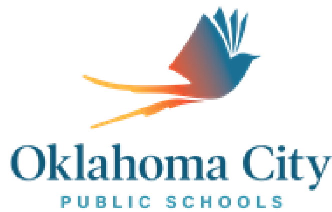

DECLINING HEALTH INSURANCE FORM

EMPLOYEE INFORMATION

Last Name: **First Name:**

SSN: **Hours per Week:** **ID#:** **Hire Date:**

REASON FOR DECLINING COVERAGE:

☐ I am enrolled on my spouse's health insurance plan.

☐ I am enrolled on an individual health plan.

☐ I am not enrolled on any health insurance plan but do not want this coverage.

☐ Other ____

NOTICE: If you are declining Medical Coverage for yourself, your spouse, or your dependents as a new hire you may in the future be able to enroll during Open Enrollment or if a Qualifying Event were to occur.

Qualifying events for Special Enrollment include, termination of employment, reduction of work hours, legal separation, divorce, death, or if COBRA/state mandated continuation of coverage has been exhausted. A change form will need to be turned in the HR office along with documentation of the Qualifying event.

Open Enrollment occurs during the fall each year and gives our employees the opportunity to enroll and/or to change selected group insurance plans

STATEMENT: I have been offered Health Coverage and have elected not to be covered. I understand the Notice above and do not wish to enroll as New Hire at this time. I have read completely the guidelines attached and understand the process. I have asked all questions that I need answered prior to signing this form.

Employee Signature:	**Date:**

☐ I plan on enrolling in coverage within my 30 day window. I understand by signing this form that if I do not return my Health Insurance Enrollment form I will not have health coverage and will not be able to enroll unless there is a qualifying event to take place or during Annual Open Enrollment.

Teachers' Retirement System of Oklahoma
P.O. Box 53524
Oklahoma City, OK 73152-3524
TRS Member Services: 877-738-6365 (toll-free)
or 405-521-2387 (OKC)

INSTRUCTIONS FOR COMPLETING BENEFICIARY DESIGNATION FORM 2A

This beneficiary form applies to active and non-retired members of the Teachers' Retirement System of Oklahoma (TRS). If you are retired and wish to update or make changes to your beneficiary designation, please use Beneficiary Designation Form 2R. The beneficiary designations you make on this form revoke and replace all prior beneficiary designations with TRS. Your designations do not become effective until this form is **signed by you** and **received** by TRS. Do not alter this form. **Remember to keep a copy of your completed form for your records.**

It is very important that you provide the **full legal name, address, relationship, date of birth, and Social Security number of each beneficiary you designate**. This information is essential in ensuring that your named beneficiaries can be located and receive your intended benefit amount. The Beneficiary Designation Form has two Sections: Member Account and Death Benefit.

Section 1. Member Account - Upon the death of a member who has not retired, the designated beneficiary(ies) shall receive the member's account balance as provided by law. Provided, if more than one primary beneficiary is named, the beneficiary shall not have the option to choose Option 2 (joint annuitant) retirement, if applicable, upon the member's death. If you have more than four primary beneficiaries, use a copy of this page.

Section 2. Death Benefit - Upon the death of an active (in-service) member who has not retired, TRS will pay to a beneficiary an $18,000 death benefit as provided by law. The member may designate the same beneficiary(ies) listed in Section 1 or a different beneficiary(ies) to receive the death benefit. Provided, if the beneficiary in Section 2 differs from the sole beneficiary of the member's account in Section 1, no beneficiary shall have the option to choose Option 2 (joint annuitant) retirement, if applicable, in lieu of the death benefit. If no beneficiary is named in Section 2, the death benefit shall be paid to the beneficiary(ies) named in Section 1.

Each Section has three parts: Member Information, Primary and Contingent Beneficiary Designation, and Signature. **Please print clearly in ink.**

Member Information – Provide your full legal name and SSN or Member ID.

Primary Beneficiary Designation – You can designate one or more primary beneficiaries. All primary beneficiaries share equally unless you note otherwise. If multiple primary beneficiaries are named and a primary beneficiary dies before or simultaneously with you, the remaining primary beneficiary(ies) will be entitled to equal shares of the deceased beneficiary's designated benefit amount.

Contingent Beneficiary Designation – You can designate one or more contingent beneficiaries. Contingent beneficiaries receive benefits only in the event all primary beneficiaries die before or simultaneously with you. All contingent beneficiaries share equally unless you note otherwise on your form. If multiple contingent beneficiaries are named and a contingent beneficiary dies before or simultaneously with you, the remaining contingent beneficiary(ies) will be entitled to equal shares of the deceased beneficiary's designated benefit amount.

Signature– You must sign and date each page of the form.

Mail completed Beneficiary Designation Forms to:
Teachers' Retirement System of Oklahoma
P.O. Box 53524
Oklahoma City, OK 73152

BENEFICIARY DESIGNATION (ACTIVE or NOT RETIRED)-MEMBER ACCOUNT

______________________________ ______________________
Member Name Member SSN or TRS Member ID

SECTION 1 –MEMBER ACCOUNT: Upon the death of a member who has not retired, the designated beneficiary(ies) shall receive the member's account balance as provided by law.

