Exhibit 9

Employee Benefits Department
Human Capital Management
Office of Management and Enterprise Services

2014 BENEFITS ENROLLMENT GUIDE

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OKHealth

The OKHealth Wellness program (OKHW) is the premier wellness program for all State of Oklahoma employees. All services offered are part of the overall Employees Benefits package. OKHW specializes in health coaching, yearly Flu Shot Clinics statewide, wellness consultations statewide, Lunch-N-Learn presentations, a state-of-the-art website, the Annual State Capitol Health & Safety Expo and more!

OKHW health coaching is FREE for ALL State employees. Coaching empowers individuals to take healthy ACTIONS in physical fitness, nutrition, staying relaxed and being tobacco-free--one step at a time. Click the "Health Coaching" tab at the OKHW website: ***https://okhealth.ok.gov*** to begin your healthy journey.

OK OKHealth Program

Each autumn, Flu Shot Clinics happen "on location" across the entire state. ALL flu shots and other immunizations are provided FREE—they're covered by your insurance policy. Look for your area Flu Shot Clinic on the EBD website! ***http://www.ebc.ok.gov***

Wellness programming consultations include wellness challenges, the Choose Well Certification program and much more. Please contact the OKHW group at WellnessGroup@omes.ok.gov to make a wellness consultation appointment.

Lunch-N-Learn presentations have become popular among State agencies covering a wide range of healthy topics. Agencies may use a Choose Well Lunch-N-Learn Kit or you may contact OKHW to book your next Lunch-N-Learn. WellnessGroup@omes.ok.gov

The OKHealth Wellness website includes up-to-date wellness news, healthy recipes, worksite wellness, financial health, and a statewide wellness events calendar and much more. Visit the website soon! ***https://okhealth.ok.gov***. All employees have their own webpage and dashboard!

On October 10, 2013, OKHW will host the 18th Annual State Capitol Health & Safety Expo at the beautiful State Capitol of Oklahoma in Oklahoma City. Hundreds of resources and giveaways draw thousands each year. A State employees' Health Expo is coming soon to Tulsa!

Join OKHealth Wellness today for a healthier you and a healthier Oklahoma.

"Choose Well, Oklahoma!"

New Login Box

Your entry point for Online Enrollment in the Benefits Administration System (BAS) now looks a little different (see image at right). It is located in the upper right corner of the EBD home page, ***www.ebc.ok.gov***. Notice the *Go To* line, followed by a drop-down menu.

This is where you will choose the Benefits Administration System, which is where you'll find Online Enrollment. Your User ID is your six-digit Employee ID. If you don't know your password, either select *Forgot Your Password* or simply select *LOGIN* and you will be directed to a screen where you can update your password.

New Opt-out details

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

> *"Any active employee eligible to participate or who is a participant may opt out of the state's basic plan as outlined in Sections 1370 and 1371 of this title, or may opt out of the health and dental basic plan options only and retain the life and disability plan benefits, provided that the participant is currently covered by a separate group health insurance plan or will be covered by a separate group health insurance plan at or before the beginning of the next plan year. Any active employee eligible to participate or who is a participant opting out of coverage pursuant to this section shall provide proof of the separate health insurance plan participation and sign an affidavit attesting that the participant is currently covered and does not require state-provided health insurance each plan year. Any active employee opting out of the state's basic plan or the health and dental basic plan options pursuant to this section shall receive One Hundred Fifty Dollars ($150.00) in lieu of the flexible benefit amount the employee would be otherwise eligible to receive."*

As the new law spells out, you may opt out of the Basic Plan (all benefits) or you may opt out of health and dental benefits only, if you are currently covered by a separate group health insurance plan, or will be covered by January 1, 2014. In addition, you must provide proof of the separate group health insurance plan participation, and sign an affidavit before the opt-out will be approved. You will need to fill out a new form which is available through your Benefits Coordinator **(NOTE: Opt-outs cannot be done online)**.

The "Basic Plan" described in the new law consists of the following: health; dental; basic life; and disability insurance. If you opt out of the Basic Plan, you are no longer eligible for any of those coverage's through the State. Because Basic Life insurance is a prerequisite for the optional Supplemental Life and Dependent Life, those are eliminated as well. However, if you opt out of **health and dental** only, you may retain the life insurance and disability insurance. State employees who opt out can still take advantage of vision insurance offered by the State, as well as Flexible Spending Accounts (FSAs). Employees must opt out each year because the election does not roll over.

If you are considering opting out of the Basic Plan, please understand you are forfeiting the normal Benefit Allowance provided by your agency. In lieu of that Benefit Allowance, you will get $150 per month from your agency. That $150 can be used to pay for vision coverage, FSA contributions, and/or added to your net pay as taxable income. If you are considering opting out of **health and dental** only, the $150 per month can be used to purchase additional life insurance, vision insurance, FSA contributions, and/or added to your net pay as taxable income.

Retired Military

State employees who have retired from military service and have federal TRICARE insurance benefits can also opt out of the State's Basic Plan. Those individuals will get no coverage for health, dental, life, disability, supplemental life or dependent life insurance. In lieu of the normal Benefit Allowance, TRICARE Opt-outs will receive $150 per month from their agencies. They can still elect vision coverage as well as flexible spending account participation. A copy of the participant's DD 2 retired card (front and back) will be requested as proof of TRICARE coverage. Employees must opt out each year because the election does not roll over.

Benefit Allowance

Your Benefit Allowance Helps Cover Your Costs

The State provides a Benefit Allowance to help you pay for insurance premiums that would otherwise come out of your own pocket. In previous years the Benefit Allowance would increase or decrease as premiums increased or decreased. In the past legislative session, the Benefit Allowance was frozen at the Plan Year 2012 rate. See the *Benefit Allowances* box at the top of the 2014 Plan Rates on pages 3 and 4. The amounts are provided based upon the Health election you choose:

Eligibility Reminder

If you experience a qualifying life event during the year; for example, marriage, divorce, birth or adoption, you may be allowed to make certain changes to your insurance elections without waiting for Option Period. You must complete a change form within 30 days of the life event or wait until the next Option Period to make any changes.

Remember, it is a 30-day deadline! Contact your Benefit Coordinator.

2014 Plan Rates

Benefit Allowances
Monthly

Employee	640.98
Plus Child	870.89
Plus Children	1,006.19
Plus Spouse	1,312.75
Plus Spouse & 1 Child	1,542.66
Plus Spouse & Children	1,677.96

2014 Monthly Plan Rates

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
CommunityCare HMO	611.80	1,502.96	1,814.56	2,001.52	923.40	1,110.36
GlobalHealth HMO	430.14	1,135.60	1,362.28	1,496.98	656.82	791.52
HealthChoice High	484.87	1,160.69	1,406.86	1,540.50	731.04	864.68
HealthChoice High Alternative	484.87	1,160.69	1,406.86	1,540.50	731.04	864.68
HealthChoice Basic	421.11	1,015.89	1,232.89	1,350.08	638.11	755.30
HealthChoice Basic Alternative	421.11	1,015.89	1,232.89	1,350.08	638.11	755.30
HealthChoice S-Account	382.56	898.00	1,088.18	1,189.90	572.74	674.46
HealthChoice USA	742.17	1,484.34	1,728.09	1,860.23	985.92	674.46
TRICARE Supplement	59.00	118.00	177.00	218.00	118.00	159.00

Dental	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Assurant Freedom Preferred	28.83	57.50	79.00	115.30	50.33	86.63
Assurant Heritage Plus with SBA (Prepaid)	11.74	20.60	28.20	35.80	19.34	26.94
Assurant Heritage Secure (Prepaid)	7.20	13.18	18.38	23.56	12.40	17.58
CIGNA Dental Care Plan (Prepaid)	9.26	15.32	22.40	30.64	16.34	24.58
Delta Dental PPO	33.64	67.26	96.52	141.30	62.90	107.68
Delta Dental PPO Plus Premier	44.52	89.04	127.82	187.10	83.30	142.58
Delta Dental PPO – Choice	15.06	49.24	83.68	132.84	49.50	98.66
HealthChoice Dental	31.38	62.76	89.66	129.72	58.28	98.34

Vision	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Humana	6.76	11.82	15.39	16.28	10.33	11.22
Primary Vision Care Services (PVCS)	8.65	16.65	24.65	27.40	16.65	19.40
Superior Vision Services	7.14	14.24	20.96	28.04	13.86	20.94
UnitedHealthcare Vision	8.18	13.97	18.56	20.95	12.77	15.16
Vision Service Plan (VSP)	9.14	15.26	21.14	28.44	15.02	22.32

Disability	9.10

Life Insurance Options	
Life	4.00
Dependent Life	
Low Option	2.60
Standard Option	4.32
Premier Option	8.64

Supplemental Life First Unit	$4.00		
Supplemental Life Age Rated (Per $20,000)			
< 30	0.80	55 - 59	6.00
30 - 34	0.80	60 - 64	6.80
35 - 39	0.80	65 - 69	11.20
40 - 44	1.20	70 - 74	19.20
45 - 49	2.00	75+	29.60
50 - 54	4.00		

2014 Plan Rates

Benefit Allowances
Biweekly

Employee	295.84
Plus Child	401.95
Plus Children	464.40
Plus Spouse	605.89
Plus Spouse & 1 Child	712.00
Plus Spouse & Children	774.45

2014 Biweekly Plan Rates

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
CommunityCare HMO	282.37	693.67	837.49	923.77	426.19	512.47
GlobalHealth HMO	198.53	524.13	628.75	690.92	303.15	365.32
HealthChoice High	223.79	535.71	649.33	711.01	337.41	399.09
HealthChoice High Alternative	223.79	535.71	649.33	711.01	337.41	399.09
HealthChoice Basic	194.36	468.87	569.02	623.11	294.51	348.60
HealthChoice Basic Alternative	194.36	468.87	569.02	623.11	294.51	348.60
HealthChoice S-Account	176.57	414.47	502.25	549.19	264.35	311.29
HealthChoice USA	342.54	685.08	797.58	858.57	455.04	516.03
TRICARE Supplement	27.23	54.46	81.69	100.61	54.46	73.38

Dental	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Assurant Freedom Preferred	13.31	26.54	36.46	53.22	23.23	39.99
Assurant Heritage Plus with SBA (Prepaid)	5.42	9.51	13.02	16.53	8.93	12.44
Assurant Heritage Secure (Prepaid)	3.32	6.08	8.48	10.87	5.72	8.11
CIGNA Dental Care Plan (Prepaid)	4.27	7.07	10.34	14.14	7.54	11.34
Delta Dental PPO	15.53	31.05	44.55	65.22	29.03	49.70
Delta Dental PPO Plus Premier	20.55	41.10	59.00	86.36	38.45	65.81
Delta Dental PPO – Choice	6.95	22.73	38.63	61.31	22.85	45.53
HealthChoice Dental	14.48	28.96	41.38	59.86	26.90	45.38

Vision	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Humana	3.12	5.46	7.11	7.52	4.77	5.18
Primary Vision Care Services (PVCS)	3.99	7.68	11.37	12.64	7.68	8.95
Superior Vision Services	3.30	6.58	9.68	12.95	6.40	9.67
UnitedHealthcare Vision	3.78	6.45	8.57	9.67	5.90	7.00
Vision Service Plan (VSP)	4.22	7.04	9.75	13.12	6.93	10.30

Disability	4.20

Life Insurance Options						
Life	1.85	Supplemental Life First Unit	1.85			
Dependent Life		Supplemental Life Age Rated (Per $20,000)				
Low Option	1.20	< 30	0.37	55 - 59	2.77	
Standard Option	1.99	30 - 34	0.37	60 - 64	3.14	
Premier Option	3.99	35 - 39	0.37	65 - 69	5.17	
		40 - 44	0.56	70 - 74	8.86	
		45 - 49	0.93	75+	13.66	
		50 - 54	1.85			

Mental Health Parity and Addiction Equity

Federal law, the *Mental Health Parity and Addiction Equity Act of 2008*, requires health insurance providers to include mental health and substance abuse coverage equal to physical health coverage in terms of the financial and treatment requirements. The law removed differences in co-pays and removed limits on visits and treatment days. Provisions of the law will be in effect in all of the state's available health plans in 2014.

