

SHOP <sup>COS.</sup>



SHOP COMPANIES

PLAN YEAR  
2025-2026



OKLAHOMA EMPLOYEE BENEFIT BOOKLET



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This guide is an overview of your health benefits and does not provide a complete description of all the benefit provisions. Please refer to the summary plan descriptions for more detailed information.

The information provided by the carriers supersedes the contents of this booklet provided by Endeavor Risk Advisors.

# Welcome to Open Enrollment

Dear Employee:

We are committed to supporting the health and wellness of our team of employees. Our annual employee benefits insurance is renewing effective **12/01/2025** and will be effective through **11/30/2026**.

This benefits guide is designed to help you understand the available benefit options so you can make the best benefit elections for you and your family. It provides a comprehensive overview of your benefits package, including eligibility, election periods, and costs. In addition, the guide offers descriptions and detailed explanations of each medical plan design.

Our goal is to, as a group, be efficient consumers of healthcare. This will help keep you from wasting money when consuming services and help make the process more efficient as well.

If you have any questions about any of the benefits mentioned in this guide or need assistance please reach out to our benefits consultant, Lisa Burkham with Endeavor Risk Advisors, at [lisa@endeavorrisk.com](mailto:lisa@endeavorrisk.com).

Sincerely,

-

Your Benefits Team

# Eligibility and Mid-Year Changes

## Who is Eligible?

All regular full-time employees working at least 30 hours per week in an active payroll status are eligible for the benefits listed. The following family members are also eligible for coverage:

- Your spouse (the person to whom you are legally married under state law)
- Your children under age 26 unless incapacitated due to a disability and primarily dependent on you for support

## Who is Not Eligible?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, siblings
- Employees who work fewer than 30 hours per week, temporary employees, contract employees, or employees residing outside of the United States

## When does Coverage Begin for New Hires?

The date you are eligible to participate in these health benefits is the **first of the month after date of hire**. Employees must make elections during the first 30 days of employment to ensure you receive your ID cards in a timely manner.

## Enrollment Periods

After your initial hire date, Open Enrollment is the only time during the year employees can make changes to their benefit elections without a qualifying event.

## How to make changes

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period.

Notify Human Resources within 30 days if you experience one of the following qualifying events and would like to make changes to your coverage.

Qualifying events include things like:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child, or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

# Contacts

## ENDEAVOR | RISK ADVISORS

972-559-0461

[clientservice@endeavorrisk.com](mailto:clientservice@endeavorrisk.com)

Enrollment Questions: Lisa Burkham, Benefits Consultant

[lisa@endeavorrisk.com](mailto:lisa@endeavorrisk.com)

|                   | Carrier / TPA          | Contact      | Policy Number |
|-------------------|------------------------|--------------|---------------|
| Medical           | Blue Cross Blue Shield | 800-521-2227 | 331147        |
| Dental            | Blue Cross Blue Shield | 800-521-2227 | 331147        |
| Vision            | Blue Cross Blue Shield | 877-442-4207 | VF027849      |
| Voluntary Life    | Blue Cross Blue Shield | 877-442-4207 | VF027849      |
| Flexible Spending | ABY Benefits           | 877-731-3532 |               |

# BCBS Plan MTBCP539 - Blue Choice PPO

| Plan Features  | PPO Plan                                |   |
|--|---|---|
|  | In-Network                              | Out-of-Network*                                   |
| Deductible (per calendar year)   | Individual: \$5,000<br>Family: \$15,000 | Individual: \$10,000<br>Family: \$20,000          |
| Coinsurance  | 100%                                    | 50%   |
| Out-Of-Pocket Max (includes deductible, coinsurance, & copays)                 | Individual: \$8,150<br>Family: \$16,300 | Individual: Unlimited<br>Family: Unlimited        |
| Preventive Care  | \$0 Copay                               | Pay Full Cost                                     |
| Virtual Visits (Call BCBSTX)   | \$45 copay                              | 50% after Deductible                              |
| Primary Office Visit (general practice, internal medicine, pediatrics, OB-GYN) | \$45 copay                              | 50% after Deductible                              |
| Specialist Office Visit  | \$90 copay                              | 50% after Deductible                              |
| Urgent Care Facility   | \$75 copay                              | 50% after Deductible                              |
| Emergency Services   | \$500 copay, 0% after Ded               | 50% after Deductible                              |
| Diagnostic Lab & X-rays  | 0% after Deductible                     | 50% after Deductible                              |
| Hospitalization  | 0% after Deductible                     | 50% after Deductible                              |
| Prescription Costs   |   |   |
| Preferred Pharmacy Prescription Costs  | \$0/\$10/\$50/\$100                     | 50% allowable amount minus copay after Deductible |
| Non-Preferred Pharmacy Prescription Costs                                      | \$10/\$20/\$70/\$120                    | 50% allowable amount minus copay after Deductible |

