

OKLAHOMA

1907-2007



A Unique History. An Extraordinary Future.

PLAN YEAR
2008

EMPLOYEES
Benefits Council



BENEFITS ENROLLMENT GUIDE
Active and New Employees of the State of Oklahoma

Celebrating the History of Oklahoma



BEGINNING IN 1871, the first survey crews worked across the Oklahoma Territory through forests, mountains, swamps, and every other terrain. Their surveys would eventually determine boundaries, roads, and settlement locations for early Oklahoma, mapping what would become the 46th state.



KATE BARNARD, “MISS KATE,” was the first woman elected to a public office in the history of the United States, even though she could not legally vote for herself at the time. As Commissioner of Charities and Corrections, she worked against poverty and injustice in early Oklahoma. The impact she had on women’s role in government set the course for generations to follow.



SOLOMON LAYTON has been called the most important and influential architect in Oklahoma history. His works can be seen across the state and include the Marland Mansion in Ponca City, the Skirvin Hotel in Oklahoma City, and the University of Oklahoma original stadium and library in Norman. Perhaps his most famous design is that of the Oklahoma State Capitol Building. Layton even traveled to Paris to meet with an architect who specialized in dome construction. But a dwindling budget and the outbreak of World War I meant plans for the dome would have to be set aside. Solomon Layton went on to design scores of buildings across the state, including courthouses, schools, and office buildings, many of which still stand today.

Welcome

THE EMPLOYEES BENEFITS COUNCIL WELCOMES you to Option Period for the 2008 Plan Year. This year's Benefits Enrollment Guide honors early workers who helped create Oklahoma's Unique History. A century of hard work and great accomplishments by state employees has given Oklahoma an Extraordinary Future. As the Benefits Office for state employees, the Employees Benefits Council is committed to offering a competitive and comprehensive benefits program today and in the future, because we understand the importance of your insurance coverage.



Oklahoma Capitol, 2007.

Please take a few moments to look through this guide. Review the choices available to you and your family for 2008. Remember, it is the personal responsibility of each employee to acquire Option Period Enrollment Information by going to the Option Period Meetings or watching the Option Period Video that is provided to your agency and is available via the EBC website. Complete your enrollment either online or by using the paper form supplied by your Benefits Coordinator before the Option Period enrollment deadline.

Welcome To Option Period



Oklahoma Capitol, 1914

1

To complete your Option Period election, follow these three easy steps:

LOOK at your choices. Review this Guide, go online to the EBC website or talk to your Benefits Coordinator about your options.



Oklahoma Capitol, 1915

2

ENROLL online anytime, 24 hours a day. Or, you may also enroll by completing and submitting the paper form supplied by your Benefits Coordinator. Be sure to meet the deadlines set by your agency.



Oklahoma Capitol, 1917

3

REVIEW your selections. Review your enrollment choices online and make changes anytime prior to midnight on November 2, 2007. When your Confirmation of Benefits statement is generated in mid-November, be sure to review it for accuracy. Your benefits are important! Make sure your elections are what you wanted.

Option Period is October 8 – November 2, 2007

Benefits will be effective January 1, 2008

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

Visit EBC at www.ebc.state.ok.us

What's New in Insurance and Benefits?

No Change to HMO Plan Designs

Good news for 2008! No changes will be made to the HMO health plan benefit designs. The Standard and Alternative plan designs return and will offer the same categories and levels of coverage as in 2007. See pages 6 & 7 for health plan options and new rates.

New HealthChoice High Deductible Health Plan

The HealthChoice S-Account is a new high deductible health plan from HealthChoice. Please carefully read the HealthChoice S-Account introduction on page 6 and review the Health Plan Comparison Booklet found in the back pocket of this Guide before making your health plan selection.

HealthChoice Plans No Longer Require Waiting Period

All HealthChoice plan designs including the High and Basic plans no longer apply a six month waiting period for pre-existing conditions. Pre-certification of specific diagnostic imaging services will be required or a penalty will apply. See pages 6 & 7 for health plan options and rates. Review the Health Plan Comparison Booklet in the back pocket of this Guide for information on each plan design including deductibles, co-insurance, pharmacy benefits and more.

Enhanced Dental Benefits & New Dental Plan Introduced

Dental benefits are better than ever for 2008. The annual maximum benefit level has increased to \$2,000 while orthodontics will be covered up to a \$1,800 lifetime maximum. A new prepaid dental plan option, Assurant Heritage Secure, will be offered to employees in the coming year as well. Check out the dental plan options and rates on pages 8 & 9 of this Guide.

Flexible Spending Account News

Last year the Employees Benefits Council elected to waive the annual fee normally charged to state employees choosing the convenience of the FSA debit card. Once again, in 2008, the FSA debit card will be free. Refer to pages 12 & 13 of this guide for further information on this benefit, available with the Health Care Account and the Dependent Care Account election.

Due to federal restrictions, you cannot participate in the Health Care FSA if choosing the HealthChoice S-Account. See page 6 for further information.

Retired Military Opt-out Has Changed

Federal legislation has changed the Retired Military Opt-out rule. TRICARE Supplement Insurance will no longer be available. See page 5 of this guide for further information about available options.

Dependents May Qualify for Coverage Without Student Status

Eligible dependents between the ages of 19 and 23 may enroll for coverage without meeting student status requirements. A dependent is no longer eligible for coverage when they reach age 23. Enroll your eligible dependents through online enrollment or a paper form during Option Period. Coverage will become effective January 1, 2008. See your Benefits Coordinator for details or contact the Employees Benefits Council. Turn to page 16 for general rules of eligibility.