A. **PRIMARY BENEFICIARY(IES)**: It is very important to clearly indicate your primary beneficiary(ies). Upon the death of any designated primary beneficiary, his/her interest shall pass to the surviving primary beneficiary(ies). If multiple primary beneficiaries are named and no percentage distribution is noted, any proceeds payable to such beneficiaries will be divided equally. Provided, if more than one primary beneficiary is named, the beneficiary shall not have the option to choose Option 2 (joint annuitant) retirement, if applicable, upon the member's death. If you have more than four primary beneficiaries, use a copy of this page to list additional beneficiaries.

I hereby designate:

Name	Date of Birth	SSN	Address	Relationship	Share (must equal 100%)

B. **CONTINGENT BENEFICIARY(IES):** Proceeds are paid to contingent beneficiary(ies) only if there is no surviving primary beneficiary(ies) living at the member's death. If multiple contingent beneficiaries are named and no percentage distribution is noted, any proceeds payable to such beneficiaries will be divided equally. If you have more than four contingent beneficiaries, use a copy of this page to list additional beneficiaries.

I hereby designate:

Name	Date of Birth	SSN	Address	Relationship	Share (must equal 100%)

Revoking Previous Designation of Beneficiary: By making these elections, I hereby revoke all other former designations made by me and expressly reserve the right to make other and further changes at any time I may elect as provided by law. If there is no designated beneficiary living at the time of my death, any amount due me shall be paid as provided by Oklahoma law.

______________________________ ______________________
Member's Signature Date

The member's signature must appear exactly as the name appears on the top of this form.

Minor Beneficiary: Under Oklahoma law, if a minor child (younger than 18 years of age) is designated as beneficiary, it will be necessary that a guardian be appointed by the court before payment is made.

TRS shall not be responsible for determining the competency of any member to designate/change beneficiaries, except as otherwise provided by Oklahoma law, and shall not be liable for the validity of the beneficiary designation.

BENEFICIARY DESIGNATION (ACTIVE or NOT RETIRED)-<u>DEATH BENEFIT</u>

Member Name ____________________ Member SSN or TRS Member ID ____________________

SECTION 2 – DEATH BENEFIT: Upon the death of an active (in-service) member who has not retired, TRS will pay to a beneficiary an $18,000 death benefit as provided by law. The member may designate the same beneficiary(ies) listed in Section 1 or a different beneficiary(ies) to receive the death benefit. Provided, if the beneficiary for the $18,000 death benefit differs from the sole beneficiary of the member's account, no beneficiary shall have the option to choose Option 2 (joint annuitant) retirement, if applicable, in lieu of the death benefit. If no beneficiary is named in Section 2, the death benefit shall be paid to the beneficiary(ies) named in Section 1.

A. PRIMARY BENEFICIARY(IES): It is very important to clearly indicate your primary beneficiary(ies). Upon the death of any designated primary beneficiary, his/her interest shall pass to the surviving primary beneficiary(ies). If multiple primary beneficiaries are named and no percentage distribution is noted, any proceeds payable to such beneficiaries will be divided equally. If you have more than four primary beneficiaries, use a copy of this page to list additional beneficiaries.

I hereby designate:

Name	Date of Birth	SSN	Address	Relationship	Share (must equal 100%)

B. CONTINGENT BENEFICIARY(IES): Proceeds are paid to contingent beneficiary(ies) only if there is no surviving primary beneficiary(ies). Contingent beneficiaries do not share in the amount due if any of the primary beneficiaries are living at the member's death. If multiple contingent beneficiaries are named and no percentage distribution is noted, any proceeds payable to such beneficiaries will be divided equally. If you have more than four contingent beneficiaries, use a copy of this page to list additional beneficiaries.

I hereby designate:

Name	Date of Birth	SSN	Address	Relationship	Share (must equal 100%)

Revoking Previous Designation of Beneficiary: By making these elections, I hereby revoke all other former designations made by me and expressly reserve the right to make other and further changes at any time I may elect as provided by law. If there is no designated beneficiary living at the time of my death, any amount due me shall be paid as provided by Oklahoma law.

Member's Signature ____________________ Date ____________________

The member's signature must appear exactly as the name appears on the top of this form.

Minor Beneficiary: Under Oklahoma law, if a minor child (younger than 18 years of age) is designated as beneficiary, it will be necessary that a guardian be appointed by the court before payment is made.

TRS shall not be responsible for determining the competency of any member to designate/change beneficiaries, except as otherwise provided by Oklahoma law, and shall not be liable for the validity of the beneficiary designation.

