior to turning in your form to your Benefits Coordinator. If you have selected coverage for your family members, don't forget to complete the back side of the form.

Remember to save a copy of your benefit elections to compare to your final Confirmation of Benefits Statement.

Congratulations Page



Online Enrollment Summary



A few weeks after the Option Period ends, you will receive a Confirmation of Benefits (COB) statement showing the benefits you selected. **It is your responsibility to carefully check your statement.** If you find any errors, contact your Benefits Coordinator immediately.

SPECIAL NOTE: The Confirmation of Benefits statement will also be available to you after December 1, 2005 by logging into your Online Enrollment account using the same user ID and password you set up during Option Period.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The EAP is a cooperative effort between employees and administration, offering employees and their families an opportunity to seek and receive free assistance in resolving personal problems. Many of these problems include family, financial, legal, emotional, alcohol/drug abuse, and health problems, which adversely affect safe and efficient performance on the job. The EAP has been developed to help employees deal with serious personal problems before they result in deterioration of health, family life, or job performance.

Employees can discuss their problems on a completely confidential basis with an EAP representative who can identify the possible causes of and solution to the problems and outline the community resources available. If the employee chooses to use such a resource, the representative will make the necessary arrangement with the community resource.

The EAP is an employee benefit offered free of charge. The cost of additional treatment services is discussed with employees by the EAP representative.

Any employee can contact an EAP counselor. For a list of EAP representatives, log onto www.ebc.state.ok.us or call the Office of Personnel Management's EAP office at (405) 947-7576.

General

Enrollment in a medical or dental plan does not guarantee that a particular doctor, dentist, clinic, or hospital will remain in your plan's network for the entire year. **You enroll with the PLAN and not the provider. If your provider terminates his or her contract during the Plan Year, this does not allow you to change medical or dental plan carriers.** These benefits are effective January 1, 2006. Keep this book as a reference throughout the year. This booklet is only intended to be a brief summary of certain provisions of the State of Oklahoma Employee benefit plans. In the event of a conflict between the booklet and the laws of the State of Oklahoma or administrative rules of the Employees Benefits Council (Council) and the Oklahoma State & Education Employees Group Insurance Board (Insurance Board), the laws and administrative rules shall govern in all cases.

Consumer Information & Annual Notices

The Council and the Insurance Board comply with the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996 known as HIPAA. The Council, the Insurance Board and each HMO, dental, and vision plan offered to State employees has a Privacy Notice which describes the organization protections and acceptable uses of information. To obtain a Privacy Notice from a particular plan, contact the plan directly or contact the Council. 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 preexisting condition exclusion. The HealthChoice medical products offered by the Insurance Board are exempt from most of the portability provisions of HIPAA including, but not limited to, the following: limitations on pre-existing conditions, special enrollment rights, discrimination based upon a health factor, standards for mothers and newborns, mental health parity, and reconstructive mastectomies. See the section on General Eligibility Information for more details. The WOMEN'S HEALTH & CANCER RIGHTS ACT of 1998, a Federal Law, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). The 1998 Guidance, Questions and Answers, and Notice Requirements under WHCRA (November 1998), can be obtained by calling (800) 998.7542. The BREAST CANCER PATIENT PROTECTION ACT, an Oklahoma State Law, provides for at least 48 hours of inpatient care following a mastectomy and not fewer than 24 hours following a lymph node dissection. The NEWBORNS & MOTHERS ACT of 1996, a Federal Law, requires the availability of a hospital stay of at least 48 hours in connection with a vaginal delivery and not less than 96 hours with a cesarean delivery. The PROSTATE CANCER PROTECTION ACT, an Oklahoma State Law, Provides for an annual screening for early detection of prostate cancer in men age 50 and over and in men from age 40-50 who are in high-risk categories. The Oklahoma Prostate Surgery side effects Law, provides that all health benefit plans offered by OSEEGIB & EBC shall provide coverage for side effects that are commonly associated with radical retropubic prostatectomy surgery, including, but not limited to impotence and incontinence, and for other prostate related conditions. THE MANDATED BENEFIT FOR OB/GYN COVERAGE LAW requires any health benefit plan offered in the state of Oklahoma which provides medical and surgical benefits to also provide coverage for routine annual obstetrical/gynecological examinations. The law does not diminish already allowed health benefit diagnostics. In addition the law also specifies that obstetrical/gynecological examinations do not have to be performed by an obstetrician, gynecologist, or obstetrician/gynecologist. If you have a problem which cannot be resolved through your benefit plan's grievance process, you may have remedies with the Oklahoma State Department of Health, Oklahoma Department of Insurance, or a remedy of law. Once you become covered under a group health plan, you have certain rights under the CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you can contact the Council or the Insurance Board. You may also have rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA). USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service. The law also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services. See your agency for more information.

