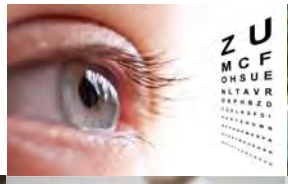
Oklahoma Higher Education Employee Interlocal Group






2018 Employee Benefits

MESSAGE TO OKHEEI EMPLOYEES:

We are pleased to present our Employee Benefits Guide for the 2018 plan year. OKHEEI is committed to providing a healthy environment including health care insurance for employees and dependents. The continual rising cost of health care has added challenges for consumers, employers, and the government. As we enter a new plan year, you'll see OKHEEI remains dedicated to offering an array of choices so you can balance cost and coverage in the way that best suits your needs and those of your family.

Preventive care and wellness benefits are important to promote well-being and to help limit the cost of health care. Our health care program with Blue Cross and Blue Shield of Oklahoma offers insurance coverage and wellness programs to help us achieve and maintain a healthier lifestyle.

Whether you have just joined the OKHEEI team and are learning about your benefit options for the first time or you are a veteran employee who understands and appreciates our benefit programs, we are confident everyone will make good use of this informative reference guide.

We thank you for the many contributions you make to the success of OKHEEI. We encourage you to take advantage of all your available resources and work toward improving your overall health, making the next year your healthiest year ever.

Northeastern State University

Seminole State College

Table of Contents

MURRAY STATE COLLEGE

NORTHEASTERN STATE UNIVERSITY

NORTHERN Oklahoma College

Northwestern OKLAHOMA STATE UNIVERSITY

SWOSU Southwestern Oklahoma State University

UNIVERSITY OF Central Oklahoma

WESTERN Oklahoma State College

This brochure provides only a brief summary of the benefits available under OKHEEI's plans. In the event of a discrepancy between this summary and the Plan Document, the Plan Document will prevail. OKHEEI retains the right to modify or eliminate these or any other benefits at any time and for any reason. More detailed information on a particular benefit plan may be found in the Summary Plan Description for that plan.

EMPLOYEE BENEFITS OPEN ENROLLMENT

Who is Eligible?

All regular, active, full-time employees working 30 or more hours per week, and their eligible dependents are eligible for OKHEEI's benefit plans. Eligible dependents include:

Northern Oklahoma College - Enid Campus

- Current Legal Spouse
- Common Law Spouse
- Married and unmarried children up to age 26, including a newborn, adopted child, stepchild, or other child for whom you or your spouse is legally responsible
- Children who are medically certified as disabled and dependent upon you or your spouse may be eligible for coverage. Please see OKHEEI Plan Document for details.

All dependents added to the plan will be verified by the institution for eligibility. The employee must prove eligibility of insurance by proving the following acceptable documentation:

Spouse:

Documentation must support the current spousal relationship and include the date of marriage. Submit one of the following documents:

- Copy of presently valid legal or religious marriage certificate, which must include the date of marriage.
- Copy of presently valid and notarized common law marriage affidavit (see HR/benefits for a copy of the affidavit).

Dependent Child

Documentation must support the parental relationship and provide the child's date of birth. Submit any one (or a combination) of the following documents:

Copy of the child's legal or hospital birth certificate naming you or your spouse as the child's parent.

- Copy of a final court order (divorce decree/custody agreement) naming you or your spouse as the child's parent. All documents must include the following information: names of the child and parent, official signature and/or court seal/stamp.
- Copy of legal adoption papers issued by the courts naming you or your spouse as the adoptive parent. All documents must include the following information: names of the child and parent, official signature and/or court seal/stamp.

- Copy of legal guardianship papers issued by the courts naming you or your spouse as the child's guardian. All documents must include the following information: names of the child and guardian, official signature and/or court seal/stamp.
- Copy of an order naming you or your spouse as the child's foster parent. All documents must include the following information: names of the child and foster parent, official signature and/or court seal/stamp.
- Copy of a Qualified Medical Child Support Order (QMCSO) showing you're required to provide medical coverage for the child. Documentation must state your current employer's name and include the names of the child and parent.

How to Make Changes?

During the open and new member enrollment period, you can add or drop dependents from your health care coverage without a qualifying event. The enrollment period is the time to make sure all of your eligible dependents are enrolled and that Human Resources has all of the correct information about your dependents on file.

The health care plan options you select during the enrollment period will remain in effect during the calendar year. In order to change benefit elections outside of the enrollment period, the employee must have:

1. Experienced an Applicable Qualifying Event, as defined by the Internal Revenue Service (IRS). Changes based on financial reasons alone are not allowed under the current IRS regulations.

   AND

2. The request for a change of benefits must be made within 31 days of the Applicable

   Qualifying Event. Within the context of changing benefits, "Applicable" refers to a change that is directly related to the individual experience the qualifying event.

A qualifying event includes:

- A birth or adoption
- Marriage, divorce or legal separation
- Death
- Child loses eligibility because of age
- Employee's spouse gains or loses coverage through employment
- Significant change in the financial terms of health benefits provided through a spouse's employer or another carrier

Except for coverage of a newborn or adopted child, all other changes in coverage begin the first day of the month following the qualifying event. Coverage for the newborn is effective on the child's date of birth. Coverage for an adopted child is effective on the date of placement. In both instances, the employee must initiate and complete the appropriate paperwork within 30 days.

Changes in provider networks (for example, your doctor leaving the network) are not considered acceptable reasons for you to be able to change your product election outside of the enrollment period.

CHOOSING A PLAN

Benefit design – There are notable differences between the plans, which impact the coverage and the out-of-pocket costs you'll have when you utilize your benefits.

All three plans promote wellness and offer preventive care and have unlimited lifetime maximums. The Red, White and Blue plans are different in office copays, deductibles, coinsurance and out-of-pocket maximums.

Premium cost – It's important to compare the rates of each plan, while keeping in mind the benefits that come with each plan.

Provider access – The Blue Choice PPO℠ network is Blue Cross Blue Shield of Oklahoma's largest network in the state. The Blue Preferred PPO℠ network is BCBSOK's second largest network. BlueOptions℠ offers a unique tiered structure that allows you the flexibility to see providers in the Blue Choice PPO℠, Blue Preferred PPO℠, or Blue Traditional℠ networks. However, you will have the lowest out-of-pocket costs when you see providers in the Blue Preferred PPO℠ network. You can verify that your current physicians are in the network for the plan you are considering by checking the provider listing on **www.bcbsok.com/okheei/.**

All PPO members have nationwide access to contracting providers through the BlueCard® program when you or your covered family members live, work, or travel anywhere in the country. Additionally, when traveling outside the United States, PPO members have access to contracting providers in more than 200 countries through BCBS Global Core formerly BlueCard WorldWide®.

Flexibility – BlueOptions℠ and BlueChoice℠ give you the most flexibility since you have coverage for both in-network and out-of- network providers. Keep in mind that you will always receive your highest level of benefits and lowest out-of-pocket costs when choosing an in- network provider. (For BlueOptions℠, you will have the lowest out-of-pocket costs when you see providers in the Blue Preferred PPO℠ network.)

Southwestern Oklahoma State University

Murray State College

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PRESCRIPTION DRUG BENEFITS

The Red, White, and Blue plans include the same prescription drug plan.

In order to provide greater discounts, Blue Cross and Blue Shield of Oklahoma has negotiated discounts with drug companies. A list of prescription drugs, both generic and brand names, compose the drug list. The purpose of the drug list is to offer less costly medications. The drug list is divided into three tiers: tier 1 includes generic drugs, tier 2 includes preferred brand drugs and tier 3 includes non-preferred brand drugs. Visit **www.myprime.com** to view the drug list and to find out which tier your medication(s) falls. Specialty drugs are handled by a separate drug program administered through Prime.