Benefits Enrollment Calculator

Your benefits costs can be easily estimated using the online Benefits Enrollment Calculator located on the web site at ***www.ebc.ok.gov***. Be sure to choose the monthly calculator if you are paid once a month and the bi-weekly calculator if you are paid every two weeks. The Benefits 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 Enrollment Calculator:

- Print your benefits calculator results for easy reference during online enrollment.
- Use the calculator as many times as you want, but to actually enroll you must use the Benefits Administration System (BAS) link on the web site 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.

Health Care Reform Update

In 2011, State employees and their families saw several changes in their health plans, thanks to the Patient Protection and Affordable Care Act passed by Congress and signed by the President.

Once again, HMO plans will cover most preventive services at 100 percent provided the services are done In-network. HealthChoice will also cover most preventive services at 100 percent. For you, this means no-cost access to such services as:

- Blood pressure, diabetes, and cholesterol tests
- Many cancer screenings
- Counseling from your health care provider on topics including quitting smoking, losing weight, eating better, treating depression, and reducing alcohol use
- Routine vaccines for diseases such as measles, meningitis or tetanus
- Flu and pneumonia shots
- Counseling, screening and vaccines for healthy pregnancies
- Regular well-baby and well-child visits, from birth to age 21

(See the Health Plan Comparison section of this guide for details.)

CAUTION:
Make Sure Your Dependents Are Eligible

Are you covering an ineligible dependent? Enrolled ineligible dependents can result in significant and unnecessary costs to the State and its employees. Even the very conservative estimates put the value in the millions of dollars.

Now is the time to make sure the dependents you claim are eligible for State coverage. Although no official action has been taken, an audit is being considered. A dependent eligibility audit is a controlled process designed to preserve the integrity of an employer's benefit plan by identifying enrolled, but ineligible participants. Examples include:

- Ineligible spouses – Member forgets to inform employer of a divorce: Once a divorce decree is issued, the employee's spouse is no longer an eligible dependent and does not qualify for State benefits. If the court orders the employee to provide the spouse with health (or other) insurance, that coverage cannot be through the State and will need to be obtained from another source.
- Ineligible children – Grandchildren, nieces and nephews (unless employee has been granted legal custody), and spouses of married dependents (daughter in-law or son in-law)

While there are financial benefits to a dependent audit, it is by no means a popular move. However, an audit may become necessary as a way to reduce costs in state government, to validate insurance claims and to make sure the State is in compliance with federal laws. While the "honor system" is still in effect for Plan Year 2014, protect yourself by verifying the eligibility of all the people you are claiming as dependents. If you're unsure whether a dependent is eligible, contact your Benefits Coordinator or the Employee Benefits Department, Human Capital Management at (405) 522-1190 or 1-800-219-8115.

Online Enrollment

Enroll Online!

Remember: Online Enrollment opens October 1 and closes October 31, 2013.

Customer assistance is available October 1st through 30th from 8 a.m. – 4 p.m. and October 31st from 8 a.m. – 8 p.m. Assistance is also available by submitting a help ticket through the help desk of the website at: www.***ebc.ok.gov*** or helpdesk@omes.ok.gov.

Last year, 91 percent of State employees went to ***ebc.ok.gov*** and used online enrollment to make their benefit elections. Join your co-workers and discover how easy it is to enroll online. The average enrollment takes just a few minutes and you can log on anytime, 24 hours a day, seven days a week during Option Period.

Online Enrollment allows you to:

- Print your confirmation of elections instantly
- Update your address, telephone, and email information online
- Change your elections and make corrections as many times as you like, until the close of Option Period (remember, your final election is the official enrollment!)

1. Go to the Employee Benefits Website at ***www.ebc.ok.gov***. Sign on to the Benefits Administration System logon area using your six digit employee number and click *Forgot Password*.
2. Follow instructions to set your personal password.
3. Choose Online Enrollment and begin.

On the home page of ***www.ebc.ok.gov***, the Benefits Administration System (BAS) access window is in the top right corner of the screen. Online enrollment is not currently available for newly hired employees outside of Option Period. Your user ID will continue to be your six digit employee number, make sure you update your email address, home address, and phone number.

Flexible Spending Accounts (FSAs)

Want to Save More On Your Taxes? – Flexible Spending Accounts (FSAs) are money-saving ways to pay for qualified health and day care expenses because the accounts are funded with pre-tax dollars. Here's how the average person, contributing just $100 per month, can increase their take-home pay by using an FSA:

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

FSAs can no longer be used to pay for some over-the-counter drugs and health products without a prescription. Check out the list of eligible items provided at ***ebc.ok.gov*** in the "Flexible Spending" section.

Experience the Convenience of the Free FSA Debit Card!

It's fast, flexible and free! The optional Flexible Spending Account (FSA) debit card can be used at hundreds of merchants.

Simply present the FSA debit card to pay for medical and dependent care expenses. The money is taken directly from your FSA account, resulting in fewer paper claims to file.

When using the FSA debit card, some charges may require proof after purchase. Save your receipts!

Occasionally we may have to request documents to substantiate your debit card purchase. If we request documents and you do not respond timely this will result in your card being temporally suspended. Once suspended, the card remains suspended until the issue is resolved even if it involves the previous plan year. Please send in all requested documents as soon as possible if requested to avoid the temporarily suspension.

Please Note the Following:

- FSAs have a "Use it or Lose it" rule. Simply stated, if you have money left in your account after March 15th of the following year, that money will be forfeited. But don't let that scare you. With a little planning, you can take advantage of this tax-reducing benefit without losing any money.
- You cannot enroll in a Flexible Spending Health Care Account if you choose the HealthChoice S-Account Plan.
- You may be restricted from enrollment in the HealthChoice S-Account if you have funds remaining in your FSA Health Care Account on January 1, 2014.
- You can continue to participate in the FSA Dependent Care Account if you elect the HealthChoice S-Account Plan.

Grace Period Extension

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

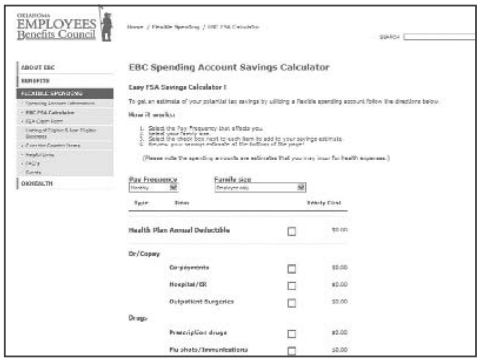
So, go to the doctor, buy a prescription or incur any approved expenses such as bandages, diabetes testing supplies, and contact lens solution until March 15th, 2014 and still file for reimbursement from your remaining 2013 FSA account fund. Check out the full list of eligible products in the Flexible Spending section of ***www.ebc.ok.gov***

When calculating your FSA contribution for Plan Year 2014, it is important to plan conservatively. Calculate based on your Plan Year estimated expenses. Do not include the extended grace period in your calculations. This extension may help you reduce the risk of losing unused funds in your FSA accounts.

Add Up Your Savings with our FSA Savings Calculator

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

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



Health Care Account (HCA)

By signing up for a Health Care Account, you can set aside up to $2,500 for you and your family's health care related expenses. Realize significant tax savings on qualified, un-reimbursed expenses by paying for the services and items pre-tax. Enroll in an HCA online or with your paper enrollment, indicating the pay period contribution you want deducted from your paycheck. Some qualifying expenses include:

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

As many FSA users are already aware, restrictions on pre-tax purchases of some over-the-counter (OTC) medications like Tylenol and Claritin took effect in 2011 and will continue to be in place for 2014. In accordance with a provision of the health care reform law, OTC drugs, medicines and biologicals can be purchased with Health Care FSA funds, but only with a letter of medical necessity from a medical provider. This letter of medical necessity must be updated every 12 months. Also, the items can no longer be purchased with the "Benny" debit card. However, products like bandages and contact lens solution will still be allowed as Benny card purchases.

Check out the list provided at ***www.ebc.ok.gov*** in the "Flexible Spending" section.

HCA Monthly Minimum: $10

HCA Monthly Maximum: $208.33

Dependent Care Account (DCA)

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

DCA Monthly Minimum: $50 DCA Monthly Maximum: $416.66

Important Notes on FSA Accounts:

- You must re-enroll every year.
- Indicate your per-pay-period contribution on your enrollment (not your annual contribution).
- View account balances and claim information online by logging onto the Benefits Administration System (BAS) via the EBD website at ***www.ebc.ok.gov***.
- After logging in using your employee ID and password, select Flexible Spending from the left menu.
- See additional important rules and regulations for FSAs on page 7 of this Guide.

See updated lists for eligible and non-eligible expenses at our web site *www.ebc.ok.gov* under the flexible spending tab.

Premium Conversion: *Do You Want to Save on Your Taxes?*

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

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

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

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

✔ Yes = tax savings!

HealthChoice S-Account Plan

The HealthChoice S-Account Plan is a qualified, high deductible health plan. Although you do not have to provide proof of a Health Savings Account (HSA) HealthChoice has contracted with American Fidelity Health Services Administration to make establishing and keeping an HSA easier and more convenient.

The S-Account Plan provides access to one of the largest provider networks in Oklahoma, the HealthChoice Provider Network. This is the same network that is available to HealthChoice High, High Alternative, Basic and Basic Alternative Plan members.

The $1,500 individual/$3,000 family deductible for the HealthChoice S-Account Plan must be met before any health or pharmacy benefits are paid by the plan. Preventive procedures are covered at 100% of Allowed Charges when using a HealthChoice Network Provider for members who meet the clinical criteria. Refer to the Health Plan Comparison section for details. The individual deductible does not apply if two or more family members are covered.

Please refer to the Benefits Enrollment Guide Plan Year 2014 for information on covered services, claim procedures, eligibility, and Plan exclusions and limitations.

For further information about the S-Account Plan contact EGID Member Services at 405-416-1800 or toll-free 1-800-782-5218. For further information about American Fidelity Health Services Administration contact 405-523-5699 or toll-free 1- 866-326-3600.

[1] Although the Employees Group Insurance Division (EGID) and the (HSA) trustee/custodian together provide health insurance benefits, each are independent entities with separate responsibilities. EGID expressly disclaims any fiduciary obligation to manage the member’s HSA funds or accounts. HSA account information concerning contributions, IRS determinations, withdrawals, or any matters regarding the HSA is the sole responsibility of the HSA trustee/custodian chosen by the member.

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

HealthChoice Health Plans

There are six health plans available:

HealthChoice High, High Alternative, Basic, Basic Alternative, S-Account, and USA Plans

- HealthChoice High, High Alternative Plans, Basic, Basic Alternative Plans, S-Account, and USA Plan There are no preexisting condition exclusions or limitations applied to any of the health plans.
- During Option Period, to enroll or remain enrolled in the HealthChoice High or Basic Plan for Plan Year 2014, you must complete the Tobacco-free Attestation located on the EGID website. If participants cannot complete the tobacco-free attestation, participants can still quality for the HealthChoice High or Basic Plan by completing one of the Reasonable Alternative Options.
- The HealthChoice USA Plan is designed for employees who receive a work assignment of more than 90 consecutive days outside of Oklahoma and Arkansas. Call HealthChoice Member Services for more details.
- Preventive procedures are covered at 100% of Allowed Charges when using a HealthChoice Network Provider for members who meet the clinical criteria. This means no cost access to such services as:
  - Blood pressure, diabetes, and cholesterol tests
  - Breast, cervical, prostate, and colorectal cancer screenings
  - Osteoporosis screening
  - Counseling from your health care provider on topics including quitting tobacco, losing weight, eating healthy, treating depression, and reducing alcohol use
  - Prescription tobacco cessation products
  - Vaccines and Administration fees for children and adults
  - Flu and pneumonia shots
  - Screening for obesity and counseling from your doctor and other health professionals to promote sustained weight loss, including dietary counseling from your doctor
  - Screening for conditions that can harm pregnant women or their babies, including iron deficiency, hepatitis B, a pregnancy related immune condition called Rh incompatibility, and a bacterial infection called bacteriuria
  - Special, pregnancy-tailored counseling from a doctor to help pregnant women quit smoking and avoid alcohol use
  - Counseling to support breast-feeding and help nursing mothers
  - Well-woman visits
  - Gestational diabetes screening that helps protect pregnant women from one of the most serious pregnancy-related diseases
  - Domestic and interpersonal violence screening and counseling
  - FDA-approved contraceptive methods and contraceptive education and counseling
  - Contraceptive Methods and Counseling
  - Breastfeeding support, supplies, and counseling
  - HPV DNA testing for women 30 or older
  - Sexually transmitted infections counseling for sexually active women
  - HIV screening and counseling for sexually active women

See the HealthChoice website at ***www.ok.gov/sib/*** or ***www.healthchoiceok.com*** for more details.