OKLAHOMA
Office of Management
& Enterprise Services

Employees Group Insurance Division
INSURANCE ENROLLMENT FORM
CURRENT EMPLOYEES

EMPLOYER INFORMATION (To be completed by insurance coordinator)

Group number 554089 Division number 0503 Group name Oklahoma City Public Schools

☑ New hire enrollment ☐ Midyear enrollment

EMPLOYEE INFORMATION (Please print)

SSN ____________ ☐ Married ☐ Single

Employee name (Please print)	First name	MI	Last name

Mailing address ____________

City State ZIP code

Primary telephone ____________ Email address ____________

Employee birth date	Mo.	Day	Yr.	Sex
				☐M ☐F

Effective date of coverage	Mo.	Day	Yr.
		0 1	

EMPLOYEE HEALTH PLAN ELECTION

☐ CommunityCare HMO ☐ Global Health HMO ☐ BlueLincs HMO
☐ HealthChoice Basic ☐ HealthChoice High ☐ HealthChoice High Deductible Health Plan (HDHP)

Employee primary physician (HMO only) ____________ ☐ Current patient ☐ New patient

EMPLOYEE DENTAL PLAN ELECTION

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

Employee primary dentist (prepaid plans only) ____________ ☐ Current patient ☐ New patient

EMPLOYEE VISION PLAN ELECTION

☐ Primary Vision Care Services
☐ Superior Vision
☐ Vision Care Direct
☐ Vision Service Plan

EMPLOYEE LIFE PLAN ELECTION

Basic and Supplemental Life can be added only during initial enrollment, during Option Period, or within 30 days of the loss of other group life insurance (with proof of loss). Guaranteed Issue (GI) Supplemental Life is equal to two times your annual salary rounded up to the next $20,000 unit. The maximum amount of Supplemental Life you can have in force at any time is $500,000. **To request amount above your GI, you must submit a Life Insurance Application for approval.**

☐ **Basic Life (required for enrollment in Supplemental Life)** **$** ____________
☐ **Supplemental Life (in $20,000 units)** **$** ____________

Total Employee Life Insurance Requested (Basic and Supplemental) **$** ____________

Dependent Life
☐ Premier Option (spouse = $20,000, each child = $10,000)
☐ Standard Option (spouse = $10,000, each child = $5,000)
☐ Low Option (spouse = $6,000, each child = $3,000)

FOR EGID USE ONLY

☐ **HEALTHCHOICE DISABILITY** (Available only to certain county employees)

DEPENDENT INFORMATION

SPOUSE

☐ Health Name ______________ SSN ______________

☐ Dental Date of birth ______________ ☐ Male ☐ Female

☐ Vision Primary physician ______________ ☐ Current patient ☐ New patient

☐ Dependent Life Primary dentist ______________ ☐ Current patient ☐ New patient

*Does your spouse currently have coverage through EGID? ☐ Yes ☐ No (If yes, list name and SSN above.)

CHILD

☐ Health Name ______________ SSN ______________

☐ Dental Date of birth ______________ ☐ Male ☐ Female

☐ Vision Primary physician ______________ ☐ Current patient ☐ New patient

☐ Dependent Life Primary dentist ______________ ☐ Current patient ☐ New patient

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CHILD

☐ Health Name ______________ SSN ______________

☐ Dental Date of birth ______________ ☐ Male ☐ Female

☐ Vision Primary physician ______________ ☐ Current patient ☐ New patient

☐ Dependent Life Primary dentist ______________ ☐ Current patient ☐ New patient

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CHILD

☐ Health Name ______________ SSN ______________

☐ Dental Date of birth ______________ ☐ Male ☐ Female

☐ Vision Primary physician ______________ ☐ Current patient ☐ New patient

☐ Dependent Life Primary dentist ______________ ☐ Current patient ☐ New patient

PLEASE USE THE DEPENDENT ATTACHMENT FORM TO LIST ADDITIONAL DEPENDENTS
(You can obtain this form from your insurance coordinator)

I certify that all selections made on this form are true and in compliance with the Plan Guidelines for Insurance Enrollment. I agree to deliver documentation that authenticates this statement to the requesting entity.

Employee signature ______________ **Date** ______________

SPOUSE MUST SIGN IF COMMON-LAW OR EXCLUDED FROM HEALTH, DENTAL AND/OR VISION COVERAGE.

☐ **COMMON-LAW SPOUSE CERTIFICATION:** I certify the person listed as my spouse and we have an actual and mutual agreement between ourselves to be married; that this is a permanent relationship, and our relationship is exclusive, as proven by our cohabitation as spouses; and do hereby hold ourselves out publicly as married. **I am aware this relationship can be dissolved only by legal divorce.**

☐ **SPOUSE EXCLUSION CERTIFICATION** (required only if children are covered and spouse is not): I certify that I am aware **I am being excluded from health, dental and/or vision coverage as indicated on this form.** I am also aware that an employee who elects to cover all eligible dependent children and **not** their spouse will not have the opportunity to enroll their spouse until either the next annual Option Period or a change of status event occurs.

Spouse signature ______________ **Date** ______________

I certify this enrollment complies with the provisions of the employer's Section 125 Plan or, if no 125 Plan is offered, complies with new hire or allowed midyear coverage enrollments as defined by Title 26, Section 125, of the Internal Revenue Codes (as amended) and pertinent regulations. I further certify that on this date, this employee's annual salary listed below (if required) is correct to the best of my knowledge.