Blue Cross and Blue Shield's national preferred pharmacy network includes most national chains and independent pharmacies across the country. The Pharmacies participating in the preferred pharmacy network are below:

- Walgreens
- Walmart (Including Sam's Club Pharmacy)
- Pharmacy Providers of Oklahoma, Inc. (PPOk - a group of independent pharmacies)
- Access Health (a group of independent pharmacies)

Please note CVS and Target pharmacies are no longer included in the preferred pharmacy network and are considered non-preferrered pharmacies. If you fill a prescription at a non-preferred pharmacy, you may pay a higher copay or cosinsurance.

When you fill your prescription drugs at retail, your pharmacy copayment depends on the tier which the drug has been classified. You will pay the cost up to the tier copay for a 102 day supply limit or 300 quantity limit per copay. Blue Cross and Blue Shield also offers a mail order pharmacy program and an extended supply network that may provide discounts for maintenance drugs. For more information about PrimeMail or to view a list of maintenance drugs, visit **www.myprime.com**.

Western Oklahoma State College

Southeastern Oklahoma State University

AVAILABLE MEDICAL PLANS

With OKHEEI, you may select one of three plans:

- Red Plan (Blue Choice PPO℠)
- White Plan (BlueOptions℠)
- Blue Plan (Blue Choice PPO℠)

Redlands Community College

Blue Choice PPO℠

Blue Choice PPO℠ is a preferred provider organization type of plan. Blue Cross and Blue Shield of Oklahoma has negotiated discounts with medical providers to reduce the cost of health care. The discount is applied before there is any payment for services from you or from BCBSOK. The Red and Blue plans offered also give you the flexibility to choose a non-PPO, "out-of-network" provider with whom BCBSOK does not have a contract. Benefits provided by "out-of-network" providers are less and will usually require you pay more for these services.

You will want to consider the plan best suited for you and your family. There are important differences between the plans that should be considered. Details of the benefits and plans are listed on the following pages for easy comparison. You have access to an extensive network of providers and hospitals throughout the country, including therapists, chiropractors, behavioral health professionals and other specialists.

You are not required to select a Primary Care Physician and referrals are not required. You can select any covered provider for care within the Blue Choice PPO℠ network or outside the network. When you receive care from in-network providers, you receive the highest level of benefits. When you receive care from out-of-network providers, you not only receive a lower level of benefits, but you may also be subject to out-of-pocket costs for amounts the provider charges that are above the maximum allowable charge.

Finding out which network your providers are located in is easy! Simply visit **www.bcbsok.com/okheei/** and click on "Search for Doctors and Hospitals in your area." Search by a doctor's name, location, network, etc. You'll find a choice of providers that meet your needs. Or, call BlueCard® Access at 800-810-BLUE (2583).

BlueOptions℠

BlueOptions℠ is a preferred provider organization plan, which gives you the flexibility to choose your provider and network at the time of service. BlueOptions℠ gives you the freedom to select any health care provider (whether they are in-network or not). You do not need to select a primary care physician. Your choice of health care providers can affect the level of health care benefits (including copayment and coinsurance amounts) – based on the network your provider is in.

With the BlueOptions℠ plan, you can choose from different networks each time you need health care. Or, you may choose to see providers that are not in a network (out-of-network).

- The Blue Preferred PPO℠ network provides the biggest discount and pays your benefits at the highest level, which means you will have the lowest out-of-pocket

costs when you use providers in the Blue Preferred PPO℠ network

- The Blue Choice PPO℠ network will pay your benefits at the second highest level, although some aspects of coverage are the same with the Blue Preferred PPO℠ and Blue Choice PPO℠ networks
- The Blue Traditional℠ network will pay your benefits at the third highest level
- If you see out-of-network providers, you will receive no discounts and your benefits will be paid at the lowest allowed amount

The office copayments and out-of-pocket are lower for the Blue Preferred PPO℠ network than the Blue Choice PPO℠ network. The coinsurance paid by BCBSOK varies by network utilized.

Finding out which network your providers are located in is easy! Simply visit **www.bcbsok.com/okheei/** and click on your plan type in the Find a Doctor section. You can search for a doctor by name, location, network, or specialty, such as dermatology or cardiology.

University of Central Oklahoma

East Central University

BLUEOPTIONS FREQUENTLY ASKED QUESTIONS

How do I find a doctor in the Blue Preferred PPO℠ or Blue Choice PPO℠ network?

Go to **www.bcbsok.com/okheei/** and use the provider directory, or call BCBSOK customer service.

How do my benefits work when I am out-of-state?

BlueOptions℠ members have nationwide access to contracting providers through the BlueCard Program when you or your covered family members live, work, or travel anywhere in the country. Your benefits will generally be paid at the Blue Choice PPO℠ benefit level, since Blue Preferred PPO℠ providers are mostly located in Oklahoma. You can search for providers in the online provider directory at **www.bcbsok.com/okheei/**.

Do I need a referral from my doctor to see a specialist?

No. With the BlueOptions℠ plan you can see any doctor at any time without a referral. If you see a specialist who is part of the Blue Preferred PPO℠ network, your benefits will be paid at the highest level and your out-of-pocket costs will be lowest. You can also see a specialist in the Blue Choice PPO℠ or Blue Traditional networks, but your benefits will be paid at a lower level.

Can my doctor be a part of both networks?

Be sure to ask your provider which network(s) they are in. They may be in more than one network. If that is the case, your benefits will be applied at the highest network level. For example, your doctor is in the Blue Preferred PPO℠ and Blue Choice PPO℠ network. If you visit your doctor, your benefits will be applied for the Blue Preferred PPO℠ network, which means that you will have the lowest out-of-pocket expense.

Can I see providers in both the Blue Preferred PPO℠ and Blue Choice PPO℠ networks?

Yes, with BlueOptions℠, you have the freedom to see any doctor you choose at any time. You can choose different networks for different health care services and/or for different members of your family. For example, you can see a physician in the Blue Preferred PPO℠ network while your spouse and children see a physician in the Blue Choice PPO℠ network. Your benefits are determined at the point of service, which means that your copayment and out-of-pocket amounts depend on which network you choose.

Keep in mind that our-of-pocket amounts vary depending on the network you choose and while they do cross apply, you may have more to satisfy if you use a different network. This means it is possible that you may have satisfied your Blue Preferred PPO℠ out-of-pocket, but still have more to satisfy for the Blue Choice PPO℠ network.

Can I see a doctor or use a service that is out-of-network?

Yes. However, the amount your plan pays for covered services is based on the allowed amount described in your Certificate of Benefits. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

WHAT'S NOT COVERED

Your plan options do not cover all health care expenses including exclusions and limitations. You should refer to plan-specific documents to determine which health care services are covered and to what extent.
The following is a partial list of services and supplies that are generally not covered.

- Charges above the allowed amount for out-of-network services
- Services that BCBSOK determines are experimental/investigational
- Custodial care such as sitters' or homemakers' services, care in a place that serves you primarily as a residence when you do not require skilled nursing, or for rest cures
- Reverse sterilization
- Compounded medications
- Acupuncture, whether for medical or anesthesia services