\* Out-of-Network providers can balance bill members for any services incurred out of the network. These costs are in addition to the benefits listed.

# BCBS Plan MTBCP547 – Blue Choice PPO

| Plan Features  | PPO Plan                                |   |
|--|---|---|
|  | In-Network                              | Out-of-Network*                                   |
| Deductible (per calendar year)   | Individual: \$7,250<br>Family: \$18,400 | Individual: \$14,500<br>Family: \$20,000          |
| Coinsurance  | 100%                                    | 50%   |
| Out-Of-Pocket Max (includes deductible, coinsurance, & copays)                 | Individual: \$8,150<br>Family: \$18,400 | Individual: Unlimited<br>Family: Unlimited        |
| Preventive Care  | \$0 Copay                               | Pay Full Cost                                     |
| Virtual Visits (Call BCBSTX)   | \$45 Copay                              | N/A   |
| Primary Office Visit (general practice, internal medicine, pediatrics, OB-GYN) | \$45 Copay                              | 50% after Deductible                              |
| Specialist Office Visit  | \$90 Copay                              | 50% after Deductible                              |
| Urgent Care Facility   | \$75 Copay                              | 50% after Deductible                              |
| Emergency Services   | \$500 Copay, then 20% after Deductible  |   |
| Diagnostic Lab & X-rays  | 0% after Deductible                     | 50% after Deductible                              |
| Hospitalization  | 0% after Deductible                     | 50% after Deductible                              |
| Prescription Costs   |   |   |
| Preferred Pharmacy Prescription Costs  | \$0/\$10/\$50/\$100                     | 50% allowable amount minus copay after Deductible |
| Non-Preferred Pharmacy Prescription Costs                                      | \$10/\$20/\$70/\$120                    | 50% allowable amount minus copay after Deductible |

\* Out-of-Network providers can balance bill members for any services incurred out of the network. These costs are in addition to the benefits listed.



## BCBS Dental DTNLM38 - Base Plan

| Calendar Year Deductible: \$50 Individual / \$150 Family   |                            |             |
|--|----------------------------|-------------|
| Coverage   | Network                    | Non-Network |
| <b>Diagnostic</b> <ul style="list-style-type: none"> <li>○ Periodic Oral Evaluations</li> <li>○ X-rays, Bitewing</li> <li>○ Comprehensive Oral Evaluations</li> </ul>  | 100%                       | 100%        |
| <b>Preventive</b> <ul style="list-style-type: none"> <li>○ Cleanings</li> <li>○ Topical Fluoride applications</li> </ul>   | 100%                       | 100%        |
| <b>Basic</b> <ul style="list-style-type: none"> <li>○ Amalgams</li> <li>○ Resin based composite restorations</li> <li>○ Non-surgical extractions</li> <li>○ Non-surgical Periodontal services</li> <li>○ General anesthesia</li> </ul> | 80%                        | 80%         |
| <b>Major</b> <ul style="list-style-type: none"> <li>○ Endodontic Services</li> <li>○ Oral Surgery Services</li> <li>○ Surgical Periodontal Services</li> <li>○ Major Restorative Services</li> <li>○ Prosthodontic Services</li> </ul> | 50%                        | 50%         |
| <b>Calendar Year Maximum</b>   | \$1,500 per covered person |             |
| <b>Orthodontics (Adult &amp; Dependent children)</b>   | 50%                        |             |
| <b>Orthodontics Lifetime Maximum</b>   | \$1,000 per covered person |             |

Dental implants are not covered.

