RETIREMENT BENEFIT OPTIONS

Must enroll in options within 30 days of when benefits end as an active employee.

Dental

As a retiree, you are eligible to continue your dental plans, if you were previously enrolled as an active employee. Coverage must be elected within 30 days of your benefits end date as an active employee. Coverage can include dependent spouses and children up to age 26. Review the enclosed material for dental plan options.

Vision

As a retiree, you are eligible to continue your vision plans, if you were previously enrolled as an active employee. Coverage must be elected within 30 days of your benefits end date as an active employee. Coverage can include dependent spouses and children up to age 26. Review the enclosed material for vision plan options.

Steps to Elect

Review Options

Review the benefit options. This will be your only opportunity to add the retiree dental and vision.

Complete the Enrollment Form

Complete the enclosed form and submit it to the Benefits Department at Okefenokee RESA
Email to: icollins@okresa.org

Have questions?

Need assistance with the plans, please contact Campus Benefits.
Phone: 866-433-7661, opt. 5
Email: mybenefits@campusbenefits.com

GET IN TOUCH

866-433-7661, opt. 5 | mybenefits@campusbenefits.com | okresabenefits.com

2026 MetLife Dental Plan and Rates (Network – PDP Plus):

Please visit https://www.okresabenefits.com/retiree-benefits for full plan details. Below is high-level overview.

Benefits	Coinsurance
Network	PDP Plus
Preventive (Type 1)	100%
Basic (Type 2)	80%
Major (Type 3)	50%
Orthodontia (Lifetime Max)	50% up to $1,000
Calendar Year Max	$1,250
Reimbursement Allowances	90th UCR

Covered Services	
(2 per benefit year) Routine Exam Bitewing X-rays Cleaning	100%
Fluoride (Children)	100% (14 & under)
(1 in 3 years) Full mount/panoramic x-rays	100%
Full Mouth Panoramic X-rays	100%
Restorative Amalgams / Composites	80%
General Anesthesia	80%
Simple & Complex Extractions	80%
Endodontics/Periodontics	80%
Onlays/Inlays	50%
Crowns & Repairs	50%
Calendar Year Deductible (Excludes Preventive)	$50/person, $150/family

Tier	Dental Plan
EE Only	$52.32
EE + Spouse	$102.28
EE + Child(ren)	$119.86
EE + Family	$182.37

2026 MetLife Vision Plan and Rates (Network – VSP Choice):

Please visit https://www.okresabenefits.com/retiree-benefits for full plan details. Below is high-level overview.

In-Network Vision Benefits Summary	High Plan	Low Plan
Exam (with dilation as necessary)	$10 Copay	
Materials Copay	Included in Lens Copay	
Contact Lens Fit/Follow-Up Standard	Max copay of $60	
Lasik or PRK	15% Discount off Retail and 5% off Promotional	
Frames (see plan certificate for featured frames allowance)	$200 allowance + 20% off balance $220 allowance on features frames $110 allowance at Costco, Walmart, and Sam's Club	$150 allowance + 20% off balance $170 allowance on features frames $85 allowance at Costco, Walmart, and Sam's Club
Lenses and Lens Options		
Single/Lines Bifocal & Trifocal/Lenticular	$10 Copay	$25 Copay
Progressive Lens	Up to $55 Copay (Standard)	
Standard UV Treatment	Covered in Full	
Standard Polycarbonate	Children: Covered in Full Adults: Up to $35 Copay	
Standard Scratch-Resistant	Up to $17 - $33 Copay	
Standard Anti-Reflective Coating (variable by type)	Up to $41 - $85 Copay	
Transition Lenses	Up to $47 - $82 Copay	
Contact Lenses		
Elective Contacts	$200 Allowance	$150 allowance
Medically Necessary	Covered in Full after eyewear Copay	
Frequencies		
Exams/Lenses or Contact Lenses/Frames	Every 12 Months	Exams, Lenses, & Contact Lenses: Every 12 Months Frames: Every 24 Months
2nd Pair Benefit (Allowance must be purchased on 2 separate invoices)	Each covered person can get: 2 pairs of prescription eyeglasses, **OR** 1 pair of prescription eyeglasses and an allowance toward contacts, **OR** Double the contact lens allowance	2nd Pair Benefit - Not Covered

Tier	High Plan	Low Plan
EE Only	$12.37	$7.43
EE + Spouse	$23.50	$14.12
EE + Child(ren)	$24.72	$14.86
EE + Family	$36.41	$21.85

Enrollment Form: Next page

2026 Enrollment Form – Retiree Dental and Vision			
Printed Name			
Benefit Effective Date	*First of the month after benefits end as an active employee.		
Home Address			
Phone Number			
Personal Email Address			
SSN			
Date of Birth			
Dependents			
Relationship	**Name**	**SSN**	**Date of Birth**
Benefit			
Dental ☐ Dental Plan		**Vision** ☐ Low Plan ☐ High Plan	
Coverage Tier			
Dental ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family		**Vision** ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family	
Primary Insured Signature			
Date			

**Payment will be submitted to Okefenokee RESA.*