ELIGIBILITY REMINDER:

If you experience a qualifying life event during the year; for example marriage, divorce, adoption or birth, you may be allowed to make certain changes to your insurance elections without waiting for Option Period. You must complete a change form within 30 days of the life event (see **pages 16 & 17** for a full list), or wait until the next Option Period to make any changes. **REMEMBER, IT IS A 30 DAY DEADLINE!**

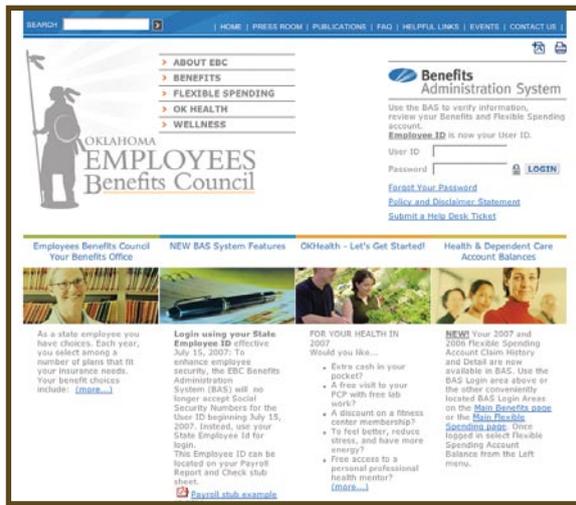
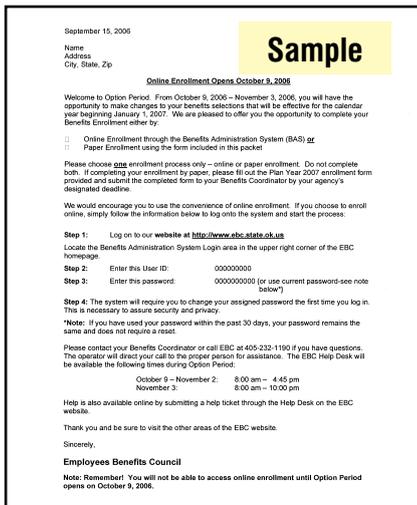
Join the Revolution! Enroll Online Today.

More than 60 percent of state employees used online enrollment to make their benefit elections last year. Join your co-workers and discover how easy it is to enroll online. The average enrollment takes just 5 minutes and you can log on anytime, 24 hours a day, seven days a week during Option Period.

Online Enrollment allows you to:

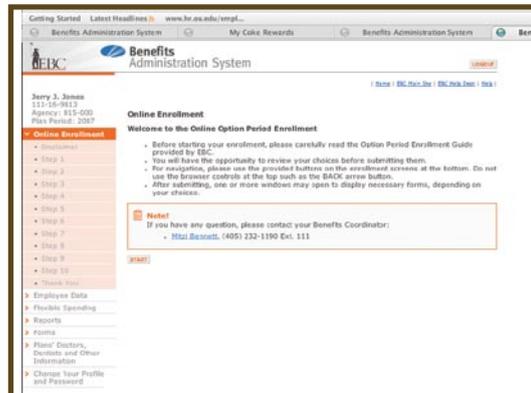
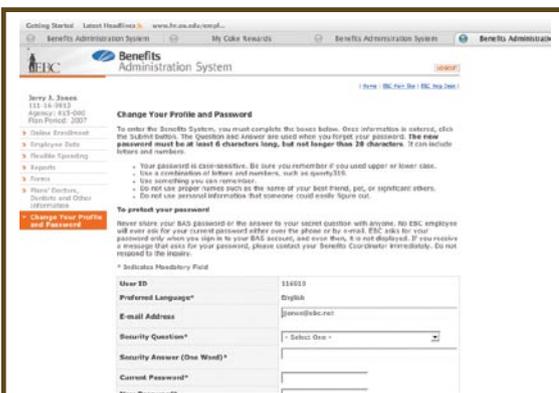
- Print your confirmation of elections instantly
- Enroll anytime during Option Period, 24 hours a day, 7 days a week
- Update address and telephone information online
- Change your elections and make corrections as many times as you like, until the close of Option Period (remember, your final election is the official enrollment!)

See the BAS Brochure in the back pocket of this Guide for step by step online enrollment instructions during Option Period. We're sorry, online enrollment is not currently available for newly hired employees outside of Option Period.



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

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



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

4 Choose Online Enrollment and begin.

Help is available by phone at the Employees Benefits Council:

(405) 232-1190 OR 1-800-219-8115

Remember: Online Enrollment opens and is available beginning October 8, 2007.

October 8 – November 1 (Monday – Friday) 8:00 a.m. – 4:30 p.m.

November 2 8:00 a.m. – 8:00 p.m.

Help is also available online by submitting a help ticket through the help desk

of the EBC website at: **www.ebc.state.ok.us**

Your Benefit Allowance Helps Cover Your Costs

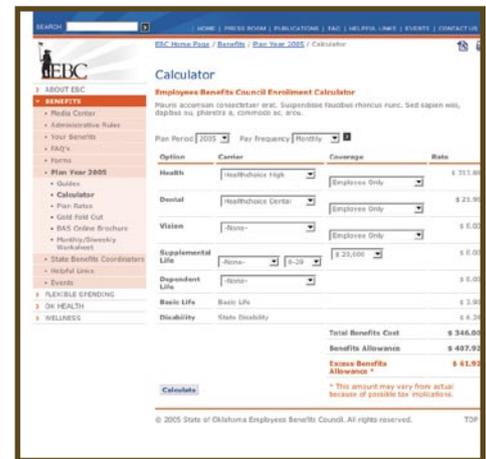
The State provides a Benefit Allowance to help you pay for insurance premiums that would otherwise come out of your own pocket. This year's employee benefit allowance has increased from last year, helping meet the rising costs of your benefits. For employees electing to cover dependents on the health option, an allowance is provided to cover 75 percent of the average of all high option premium dependent costs.

Employee Only*			Monthly		Yearly
			\$554.48		\$6,653.76
Child	\$245.08	=	\$799.56	=	\$9,594.72
Children	\$335.44	=	\$889.92	=	\$10,679.04
Spouse	\$553.41	=	\$1,107.89	=	\$13,294.68
Spouse/Child	\$798.49	=	\$1,352.97	=	\$16,235.64
Spouse/Children	\$888.85	=	\$1,443.33	=	\$17,319.96

Elected officials may have a different benefit allowance. Please check with your Benefits Coordinator for details.