HealthChoice High, High Alternative, and USA Plans

- HealthChoice High and USA Plans have an out-of-pocket maximum of $3,300 for Network individual and $3,800 for non-Network. For family $8,400 for Network and $9,900 for non-Network.
- HealthChoice High Alternative Plans has an out-of-pocket maximum of $3,550 for Network individual and $4,050 for non-Network. For family $8,400 for Network and $9,900 for non-Network.
- HealthChoice Basic Plan has an out-of-pocket maximum per member of $5,500 and $11,000 per family.
- HealthChoice Basic Alternative Plans has an out-of-pocket maximum per member of $5,750 and $11,500 per family.

HealthChoice S-Account Plan

- The out-of-pocket maximum is $3,000/individual and $6,000/family. The individual deductible does not apply if two or more family members are covered.

HealthChoice Pharmacy Benefit

- The copays are changing for all medications except generics. The generic copay will remain the same. See the Health Plan Comparison for copay amounts.
- The individual out-of-pocket maximum will remain $2,500 per calendar year. There will be a family out-of-pocket maximum of $4,000.

What is the Oklahoma Tobacco Helpline?

The Helpline is a highly effective service that provides a series of one-on-one tobacco cessation coaching sessions over the telephone. Once enrolled in the program, most participants also receive nicotine replacement products such as patches, gum, or lozenges. The Helpline has been proven to work for Oklahomans, and similar Helplines have been proven to work for people all over the country.

How does telephone coaching work?

Identify yourself as a HealthChoice participant when you call the Helpline at 1-800-QUIT-NOW. You'll speak with a helpful registration assistant who will gather basic contact information and ask a few questions about your reason for calling. Then, a Helpline Quit Coach™ will work with you to determine your readiness to quit, discuss your options for using nicotine replacement products or other cessation aids, and assist you in developing a quit plan that is right for you. The Quit Coach will also schedule up to four follow-up sessions throughout your quitting process and you may call in to speak with a coach as needed between scheduled calls.

Who is eligible to receive Helpline services?

Anyone living in Oklahoma age 13 and older may call the Helpline and receive services at no charge up to twice per year. Helpline specialists assist tobacco users, health care professionals, and concerned family members and friends. The level of services available will depend on an individual's age and insurance status.

Do HealthChoice participants have to be tobacco-free?

To remain enrolled in the HealthChoice High or HealthChoice Basic Plan, participants must attest that they and their covered dependents are tobacco-free. For participants who can't complete the tobacco-free attestation and would like to remain on the HealthChoice High or Basic Plan, they can still qualify by completing one of the following Reasonable Alternative Options:

1. Enrolling in the quit tobacco program as mentioned on this flyer and completing three (3) coaching calls prior to the deadline within the calendar year of their Option Period.
2. By providing a letter from their physician prior to the deadline.

What are the Oklahoma Tobacco Helpline hours?

The Helpline is available 24 hours a day, 7 days a week.

Do HealthChoice members receive additional Helpline Benefits?

HealthChoice members enrolled in the Helpline program may receive up to 12 weeks of nicotine replacement products up to twice per year with no co-pay or deductible. The products are mailed directly to your home.

Employee Life Insurance

All eligible current State employees are covered by the HealthChoice Life Insurance Plan which provides a $20,000 basic term life insurance policy called Basic Life. An additional term life policy, called Supplemental Life, is available in $20,000 units for employees who need more coverage.

Basic Life Coverage

As a State employee, you are **automatically** enrolled in Basic Life. This also includes Accidental Death and Dismemberment (AD&D) coverage.

Supplemental Life Coverage

You can elect to increase your life insurance coverage in $20,000 units up to a maximum of $500,000. To increase your coverage, a Life Insurance Application must be submitted and approved. Your application must be approved before coverage can take effect. The postmark deadline for submitting the Life Insurance Application is **Friday, November 15, 2013**.

AD&D Coverage

Basic Life ($20,000) and the first unit ($20,000) of Supplemental Life include Accidental Death and Dismemberment coverage. AD&D coverage pays additional benefits for the loss of life, loss of limb or limbs, or the loss of sight. See the HealthChoice Life Insurance Handbook for more information. The handbook is available online at ***www.ok.gov/sib*** or ***www.healthchoiceok.com***.

Guaranteed Issue (New employees only)

You may enroll in life insurance coverage in an amount up to two times your base annual salary without completing a *Life Insurance Application*. See your Benefits Coordinator for details.

How to Increase Your Life Insurance Coverage

During Option Period, to increase your life insurance coverage, please complete a *Life Insurance Application* and mail directly to the **Employees Group Insurance Division (EGID)**. The address is located on the back of the form.

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

Dependent Life Insurance

You have three options to choose from when purchasing dependent life insurance coverage:

Dependent Life Premier Option	Dependent Life Standard Option
• $20,000 term life policy for spouse	• $10,000 term life policy for spouse
• $10,000 term life policy for each child	• $5,000 term life policy for each child
• $1,000 term life policy for newborns to 6 months	• $1,000 term life policy for newborns to 6 months
Dependent Life Low Option	
• $6,000 term life policy for spouse	• $1,000 term life policy for newborns to 6 months
• $3,000 term life policy for each child	

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

Basic Life ($20,000)		**First $20,000 Supplemental Life**	
Includes AD&D	$4.00	Includes AD&D	$4.00
Additional Units of Supplemental Life			
Age-Rated (Per $20,000)			
Under 30 years	$0.80	55-59 years	$6.00
30-34 years	$0.80	60-64 years	$6.80
35-39 years	$0.80	65-69 years	$11.20
40-44 years	$1.20	70-74 years	$19.20
45-49 years	$2.00	75+ years	$29.60
50-54 years	$4.00		
Dependent Life			
Low Option	$2.60	Standard Option	$4.32
Premier Option	$8.64		
Disability	$9.10		

HEALTH PLAN COMPARISON

2014 Health Plans See the Health Plan Monthly Rates on page 3	CommunityCare HMO *www.ccok.com*	GlobalHealth HMO *www.globalhealth.com*
Choice of Provider	Contact your PCP for all medical care (New Hires & New Enrollees must indicate PCP on Enrollment Form) Members may self-refer to most specialists for initial visit.	Contact your PCP for all medical care (New Hires & New Enrollees must indicate PCP on Enrollment Form) PCP referral & HMO authorization required for all care received outside PCP office, You may self-refer to an in-network OB/GYN. **For children, you may designate a pediatrician as the primary care provider**
Calendar Year Deductible	None	None
Annual Out-of-Pocket Maximum	Individual: $4,000 Family: $8,000	Individual: $3,000 Family: $5,000 Includes all copayments and coinsurance paid on covered services, prescriptions, and durable medical equipment
Office visits (Professional services)	Copays $35 PCP copay per visit $50 Specialist copay per visit	Copayments $25 PCP $50 Specialist

HealthChoice High & High Alternative Network A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider ***www.healthchoiceok.com***	**HealthChoice High & High Alternative Non-Network** A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider ***www.healthchoiceok.com***	**HealthChoice Basic & Basic Alternative** Additional out-of-pocket costs apply when using a non-Network provider ***www.healthchoiceok.com***	**HealthChoice S-Account Network** A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider ***www.healthchoiceok.com***
Choice of Network Provider for medically necessary services	Choice of any Provider, Allowed Charges for medically necessary Services. Member responsible for amount that exceeds the Allowed Charges when using a non-Network provider and all ineligible expenses.	Choice of any Provider, Allowed Charges for medically necessary services. Member responsible for amount that exceeds the Allowed Charges when using a non-Network provider and all ineligible expenses.	Choice of Provider for medically necessary services
High Individual: $500 Family: $1,500 High Alternative Individual: $750 Family: $2,250	High Individual: $500 Family: $1,500 High Alternative Individual: $750 Family: $2,250	Basic Individual: $500 Family: $1,000 Deductible applies after Plan pays first $500 of Allowed Charges. Basic Alternative Individual: $750 Family: $1,500 Deductible applies after Plan pays first $250 of Allowed Charges.	Individual: $1,500 Family: $3,000 The combined medical and pharmacy deductible must be met before benefits are paid. The individual deductible does not apply if two or more family members are covered
High Individual: $3,300 Family: $8,400 (includes deductible) High Alternative Individual: $3,550 Family: $8,400 (includes deductible) Non-covered services and balance billing amounts do not apply. Copay applies	High Individual: $3,800 Family: $9,900 (includes deductible) High Alternative Individual: $4,050 Family: $9,900 (includes deductible) plus Member is responsible for amount that exceeds the Allowed Charges, inpatient deductible, ER copay & charges over maximum benefit limitations	Basic Individual: $5,500 Family: $11,000 Basic Alternative Individual: $5,750 Family: $11,500	Individual: $3,000 Family: $6,000 Non-Network charges do not count toward out-of-pocket limit
$30 Physician copay; $50 Specialist copay per office visit; for other professional services, the calendar year deductible applies first; member pays 20% of Allowed Charges	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses	See *Hospital Inpatient* for a description of benefits	After the calendar year deductible, $30 Physician copay /$50 Specialist copay per office visit

2014 Health Plans See the Health Plan Monthly Rates on page 3	CommunityCare HMO *www.ccok.com*	GlobalHealth HMO *www.globalhealth.com*
Prescription Drugs	Up to $0 select generic formulary Up to $10 generic formulary Up to $40 brand formulary (when no generic is available) Up to $65 brand formulary (when generic is available) Up to $65 non formulary 30-day supply Selected medications may have restricted quantities Convenience Mail Order Pharmacy Up to 90-day supply for 3 copays	$10/$50/$75 $4 copay for selected generics 30-day supply Certain medications may have restricted quantities These copays apply to the maximum out-of-pocket Home Delivery and Retail Extended Supply up to 90-day supply for 2 copays
OK Health Program **(Only for State employees participating in the OK Health Program, dependents do not qualify.)**	No charge on time per plan year for PCP visits, biometric measurements and lab work as specified by OK Health Program. If any other services are provided during PCP office visit, member will be charged an office copay and other appropriate charges	No charge one time per plan year for PCP visits, biometric measurements and lab work as specified by OK Health Program

