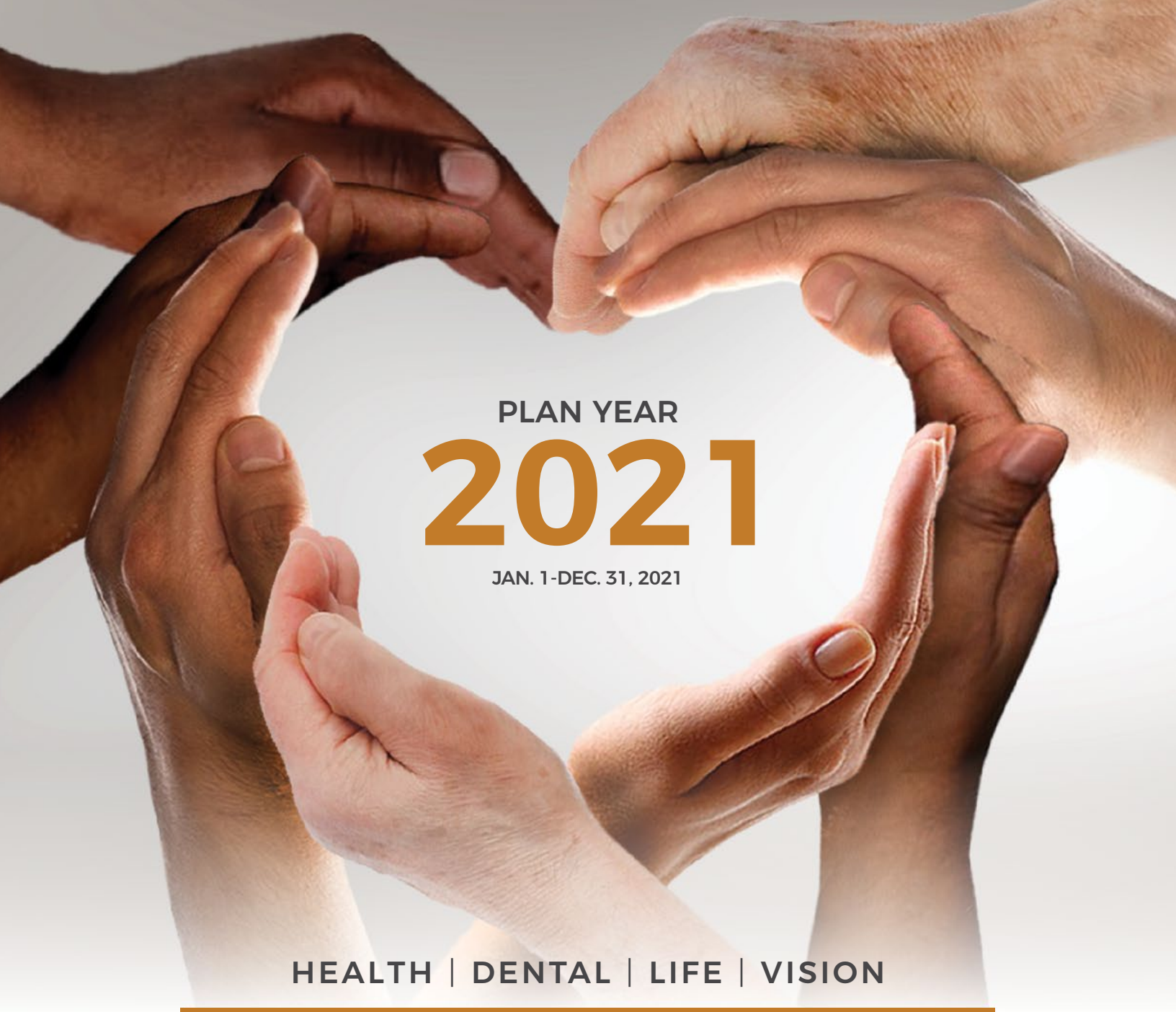

PLAN YEAR

2021

JAN. 1-DEC. 31, 2021

HEALTH | DENTAL | LIFE | VISION

EMPLOYEE BENEFIT

ENROLLMENT GUIDE

Biweekly Cumulative Plan Premiums for Current Employees
Plan Year Jan. 1-Dec. 31, 2021

Biweekly Benefit Allowances

	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
	$ 329.95	$ 656.38	$ 771.33	$ 838.98	$ 446.12	$ 527.09

Biweekly Plan Rates

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Blue Cross Blue Shield of Oklahoma – BlueLincs HMO	$ 296.75	$ 734.80	$ 895.13	$ 996.60	$ 457.08	$ 558.55
CommunityCare HMO	$ 533.64	$ 1,310.95	$ 1,582.74	$ 1,745.82	$ 805.43	$ 968.51
GlobalHealth HMO	$ 399.96	$ 990.35	$ 1,218.75	$ 1,363.34	$ 628.36	$ 772.95
HealthChoice High and High Alternative	$ 307.95	$ 669.01	$ 823.91	$ 931.87	$ 462.85	$ 570.81
HealthChoice Basic and Basic Alternative	$ 243.68	$ 529.66	$ 655.33	$ 742.23	$ 369.35	$ 456.25
HealthChoice High Deductible Health Plan (HDHP)	$ 211.13	$ 459.06	$ 568.11	$ 643.17	$ 320.18	$ 395.24
TRICARE Supplement – Selman&Company	$ 30.25	$ 59.75	$ 80.25	$ 80.25	$ 59.75	$ 80.25

DENTAL	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
BCBSOK – BlueCare Dental High Plan	$ 19.02	$ 38.04	$ 53.44	$ 77.40	$ 34.42	$ 58.38
BCBSOK – BlueCare Dental Low Plan	$ 13.14	$ 26.28	$ 37.59	$ 54.00	$ 24.45	$ 40.86
Cigna Prepaid High (K1I09)	$ 6.15	$ 11.13	$ 14.95	$ 17.68	$ 9.97	$ 12.70
Cigna Prepaid Low (OKIV9)	$ 4.75	$ 7.84	$ 9.94	$ 12.57	$ 6.85	$ 9.48
Delta Dental PPO	$ 19.02	$ 38.04	$ 54.59	$ 79.88	$ 35.57	$ 60.86
Delta Dental PPO – Choice	$ 7.84	$ 25.62	$ 43.53	$ 69.10	$ 25.75	$ 51.32
HealthChoice Dental	$ 20.86	$ 41.72	$ 58.58	$ 84.97	$ 37.72	$ 64.11
MetLife High Classic MAC	$ 24.30	$ 48.60	$ 69.42	$ 100.15	$ 45.12	$ 75.85
MetLife Low Classic MAC	$ 14.00	$ 28.00	$ 40.00	$ 57.50	$ 26.00	$ 43.50
Sun Life Preferred Active PPO	$ 18.09	$ 36.09	$ 49.59	$ 72.37	$ 31.59	$ 54.37

VISION	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Primary Vision Care Services (PVCS)	$ 5.20	$ 9.84	$ 14.44	$ 15.59	$ 9.80	$ 10.95
Superior Vision	$ 3.81	$ 7.60	$ 11.19	$ 14.97	$ 7.40	$ 11.18
Vision Care Direct	$ 7.95	$ 13.58	$ 19.21	$ 24.95	$ 13.58	$ 19.32
VSP (Vision Service Plan)	$ 4.36	$ 7.25	$ 10.10	$ 13.49	$ 7.21	$ 10.60

DISABILITY	$5.18 (Limited city and county participation only)	
LIFE	HealthChoice Basic Life ($20,000) $2.10	First $20,000 of Supplemental Life $2.10

SUPPLEMENTAL LIFE–Age-Rated Cost Per $20,000 Unit

< 30 – $0.60	30-34 – $0.60	35-39 – $0.60	40-44 – $0.80
45-49 – $1.40	50-54 – $2.60	55-59 – $4.00	60-64 – $4.60
65-69 – $7.40	70-74 – $12.80	75+ – $19.60	

DEPENDENT LIFE	Low Option $1.30	Standard Option $2.16	Premier Option $4.71

Dependent Life does not include Accidental Death and Dismemberment (AD&D).
For TRICARE Supplement Plan information for military only, refer to Page 5.

Monthly Cumulative Plan Premiums for Current Employees
Plan Year Jan. 1-Dec. 31, 2021

Monthly Benefit Allowances

	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
	$ 659.89	$ 1,312.75	$ 1,542.66	$ 1,677.96	$ 892.24	$ 1,054.18

Monthly Plan Rates

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Blue Cross Blue Shield of Oklahoma – BlueLincs HMO	$ 593.50	$ 1,469.60	$ 1,790.26	$ 1,993.20	$ 914.16	$ 1,117.10
CommunityCare HMO	$ 1,067.28	$ 2,621.90	$ 3,165.48	$ 3,491.64	$ 1,610.86	$ 1,937.02
GlobalHealth HMO	$ 799.92	$ 1,980.70	$ 2,437.50	$ 2,726.68	$ 1,256.72	$ 1,545.90
HealthChoice High and High Alternative	$ 615.90	$ 1,338.02	$ 1,647.82	$ 1,863.74	$ 925.70	$ 1,141.62
HealthChoice Basic and Basic Alternative	$ 487.36	$ 1,059.32	$ 1,310.66	$ 1,484.46	$ 738.70	$ 912.50
HealthChoice High Deductible Health Plan (HDHP)	$ 422.26	$ 918.12	$ 1,136.22	$ 1,286.34	$ 640.36	$ 790.48
TRICARE Supplement – Selman&Company	$ 60.50	$ 119.50	$ 160.50	$ 160.50	$ 119.50	$ 160.50

DENTAL	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
BCBSOK – BlueCare Dental High Plan	$ 38.04	$ 76.08	$ 106.88	$ 154.80	$ 68.84	$ 116.76
BCBSOK – BlueCare Dental Low Plan	$ 26.28	$ 52.56	$ 75.18	$ 108.00	$ 48.90	$ 81.72
Cigna Prepaid High (K1I09)	$ 12.30	$ 22.26	$ 29.90	$ 35.36	$ 19.94	$ 25.40
Cigna Prepaid Low (OKIV9)	$ 9.50	$ 15.68	$ 19.88	$ 25.14	$ 13.70	$ 18.96
Delta Dental PPO	$ 38.04	$ 76.08	$ 109.18	$ 159.76	$ 71.14	$ 121.72
Delta Dental PPO – Choice	$ 15.68	$ 51.24	$ 87.06	$ 138.20	$ 51.50	$ 102.64
HealthChoice Dental	$ 41.72	$ 83.44	$ 117.16	$ 169.94	$ 75.44	$ 128.22
MetLife High Classic MAC	$ 48.60	$ 97.20	$ 138.84	$ 200.30	$ 90.24	$ 151.70
MetLife Low Classic MAC	$ 28.00	$ 56.00	$ 80.00	$ 115.00	$ 52.00	$ 87.00
Sun Life Preferred Active PPO	$ 36.18	$ 72.18	$ 99.18	$ 144.74	$ 63.18	$ 108.74