Employee's annual salary (Required for Supplemental Life **in excess of** $20,000) $ ______________

Insurance coordinator signature ______________ **Date** ______________
(Must be signed by insurance coordinator to be valid)

Employees Group Insurance Division
Beneficiary Designation Form

Please read the instructions carefully and complete this form in ink.

SSN or Member ID: ____________________ Member Name: ____
First MI Last

Address: ____
☐ New Address Street City State ZIP

Phone: (____) ______________________________ Alt Phone: (____) __________________________

Important*: Please ensure the "Share Percentage" section in both Primary Beneficiary(ies) and Contingent Beneficiary(ies) add up to 100 percent. Payment will be made in equal shares to all surviving beneficiaries unless otherwise indicated.

PRIMARY BENEFICIARY(IES)

Primary Beneficiary's Name and Address	SSN	Phone #	Relationship	Date of Birth	Share Percentage
					100%

CONTINGENT BENEFICIARY(IES)

Proceeds are paid to the contingent beneficiary(ies) identified below only if there is no surviving primary beneficiary(ies).

Contingent Beneficiary's Name and Address	SSN	Phone #	Relationship	Date of Birth	Share Percentage
					100%

I have named the above beneficiary(ies) to receive my life insurance benefits from HealthChoice. I understand this form replaces and cancels all prior beneficiary designations and will become effective only when it is received by EGID.

______________________________________ ____________________
Member Signature - original signature required Date

Mail this form to OMES EGID at P.O. Box 11137, Oklahoma City, OK 73136-9998

Instructions for Completing the Beneficiary Designation Form

This beneficiary form applies to the HealthChoice Life Insurance Plan offered through the Office of Management and Enterprise Services Employees Group Insurance Division. If you are retired, it does not affect the beneficiaries for any death benefit you may have through your retirement system.

The beneficiary designations you make on this form replace and cancel all prior life insurance beneficiary designations with EGID. Your designations do not become effective until this form is **signed** and **received** by EGID. Do not alter this form or attach additional pages.

It is very important that you provide the **full legal name, address, relationship, date of birth and Social Security number of each beneficiary you designate.** This information is essential in ensuring that your named beneficiaries can be located and receive your intended benefit amount. The Beneficiary Designation Form has three parts: Member Information, Primary and Contingent Beneficiary Designation and Signature. **Please print clearly in ink.**

Employer Name – Provide the name of your employer. This information is not required of a former employee/retiree.

Member Information – Provide your name, SSN or Member ID and address.

Primary Beneficiary Designation – You can designate one or more primary beneficiaries. All primary beneficiaries share equally, unless you note otherwise. In the event that multiple primary beneficiaries are named and a primary beneficiary dies before or simultaneously with you, the remaining primary beneficiary(ies) will be entitled to equal share of the deceased beneficiary's designated benefit amount.

Contingent Beneficiary Designation – You can designate one or more contingent beneficiaries. Contingent beneficiaries receive benefits only in the event all primary beneficiaries die before or simultaneously with you. All contingent beneficiaries share equally, unless you note otherwise on your form. In the event that multiple contingent beneficiaries are named and a contingent beneficiary dies before or simultaneously with you, the remaining contingent beneficiary(ies) will be entitled to equal share of the deceased beneficiary's designated benefit amount.

Signature – You must sign and date your form.

Special Beneficiary Designations

Sometimes members wish to make a special designation for trusts, minors or institutions. If you wish to make a special designation, please read the following information carefully.

Designating a trust as beneficiary – To designate a trust as beneficiary, provide the actual name of the trust and the date the trust was created in the space provided.

Designating a minor as beneficiary – A minor can be named your beneficiary; however, it is often difficult and costly for a minor to receive payment, especially if the amount exceeds $10,000. Before you designate a minor as your beneficiary, you should consult an attorney or professional financial advisor.

Designating an institution as beneficiary – To designate an institution (church, charity, funeral home, etc.) as your beneficiary, provide the full name of the institution and list the address in the space provided.

After you complete and sign the Beneficiary Designation Form, mail it to:

Office of Management and Enterprise Services
Employees Group Insurance Division
P.O. Box 11137, Oklahoma City, OK 73136-9998

Remember to keep a copy of your completed form for your records.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) AND DISABILITY INCOME INSURANCE ENROLLMENT OPEN ENROLLMENT M/D/Y THROUGH M/D/Y

ReliaStar Life Insurance Company, Minneapolis, MN
Telephone: 800-955-7736
A member of the Voya® family of companies

PLAN INFORMATION section to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. **All** new Life or Disability Income coverage or **any** increases in Life or Disability Income coverage will require evidence of insurability if plan participation requirements are not met. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

PLAN INFORMATION

Employer/Plan Sponsor Name Oklahoma City Public Schools ________ Effective Date of Coverage or Change ________
Group/Plan Number 706451 ________ Account Number/Location 0001 ________
Class/Occupation ________
Date of Hire ________ Annual Salary $________ Employment Status: ☐ Active Full-Time ☐ Active Part-Time ☐ Retired
This change is due to *(Check all that apply.)*:
☐ Initial Eligibility Following Hire ☐ Change in Coverage Amount ☐ Late Entrant [1] ☐ Other ________

[1] A late entrant is an individual who is first enrolling after the initial available opportunity.