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30 day supply: Generic - Up to $10 Preferred Brand – Up to $45 Non-Preferred Brands – Up to $75 **31-90 day supply:** Generic – Up to $25 Preferred Brand –Up to $90 Non-Preferred Brand – Up to $150 **Specialty Medication Copay:** Preferred -Up to $100 per 30-day supply Non-Preferred Up to $200 per 30-day supply **Brand/Generic difference:** Member is responsible for the difference in the brand and generic if a brand is purchased when a generic is available. For more details visit ***www.healthchoiceok.com*** or ***www.sib.ok.gov***	**Generic & Preferred Brand –** 50% plus the dispensing fee (no maximum). **Non-Preferred Brands –**75% plus the dispensing fee (no maximum)	**30 day supply:** Generic –Up to $10 Preferred Brand- Up to $45 Non-Preferred Brands – Up to $75 **31-90 day supply:** Generic – Up to $25 Preferred Brand- Up to $90 Non-Preferred Brand - Up to $150 **Specialty Medication Copay:** Preferred- Up to $100 per 30-day supply Non-Preferred- Up to $200 per 30-day supply **Brand/Generic difference:** Member is responsible for the difference in the brand and generic if a brand is purchased when a generic is available. For more details visit ***www.healthchoiceok.com*** or ***www.sib.ok.gov***	After the $1,500 individual or $3,000 family deductible has been met, the pharmacy benefits are: **30 day supply** Generic –Up to $10 Preferred Brand- Up to $45 Non-Preferred Brands – Up to $75 **31-90 day supply:** Generic –Up to$25. Preferred Brand- Up to $90 Non-Preferred Brand- Up to $150 **Specialty Medication Copay:** Preferred - Up to $100 per 30-day supply Non-Preferred -Up to $200 per 30-day supply **Brand/Generic difference:** Member is responsible for the difference in the brand and generic if a brand is purchased when a generic is available. For more details visit www.healthchoiceok.com or www.sib.ok.gov
One free initial doctor's office visit related to OK Health Program requirements. One free fasting lipid (Cholesterol/ triglycerides) profile One fasting glucose (sugar) test	Not covered for non-Network	One free initial doctor's office visit related to OK Health Program requirements. One free fasting lipid (Cholesterol/ triglycerides) profile One fasting glucose (sugar) test	One free initial doctor's office visit related to OK Health Program requirements. One free fasting lipid (Cholesterol/ triglycerides) profile One fasting glucose (sugar) test

HEALTH PLAN COMPARISON

2014 Health Plans See the Health Plan Monthly Rates on page 3	CommunityCare HMO *www.ccok.com*	GlobalHealth HMO *www.globalhealth.com*
Hospital Inpatient	$750 copay per admission (authorization required)	$250 copayment per inpatient day $750 max. per admission Preauthorization required
Hospital Outpatient	$500 copay per visit outpatient surgical facility (authorization required)	$250 copay/visit – free standing facility $750 copay/visit – hospital facility Preauthorization required
Emergency Health Care	$200 per visit copay (waived if admitted)	$300 per visit copay (waived if admitted)
After Hours Urgent Care	$50 copay per visit	$50 copay per visit NOTE: Must use in-network facilities
Diagnostic X-ray and Lab	No additional copay for laboratory services or outpatient radiology. $200 copay per scan for MRI, CT, MRA and PET Scan	No additional copay for laboratory services or outpatient radiology. Specialty scans: MRI, CT, MRA, PET,and nuclear scans $250 copay/scan – free standing facility $750 copay/scan – hospital facility
Allergy Treatment and Testing	$35 copay per visit to PCP $50 copay per visit to Specialist $30 copay for allergy serum (six week supply - including shots)	$25 PCP /$50 Specialist $30 copayment per 6 weeks antigen and shots
Well-Child Care	No copay	No Copayment up to age 21

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Member pays 20% of Allowed Charges after the calendar year deductible. Certification required	Member pays 50% of Allowed Charges after the calendar year deductible and $300 per confinement hospital copay, plus amount that exceeds the Allowed Charges and all ineligible expenses. Certification required	•Copays do not apply •All covered services, exceptions, limitations, and conditions are identical to the HealthChoice High Plan **Basic Plan** Member pays: •$0 the first $500 of Allowed Charges •100% of the next $500 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible **Basic Alternative Plan** Member pays: •$0 the first $250 of Allowed Charges •100% of the next $750 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible **Both Basic Plans** 50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over the individual or family out-of-pocket limit •No deductible for well child care visit •You can use non-Network providers, but it will be more costly $0 Copay for preventative well-baby exam Well-baby & Adult immunizations covered at 100% See Hospital Inpatient for description of benefits. See Prescription Drugs	Member pays 20% of Allowed Charges after the calendar year deductible and $300 per confinement hospital copay when using a non-Network provider plus amount that exceeds the Allowed Charges and all ineligible expenses Certification required
Member pays 20% of Allowed Charges after the calendar year deductible. Certification required for certain outpatient surgeries	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses. Certification required for certain outpatient surgeries		Member pays 20% of Allowed Charges after the calendar year deductible. Certification required for certain outpatient surgeries
Member pays 20% of Allowed Charges after the calendar year deductible. $100 ER copay; waived if hospitalized	Member pays 20% of Allowed Charges after the calendar year deductible, plus amount that exceeds the allowed charges. $100 ER copay; waived if hospitalized		Member pays 20% of Allowed Charges after the calendar year deductible. $100 ER copay; waived if hospitalized
Member pays 20% of Allowed Charges after the calendar year deductible	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses		Member pays 20% of Allowed Charges after the calendar year deductible
Member pays 20% of Allowed Charges after the calendar year deductible	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses		Member pays 20% of Allowed Charges after the calendar year deductible
Member pays 20% of Allowed Charges after the calendar year deductible. Limit: Battery of 60 tests every 24 months	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses Limit: Battery of 60 tests every 24 months		Member pays 20% of Allowed Charges after the calendar year deductible Limit: Battery of 60 tests every 24 months
$0 copay for preventive well baby exam	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses		$0 copay for preventive well baby exam

2014 Health Plans See the Health Plan Monthly Rates on page 3	CommunityCare HMO *www.ccok.com*	GlobalHealth HMO *www.globalhealth.com*
Immunizations	No copay for childhood immunizations up to 18 No copay for medically necessary immunizations 19 and over	$0 copay birth through age 18 years $0 copay ages 19 and over When appropriate following the recommendation of ACIP Office copayments may apply
Maternity	$35 copay for initial visit only (includes prenatal and postnatal care) No copay for Prenatal Classes Amniocentesis (medically necessary; outpatient surgical facility copay may apply) $750 per admission	$0 copay for prenatal care $25 one-time copay for delivery and all post natal care $250 per day, $750 Maximum per hospital admission
Contraceptive Services	$35 PCP/$50 Specialist copay per visit for consultation $35 PCP/$50 Specialist copay for surgical procedure (in office)	No copayment for women on FDA approved contraceptive services, not including abortifacient drugs $50 copayment for men if services performed in an office setting
Contraceptive Drugs	See *Outpatient Prescription Drug Benefits* or *Formulary Guide* Up to $0 select generic formulary (Oral contraceptive) Up to $40 brand formulary (when no generic is available) Up to $65 brand formulary (when generic is available) Up to $65 non formulary 30-day supply Selected medications may have restricted quantities. One copay per injectable contraceptive.	Selected FDA approved contraceptive prescriptions provided for no copayment. All others are subject to prescription copays and possible prior authorization Tier 1: $4/$10 Tier 2: $50 Tier 3: $75 See Drug Formulary Over the counter contraceptives are covered if the method is both FDA approved and prescribed for a woman by her health care provider
Infertility Services	$35 PCP copay per visit $50 Specialist copay per visit Office visit copays apply Infertility Services 50% Copay Infertility Medications (require prior authorization) are subject to a 50% copay	50% coinsurance, office visit copayments apply

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Well-baby and adult immunizations and administration charge covered at 100%, Office visit is subject to Copay. $30 Physician* $50 Specialist *Physicians include; General Practitioners Internal Medicine Physicians OB/GYN Pediatricians Physicians Assistants Nurse Practitioners	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses	Well-baby & Adult immunizations covered at 100% •Copays do not apply •All covered services, exceptions, limitations, and conditions are identical to the HealthChoice High Plan **Basic Plan** Member pays: •$0 the first $500 of Allowed Charges •100% of the next $500 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible **Basic Alternative Plan** Member pays: •$0 the first $250 of Allowed Charges •100% of the next $750 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible **Both Basic Plans** 50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over the individual or family out-of-pocket limit •No deductible for well child care visit •You can use non-Network providers, but it will be more costly	Well-baby and adult immunizations and administration charge covered at 100%. Office visit is subject to $30 Physician Copay or $50 Specialist Copay per office visit. Some guidelines apply
Member pays 20% of Allowed Charges after the calendar year deductible Includes one postpartum home visit (must meet criteria) Also see *Hospital Inpatient* Benefits	Member pays 50% of Allowed Charges after the calendar year deductible and $300 per confinement hospital copay, plus amount that exceeds the Allowed Charges and all ineligible expenses. Includes one postpartum home visit (must meet criteria) Also see *Hospital Inpatient* Benefits		Member pays 20% of Allowed Charges after the calendar year deductible. Includes one postpartum home visit (must meet criteria) Also see *Hospital Inpatient* Benefits
Covered at 100% for members meeting clinical criteria.	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses		Covered at 100% for members meeting clinical criteria
See *Prescription Drugs*	See *Prescription Drugs*	See *Prescription Drugs*	After the $1,500 individual or $3,000 family deductible has been met, all Pharmacy copays apply. See *Prescription Drugs*
Member pays 20% of Allowed Charges after the calendar year deductible Benefits available for diagnosis and some treatment. See exclusions in member materials	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds Allowed Charges and all ineligible expenses Benefits available for diagnosis and some treatment. See exclusions in member materials	See *Hospital Inpatient* for benefit details	Member pays 20% of Allowed Charges after the calendar year deductible Benefits available for diagnosis and some treatment. See exclusions in member materials

2014 Health Plans See the Health Plan Monthly Rates on page 3	CommunityCare HMO *www.ccok.com*	GlobalHealth HMO *www.globalhealth.com*
Mental Health Inpatient	$750 copay per admission (requires prior authorization through CCOK Behavioral Health Services)	$250 per inpatient day copayment **$750 max. per admission** Must be preauthorized
Mental Health Outpatient ***Including Gambling Addiction***	$35 PCP/specialist copay per visit (requires prior authorization through CCOK Behavioral Health Services)	$25 copayment per visit Must be preauthorized
Substance Abuse Inpatient	$750 copay per admission (requires prior authorization through CCOK Behavioral Health Services)	$250 per inpatient day copayment **$750 max. per admission** Must be preauthorized
Substance Abuse Outpatient	$35 PCP/specialist copay per visit (requires prior authorization through CCOK Behavioral Health Services)	$25 copayment per visit Must be preauthorized
Hearing Screening	$0 copay per visit (covered under preventive care services and limited to one per year)	No copayment per visit up to age 21 $25 copayment per visit age 22 and over limited to 1 per year
Hearing Aids	20% copay for children up to age 18. Coverage shall only apply to hearing aids that are prescribed, filled and dispensed by a licensed audiologist, and may limit the hearing aid benefit payable for each hearing-impaired ear to every forty-eight (48) months; provided, however, such coverage may provide for up to four (4) additional ear molds per year for children up to two (2) years of age	Covered for children up to age 18 only 20% coinsurance
Physical, Occupational, or Speech Therapy	No copay for Inpatient Rehabilitation $50 copay for Outpatient Physical, Occupational or Speech Therapy (up to 60 treatment days per disability)	No copayment for inpatient rehabilitation $50 Specialist copayment per visit for outpatient Limited to 60 days combined inpatient and outpatient visits per acute illness or injury