General Eligibility Information

The following are rules of eligibility that apply to commonly occurring situations. The rules are listed in no particular order. This is not an exhaustive list. Any active state of Oklahoma employee scheduled to work at least 1000 hours per year is eligible for benefits coverage if he/she is not a temporary or seasonal employee. New Hire coverage is effective on the first day of the month following the entry-on-duty date. Coverage ends on the last day of the termination month. All eligible dependents must be covered when one dependent is covered under health, dental, or vision insurance unless proof of other group coverage is provided. Eligible dependents are defined by the Internal Revenue Code and include a spouse, unmarried children up to the age of 19, unmarried children who are full time students up to age 25, and incapacitated or totally disabled children of any age if their incapacity occurred and was verified prior to age 19. Two State employees cannot claim coverage for the same dependents for health, dental, and vision benefits. A 19-year-old dependent, still in school, can still be covered until age 25 if enrolled as a full-time student at an accredited university or institution of higher learning, secondary school, or college. A signed "Certification of Student Status" form must be on file with your Benefits Coordinator and EBC. A dependent who has been dropped from coverage cannot be re-enrolled for 12-months. The Working Families Tax Relief Act of 2004, changed the definition of dependent for federal income tax purposes, effective January 1, 2005. The IRS indicates that the change is not intended to affect the coverage of dependents under employer-sponsored medical plans. However if you cover dependents, EBC suggests you obtain professional tax advice when completing your income tax return(s). Thirty-day written notice is required to reinstate coverage. Reinstated health coverage may be subject to penalty for preexisting conditions. If you are considering coverage under a HealthChoice medical plan,

please know that if continuous health coverage from a previous group health plan is not in place prior to the effective date of coverage through the HealthChoice plan, all medical care provided to you and your covered dependents within the 180 days prior to coverage may be reviewed for preexisting conditions. If the review finds a preexisting condition, services for that condition will not be covered for the first 180 days of HealthChoice coverage. Under HealthChoice, pregnancy can be considered a preexisting condition.

Changes to Benefit Plan Elections

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

Flexible Spending Accounts Information

These accounts let you set-aside money from your paycheck, pre-tax, to pay for planned dependent care charges and expected out-of-pocket healthcare expenses. You must enroll each Option Period or you lose the account. Plan carefully when deciding your contributions. Direct deposit of your reimbursements is available into the same account as your payroll deposit. If you terminate employment with the state any daycare or medical services must be incurred prior to the last day of your termination month. If you are not on active payroll (on some type of leave) it is your responsibility to mail in your pledged contribution. Viewing your account information is easy using our online service. For further information on allowable expenses see EBC's website at www.ebc.state.ok.us and review IRS Publication 502 and 503. Keep in mind that the state's plan is a qualified Flexible Benefit Program. Some #502 and #503 information may not describe these plan restrictions. There is a 2.5 month grace period in which claims can be incurred and filed against a Flexible Spending Account. For reimbursements from a Flexible Spending Account from funds contributed during calendar year 2006, services must be rendered on or before March 15, 2007. However, you may send your claims through March 31, 2007. Reimbursement for eligible expenses must occur no later than 2.5 months after the plan year, so plan accordingly. For tax questions, seek advice from a qualified professional.

