HIGH FIVE MEDIA

Benefit Highlight Sheet

Eligibility: Full-time employees are eligible for coverage the 1st of the month following 30 days of employment.
Dependent Eligibility: Employees can cover their spouse, natural children, step children, legally adopted children, children for whom the employee or spouse is the legal guardian, disabled dependents for approved medically certified diagnoses (requires periodic re-certification, no age limit). Dependent children are covered until the end of the month of their 26th birthday.
Open Enrollment: Elections you make during open enrollment will remain in place for the plan year (January 1, 2024 through December 31, 2024), unless you have a qualified change in status. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption or a child, change in a child's dependent status, death of a spouse, child or other qualified dependent, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status. All qualified changes must be requested within 30 days of the event and must be consistent with the event.

Medical and Prescription Drugs

Carrier	BlueCross BlueShield		
Plan Design	**B730ADT**	**S730ADT (Base Plan)**	**G730PFR**
Network	Blue Advantage	Blue Advantage	Blue Preferred
In-Network Benefits			
Deductible			
- Individual	$7,250	$4,250	$2,000
- Family	$13,800	$12,750	$6,000
Coinsurance	0%	40%	30%
Maximum Out-of-Pocket			
- Individual	$7,250	$9,100	$5,000
- Family	$13,800	$18,200	$15,000
Office Visit			
- Primary Care Provider	0% after deductible	$45	$45
- Specialist	0% after deductible	$65	$65
Hospitalization			
- Inpatient	0% after deductible	$250 copay per admit then 40% after deductible	$300 copay per admit then 30% after deductible
- Outpatient	$75 copay per visit then 0% after deductible	$200 copay per visit then 40% after deductible	$300 copay per visit then 30% after deductible
Preventative Care	No charge	No charge	No charge
Lab, X-Ray and Diagnostics	0% after deductible	40% after deductible	30% after deductible
Imaging – MRI, CT, PET and etc.	0% after deductible	40% after deductible	30% after deductible
Emergency Room	$150 copay per visit then 0% after deductible	$500 copay per visit then 40% coinsurance	$650 copay per visit then 30% coinsurance
Urgent Care – **(copay may apply)**	0% after deductible	$50 copay per visit	$50 copay per visit
Prescription Drug	In-Network	Preferred / Non-Preferred	Preferred / Non-Preferred
- Preferred Generic		$10 / $20	$10 / $20
- Generic		$20 / $30	$20 / $30
- Preferred Brand Name	0% after deductible	$50 / $70	$50 / $70
- Non-Preferred Brand Name		$100 / $120	$100 / $120
- Preferred Specialty		$150	$150
- Non-Preferred Specialty		$250	$250

Benefits illustrated are for comparison purposes only. Please review the Summary of Benefits and Coverage and Plan Documents for full details regarding benefits. If any discrepancies exist between the information presented herein and the information contained in the plan documents, the actual provisions of the benefit plan will govern

Medical – Per Paycheck Employee Rates

	BlueCross BlueShield Health Insurance		
	B730ADT	**S730ADT (Base Plan)**	**G730PFR**
Rates	**Per Paycheck**	**Per Paycheck**	**Per Paycheck**
Employee Only	$35.58	$61.24	$132.84
Employee/Spouse	$224.98	$276.28	$419.48
Employee/Child(ren)	$224.98	$276.28	$419.48
Employee/Family	$414.37	$491.33	$706.12

Dental – Voluntary

Carrier	**Delta Dental**
Plan Design	**PPO – Plus Premier**
Network	
In/Out Network Benefits	
Deductible - Individual	$50
Deductible – Family	$150
Annual Maximum	$1,500
Services – See Summary Plan Description for limitations	
Preventative/ Diagnostic	0%
Basic Restorative Services	20%
Major Restorative Services	50%
Orthodontics Child only	50%
Orthodontics – Lifetime Maximum	$1,500
Rates	**Per Paycheck**
Employee Only	$24.00
Employee/Spouse	$46.62
Employee/Child(ren)	$61.85
Employee/Family	$91.85

Vision Insurance – Voluntary

Carrier	VSP
Plan Design	**Choice - Plan B**
In-Network Benefits	
Vision Exam	$10 copay
Materials	$10 copay
Frequency – Exam – Lenses – Frames	 Once every 12 months Once every 12 months Once every 24 months
Frames	$150 retail allowance
Lenses	0% coinsurance after $10 copay
Contact Lenses (in lieu of glasses)	$150 retail allowance

	Vision Insurance
	Choice – Plan B
Rates	**Per Paycheck**
Employee Only	$9.16
Employee/Spouse	$14.65
Employee/Child(ren)	$14.96
Employee/Family	$24.12

Contacts:

Benefit questions/Enrollment:
Tana Sanger
Accounting/HR

Benefits or claims questions or issues:
Kelly Holman or Krissy Jennings
BancFirst Insurance Services
(405) 600-1828 / (405) 600-1818
Kelly.Holman@BancFirst.Insurance or
Krissy.Jennings@BancFirst.Insurance