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Member pays 20% of Allowed Charges after calendar year deductible. Requires certification after 15 visits or penalty will apply	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses. Requires certification after 15 visits or penalty will apply	•Copays do not apply •All covered services, exceptions, limitations, and conditions are identical to the HealthChoice High Plan **Basic Plan** Member pays: •$0 the first $500 of Allowed Charges •100% of the next $500 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible **Basic Alternative Plan** Member pays: •$0 the first $250 of Allowed Charges •100% of the next $750 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible **Both Basic Plans** Member pays: •50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over the individual or family out-ofpocket limit •No deductible for well child care visit. •You can use non-Network providers, but it will be more costly	Member pays 20% of Allowed Charges after the calendar year deductible. Requires certification after 15 visits or penalty will apply
Member pays 20% of Allowed Charges after the calendar year deductible. Requires certification after 15 visits or penalty will apply	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges & all ineligible expenses. Requires certification after 15 visits or penalty will apply		Member pays 20% of Allowed Charges after the calendar year deductible. Requires certification after 15 visits or penalty will apply
Member pays 20% of Allowed Charges after the calendar year deductible Certification required	Member pays 50% of Allowed Charges after the calendar year deductible and $300 per confinement copay, plus amount above the Allowed Charges and all ineligible expenses Certification required		Member pays 20% of Allowed Charges after the calendar year deductible Certification required
Member pays 20% of Allowed Charges after the calendar year deductible. Requires certification after 15 visits or penalty applies	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges & all ineligible expenses. Requires certification after 15 visits or penalty applies		Member pays 20% of Allowed Charges after the calendar year deductible. Requires certification after 15 visits or penalty applies
$30 Physician copay,$50 Specialist copay per office visit for a basic hearing screening only (does not include a comprehensive hearing exam) One per calendar year Infants age one or younger paid at 100%. One total per calendar year	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount that exceeds the Allowed Charges and all ineligible expenses. Basic hearing screening only		$30 Physician copay/$50 Specialist copay per visit after the calendar year deductible for a basic hearing screening (does not include a comprehensive hearing exam) One per calendar year Infants age one or younger paid at 100%. One total per calendar year
Benefit limited to children up to age 18; audiological services and hearing aids are covered as Durable Medical Equipment. No benefits for ages 18 and over; certification required	Benefit limited to children up to age 18; audiological services and hearing aids are covered as Durable Medical Equipment. No benefits for ages 18 and over; certification required		Benefit limited to children up to age 18; audiological services and hearing aids are covered as Durable Medical Equipment. No benefits for ages 18 and over; certification required
Member pays 20% of Allowed Charges after calendar year deductible. Certification required after 20 visits. Each service limited to 60 visits per year	Member pays 50% of Allowed Charges after calendar year deductible plus amount that exceeds the Allowed Charges and all ineligible expenses. Certification required after 20 visits. Each service limited to 60 visits per year		Member pays 20% of Allowed Charges after the calendar year deductible. Certification required after 20 visits. Each service limited to 60 visits per year

2014 Health Plans See the Health Plan Monthly Rates on page 3	CommunityCare HMO *www.ccok.com*	GlobalHealth HMO *www.globalhealth.com*
Chiropractic and Manipulative Therapy	$50 copay per visit (15 visits per year)	$20 copayment per visit Must be preauthorized
Durable Medical Equipment (DME)	20% copay (prior authorization required)	20% coinsurance for purchase, rental, repair, or replacement Must be preauthorized and obtained from a contracted network provider
Blood and Blood Products	No copay	No copayment
Skilled Nursing Facility	No copay (Limit: Max 100 days per year)	Limit: 100 days per Plan Year $250/day copayment $750 max. per admission
Periodic Health Exams	$0 copay routine physicals	No copayment per PCP limited to 1 per year
Temporo-mandibular Joint Dysfunction	$100 copay per treatment plan (lifetime non-surgical maximum of $1,500)	$100 copayment per treatment plan NOTE: Lifetime non-surgical maximum of $1,500. Surgical is under medical

HealthChoice High & High Alternative Network A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider ***www.healthchoiceok.com***	**HealthChoice High & High Alternative Non-Network** A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider ***www.healthchoiceok.com***	**HealthChoice Basic & Basic Alternative** Additional out-of-pocket costs apply when using a non-Network provider ***www.healthchoiceok.com***	**HealthChoice S-Account Network** A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider ***www.healthchoiceok.com***
Member pays 20% of Allowed Charges after calendar year deductible Certification required after 20 visits. Each service limited to 60 visits per year	Member pays 50% of Allowed Charges after calendar year deductible plus amount that exceeds the Allowed Charges and all ineligible expenses. Certification required after 20 visits. Each service limited to 60 visits per year	•Copays do not apply •All covered services, exceptions, limitations, and conditions are identical to the HealthChoice High Plan **Basic Plan** Member pays: •$0 the first $500 of Allowed Charges •100% of the next $500 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible **Basic Alternative Plan** Member pays: •$0 the first $250 of Allowed Charges •100% of the next $750 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible **Both Basic Plans** 50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over the individual or family out-of-pocket limit •No deductible for well child care visit •You can use non-Network providers, but it will be more costly	Member pays 20% of Allowed Charges after the calendar year deductible Certification required after 20 visits. Each service limited to 60 visits per year
Member pays 20% of Allowed Charges after the calendar year deductible for covered items. Purchase, rental, repair, or replacement must be certified	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. Purchase, rental, repair, or replacement must be certified		Member pays 20% of Allowed Charges after the calendar year deductible for covered items. Purchase, rental, repair, or replacement must be certified
Member pays 20% of Allowed Charges after the calendar year deductible	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses		Member pays 20% of Allowed Charges after the calendar year deductible
Member pays 20% of Allowed Charges after the calendar year deductible. Certification required Limit: 100 days per year	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. Certification required Limit: 100 days per year		Member pays 20% of Allowed Charges after the calendar year deductible. Certification required Limit: 100 days per year
$0 copay for one preventive services visit per calendar year for members and dependents age 20 and older. H.E.L.P. Check program pays primary member $200 for completing preventive services visit, metabolic and lipid panels, and health risk assessment	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses		$0 copay for one preventive services visit per calendar year for members and dependents age 20 and older. H.E.L.P. Check program pays primary member $200 for completing preventive services visit, metabolic and lipid panels, and health risk assessment
Member pays 20% of Allowed Charges after the calendar year deductible. Certification required	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. Certification required		Member pays 20% of Allowed Charges after the calendar year deductible. Certification required

2014 Health Plans See the Health Plan Monthly Rates on page 3	CommunityCare HMO *www.ccok.com*	GlobalHealth HMO *www.globalhealth.com*
Home Health Services	No copay (prior authorization required)	$0 copayment Must be prescribed by PCP
Medical Transportation	Ambulance No copay (must have prior authorization except for emergencies)	$100 copayment
Transplants	No copay (all transplant services, including evaluations must be preauthorized)	Inpatient copayment applies Preapproval and precertification required
Hospice	No copay	No copayment for terminal illness of six months or less Preapproval required
Preventive Services		
Eye Care	$0 copay Vision Screening and Refraction (one every 365 days) Contact Members Services for a contracted provider	

HealthChoice High & High Alternative Network A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider ***www.healthchoiceok.com***	**HealthChoice High & High Alternative Non-Network** A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider ***www.healthchoiceok.com***	**HealthChoice Basic & Basic Alternative** Additional out-of-pocket costs apply when using a non-Network provider ***www.healthchoiceok.com***	**HealthChoice S-Account Network** A reduced benefit level and additional out-of-pocket costs apply when using a non-Network provider ***www.healthchoiceok.com***
Member pays 20% of Allowed Charges after the calendar year deductible. Certification required Limit: 100 visits per calendar year	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. Certification required Limit: 100 visits per calendar year	•Copays do not apply •All covered services, exceptions, limitations, and conditions are identical to the HealthChoice High Plan **Basic Plan** Member pays: •$0 the first $500 of Allowed Charges •100% of the next $500 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible **Basic Alternative Plan** Member pays: •$0 the first $250 of Allowed Charges •100% of the next $750 of Allowed Charges (deductible) Only Allowed Charges count toward the deductible **Both Basic Plans** 50% of the next $10,000 of Allowed Charges •$0 of Allowed Charges over the individual or family out-of-pocket limit •No deductible for well child care visit •You can use non-Network providers, but it will be more costly	Member pays 20% of Allowed Charges after the calendar year deductible. Certification required Limit: 100 visits per calendar year
Member pays 20% of Allowed Charges after the calendar year deductible. If not an emergency, requires certification	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. If not an emergency, requires certification		Member pays 20% of Allowed Charges after the calendar year deductible. If not an emergency, requires certification
Member pays 20% of Allowed Charges after the calendar year deductible. Certification required	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. Certification required		Member pays 20% of Allowed Charges after the calendar year deductible. Certification required
Member pays 20% of Allowed Charges after the calendar year deductible. For life expectancy of six months or less Certification is required	Member pays 50% of Allowed Charges after the calendar year deductible, plus amount above Allowed Charges and all ineligible expenses. For life expectancy of six months or less Certification is required		Member pays 20% of Allowed Charges after the calendar year deductible. For life expectancy of six months or less Certification is required
Age 20 and older, no charge one time per calendar year for preventative service visit, metabolic panel, and comprehensive lipid panel H.E.L.P. Check program pays primary member $200 for completing preventive services visit, metabolic and lipid panels, and health risk assessment. One mammogram per year at no charge for woman age 40 and older. For woman under age 40, $30 Physician copay or $50 Specialist copay per office visit. Some guidelines apply Refer to ***ok.sib.ok.gov*** for all Preventive Services	Member pays 50% of Allowed Charges after the individual calendar year deductible, plus amount above Allowed Charges and all ineligible expenses No copay or deductible for one mammogram per calendar year for women age 40 and over, member pays charges over $115. Some guidelines apply Refer to ***ok.sib.ok.gov*** for all Preventive Services	Age 20 and older, no charge one time per calendar year for preventive service visit, metabolic panel, and comprehensive lipid panel H.E.L.P. Check program pays primary member $200 for completing preventive services visit, metabolic and lipid panels, and health risk assessment Refer to ***ok.sib.ok.gov*** for all Preventive Services	Age 20 and older, no charge one time per calendar year for preventive service visit, metabolic panel, and comprehensive lipid panel H.E.L.P. Check program pays primary member $200 for completing preventive services visit, metabolic and lipid panels, and health risk assessment. One mammogram per year at no charge for woman age 40 and older. For woman under age 40, $30 Physician copay or $50 Specialist copay per office visit. Some guidelines apply Refer to ***ok.sib.ok.gov*** for all Preventive Services

DENTAL PLAN COMPARISON

2014 Dental Plans

See the Dental Plan Monthly Rates on page 3

	Assurant Employee Benefits Freedom Preferred Plan *www.assurantemployeebenefits.com*		Assurant Employee Benefits ***Heritage *www.assurantemployeebenefits.com*	
	In-Network	**Out-of-Network**	**SECURE Prepaid Plan** *(Requires choosing a primary care dentist)*	**PLUS Prepaid Plan** *(Requires choosing a primary care dentist)*
Deductibles	$25 per person (Waived for Class A Services)	$25 per person	None	None
Diagnostic & Preventive Care (Class A) Includes routine cleanings, check-ups, X-rays for adults and children, fluoride treatments	100% of allowable amounts Topical fluoride application for children up to age 16	100% of allowable amounts Topical fluoride application for children up to age 16	Example Services Copays Sealant per tooth: $22 copay Routine Cleaning (once every 6 months): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge	Example Services Copays Sealant per tooth: $15 copay Routine Cleaning (once every 6 months): No charge Topical Fluoride Application (up to age 18): No charge Periodic Oral Evaluations: No charge
Basic Care (Class B) Includes fillings, some X-rays, extractions, periodontal care, and some root canal oral surgery	85% of allowable amounts after deductible.	70% of allowable amounts after deductible.	Example Services/ Copays Amalgam – one surface, permanent teeth $32	Example Services/ Copays Amalgam – one surface, permanent teeth $25
Major Care (Class C) Includes crowns, bridges and dentures	60% of allowable amounts after deductible	50% of allowable amounts after deductible	Example Services/ Copays Root Canal Anterior $175 Periodontal/Scaling/ Root planning 1-3 teeth (per quadrant) $54 Endodontist: 15 percent discount	Example Services/ Copays Root Canal Anterior $165 Periodontal/Scaling/Root planning 1-3 teeth (per quadrant) $36 Specialty rider Pays specialist at set Copays
Orthodontic Care (Class D)	No deductible, plan pays 60% up to lifetime maximum of $2,000 Dependents under age 19	No deductible, plan pays 50% up to lifetime maximum of $2,000 Dependents under age 19	25% discount for Adults and Children	25% discount for Adults and Children
Annual Maximum Benefit	$2,000 per person per policy year	$2,000 per person per policy year	No plan year dollar maximum	No plan year dollar maximum

NOTES:

Non-network benefits may allow dentist to balance bill.