VISION	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Primary Vision Care Services (PVCS)	$ 10.40	$ 19.68	$ 28.88	$ 31.18	$ 19.60	$ 21.90
Superior Vision	$ 7.62	$ 15.20	$ 22.38	$ 29.94	$ 14.80	$ 22.36
Vision Care Direct	$ 15.90	$ 27.16	$ 38.42	$ 49.90	$ 27.16	$ 38.64
VSP (Vision Service Plan)	$ 8.72	$ 14.50	$ 20.20	$ 26.98	$ 14.42	$ 21.20

DISABILITY	$10.36 (Limited city and county participation only)	
LIFE	HealthChoice Basic Life ($20,000) $4.20	First $20,000 of Supplemental Life $4.20

SUPPLEMENTAL LIFE–Age-Rated Cost Per $20,000 Unit

< 30 – $1.20	30-34 – $1.20	35-39 – $1.20	40-44 – $1.60
45-49 – $2.80	50-54 – $5.20	55-59 – $8.00	60-64 – $9.20
65-69 – $14.80	70-74 – $25.60	75+ – $39.20	

DEPENDENT LIFE	Low Option $2.60	Standard Option $4.32	Premier Option $9.42

Dependent Life does not include Accidental Death and Dismemberment (AD&D).
For TRICARE Supplement Plan information for military only, refer to Page 5.

TABLE OF CONTENTS

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

A fully accessible version of this guide is available at **omes.ok.gov**. Select Services, then Human Capital Management, select Employee Benefits, select Health Care.

2021 PLAN CHANGES AND IMPORTANT REMINDERS

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

HEALTH PLANS

CommunityCare HMO

- Bariatric surgery is now a covered benefit with a $350 copay per day with a $1,750 maximum per admission.
- CDC-recognized National Diabetes Prevention Program is now a covered benefit with a $0 copay.

DENTAL PLANS

Blue Cross Blue Shield of Oklahoma

- BCBSOK – BlueCare Dental High Plan and BCBSOK – BlueCare Dental Low Plan are new dental plans for 2021. Refer to the Comparison of Benefits for Dental Plans.

Cigna

- The name of the 2020 Cigna Dental Care Plan (Prepaid) has been changed to Cigna Prepaid Low (OKIV9) for 2021.
- Cigna Prepaid High (K1I09) is a new dental plan for 2021. Refer to the Comparison of Benefits for Dental Plans.
- If you are currently on the Cigna Dental Care Plan (Prepaid) in 2020, you MUST actively enroll in Cigna Prepaid Low (OKIV9) or choose another dental plan for 2021. If you choose not to actively enroll you will be defaulted into Cigna Prepaid Low (OKIV9).

REMINDER

The online attestation for Plan Year 2021 is open Sept. 21-Nov. 13, 2020. HealthChoice members who are tobacco free can update their annual Verification of Other Insurance Coverage and their Tobacco-Free Attestation online in just a few minutes.

Tobacco-Free Attestation

If you are enrolled in the HealthChoice High or Basic plan and wish to stay enrolled in that plan, you must complete the online Tobacco-Free Attestation for Plan Year 2021 available at **healthchoiceconnect.com** by Nov. 13, 2020. This does not apply to HDHP members.

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

If you cannot sign the Tobacco-Free Attestation because either you or a covered dependent uses tobacco, you can still qualify for the High or Basic plan if those who use tobacco complete one of the following alternatives by Nov. 13:

- Show proof of an attempt to quit using tobacco by enrolling in the quit tobacco program available through the Oklahoma Tobacco Helpline (800-QUIT-NOW) and Optum and completing three coaching calls.
- Provide a letter from your doctor indicating it is not medically advisable for you or your covered dependents to quit tobacco.

If you do not complete the Tobacco-Free Attestation or complete one of the reasonable alternatives and you are not in the first-year grace period, you will automatically be enrolled in the HealthChoice High Alternative or Basic Alternative plan effective Jan. 1, and your annual deductible will be higher. Refer to the Comparison of Network Benefits for Health Plans.

Coordination of benefits

You are required to annually verify if you or any of your covered dependents have other health or dental insurance. Failure to verify other insurance coverage will result in denial of claims until verification is completed. You may complete your verification by registering at **healthchoiceconnect.com** or by calling HealthChoice Customer Care at 800-323-4314.

Coordination of benefits is an industry standard process that occurs when two insurance plans must work together to pay claims for the same person. Coordinating benefits establishes which plan is primary and which plan is secondary and helps avoid duplicate payments by making sure the two plans do not pay more than the total amount of the claim. The primary plan pays first and the secondary plan pays any remaining balance after your share of the costs is deducted. This process also helps reduce the cost of insurance premiums.

Life insurance applications

Life insurance applications may be completed beginning Sept. 21, 2020. The **deadline** to submit a life application for 2021 is Oct. 30, 2020.

GENERAL INFORMATION

The benefits you select will take effect Jan. 1 – or for new employees, the effective date of your coverage – through Dec. 31, 2021, or the last day of the month of your termination date.

After enrollment, the plans you select will provide more information about your benefits. Contact each plan directly if you have questions about your benefits. The contact information is provided at the end of this guidebook.

It is your responsibility to review your benefits carefully so you know what is covered before you choose your benefits.

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

HEALTH PLANS

There are several health plans available:

- BCBSOK – BlueLincs HMO.
- CommunityCare HMO.
- GlobalHealth HMO.
- HealthChoice High and High Alternative.
- HealthChoice Basic and Basic Alternative.
- HealthChoice HDHP.
- TRICARE Supplement Plan.

Refer to Comparison of Network Benefits for Health Plans on Pages 24-35 for benefit information.

- There are no preexisting condition exclusions or limitations applied to any of the health plans.
- All health plans coordinate benefits with other group insurance plans you have in force.
- If you select an HMO:
  - You must **live or work** within an HMO's ZIP code service area to be eligible. Post office box addresses cannot be used to determine your HMO eligibility. Refer to **Pages 17-23** for the HMO ZIP Code Lists.
  - You must use the provider network designated by that plan for Oklahoma.
- If you select HealthChoice:
  - To remain enrolled in the HealthChoice High or Basic plan for 2021, you must complete the Tobacco-Free Attestation located on the HealthChoice website or one of the two listed reasonable alternatives.

Health Savings Account information for HealthChoice HDHP

HSAs for HealthChoice HDHP members allow you to save money for HSA-eligible expenses, and they give you the ability to take greater control of your own health care costs. An HSA allows you to have pretax HSA contributions withheld from your paycheck.

NOTE: A member cannot contribute to both an HSA and the Section 125 Medical Reimbursement Account. A member can contribute to an HSA and the Section 125 Dependent Care Account.

Triple tax savings advantage

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

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

HSA card

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

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

Online account access

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

Electing a TRICARE Supplement Plan (Military only)

NOTE: If you do not currently have TRICARE coverage as a current or former military member, you are not eligible for the TRICARE Supplement Plan. If you currently have TRICARE coverage and are younger than age 65, you can choose to enroll in the TRICARE Supplement Plan. Electing to purchase the TRICARE Supplement Plan means TRICARE will be primarily responsible for your medical coverage and the supplement plan will be secondarily responsible for coverage. The plan covers the cost shares and copays, including prescription drugs, a portion of the TRICARE deductible, and excess charges up to the legal limit. For active state employees, please understand by electing the Tricare Supplemental Plan, you are opting out of all core benefits which include life and disability. You can still elect coverage for vision, Medical Reimbursement Account and Dependent Care Account. By your election, you submit to the eligibility rules of TRICARE and the TRICARE Supplement Plan. These rules may be different from the rules of eligibility created by the State of Oklahoma. Medicare may become the primary insurer upon attaining eligibility for Medicare. For more information on the TRICARE Supplement Plan, refer to **omes.ok.gov/services/employees-group-insurance-division/tricare-supplement**.

DENTAL PLANS

There are several dental plans available:

- BCBSOK – BlueCare Dental High Plan.
- BCBSOK – BlueCare Dental Low Plan.
- Cigna Prepaid High (K1I09).
- Cigna Prepaid Low (OKIV9).
- Delta Dental PPO.
- Delta Dental PPO – Choice.
- HealthChoice Dental.
- MetLife High Classic MAC.
- MetLife Low Classic MAC.
- Sun Life Preferred Active PPO.

Refer to Comparison of Benefits for Dental Plans on Pages 36-43 for benefit information.

- You must select a primary care dentist for yourself and each covered dependent when enrolling in a prepaid dental plan.
- Some plans may not be available in all areas.

VISION PLANS

There are several vision plans available:

- Primary Vision Care Services.
- Superior Vision.
- Vision Care Direct.
- VSP.

Refer to Comparison of Benefits for Vision Plans on Pages 44-46 for benefit information.

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

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

HEALTHCHOICE LIFE INSURANCE PLAN

- As a **new employee**, you can elect life insurance coverage within 30 days of your employment or initial eligibility date. You can enroll in Guaranteed Issue, in addition to Basic Life, without a life insurance application. Guaranteed Issue is two times your annual salary rounded up to the nearest $20,000. All requests for supplemental coverage above Guaranteed Issue require you to submit a life insurance application for approval.
- As a **current employee**, if you did not enroll in life coverage when first eligible, you can enroll:
  - During the annual Option Period (enroll in or increase life coverage).
  - Within 30 days of a midyear qualifying event, such as birth of a child or marriage.
  - A life insurance application, available from your benefits coordinator, must be submitted for approval.
- The **deadline** to submit a life application is Oct. 30, 2020.

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

Basic Life insurance: For you

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

Supplemental Life insurance: For you

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

Beneficiary designation

For Basic Life and Supplemental Life benefits, you must name your beneficiaries when you enroll. Your designation can be changed at any time. Contact your benefits coordinator for a Beneficiary Designation Form or more information. This form is also available at **healthchoiceconnect.com** under Member Forms. Life insurance benefits are paid according to the information on file.