Benefits Calculator

Your benefit costs can be easily estimated 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 bi-weekly 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:

- 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

For Benefits Calculator, logon to www.ebc.state.ok.us/en/Benefits/PlanYear2008/calculator/

Retired Military Choices

State employees who are retired from military service and have federal TRICARE insurance benefits may elect either 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)

Opting-out requires a paper enrollment and proof of your DD2 form. See your Benefits Coordinator to complete the appropriate forms. Online enrollment is not available when choosing retired military opt-out.

Note: Due to changes in federal regulation, the TRICARE Supplement option is no longer available through EBC.

For more information, visit the Retired Military Opt-Out page on the EBC website at:

www.ebc.state.ok.us/en/Benefits/Militaryoptout/

Premium Conversion It's About Saving Taxes...

Premium Conversion is an optional IRS-approved election chosen by more than 97 percent of State employees, allowing them to save by paying NO TAX on their eligible insurance premiums. By paying insurance premiums for health, dental, vision, flexible spending accounts and a portion of supplemental life pre-tax, you have more take home pay than you would if you paid the same premiums with after-tax dollars.

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

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

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

 **Yes = tax savings!**



*Kate Bernard, 1907
Commissioner of Charities and Corrections*

Photo courtesy of Oklahoma Historical Society

Health Plans

Plan Year 2008 Monthly Rates

	Employee	Employee & Spouse	Employee, Spouse & Child
HealthChoice High	364.24	860.85	1,042.29
HealthChoice Basic	318.18	743.83	899.15
HealthChoice S-Account	290.48	689.84	837.00
Aetna Standard	641.64	1,494.92	2,123.68
Aetna Alternative	385.34	897.80	1,275.42
CommunityCare Standard	633.42	1,539.20	1,855.90
CommunityCare Alternative	428.96	1,042.36	1,256.84
GlobalHealth Standard	340.64	846.08	1,028.74
GlobalHealth Alternative	303.98	755.06	918.08
PacifiCare Standard	649.14	1,577.41	1,901.68
PacifiCare Alternative	377.57	917.68	1,106.03
PLAN YEAR 2008 Benefit Allowance	\$554.48	\$1,107.89	\$1,352.97

For Retiree rates, visit the OSEEGIB website at www.healthchoiceok.com

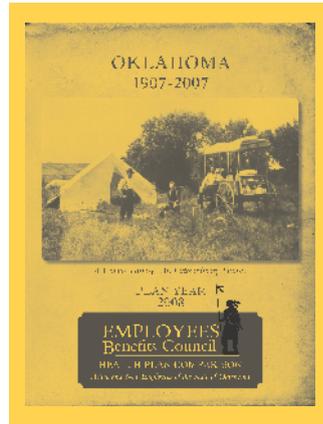
HealthChoice S-Account Plan

The S-Account Plan is a qualified high deductible health plan to be used exclusively with a Health Savings Account (HSA). If you enroll in this plan you must:

- Provide proof that you have set up an HSA at a bank or other financial institution. ¹ Proof must be submitted to the Employees Benefits Council by December 15, 2007.
 - **If you do not provide the necessary HSA documentation by December 15, 2007, you will be removed from the S-Account Plan and enrolled in your health plan election from the prior year. You will lose participation in the Health Care flexible spending account. The election will be in effect for the entire Plan Year beginning January 1, 2008.**
- Please Note the Following:**
- **You cannot enroll in a Flexible Spending Health Care Account if you choose the HealthChoice S-Account Plan.**
 - **You may be restricted from enrollment in the HealthChoice S-Account if you have funds remaining in your FSA Health Care Account on January 1, 2008.**
 - **In limited circumstances, you may be eligible to roll over certain remaining amounts from your FSA Health Care Account to your newly established HSA account.²**
 - **You can continue to participate in the FSA Dependent Care Account if you elect the HealthChoice S-Account Plan.**

For further information contact OSEEGIB at 405-717-8780

Employee, Spouse & Children	Employee & One Child	Employee & Two or More Children
1,151.07	545.68	654.46
992.71	473.50	567.06
924.04	437.64	524.68
2,123.68	1,270.40	1,270.40
1,275.42	762.96	762.96
2,045.92	950.12	1,140.14
1,385.52	643.44	772.12
1,137.34	523.30	631.90
1,014.98	467.00	563.90
2,096.71	973.41	1,168.44
1,219.30	566.22	679.49
\$1,443.33	\$799.56	\$889.92



Health Plan Comparison

For details about each health plan's benefit design, see the Health Plan Comparison Booklet in the back pocket of this Guide.

Health Plan Choices

All HMO plans and HealthChoice plans return in Plan Year 2008. The S-Account is new for 2008. You have the following health plan choices:

HealthChoice (available statewide)

- HealthChoice High
- HealthChoice Basic
- HealthChoice S-Account

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

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.

The \$1,500 individual/\$3,000 family deductible for the HealthChoice S-Account Plan must be met before any benefits are paid, with certain exceptions for preventive care. Refer to the Health Plan Comparison Booklet for details.