The above is a listing of common services available through your network of Contracting Dentists.

The Member's share of the cost is determined by whether care is received from a Contracting or Non-Contracting Dentist.

Out of Network Reimbursement is MAC.

## BCBS Dental DTNHR33 - Buy Up Plan

| Calendar Year Deductible: \$50 Individual / \$150 Family  |                            |             |
|---|----------------------------|-------------|
| Coverage  | Network                    | Non-Network |
| <b>Diagnostic</b> <ul style="list-style-type: none"> <li>○ Periodic Oral Evaluations</li> <li>○ X-rays, Bitewing</li> <li>○ Comprehensive Oral Evaluations</li> </ul>   | 100%                       | 100%        |
| <b>Preventive</b> <ul style="list-style-type: none"> <li>○ Cleanings</li> <li>○ Topical Fluoride applications</li> </ul>  | 100%                       | 100%        |
| <b>Basic</b> <ul style="list-style-type: none"> <li>○ Amalgams</li> <li>○ Resin based composite restorations</li> <li>○ Non-surgical extractions</li> <li>○ Non-surgical Periodontal services</li> <li>○ General anesthesia</li> <li>○ Endodontic Services</li> <li>○ Oral Surgery Services</li> <li>○ Surgical Periodontal Services</li> </ul> | 80%                        | 80%         |
| <b>Major</b> <ul style="list-style-type: none"> <li>○ Major Restorative Services</li> <li>○ Prosthodontic Services</li> <li>○ Implants</li> </ul>   | 50%                        | 50%         |
| <b>Calendar Year Maximum</b>  | \$1,500 per covered person |             |
| <b>Orthodontics (Adult &amp; Dependent children)</b>  | 50%                        |             |
| <b>Orthodontics Lifetime Maximum</b>  | \$1,500 per covered person |             |

The above is a listing of common services available through your network of Contracting Dentists.

The Member's share of the cost is determined by whether care is received from a Contracting or Non-Contracting Dentist.

## BCBS Vision

| Vision – 8-12/12/24 \$130 600V   |  |  |
|--|--|--|
| Coverage   | Network  | Non-Network  |
| <b>Eye Examination</b> <ul style="list-style-type: none"> <li>Comprehensive exam of visual functions &amp; prescription of corrective eyewear</li> </ul>   | \$10 Copay   | Up to \$30   |
| <b>Materials / Eyewear</b><br><b>Standard Corrective Lenses</b> <ul style="list-style-type: none"> <li>Single Vision</li> <li>Lined Bifocal</li> <li>Lined Trifocal</li> <li>Lenticular</li> </ul>                                   | \$25 copay   | Up to \$25<br>Up to \$40<br>Up to \$55<br>Up to \$55 |
| <b>Frame Allowance</b><br>(You will receive 20% off any amount over your allowance.)   | \$130 allowance  | Up to \$65   |
| <b>Contact Lenses (in lieu of glasses)</b> <ul style="list-style-type: none"> <li>Contact Fitting &amp; Evaluation</li> <li>Elective Lenses (You will receive 15% off any amount over your allowance.)</li> <li>Necessary</li> </ul> | Up to \$40 Standard<br><br>\$130 allowance<br><br>Covered in full        | N/A<br><br>Up to \$104<br><br>Up to \$210            |
| <b>Frequency</b> <ul style="list-style-type: none"> <li>Examinations</li> <li>Standard Corrective Lenses</li> <li>Frames</li> <li>Contact Lenses</li> </ul>  | 1 per 12 months<br>1 per 12 months<br>1 per 24 months<br>1 per 12 months |  |



# Voluntary Life Insurance and AD&D

When you enroll yourself or yourself and your dependents in this Voluntary Life/AD&D, you pay the full cost through payroll deductions. You must enroll to enroll your dependents.