Dependent Life insurance: For your eligible dependents

- If you are enrolled in Basic Life, you can elect Dependent Life for your spouse and other eligible dependents during your initial enrollment, the annual Option Period, within 30 days of the loss of other group life insurance or other midyear qualifying event without a life insurance application. There is no beneficiary designation for Dependent Life. Any Dependent Life proceeds are paid directly to the member.
- Each eligible dependent must be enrolled in Dependent Life. Regardless of the number of dependents covered, the monthly premium is a flat amount. Benefits are paid only to the member. Below are the three levels of coverage:

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

Dependent Life does not include AD&D benefits.

HEALTHCHOICE DISABILITY PLAN (limited city and county participation)

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

Eligibility

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

For further details, refer to the HealthChoice Disability Handbook.

ENROLLMENT PERIODS

Option Period enrollment: Coverage effective Jan. 1, 2021

This is the time when eligible employees can:

- Enroll in coverage.
- Change plans or drop coverage.
- Increase or decrease life coverage.
- Add or drop eligible dependents from coverage.

You can enroll in health, dental, life and/or vision coverage for yourself and/or your dependents during the annual Option Period, as long as you have not dropped that coverage within the past 12 months. If you have dropped coverage within the past 12 months without a midyear qualifying event, you cannot reinstate that coverage for at least 12 months.

Initial enrollment: Coverage effective the first of the month following your employment date or the date set by your employer

This is the time when new employees are eligible to:

- Enroll in coverage.
- Enroll eligible dependents.
- Submit a life insurance application for review and approval for life insurance coverage above Guaranteed Issue.

As a new employee, you have 30 days from your employment or eligibility date to enroll in coverage. Check with your benefits coordinator for more information.

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

HIPAA special enrollment rights: Coverage generally effective the first of the month following a qualifying event

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

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

Midyear changes: Coverage generally effective the first of the month following a qualifying event

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

ENROLLMENT

Benefits Enrollment Calculator

Your benefits costs can be easily estimated using the online Benefits Enrollment Calculator located on the website at **ebd.ok.gov**. Be sure to choose the monthly or biweekly calculator, depending on your pay frequency. The Benefits Enrollment Calculator can add your benefits costs, apply your benefits allowance and provide an estimated total, showing any out-of-pocket expense or additional take-home pay you may realize in your paycheck.

Important Notes about the Benefits Enrollment Calculator:

- Print your benefits calculator results for easy reference during online enrollment.
- Use the calculator as many times as you want, but to actually enroll you must log on to the Benefits Administration System website or complete your paper enrollment form.
- The online benefits calculator provides estimates only. Although every attempt has been made to provide accurate information, the calculator provides no guarantee of compensation, benefits or tax implications.

Benefit Allowance

Your Benefit Allowance Helps Cover Your Costs

The state provides a benefit allowance to help you pay for insurance premiums that would otherwise come out of your own pocket. Refer to the benefit allowances at the top of the plan rate charts at the beginning of this guide. **The amount of your allowance is determined based upon the dependents you choose to include in coverage.**

Online Enrollment

Enroll Online!

Remember: Online enrollment opens Oct. 1 and closes Oct. 31, 2020.

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

Last year, 80% of state employees went to **ebd.ok.gov** and used online enrollment to make their benefit elections. Join your co-workers and discover how easy it is to enroll online. The average enrollment takes just a few minutes, and you can log on anytime during Option Period.

Online enrollment allows you to:

- Print your confirmation of benefits elections instantly.
- Update your address (do not use punctuation), telephone and email information online.
- Change your elections and make corrections as many times as you like, until the close of Option Period. (**Remember, your final election is the official enrollment.**)

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

Changes to Benefit Plan Elections

Benefit elections made during Option Period are generally irrevocable. Changes can be made to Option Period elections only if the change is authorized and consistent with IRS regulations. If you experience an event that you believe qualifies you to change your benefit elections, contact your benefits coordinator within 30 days of the event.

Midyear Changes

Life events that qualify you to change your benefit elections midyear include:

- Marriage.
- Birth.
- Adoption or placement of an adopted child.
- Loss of other coverage.
- Change in marital status.
- Change in the number of dependents.
- Change in employment status of employee, spouse or dependent that affects eligibility.
- Event causing employee's dependent to satisfy or cease to satisfy eligibility requirements.
- Change in place of residence of employee, spouse or dependent (HMO coverage).
- Commencement of or termination of adoption proceedings.
- Judgments, decrees or orders.
- Medicare or Medicaid (for dependents only).
- Significant cost increases (limited to DCA using unrelated care provider).
- Changes in coverage of spouse or dependent under other employer's plan (except HCA).
- Family and Medical Leave Act leave.
- Other events, which may permit such modification of election under the IRS consistency rule as found in Treasury Regulations 1.125-4 and in accordance with other applicable and prevailing IRS Code regulations promulgated under, and in accordance with other applicable rules and regulations.

ELIGIBILITY

Members

- You must be a current state employee regularly scheduled to work at least 1,000 hours a year, and not classified as temporary or seasonal.
- Any current state employee regularly scheduled to work 30 hours per week shall be eligible for and offered insurance coverage under the provisions of the Patient Protection and Affordable Care Act.

Dependents

- If one eligible dependent is covered, all eligible dependents must be covered. Exceptions apply (refer to “Excluding dependents from coverage” in this section).
- Eligible dependents include:
  - Your legal spouse (including common-law).
  - Your daughter, son, stepdaughter, stepson, eligible foster child, adopted child or child legally placed with you for adoption up to age 26, whether married or unmarried.
  - A dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26. Subject to medical review and approval.
  - Other unmarried dependent children up to age 26, upon completion and approval of an Application for Coverage for Other Dependent Children. Guardianship papers or a tax return showing dependency can be provided in lieu of the application.
- If your spouse is enrolled separately in one of the plans offered through EGID, your dependents can be covered under either parent’s health, dental and/or vision plan, but not both. However, both parents can cover dependents under Dependent Life.
- Dependents who are not enrolled within 30 days of your eligibility date cannot be enrolled until the next annual Option Period, unless a qualifying event such as birth, marriage or loss of other group coverage occurs. Dependent coverage can be dropped midyear with a qualifying event.
- Dependents can be enrolled only in the same types of coverage and in the same plans you elect for yourself.
- To enroll your newborn, the appropriate form must be provided to your benefits coordinator within 30 days of the birth. This coverage is effective the first of the birth month. If you do not enroll your newborn during this 30-day period, you cannot do so until the next annual Option Period. Direct notification to a plan will not enroll your newborn or any other dependents. The newborn’s Social Security number is not required at the time of initial enrollment but must be provided once it is received from the Social Security Administration. Insurance premiums for the month the child was born must be paid.

- Without newborn enrollment:
  - HealthChoice: A newborn has limited coverage without an additional premium only for the first 48 hours following a vaginal birth or the first 96 hours following a cesarean section birth. Under the HealthChoice plans, a separate deductible and coinsurance apply.
  - BCBSOK – BlueLincs, CommunityCare and GlobalHealth HMOs: A newborn is covered for 31 days without an additional premium.

Newly hired employees and current employees with newly acquired dependents are required to provide documentation to verify dependent eligibility. Following is the acceptable documentation for dependent verification:

Spouse

Copy of your marriage certificate and one of the following:

- Copy of the front page of your filed 2019 federal tax return confirming this dependent is your spouse.
- A document dated within the last 60 days showing current relationship status such as a recurring monthly household bill or statement of account.

Common-law spouse

Copy of a completed Affidavit of Common-Law Spouse and one of the following:

- Copy of the front page of your filed 2019 federal tax return confirming this dependent is your spouse.
- A document dated within the last 60 days showing current relationship status such as a recurring monthly household bill or statement of account.

Children up to age 26 and disabled children

Birth certificate, hospital birth record or adoption certificate naming you or your spouse as the child's parent or a copy of the court order naming you or your spouse as the child's legal guardian.

- If you have any questions regarding verifying eligibility, please contact your benefits coordinator.

Opt-Out Details

With the approval of House Bill 1107 in May 2013 (which revised HB 2088), state employees and elected officials were given the right to opt out of state benefits. Specifically:

> Any active employee eligible to participate or who is a participant may opt out of the state's basic plan as outlined in Sections 1370 and 1371 of this title, or may opt out of the health and dental basic plan options only and retain the life and disability plan benefits, provided that the participant is currently covered by a separate group health insurance plan or will be covered by a separate group health insurance plan

> at or before the beginning of the next plan year. Any active employee eligible to participate or who is a participant opting out of coverage pursuant to this section shall provide proof of the separate health insurance plan participation and sign an affidavit attesting that the participant is currently covered and does not require state-provided health insurance each plan year. Any active employee opting out of the state's basic plan or the health and dental basic plan options pursuant to this section shall receive One Hundred Fifty Dollars ($150.00) in lieu of the flexible benefit amount the employee would be otherwise eligible to receive.

As the law spells out, you may opt out of the basic plan (health, dental, Basic Life and disability insurance), or you may opt out of health and dental benefits only if you are currently covered by a separate group health insurance plan or will be covered by Jan. 1, 2021. In addition, you must provide proof of the separate group health insurance plan participation and sign an affidavit before the opt-out will be approved. You will need to fill out an Option Period enrollment form, which is available through your benefits coordinator, every year. State employees who have federal TRICARE insurance benefits and choose to enroll in the TRICARE Supplement Plan will opt out of health, dental, life, disability, Supplemental Life and Dependent Life. They can elect to participate in vision and flexible spending accounts.

The basic plan described in the law consists of the following: health, dental, Basic Life and disability insurance. If you opt out of the basic plan, you are no longer eligible for any of those coverages through the state. Because Basic Life insurance is a prerequisite for the optional Supplemental Life and Dependent Life, those are eliminated as well. However, if you opt out of health and dental only, you may retain both life and disability insurance. State employees who opt out can still take advantage of vision insurance offered by the state, as well as a flexible spending account. Employees must opt out each year because the election does not rollover.

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

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

Excluding dependents from coverage

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

Confirming Your Benefits

- Once you enroll in or make changes to your benefits, select Confirmation of Benefits to save your enrollment confirmation for future reference.
- Your confirmation statement lists the coverage you are enrolled in, the effective date of your coverage and the premium amounts. If the coverage listed is incorrect, it is your responsibility to immediately notify your benefits coordinator. **Always review your confirmation statement to verify your coverage is correct.**

Transfer employee

- You can keep your coverage continuous when you move from one participating employer to another as long as there is no break in coverage that lasts longer than 30 days. Premiums must be paid upon reporting to work.