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

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

Dental Plans

	HealthChoice Dental <i>www.healthchoiceok.com</i>		Assurant Heritage <i>www.assurantemployeebenefits.com</i>	
	In-Network	Out-of-Network	Secure Prepaid Plan <i>(Requires choosing a primary care dentist)</i>	Plus Prepaid Plan <i>(Requires choosing a primary care dentist)</i>
Deductibles	\$25 per person for Basic and/or Major Combined; \$50 Deductible for Orthodontia	\$25 per person for Preventive, Basic and or Major Combined; \$150 for Orthodontia	None	None
Preventive Care (Class A) Includes routine cleanings, check-ups and X-rays for adults and children, and fluoride treatments	100% of allowed charges Flouride treatments for children under age 16	100% of allowed charges after the deductible	Example Services/Copays Sealant per tooth: \$22 copay Routine Cleaning (once every 6 months): No Charge Topical Fluoride Application (up to age 18): No Charge Periodic Oral Evaluations: No Charge	Example Services/Copays Sealant per tooth: \$15 copay Routine Cleaning (once every 6 months): No Charge Topical Fluoride Application (up to age 18): No Charge Periodic Oral Evaluations: No Charge
Basic Care (Class B) Includes fillings, extractions, periodontal care, and some oral surgery	85% of allowed charges after deductible	70% of allowed charges after deductible	Example Services/Copays Amalgam - one surface, permanent teeth \$32	Example Services/Copays Amalgam - one surface, permanent teeth \$25
Major Care (Class C) Includes crowns, bridges, dentures, and root canals	60% of allowed charges after deductible	50% of allowed charges after deductible	Example Services/Copays Root Canal, Anterior \$165 Periodontal/Scaling/Root Planing 1-3 teeth (per quadrant) \$54 *Endodontist: 15 percent discount	Example Services/Copays Root Canal, Anterior \$165 Periodontal/Scaling/Root Planing 1-3 teeth (per quadrant) \$36 *Speciality rider pays specialist at set copays.
Orthodontic Care (Class D)	Separate \$50 deductible, plan pays 60% of allowed charges up to lifetime maximum of \$1,800	Separate \$150 deductible, plan pays 50% of allowed charges up to lifetime maximum of \$1,800	25% discount	25% discount
Annual Maximum Benefit	\$2,000 per person per calendar year	\$2,000 per person per calendar year	No plan year dollar maximum	No plan year dollar maximum

MONTHLY RATES

HealthChoice	Assurant Heritage <small>Secure</small>	Assurant Heritage <small>Plus Prepaid</small>	Assurant Freedom <small>Preferred Plan</small>	CIGNA Dental
Employee Only \$26.80	Employee Only \$7.20	Employee Only \$11.74	Employee Only \$24.84	Employee Only \$9.26
Employee & Spouse \$53.60	Employee & Spouse \$13.18	Employee & Spouse \$20.60	Employee & Spouse \$49.54	Employee & Spouse \$15.32
Employee, Spouse & Child \$75.94	Employee, Spouse & Child \$18.38	Employee, Spouse & Child \$28.20	Employee, Spouse & Child \$68.06	Employee, Spouse & Child \$22.40
Employee, Spouse & Children \$111.58	Employee, Spouse & Children \$23.56	Employee, Spouse & Children \$35.80	Employee, Spouse & Children \$99.34	Employee, Spouse & Children \$30.64
Employee & One Child \$49.14	Employee & One Child \$12.40	Employee & One Child \$19.34	Employee & One Child \$43.36	Employee & One Child \$16.34
Employee & Two or more Children \$84.78	Employee & Two or more Children \$17.58	Employee & Two or more Children \$26.94	Employee & Two or more Children \$74.64	Employee & Two or more Children \$24.58

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
In-Network	Out-of-Network	Prepaid Plan <i>(Requires choosing a primary care dentist)</i>	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	\$100 deductible per person on Major Services (Level 4) 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): no charge Topical Fluoride Application (up to age 18): no charge Periodic Oral Evaluations: no charge	100% of allowable amounts	100% of allowable amounts after deductible	Schedule of covered services and Enrollee Copayments: Example Services/Copays Routine Cleaning: \$5 copay Periodic Oral Evaluations: \$5 copay Topical Fluoride Application (up to age 19): \$5 copay
85% 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	Schedule of covered services and Enrollee Copayments: 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 copay	60% of allowable amounts after deductible	50% of allowable amounts after deductible	Schedule of covered services and Enrollee Copayments: Example Services/Copays Crown-porcelain/ceramic substrate: \$241 copay Complete denture-maxillary: \$320 copay
No deductible, plan pays 60% up to lifetime maximum of \$1,800	No deductible, plan pays 50% up to lifetime maximum of \$1,800	\$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 \$1,800	No deductible, plan pays 60% of allowable amounts, up to lifetime maximum of \$1,800	You pay charges in excess of \$50 per month. Lifetime maximum of \$1,800
\$2,000 per person per calendar year	\$2,000 per person per calendar year	No plan year dollar maximum	\$2,000 per person per calendar year	\$2,000 per person per calendar year	\$2,000 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.

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

IMPORTANT DETAILS

ABOUT 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 benefits.

Delta Dental PPO ^{Point of Service}	Delta's Choice - PPO
Employee Only \$28.44	Employee Only \$12.26
Employee & Spouse \$56.90	Employee & Spouse \$40.32
Employee, Spouse & Child \$81.92	Employee, Spouse & Child \$68.18
Employee, Spouse & Children \$120.58	Employee, Spouse & Children \$108.46
Employee & One Child \$53.46	Employee & One Child \$40.12
Employee & Two or more Children \$92.12	Employee & Two or more Children \$80.40

Vision Plans

MONTHLY RATES

CompBenefits

Employee Only	\$6.76
Employee & Spouse	\$11.82
Employee, Spouse & Child	\$15.39
Employee, Spouse & Children	\$16.28
Employee & One Child	\$10.33
Employee & Two or more Children	\$11.22

PVCS

Employee Only	\$9.25
Employee & Spouse	\$17.00
Employee, Spouse & Child	\$25.25
Employee, Spouse & Children	\$27.25
Employee & One Child	\$17.50
Employee & Two or more Children	\$19.50

Spectera

Employee Only	\$8.18
Employee & Spouse	\$13.97
Employee, Spouse & Child	\$18.56
Employee, Spouse & Children	\$20.95
Employee & One Child	\$12.77
Employee & Two or more Children	\$15.16

Superior

Employee Only	\$6.98
Employee & Spouse	\$13.88
Employee, Spouse & Child	\$20.48
Employee, Spouse & Children	\$20.48
Employee & One Child	\$13.58
Employee & Two or more Children	\$13.58