EMPLOYEE INFORMATION

Employee Name *(First, Middle Initial, Last)* ________
Birth Date ________ SSN ________ Gender: ☐ Male ☐ Female
Employee ID Number ________ Work Phone (____)________ Home Phone (____)________
Address ________ City ________ State ________ ZIP ________

EMPLOYEE LIFE / AD&D INSURANCE

Basic Life / AD&D Insurance Election

☑ Employee Only—Elect Coverage *(Note: Basic Life insurance is employer provided.)*
☐ Waive coverage.

Supplemental Life Insurance

Guaranteed Issue (GI) Limit = $150,000. When you are first eligible for supplemental life coverage, you can elect up to the GI Limit without evidence of insurability. At each annual enrollment, if you have current supplemental life coverage you can elect to increase supplemental life coverage by one plan increment without evidence of insurability. Total supplemental life coverage up to $400,000 is available if you complete an Evidence of Insurability form subject to approval by the insurance company.

Supplemental Life Insurance Election

☐ I currently have supplemental life coverage of: $________.
☐ I am applying for additional supplemental life coverage of: $________. *($25,000 increments, not to exceed 5 TIMES MY ANNUAL SALARY)*
☐ Total supplemental life coverage (current plus additional): $________.
☐ Waive coverage.

BENEFICIARY INFORMATION

(Designate your beneficiary(ies) below. Percentages must total 100%, using whole percentages only. If additional space is required please attach a separate signed and dated document with the same information for each beneficiary.)

	Name *(First, MI, Last)*	DOB	Gender	SSN / TIN	Relationship	%	Beneficiary Type
1			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			
2			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			
3			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			

SPOUSE LIFE INSURANCE *(The use of "spouse" in this form means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the plan. Please contact the Employer for more information.)*

When you are initially eligible for Spouse coverage, you can elect up to $20,000 in coverage without evidence of insurability. Total Spouse coverage up to $100,000 is available if Spouse completes an Evidence of Insurability form subject to approval by the insurance company. Spouse coverage is limited to 50% of the employee's coverage amount.

Spouse Name *(First, Middle Initial, Last)* ______________________________ Birth Date ______________

Spouse Life Insurance Election

☐ Elect: $______________ *($10,000 increments)*

☐ Waive coverage.

Note: The employee is the beneficiary for any Spouse insurance coverage.

CHILDREN LIFE INSURANCE

When you are initially eligible for Children coverage, you can elect it without evidence of insurability. At all other times, you must complete an Evidence of Insurability form for your children subject to approval by the insurance company. Coverage is limited to 50% of the employee's coverage amount.

Children Life Insurance Election

☐ $10,000 for each eligible child

☐ Waive coverage.

Note: The employee is the beneficiary for any Children insurance coverage.

SPOUSE AND CHILDREN INFORMATION

Enter information below. If additional space is required please attach a separate document.

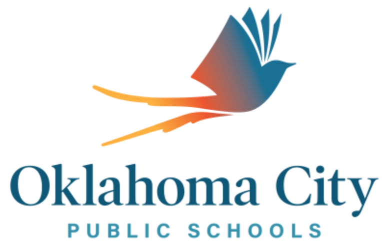
	Spouse Name *(First, MI, Last)*	DOB	Gender	SSN
			☐M ☐F	
	Address			**Phone ( )**

	Child Name *(First, MI, Last)*	DOB	Gender	SSN
1			☐M ☐F	
	Address			**Phone ( )**
2			☐M ☐F	
	Address			**Phone ( )**
3			☐M ☐F	
	Address			**Phone ( )**

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by ReliaStar Life Insurance Company, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

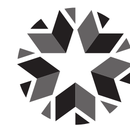
Employee Signature ______________________________ Date ______________



Retirement Savings Annuity Vendors

Vendors	Product	Phone Number
American Fidelity	403(b) and 457(b)	405-416-8810
Valic	403(b) and 457(b)	1-800-448-2542

Monthly Premiums for Current Employees
Plan Year Jan. 1-Dec. 31, 2023



OKLAHOMA
Office of Management
& Enterprise Services

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Blue Cross Blue Shield of Oklahoma – BlueLincs HMO	$ 580.46	$ 798.04	$ 538.06	$ 1,255.14
CommunityCare HMO	$ 622.06	$ 729.34	$ 312.90	$ 530.98
GlobalHealth HMO	$ 932.72	$ 1,376.78	$ 532.64	$ 869.82
HealthChoice High and High Alternative	$ 640.28	$ 750.70	$ 322.08	$ 546.54
HealthChoice Basic and Basic Alternative	$ 511.82	$ 600.64	$ 263.94	$ 446.46
HealthChoice High Deductible Health Plan (HDHP)	$ 446.30	$ 524.08	$ 230.52	$ 389.18