Retiring and changing plans

If you are retiring on or before Jan. 1, 2021, go to **omes.ok.gov/services/employees-group-insurance-division** for the appropriate Option Period materials. Select the Option Period banner, then select (according to your status as of Jan. 1) Pre-Medicare or Medicare. Your benefits coordinator can assist you and must also provide you the required Application for Retiree/Vested/Non-Vested/Defer Insurance. If you or your dependents will be Medicare eligible by Jan. 1, an additional form will be required to enroll in one of the Medicare supplement plans or Medicare Advantage prescription drug plans. You can also call EGID for assistance. Refer to Contact Information at the back of this guide.

Termination of coverage

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

COBRA: Temporary continuation of coverage

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

STATE SHARED LEAVE PROGRAM

The state leave sharing program permits state employees to donate annual or sick leave to fellow state employees who have exhausted or will exhaust all types of leave. The Leave of Last Resort Bank was created for qualifying employees who are unable to obtain the necessary number of donated leave hours from his or her agency. The Leave of Last Resort Bank is administered by OMES and funded by voluntary donations of annual and sick leave from employees retiring or leaving state service (donor). The donor may donate any of their excess leave to the Leave of Last Resort Bank. Employees retiring or leaving state service may submit the **Separation from State Service Donation to Leave Bank Form (HCM-33C)** to their agency HR for further submission to the state shared leave liaison.

Current state employees also may donate leave to a co-worker in need of shared leave by submitting the **Request to Donate Shared Leave Form (HCM-33B)** to their Agency HR for verification and approval.

If an employee is in need of shared leaved, they may submit the **Request to Receive Shared Leave/Bank Leave Form (HCM-33A)** to their agency HR for verification and approval. The agency seeks to secure leave from within. If none is found, the request moves to the state shared leave liaison, who will seek to secure leave from the employing agency, other state agencies and the Leave of Last Resort Bank. The requesting employee and the employing agency must also continue to advocate for leave for the requesting employee.

For any questions regarding the state leave sharing program, email **HCMClassComp@omes.ok.gov**.

THRIVE: OKLAHOMA EMPLOYEE WELL-BEING

Thrive's state employee well-being program mission is to empower employees to be valued, engaged and productive. Our approach is based on six essential elements of well-being: career and purpose, social, financial, physical, community and emotional. We work with wellness coordinators to provide information, activities and opportunities that enable employees to improve and enhance their overall well-being. We create wellness initiatives that include challenges, programs, coordination of employee recreational leagues and many educational opportunities such as monthly toolkits, Lunch and Learn presentations, and classes through our training department.

In 2021, we will be providing new programs, challenges and additional educational opportunities.

Thrive's website and social media house all of this information. We invite employees and their families to visit our website, **thrive.ok.gov**, and sign up for our monthly newsletter and blog updates.

HMO ZIP CODE LISTS

BCBSOK – BlueLincs ZIP code list

73001	73002	73003	73004	73005	73006	73007	73008
73009	73010	73011	73012	73013	73014	73015	73016
73017	73018	73019	73020	73021	73022	73023	73024
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73061	73062	73063	73064	73065	73066	73067	73068
73069	73070	73071	73072	73073	73074	73075	73077
73078	73079	73080	73082	73083	73084	73085	73086
73089	73090	73092	73093	73094	73095	73096	73097
73098	73099	73101	73102	73103	73104	73105	73106
73107	73108	73109	73110	73111	73112	73113	73114
73115	73116	73117	73118	73119	73120	73121	73122
73123	73124	73125	73126	73127	73128	73129	73130
73131	73132	73134	73135	73136	73137	73139	73140
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73149	73150	73151	73152	73153	73154	73155	73156
73157	73159	73160	73162	73163	73164	73165	73167
73169	73170	73172	73173	73178	73179	73184	73185
73189	73190	73193	73194	73195	73196	73197	73198
73199	73401	73402	73403	73425	73430	73432	73433
73434	73435	73436	73437	73438	73439	73440	73441
73442	73443	73444	73446	73447	73448	73449	73450
73453	73455	73456	73458	73459	73460	73461	73463
73481	73487	73488	73491	73501	73502	73503	73505
73506	73507	73520	73521	73522	73523	73526	73527
73528	73529	73530	73531	73532	73533	73534	73536
73537	73538	73539	73540	73541	73542	73543	73544
73546	73547	73548	73549	73550	73551	73552	73553
73554	73555	73556	73557	73558	73559	73560	73561
73562	73564	73565	73566	73567	73568	73569	73570
73571	73572	73573	73601	73620	73622	73624	73625
73626	73627	73628	73632	73638	73639	73641	73642
73644	73645	73646	73647	73648	73650	73651	73654

ZIP codes are subject to change by plan.

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BCBSOK – BlueLincs ZIP code list

73655	73658	73659	73660	73661	73662	73663	73664
73666	73667	73668	73669	73673	73701	73702	73703
73705	73706	73716	73717	73718	73719	73720	73722
73724	73726	73727	73728	73729	73730	73731	73733
73734	73735	73736	73737	73738	73739	73741	73742
73743	73744	73746	73747	73749	73750	73753	73754
73755	73756	73757	73758	73759	73760	73761	73762
73763	73764	73766	73768	73770	73771	73772	73773
73801	73802	73832	73834	73835	73838	73840	73841
73842	73843	73844	73848	73851	73852	73853	73855
73857	73858	73859	73860	73901	73931	73932	73933
73937	73938	73939	73942	73944	73945	73946	73947
73949	73950	73951	74001	74002	74003	74004	74005
74006	74008	74010	74011	74012	74013	74014	74015
74016	74017	74018	74019	74020	74021	74022	74023
74026	74027	74028	74029	74030	74031	74032	74033
74034	74035	74036	74037	74038	74039	74041	74042
74043	74044	74045	74046	74047	74048	74050	74051
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74072	74073	74074	74075	74076	74077	74078	74079
74080	74081	74082	74083	74084	74085	74101	74102
74103	74104	74105	74106	74107	74108	74110	74112
74114	74115	74116	74117	74119	74120	74121	74126
74127	74128	74129	74130	74131	74132	74133	74134
74135	74136	74137	74141	74145	74146	74147	74148
74149	74150	74152	74153	74155	74156	74157	74158
74159	74169	74170	74171	74172	74182	74183	74184
74186	74187	74189	74192	74193	74194	74301	74330
74331	74332	74333	74335	74337	74338	74339	74340
74342	74343	74344	74345	74346	74347	74349	74350
74352	74354	74355	74358	74359	74360	74361	74362
74363	74364	74365	74366	74367	74368	74369	74370
74401	74402	74403	74421	74422	74423	74425	74426
74427	74428	74429	74430	74431	74432	74434	74435

ZIP codes are subject to change by plan.

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BCBSOK – BlueLincs ZIP code list

74436	74437	74438	74439	74440	74441	74442	74444
74445	74446	74447	74450	74451	74452	74454	74455
74456	74457	74458	74459	74460	74461	74462	74463
74464	74465	74467	74468	74469	74470	74471	74472
74477	74501	74502	74521	74522	74523	74525	74528
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74540	74542	74543	74545	74546	74547	74549	74552
74553	74554	74555	74556	74557	74558	74559	74560
74561	74562	74563	74565	74567	74569	74570	74571
74572	74574	74576	74577	74578	74601	74602	74604
74630	74631	74632	74633	74636	74637	74640	74641
74643	74644	74646	74647	74650	74651	74652	74653
74701	74702	74720	74721	74722	74723	74724	74726
74727	74728	74729	74730	74731	74733	74734	74735
74736	74737	74738	74740	74741	74743	74745	74747
74748	74750	74752	74753	74754	74755	74756	74759
74760	74761	74764	74766	74801	74802	74804	74818
74820	74821	74824	74825	74826	74827	74829	74830
74831	74832	74833	74834	74836	74837	74839	74840
74842	74843	74844	74845	74848	74849	74850	74851
74852	74854	74855	74856	74857	74859	74860	74864
74865	74866	74867	74868	74869	74871	74872	74873
74875	74878	74880	74881	74883	74884	74901	74902
74930	74931	74932	74935	74936	74937	74939	74940
74941	74942	74943	74944	74945	74946	74947	74948
74949	74951	74953	74954	74955	74956	74957	74959
74960	74962	74963	74964	74965	74966		

ZIP codes are subject to change by plan.

CommunityCare ZIP code list

74001	74002	74003	74004	74005	74006	74008	74009
74010	74011	74012	74013	74014	74015	74016	74017
74018	74019	74020	74021	74022	74027	74028	74029
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74038	74039	74041	74042	74043	74044	74045	74046
74047	74048	74050	74051	74052	74053	74054	74055
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74105	74106	74107	74108	74110	74112	74114	74115
74116	74117	74119	74120	74121	74126	74127	74128
74129	74130	74131	74132	74133	74134	74135	74136
74137	74141	74145	74146	74147	74148	74149	74150
74152	74153	74155	74156	74157	74158	74159	74169
74170	74171	74172	74182	74183	74184	74186	74187
74189	74192	74193	74194	74301	74330	74331	74332
74333	74335	74337	74338	74339	74340	74342	74343
74344	74345	74346	74347	74349	74350	74352	74353
74354	74355	74358	74359	74360	74361	74362	74363
74364	74365	74366	74367	74368	74369	74370	74401
74402	74403	74421	74422	74423	74425	74426	74427
74428	74429	74430	74431	74432	74434	74435	74436
74437	74438	74439	74440	74441	74442	74444	74445
74446	74447	74450	74451	74452	74454	74455	74456
74457	74458	74459	74460	74461	74462	74463	74464
74465	74466	74467	74468	74469	74470	74471	74472
74477	74501	74502	74521	74522	74523	74525	74526
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74574	74576	74577	74578	74604	74633	74637	74644
74650	74651	74652	74727	74728	74735	74738	74743
74754	74756	74759	74760	74761	74764	74839	74845
74880	74901	74902	74930	74931	74932	74935	74936
74937	74939	74940	74941	74942	74943	74944	74945
74946	74947	74948	74949	74951	74953	74954	74955
74956	74957	74959	74960	74962	74964	74965	74966

ZIP codes are subject to change by plan.