VSP

Employee Only	\$8.96
Employee & Spouse	\$14.96
Employee, Spouse & Child	\$20.70
Employee, Spouse & Children	\$27.88
Employee & One Child	\$14.70
Employee & Two or more Children	\$21.88

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	\$25 Copay then plan pays: 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 annually
Frames	\$25 Copay, up to plan limits	\$25 Copay then plan pays up to \$45	Member pays: Wholesale Cost No limit to number of frames	Member pays normal doctor fee reimbursed up to \$40-60 for one set of lenses and frames annually
Contact Lenses	**Plan pays up to \$130 Conventional \$130 Disposable Medically Necessary Covered in full (see notes)	**Plan pays up to \$130 Conventional \$130 Disposable \$210 Medically Necessary (see notes)	Member pays: Wholesale Cost for annual supply of contacts	Limit of one set annually in lieu of eyeglasses. Member pays normal doctor Fees reimbursed up to \$60
Laser Vision Correction	Discount thru TLC, member will pay no more than \$1,800 per eye for conventional Lasik	No Benefit	Discount at multiple state locations: TLC; Wells Vision & Laser Center; Omni Eye Center	No Benefit
Lens Options	Substantial discount \$15 member cost	No Benefit	\$9 Copay, no limit	Member pays normal doctor Fees
UV Coating	Substantial discount \$13 member cost	No Benefit	\$9 Copay and up, no limit	Member pays normal doctor Fees
Tint	Substantial discount \$16 member cost	No Benefit	\$13 Copay, no limit	Member pays normal doctor Fees
Standard scratch resist	Substantial discount \$30 member cost	No Benefit	\$45 Copay and up SV, no limit	One set, Member pays normal doctor Fees
Standard Polycarbonate	Substantial discount \$82 member cost	No Benefit	Wholesale cost, no limit	Member pays normal doctor Fees
Standard Progressive	Substantial discount \$46 member cost	No Benefit	\$40 Copay, no limit	Member pays normal doctor Fees
Anti-Reflective				

NOTES:

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

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

PVCS: Member must select either in-network or out-of-network for entire plan year. All in-network services are unlimited. Out-of-network services (one eye exam, one set of eyeglasses or contacts) are limited to once annually. A \$50.00 service fee applies to all soft contact lens fittings; a \$75.00 service fee applies to rigid or gas permeable contact lens fittings. Simple replacements are not assessed with these fees. Limitations/Exclusions include the following: 1) Medical eye care, 2) Vision Therapy, 3) Nonroutine vision services and tests, 4) Nonprescription

IMPORTANT DETAILS ABOUT VISION COVERAGE:

- Each plan offers statewide coverage
- Vision coverage is optional
- Vision coverage will roll over automatically

Spectera <i>www.spectera.com</i>		Superior <i>www.superiorvision.com</i>		VSP <i>www.vsp.com</i>	
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 - Ophthalmologist \$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	Annual \$25 Copay applies to lenses or frames, single/multifocal lenses covered in full lens options up to 20% savings	\$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 \$120 Lens options up to 20% savings	\$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 \$150 Conventional \$150 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 or Disposable. Medically necessary contacts covered in full with prior authorization.	No Copay Plan pays up to: \$105 Conventional or Disposable \$210 Medically necessary
Discount 15 percent off the usual & customary price, 5% off promotional price	No Benefit	20% Discount off surgical fees	No Benefit	15% average off usual and customary price or 5 percent off the laser center's promotional price	No Benefit
Available 20-40% discount	Available 20-40% discount	20% discount	No Benefit	Preferred member pricing	No Benefit
Available 20-40% discount	Available 20-40% discount	20% discount	No Benefit	Preferred member pricing	No Benefit
Covered-in-full	Covered-in-full	20% discount	No Benefit	Preferred member pricing	No Benefit
Available 20-40% discount	Available 20-40% discount	20% discount	No Benefit	Preferred member pricing	Up to \$55
Available 20-40% discount	Available 20-40% discount	\$25 Copay, retail trifocal amount, after copay	Up to \$49	Preferred member pricing	No Benefit
Substantial discount \$46 member cost	No Benefit	20% discount	No Benefit	Preferred member pricing	No Benefit

eye wear, and 5) Luxury frames (wholesale cost of frame is \$100 or more).

Spectera: For either glasses or contact lenses there is one \$25 materials copay. In lieu of lenses and frames, you may select contact lenses. Covered contact lens benefit includes the fitting/evaluation fees, contact lenses, and up to two follow-up visits. If covered disposable contact lenses are chosen, up to four boxes (depending on prescription) are included when obtained from a network provider. It is important to note that Spectera's covered contact lenses may vary by provider. Should you choose contact lenses outside of the covered selection, a \$150 allowance will be applied toward the fitting/evaluation fees and purchase of contact lenses once every 12 months (materials copay does not apply). Toric, gas permeable, and bifocal contact lenses

are examples of contact lenses that are outside of our covered contacts. Necessary contacts are covered-in-full after applicable copay. Exams, lenses, frame benefits provided once every 12 months.

Superior: *Materials copayment applies to lenses or frames, not both. Discounts for lens add-ons will be given by contracted providers with a "DP" in their listing. Online, in-network contact lens materials available at www.svcontacts.com. Exams, lenses, frame benefits provided once every 12 months.

VSP: The \$25 materials copay applies to lenses or frames, but not to both. If you choose a frame valued at more than your allowance, you'll save 20 percent on your out-of-pocket costs when you use a VSP doctor. Contact lenses are in lieu of spectacle lenses

and frames. The \$120 allowance in-network and \$105 out-of-network applies to the cost of your contact lens exam (fitting and evaluation) and the contact lens. (conventional or disposable) You'll receive a 15 percent discount off the cost of a contact lens exam from a VSP provider. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts. Prescription glasses – 20 percent off additional complete pairs of prescription glasses, and up to 20 percent savings on non-covered lens options when you use a VSP doctor. Services and materials must be received within 12 months of the last covered eye exam. Exams, lenses, frame benefits provided once every 12 months.