TRICARE SUPPLEMENT	MEMBER	MEMBER + ONE	MEMBER + TWO OR MORE
Selman & Company	$ 65.50	$ 129.50	$ 181.00

DISABILITY (Employee only)	$ 10.36 (Limited city and county participation only)

DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
BCBSOK – BlueCare Dental High Plan	$ 35.08	$ 35.08	$ 28.44	$ 72.52
BCBSOK – BlueCare Dental Low Plan	$ 23.84	$ 23.84	$ 20.60	$ 50.40
Cigna Prepaid High (K1I09)	$ 12.56	$ 10.16	$ 7.78	$ 13.36
Cigna Prepaid Low (OKIV9)	$ 9.70	$ 6.30	$ 4.28	$ 9.64
Delta Dental PPO	$ 40.92	$ 40.92	$ 35.60	$ 90.00
Delta Dental PPO – Choice	$ 17.26	$ 39.12	$ 39.42	$ 95.66
HealthChoice Dental	$ 47.48	$ 47.48	$ 38.38	$ 98.44
MetLife High Classic MAC	$ 47.32	$ 47.32	$ 40.56	$ 100.38
MetLife Low Classic MAC	$ 26.88	$ 26.88	$ 23.06	$ 56.66
Sun Life Preferred Active PPO	$ 34.98	$ 34.80	$ 26.12	$ 70.14

VISION PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Primary Vision Care Services (PVCS)	$ 10.40	$ 9.28	$ 9.20	$ 11.50
Superior Vision	$ 7.40	$ 7.34	$ 6.96	$ 14.30
Vision Care Direct	$ 15.70	$ 11.20	$ 11.20	$ 22.00
VSP (Vision Service Plan)	$ 8.62	$ 5.66	$ 5.58	$ 12.22

LIFE	Basic Life ($20,000) $5.20	First $20,000 of Supplemental Life $5.20

SUPPLEMENTAL LIFE – Age-rated cost per additional $20,000 unit			
<30 – $ 1.20	30-34 – $ 1.20	35-39 – $ 1.20	40-44 – $ 1.60
45-49 – $ 2.80	50-54 – $ 5.20	55-59 – $ 8.00	60-64 – $ 9.20
65-69 – $ 14.80	70-74 – $ 25.60	75+ – $ 39.20	

DEPENDENT LIFE	Low Option $2.60	Standard Option $4.32	Premier Option $11.26
Spouse	$ 6,000 of coverage	$ 10,000 of coverage	$ 20,000 of coverage
Child (live birth to age 26)	$ 3,000 of coverage	$ 5,000 of coverage	$ 10,000 of coverage

Dependent Life does not include Accidental Death and Dismemberment (AD&D).

Monthly Cumulative Plan Premiums for Current Employees
Plan Year Jan. 1-Dec. 31, 2023

HEALTH	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Blue Cross Blue Shield of Oklahoma – BlueLincs HMO	$ 580.46	$ 1,378.50	$ 1,916.56	$ 2,633.64	$ 1,118.52	$ 1,835.60
CommunityCare HMO	$ 622.06	$ 1,351.40	$ 1,664.30	$ 1,882.38	$ 934.96	$ 1,153.04
GlobalHealth HMO	$ 932.72	$ 2,309.50	$ 2,842.14	$ 3,179.32	$ 1,465.36	$ 1,802.54
HealthChoice High and High Alternative	$ 640.28	$ 1,390.98	$ 1,713.06	$ 1,937.52	$ 962.36	$ 1,186.82
HealthChoice Basic and Basic Alternative	$ 511.82	$ 1,112.46	$ 1,376.40	$ 1,558.92	$ 775.76	$ 958.28
HealthChoice High Deductible Health Plan (HDHP)	$ 446.30	$ 970.38	$ 1,200.90	$ 1,359.56	$ 676.82	$ 835.48
TRICARE Supplement – Selman & Company	$ 65.50	$ 129.50	$ 181.00	$ 181.00	$ 129.50	$ 181.00

DENTAL	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
BCBSOK – BlueCare Dental High Plan	$ 35.08	$ 70.16	$ 98.60	$ 142.68	$ 63.52	$ 107.60
BCBSOK – BlueCare Dental Low Plan	$ 23.84	$ 47.68	$ 68.28	$ 98.08	$ 44.44	$ 74.24
Cigna Prepaid High (K1I09)	$ 12.56	$ 22.72	$ 30.50	$ 36.08	$ 20.34	$ 25.92
Cigna Prepaid Low (OKIV9)	$ 9.70	$ 16.00	$ 20.28	$ 25.64	$ 13.98	$ 19.34
Delta Dental PPO	$ 40.92	$ 81.84	$ 117.44	$ 171.84	$ 76.52	$ 130.92
Delta Dental PPO – Choice	$ 17.26	$ 56.38	$ 95.80	$ 152.04	$ 56.68	$ 112.92
HealthChoice Dental	$ 47.48	$ 94.96	$ 133.34	$ 193.40	$ 85.86	$ 145.92
MetLife High Classic MAC	$ 47.32	$ 94.64	$ 135.20	$ 195.02	$ 87.88	$ 147.70
MetLife Low Classic MAC	$ 26.88	$ 53.76	$ 76.82	$ 110.42	$ 49.94	$ 83.54
Sun Life Preferred Active PPO	$ 34.98	$ 69.78	$ 95.90	$ 139.92	$ 61.10	$ 105.12