GlobalHealth ZIP code list

73001	73002	73003	73004	73005	73006	73007	73008
73009	73010	73011	73012	73013	73014	73015	73016
73017	73018	73019	73020	73021	73022	73023	73024
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73141	73142	73143	73144	73145	73146	73147	73148
73149	73150	73151	73152	73153	73154	73155	73156
73157	73159	73160	73162	73163	73164	73165	73167
73169	73170	73172	73173	73178	73179	73184	73185
73189	73190	73193	73194	73195	73196	73197	73198
73199	73401	73402	73403	73425	73430	73432	73433
73434	73435	73436	73437	73438	73439	73440	73441
73442	73443	73444	73446	73447	73448	73449	73450
73453	73455	73456	73458	73459	73460	73461	73463
73481	73487	73488	73491	73501	73502	73503	73505
73506	73507	73520	73521	73522	73523	73526	73527
73528	73529	73530	73531	73532	73533	73534	73536
73537	73538	73539	73540	73541	73542	73543	73544
73546	73547	73548	73549	73550	73551	73552	73553
73554	73555	73556	73557	73558	73559	73560	73561
73562	73564	73565	73566	73567	73568	73569	73570
73571	73572	73573	73601	73620	73622	73624	73625
73626	73627	73628	73632	73638	73639	73641	73642
73644	73645	73646	73647	73648	73650	73651	73654
73655	73658	73659	73660	73661	73662	73663	73664
73666	73667	73668	73669	73673	73701	73702	73703

ZIP codes are subject to change by plan.

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GlobalHealth ZIP code list

73705	73706	73716	73717	73718	73719	73720	73722
73724	73726	73727	73728	73729	73730	73731	73733
73734	73735	73736	73737	73738	73739	73741	73742
73743	73744	73746	73747	73749	73750	73753	73754
73755	73756	73757	73758	73759	73760	73761	73762
73763	73764	73766	73768	73770	73771	73772	73773
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73857	73858	73859	73860	73901	73931	73932	73933
73937	73938	73939	73942	73944	73945	73946	73947
73949	73950	73951	74001	74002	74003	74004	74005
74006	74008	74010	74011	74012	74013	74014	74015
74016	74017	74018	74019	74020	74021	74022	74023
74026	74027	74028	74029	74030	74031	74032	74033
74034	74035	74036	74037	74038	74039	74041	74042
74043	74044	74045	74046	74047	74048	74050	74051
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74061	74062	74063	74066	74067	74068	74070	74071
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74114	74115	74116	74117	74119	74120	74121	74126
74127	74128	74129	74130	74131	74132	74133	74134
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74149	74150	74152	74153	74155	74156	74157	74158
74159	74169	74170	74171	74172	74182	74183	74184
74186	74187	74189	74192	74193	74194	74301	74330
74331	74332	74333	74335	74337	74338	74339	74340
74342	74343	74344	74345	74346	74347	74349	74350
74352	74354	74355	74358	74359	74360	74361	74362
74363	74364	74365	74366	74367	74368	74369	74370
74401	74402	74403	74421	74422	74423	74425	74426
74427	74428	74429	74430	74431	74432	74434	74435
74436	74437	74438	74439	74440	74441	74442	74444
74445	74446	74447	74450	74451	74452	74454	74455
74456	74457	74458	74459	74460	74461	74462	74463
74464	74465	74467	74468	74469	74470	74471	74472

ZIP codes are subject to change by plan.

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GlobalHealth ZIP code list

74477	74501	74502	74521	74522	74523	74525	74528
74529	74530	74531	74533	74534	74535	74536	74538
74540	74542	74543	74545	74546	74547	74549	74552
74553	74554	74555	74556	74557	74558	74559	74560
74561	74562	74563	74565	74567	74569	74570	74571
74572	74574	74576	74577	74578	74601	74602	74604
74630	74631	74632	74633	74636	74637	74640	74641
74643	74644	74646	74647	74650	74651	74652	74653
74701	74702	74720	74721	74722	74723	74724	74726
74727	74728	74729	74730	74731	74733	74734	74735
74736	74737	74738	74740	74741	74743	74745	74747
74748	74750	74752	74753	74754	74755	74756	74759
74760	74761	74764	74766	74801	74802	74804	74818
74820	74821	74824	74825	74826	74827	74829	74830
74831	74832	74833	74834	74836	74837	74839	74840
74842	74843	74844	74845	74848	74849	74850	74851
74852	74854	74855	74856	74857	74859	74860	74864
74865	74866	74867	74868	74869	74871	74872	74873
74875	74878	74880	74881	74883	74884	74901	74902
74930	74931	74932	74935	74936	74937	74939	74940
74941	74942	74943	74944	74945	74946	74947	74948
74949	74951	74953	74954	74955	74956	74957	74959
74960	74962	74963	74964	74965	74966		

ZIP codes are subject to change by plan.

COMPARISON OF NETWORK BENEFITS FOR HEALTH PLANS

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Calendar Year Deductible	No deductible	No deductible	No deductible
Calendar Year Out-of-Pocket Maximum	$3,500 individual $10,500 family Includes medical and pharmacy	$4,000 individual $8,000 family Includes medical and pharmacy	$4,000 individual $12,000 family Includes medical and pharmacy
Office Visit	$0 copay/PCP $50 copay/specialist	$35 copay/PCP $50 copay/specialist	$0 copay/PCP $50 copay/specialist

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Your Costs for Network Services	HealthChoice High and High Alternative	HealthChoice HDHP	HealthChoice Basic and Basic Alternative
Calendar Year Deductible **(For pharmacy deductible, refer to Page 35)**	High plan $750 individual $2,000 family High Alternative plan $1,000 individual $2,750 family Copays do not apply to deductible Separate pharmacy deductible A family is three or more covered individuals	$1,750 individual $3,500 family One member may be responsible for up to the full family deductible The combined medical and pharmacy deductible must be met before benefits are paid A family is two or more covered individuals	Medical First-Dollar Coverage Applies to each covered family member Plan pays first $500 (Basic) or $250 (Basic Alternative) for covered expenses Medical Deductible After first-dollar coverage, you pay the deductible for covered expenses Basic: $1,000 individual or $1,500 family Basic Alternative: $1,250 individual or $1,750 family A family is two or more covered individuals
Calendar Year Out-of-Pocket Maximum	High plan $3,300 individual $8,400 family High Alternative plan $3,550 individual $8,400 family For both plans: Deductible, coinsurance and copays apply; excludes pharmacy expenses For pharmacy out-of-pocket maximum, refer to Page 35	$6,000 individual $12,000 family Deductible, coinsurance and copays apply; includes pharmacy expenses	Medical Coinsurance (Basic and Basic Alternative) After medical deductible, you pay 50% and plan pays 50% for covered expenses until your out-of-pocket maximum is reached Medical Calendar Year Out-of-Pocket Maximum (Basic and Basic Alternative) $4,000 maximum per member, no more than $9,000 per family Deductible and coinsurance apply to maximums. Once your maximum limit is met, the plan pays 100% of allowable amounts for covered services For pharmacy deductible and maximums, refer to Page 35
Office Visit	$30 copay/general physician $50 copay/specialist	You pay 100% of allowable amounts until deductible is met $30/$50 copay applies after deductible	First-dollar coverage, deductibles and coinsurance apply

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
X-Ray and Lab	$0 copay for X-ray and lab $250 copay per scan/ procedure (MRI, CT, PET, EEG, ECG, MPS and similar); and pathology and lab under CPT codes of cytogenetic studies, surgical pathology or transcutaneous procedures	$0 copay for routine X-ray and lab $200 copay per scan Specialty scans: MRI, CT, MRA and PET scans	$10 copay for X-ray and lab For MRI, MRA, PET, CAT and nuclear scans: $250 copay per scan in a preferred facility $750 copay per scan in a non-preferred facility
Allergy Testing and Treatment	$0 copay/PCP $50 copay/specialist Serum and shots including a 6-week supply of antigen	$35 copay/PCP $50 copay/specialist $30 serum and shots including a 6-week supply of antigen	$0 copay/PCP $50 copay/specialist $30 serum and shots including a 6-week supply of antigen and administration
Preventive Services	$0 copay (PCP or specialist) $0 copay per OB/GYN visit, no referral required for annual routine services	$0 copay (PCP or specialist)	$0 copay PCP/routine physical exam $0 copay well-woman exam and preventive services
Well-Child Care	$0 copay	$0 copay	$0 copay per well-child visit
Immunizations	$0 copay	$0 copay birth through age 20 years $0 copay ages 21 and older when following the recommendation of ACIP	$0 copay when following the recommendation of ACIP

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Your Costs for Network Services	HealthChoice High and High Alternative	HealthChoice HDHP	HealthChoice Basic and Basic Alternative
X-Ray and Lab	20% of allowable amounts after deductible	20% of allowable amounts after deductible	First-dollar coverage, deductibles and coinsurance apply
Allergy Testing and Treatment	20% of allowable amounts after deductible Limit of 60 tests every 24 months	20% of allowable amounts after deductible Limit of 60 tests every 24 months	First-dollar coverage, deductibles and coinsurance apply Limit of 60 tests every 24 months
Preventive Services (for full list refer to healthchoiceconnect.com)	$0 copay; no deductible or coinsurance Includes two preventive services office visits per calendar year for members and dependents ages 18 and older; one mammogram per year for women.	$0 copay; no deductible or coinsurance Includes two preventive services office visits per calendar year for members and dependents ages 18 and older; one mammogram per year for women	$0 copay; no deductible or coinsurance Includes two preventive services office visits per calendar year for members and dependents ages 18 and older; one mammogram per year for women
Well-Child Care	$0 copay; no deductible or coinsurance	$0 copay; no deductible or coinsurance	$0 copay; no deductible or coinsurance
Immunizations	No charge for well-child and adult immunizations and administration $30/$50 office visit copay may apply	No charge for well-child and adult immunizations and administration $30/$50 office visit copay may apply	No charge for well-child and adult immunizations and administration Office visit: First-dollar coverage, deductibles and coinsurance apply

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Hearing Screening and Hearing Aid	Hearing screening $0 copay Limit of one per year Hearing aids 20% coinsurance	Hearing screening $0 copay when performed by PCP Limit of one per year Hearing aids 20% coinsurance	Hearing screening $0 copay Limit of one per year Hearing aids 20% coinsurance
Hospital Inpatient	$250 copay per day $750 maximum per admission	$350 copay per day $1,750 maximum per admission Preauthorization required	$300 copay per day $900 maximum per admission
Hospital Outpatient	$250 copay per visit	$300 copay per visit	$300 copay in a preferred facility $800 copay in a non-preferred facility
Emergency Room	$300 copay; waived if admitted	$200 copay; waived if admitted	$400 copay for facility charge; waived if admitted
Urgent Care	$25 copay for outpatient or professional urgent care facility per visit	$50 copay per visit	$25 copay per visit
Maternity Prenatal and Postnatal Care	$0 copay for prenatal and postnatal care $500 copay per admission	$0 copay for preventive prenatal and postnatal care $35 copay/PCP $50 copay/ specialist for confirmation visit $350 copay per day $1,750 maximum per admission Preauthorization required	**$0** copay for prenatal and **postnatal** care $500 per hospital admission