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

Age limits and restrictions may apply, please consult each plan.

Orthodontic benefits on the PPO options are typically only available for dependents under the age of 19 or anyone with TMD. Contact the plan to determine limits on Orthodontic benefits prior to enrollment. If new hires and/or new enrollees did not have continuous group dental coverage in effect prior to becoming covered under Assurant Freedom PPO, a 12-month waiting period is applied for orthodontic services. *No waiting period applies for orthodontic benefits under the Delta Dental plans.

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

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

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

Assurant Employee Benefits is the brand name for dental products provided by Union Security Insurance Company.

***No orthodontic benefits are available for participants under the age of 19 or to members age 19 and over for the treatment of temporomandibular joint dysfunction. Certification is required for members age 19 and over. Contact the plan to determine limits on orthodontic benefits prior to enrollment.

IMPORTANT:

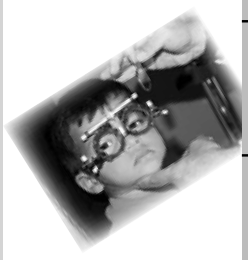
This Dental Plan Comparison Chart provides a brief summary. Please review the detailed dental enrollment materials for all plan features, including all plan limitations, exclusions, and restrictions before enrolling and selecting a dental product.

CIGNA Dental *www.cigna.com*	Delta Dental *www.DentaDentalOK.org*	Delta Dental *www.DentaDentalOK.org*	Delta Dental *www.DentaDentalOK.org*	HealthChoice Dental *www.healthchoiceok.com*	
Prepaid Plan *(Requires choosing a primary care dentist)*	**PPO In-Network and Out-of-Network**	**PPO Plus Premier In-Network and Out-of-Network**	**PPO-Choice Delta Dental PPO Network**	**Network Provider**	**Non-Network Provider**
None $5 office copay applies	$25 per person per calendar year- Classes B & C only	$50 per person per calendar year- Classes A, B and C only	$100 deductible per person on Major Services only (level 4)	$25 per person Basic Care and Major Care combined	$25 per person Preventive, Basic, and Major Care combined
Example Services Copays Sealant per tooth: $17 copay Routine cleaning (once every 6 months): no charge Topical Fluoride Application	100% of allowable amounts No deductible applies	100% of allowable amounts after deductible	Schedule of Covered Services and Enrollee Copayments: Example Services/Copays Routine Cleaning: $5 copay; Periodic oral evaluations:$5 copay; Topical fluoride application (up to age 19): $5 copay	100% of Allowed Charges	100% of Allowed Charges after the deductible
Example Services/ Copays Amalgam – one surface, permanent teeth $23	85% of allowable amounts after deductible	70% of allowable amounts after deductible	Schedule of Covered Services and Enrollee Copayments: Example Services/Copays Amalgam one surface, primary or permanent tooth $12 copay	85% of Allowed Charges after deductible	70% of Allowed Charges after deductible
Example Services/ Copays Root Canal, Anterior $375 copay Periodontal Scaling/ Root planning 1-3 teeth (per quadrant) $75 copay	60% of allowable amounts after deductible	50% of allowable amounts after deductible	Schedule of Covered Services and Enrollee Copayments: Example Services/Copays Crown-porcelain/ ceramic substrate: $241 copay; Complete denture-maxillary $320 copay	60% of Allowed Charges after deductible	50% of Allowed Charges after deductible
$2,472 out-of-pocket child; 3,384 out-of-pocket adult (24 month treatment); excludes orthodontic treatment plan and banding.	60% of allowable amounts up to $2,000 lifetime maximum per person (eligible employee, spouse, and dependent children) See Notes	60% of allowable amounts up to $2,000 lifetime maximum per person (eligible employee, spouse, and dependent children) See Notes	You pay charges in excess of $50 per month. Lifetime maximum up to $1,800 per person (eligible employee, spouse, and dependent children) See Notes	50% of allowed charges 12-month waiting period may apply*** No lifetime maximum for Network or Non-Network	
No plan year dollar maximum	$2,500 per person per calendar year	$3,000 per person per calendar year	$2,000 per person per calendar year	$2,500 per person per calendar year Preventive, Basic, and Major Care combined	

IMPORTANT DETAILS ABOUT DENTAL COVERAGE:

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

VISION PLAN COMPARISON



2014 Vision Plans See Rates on page 3	Humana www.visioncare.com		PVCS www.pvcs-usa.com	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Eye Exams	$10 copay One exam for eyeglasses or contacts every calendar year	Plan pays up to $35; One exam every calendar year	No Copay No Limit to frequency	Plan pays up to $40 Limit 1 exam
Lenses Per Pair	$25 Copay for single/ multi-focal lenses	Plan pays up to: Single $25 Bifocals $40 Trifocals $60 Lenticular $100	Member pays wholesale cost. No limit to number of pairs	Member pays normal doctor fees, reimbursed up to $60 for one set of lenses & frames annually
Frames	$25 Copay, up to plan limits. One set of frames every calendar year	Plan pays up to $45	Member pays wholesale cost. No limit to number of frames	Member pays normal doctor fee, reimbursed up to $60 for one set of lenses & frames annually
Contact Lenses	$130 allowance for conventional or disposable lenses and fitting fee in lieu of all other benefits every calendar year Medically necessary contacts, plan pays 100%	**$130 allowance for contacts, and fitting fee in lieu of all other benefits Medically necessary contacts, plan pays up to $210	Member pays wholesale cost for annual supply of contacts	Limit of one set annually in lieu of eyeglasses Member pays normal doctor fees reimbursed up to $60
Laser Vision Correction	Discount thru TLC, member will pay no more than $895 per eye for conventional Lasik, $1,295 Custom plus bladeless when services are rendered by a TLC network provider	No Benefit	Discount nationwide at The Laser Center (TLC)	No Benefit
Lens Options **UV Coating**	Substantial discount $15 member cost	No Benefit	$14 Copay No limit	Member pays normal doctor fees
Tint	Substantial discount $13 member cost	No Benefit	$14 Copay and up No limit	Member pays normal doctor fees
Standard Scratch Resistant Coating	Substantial discount $16 member cost	No Benefit	$13 Copay and up No limit	Member pays normal doctor fees
Standard Polycarbonate	Substantial discount $30 member cost	No Benefit	Wholesale cost No limit	Member pays normal doctor fees
Standard Progressive	Substantial discount $82 member cost	No Benefit	Wholesale cost, No limit	Member pays normal doctor fees
Anti-Reflective	Substantial discount $46 member cost	No Benefit	$45 Copay and up: No limit	Member pays normal doctor fees

NOTES: ***Humana***: The contact lens benefit provides a $130 yearly allowance for the annual vision exam to evaluate eye health, contact lens exam for fitting and evaluation, and the purchase of either conventional or disposable contacts. If a member prefers contact lenses, the plan provides the contact lens allowance in lieu of all other benefits. Instead if a member opts for lenses and frames during the plan year; a $25 copay applies for these two material items. More than 23,000 frames are covered in full by the $25 copay with in-network providers. Exams, lenses and frame benefits are provided once every 12 months. Oklahoma City LasikPlus Traditional Intralase (bladeless) with a one year plan with insurance discount is $695 per eye equals $1,390 Traditional Intralase (bladeless) with a lifetime plan with insurance discount is $1,395 per eye equals $2,790 CustomVue Intralase (bladeless) with lifetime plan with insurance discount is $1,784.15 per eye equals $3,568.30.

PVCS: Member must select either in-network or out-of-network for entire plan year. In-network services are unlimited. Out-of-network services (one eye exam, one set of eyeglasses or contacts) are limited to once annually. A $50 service fee applies to soft contact lens fittings; a $75 service fee applies to rigid or gas permeable contact lens fittings; and a $150 service fee applies to hybrid contact lens fittings. Simple replacements are not assessed with these fees. Limitations/Exclusions include the following: 1) Medical eye care, 2) Vision therapy, 3) Non routine vision services and tests, 4) Luxury frames (wholesale cost of frame exceeds $100, 5) Premium prescription lenses, and 6) Non prescription eye wear. For more information, call 1-888-357-6912.

Superior:** Materials copay applies to lenses and/ or frames. Discounts for lens add-ons will be given by contracted providers with a "DP" in their listing. Online, in-network contact lens materials available at ***www.svcontacts.com. Exams, lenses, and frames are provided once per calendar year. Progressive Lenses (no-line bifocals) – you pay the difference between the retail price of the selected progressive lens and the retail price of the provider's lined trifocal. The difference may also be subject to a discount. Standard contact lens fitting applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The Specialty contact lens fitting applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multifocal lenses.

Superior www.superiorvision.com		UnitedHealthcare Vision www.myuhcvision.com		VSP www.vsp.com	
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
$10 Copay	Plan pays: $34 Ophthalmologist, $26 Optometrist	$10 Copay	Reimbursement up to $40	$10 Copay	$10 Copay then plan pays up to $35
$25 Copay **Standard Progressive:** $25 Copay *See notes	$Plan pays: Single up to $26 Bifocals up to $39 Trifocals up to $49 Lenticular up to $78 **Standard Progressive:**Up to $49 *See notes	$25 Copay	Single up to $40 Bifocals up to $60 Trifocals up to $80 Lenticular up to $80	$25 Copay applies to lenses or frame. Single vision, lined bifocal and trifocal lenses covered in full. Average 35% to 40% discount on lens options	$25 Copay then plan pays: Single up to $25 Bifocals up to $40 Trifocals up to $55 Lenticular up to $80
$25 Copay then plan pays up to $125 retail	Plan pays up to $68	$25 Copay	Reimbursement up to $45	$25 Copay then plan pays up to $120	$25 Copay, then plan pays up to $45
No Copay, Plan pays up to $120 all contacts Medically necessary contacts covered in full (**Contact lens fit copay:** Standard $25, after copay, covered in full; specialty $25, after copay, plan pays up to $50)	No Copay Plan pays up to $100 all contacts; $210 medically necessary contacts (**Contact lens fit copay:** Standard not covered; specialty not covered)	$25 Copay on covered-in-full qualifying lenses (covers fittings and evaluation fees, contact lenses and up to 2 follow-up visits) *See notes below	Reimbursement up to $150 elective contact lenses; $210 medically necessary contact lenses	No Copay Plan pays up to $120 conventional or disposable Medically necessary contacts covered in full	No Copay Plan pays up to $105 conventional or disposable $210 medically necessary contacts
5% - 50% Discount off surgical fees	No Benefit	15% Discount off the usual & customary price, 5% off promotional price	No Benefit	15% average off usual and customary price or 5% off the laser center's promotional price	No Benefit
20% Discount	No Benefit	Covered in full	No Benefit	$14 copay	No Benefit
20% Discount	No Benefit	Covered in full	No Benefit	$13-$15 copay	No Benefit
20% Discount	No Benefit	Covered in full	No Benefit	$15 copay	No Benefit
20% Discount	No Benefit	Covered in full	No Benefit	Covered in full for dependent children $23-$28 copay for all other members	No Benefit
*See notes below	*See notes below	Available 20-40% discount	No Benefit	$50 copay	No Benefit
20% Discount	No Benefit	Available 20-40% discount	No Benefit	$37 copay	No Benefit

UHCVision: For either glasses or contact lenses, there is one $25 materials copay. In lieu of lenses and frames, you may select contact lenses. Covered contact lens benefit includes the fitting/evaluation fee, contact lenses, and up to two follow-up visits. If covered disposable contact lenses are chosen, up to six boxes (depending on prescription) are included when obtained from a network provider. It is important to note that UHC covered contact lenses may vary by provider. Should you choose contact lenses outside the covered selection, a $150 allowance will be applied toward the fitting/evaluation fees and purchase of contact lenses (material copay does not apply). Toric and gas permeable contact lenses are examples of contact lenses that are outside of our covered contacts. Necessary contacts are covered-in-full after applicable copay. Exams, lenses, and frame benefits are provided once every calendar year.