BlueCross BlueShield of Oklahoma

Benefit Summary 2018

	RED PLAN		WHITE PLAN				BLUE PLAN	
Network	Blue Choice PPO℠		BlueOptions℠				Blue Choice PPO℠	
	In Network	Out of Network	Blue Preferred PPO℠	Blue Choice PPO℠	Blue Traditional℠	Out of Network	In Network	Out of Network
General Plan Information							1st Dollar Coverage: Plan pays 100% of the first $500 of eligible charges for each individual then:	
Calendar Year Deductible (CYD)	$1,000 Ind. / $3,000 Family	$1,000 Ind. / $3,000 Family	$1,250 Ind. / $3,750 Family				$500 Ind. / $1,000 Family	$500 Ind. / $1,000 Family
General Payment Level	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Calendar Year Out-Of-Pocket Max (Includes deductible and pharmacy/medical copays)	$3,300 Ind. / $9,900 Family	$3,800 Ind. / $11,400 Family	$3,500 Ind. / $10,500 Family	$4,000 Ind. / $12,000 Family	$4,500 Ind. / $13,500 Family	$6,500 Ind. /$13,000	$5,500 Ind. / $11,000 Family	$5,500 Ind. / $11,000 Family
Coinsurance	Plan Pays 80% after CYD	Plan pays 50% after CYD	Plan Pays 80% after CYD	Plan Pays 70% after CYD	Plan Pays 60% after CYD	Plan Pays 50% after CYD	Plan Pays 50% after CYD	
Lifetime Max - Medical	Unlimited							
Lifetime Max - Pharmacy	Unlimited							
Primary Care Office Visit	$25 copay	50% after CYD	$25 copay	$35 copay	60% after CYD	50% after CYD	50% after CYD	
Specialist Office Visit	$40 copay	50% after CYD	$40 copay	$50 copay	60% after CYD	50% after CYD	50% after CYD	
Diagnostic X-ray/Lab	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Inpatient Hospital*	80% after CYD	Additional $300 deductible per admit, then 50% after CYD	80% after CYD	70% after CYD	60% after CYD	Additional $300 deductible per admit, then 50% after CYD	50% after CYD	Additional $300 deductible per admit, then 50% after CYD
Outpatient Surgery	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Well Baby Care	100%	70% after CYD	100%			70% after CYD	100%	70% after CYD
Adult Immunizations	100%	70% after CYD	100%			70% after CYD	100%	70% after CYD
Routine Health Exams	100%	70% after CYD	100%			70% after CYD	100%	70% after CYD
Childhood Immunizations	100%							
Routine Mammograms	100%							
Allergy Treatment/Testing (60 tests every 24 months)	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Emergency Room	$100 copay; then 80% after CYD (copay waived if admitted)		$150 copay; then 80% after CYD (copay waived if admitted)				50% after CYD	
Health Assessment (HA) - $250 deductible credit to employee, spouse, and dependents over age of 18.	HA deductible credit applies to 2018 plan year and must be completed between 01/01/2018 and 12/31/2018. HA must be completed and credited prior to claims payment. No retroactive claim adjustments will be allowed.							
Mental Health and Substance Abuse								
Inpatient*	80% after CYD	Additional $300 deductible, then 50% after CYD	80% after CYD	70% after CYD	60% after CYD	Additional $300 deductible per admit, then 50% after CYD	50% after CYD	Additional $300 deductible, then 50% after CYD
Outpatient	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	

Network	RED PLAN		WHITE PLAN				BLUE PLAN	
	Blue Choice PPO℠		BlueOptions℠				Blue Choice PPO℠	
	In Network	Out of Network	Blue Preferred PPO℠	Blue Choice PPO℠	Blue Traditional℠	Out of Network	In Network	Out of Network
Occupational & Speech Therapy (Each service limited to 60 visits per CY)	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Physical and Chiropractic Therapy (Services combined limited to 60 visits per CY)	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Durable Medical Equipment (DME), Prosthetics and Orthotics	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Skilled Nursing Facility (100 days per CY)*	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Home Health Care (100 visits per CY)*	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Hospice*	80% after CYD	50% after CYD	80% after CYD	70% after CYD	60% after CYD	50% after CYD	50% after CYD	
Hearing Screening (limited to one per CY)	100% after copay	50% after CYD	100% after copay		60% after CYD	50% after CYD	50% after CYD	
Hearing Aids	Covered as DME up to age 18							

Pharmacy	RED, WHITE and BLUE PLANS	
	In Network	Out of Network
Generic & Preferred – Cost of Rx: $100 or less	Member pays lesser of $25 or actual cost	Member pays cost of Rx up to $75 max plus dispensing fee
Generic & Preferred – Cost of Rx: Greater than $100	Member pays 25% up to $50 max	Member pays cost of Rx up to $75 max plus dispensing fee
Non-Preferred – Cost of Rx: $100 or less	Member pays lesser of $50 or actual cost	Member pays cost of Rx up to $125 max plus dispensing fee
Non-Preferred – Cost of Rx: Greater than $100	Member pays 50% up to $100 max	Member pays cost of Rx up to $125 max plus dispensing fee
102 day supply limit or 300 quantity limit per copay		

*Requires pre-certification

This benefit summary is a Non-Grandfathered health plan. Benefits assume, and are subject to the use of BCBSOK's administrative policies, procedures, and medical policies. Out-of-network charges are paid utilizing the Blue Choice PPO℠ allowable amount. Members may be balanced billed by the provider. This benefit summary does not contain a complete list of benefits available to you nor does it contain a listing of exclusions, limitations, and conditions which apply to the benefits shown. Full information can be found only in the Group Contract and Certificate of Benefits.

DENTAL BENEFITS

As a participant and/or covered dependent of Delta Dental of Oklahoma, your dental benefits program allows payment for eligible services performed by any properly licensed dentist. However, maximum savings are achieved when treatment is provided by a Delta Dental participating dentist through the PPO network.

OKHEEI offers three different dental plan options through Delta Dental of Oklahoma to all eligible employees and dependents. These include:

- High Option (PPO and Premier Network)
- Low Option (PPO and Premier Network)
- Preventive Option (PPO Network ONLY)

Similar to the medical coverage, the annual deductible must first be reached for all covered Basic and Major Care (except for the Preventive Plan that doesn't cover Major Care and limited basic services). The deductible does not apply to preventive care of orthodontia.

Please refer to your Dental Care Certificate regarding limitations and exclusions.

Preventive Care Includes:

- Routine Cleanings
- Exams
- X-Rays
- Fluoride treatments

Routine cleanings, exams, and bitewing x-rays are covered twice in a benefit period. Topical fluoride application is covered twice in a benefit period for children up to age 18.

Basic Care Includes:

- Fillings
- Extractions*
- Endodontics*
- Periodontics*

Major Care Includes:

- Crowns
- Bridges
- Dentures
- Implants

Orthodontia:

- ONLY available on the High Option
- No waiting period
- No lifetime maximum
- Covered at 50% of covered and allowed amount
- For dependent children up to age 26

Rose State College

	HIGH OPTION			LOW OPTION			Preventive
	PPO Network	Premier Network	Out of Network	PPO Network	Premier Network	Out of Network	PPO Network ONLY
Annual Deductible	$25 Ind./ $75 Family	$25 Ind./ $75 Family	$25 Ind./ $75 Family	$50 Ind./ $100 Family	$50 Ind./ $100 Family	$50 Ind./ $100 Family	$50 Ind./ $100 Family
Preventive Care	100%, no deductible						Plan covers preventive services at 100%, no deductible
Basic Care*	85% after deductible	70% after deductible	70% after deductible	75% after deductible	70% after deductible	70% after deductible	80% after deductible for services such as amalgam and composite fillings.
Major Care	60% after deductible	50% after deductible	50% after deductible	60% after deductible	50% after deductible	50% after deductible	No Major Care Coverage
Orthodontic Care Available to children up to age 26	50%, no deductible No waiting period			No Orthodontic Coverage			No Orthodontic Coverage
Maximums	Dental: $2,000 per person/ Calendar Year Orthodontia: None			Dental: $1,000 per person/Calendar Year Orthodontia: Not Covered			Dental:$750 per person Ortho: Not Covered

**Note: Endodontics, Periodontics, and oral surgery only covered under the High and Low option plans.*

The information contained herein is an example of benefits and not intended as a Dental Care Certificate. The information is not designed to serve as Evidence of Coverage for this program and is subject to the provisions of the Dental Care Certificate For an accurate description of your benefits, see the Dental Care Certificate or contact Delta Dental of Oklahoma as some benefits are subject to limitations such as age of patient, frequency of procedure, exclusions, plan changes, etc. Out-of-Network - Members may be balanced billed by the provider for charges over the allowable amount and or services that are not covered.

Get access to the best in eye care and eyewear with Oklahoma Higher Education Employees Interlocal Group and VSP® Vision Care.

Why enroll in VSP? As a member, you'll receive access to care from great eye doctors, quality eyewear, and the affordability you deserve, all at the lowest out-of-pocket costs.

You'll like what you see with VSP.