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Your Costs for Network Services	HealthChoice High and High Alternative	HealthChoice HDHP	HealthChoice Basic and Basic Alternative
Hearing Screening and Hearing Aid	Hearing screening $30/$50 copay unless preventive Limit of one per year Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required	Hearing screening $30/$50 copay after deductible unless preventive Limit of one per year Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required	First-dollar coverage, deductibles and coinsurance apply unless preventive Hearing screening Limit of one per year Hearing aids Covered as durable medical equipment for children ages 17 and younger Certification required
Hospital Inpatient	20% of allowable amounts after deductible	20% of allowable amounts after deductible	First-dollar coverage, deductibles and coinsurance apply
Hospital Outpatient	20% of allowable amounts after deductible	20% of allowable amounts after deductible.	First-dollar coverage, deductibles and coinsurance apply
Emergency Room	$200 copay – waived if admitted 20% of allowable amounts after deductible	$200 copay – waived if admitted 20% of allowable amounts after deductible	First-dollar coverage, deductibles and coinsurance apply
Urgent Care	$30 office visit copay 20% of allowable amounts after deductible	$30 office visit copay after deductible 20% of allowable amounts after deductible	First-dollar coverage, deductibles and coinsurance apply
Maternity Prenatal and Postnatal Care	Prenatal: $0 copay Postnatal: 20% of allowable amounts after deductible Labor and delivery: Based on location and type of service as applicable (such as hospital inpatient or hospital outpatient benefits)	Prenatal: $0 copay Postnatal: 20% of allowable amounts after deductible Labor and delivery: Based on location and type of service as applicable (such as hospital inpatient or hospital outpatient benefits)	Prenatal: $0 copay Postnatal: first-dollar coverage, deductibles and coinsurance apply Labor and delivery: Based on location and type of service as applicable (such as hospital inpatient or hospital outpatient benefits)

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Durable Medical Equipment	20% coinsurance	20% coinsurance	20% coinsurance
Mental Health or Substance Use Disorder Inpatient	$250 copay per day $750 maximum per admission	$350 copay per day $1,750 maximum per admission Preauthorization required	Residential treatment center or medical detox $300 copay per day $900 maximum per admission
Mental Health or Substance Use Disorder Outpatient	$0 copay/PCP $50 copay/specialist	$35 copay/PCP $0 copay outpatient/other	$0 copay per visit
Occupational or Speech Therapy Visit	$0 copay inpatient $50 copay per outpatient therapy Limit of 60 visits combined for all therapies per year	Inpatient $350 copay per day $1,750 maximum per admission Preauthorization required $50 copay per outpatient therapy visit Up to 60 days treatment per disability	$0 copay inpatient $35 copay per outpatient visit Limit of 60 treatment days per course of therapy
Physical Therapy or Physical Medicine Visit			

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Your Costs for Network Services	HealthChoice High and High Alternative	HealthChoice HDHP	HealthChoice Basic and Basic Alternative
Durable Medical Equipment	20% of allowable amounts after deductible for purchase, rental, repair or replacement	20% of allowable amounts after deductible for purchase, rental, repair or replacement	First-dollar coverage, deductibles and coinsurance apply for purchase, rental, repair or replacement
Mental Health or Substance Use Disorder Inpatient	20% of allowable amounts after deductible	20% of allowable amounts after deductible	First-dollar coverage, deductibles and coinsurance apply
Mental Health or Substance Use Disorder Outpatient	20% of allowable amounts after deductible Limit: 20 services/year without certification	20% of allowable amounts after deductible Limit: 20 services/year without certification	First-dollar coverage, deductibles and coinsurance apply Limit: 20 services/year without certification
Occupational or Speech Therapy Visit	20% of allowable amounts after deductible; 60 visits/ year maximum Occupational therapy Limit: 20 visits/year without certification Speech therapy For ages 17 and younger, certification required	20% of allowable amounts after deductible; 60 visits/ year maximum Occupational therapy Limit: 20 visits/year without certification Speech therapy For ages 17 and younger, certification required	First-dollar coverage, deductibles and coinsurance apply; 60 visits/year maximum Occupational therapy Limit: 20 visits/year without certification Speech therapy For ages 17 and younger, certification required
Physical Therapy or Physical Medicine Visit	20% of allowable amounts after deductible Limits: 20 visits/year without certification; 60 visits/year maximum	20% of allowable amounts after deductible Limits: 20 visits/year without certification; 60 visits/year maximum	First-dollar coverage, deductibles and coinsurance apply Limits: 20 visits/year without certification; 60 visits/year maximum

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Chiropractic and Manipulative Therapy Visit	$50 copay Included under physical and occupational therapy, no separate visit limit per year	$50 copay	$25 copay Limit 15 visits per year
Bariatric Surgery	$250 per day $750 maximum per admission	**$350 copay per day** **$1,750 maximum per admission** **Preauthorization required**	$300 per day $900 maximum per admission
National Diabetes Prevention Program	Covered at 100%	**Covered at 100%**	Covered at 100%

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Your Costs for Network Services	HealthChoice High and High Alternative	HealthChoice HDHP	HealthChoice Basic and Basic Alternative
Chiropractic and Manipulative Therapy Visit	Chiropractic therapy 20% of allowable amounts after deductible $50 specialist office visit copay may apply Limits: 20 visits/year without certification; 60 visits/year maximum Manipulative therapy Included within physical or chiropractic therapy limits	Chiropractic therapy 20% of allowable amounts after deductible $50 specialist office visit copay may apply Limits: 20 visits/year without certification; 60 visits/year maximum Manipulative therapy Included within physical or chiropractic therapy limits	Chiropractic therapy First-dollar coverage, deductibles and coinsurance apply Limits: 20 visits/year without certification; 60 visits/year maximum Manipulative therapy Included within physical or chiropractic therapy limits
Bariatric Surgery	20% of allowable amounts after deductible; some limitations and exclusions apply	20% of allowable amounts after deductible; some limitations and exclusions apply	First-dollar coverage, deductibles and coinsurance apply; some limitations and exclusions apply
National Diabetes Prevention Program	$0 copay for preventive service	$0 copay for preventive service	$0 copay for preventive service

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Your Costs for Network Services	BCBSOK – BlueLincs HMO	CommunityCare HMO	GlobalHealth HMO
Pharmacy Benefits	Retail Preferred generic: $0 Non-preferred generic: $10 Preferred brand: $40 Non-preferred brand: $80 Mail-order Preferred generic: $0 Non-preferred generic: $25 Preferred brand: $100 Non-preferred brand: $200 Specialty Preferred: $100 Non-preferred: $200	Retail (30-day supply) Select generic: $0 Preferred generic/Tier 1: $15 Preferred brand/Tier 2: $40* Non-preferred brand or generic/Tier 3: $70* Specialty/Tier 4: $160* Mail-order (90-day supply) Select generic: $0 Preferred generic/Tier 1: $45 Preferred brand/Tier 2: $120* Non-preferred brand or generic/Tier 3: $210* Mail-order (30-day supply) Specialty/Tier 4: $160* *If you choose to obtain a brand-name drug when a generic is available, you pay the applicable copay or coinsurance for the brand name drug, plus the difference in cost between the brand name drug and its generic equivalent The difference in cost between the brand name drug and its generic equivalent will not count toward your annual out-of-pocket maximum	Retail or mail-order (30-day supply) Tier 1 generic: $10 Preferred brand: $65 Non-preferred drugs: $90 90-day supply Tier 1 generic: $20 Preferred brand: $130 Non-preferred drugs: $180 Specialty Preferred: $200 Non-preferred: $400

Bold text indicates significant plan changes. This is only a sample summary of each plan's network services. For all plan benefits/limitations, contact each plan. Refer to Contact Information at the back of this guide.

Your Costs for Network Services	HealthChoice High, High Alternative, Basic, Basic Alternative and HDHP Plans The applicable pharmacy deductible must be met before pharmacy copays apply. Refer to the bottom of the page for more details.	
Prescription Medications	**30-Day Supply**	**31- to 90-Day Supply**
Generic Drugs	Up to $10	Up to $25
Preferred Drugs	Up to $45	Up to $90
Non-Preferred Drugs	Up to $75	Up to $150
Specialty Drugs	Generic – $10 copay Preferred drugs – $100 copay Non-preferred drugs – $200 copay	Copays are for up to a 30-day supply

HEALTHCHOICE HIGH, HIGH ALTERNATIVE, BASIC AND BASIC ALTERNATIVE PLANS

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

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

HEALTHCHOICE HDHP

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

ALL HEALTHCHOICE PLANS

HealthChoice Preventive Medication List – These medications are not subject to pharmacy deductible on the High, High Alternative, Basic or Basic Alternative plans, or the combined medical/pharmacy deductible on the HDHP.

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

HealthChoice covers **up to a 168-day supply** of tobacco cessation medications at 100% when filled at a network pharmacy. Visit the Be Tobacco-Free page at **healthchoiceconnect.com** for details.

CDC-recommended vaccinations, such as for shingles, are covered at 100% when using a network pharmacy. **NOTE:** These can also be covered under the health benefit if provided by a recognized network health provider, such as a physician or health department.

Amounts paid by copay assistance programs, manufacturer copay cards or other third parties do not apply toward deductibles or out-of-pocket maximums.