Debit Cards

The Council will reimburse an FSA participant for eligible expenses incurred through use of the participant's debit card provided the participant properly activates the debit card, pays the appropriate fee to use the card, properly substantiates the claim for expenses, and abides by the terms of use of the debit card. The Council reserves the right to set the fee charged to participants for use of the card, discontinue use of the debit card, or require paper substantiation prior to the reimbursement of expenses. The rules of eligibility for Dependent Care Reimbursement and Health Care Reimbursement apply to participants using the debit card. Debit card participants shall be reimbursed for dependent expenses on a weekly or other reasonable basis during the Plan Year as determined by the Plan Administrator. Reimbursement can also be made for expenses incurred by any participant during the Grace Period. The "Grace Period" is the period from the end of the Plan Year through March 15th of the subsequent Plan Year during which reimbursable expenses can be incurred and attributable to the previous Plan Year's account balance. The final payment of benefits for any Plan Year may be made following the close of such Plan Year based on accepted claims filed with the Plan Administrator no later than the end of the Run Out Period. The "Run Out Period" means the ninety (90) day period following a Plan Year in which claims can be made for reimbursable expenses incurred during the Plan Year. Upon demand a participant shall immediately refund any overpayment made by the Plan Administrator on behalf of the participant. Likewise, items charged to a debit card that are unacceptable to the Plan Administrator will require a participant to immediately refund such an overpayment to the Plan Administrator. Amounts remaining in a participant's dependent care reimbursement account following final payment of all 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.

Healthcare (Medical) Spending Account Information

The IRS Code Uniform Reimbursement Rule allows you to have access to your full annual election after your first payroll withholding activates your account. You spend your own money for after-insurance, qualified medical expenses, deductibles, copays and certain over-the-counter items. These expenses may be eligible for reimbursement according to the IRS Code, enabling you to submit a claim voucher with the appropriate documentation and receive reimbursement from your own tax-free account. Attach the itemized bill and/or the Insurance Explanation of Benefits (HealthChoice State Plan or Dental Indemnity Plan EOB) to your signed EBC Expense Reimbursement Voucher (claim form) and mail to the address on the form. Funds will be disbursed for the amount requested within ten days of receipt if you submit all required documentation. Eligible expenses include: copayments, acupuncture, chiropractic care, certain over-the-counter items, vision expenses (glasses, contacts, contact solution, Laser corrective eye surgery), orthodontics, deductibles, gynecological exams, immunizations, insulin and diabetic supplies, lab exams, psychiatric care, oxygen, orthopedics, sterilization fees, wheelchair, dentures, hearing exams and devices, smoking program, and weight loss program weekly meeting fees (doctor letter of medical necessity and diagnosis required [diagnosis can be obesity]), and mileage at $0.14 per mile (amount subject to change). Check out the list of approved over-the-counter items on our website. Documentation required for approved OTC items is the computerized receipt, name of item, medical condition it treats, date of purchase, and amount paid. Pharmacy labels need to include the printed name of the drug. Non-eligible expenses include: personal care items, warranties, late fees or finance charges, membership/health club dues, food items of any kind, clip-on sunglasses, teeth whitening, vitamins, dietary supplements, items or services for cosmetic purposes, massage therapy, marriage and family counseling, insurance premiums, and naturopathic or alternative medicine supplements. The date of service is the date you incur the expense (i.e., date you drop off the prescription at the pharmacy, date you receive the medical care). This date must be during the plan year and while actively participating in the program (making monthly contributions). The minimum monthly contribution is $10 and the maximum monthly contribution is $350. Claim deadlines are Tuesday, at 1:00 p.m. (Subject to change during holidays).

Dependent Care Spending Account Information

If you have an eligible dependent (children 12 or younger who have been included on your income tax return or any other eligible dependent person physically or mentally incapable of self-care) who spends at least eight hours a day in your home you may want to participate in the Dependent Care Flexible Spending Account. This account pays daycare provider expenses while you and your spouse work up to a combined calendar year total of $5,000. The daycare provider cannot also be your tax dependent. The individual calendar year limit is $2,500. Form 2441 must still be filed with your taxes. You can receive reimbursement for the amount you have currently deposited in your Dependent Care Account. The signed Expense Reimbursement Voucher allows you to send proof of payment for reimbursement. With proof of payment and the dates of service your daycare provider is no longer required to sign the Dependent Care acknowledgement form. The minimum monthly contribution is $50 and the maximum monthly contribution is $416.66.

Termination of Employment

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

Change of Address

The Employees Benefits Council must be notified immediately of any change of address for the employee and/or dependents. In the event of the change of address, contact your agency's Benefits Coordinator to complete a Change Request Form.