- **High Quality Vision Care.** You'll get the best care from a VSP network doctor, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP network doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Save with VSP Coverage	Without VSP Coverage	With VSP Coverage
Eye Exam	$168	$10
Frame	$150	$25
Single Vision Lenses	$92	
Photochromic Adaptive Lenses	$111	$70
Anti-reflective Coating	$114	$69
Member-only Annual Contribution	N/A	$78.48
Total	**$635**	**$252.48**

Comparison based on national averages for comprehensive eye exams and most commonly purchased brands

NOTE: Dollar amounts in the savings chart are estimates and don't reflect additional discounts from current VSP offers and promotions.

Average Annual Savings with a VSP Provider: $382.52

Enroll in VSP today. You'll be glad you did.
Contact us. **800.877.7195**
vsp.com

Using your VSP benefit is easy.

- **Create an account at vsp.com**. Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** Visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.[1] Visit **vsp.com** to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.[2] Prefer to shop online? Check out all of the brands at **eyeconic.com**®, VSP's online eyewear store.

Your VSP Vision Benefits Summary

Oklahoma Higher Education Employees Interlocal Group and VSP provide you with an affordable eye care plan.

VSP Provider Network: VSP Choice

Benefit	Description	Copay	Frequency
	Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every calendar year
Prescription Glasses		$25	See frame and lenses
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Costco® frame allowance	Included in Prescription Glasses	Every calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every calendar year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$55 $95 - $105 $150 - $175	Every calendar year
Contacts (instead of glasses)	• $150 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation)	$0	Every calendar year
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit **vsp.com** for plan details.

Exam ..... up to $45	Lined Bifocal Lenses ..... up to $50	Progressive Lenses ..... up to $50
Frame ..... up to $70	Lined Trifocal Lenses ..... up to $65	Contacts ..... up to $105
Single Vision Lenses ..... up to $30		

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Contact us. **800.877.7195** | **vsp.com**

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

LIFE/AD&D INSURANCE

Basic Life/AD&D

Basic Life and Accidental Death and Dismemberment (AD&D) is part of OKHEEI's benefits plan and is an essential part of your future financial security. It is important to understand how your plan works and what benefits you will receive. Just as you would keep track of money that you put into a bank or other financial institution, it is in your best interest to keep track of your survivor benefits.

OKHEEI provides full-time, regular employees **company paid** group term Life and Accidental Death and Dismemberment (AD&D) insurance through MetLife.

Basic Life/AD&D Plan Features	
Basic Life Benefit	2 times Basic Annual Earnings
Accidental Death & Dismemberment	An amount equal to Your Basic Life Insurance.
Plan Maximum	The lesser of 2 times Basic Annual Earnings or $250,000
Non-Medical Maximum	The lesser of 2 times Basic Annual Earnings or $250,000
Age Reduction Formula	35% at age 65; Additional 15% of original amount at age 70; Additional 15% of original amount at age 75: Benefits terminate at retirement*

* Unless eligible for retiree benefits.

Northwestern Oklahoma State University

LIFE/AD&D INSURANCE

Voluntary Life/AD&D*

Employees may purchase Voluntary Life Insurance through MetLife for themselves and their dependents. Premiums are paid through post-tax payroll deductions. Employee and spouse premiums are based on the employee's age. **Your cost automatically adjusts on January 1 of the year after you reach a new age band.**

How do you enroll in Voluntary Life?

Completion, review and approval of the Evidence of Insurability form will be required:

- If you are electing coverage for the first time
- If you are increasing coverage more than two (2) increments above your current election
- If you are increasing the amount of Spouse Life (and AD&D)

	Employee	Spouse and Child	
Life Coverage: provides a benefit in the event of death Schedules:	Increments of $10,000	Option 1: $10,000 Spouse; $5,000 Child (Life Only) Option 2: $20,000 Spouse; $10,000 Child (Life Only) Option 3: $50,000 Spouse; $10,000 Child (Life Only) Option 4: $10,000 Spouse; $5,000 Child (Life and AD&D) Option 5: $20,000 Spouse; $10,000 Child (Life and AD&D) Option 6: $50,000 Spouse; $10,000 Child (Life and AD&D)	
Non-Medical Maximum	$300,000	$50,000	$10,000
Overall Benefit Maximum	The lesser of 5 times Your Basic Annual Earnings, or $500,000	$50,000	$10,000
AD&D Coverage: provides a benefit in the event of death or dismemberment resulting from a covered accident Schedules:	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)
AD&D Maximum	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
Employee Contribution	100%	100%	100%
Benefit Reduction			
Benefits will reduce:	35% at age 65; Additional 15% of original amount at age 70; Additional 15% of original amount at age 75: Benefits terminate at retirement**	Benefits terminate at Employee retirement	N/A

*Voluntary Life AD&D is not available for employees at Redlands Community College.
**Unless eligible for retiree benefits.

LIFE/AD&D INSURANCE

Voluntary Life/AD&D*

Monthly Premium Calculation Table

Employee Age	Monthly Rate Per $1,000	Monthly Premium For: Supplemental Employee Life and AD&D							
		$10,000	$20,000	$40,000	$50,000	$100,000	$150,000	$200,000	$300,000
Up to 29	$0.08	$0.80	$1.60	$3.20	$4.00	$8.00	$12.00	$16.00	$24.00
30 to 34	$0.10	$1.00	$2.00	$4.00	$5.00	$10.00	$15.00	$20.00	$30.00
35 to 39	$0.11	$1.10	$2.20	$4.40	$5.50	$11.00	$16.50	$22.00	$33.00
40 to 44	$0.15	$1.50	$3.00	$6.00	$7.50	$15.00	$22.50	$30.00	$45.00
45 to 49	$0.23	$2.30	$4.60	$9.20	$11.50	$23.00	$34.50	$46.00	$69.00
50 to 54	$0.34	$3.40	$6.80	$13.60	$17.00	$34.00	$51.00	$68.00	$102.00
55 to 59	$0.56	$5.60	$11.20	$22.40	$28.00	$56.00	$84.00	$112.00	$168.00
60 to 64	$0.69	$6.90	$13.80	$27.60	$34.50	$69.00	$103.50	$138.00	$207.00

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

Original Benefit Amount		$10,000	$20,000	$40,000	$50,000	$100,000	$150,000	$200,000	$300,000
	Age Reduction:	$6,500	$13,000	$26,000	$32,500	$65,000	$97,500	$130,000	$195,000
65 to 69**	$1.29	$8.39	$16.77	$33.54	$41.93	$83.85	$125.78	$167.70	$251.55
	Age Reduction:	$5,000	$10,000	$20,000	$25,000	$50,000	$75,000	$100,000	$150,000
70 to 74**	$2.08	$10.40	$20.80	$41.60	$52.00	$104.00	$156.00	$208.00	$312.00
	Age Reduction:	$3,500	$7,000	$14,000	$17,500	$35,000	$52,500	$70,000	$105,000
75+ **	$2.08	$7.28	$14.56	$29.12	$36.40	$72.80	$109.20	$145.60	$218.40

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

**Age Reductions Apply. 65% of Original, 50% of Original, 35% of Original.

EXAMPLE:
Use this formula calculate premium costs for supplemental life benefit coverage amounts not show in the illustration above.

Age	Monthly Rate Per $1,000	X	Benefits in $1,000	=	Monthly Cost
35	$0.11	X	110	=	$12.10

Monthly Premium for Dependent Life (Spouse/Child) Child Options				
Spouse and/or Child - Life Only			Spouse and/or Child - Life and AD&D	
Option 1	$2.40 per family unit		Option 4	$2.65 per family unit
Option 2	$4.80 per family unit		Option 5	$5.30 per family unit
Option 3	$12.00 per family unit		Option 6	$13.00 per family unit

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

*Voluntary Life AD&D is not available for employees at Redlands Community College.

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between MetLife and your employer. Specific details regarding these provisions can be found in the certificate. If you have additional questions regarding the Life Insurance program underwritten by MetLife, please contact your benefits administrator or MetLife. Like most group life insurance policies, MetLife group policies contain exclusions, limitations, terms and conditions for keeping them in force. Please see your certificate for complete details.