COMPARISON OF BENEFITS FOR DENTAL PLANS

Allowable Amounts Apply for All Benefits	BCBSOK – BlueCare Dental High Plan	BCBSOK – BlueCare Dental Low Plan
Annual Deductible	Network: $25 individual/$75 family Basic and Major services combined Non-network: $25 individual/$75 family Preventive, basic and major services combined plus amounts above allowable fees	Network: $50 individual/$150 family Basic and Major services combined Non-network: $50 individual/$150 family Preventive, basic and major services combined plus amounts above allowable fees
Diagnostic and Preventive Care (cleanings, routine oral exams)	Network: 0% Non-Network 0% after charges above the allowable amounts	Network: 0% Non-Network 0% after maximum allowed charge
Basic Care (extractions, oral surgery)	Network: 15% in-network after deductible Non-Network: 30% after deductible and charges above the allowable amounts	Network: 15% in-network after deductible Non-Network: 30% after deductible and maximum allowed charge

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

Allowable Amounts Apply for All Benefits	Cigna Prepaid High (K1I09)	Cigna Prepaid Low (OKIV9)
Annual Deductible	No deductible $0 office copay applies	No deductible $5 office copay applies
Diagnostic and Preventive Care (cleanings, routine oral exams)	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) Example Services/Copays: Sealant per tooth: $12 Copay Routine cleaning (once every 6 months): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) Example Services/Copays: Sealant per tooth: $17 Copay Routine cleaning (once every 6 months): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge
Basic Care (extractions, oral surgery)	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) Example Services/Copays Amalgam – one surface, permanent teeth: $0 copay	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) Example Services/Copays Amalgam – one surface, permanent teeth: $23 copay

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

Allowable Amounts Apply for All Benefits	Delta Dental PPO	Delta Dental PPO – Choice	HealthChoice Dental
Annual Deductible	In-Network and Out-of-Network: $25 per person, per year. Applies to Basic and Major services only	In-Network and Out-of-Network: $100 per person per year. Applies to only Major Restorative (Level 4) services	Network: $25 individual $75 family Basic and major services combined Non-network: $25 individual $75 family Preventive, basic and major services combined Separate network and non-network deductibles A family is 3 or more covered individuals.
Diagnostic and Preventive Care (cleanings, routine oral exams)	In-Network and Out-of-Network: Plan pays 100% of allowable amounts No deductible applies	In-Network and Out-of-Network: Member pays on a service by services basis with co-payments for all tiers of service (Levels 1-5) based on a fee table No deductible applies	Network: You pay $0 Non-network: You pay $0 after deductible plus charges above the allowable amounts
Basic Care (extractions, oral surgery)	In-Network and Out-of-Network: Plan pays 85% of allowable amounts after deductible is met	In-Network and Out-of-Network: Member pays on a service by services basis with co-payments for all tiers of service (Levels 1-5) based on a fee table No deductible applies	Network: You pay 15% after deductible Non-network: You pay 30% after deductible plus charges above the allowable amounts

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

Allowable Amounts Apply for All Benefits	MetLife High Classic MAC	MetLife Low Classic MAC	Sun Life Preferred Active PPO
Annual Deductible	Network and Non- Network: $25 individual/$75 family Basic and Major Care combined	Network and Non- Network: $50 individual/$150 family Basic and Major Care combined	$25 per person, waived for Network preventive services
Diagnostic and Preventive Care (cleanings, routine oral exams)	You pay Network: $0 Non-network: Amounts above maximum allowed charge	You pay Network: $0 Non-network: Amounts above maximum allowed charge	Network: Plan pays 100% of allowable amounts Non-network: Plan pays 100% of usual and customary after deductible
Basic Care (extractions, oral surgery)	You pay Network: 15% Non-network: 15% plus amounts above maximum allowed charge Deductible applies	You pay Network: 30% Non-network: 30% plus amounts above maximum allowed charge Deductible applies	Network: Plan pays 85% of allowable amounts after deductible Non-network: Plan pays 70% of usual and customary after deductible

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

Allowable Amounts Apply for All Benefits	BCBSOK – BlueCare Dental High Plan	BCBSOK – BlueCare Dental Low Plan
Major Care (dentures, bridge work)	Network: 40% after deductible Non-Network: 50% after deductible and charges above the allowable amounts	Network: 50% after deductible Non-Network: 50% after deductible and maximum allowed charge
Orthodontic Care	Network: 50%. Deductible waived. Non-Network: 50% after charges above the allowable amounts $5,000 Lifetime maximum Dependents covered up to age 19. No waiting period for orthodontic benefits	Member Pays Network: 50%. Deductible waived. Non-Network: 50% after maximum allowed charge $1,500 Lifetime maximum Dependents covered up to age 19. No waiting period for orthodontic benefits
Plan Year Maximum	$2,500	$1,500
Filing Claims	Network: No claims to file Non-Network: You may file claims, provider may file claims .	Network: No claims to file Non-Network: You may file claims, provider may file claims.

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

Allowable Amounts Apply for All Benefits	Cigna Prepaid High (K1I09)	Cigna Prepaid Low (OKIV9)
Major Care (dentures, bridge work)	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) Example Services/Copays Root Canal, Anterior: $210 copay Periodontal Scaling/Root planing 1-3 teeth (per quadrant): $42 copay	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) Example Services/Copays Root Canal, Anterior: $375 copay Periodontal Scaling/Root planing 1-3 teeth (per quadrant): $75 copay
Orthodontic Care	There is a $0 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule K1I09) $2,040 out-of-pocket child; $2,376 out-of-pocket adult (24 month treatment) Excludes orthodontic treatment plan and banding No waiting period for orthodontic benefits	There is a $5 office visit fee (per patient, per office visit in addition to any other applicable patient charge as described in the patient charge schedule OKIV9) $2,472 out-of-pocket child; $3,384 out-of-pocket adult (24 month treatment) Excludes orthodontic treatment plan and banding No waiting period for orthodontic benefits
Plan Year Maximum	Plan year maximum is unlimited No plan year dollar maximum	Plan year maximum is unlimited No plan year dollar maximum
Filing Claims	If services are rendered by a participating dentist, the Prepaid dentist is contractually obligated to file the claim on the patient's behalf If a claim must be filed by the member, the member can obtain a claim form by logging into **www.mycigna.com** Customer Service can also assist in filing a claim by dialing 800-244-6224 24 hours a day/7 days a week	If services are rendered by a participating dentist, the Prepaid dentist is contractually obligated to file the claim on the patient's behalf If a claim must be filed by the member, the member can obtain a claim form by logging into **www.mycigna.com** Customer Service can also assist in filing a claim by dialing 800-244-6224 24 hours a day/7 days a week

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

Allowable Amounts Apply for All Benefits	Delta Dental PPO	Delta Dental PPO – Choice	HealthChoice Dental
Major Care (dentures, bridge work)	In-Network and Out-of-Network: Plan pays 60% of allowable amounts after deductible is met	In-Network and Out-of-Network: Member pays on a service by services basis with co-payments for all tiers of service (Levels 1-5) based on a fee table Deductible applies to Major Restorative (Level 4) services	Network: You pay 40% after deductible Non-network: You pay 50% after deductible plus charges above the allowable amounts
Orthodontic Care	In-Network and Out-of-Network: Plan pays 60% of allowable amounts, up to the $2,000 lifetime maximum per person Orthodontic benefits are available to eligible employees, spouses and dependent children No waiting period for orthodontic benefits	In-Network and Out-of-Network: Plan pays up to the $1,800 lifetime maximum per person Orthodontic (Level 5) service co-payments are based on a fee table Orthodontic benefits are available to eligible employees, spouses and dependent children No waiting period for orthodontic benefits	Network: You pay 50% of allowable amounts; no deductible applies Non-network: You pay 50% of the allowable amounts, plus charges above the allowable amounts; no deductible applies Covered for members age 18 and under Covered for treatment of TMD at any age No lifetime maximum 12-month waiting period for orthodontic benefits (some exceptions apply)
Plan Year Maximum	In-Network and Out-of-Network: $2,500 per person per year for Diagnostic, Preventive, Basic and Major services	In-Network and Out-of-Network: $2,000 per person per year for Levels 1, 2, 3 and 4 services	Network and non- network: $2,500 per person You are responsible for all charges billed by provider after plan year maximum is met
Filing Claims	Claims are filed by participating dentists Members must file claims for reimbursement for non-participating providers	Claims are filed by participating dentists Members must file claims for reimbursement for non-participating providers	Network: No claims to file Non-network: You file claims

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

Allowable Amounts Apply for All Benefits	MetLife High Classic MAC	MetLife Low Classic MAC	Sun Life Preferred Active PPO
Major Care (dentures, bridge work)	You pay Network: 40% Non-network: 40% plus amounts above maximum allowed charge Deductible applies	You pay Network: 50% Non-network: 50% plus amounts above maximum allowed charge Deductible applies	Network: Plan pays 60% of allowable amounts after deductible Non-network: Plan pays 50% of usual and customary after deductible
Orthodontic Care	You pay Network: 40% Non-network: 40% plus amounts above maximum allowed charge $2,000 lifetime maximum per person No waiting period for orthodontic benefits	You pay Network: 50% Non-network: 50% plus amounts above maximum allowed charge $2,000 lifetime maximum per person No waiting period for orthodontic benefits	Network: Plan pays 60% Non-network: Plan pays 50% up to lifetime maximum of $2,000 for dependents under age 19 12-month waiting period applies
Plan Year Maximum	Network and non-network: $5,000 per person	Network and non-network: $1,500 per person	$2,000 per person
Filing Claims	Claims are filed by network and non-network dentists	Claims are filed by network and non-network dentists	Member/provider must file claims

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

COMPARISON OF BENEFITS FOR VISION PLANS

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

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

	Vision Care Direct		VSP	
Covered Services	**Network**	**Non-Network**	**Network**	**Non-Network**
Eye Exams	$15 copay for full comprehensive exam including dilation	Reimbursed up to $50	Covered in full after $10 copay	Reimbursed up to $45 after $10 copay
Lenses Per Pair	$15 copay Single vision, bifocal, trifocal, lenticular lenses At a PLUS PLAN Provider, you receive free upgrades for HD polycarbonate, no-line progressive lenses with high quality anti-reflection, scratch and UV coatings (refer to Vision Notes for details)	Reimbursed up to: $50 single $75 bifocal $100 trifocal $100 progressive	Covered in full after $25 materials copay Polycarbonate lenses covered in full for dependent children Standard progressives covered in full	Reimbursed up to: $30 single $50 bifocal $65 trifocal $50 progressive After $25 materials copay
Frames	Covered in full up to $130 for any frame	Reimbursed up to $60	Covered in full up to $170 or $220 for featured frame brands 20% discount on any overage	Reimbursed up to $70 after $25 materials copay
Contact Lenses	No copay for fitting fee $130 allowance, in lieu of glasses $250 allowance for medically necessary contacts	$80 allowance, in lieu of glasses	$120 allowance, in lieu of glasses Up to $60 copay for contact lens exam (fitting and evaluation) Medically necessary contacts are covered in full after the $25 material copay	Reimbursed up to $105, in lieu of glasses Medically necessary contacts are covered up to $210 after the $25 copay
Laser Vision Correction	Up to $1,000 discount at any one of our Lasik providers. Go to: ok.vision/lasik-discount-network	No benefit	Average discount of 15% off regular price or 5% off promotional price	No benefit

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

VISION PLAN NOTES

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

Superior Vision: Vision Plan information/detail is available at **microsite.versanthealth.com/stateofoklahoma/**. Materials copay applies to lenses and/or frames. Discounts for lens add-ons will be given by contracted providers with a "DP" in their listing. Exams, lenses and frames are provided once per calendar year. Progressive lenses (no-line bifocals) – you pay the difference between the retail price of the selected progressive lens and the retail price of the lined trifocal. The difference may also be subject to a discount with provider offices that accept our discount plans. Standard contact lens fitting applies to an existing contact lens user who wears disposable, daily wear or extended wear lenses only. The specialty contact lens fitting applies to new contact lens wearers and/or members who wear toric, gas permeable or multifocal lenses.