VISION	Employee	Employee & Spouse	Employee, Spouse & Child	Employee, Spouse & Children	Employee & Child	Employee & Children
Primary Vision Care Services (PVCS)	$ 10.40	$ 19.68	$ 28.88	$ 31.18	$ 19.60	$ 21.90
Superior Vision	$ 7.40	$ 14.74	$ 21.70	$ 29.04	$ 14.36	$ 21.70
Vision Care Direct	$ 15.70	$ 26.90	$ 38.10	$ 48.90	$ 26.90	$ 37.70
VSP (Vision Service Plan)	$ 8.62	$ 14.28	$ 19.86	$ 26.50	$ 14.20	$ 20.84

EGID Life Premium Chart for Current Employees

Jan. 1 through Dec. 31, 2023

The coverage levels and monthly premiums listed below include Basic Life.

Amount/Age*	< 30	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75 +
Basic $ 20,000**	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20	5.20
$ 40,000	10.40	10.40	10.40	10.40	10.40	10.40	10.40	10.40	10.40	10.40	10.40
$ 60,000	11.60	11.60	11.60	12.00	13.20	15.60	18.40	19.60	25.20	36.00	49.60
$ 80,000	12.80	12.80	12.80	13.60	16.00	20.80	26.40	28.80	40.00	61.60	88.80
$ 100,000	14.00	14.00	14.00	15.20	18.80	26.00	34.40	38.00	54.80	87.20	128.00
$ 120,000	15.20	15.20	15.20	16.80	21.60	31.20	42.40	47.20	69.60	112.80	167.20
$ 140,000	16.40	16.40	16.40	18.40	24.40	36.40	50.40	56.40	84.40	138.40	206.40
$ 160,000	17.60	17.60	17.60	20.00	27.20	41.60	58.40	65.60	99.20	164.00	245.60
$ 180,000	18.80	18.80	18.80	21.60	30.00	46.80	66.40	74.80	114.00	189.60	284.80
$ 200,000	20.00	20.00	20.00	23.20	32.80	52.00	74.40	84.00	128.80	215.20	324.00
$ 220,000	21.20	21.20	21.20	24.80	35.60	57.20	82.40	93.20	143.60	240.80	363.20
$ 240,000	22.40	22.40	22.40	26.40	38.40	62.40	90.40	102.40	158.40	266.40	402.40
$ 260,000	23.60	23.60	23.60	28.00	41.20	67.60	98.40	111.60	173.20	292.00	441.60
$ 280,000	24.80	24.80	24.80	29.60	44.00	72.80	106.40	120.80	188.00	317.60	480.80
$ 300,000	26.00	26.00	26.00	31.20	46.80	78.00	114.40	130.00	202.80	343.20	520.00
$ 320,000	27.20	27.20	27.20	32.80	49.60	83.20	122.40	139.20	217.60	368.80	559.20
$ 340,000	28.40	28.40	28.40	34.40	52.40	88.40	130.40	148.40	232.40	394.40	598.40
$ 360,000	29.60	29.60	29.60	36.00	55.20	93.60	138.40	157.60	247.20	420.00	637.60
$ 380,000	30.80	30.80	30.80	37.60	58.00	98.80	146.40	166.80	262.00	445.60	676.80
$ 400,000	32.00	32.00	32.00	39.20	60.80	104.00	154.40	176.00	276.80	471.20	716.00
$ 420,000	33.20	33.20	33.20	40.80	63.60	109.20	162.40	185.20	291.60	496.80	755.20
$ 440,000	34.40	34.40	34.40	42.40	66.40	114.40	170.40	194.40	306.40	522.40	794.40
$ 460,000	35.60	35.60	35.60	44.00	69.20	119.60	178.40	203.60	321.20	548.00	833.60
$ 480,000	36.80	36.80	36.80	45.60	72.00	124.80	186.40	212.80	336.00	573.60	872.80
$ 500,000	38.00	38.00	38.00	47.20	74.80	130.00	194.40	222.00	350.80	599.20	912.00
$ 520,000	39.20	39.20	39.20	48.80	77.60	135.20	202.40	231.20	365.60	624.80	951.20

*Chart based on member's age as of Jan. 1, 2023.