Experience the Convenience of the Flex Debit Card and it's Free!

The optional FSA debit card can be used at hundreds of merchants. Participants simply present the FSA debit card to pay for IRS approved medical and dependent care expenses. The money is taken directly from your FSA account, resulting in fewer claims to file. Experience the convenience of the FSA debit card in 2008. . .it's fast, flexible and **free!**



Note: FSA debit cards are available only in conjunction with the flexible spending accounts. When using the FSA debit card, some charges may require proof after purchase. Save your receipts!

Please Note the Following:

- You cannot enroll in a Flexible Spending Health Care Account if you choose the HealthChoice S-Account Plan
- You may be restricted from enrollment in the HealthChoice S-Account if you have funds remaining in your FSA Health Care Account on January 1, 2008
- In limited circumstances, you may be eligible to roll over certain remaining amounts from your FSA Health Care Account to your newly established HSA account
- You can continue to participate in the FSA Dependent Care Account if you elect the HealthChoice S-Account Plan

Grace Period Extension

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

So, go to the doctor, buy a prescription, medication, or incur any IRS approved expenses until March 15, 2009 and still file for reimbursement from your remaining 2008 FSA account fund.

When calculating your FSA contribution for Plan Year 2008, it is important to plan conservatively. Calculate based on your Plan Year estimated expenses. Do not include the extended grace period in your calculations. This extension may help you reduce the risk of losing unused funds in your FSA accounts.

Calculate Your Savings with the 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.mybenny.com and use the 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.

www.mybenny.com

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

Health Care Account (HCA)

By signing up for a Health Care 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 HCA account online 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

Remember, some expenses are eligible that are not covered by your insurance plans. A list of expenses eligible for reimbursement is available at www.ebc.state.ok.us.

HCA Monthly Minimum: \$10

HCA Monthly Maximum: \$350

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	-1,200
<hr/>		
Taxable Income	\$25,000	\$23,800
Estimated Taxes (30 percent)	- 7,500	-7,140
Health Care Expenses	- 1,200	0
Take Home Pay	\$16,300	\$16,660
<hr/>		
Annual Increase in Take Home Pay		\$360

Dependent Care Account (DCA)

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

DCA Monthly Minimum: \$50

DCA Monthly Maximum: \$416.66

Important Notes on FSA Accounts:

- You must re-enroll every year
- Indicate your per pay period contribution on your enrollment (not your annual contribution)
- View account balances and claim information on line by logging onto the Benefits Administration System (BAS) via the EBC website at www.ebc.state.ok.us. After logging in using your employee ID and password, select Flexible Spending from the left menu
- See additional important rules and regulations for FSA accounts on page 17 of this Guide

Employee Life Insurance

All eligible current state employees are covered by a basic term life policy of \$20,000. Employees may also choose to supplement their basic coverage with additional optional term life insurance.

Basic Life 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 and Dismemberment (AD&D).

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, loss of limb, or loss of sight 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 annual salary, whichever is LESS. The total amount issued depends on the submission and approval of the Life Insurance Application/Evidence of Insurability Form including requested medical records. The postmark deadline for submitting the Life Insurance Application is **November 9, 2007**.

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 a Life Insurance Application/Evidence of Insurability Form. See your Benefits Coordinator for details.

How to Apply

Complete a Life Insurance Application/Evidence of Insurability Form and obtain your Coordinator's signature, if required. **Mail directly to Oklahoma State and Education Employees Group Insurance Board (OSEEGIB)**. The address is located on the back of the form.

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

Basic Life (\$20,000) \$3.90
Includes AD&D

First \$20,000 Supplemental Life \$3.90
Includes AD&D

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

Under 30 years \$1.20
30-34 years \$1.20
35-39 years \$1.80
40-44 years \$2.60
45-49 years \$4.20
50-54 years \$7.00
55-59 years \$11.60
60-64 years \$13.40
65-69 years \$22.00
70-74 years \$37.20
75+ years \$57.80

Dependent Life

Low Option \$2.16
Standard Option \$3.60
Premier Option \$7.20

Disability \$7.54



Oklahoma Capitol
Groundbreaking, 1914

Photo courtesy of Oklahoma Historical Society

Dependent Life Insurance/Disability

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

Dependent Life Premier Option

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

Dependent Life Standard Option

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

Dependent Life Low Option

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

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

Disability Insurance

Disability

No one expects to become disabled, but the financial burden can be reduced by your coverage under the HealthChoice Disability Plan. Basic disability coverage pays 60 percent of your base salary up to a maximum dollar limit 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.* Claims must be filed within one year of the date you first became disabled.

Definition of Disability

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

What the Plan Pays

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

Monthly Maximum Disability Income

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

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

When the Plan Pays

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

*For a complete description of the disability plan's 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.