DISABILITY INSURANCE
Long Term Disability

Long Term Disability Insurance protects your income if you become partially or totally disabled for a long period of time off the job.

If you elect to buy-up your coverage at any time other than initial eligibility, you will be required to submit proof of health which is subject to approval by MetLife. Any election amount will not be effective until EOI is reviewed and approved.

LONG TERM DISABILITY PLAN FEATURES		
	Core Plan	**Buy-Up Plan**
Benefits Begin	180 days	90 days
Percentage of Income Replaced	60% of the first $13,333 of Your Pre-disability Earnings	60% of the first $13,333 of Your Pre-disability Earnings
Maximum Monthly Benefit	$8,000	$8,000
Minimum Monthly Benefit	$100	$100
Pre-Existing Conditions	Sickness or accidental injury in which you received medical treatment, care or service within 3 months of the effective date and you have been Actively at Work for less than 12 consecutive months after the effective date	
Mental Nervous Illness/Substance Abuse	Lesser of 24 months or your Maximum Benefit Period	

LTD Example: Monthly Calculation for LTD CORE Benefit

A. Annual Earnings =	$30,000.00	A. Annual Earnings =	
B. Monthly Earnings = (A divided by 12)	$2,500.00	B. Monthly Earnings = (A divided by 12)	
C. Value Per $100 = (B divided by $100)	$25.00	C. Value Per $100 = (B divided by $100)	
D. Estimated Monthly Contribution = (C multiplies by 0.148)	$3.70	D. Estimated Monthly Contribution = C multiplies by 0.148)	

Note: LTD CORE benefit is provided at no cost to employees with the exception of Seminole State College. Employees at this institution please use Monthly Calculation table above for estimated monthly rate.

LTD Example: Monthly Calculation for LTD BUY-UP Benefit

A. Annual Earnings =	$30,000.00	A. Annual Earnings =	
B. Monthly Earnings = (A divided by 12)	$2,500.00	B. Monthly Earnings = (A divided by 12)	
C. Value Per $100 = (B divided by $100)	$25.00	C. Value Per $100 = (B divided by $100)	
D. Estimated Monthly Contribution = (C multiplies by 0.08)	$2.00	D. Estimated Monthly Contribution = (C multiplies by 0.08)	

An Easy Way to Pay for Expenses

A Section 125 Plan provides a tax-saving way to pay for eligible medical or dependent care expenses. The funds are automatically deducted from your paycheck before income tax is applied. Simply choose the amount to be deducted, and the funds are set aside to be used for eligible expenses throughout the year.

Here's How It Works

A Section 125 Plan reduces your tax and increases your spendable income by allowing you to deduct the cost of eligible benefits from your earnings before tax. Plus, the plan is available to you at no cost, and you're already eligible. All you have to do is enroll.

Is It Right for Me?

The savings you may experience with a Section 125 Plan are outlined below. By utilizing the Section 125 Plan, Jane would have $70 more every month to apply toward her insurance benefits or other needs. That's a savings of $840 a year.

Ready to Enroll?

To enroll in the Section 125 Plan, just complete an election form. You'll receive plenty of advance notice when it's time to enroll. And, in most cases, you must re-enroll each year to keep participating in the plan.

How to Make Election Changes

You're able to change your election each year during your annual benefits enrollment, but the only time Internal Revenue Code regulations allow you to make a change during the plan year itself is if you experience a qualified event. Some examples include:

- **Change in legal married status**
- **Change in number of dependents**
- **Termination or commencement of employment**
- **Dependent satisfies or ceases to satisfy dependent eligibility requirements**
- **Change in residence or worksite that affects eligibility for coverage**

These examples may not be all-inclusive. Please contact your employer for guidance with your specific situation.

Employee Name: Smith, Jane
SSN: 123-45-XXXX
Employee Number: 0515
Payment Date: 1/1/17
Period Begin Date: 1/30/17

Earnings & Hours	Without S125	With S125
Monthly Salary	$2,000	$2,000
Medical Expenses	*N/A*	-$250
Taxable Gross	***$2,000***	***$1,750***
Taxes (Federal & State @ 20%)	-$400	-$350
Less Estimated FICA (7.65%)	-$153	-$133
Medical Deductions	*-$250*	*N/A*
Take Home Pay	***$1,197***	***$1,267***

That's a difference of $70!

Where allowable by law. If you are subject to FICA taxes, there might be a reduction in your social security benefit due to the reduction of FICA contributions. ***Example is hypothetical for illustrative purposes only. Please consult your tax advisor for actual tax savings.***

SB-30531-0716

AMERICAN FIDELITY
a different opinion

Help Save for Medical Expenses

Are you looking for a way to reduce your taxable income and help pay for medical and dependent care expenses? Reimbursement accounts can do just that.

With these accounts, you'll enjoy a money-saving way to pay for eligible medical or dependent care expenses with pre-tax dollars from your paycheck.

Just choose the amount to be deducted, and the funds are set aside to be used for expenses throughout the year. It's that easy.

Here's How They Work

A **Dependent Day Care Flexible Spending Account (Dependent Day Care FSA)** allows you to set aside pre-tax dollars to reimburse yourself for eligible dependent care expenses. Because your money goes into the account before income tax is withheld, you pay less in tax and have more disposable income. You may allocate up to $5,000 per tax year for reimbursement of eligible dependent care services (or $2,500 if you are married and file a separate tax return).

A **Health Flexible Spending Account (Health FSA)** can save you money by allowing you to set aside part of your pay, on a pre-tax basis, to reimburse yourself for eligible medical expenses such as copayments, deductibles, prescriptions, and more. The maximum amount allowed to contribute into this account is $2,600 per calendar year. (Please see your employer for the maximum amount allowed by your plan.)

Fast, Easy Reimbursements

If you're interested in either of these accounts, we're happy to set up your account for direct deposit. You can either have your reimbursements deposited straight into your bank account or receive a check by mail – it's entirely up to you.

If you don't file sufficient claims for reimbursement, you could lose the unused amount remaining in your account at the end of the plan year. This is often referred to as the "use-or-lose" rule.

Your employer may offer a carryover of up to $500 each plan year *or* a grace period, which is a period of time after the plan year ends where you may incur expenses and be reimbursed from the remaining balance in your previous year's account.

Examples of Eligible Expenses

- Acupuncture
- Alcohol/drug rehab
- Anesthetist
- Artificial limbs/teeth
- Chiropractor
- Dental care
- Eye exam/eyeglasses/contact lenses
- Hearing aids/batteries
- Insulin
- Invitro fertilization
- Laser eye surgery
- Midwife
- Optometrist
- Orthodontia*
- Out-patient care
- OTC drugs and medicines for treatment of a medical condition**
- Pediatrician
- Physical therapy provided by licensed therapist
- Practical nurse
- Psychiatrist
- Psychologist
- Stop-smoking program
- Transportation expenses relative to medical care based on IRS standard mileage allowance
- Weight loss program for obesity***

Examples of Ineligible Expenses

- Capital expenditures
- Cosmetic procedures
- Exercise equipment
- Insurance premiums
- Mattresses/pillows
- Personal use items
- Teeth whitening

**Service must have been incurred or already paid.*
***Will require a medical practitioner's prescription.*
****May need doctor's statement for medical necessity.*

SB-30532-0716

AMERICAN FIDELITY
a different opinion


SB-30432-0716

Disability Income Insurance

If you were suddenly faced without a paycheck, would you be fully prepared? Could you afford your expenses while maintaining your current lifestyle?

One of the most important assets a person possesses is the ability to earn an income. Disability Income Insurance from American Fidelity is a cost-effective solution designed to help protect you if you become disabled and cannot work due to a covered injury or sickness.

These products may contain limitations, exclusions, and waiting periods. Applicant's eligibility for this program may be subject to insurability.


SB-30430-0716

Cancer Insurance

If you were faced with a cancer diagnosis, will your major medical insurance be enough? Even with a good plan, the out-of-pocket costs of treatment, such as travel, child care, and loss of income, can be expensive.