Vision Care Direct: With VCD you can get your exam, frames, and lenses with free upgrades (high definition polycarbonate and progressive lenses with premium anti-reflective and UV coatings) for $30. Other plans may offer discounts for extra services, but we include the extras the doctor wants you to have. What would normally cost you over $300 for progressive lenses will cost you much less with VCD. Choose any frame up to $130 and simply pay the difference if you go over. When you compare the total cost of your premiums and what you spend in the doctor's office you will see, in most cases, we offer a plan that will cost you less money overall. We are an Oklahoma-owned and operated company, which means customer service is here in the state to help you anytime you need help. It also means that you support your local community and schools when you buy a plan based in Oklahoma! VCD is not an insurance company so our focus is on delivering the very best patient care with quality materials at a very affordable price because we want you to SEE THE DIFFERENCE. Visit www.okstate.vision for more information and to search for providers. (To get the free upgrades mentioned above be sure to look for the "VCD Plus" logo when searching for a provider.) If you have questions or want more information, call 855-918-2020 or email **oklahoma@visioncaredirect.com.**

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

FLEXIBLE SPENDING ACCOUNTS

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

Important Notes on FSA Accounts:

- You must enroll every year.
- Indicate your per-pay-period contribution when you enroll.
- Reimbursement can also be made for expenses incurred by any participant during the grace period (Jan. 1-March 15 of the following plan year).
- FSAs have a use-it-or-lose-it rule. Simply stated, if you have money left in your account after March 15 of the following year, that money will be forfeited. It is important to forecast your expected expenses when enrolling in an FSA.
- You cannot enroll in an FSA if you enroll in the HealthChoice HDHP.
- You may be restricted from contributing to the health savings account if you have funds remaining in your FSA on Jan. 1, 2020.
- You can continue to participate in the DCA if you elect the HealthChoice HDHP.
- Distributions from a health FSA must be paid only to reimburse you for qualified medical expenses you incurred during the period of coverage.

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

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

Health Care Account/Flexible Spending Account

The 2021 HCA limit, which is set by the IRS, will not be announced until November 2020. The 2020 HCA limit is $2,750. Employees may elect up to that maximum, and, if the limit for 2021 is increased beyond that level, employees may raise their withholdings by contacting their benefits coordinator by Dec. 15, 2020. You can realize significant tax savings on qualified, unreimbursed expenses by paying for the services and items pretax. Some qualifying expenses include:

- Doctor visits, deductibles and copays.
- Dental care, including orthodontic expenses.
- Prescription drugs.
- Physical therapy.
- Vision care, laser eye surgery, eyeglasses and lenses.

HCA Pretax Withdrawal Limits

- HCA monthly minimum: $10.
- HCA biweekly minimum: $5.
- HCA monthly maximum: $229.16 (subject to change depending on IRS limit).
- HCA biweekly maximum: $114.58 (subject to change depending on IRS limit).

Dependent Care Account

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

Your qualifying child who is your dependent and who was under age 13 when the care was provided.

Your spouse who wasn't physically or mentally able to care for himself or herself and lived with you for more than half the year.

A person who wasn't physically or mentally able to care for himself or herself, lived with you for more than half the year, and either: Was your dependent.

Would have been your dependent, except that: He or she received gross income of $4,050 or more.

He or she filed a joint tax return.

You, or your spouse if filing jointly, could be claimed as a dependent on someone else's previous year's tax return.

DCA Pretax Withdrawal Limits

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

Below is an example of how an average person, contributing just $100 per month, can increase their take-home pay by using an FSA:

	Without FSA	With FSA
Annual Salary	$ 35,000	$ 35,000
Flexible Spending Account Deposit (annual)	0	1,200
Taxable Income	35,000	33,800
Estimated Taxes (30%)	-10,500	-10,140
Health Care Expenses	-1,200	0
Take-home Pay	23,300	23,660
Annual Increase in Take-home Pay		$ 360

Run-Out Period

The final payment of benefits for any plan year can be made following the close of such plan year based on accepted claims filed with the plan administrator no later than the end of the run-out period. The run-out period means the 90-day period following a plan year in which claims can be made for reimbursable expenses incurred during the plan year. You cannot pay for prior year expenses from current year account funds. All expenses use the date of service, not the date they are paid, for eligibility purposes.

Grace Period

The IRS allows a grace period extension for incurring approved expenses that are reimbursable from your FSA. You have until March 15 of the following year to use funds from your current year's account.

For individual account information contact:

HealthSCOPE Benefits 877-385-8775 **CDHAdmin@healthscopebenefits.com**
www.healthscopebenefits.com

Premium Conversion Saves on Your Taxes

Premium conversion is an optional, IRS-approved election that allows you to save money by not paying taxes on your eligible insurance premiums and FSA contributions. By paying eligible insurance premiums and contributions to FSAs with pretax dollars, you have more take-home pay than if you paid the same premiums with after-tax dollars.

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

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

✓ Yes = tax savings!

ADDITIONAL BENEFITS

- Employees may be eligible to receive additional benefits, including:
- Retirement plans.
- Leave benefits.
- Longevity.
- Paid holidays.
- Unemployment and workers' compensation.
- Voluntary payroll deductions.
- Employee Assistance Program.

CONSUMER INFORMATION AND ANNUAL NOTICES

OMES Human Capital Management and OMES EGID comply with the Health Insurance Portability and Accountability Act of 1996 known as HIPAA. OMES HCM and EGID and each HMO, dental and vision plan offered to state employees has a privacy notice that describes the organization's protections and acceptable uses of information.

To obtain a privacy notice from a particular plan, contact the plan directly or contact OMES HCM. HIPAA also provides you and your dependents certain rights to enroll if you lose your group health plan coverage. HIPAA also prohibits a group health plan from keeping you (or your dependents) out of the plan based on anything related to your health. Finally, HIPAA 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 exclusions.

The HealthChoice medical products offered by EGID are exempt from most of the portability provisions of HIPAA including, but not limited to, the following: limitations on preexisting conditions, special enrollment rights, discrimination based upon a health factor, standards for mothers and newborns, mental health parity and reconstructive mastectomies. Refer to General Eligibility Information for more details.

The Mental Health Parity and Addiction Equity Act, a federal law, requires health insurance providers to include mental health and substance use disorder coverage equal to physical health coverage in terms of the financial and treatment requirements. The law removed differences in copays and removed limits on visits and treatment days. Provisions of the law went into effect in all of the state's available health plans in 2019.

The Women's Health and Cancer Rights Act of 1998, a federal law, provides benefits for mastectomy related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). The 1998 Guidance, Questions and Answers, and Notice Requirements under WHCRA (November 1998), can be obtained by calling 866-444-3272.

The Breast Cancer Patient Protection Act, an Oklahoma state law, provides for at least 48 hours of inpatient care following a mastectomy and not fewer than 24 hours following a lymph node dissection.

The Newborns and Mothers Act of 1996, a federal law, requires the availability of a hospital stay of at least 48 hours in connection with a vaginal delivery and not less than 96 hours with a cesarean delivery.

The Mandated Benefit for OB/GYN Coverage Law requires any health benefit plan offered in the State of Oklahoma, which provides medical and surgical benefits, to also provide coverage for routine annual obstetrical/gynecological examinations. The law does not diminish already allowed health benefit diagnostics. In addition, the law also specifies that obstetrical/gynecological examinations do not have to be performed by an obstetrician, gynecologist or obstetrician/gynecologist. If you have a problem which cannot be resolved through your benefit plan's grievance process, you may have remedies with the Oklahoma State Department of Health, Oklahoma Department of Insurance, or a remedy of law.

The Prostate Cancer Protection Act, an Oklahoma state law, provides for an annual screening for early detection of prostate cancer in men age 50 and over and in men from age 40-50 who are in high-risk categories. The Oklahoma Prostate Surgery Side Effects Law provides that all health benefit plans offered by OMES HCM and OMES EGID shall provide coverage for side effects that are commonly associated with radical retropubic prostatectomy surgery, including, but not limited to impotence and incontinence, and for other prostate related conditions.

Once you become covered under a group health plan, you have certain rights under the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA 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 OMES HCM or OMES EGID.

You may also have rights under the Uniformed Services Employment and Reemployment Rights Act. USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service. The law also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services. Refer to your agency for more information.

CONTACT INFORMATION

HEALTH PLANS

BCBSOK – BlueLincs
855-609-5684
www.bcbsok.com/state
www.bcbsok.com

CommunityCare
918-594-5242 or 800-777-4890
TDD 800-722-0353
state.ccok.com

GlobalHealth Inc.
405-280-5600 or 877-280-5600
TTY 711
www.GlobalHealth.com

HealthChoice

Medical
800-323-4314
TTY 711

Pharmacy
877-720-9375
TTY 711
healthchoiceconnect.com

LIFE INSURANCE

HealthChoice
800-323-4314
TTY 711
healthchoiceconnect.com

ADDITIONAL

EGID
405-717-8780 or 800-752-9475
TTY 711
omes.ok.gov

HealthSCOPE Benefits
877-385-8775
CDHAdmin@healthscopebenefits.com
www.healthscopebenefits.com

DENTAL PLANS

BCBSOK – BlueCare
855-609-5684
www.bcbsok.com/state
www.bcbsok.com

Cigna Prepaid Dental
800-244-6224
Hearing-impaired relay 800-654-5988
www.cigna.com

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

HealthChoice
800-323-4314
TTY 711
www.healthchoiceconnect.com

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

Sun Life
800-442-7742
www.sunlife.com

VISION PLANS

Primary Vision Care Services (PVCS)
888-357-6912 or TDD 800-722-0353
www.pvcs-usa.com

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

Vision Care Direct
877-488-8900 or TTY 711
www.okstate.vision

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

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