VOLUNTARY DENTAL INSURANCE

Delta Dental of Oklahoma

Networks: PPO or Plus Premier

Plan Year Deductible

Individual	\$50
Family	\$150

Coinsurance

Preventative – Class I	100%
Basic – Class II	80%
Major – Class III	50%
Child Orthodontics— Class IV	50%
(child up to age 26)	

Plan Year Maximum

\$1,000

Lifetime Orthodontics Maximum

\$1.000 Your deepest discounts are going to be in the PPO network. No

balance billing occurs in the PPO and Premier networks. If you go out- of-network you are subject to balance billing. In the dentist listing handout or on the website, dentists that are listed as "PPO" and "Premier" are in the Delta Dental network.

	Full Premium	HOH Pays	EE Pays Monthly	EE Per Check
EE	\$26.20	\$0.00	\$26.20	\$13.10
ES	\$52.38	\$0.00	\$52.38	\$26.19
EC	\$58.10	\$0.00	\$58.10	\$29.05
EF	\$73.18	\$0.00	\$73.18	\$36.59

LIFE AND AD&D INSURANCE

BlueCross BlueShield of Oklahoma

Employee: Flat \$15,000 Term Life Policy. Please refer to benefit summaries for age reductions and other benefit limits.

* This benefit is provided by Home of Hope at no cost to the employee.

COMPANY BENEFITS

Additional Benefits offered to you upon eligibility.

- Employee Assistance Program
- Retirement Plan
- Crisis Fund
- Employee Discounts (Access Perks & LifeMart)
- Angel Tree

VOLUNTARY VISION INSURANCE

VSP Vision

Network: Signature

	In-Network	Non-Network
ye Exam	\$10	Up to \$50
rescription Gla	sses	
Single Vision Len	ses \$25	Up to \$50
Lined Bifocal Len	ses \$25	Up to \$75
Lined Trifocal Le	nses \$25	Up to \$100
Lenticular Lenses	s \$25	Up to \$100
Progressive	\$0-\$160	Up to \$75
rames \$	130 Allowance;	Up to \$70
\$	150 Allowance fo	or
f€	eatured brands	

Contacts Lenses

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Elective In Lieu of frames/lenses:

\$130 Allowance Up to \$105

Fitting and follow-up Up to \$60 Medically Necessary \$0 copay; Up to \$210 covered in full

20% off balance

Coverage:

Every 12 months Exam

Prescription Glasses

Lenses Every 12 months Every 24 months Frames Contacts Every 12 months

^{**}Additional Discounts & Savings Included with your plan, See Plan Summary documents for complete details.

	Full Premium	HOH Pays	EE Pays Monthly	EE Per Check
EE	\$10.71	\$0.00	\$10.71	\$5.36
ES	\$17.14	\$0.00	\$17.14	\$8.57
EC	\$17.49	\$0.00	\$17.49	\$8.75
EF	\$28.21	\$0.00	\$28.21	\$14.11

This Benefits Tri-Fold is only a Summary, not a guarantee of benefits.

CARRIER CONTACT INFORMATION

CommunityCare ~ Medical Group #D10201

www.ccok.com (800) 777-4890

Delta Dental of Oklahoma ~ Dental

Group #2870-0001 www.deltadentalok.org (800) 522-0188

VSP ~ Vision

Group #30049623

(800) 877-7195 www.vsp.com

BlueCross BlueShield of Oklahoma ~

Group Term Life/AD&D Group #F015249

(888) 381-9727

www.ancillaryquestionsok@bcbsok.com

Travel Resources:

Europe Assistance:

ops@europpassistance-usa.com US & Canada: (877) 715-2593

Call Collect +1 (202) 659-7807

Grief Counseling: (800) 769-9187

Connect Your Care ~ FSA/HSA Admin

(877) 292-4040

service@connectyourcare.com

Insure OK ~ Pam Garrett

(918) 256-7825 ext. 155

pam.garrett@homeofhope.com

Colonial ~ Supplemental Products

Kelly Pugh (918) 286-2778

kpugh@tulsacoxmail.com

www.coloniallife.com

Mutual of Omaha ~ Voluntary Life/AD&D

Michael McConnell (918) 581-8819

EAP Community Care ~ EAP

(800) 221-3976

www.ccok.com/EAP

Human Resources ~ HR Contact

Amy Johnson

(918) 256-7825 ext. 303

amy.johnson@homeofhope.com

Benefit Advisor ~ Summit

Kav Alldredge

kalldredge@yoursummit.com

(918) 280-7703



Employee Benefit Plans

July 1, 2021

June 30, 2022

Presented by



www.yoursummit.com

ELGIBILITY

All employees are eligible for benefits the first of the month following 60 days after your hire date.

Insurance is available to Full Time employees. Full Time is defined as employees working at least thirty (30) hours per week.

You must enroll in the benefit plans when you are first eligible, or if you have a Qualifying Event. Otherwise you will not be able to enroll until open enrollment, or if you have a change in family status. These "Qualifying Events" include the following changes in family status: Marriage, Divorce, Death, Birth, Adoption, Job Change.

Enrollment and any change in family status must be done within <u>thirty (30) days</u> of the date of the Qualifying Event.

VOLUNTARY SUPPLEMENTAL COVERAGES

Colonial Life

- ♦ Accident Insurance
- ♦ Term Life Insurance
- ♦ Whole Life Insurance
- ♦ Cancer Insurance
- ♦ Individual Shor Term Disability Insurance
- ♦ (Specified) & Critical Illness Insurance
- ♦ Hospital Indemnity Insurance

The benefits are paid directly to you and are portable if you ever leave Home of Hope. Premiums are paid by payroll deduction and participation is voluntary.

