Quick-Start Guide To Your Health Plan

2018-19 Plan Year

Welcome to the Oklahoma Public Employees Health & Welfare Plan (OPEH&W). Some of the Plan's benefits are outlined below. The Plan year runs from July 1-June 30th. For more detailed information, please refer to the Plan's Benefit Book which is available on our website at www.opehw.com.

Medical Coverage Highlights

Vendor: BlueCross BlueShield of Oklahoma (www.bcbsok.com) **Customer Service**: 800.672.2567

Annual Out-of-Pocket Maximum:
In-Network Claims - **$5,000** per individual - **$10,000** max per family of 2 or more.
Out-of-network Claims - **$10,000** per individual - **$20,000** max per family of 2 or more.
Note - Amounts paid for Office Visit Co-pays, Deductibles and Co-Insurance count towards the Annual Out-of-Pocket Maximum. HOWEVER, amounts paid for in-network coverage DO NOT count towards out-of-network coverage and vice versa.

Office Visit Co-pays:
In-Network Office Visits with a primary care physician - **$20**. In-Network Office Visits with a specialist - **$50**. The Office Visit Co-pay only applies to the Office Visit charge; it does not count towards any additional services received during the visit.

Deductibles:
In-Network - **$750** per individual per Plan Year - **$1,500** max per family of 2 or more.
Out-of-Network - **$1,500** per individual per Plan Year - **$3,000** max per family of 2 or more.
The Plan offers a Deductible Reimbursement Program for Dependent Children. See the Plan's Benefit Book for details and reimbursement amounts.

Co-Insurance (after deductible has been met):
In-Network **Blue Preferred PPO** Providers - member pays **20%** co-insurance.
Out-of-Network Providers - member pays **30%** co-insurance. When using Out-of-Network providers, the member is also responsible for any amounts billed above the Plan's allowable charge (also known as balance billing). However, if the member uses a Blue Choice PPO Provider outside the state of Oklahoma, balance billing does not apply.

Prescription Drug (Rx) Coverage Highlights

Vendor: Express Scripts (www.express-scripts.com) **Customer Service:** 855.315.2460

Annual Out-of-Pocket Maximum:
In-Network claims - **$2,000** per individual - **$4,000** max per family of 2 or more.
Out-of-Network claims – **no** annual out-of-pocket maximum.

Rx Deductible:
$50 per Plan Year for Brand Name medications only (per person, not per drug)

Rx Co-Pays - Retail Pharmacy:

30-Day supply		**90-Day supply (if available) for 2 1/2 copays**	
Generic	**$10**	Generic	**$25**
Brand	**$45**	Brand	**$112**

Mail Order Rx:
Get a 90 Day supply for 2 1/2 Co-pays (doesn't apply to Specialty Drugs)

Specialty Rx:
$10 Generic **/ $60** Brand Name **/ $100** Non-Preferred Brand
Mail Order Pharmacy only, 30 day supply

Rx Benefit Enhancements:
Prescription required
OTC = Over-The-Counter

$0 Oral Contraceptives & Devices
$5 OTC Anti-Allergy Medications (Allavert, Claritin, Nasacort, Mucinex, Flonase & Zyrtec)
$0 OTC Prilosec, Prevacid, Omeprazole and Nexium
$5 Generic Diabetic Medications and Diabetic Supplies (or **$12** for a **90**-day supply)
$0 Tobacco Cessation Products (limitations & exclusions apply)

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Dental Coverage Highlights (If Applicable)

Vendor: BlueCross BlueShield of Oklahoma (www.bcbsok.com) Customer Service: 888.381.9727

Plan Year Maximum:	**$1,500** per individual per Plan Year
Plan Year Deductible:	**$50** per individual per Plan Year
Preventive & Diagnostic Services:	Plan pays **100%** of In-Network services, twice per plan year, not subject to deductible. Examples include : cleaning, polishing, bite-wing x-rays & prophylaxis.
Basic Services:	Plan pays **80%** of allowable charges up to the Plan Year Maximum of **$1,500**. You pay **20%** after meeting your Plan Year Deductible. Once the Plan has paid the Plan Year Maximum, you are then responsible for any remaining charges. Examples of Basic Services include, but are not limited to: fillings, simple extractions, surgical removal of teeth, root canals.
Major Services:	Plan pays **50%** of allowable charges up to the Plan Year Maximum of **$1,500**. You pay **50%** after meeting your Plan Year Deductible. Once the Plan has paid the Plan Year Maximum, you are then responsible for any remaining charges. Examples of Major Services include, but are not limited to: crowns, full and partial dentures, bridge repairs, occlusal guards.
Orthodontics:	Coverage for dependent children only, up to age **26**. Plan pays **50%** of allowable charges, up to a **$1,500** Lifetime Maximum, then member pays **100%** of services.

Vision Coverage Highlights (If Applicable) - Enhanced Plan

Vendor: VSP (www.vsp.com) Customer Service: 800.877.7195

Annual Eye Exams:	**$10** Co-pay for **1** eye exam every **12** months
Prescription Glasses:	**$25** Co-pay for **1** set of frames and/or lenses every **12** months. Covered lens options include: single vision, lined bifocal, lined trifocal, photochromic lenses and polycarbonate lenses for children. Progressive (No-Line) lenses are available for an additional Co-pay. Frame allowance of **$120**, then receive a **20%** discount for any amount over your allowance. See the Plan's Benefit Book for more information.
Contacts (instead of glasses):	Once every **12** months, you get a **15%** discount off your contact lens fitting and evaluation and pay a maximum of **$60**. You also get a **$120** allowance to spend on Contact Lenses.
Laser Vision Correction:	Discounts available, contact VSP for more details.

Group Term-Life Coverage Highlights (If Applicable)

Following are the Group Term-Life amounts available to each Group. These amounts vary by Group so please check with your Benefit Coordinator to determine which amount applies to your Group.

Group Life Employee Amounts:*	**$20,000**	**$30,000**	**$40,000**	**$50,000**
Group Life Spouse Amounts:	**$5,000**	**$7,500**	**$10,000**	**$12,500**
Group Life Child Amounts:	**$2,000**	**$3,000**	**$4,000**	**$5,000**

*Group Term-Life Coverage is guaranteed issue and usually paid for by your Employer. Group Life also includes an Accidental Death & Dismemberment (AD&D) benefit, which pays twice the amount if you are killed in an accident. It also pays a benefit if you should suffer an injury in an accident, such as loss of a limb, loss of the use of a limb, loss of sight or loss of hearing. AD&D coverage is only available to the employee.

Additional Life Coverage: Check with your Benefit Coordinator for additional life coverage availability.

For additional questions or help please contact the OPEH&W Plan Administration Office: 800.468.5744