American Fidelity's **Limited Benefit Cancer Insurance** may help. Benefit payments are made directly to you, allowing you to pay for expenses like copayments, hospital stays, and house and car payments.

Not all riders may be available in every state. Limitations, exclusions, and waiting periods may apply. ***This product is inappropriate for people who are eligible for Medicaid coverage.***


SB-30426-0716

Accident Only Insurance

Accidents are inevitable. Even though you can't always prepare for unforeseen events, you can plan ahead. A **Limited Benefit Accident Only Insurance** plan may help ease the impact on your finances.

American Fidelity's Accident Only Insurance is designed to help cover some of the expenses that can result from a covered accident, and benefit payments are made directly to you.

Limitations, exclusions, and waiting periods may apply. Not all products and benefits may be available in all states. ***This product is inappropriate for people who are eligible for Medicaid coverage.***


SB-30505-0716

Life Insurance

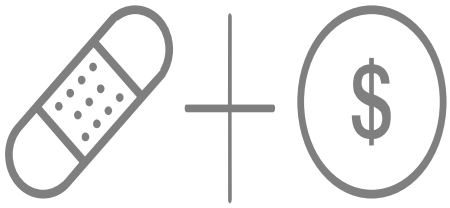
Ensuring your family is financially covered in the event of a loss is an important way of showing them you care about their needs. Life Insurance can help.

Portable, Individual Life Insurance policies may help your family in the event of your death. The application process is simple. You only have to answer three health questions, and there are no medical exams required. Term Life Insurance provides short-term coverage at a competitive price, while Whole Life Insurance provides lifelong protection.

Issuance of the policy may depend upon the answers to the health questions. Please consult your tax advisor for your specific situation. Limitations, exclusions, and waiting periods may apply. Not generally qualified benefits under Section 125 Plans.

How It Works

this will walk you through the benefit so you know how everything works



Healthcare can be confusing and expensive

That's why we are here! For hundreds of services like surgery, imaging and even prescriptions we can help

1

Your doctor says you need a procedure or service

You can always go see your regular doctor as he or she will often determine exactly what you need done. It may be a surgery, an MRI or just a simple lab test but we can help with all those things!

2

You call or email us to make sure it is covered

Once you know what you need you can email us or just give us a call and we can let you know if it is covered and all the places you can go.

3

We take care of the details of you always pay $0

We will send the referral to the provider you choose and even help with scheduling and the transfer of medical records. Your plan covers everything at 100% so you will always pay $0 .

If you don't hear back from the provider within 2 business days you can email us at help@thezerocard.com

If you ever get a bill please send a copy to us right away so we can get it fixed!

Frequently Asked Questions

The Zero Card offers hundreds of procedures and services that cost you $0.

How do I use The Zero Card?

When your doctor tells you that you need a service or procedure, call your Personal Health assistant at 855.816.0001. We take care of the details and you always pay zero.

What does The Zero Card cover?

The Zero Card includes services such as surgeries, x-ray, advanced imaging (MRI, CT,), lab and many others.

What does it cost me to use The Zero Card?

When you use The Zero Card, your health plan pays 100% of the charges. That means no deductible, no co-pay and no co-insurance coming out of your pocket.

How do I know what providers are covered?

Most providers are listed on our website, www.thezerocard.com. We do always encourage you to call us as we are always adding additional providers.

What do I do if I receive a bill?

Receive a bill, no worries! Simply call us at 855.816.0001 or email us at help@thezerocard.com and we will take care of it.

Still have questions? Call us at 855.816.0001 or email us at help@thezerocard.com

BlueCross BlueShield of Oklahoma

Looking for the right doctor?

Provider Finder® is the quick and easy way to make better health care decisions for you and your family.

Provider Finder from Blue Cross and Blue Shield of Oklahoma (BCBSOK) is an innovative tool for helping you choose a provider, plus estimate and manage health care costs.

By logging in to Blue Access for Members℠ (BAM) you can use Provider Finder to:

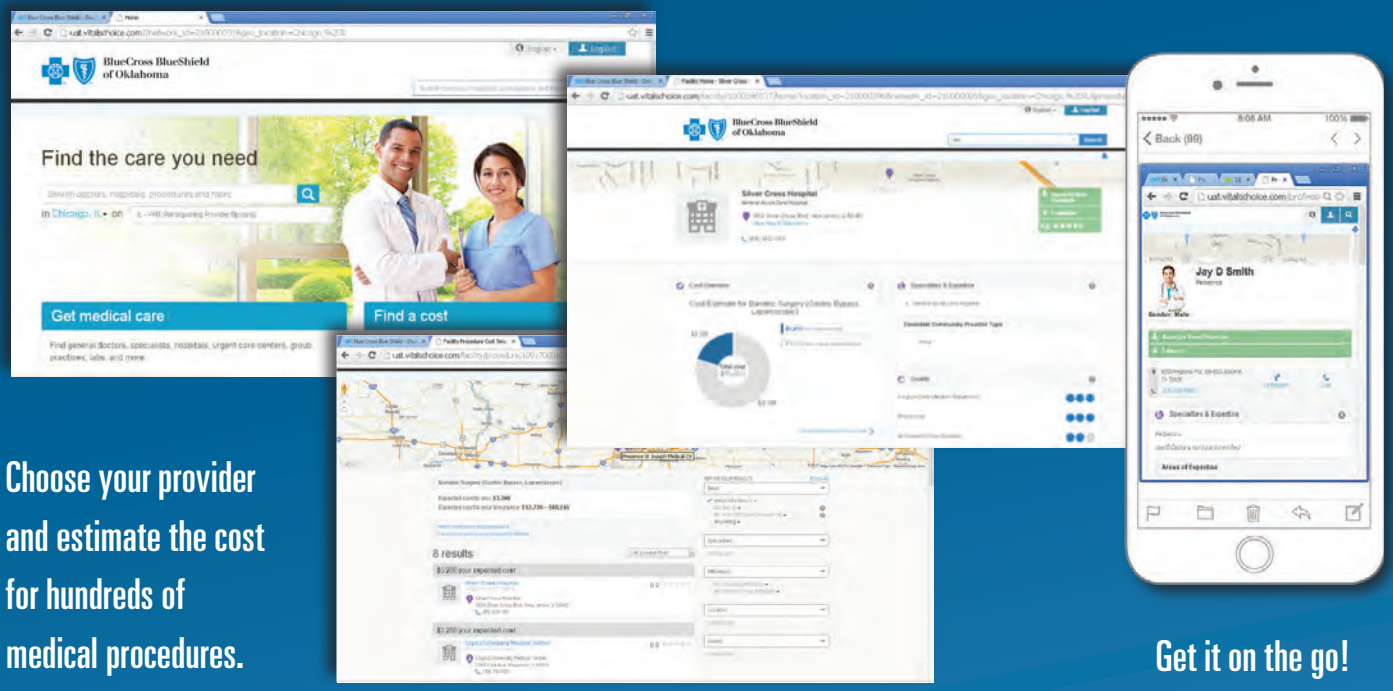
- Find a network primary care physician, specialist or hospital.
- Filter search results by doctor, specialty, ZIP code, language and gender – even get directions.
- Estimate the cost of hundreds of procedures, treatments and tests and your out-of-pocket expenses.
- Determine if Blue Distinction Center® (BDC), BDC+ or Blue Distinction Total Care is an option for treatment.
- View patient feedback or add your review for a provider.
- Review providers' certifications and recognitions.

It's easy, immediate, secure – and available at bcbsok.com.

You're in charge with more information.

- Do you want to know more about the providers who take care of you or your family?
- Do you need to know the estimated cost of a medical service?
- Do you want to know what feedback other patients had on a provider?

Informed Choice. Cost Management. More Options.



Choose your provider and estimate the cost for hundreds of medical procedures.

Get it on the go!

Screen shots are for illustrative purpose only.