FSA/HSA ACCOUNTS

Home of Hope offers a Flexible Spending Account to eligible employees.

Medical Care - You have the option of electing up to \$2,750 (pre-tax) per calendar year for qualified medical/dental/vision expenses. There is a 2 1/2 month grace period to claim the prior years money. You may rollover up to \$500 each year in pretax elections.

Dependent Care - You also have the option to elect up to \$5,000 (pre-tax) for dependent care costs. No carry-over applies. Money is available as it is deposited into the account.

All qualified claims must be turned in by Tuesday to receive reimbursement by Thursday.

*Employees who did not elect the maximum contribution for the 2020 plan year, have a one-time opportunity to increase your election amount effective 7/1. HSA available with HDHP (Indiv \$3,600/Family \$7,200)

MEDICAL INSURANCE BENEFITS

CommunityCare PPO ~ Fundamental 3 OE Lg Network: PPO Standard Insure Oklahoma Qualified Plan

Calendar Year Deductible	<u>Network</u>
Individual	\$2,000
Family	\$4,000
Coinsurance	70%

Out-of-Pocket Limit Per Calendar Year

(Includes Deductible and Medical/RX copays)

Individual	\$3,000
Family	\$6,000

Physician Services

Office Visit (PCP) \$25

Preventive Care No Charge

Office Visit (Specialist) \$40

Outpatient Therapy 30% after Ded

(limit 60 visits per disability, per year for speech, OT, PT)

Emergency Room 30% after Ded

Urgent Care \$50

Inpatient Hospital30% after DedOutpatient Surgery30% after Ded

Outpatient Lab/Radiology \$0
MRI, CT Scan, Pet Scan Ded

\$100 RX Calendar Year Deductible then:

Preferred Generic	\$15
Preferred Brand	\$40
Non-Preferred Generic	\$70
Non-Preferred Brand	\$70
Specialty	\$160

Rx Mail Order 2 Co-pays for 90 Day Supply

^{*} Premiums may be reduced if you qualify for Insure Oklahoma assistance. Please see Pam for details.

	Full Premium	HOH Pays	EE Pays Monthly	EE Per Check
EE	\$776.78	\$582.59	\$194.20	\$97.10
ES	\$1789.49	\$984.22	\$805.27	\$402.64
EC	\$1731.17	\$952.14	\$779.03	\$389.51
EF	\$2172.06	\$1194.63	\$977.43	\$488.71

MEDICAL INSURANCE BENEFITS

Community Care HMO ~ CC 100/3000 OE CR17 Network: HMO Standard Insure Oklahoma Qualified Plan

Calendar Year Deductible	$\underline{\text{Network}}$
Individual	\$3,000
Family	\$6,000
Coinsurance	100%

Out-of-Pocket Limit Per Calendar Year

(Includes Deductible and Medical/RX copays)

Individual	\$3,000
Family	\$6,000

Physician Services

Office Visit (PCP) \$20

Preventive Care No Charge

Office Visit (Specialist) \$50

Outpatient Therapy Deductible

(limit 60 visits per disability, per year for speech, OT, PT)

Emergency Room Deductible

Urgent Care \$50

Inpatient HospitalDeductibleOutpatient SurgeryDeductible

Outpatient Lab/Radiology Deductible

MRI, CT Scan, Pet Scan Deductible

\$100 RX Calendar Year Deductible then:

Preferred Generic	\$15
Preferred Brand	\$40
Non-Preferred Generic	\$70
Non-Preferred Brand	\$70
Specialty	\$160

Rx Mail Order 2 Co-pays for 90 Day Supply

^{*} Premiums may be reduced if you qualify for Insure Oklahoma assistance. Please see Pam for details.

	Full Premium	HOH Pays	EE Pays Monthly	EE Per Check
EE	\$675.61	\$506.71	\$168.90	\$84.45
ES	\$1556.48	\$856.06	\$700.42	\$350.21
EC	\$1505.71	\$828.14	\$677.57	\$338.78
EF	\$1889.24	\$1039.08	\$850.16	\$425.08

MEDICAL INSURANCE BENEFITS

CommunityCare ~ CC 80/3500 HDHP

HSA Qualified Health Plans

Network

Individual	\$3,500
Family	\$7,000

Calendar Year Deductible

Coinsurance 80% after Ded

Out-of-Pocket Limit Per Calendar Year

(Includes Deductible and Medical/RX copays)

Individual	\$6,000
Family	\$12,000

Urgent Care \$50 after Ded

Preventive Care No Charge

Outpatient Therapy 20% after Ded

(limit 60 visits per disability, per year for speech, OT, PT)

Network: HMO Standard

Physician Services

Office Visit (PCP)	\$25 after Ded
Office Visit (Specialist)	\$35 after Ded

	Full Premium	HOH Pays	EE Pays Monthly	EE Per Check
EE	\$562.15	\$421.61	\$140.54	\$70.27
ES	\$1,295.10	\$712.31	\$582.80	\$291.40
EC	\$1,252.85	\$689.07	\$563.78	\$281.89
EF	\$1,571.98	\$864.59	\$707.39	\$353.70

Network: PPO Standard

Physician Services

Office Visit (PCP) \$30 after Ded
Office Visit (Specialist) \$40 after Ded

	Full Premium	HOH Pays	EE Pays Monthly	EE Per Check
EE	\$635.68	\$476.76	\$158.92	\$79.49
ES	\$1,464.44	\$805.44	\$659.00	\$329.50
EC	\$1,416.72	\$779.20	\$637.52	\$318.76
EF	\$1,777.52	\$977.64	\$799.88	\$399.94