

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

The deepest discounts are in the PPO network. . If you go **out-of-network** you are subject to balance billing.

Go to deltadentalok.org, to see dentists in the PPO/Premier networks..

	Full Premium	HOH Pays	EE Pays Monthly	EE Per Check
EE	\$31.70	\$0.00	\$31.70	\$15.85
ES	\$63.38	\$0.00	\$63.38	\$31.69
EC	\$70.32	\$0.00	\$70.32	\$35.16
EF	\$88.56	\$0.00	\$88.56	\$44.28

LIFE AND AD&D INSURANCE

Blue Cross Blue Shield 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

Provided for you by Home of Hope.

- ◆ Employee Assistance Program
- ◆ Employee Growth & Wellbeing
- ◆ Holiday Savings Plan
- ◆ Retirement Plan
- ◆ Employee Crisis Fund
- ◆ Employee Discounts (Access Perks)

VOLUNTARY VISION INSURANCE

VSP Vision

Network: Signature

	In-Network	Non-Network
Eye Exam	\$10	Up to \$50
Prescription Glasses		
Single Vision Lenses	\$25	Up to \$50
Lined Bifocal Lenses	\$25	Up to \$75
Lined Trifocal Lenses	\$25	Up to \$100
Lenticular Lenses	\$25	Up to \$100
Progressive	\$0-\$160	Up to \$75
Frames	\$130 Allowance;	Up to \$70
	\$150 Allowance for featured brands, then 20% off balance	

Contacts Lenses

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

Coverage:

Exam	Every 12 months
Prescription Glasses	
Lenses	Every 12 months
Frames	Every 24 months
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 benefit guide is only an overview of benefits, not a guarantee of coverage. Please refer to your plan documents for detailed information.

CARRIER CONTACT INFORMATION

Community Care ~ 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
www.vsp.com (800) 877-7195

BlueCross BlueShield of Oklahoma ~

Group Term Life/AD&D
Group #F015249
(888) 381-9727
www.ancillaryquestionsok@bcbsok.com
Grief Counseling: (800) 769-9187

Mutual of Omaha ~ Voluntary Life /AD&D

(918) 581-8819
Michael McConnell

Paylocity ~ FSA/HSA Admin

(888) 873-8205
paylocity.com

Insure OK ~ Pam Garrett

(918) 256-7825 ext. 1062
pam.garrett@homeofhope.com

Colonial Life ~ Supplemental Products

Kelly Pugh
(918) 286-2778
kpugh@tulsacoxmail.com
www.coloniallife.com

Retirement Plan ~ 403 (b)

(918) 256-7825 ext. 1062
pam.garrett@homeofhope.com

EAP Community Care ~ EAP

(800) 221-3976
www.ccok.com/EAP

Director of Human Resources ~ HR Contact

Amy Johnson
(918) 256-7825 ext. 1060
amy.johnson@homeofhope.com

Benefit Advisor ~ Summit Financial Group

Ellen Ezell/Tawny Moore
tmoore@yoursummit.com
(918) 663-0991



Employee Benefit Plans

July 1, 2024

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June 30, 2025



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 thirty (30) days of the date of the Qualifying Event.**

COLONIAL LIFE PRODUCTS

- Colonial Life**
- ◆ Accident Insurance
 - ◆ Term Life Insurance
 - ◆ Whole Life Insurance
 - ◆ Cancer Insurance
 - ◆ Individual Short 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 through 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 \$3,200 (pre-tax) per calendar year for qualified medical/dental/vision expenses. There is a 60 day grace period to claim the prior years money. You may rollover up to \$610 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.**

MEDICAL HMO

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

Calendar Year Deductible	<u>In-Network</u>
Individual	\$3,000
Family	\$6,000
Coinsurance	100%
Out-of-Pocket Limit Per Calendar Year	
<i>(Includes Deductible and Medical/RX copays)</i>	
Individual	\$3,000
Family	\$6,000
Physician Services	
Office Visit (PCP)	\$20
Preventive Care	No Charge
Office Visit (Specialist)	\$50
Emergency Room	Deductible
Urgent Care	\$50
Inpatient Hospital	Deductible
Outpatient Surgery	Deductible
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 Garrett for details.*

	Full Premium	HOH Pays	EE Pays Monthly	EE Per Check
EE	\$1,040.81	\$780.61	\$260.20	\$130.10
ES	\$2,397.83	\$1,318.81	\$1,079.02	\$539.51
EC	\$2,319.61	\$1,275.79	\$1,043.82	\$521.91
EF	\$2,910.44	\$1,600.74	\$1,309.70	\$654.85

MEDICAL PPO

Community Care PPO ~ Fundamental 3k
Network: PPO Standard Network

Calendar Year Deductible	<u>In-Network</u>
Individual	\$3,000
Family	\$6,000
Coinsurance	70%
Out-of-Pocket Limit Per Calendar Year	
<i>(Includes Deductible and Medical/RX copays)</i>	
Individual	\$6,000
Family	\$12,000
Physician Services	
Office Visit (PCP)	\$35
Preventive Care	No Charge
Office Visit (Specialist)	\$45
Emergency Room	30% after Ded
Urgent Care	\$50
Inpatient Hospital	30% after Ded
Outpatient Surgery	30% after Ded
Outpatient Lab/Radiology	\$0
MRI, CT Scan, Pet Scan	30% after 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

	Full Premium	HOH Pays	EE Pays Monthly	EE Per Check
EE	\$1,064.56	\$798.55	\$266.01	\$133.01
ES	\$2,452.45	\$1,349.38	\$1,103.07	\$551.53
EC	\$2,372.53	\$1,305.42	\$1,067.11	\$533.56
EF	\$2,976.77	\$1,637.87	\$1,338.90	\$669.45

MEDICAL HDHP PLANS HMO & PPO

Community Care ~ HMO HDHP 80/6000
HMO Standard Network
HSA Qualified Health Plans

Calendar Year Deductible	<u>In-Network</u>
Individual	\$6,000
Family	\$12,000
Coinsurance	80%
Out-of-Pocket Limit Per Calendar Year	
<i>(Includes Deductible and Medical/RX copays)</i>	
Individual	\$7,500
Family	\$15,500
Urgent Care	\$50 after Ded
Preventive Care	No Charge
PCP/Specialist	\$25/\$35 after Ded

	Full Premium	HOH Pays	EE Pays Monthly	EE Per Check
EE	\$747.47	\$602.07	\$145.40	\$72.70
ES	\$1,722.03	\$947.51	\$774.52	\$387.26
EC	\$1,665.85	\$916.60	\$749.25	\$374.63
EF	\$2,090.16	\$1,150.06	\$940.10	\$470.05

Community Care ~ PPO HDHP 80/5000

Network: PPO Standard Network

In-Network Deductible \$5000 /\$10,000
 In-Network Out of Pocket \$6,650/\$13,300
 In-Network Coinsurance 80%

Preventive Care No Charge
 Office Visit (PCP) \$30 after Ded

	Full Premium	HOH Pays	EE Pays Monthly	EE Per Check
EE	\$891.78	\$669.00	\$222.78	\$111.39
ES	\$2,054.42	\$1,130.62	\$923.80	\$461.90
EC	\$1,987.46	\$1,093.76	\$893.70	\$446.85
EF	\$2,493.64	\$1,372.35	\$1,121.29	\$560.65