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. Differences may include, but are not limited to, the following: 1) Coverage for dependents who are full-time students may end at age 23, and 2) Medicare may become the primary insurer upon attaining eligibility for Medicare.

THE OKLAHOMA PUBLIC EMPLOYEES RETIREMENT SYSTEM

The Oklahoma Public Employees Retirement System (OPERS) administers retirement plans for several different types of state and local government employees. The OPERS defined benefit plan provides a lifetime retirement benefit when the member meets certain eligibility requirements. Membership is a mandatory condition of employment and includes state and local government employees, state and county elected officials, and hazardous duty employees. Active members contribute a certain portion of their compensation each month. The employer also contributes a percentage of the member's compensation. The member and employer contributions are invested by OPERS, under the direction of the Board of Trustees, to provide lifetime benefits to present and future retired members. The amount of member and employer paid contributions do not determine the amount of the benefit that the plan promises the member. The member's benefit at retirement is determined by a formula which includes the member's final average compensation times the number of years of credited service times a multiplier.

The benefit formula for regular members is:

FINAL AVERAGE SALARY X 2% X YEARS OF SERVICE*

**The formula is different for other members.*

SOONERSAVE RETIREMENT PLANS

OPERS also administers SoonerSave, which is available to most state employees. SoonerSave is one program with two retirement savings components. Employees contribute pre-tax dollars through voluntary salary deferral into the Oklahoma State Employees Deferred Compensation Plan. Employees who take advantage of SoonerSave receive a contribution of $25 from the State of Oklahoma into the Savings Incentive Plan.

SoonerSave is an excellent way to shield current income from federal and state taxes while saving for the future. In both plans, contributions and any earnings grow tax-deferred until money is withdrawn, usually during retirement when the participant is typically receiving less income and may be in a lower tax bracket than while working. In order to properly plan for your retirement years, OPERS strongly encourages you to consider participating in SoonerSave (if you are eligible) as a way to supplement the income you will receive from your defined benefit plan and Social Security. For more information about SoonerSave or to update your beneficiary information, call 1-800-733-9008 or (405) 858-6781. You can also obtain information, including enrollment forms, by visiting **www.soonersave.com.**

OK Health

NEW FOR YOU IN 2006 AND IT'S FREE!

Would you like…

- **Possible extra cash in your pocket?**
- **A free visit to your PCP with free lab work?**
- **A discount on a fitness center membership?**
- **To feel better, reduce stress, and have more energy?**
- **Free access to a personal professional health mentor?**

YES, then OK Health is for you!

The goal of the OK Health Program is to give you the right tools to help you feel better and improve your health. The first step to improving your health is to enroll in the OK Health Program and complete a health risk assessment and by visiting your Primary Care Physician. As a program participant, the initial cost to visit your physician and to receive lab work is free. After completing the health risk assessment, a personalized professional health mentor will work with you to establish goals and action plans for twelve-months of mentoring tailored to your health needs. Components of the program are physical activities, healthy nutrition, smoking cessation, stress management, diabetes and cardiovascular disease prevention and control. As your benefits office, the Employees Benefits Council has coordinated several incentives for OK Health participants. The incentives include:

- **FINANCIAL INCENTIVES: Three levels of financial incentives $100.00, $300.00, and $500.00 (check with your agency for details)**
- **NO COPAY OR DEDUCTIBLE: Initial PCP visit and specified lab work will be free**
- **DISCOUNTS: On selected Fitness Centers throughout Oklahoma**

To learn how you can get started in the OK Health program, check with your agency Wellness Coordinator or **detach and complete the enclosed self-addressed postcard** and a professional health mentor will contact you. You can also enroll online or by paper during Option Period.

"Our state employees represent the foundation of Oklahoma State government, and we must do whatever it takes to improve their health. I encourage all state employees to participate in the OK Health Program."