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, 2008. 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 pre-existing condition exclusions. The HealthChoice medical products offered by the Insurance Board are exempt from most of the portability provisions of HIPAA including, but not limited to, the following: limitations on pre-existing conditions, special enrollment rights, discrimination based upon a health factor, standards for mothers and newborns, mental health parity, and reconstructive mastectomies. See the section on General Eligibility Information for more details. The WOMEN'S HEALTH & CANCER RIGHTS ACT of 1998, a Federal Law, provides benefits for mastectomy related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). The 1998 Guidance, Questions and Answers, and Notice Requirements under WHCRA (November 1998), can be obtained by calling 1-866-444-3272. The BREAST CANCER PATIENT PROTECTION ACT, an Oklahoma State Law, provides for at least 48 hours of inpatient care following a mastectomy and not fewer than 24 hours following a lymph node dissection. The NEWBORNS & MOTHERS ACT of 1996, a Federal Law, requires the availability of a hospital stay of at least 48 hours in connection with a vaginal delivery and not less than 96 hours with a cesarean delivery. The PROSTATE CANCER PROTECTION ACT, an Oklahoma State Law, provides for an annual screening for early detection of prostate cancer in men age 50 and over and in men from age 40-50 who are in high-risk categories. The Oklahoma Prostate Surgery Side Effects Law, provides that all health benefit plans offered by OSEEGIB & 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 1,000 hours per year is eligible for benefits coverage if he/she is not a temporary or seasonal employee. New Hire coverage is effective on the first day of the month following the entry-on-duty date. Coverage ends on the last day of the termination month. All eligible dependents must be covered when one dependent is covered under health, dental, or vision insurance unless proof of other group coverage is provided. Eligible dependents can include a spouse, unmarried children up to the age of 23 and incapacitated or totally disabled children of any age if their incapacity occurred and was verified prior to age 23. Two State employees cannot claim coverage for the same dependents for health, dental, and vision benefits. A dependent age 22 up to age 25 and covered under the State health plans as of June 30, 2006, and 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, secondary school, or college. Student status audits will be performed regularly and dependents will be dropped if no longer an active full-time student. Re-enrollment will not be available. 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.

Changes to Benefit Plan Elections

Benefit elections made during the Option Period are generally irrevocable. Changes can be made to Option Period elections only if the change is authorized and consistent with Internal Revenue Service regulations. If you experience an event which you believe qualifies you to change your

benefit elections, contact your Benefits Coordinator **within 30 days of the event**. Life events that qualify you to change your benefit elections include: marriage, birth, adoption or placement of an adopted child, loss of other coverage, change in marital status, change in the number of dependents, change in employment status of employee, spouse or dependent that affects eligibility, event causing employee's dependent to satisfy or cease to satisfy eligibility requirements, change in place of residence of employee, spouse or dependent (HMO coverage), commencement of or termination of adoption proceedings, judgments, decrees or orders, Medicare or Medicaid, significant cost increases (limited to Dependent Care Account using unrelated care provider), changes in coverage of spouse or dependent under other Employer's plan (except HCA), FMLA Leave, or other such events, which may permit such modification of election under the IRS consistency rule as found in Treasury Regulations 1.125-4 and in accordance with other applicable and prevailing Internal Revenue Code regulations promulgated under, and in accordance with 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 into the same account as your payroll deposit is required by state law. If you terminate employment with the state, any daycare or medical services must be incurred prior to the last day of your termination month. If you are not on active payroll (on some type of leave) it is your responsibility to mail in your pledged contribution. Viewing your account information is easy using the EBC website. For further information on allowable expenses see EBC's website at www.ebc.state.ok.us and review IRS Publications 969, 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 2008, services must be rendered on or before March 15, 2009. However, you may send your claims through March 31, 2009. 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.

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.

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

FSA Health Care (Medical) Account Information

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 \$0.18 per mile (amount subject to change). Check out the list of approved over-the-counter items on the EBC 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 Mondays, at 1:00 p.m. (Subject to change during holidays). Rollover distributions to a qualified Health Savings Account (HSA) are permitted under amendments to the Internal Revenue Code by section 302 of the Health Opportunity Patient Empowerment Act of 2006 (the Act) included in the Tax Relief and Health Care Act of 2006 and are permitted under the States Plan. The new rules provide, in

limited circumstances, for certain amounts in a health FSA to be rolled over into an HSA and for the rollover to receive favorable tax treatment. The maximum contribution is the balance in the FSA as of September 21, 2006, or if less, the balance on December 31, 2007, the date of transfer. If the account balance on September 21, 2006 is -0-, or there was no enrollment in a HealthCare Spending account at that time, then the rollover is not permitted. For additional guidance you may see IRS Rev. Rul. 2004-45.

FSA Dependent Care Account Information

If you have an eligible dependent (children 12 or younger who have been included on your income tax return or any other eligible dependent person physically or mentally incapable of self-care) who spends at least eight hours a day in your home you may want to participate in the Dependent Care Flexible Spending Account. This account pays daycare provider expenses while you and your spouse work up to a combined calendar year total of \$5,000. The daycare provider cannot also be your tax dependent. The individual calendar year limit is \$2,500. Form 2441 must still be filed with your taxes. You can receive reimbursement for the amount you have currently deposited in your Dependent Care Account. 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 pre-existing 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 in most situations. Certain time limits apply to be eligible to continue coverage and an additional fee is added to your insurance premiums. Contact your Benefits Coordinator or OSEEGIB immediately upon termination of your employment to determine your COBRA rights. The Insurance Board administers the COBRA program for state employees.

Change of Address

The 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, or make your address change online in EBC's Benefits Administration System (BAS) under the Basic Information screen.

Prescription Drug Plan Creditable Coverage Statement

The Employees Benefits Council has determined that the prescription drug coverage with the State of Oklahoma Employees Benefits Council Health Plans is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Because your coverage through your health plan offered through the Council is on average at least as good as standard Medicare prescription drug coverage, you can keep your coverage and not pay extra if you later decide to enroll in Medicare coverage. If you decide to enroll in a Medicare prescription drug plan and drop your State of Oklahoma Employees Benefits Council prescription drug coverage, be aware that you may not be able to get this coverage back. A notice of creditable coverage is provided in the back pocket of this Guide and can also be obtained by contacting the Employees Benefits Council at (405) 232-1190 or downloading a copy from the EBC website at www.ebc.state.ok.us

Automatic Premium Conversion Election:

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

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 percent 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.

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 the EAP, 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, EAP 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.

Any employee can contact the EAP. Employees should ask their Human Resource Representative at their agency for information on how to contact the EAP program or log onto the EBC website: www.ebc.state.ok.us/en/wellness/programs and select Employee Assistance Program.



OK Health Mentoring Program

Email: OKHealth@ebc.state.ok.us
(405) 232-1190 • Toll free (800) 219-8115

Check out our Web site at:
www.ebc.ok.us/en/okhealth
for more information

Would you like...