**Basic Life must be purchased before Supplemental Life coverage is available.

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VOYA Supplemental Life Insurance

effective 10/1/2018

Employee Monthly Premium Table

		25,000	50,000	75,000	100,000	125,000	150,000	175,000	200,000	225,000	250,000	275,000	300,000	325,000	350,000	375,000	400,000
0 - 24	**0.06**	1.50	3.00	4.50	6.00	7.50	9.00	10.50	12.00	13.50	15.00	16.50	18.00	19.50	21.00	22.50	24.00
25-29	**0.07**	1.75	3.50	5.25	7.00	8.75	10.50	12.25	14.00	15.75	17.50	19.25	21.00	22.75	24.50	26.25	28.00
30-34	**0.08**	2.00	4.00	6.00	8.00	10.00	12.00	14.00	16.00	18.00	20.00	22.00	24.00	26.00	28.00	30.00	32.00
35 - 39	**0.09**	2.25	4.50	6.75	9.00	11.25	13.50	15.75	18.00	20.25	22.50	24.75	27.00	29.25	31.50	33.75	36.00
40 - 44	**0.14**	3.50	7.00	10.50	14.00	17.50	21.00	24.50	28.00	31.50	35.00	38.50	42.00	45.50	49.00	52.50	56.00
45 - 49	**0.22**	5.50	11.00	16.50	22.00	27.50	33.00	38.50	44.00	49.50	55.00	60.50	66.00	71.50	77.00	82.50	88.00
50 - 54	**0.33**	8.25	16.50	24.75	33.00	41.25	49.50	57.75	66.00	74.25	82.50	90.75	99.00	107.25	115.50	123.75	132.00
55 - 59	**0.61**	15.25	30.50	45.75	61.00	76.25	91.50	106.75	122.00	137.25	152.50	167.75	183.00	198.25	213.50	228.75	244.00
60 - 64	**0.66**	16.50	33.00	49.50	66.00	82.50	99.00	115.50	132.00	148.50	165.00	181.50	198.00	214.50	231.00	247.50	264.00
65 - 69	**1.27**	31.75	63.50	95.25	127.00	158.75	190.50	222.25	254.00	285.75	317.50	349.25	381.00	412.75	444.50	476.25	508.00
70 +	**2.06**	51.50	103.00	154.50	206.00	257.50	309.00	360.50	412.00	463.50	515.00	566.50	618.00	669.50	721.00	772.50	824.00

Spouse Monthly Premium Table

		10,000	20,000	30,000	40,000	50,000	60,000	70,000	80,000	90,000	100,000
0 - 24	**0.16**	1.60	3.20	4.80	6.40	8.00	9.60	11.20	12.80	14.40	16.00
25-29	**0.18**	1.80	3.60	5.40	7.20	9.00	10.80	12.60	14.40	16.20	18.00
30-34	**0.2**	2.00	4.00	6.00	8.00	10.00	12.00	14.00	16.00	18.00	20.00
35 - 39	**0.26**	2.60	5.20	7.80	10.40	13.00	15.60	18.20	20.80	23.40	26.00
40 - 44	**0.34**	3.40	6.80	10.20	13.60	17.00	20.40	23.80	27.20	30.60	34.00
45 - 49	**0.54**	5.40	10.80	16.20	21.60	27.00	32.40	37.80	43.20	48.60	54.00
50 - 54	**0.8**	8.00	16.00	24.00	32.00	40.00	48.00	56.00	64.00	72.00	80.00
55 - 59	**1.26**	12.60	25.20	37.80	50.40	63.00	75.60	88.20	100.80	113.40	126.00
60 - 64	**1.28**	12.80	25.60	38.40	51.20	64.00	76.80	89.60	102.40	115.20	128.00
65 - 69	**3.82**	38.20	76.40	114.60	152.80	191.00	229.20	267.40	305.60	343.80	382.00
70 +	**5.98**	59.80	119.60	179.40	239.20	299.00	358.80	418.60	478.40	538.20	598.00

Monthly Premium All Children

$10,000 of Coverage
1.00

CONTACT INFORMATION

HEALTH PLANS

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

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

GlobalHealth Inc.
405-280-5600 or 877-280-5600
TTY 711
GlobalHealth.com/oklahoma/mystateplan

HealthChoice

Medical
800-323-4314
TTY 711
HealthChoiceOK.com

Pharmacy
877-720-9375
TTY 711
Caremark.com

LIFE INSURANCE

HealthChoice
800-323-4314
TTY 711
HealthChoiceOK.com

ADDITIONAL

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

American Fidelity Health Services Administration
800-662-1113
afhsa.com

DENTAL PLANS

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

Cigna Prepaid Dental
800-244-6224
Hearing-impaired relay 800-654-5988
http://view.ceros.com/cigna/ok-ins-benefits

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

HealthChoice
800-323-4314
TTY 711
HealthChoiceOK.com

MetLife
855-676-9443
https://www.metlife.com/oklahoma/oklahoma

Sun Life
800-442-7742
onboard.sunlifeconnect.com

VISION PLANS

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

Superior Vision
800-507-3800 or TDD 916-852-2382
superiorvision.com/stateofoklahoma/benefits

Vision Care Direct
855-918-2020 or TTY 711
okstate.vision

VSP
800-877-7195 or TDD 800-428-4833
stateofok.vspforme.com