It's easy to get started with Provider Finder by registering for Blue Access for Members℠ (BAM):

1. Go to **bcbsok.com**.
2. Click the **Log In** tab, and then click the **Register Now** link.
3. Use the information on your BCBSOK ID card to complete the process.
4. Then, log in to BAM. Provider Finder is located under the **Doctors & Hospitals** tab.

You can also call a BCBSOK Customer Service Advocate at the toll-free telephone number on the back of your member ID card for help in locating a provider.

Get assistance while you're away from home.

Go to bcbsok.com and register or log in to BAM. You can stay connected to your claims activity, member ID card and coverage details – you can also receive prescription reminders and health tips via text messages.

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Health Assessment

Would you like to reduce your annual medical deductible by $250?

All enrolled members in Blue Cross Blue Shield, including employees, spouses, and dependent children over the age of 18 are now eligible to take a health assessment for a $250 credit EACH towards the annual medical calendar year deductible! This online assessment is completed through the member's Blue Access for Members, or BAM, account and MUST be completed prior to incurring a claim that would go towards the deductible.

Steps to set up a personal BCBS "*BAM*" account:

Go to: **www.bcbsok.com/okheei/** (also on the back of your medical card)

- In the "BlueAccess for Members" box click on *Register Now*
- Follow steps to set up account with BCBS:
  - Complete Member information
  - Complete Plan information (numbers found on your card)
  - Complete Security information
  - "Agree" with the Terms of Use
  - Access your e-mail account to validate your e-mail address with BCBS
  - Make note of your log-in and password for future use

Log into your BAM account with BCBS and take the Health Assessment. Each eligible member will have to create their own BAM account and complete the Health Assessment to receive the $250 credit.

REMINDER: The Health Assessment may be taken anytime during the calendar year; however, it must be taken before a claim is incurred to receive the $250 credit.

How to take the assessment:

1. Log into your BAM account at BCBS
2. Under the Quick Links on the right hand side of the screen, click Take Your Health Assessment

After successfully completing your Health Assessment, your $250 incentive will show up in your BAM account/My Coverage/Incentives in approximately 10 business days. If you experience difficulties, call the customer service number on the back of your BCBS ID card: 1-800-672-2567.

Once you have your personal on-line account set up with BCBS you will be able to access your claims information and *MyPrime* regarding prescription drugs. You will find articles on a variety of health topics and fitness programs, be able to request a new ID card, and find doctors and hospitals on your plan

BlueCross BlueShield of Oklahoma

Well onTarget®

Live Well with the Well onTarget Member Wellness Portal

The Well onTarget Member Wellness Portal at **wellontarget.com** provides you with tools to help you set and reach your wellness goals. The portal is user-friendly, so you can find everything you need quickly and easily.

EXPLORE YOUR WELLNESS WORLD

When you log in to your portal, you will find a wide variety of health and wellness resources, including:

- The Health Assessment (HA)
- Self-directed Courses
- Health trackers
- Trusted news and health education content

SEE YOUR STATS IN A FLASH

Everything you want to see quickly is on your dashboard. The dashboard shows all of your Well onTarget programs. You can see where you are today compared with where you were when you started. You can also read the latest health news, check your activity progress and more.

TAKE A SNAPSHOT OF YOUR HEALTH

The HA asks you questions about your health and habits. You then get a Personal Wellness Report. This report suggests ways to make positive lifestyle changes. Your report can also help you decide which Well onTarget program to start first to get the most benefit. You can even print a Provider Report to share with your doctor.

BLUEPOINTS℠ PROGRAM*

Small rewards might motivate you to make positive changes to meet your wellness goals. With Well onTarget, you can earn Blue Points for making healthy choices. If you enroll in the Fitness Program or take your HA, you earn points. You can also earn points when you achieve milestones in the Self-directed Courses. Redeem your Blue Points in the online shopping mall, which offers a wide variety of merchandise.

HEALTH TOOLS AND TRACKERS

Knowing what you eat and how much you work out can help you reach your goals. But keeping track of all you do can be time-consuming. To make it easy, the portal has an interactive food and exercise diary. You can record all of your nutrition and fitness information in one place. The diary will track your progress toward your goals. For example, you can list how many glasses of water you drink every day.

Other trackers let you record how much sleep you get, your stress levels, your blood pressure readings and your cholesterol levels.

The portal also offers a symptom checker. When you don't feel well, this tool can help you decide if you should see a doctor.

SELF-DIRECTED COURSES

These 12-week courses allow you to study on your own time. Taking these courses can help you get to the next level of wellness. Course topics are nutrition, weight management, physical activity, stress management and tobacco cessation. You can enroll in up to three courses at a time.

FITNESS TRACKING

Earn Blue Points for tracking your fitness activity using popular fitness devices and mobile apps.

* Blue Points Program Rules are subject to change without prior notice. See the Program Rules on the Well onTarget Member Wellness Portal for further information.

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Take Wellness on the Go

Check out the Well onTarget mobile app, available for iPhone® and Android™ smartphones. It can help you work on your wellness goals — anytime and anywhere.

Are you managing your chronic condition or is it managing you?

BlueCross BlueShield of Oklahoma

Call Condition Management if you or any of your covered family members have:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Depression
- Diabetes
- Low back pain

Take control and be the boss of your health

If you have a chronic condition, managing your health better can pay off later on. So take the first step to a healthier tomorrow and join the Condition Management program.

Condition Management is available to you and your covered family members through your Blue Cross and Blue Shield of Oklahoma (BCBSOK) benefits at no additional cost. It's easy to join; just call 866-670-6681 and select "Blue Care Connection" to enroll.

A Blue Care Advisor℠ will call you

A Blue Care Advisor is a licensed clinician with special training to help you manage your health condition. Your Advisor will schedule regular phone calls with you to try to help you set and reach health goals.

You will work together to figure out if there are any obstacles to taking better care of yourself and how to overcome them. Your Advisor will also work with your doctors to make sure you are getting the care you need.

Blue Care Connection®

BlueCross BlueShield of Oklahoma

83% of members who participated in the Condition Management program remained stable or improved.*

* Internal data analysis: Condition Management severity level measured initially in January 2013, final severity level measured June 2014

Rather do it online? No problem! Visit careontarget.com.

Care onTarget®, our condition management website, is available whenever you are. It provides you with these tools to try to help you better manage your chronic condition:

Take a Condition Assessment: Just answer some basic questions about your health. You can take assessments for asthma, coronary artery disease (CAD), diabetes, depression and more.

Watch Online Health Tutorials: Based on your assessment answers, Care onTarget will suggest online tutorials that may help you better understand your health needs and take a more active role in your care.

Find Health Resources: This section can help you access useful information from well-known sources such as the National Institutes of Health and the Centers for Disease Control and Prevention.

Live Chat with a Clinician: Have a question about your health? Chat with a clinician Monday through Friday, 8:30 a.m. to 5 p.m. Central time (excluding holidays).

Getting your chronic condition under control may help you be healthier in the years to come. Call 866-670-6681 and select "Blue Care Connection" today to join the Condition Management program, or visit careontarget.com and start a live chat with a clinician.

Blue Care Connection

603063.0216

OTHER RESOURCES TO HELP YOU

Blue Cross and Blue Shield of Oklahoma also provides other health and wellness information.

Preventive Health Care Guidelines are published each year and made available via **www.bcbsok.com/okheei/.** This is a good source of information on preventive care guidelines, which are based on recommendations set by national health agencies and medical associations. You can learn about recommended screenings, and immunizations and doctor visits for all ages, from prenatal care and infancy through the senior years.

Be Smart. Be Well.® Is our website dedicated to raising awareness of largely preventable health and safety issues. You'll find in-depth information on a variety of issues, including traumatic brain injuries, drug interactions and mental health at **www.besmartbewell.com**.

Glucose Meters help members with diabetes manage their condition and can be ordered at no charge. For information on the meters that are available, call customer service at 800-672-2567.