VSP: Exam, lenses, and frame benefit provided annually. The $25 materials copay applies to lenses or frames, but not to both. Copays/prices listed are for standard lens options. Premium lens options will vary. If you choose a frame valued at more than your allowance, you'll save 20% on your out-of-pocket costs when you use a VSP doctor. Contact lenses are in lieu of spectacle lenses and frame. The $120 in-network allowance applies to the contact lenses. With a VSP provider, the contact lens exam (fitting and evaluation) is covered in full after a copay up to $60. The $105 out-of-network allowance applies to the contacts and contact lens exam. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts. Prescription glasses - 30% off additional complete pairs of glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months from your last WellVision Exam. Contact VSP or visit ***vsp.com*** to learn about retail chain Affiliate Providers.

Disability Insurance

No one expects to become disabled, but the financial burden can be eased by your coverage under the HealthChoice Disability Plan. Disability coverage pays an amount equal to 60 percent of your base salary up to a maximum dollar limit based on your age, salary, and years of service from the onset of your disability.

Eligibility

Disability benefits are available to all employees who have completed at least one month of continuous employment. No benefits are payable for any disability caused by a pre-existing condition.* Claims must be filed within one year of the date you first became disabled.

Definition of Disability

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

What the Plan Pays

The disability plan will pay a monthly income equal to 60 percent of your base pay up to a maximum (minus offsets).

Monthly Maximum Disability Income

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

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

When the Plan Pays

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

*For a complete description of the disability plan's eligibility and benefits, please refer to the HealthChoice Disability Insurance Handbook. The handbook is available online at ***www.ok.gov/sib*** or ***www.healthchoiceok.com***.

Employee Assistance Program (EAP)

The EAP is a cooperative effort between employees and administration, offering employees and their families an opportunity to seek and receive free assistance in resolving personal issues. Some of these issues include family, financial, emotional, alcohol/drug abuse, addiction, trauma, and work relationships, which adversely affect safe and efficient performance on the job. The EAP is available to help employees deal with personal issues before they result in deterioration of health, family life, or job performance. EAP specialists provide confidential assistance, information and referrals for employees/family members in using their behavioral health benefit and/or finding a community resource. EAP specialists also consult with supervisors/managers on how employees can be referred for assistance. For more information, contact your agency's Human Resource Office, review Merit Rule 530:10-21-1 through 9, or go to the Benefit web site, ***www.ebc.ok.gov***, click on *OKHealth,* then *Wellness*, then *Programs*.

Password: savenow

SoonerSave – Prepare for Retirement Wisely

SoonerSave is a voluntary long-term retirement savings plan available to State employees only. It is a division of the Oklahoma Public Employees Retirement System (OPERS) and is designed to supplement the benefit you receive from your State retirement system. SoonerSave is comprised of two defined contribution plans: The Deferred Compensation 457 Plan and the Deferred Savings Incentive 401(a) Plan. When you contribute money to SoonerSave, your contribution is deposited in the Deferred Compensation 457 Plan. As an incentive to contribute to SoonerSave, the State will contribute $25 per month to the Deferred Savings Incentive 401(a) Plan.

A few reasons to join SoonerSave today include:

• Easy Enrollment and Savings—You can now enroll in SoonerSave using the same Online Enrollment process that you use to make your other benefit elections. Just follow the directions at the end of the Benefit on-line enrollment and enter the password ***savenow*** when you are redirected to the SoonerSave Enrollment page. Decide how much you want to contribute and how you want it invested—then you are on your way to investing for your retirement through convenient payroll deduction. Your contributions to SoonerSave will begin in January.

• Tax Savings—Your contributions are deducted from your paycheck before federal and state income taxes are calculated—lowering your taxable income. Plus, your contributions and any earnings grow on a tax-deferred basis.

• Money from the State of Oklahoma—You will receive a $25 state contribution each month just for participating in SoonerSave.

Are you already participating in SoonerSave? Great! You've taken the first step to preparing yourself for retirement. Now, you may want to take the next step and increase your contribution amount using the Online Enrollment process. Increasing your contributions to SoonerSave by even a small amount could make a big difference in your long-term retirement savings plan. The table below illustrates the impact an increased:

Employee Contribution Amount	Employer Contribution Amount	Total Contribution Amount	SoonerSave Balance After 20 Years*	Monthly Benefit for 20 Years (Before Tax Withholding)*
$50/month	$25/month	$75/month	$44,177	$279.48
$100/month	$25/month	$125/month	$73,628	$465.81
$150/month	$25/month	$175/month	$103,079	$652.13
$200/month	$25/month	$225/month	$132,530	$838.45

*FOR ILLUSTRATIVE PURPOSES ONLY. This hypothetical illustration does not represent the performance of any investment options. The accumulation stage assumes an 8% rate of return, reinvestment of earnings and no withdrawals. The payout stage assumes 12 monthly payments per year with a 4.5% rate of return. Withdrawals of tax-deferred accumulations are subject to ordinary income tax. This illustration does not reflect any charges, expenses or fees that may be associated with your Plan. The tax-deferred accumulations shown above would be reduced if these fees had been deducted. In order to properly plan for your retirement years, OPERS strongly encourages you to consider participating in SoonerSave (if you are eligible) as a way to supplement the income you will receive from your defined benefit plan and Social Security. For more information about SoonerSave or to update your beneficiary information, call 1-800-733-9008 or (405) 858-6781. You can also obtain information, change your contribution amount or find enrollment forms by visiting ***www.soonersave.com***. SoonerSave is a division of the Oklahoma Public Employees Retirement System.

Benefits Details

General

Enrollment in a medical or dental plan does not guarantee that a particular doctor, dentist, clinic, or hospital will remain in your plan's network for the entire year. You enroll with the PLAN and not the provider. If your provider terminates his or her contract during the Plan Year, this does not allow you to change medical or dental plan carriers. These benefits are effective January 1, 2014. Keep this book as a reference throughout the year. This booklet is only intended to be a brief summary of certain provisions of the State of Oklahoma Employee benefit plans. In the event of a conflict between the booklet and the laws of the State of Oklahoma or administrative rules of the Employee Benefits Department (EBD) and the Employees Group Insurance Division (EGID), the laws and administrative rules shall govern in all cases.

Dental

Out-of-network benefits may allow dentists to balance bill. Balance Billing – the practice of a provider charging full fees and billing the member for the portion of the bill insurance doesn't cover.

Orthodontic benefits on the PPO options are typically only available for dependents under the age of 19 or anyone with TMD. Contact the plan to determine limits on Orthodontic benefits prior to enrollment.

If new hires and/or new enrollees did not have group dental coverage in effect prior to becoming covered under HealthChoice Dental; and Assurant Freedom PPO a 12-month waiting period is applied for orthodontic services.

*No waiting period applies for orthodontic benefits under the Delta Dental plans.

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

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

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

HealthChoice Dental Notes:

You are responsible for non-Network amounts that exceed the Allowed Charges and for all non-covered services. Age limits and restrictions may apply, please consult each plan.

Orthodontic benefits are only available to dependents under the age of 19 with certification required for members greater than 19 years of age. Contact the plan to determine limits on orthodontic benefits prior to enrollment.

*If you are a new hire and/or a new enrollee and you did not have group dental coverage in effect prior to becoming covered under HealthChoice Dental; a 12-month waiting period will be applied to orthodontic services.

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

Vision

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

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

PVCS: Member must select either in-network or out-of-network for entire plan year. In-network services are unlimited. Out-of-network services (one eye exam, one set of eyeglasses or contacts) are limited to once annually. A $50.00 service fee applies to all soft contact lens fittings; a $75.00 service fee applies to rigid or gas permeable contact lens fittings; and a $150.00 service fee applies to hybrid contact lens fittings. Simple replacements are not assessed with these fees. Limitations/Exclusions include the following: 1) Medical eye care, 2) Vision Therapy, 3) Non-routine vision services and tests, 4) Luxury frames (wholesale cost of frame exceeds $100), 5) Premium prescription lenses, and 6) Non prescription eye wear. For more information, call (888) 357-6912.

UnitedHealthcare: For either glasses or contact lenses there is one $25 materials copay. In lieu of lenses and frames, you may select contact lenses. Covered contact lens benefit includes the fitting/evaluation fee, contact lenses, and up to two follow-up visits. If covered disposable contact lenses are chosen, up to six boxes (depending on prescription) are included when obtained from a network provider. It is important to note that UHC covered contact lenses may vary by provider. Should you choose contact lenses outside the covered selection, a $150 allowance will be applied toward the fitting/evaluation fees and purchase of contact lenses (material copay does not apply). Toric, gas permeable, and bifocal contact lenses are examples of contact lenses that are outside of our covered contacts. Necessary contacts are covered in-full after applicable copay. Exams, lenses, frame benefits are provided once every calendar year.

Superior: *Materials copay applies to lenses and/or frames. Discounts for lens add-ons will be given by contracted providers with a "DP" in their listing. Online, in-network contact lens materials available at ***www.svcontacts.com***. Exams, lenses and frames are provided once per calendar year. *Progressive Lenses (no-line bifocals) – you will pay the difference between the retail price of the selected progressive lens and the retail price of the lined trifocal. The difference may also be subject to a discount. Standard contact lens fitting applies to an existing contact lens user who wears disposable, daily wear, or extended wear lenses only. The specialty contact lens fitting applies to a new contact lens wearer and/or a member who wears toric, gas permeable or multifocal lenses.

VSP: Exam, lenses and frame benefit provided annually. The $25 materials copay applies to lenses or frames, but not to both. Copays/price on premium lens options will vary. If you choose a frame valued at more than your allowance, you'll save 20% on your out-of-pocket costs when you use a VSP doctor. Contact lenses are in lieu of spectacle lenses and frames. The $120 in-network allowance applies to the contact lenses. With a VSP provider, the contact lens exam (fitting and evaluation) is covered in full after a copay up to $60. The $105 out-of-network allowance applies to the contacts and contact lens exam. Your contact lens exam is performed in addition to your routine eye exam to check for eye health risks associated with improper wearing or fitting of contacts. Prescription glasses - 30% off additional complete pairs of glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months from your last WellVision Exam.