— John Richard, Director
Department of Central Services
Member, Governor's Wellness Initiative

OK Health Program

Email: OKHealth@ebc.state.ok.us
(405) 232-1190, ext. 120 or ext. 131
Toll free (800) 219-8115

A special note: The Employees Benefit Council's State Wellness Program in conjunction with the State Department of Health/Chronic Disease Services and the Department of Human Services designed the OK Health Lifestyle Health Mentoring Program based on a successful pilot program with employees from the Department of Human Services. This program, has been developed for active State employees and is recognized by Governor Henry's "Strong and Healthy Oklahoma" initiative. All participant information is confidential and is protected by the Employees Benefits Council.

EMPLOYEES BENEFITS COUNCIL PLAN YEAR 2006

Local (405) 232-1190 Toll Free (800) 219-8115

EXECUTIVE / ADMINISTRATION	TELEPHONE
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EMPLOYEES
Benefits Council

405-232-1190
1-800-219-8115 TOLL FREE

200 North Harvey, Suite 1200
Oklahoma City, OK 73102-4003

www.ebc.state.ok.us

HEALTH

HealthChoice (State Plan) Oklahoma City Metro . . . . . .(405) 717-8780
Toll Free . . . . . .(800) 752-9475
TDD . . . . . .(405) 949-2281 or (866) 447-0436
Website . . . . . .www.healthchoiceok.com or www.sib.ok.gov
Health, Dental & Life Claims . . . . . .(405) 499-4920
Toll-Free . . . . . .(800) 782-5218
Pharmacy Claims/ID Cards . . . . . .(800) 903-8113
Pre-certification/Emergencies Toll-Free . . . . . .(800) 848-8121
COBRA . . . . . .(405) 717-8780
Toll-Free . . . . . .(800) 752-9475
Website . . . . . .www.healthchoiceok.com or www.sib.ok.gov
Aetna HMO All Areas . . . . . .(800) 949-3104
TDD . . . . . .(800) 628-3323
Website . . . . . .www.aetna.com/okstateemployees/
CommunityCare HMO All Areas . . . . . .(800) 777-4890
Website . . . . . .www.ccok.com
GlobalHealth HMO OKC Metro . . . . . .(405) 280-5600
Toll-Free . . . . . .(877) 280-5600
TTY/TDD/Voice . . . . . .(800) 522-8506
Website . . . . . www.globalhealth.cc
PacifiCare HMO All Areas . . . . . .(800) 825-9355
Website . . . . . .www.pacificare.com

DENTAL

HealthChoice Dental Plan Oklahoma City Metro . . . . . .(405) 717-8780
Toll Free . . . . . .(800) 752-9475
Website . . . . . .www.healthchoiceok.com or www.sib.ok.gov
Assurant Heritage Plus Prepaid Dental . . . . . .(800) 443-2995
Assurant Freedom Preferred Indemnity . . . . . .(800) 442-7742
Website . . . . . www.assurantemployeebenefits.com
CIGNA Dental Prepaid . . . . . .(800) 367-1037
Website . . . . . www.cigna.com
Delta Dental of Oklahoma, Oklahoma City Metro . . . . . .(405) 607-2100
Toll Free . . . . . .(800) 522-0188
Website . . . . . .www.deltadentalok.org

VISION

CompBenefits . . . . . .(800) 865-3676
Website . . . . . .www.visioncare.com
Primary Vision Care Services . . . . . .(888) 357-6912
Website . . . . . .www.pvcs-usa.com
Spectera . . . . . .(800) 638-3120
Website . . . . . .www.spectera.com
Superior . . . . . .(800) 507-3800
Website . . . . . .www.superiorvision.com
Vision Service Plan . . . . . .(800) 877-7195
Website . . . . . .www.vsp.com

EMPLOYEES BENEFITS COUNCIL

Main . . . . . .(405) 232-1190
Toll Free . . . . . .(800) 219-8115
Benefits/ Wellness Fax . . . . . .(405) 232-1324
Administration Fax . . . . . .(405) 232-3158
Finance Fax . . . . . .(405) 232-1729
TDD . . . . . .(405) 235-4625
Flexible Spending Accounts . . . . . .(405) 232-1190 x301
Toll Free . . . . . .(800) 219-8115 x301

This publication, printed by the University of Oklahoma's Printing Services Division, is issued by the Employees Benefits Council as authorized by its Executive Director. 50,000 copies have been prepared and distributed at a cost of 65¢ per copy. Copies have been deposited with the Publication Clearinghouse of the Department of Libraries. 09/05