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

Then OK Health Mentoring Program 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 Mentoring 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 (specific to OK Health) is waived. After completing the online 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 are offered by participating agencies (check with your agency for details)
- **NO CO PAY OR DEDUCTIBLE:**
Initial PCP visit and specified lab work will be waived
- **DISCOUNTS:**
On selected Fitness Centers throughout Oklahoma

To learn how you can get started in the OK Health Mentoring Program, check with your agency Wellness Coordinator and a professional health mentor will contact you. **You can also enroll online at anytime throughout the year by visiting the OK Health page on the EBC website.** If you are a current participant there is no need to re-enroll.

What OK Health participants are saying about us...

“Excellent support system and encouragement. Mentor stays on track, keeps me focused on goals and helps me avoid the consequences of my impatience with myself.”

“The program has been helpful and the staff very helpful. I’ve recommended it to others.”

“Excellent program — so glad I enrolled — very educating. . .even my husband is following an exercise and meal plan because of my involvement with this. Thanks very much.”

MENTOR NAMES	Important Numbers	
Amreen Hemani	609-3416	X116
Jay Camp	609-3405	X105
Jessica Smith	609-3457	X157
Laura Hook	609-3431	X131
Miranda Manning	609-3425	X125
Myka Saltsman	609-3426	X126
Myra Moreno	609-3442	X142
Sherritta Harris	609-3419	X119
Susie Robinson	609-3418	X118
Valerie Bjerck	609-3455	X155

EBC Main Line	405-232-1190
Toll-free Number	1-800-219-8115
OK Health FAX	405-609-3475

EXECUTIVE / ADMINISTRATION	TELEPHONE
Philip Kraft, Executive Director	101
Executive Assistant	102
Deputy Director, Agency & Regulatory Affairs	128
Nancy Stewart, Receptionist	100
Craig Cates, Administrative Assistant	140
Nancy Haller, Manager, State Wellness Program	120
Miranda Manning, Health Educator	125
 BENEFITS & CONTRACTS	
Colleen Dame, Deputy Director, Benefits & Contracts Administration	104
Jimmy Trotter, Manager, Flexible Benefits Administration	103
Rosalie Garten, Administrative Programs Officer	122
Gary Grizzle, Flexible Benefits Analyst	108
Barbara Wagoner, Flexible Benefits Representative	115
Beth Moore, Flexible Benefits Representative	113
Ken Bassett, Flexible Benefits Representative	106
Peggy Utter, Flexible Benefits Representative	163
Sheila Petross, Administrative Technician	164
 INFORMATION SERVICES	
Frank Wade, Information Services Administrator	148
Phillip Moore, Web Applications Administrator	150
Mike DeRose, Database Administrator	149
Steve Coffey, Network Administrator	107
Carol Sawatzky, Administrative Assistant	145
 FISCAL SERVICES	
Dan Melton, Deputy Director, Finance & Accounting	110
Phil Crowder, Financial Manager	109
Suzi Bryan, Administrative Programs Officer	117
Sherry Jenkins, Member Accounts Manager	129
Tasha Franklin-Blevins, Benefits Accounts Specialist	151
Marka Potts, Benefits Accounts Specialist	112
Deniece Bryan, Flexible Spending Accounts Specialist	144
Sandra Smith, Flexible Spending Accounts Specialist	143
 HUMAN RESOURCES	
Mitzi Bennett, Human Resources Manager	111

EMPLOYEES BENEFITS COUNCIL MEMBERS

Bryce Fair, Chairman	
Weldon Davis, Vice-Chairman	Oscar B. Jackson, Jr., Council Member
Cliff Peden, Secretary	Becky Payton, Council Member



EMPLOYEES Benefits Council

YOUR BENEFITS OFFICE

120 N. Robinson Avenue, Suite 1100 • Oklahoma City, OK 73102
TOLL FREE 1-800-219-8115 • MAIN 405-232-1190
FAX 405-609-3474

HEALTH

HealthChoice (Member Services) Oklahoma City Metro	(405) 717-8780
Toll Free	(800) 752-9475
TDD	(405) 949-2281 or (866) 447-0436
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
Web:	www.healthchoiceok.com or www.sib.ok.gov
Aetna, Inc. All Areas	(800) 949-3104
Web:	www.aetna.com/okstateemployees/
TDD	(800)-628-3323
CommunityCare HMO All Areas	(800) 777-4890
TTY/TDD	(800) 722-0353
Web:	www.ccok.com
GlobalHealth HMO All Areas	(405) 280-5600
Web:	www.globalhealth.cc
Toll-Free	(877) 280-5600
TY/TDD/Voice	(800) 522-8506
PacifiCare of Oklahoma All Areas	(800) 825-9355
TDHI	(800) 577-7595
Web:	www.pacificare.com

DENTAL

HealthChoice Dental Plan Oklahoma City Metro	(405) 717-8780
Web:	www.healthchoiceok.com or www.sib.ok.gov
Toll Free	(800) 752-9475
TDD	(405) 949-2281 or (866) 447-0436
Assurant Prepaid Dental (Plus and Secure) All Areas	(800) 443-2995
Assurant Freedom Preferred Indemnity All Areas	(800) 442-7742
Web:	www.assurantemployeebenefits.com
CIGNA Dental Prepaid	(800) 367-1037
Web:	www.cigna.com
Delta Dental of Oklahoma Oklahoma City Metro	(405) 607-2100
Web:	www.deltadentalok.org
Toll Free	(800) 522-0188

VISION

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

EMPLOYEES BENEFITS COUNCIL

Main	(405) 232-1190
Toll Free	(800) 219-8115
Administration FAX	(405) 609-3477
Benefits FAX	(405) 609-3474
Finance FAX & Flexible Benefits FAX	(405) 609-3476
Wellness FAX	(405) 609-3475
TDD	(405) 609-3473
Flexible Spending Accounts	(405) 232-1190 x301
Toll Free	(800) 219-8115 x301
HIPAA	(405) 232-1190 x122