**Employee**

**Spouse**

**Child**

|  |   |   |   |
|--|---|---|---|
| <b>Life Coverage: provides a benefit in the event of death Schedules:</b>  | Increments of \$10,000  | Increments of \$5,000   | Flat Amount: \$1,000, \$2,000, \$4,000, \$5,000, or \$10,000    |
| <b>Non Medical Maximum</b>   | \$100,000   | \$25,000  | \$10,000  |
| <b>Overall Benefit Maximum</b>   | The lesser of 5 times Your Basic Annual Earnings, or \$500,000  | Not to exceed 50% of Employees coverage                         | \$10,000  |
| <b>AD&amp;D Coverage: provides a benefit in the event of death or dismemberment resulting from a covered accident Schedules:</b> | Yes (benefit amount is same as Supplemental Term Life coverage) | Yes (benefit amount is same as Supplemental Term Life coverage) | Yes (benefit amount is same as Supplemental Term Life coverage) |
| <b>AD&amp;D Maximum</b>  | Maximum amount is same as Supplemental Term Life coverage       | Maximum amount is same as Supplemental Term Life coverage       | Maximum amount is same as Supplemental Term Life coverage       |
| <b>Employee Contribution</b>   | 100%  | 100%  | 100%  |

Any Purchase or increase in benefits, which does not take place within 31 days of employee's or dependent's eligibility effective date is subject to evidence of insurability. Coverage is subject to the approval of BCBS.

Due to rounding, your actual payroll deduction amount may vary slightly.

## Your Semi-Monthly Cost

| <b>MEDICAL</b> |               |                   |                     |                   |
|----------------|---------------|-------------------|---------------------|-------------------|
|                | Employee Only | Employee & Spouse | Employee & Children | Employee & Family |
| MTBCP539       | \$187.41      | \$824.80          | \$770.03            | \$1,407.46        |
| MTBCP547       | \$165.48      | \$770.89          | \$718.88            | \$1,324.34        |

| <b>DENTAL</b> |               |                   |                     |                   |
|---------------|---------------|-------------------|---------------------|-------------------|
|               | Employee Only | Employee & Spouse | Employee & Children | Employee & Family |
| BASE PLAN     | \$17.38       | \$34.76           | \$44.64             | \$68.28           |
| BUY UP PLAN   | \$25.50       | \$50.98           | \$62.50             | \$96.49           |

| <b>VISION</b> |               |                   |                     |                   |
|---------------|---------------|-------------------|---------------------|-------------------|
|               | Employee Only | Employee & Spouse | Employee & Children | Employee & Family |
| BASE PLAN     | \$3.40        | \$6.45            | \$6.79              | \$9.98            |

| <b>Voluntary Life</b> |                                |                                |   |                               |
|-----------------------|--------------------------------|--------------------------------|---|-------------------------------|
| Age Band              | EE & SP Life Rates per \$1,000 | EE & SP AD&D Rates per \$1,000 | EE & SP Total Monthly Rates per \$1,000 | Child Total Rates per \$1,000 |
| >20 – 29              | 0.070                          | 0.030                          | 0.100                                   | 0.481                         |
| 30-34                 | 0.100                          | 0.030                          | 0.130                                   | 0.481                         |
| 35-39                 | 0.120                          | 0.030                          | 0.150                                   | 0.481                         |
| 40-44                 | 0.150                          | 0.030                          | 0.180                                   | 0.481                         |
| 45-49                 | 0.210                          | 0.030                          | 0.240                                   | 0.481                         |
| 50-54                 | 0.390                          | 0.030                          | 0.420                                   | 0.481                         |
| 55-59                 | 0.650                          | 0.030                          | 0.680                                   | 0.481                         |
| 60-64                 | 0.980                          | 0.030                          | 1.010                                   | 0.481                         |
| 65-69                 | 1.570                          | 0.030                          | 1.600                                   | 0.481                         |
| 70 +                  | 2.970                          | 0.030                          | 3.000                                   | 0.481                         |

***The insurance carrier and published plans take precedence as the correct information in the event of any conflicting information. Endeavor Risk Advisors is not responsible for any errors or omissions in this book.***