Consumer Information & Annual Notices

The Employee Benefits Department and the Employees Group Insurance Division comply with the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996 known as HIPAA. The Employee Benefits Department, the Employees Group Insurance Division and each HMO, dental, and vision plan offered to State employees has a Privacy Notice which describes the organization protections and acceptable uses of information. To obtain a Privacy Notice from a particular plan, contact the plan directly or contact the Employee Benefits Department. HIPAA also provides you and your dependents certain rights to enroll if you lose your group health plan coverage. HIPAA also prohibits a group health plan from keeping you (or your dependents) out of the plan based on anything related to your health. Finally, HIPAA also gives you the right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without pre-existing condition exclusions. The HealthChoice medical products offered by the Employees Group Insurance Division are exempt from most of the portability provisions of HIPAA including, but not limited to, the following: limitations on pre-existing conditions, special enrollment rights, discrimination based upon a health factor, standards for mothers and newborns, mental health parity, and reconstructive mastectomies. See the section on General Eligibility Information for more details. The WOMEN'S HEALTH & CANCER RIGHTS ACT of 1998, a Federal Law, provides benefits for mastectomy related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). The 1998 Guidance, Questions and Answers, and Notice Requirements under WHCRA (November 1998), can be obtained by calling 1-866-444-3272. The BREAST CANCER PATIENT PROTECTION ACT, an Oklahoma State Law, provides for at least 48 hours of inpatient care following a mastectomy and not fewer than 24 hours following a lymph node dissection. The NEWBORNS & MOTHERS ACT of 1996, a Federal Law, requires the availability of a hospital stay of at least 48 hours in connection with a vaginal delivery and not less than 96 hours with a cesarean delivery. The PROSTATE CANCER PROTECTION ACT, an Oklahoma State Law, provides for an annual screening for early detection of prostate cancer in men age 50 and over and in men from age 40-50 who are in high-risk categories. The Oklahoma Prostate Surgery Side Effects Law provides that all health benefit plans offered by EGID & EBD shall provide coverage for side effects that are commonly associated with radical retropubic prostatectomy surgery, including, but not limited to impotence and incontinence, and for other prostate related conditions. THE MANDATED BENEFIT FOR OB/GYN COVERAGE LAW requires any health benefit plan offered in the state of Oklahoma which provides medical and surgical benefits to also provide coverage for routine annual obstetrical/gynecological examinations. The law does not diminish already allowed health benefit diagnostics. In addition the law also specifies that obstetrical/gynecological examinations do not have to be performed by an obstetrician, gynecologist, or obstetrician/gynecologist. If you have a problem which cannot be resolved through your benefit plan's grievance process, you may have remedies with the Oklahoma State Department of Health, Oklahoma Department of Insurance, or a remedy of law. Once you become covered under a group health plan, you have certain rights under the CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you can contact the Employee Benefits Department or the Employees Group Insurance Division. You may also have rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA). USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service. The law also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services. See your agency for more information.

General Eligibility Information

The following are rules of eligibility that apply to commonly occurring situations. The rules are listed in no particular order. This is not an exhaustive list. Any active State of Oklahoma employee scheduled to work at least 1,000 hours per year is eligible for benefits coverage if he/she is not a temporary or seasonal employee. New Hire coverage is effective on the first day of the month following the entry-on duty date. Coverage ends on the last day of the termination month. All eligible dependents must be covered when one dependent is covered under health, dental, or vision insurance unless proof of other group coverage is provided. Eligible dependents can include a spouse, children up to the age of 26 and incapacitated or totally disabled children of any age if their incapacity occurred and was verified prior to age 26. Two State employees cannot claim coverage for the same dependents for health, dental, and vision benefits. The Working Families Tax Relief Act of 2004 changed the definition of dependent for federal income tax purposes, effective January 1, 2005. The IRS indicates that the change is not intended to affect the coverage of dependents under employer sponsored medical plans. However if you cover dependents, EBD suggests you obtain professional tax advice when completing your income tax return(s). Thirty-day written notice is required to reinstate coverage.

Electing a TRICARE Supplement Plan

Electing to purchase a TRICARE supplement plan means that TRICARE will be primarily responsible for your medical coverage and the supplement plan will be secondarily responsible for coverage. By your election, you submit to the eligibility rules of TRICARE and the TRICARE Supplement plan. These rules may be different from the rules of eligibility created by the State of Oklahoma. Medicare may become the primary insurer upon attaining eligibility for Medicare.

Changes to Benefit Plan Elections

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

Flexible Spending Accounts Information

These accounts let you set aside money from your paycheck, pretax, to pay for planned dependent care charges and expected out-of-pocket healthcare expenses. You must enroll each Option Period or you lose the account. Plan carefully when deciding your contributions. Direct deposit of your reimbursements into the same account as your payroll deposit is required by state law. If you terminate employment with the state, any daycare or medical services must be incurred prior to the last day of your termination month. If you are not on active payroll (on some type of leave) it is your responsibility to mail in your pledged contribution. Viewing your account information is easy using the Benefits website. For further information on allowable expenses see the Benefits website at ***www.ebc.ok.gov***. Reimbursement can also be made for expenses incurred by

any participant during the Grace Period. The "Grace Period" is the period from the end of the Plan Year through March 15th of the subsequent Plan Year during which reimbursable expenses can be incurred and attributable to the previous Plan Year's account balance. The final payment of benefits for any Plan Year may be made following the close of such Plan Year based on accepted claims filed with the Plan Administrator no later than the end of the Run Out Period. The "Run Out Period" means the ninety (90) day period following a Plan Year in which claims can be made for reimbursable expenses incurred during the Plan Year. 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.

Debit Cards

The Employee Benefits Department will reimburse an FSA participant for eligible expenses incurred through use of the participant's debit card provided the participant properly activates the debit card, properly substantiates the claim for expenses, and abides by the terms of use of the debit card. The Employee Benefits Department reserves the right to set the fee charged to participants for use of the card, waive the annual fee, discontinue use of the debit card, or require paper substantiation of expenses.

The rules of eligibility for Dependent Care Accounts and Health Care Accounts apply to participants using the debit card. Upon demand a participant shall immediately refund any overpayment made by the Plan Administrator. Likewise, items charged to a debit card that are unacceptable to the Plan Administrator will require a participant to immediately refund such an overpayment to the Plan Administrator. Amounts remaining in a participant's healthcare and/or dependent care accounts following final payment of all healthcare and/or dependent care expenses incurred during the periods described in OAC 87:10-25-9(b) shall be forfeited to pay administrative expenses of the Flexible Benefits Plan.

FSA Health Care (Medical) Account Information

You spend your own money for after-insurance, qualified medical expenses, deductibles, copays and certain over-the-counter items. These expenses may be eligible for reimbursement according to the IRS Code, enabling you to submit a claim voucher with the appropriate documentation and receive reimbursement from your own tax-free account. Attach the itemized bill and/or the Insurance Explanation of Benefits (HealthChoice State Plan or Dental Indemnity Plan EOB) to your signed EBD Expense Reimbursement Voucher (claim form) and mail to the address on the form. Funds will be disbursed for the amount requested within ten days of receipt if you submit all required documentation. Check out the list of approved over-the-counter items on the benefits website. Documentation required for approved OTC items is the computerized receipt, name of item, date of purchase, and amount paid. Pharmacy labels need to include the printed name of the drug. The date of service is the date you incur the expense (i.e. date you drop off the prescription at the pharmacy, date you receive the medical care). This date must be during the plan year and while actively participating in the program (making monthly contributions). Claim deadlines are Fridays, at 1:00 p.m. (Subject to change during holidays).

FSA Dependent Care Account Information

If you have an eligible dependent (children 12 or younger who have been included on your income tax return or any other eligible dependent person physically or mentally incapable of self-care) who spends at least eight hours a day in your home, you may want to participate in the Dependent Care Flexible Spending Account. This account pays daycare provider expenses while you and your spouse work up to a combined calendar year total of $5,000. The daycare provider cannot also be your tax dependent.

Form 2441 must still be filed with your taxes. You can receive reimbursement for the amount you have currently deposited in your Dependent Care Account. With proof of payment and the dates of service your daycare provider is no longer required to sign the Dependent Care acknowledgement form.

Termination of Employment

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

Change of Address

The Employee Benefits Department must be notified immediately of any change of address for the employee and/or dependents. In the event of the change of address, contact your agency's Benefits Coordinator or make your address change online in EBD's Benefits Administration System (BAS) under the Basic Information screen.

Prescription Drug Plan Creditable Coverage Statement The Employee Benefits Department has determined that the prescription drug coverage with the State of Oklahoma Employee Benefits Department Health Plans is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Because your coverage through your health plan offered through the Employee Benefits Department is on average at least as good as standard Medicare prescription drug coverage, you can keep your coverage and not pay extra if you later decide to enroll in Medicare coverage. If you decide to enroll in a Medicare prescription drug plan and drop your State of Oklahoma Employee Benefits Department prescription drug coverage, be aware that you may not be able to get this coverage back. A notice of creditable coverage is provided in the back pocket of this Guide and can also be obtained by contacting the Employee Benefits Department at (405) 522-1190 or downloading a copy from the benefits website at ***www.ebc.ok.gov***

Automatic Premium Conversion Election:

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

Glossary

BAS – Benefits Administration System – Benefits system for all active state employees. You can sign on from ***www.ebc.ok.gov*** (upper right corner).

Co-insurance – A percentage of each health insurance claim above the deductible paid by the member. For a 20-percent health coinsurance clause, the policyholder pays for the deductible and co-pay, plus 20 percent of covered charges, while the plan pays the other 80 percent.

Co-pay – A predetermined, flat fee an individual pays for health, dental or vision care services, in addition to what insurance covers.

"Cover One, Cover All" – All eligible dependents must be covered when one dependent is covered under health, dental, or vision insurance unless proof of other group coverage is provided.

Coverage – The scope of protection provided under an insurance policy.

Date of Service – The date the medical care is provided to the participant (date of prescription, order date of glasses, dentures, hearing aids, etc.), not when formally billed, charged for, or paid. For terminated employees: date of medical care must be prior to the end of the month of the termination month.

Deductible – Amount of loss that the insured pays before the insurance kicks in.

Dependent – A family member or other person who is supported financially by another, especially one living in the same house. This typically includes the spouse and/ or eligible children of the state employee.

Employee ID – six-digit number assigned by the Office of State Finance for all employees. The Employee ID appears on your payroll stub. The Employee ID is used to access the Benefits Administration System (BAS).

Explanation of Benefits (EOB) – A report from your insurance carrier that shows what recent treatment was allowed as covered under your plan, what they have paid, what the provider must write off, and what the employee owes for particular dates of service.

Flexible Spending Account (FSA) – An account in which an employee can deposit payroll deductions for future medical or childcare expenses and in so doing, reduce taxable income.

Grace Period – January 1 to March 15. This is the period of time when you can use previous year funds from your spending account for current year services. This period of time allows employees with a previous years balance to continue to spend funds that would otherwise have been forfeited. Our system is programmed to use these funds first whenever claims are processed during the grace period.

HMO – Health Maintenance Organization. Out-of-pocket expenses for members are limited to set co-pays. All have defined coverage areas, based on zip codes.

Health Savings Account (HSA) – An account that allows you to contribute pre-tax money to be used for qualified medical expenses. HSAs, which are portable, must be linked to a high-deductible health insurance policy.

Itemized Statement – Itemized Invoice from the person providing services showing NATURE OF the expense, FOR WHOM it was incurred, AMOUNT CHARGED for the services, and DATES OF SERVICES including insurance payment and any write off (or denies to pay). Cancelled checks and charge receipts do not include the necessary information.

OTC Rule – The health care reform legislation (PPACA) signed into law by the President impacts over-the-counter (OTC) purchases with Health Care Flexible Spending Accounts beginning in January of 2011. OTC drugs, medicines and biologicals remain eligible, but only with a letter of medical necessity from a medical provider. NOTE: Because these items now require a doctor's directive, these items can no longer be purchased by the debit card program; however, they could be reimbursed by filing a paper claim with a doctor's letter of medical necessity.

PCP – Primary Care Physician. This is the doctor you typically see first for medical problems and routine care. Naming a PCP is required for State employees and their families who choose an HMO.

PPO – Preferred Provider Organization. The only PPO like options for State employees and their families come from HealthChoice's plans, which operate as PPOs and self-insured indemnity plans. The plans are available statewide and out-of-pocket expenses include co-pays, deductibles and co-insurance.

Premium Audit – A review of an employee's benefits account that seeks to reconcile premiums paid with premiums due, according to enrolled options.

Accounts are periodically audited to assure accuracy. A notification may be sent to the employee and their agency if insurance premiums or flexible spending accounts are found to have been overpaid or underpaid.

Premium Conversion – A program based on federal tax rules that let employees deduct their share of insurance premiums from their taxable income, thereby reducing their taxes.

"Use It or Lose It" – FSA participants must spend their total annual election amount by March 15th of the following year, otherwise the remaining funds will be forfeited. For example, if participants did not use all of their Plan Year 2014 FSA funds by March 15, 2015, they would lose those funds.

Notes