Blue Access for Members - Go to **www.bcbsok.com/okheei/** to register. You will be able to:

- Check the status or history of a claim
- Locate a doctor or hospital in your plan's network
- Request a new ID card or print a temporary one
- Access to health and wellness information
  - Find Cost Estimates
  - Compare providers
- Estimate Out-of-Pocket expenses for common procedures Start your journey to wellness today!

HOW TO REDUCE YOUR PHARMACY COSTS

Everyone is looking for ways to reduce medical costs. One of the most effective ways to do this is to manage your pharmacy costs. Here are some tips to make your medical dollars go further:

- Choose generic medications over brand name counterparts. Generic drugs are Food and Drug Administration-approved and are as safe and effective as their brand name equivalents. There was a time when people questioned generics, but most doctors and patients embrace them today. The FDA mandates that generics are made with the same active ingredients and are available in the same strength and dosage as their competitors. Most generics are dramatically cheaper than brand name drugs and many are manufactured by the same companies that make the original brand name drug.
- Step therapy is a pharmacy policy based on the concept of comparative effectiveness. Comparative effectiveness examines forms of treatment to determine which is best in a given situation. Many assume that the most expensive option is the best, but as generics prove, this is not always the case. Ask your doctor to explore less expensive treatments before resorting to more expensive drug therapies. If the first treatment fails, then the next will be explored, and so on.
- And as always, prevention is the best medicine. Taking care of yourself, eating well, exercising and general preventive health care will help keep your need for prescription drugs down overall.

BCBSOK ONLINE BENEFIT RESOURCES

RESOURCE	PURPOSE	HOW TO ACCESS
BCBSOK Website for OKHEEI	● Log in to Blue Access for Members to access the Well on Target portal or view claims ● View/print benefit brochures ● Locate a doctor or hospital	www.bcbsok.com/okheei/
Blue Access for Members	Site provides: ● Ability to print a temporary member ID card and order a new card ● View claim status and Explanation of Benefits (EOB) ● Find a doctor or hospital ● View wellness rewards points ● Access to Well on Target	Go to www.bcbsok.com/okheei/ or visit www.blue365deals.com/BCBSOK ● Enter Blue Access for Members user ID and password ● If you do not have a user ID and password, go to "Register Now".
Blue Points	Earn points, redeemable for rewards, for health-related activities	Go to BAM at www.bcbsok.com/okheei/ ● Click on Well on Target
Locate a Health Care Provider	Find a doctor, specialist, or hospital in your area	Go to www.bcbsok.com/okheei/ or visit www.blue365deals.com/BCBSOK ● Click on Find a Doctor
OKHEEI Benefits Website	Find benefit related information	www.okheei.org/
Pharmacy	● Compare Drugs ● Find generic alternatives ● Obtain cost estimates ● View drug list	www.myprime.com

Vendor Contact Information

Refer to this list when you need to contact one of your benefit vendors.

MEDICAL AND PRESCRIPTION DRUG BENEFITS:

Carrier Name:	BCBSOK
Customer Service Phone Number:	800-672-2567
Website Address:	www.bcbsok.com/okheei

DENTAL BENEFITS:

Carrier Name:	Delta Dental Oklahoma
Customer Service Phone Number:	800-522-0188 or405-607-2100
Email:	customerservice@deltadentalok.org
Network:	PPO or Premier
Website Address:	www.deltadentalok.org

VISION BENEFITS:

Carrier Name:	Vision Service Plan
Customer Service Phone Number:	800-877-7195
Network:	Choice
Website Address:	www.vsp.com

LIFE & AD& D AND VOLUNTARY LIFE & AD&D:

Carrier Name:	MetLife
Customer Service Phone Number:	800-638-6420
Website Address:	www.metlife.com

DISABILITYINCOME BENEFITS (LONG TERM DISABILITY):

Carrier Name:	MetLife
Customer Service Phone Number:	866-729-9200
Website Address:	www.metlife.com

COBRA ADMINISTRATION:

Carrier Name:	HealthSmart Benefit Services
Customer Service Phone Number:	877-287-1605
Email:	okheei@healthsmart.com

RETIREE BILLING:

Carrier Name:	HealthSmart Benefit Services
Customer Service Phone Number:	877-287-1605
Email:	okheei@healthsmart.com

OKLAHOMA TEACHER'S RETIREMENT

Customer Service Phone Number:	877-287-1605
Email:	mail@trs.ok.gov
Website Address:	www.ok.gov/trs

REQUIRED NOTIFICATIONS

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- ☐ Your hours of employment are reduced, or
- ☐ Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- ☐ Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- ☐ Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- ☐ You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- ☐ The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- ☐ The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- ☐ The parents become divorced or legally separated; or
- ☐ The child stop being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Oklahoma Higher Education Employee Interlocal Group, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employee must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. For all qualifying events please notify your institution's Benefits Department.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Your Institution's Benefits Department or,

Oklahoma Higher Education Employee Interlocal Group
3555 N. W. 58th St. Suite 320
Oklahoma City, OK 73112
Whitney Popchoke
405-942-8817

Dependent Coverage Up to Age 26

The Affordable Care Act (ACA) provides that health plans and issuers that offer dependent coverage to children on their parents' plans must make the coverage available until the adult child reaches the age of 26. The extension of coverage to young adult children took effect on the first day of the first plan year that began on or after Sept. 23, 2010.

What Does the Law Require?

Group health plans and health insurance issuers offering group or individual health insurance policies that provide dependent coverage of children must make coverage available for adult children up to age 26, regardless of the child's marital status.

The mandate applies to plans that have "grandfathered" status under ACA and to non-grandfathered plans. However, for plan years beginning before Jan. 1, 2014, grandfathered plans are not required to cover adult children under age 26 if they are eligible for other employer-sponsored group health coverage.

Parents can decide whether to add adult children to their plan. ACA's extension of dependent coverage did not create independent enrollment rights for dependents. In addition, there is no requirement to cover the child of a dependent child (that is, a grandchild).

Restrictions on Definition of "Dependent"

ACA restricts the definition of "dependent" that health plans and issuers may use for children under the age of 26. A plan or issuer may not define dependent for purposes of eligibility for this coverage other than in terms of the child's age and the relationship between the child and the participant.

For example, a plan or issuer may not deny or restrict coverage for a child who is under age 26 based on one or more of the following factors:

- ☐ Financial dependence on the participant or any other person;
- ☐ Residency with the participant or with any other person;
- ☐ Student status;
- ☐ Marital status;
- ☐ Employment status; or
- ☐ Eligibility for other coverage (unless the plan or coverage has grandfathered status and the child is eligible for other employer-sponsored group health coverage for plan years beginning before Jan. 1, 2014)

Although the term "child" is not specifically defined in ACA, guidance indicates that it means an individual who is a son, daughter, stepson, stepdaughter or adopted child of the participant. There is some suggestion that a foster child would be included as well, although this is not entirely clear.

Uniformity in Plan Terms

The terms of the plan or health insurance coverage providing dependent coverage of children, including the premiums charged, cannot vary based on age (except for children who are age 26 or older). This means that adult children must be offered all of the benefit packages available to other plan participants, and these dependents cannot be required to pay more for coverage.

The following examples illustrate the uniformity requirement.

Example: A group health plan offers a choice of self-only or family health coverage. Dependent coverage is provided under family health coverage for children of participants who have not reached age 26. The plan imposes an additional premium surcharge for children who are older than age 18. This plan violates the uniformity requirement because the plan varies the terms for dependent coverage of children based on age.

Example: A group health plan offers a choice among the following tiers of health coverage: self-only, self-plus-one, self-plus-two and self-plus-three-or-more. The cost of coverage increases based on the number of covered individuals. The plan provides dependent coverage of children who have not reached age 26. In this example, the plan does not violate the uniformity requirement. Although the cost of coverage increases for tiers with more covered individuals, the increase applies without regard to the age of any child.

Example: A group health plan offers two benefit packages -- an HMO option and an indemnity option. Dependent coverage is provided for children of participants who have not reached age 26. The plan limits children who are older than age 18 to the HMO option. This plan violates the uniformity requirement because the plan, by limiting children who are older than age 18 to the HMO option, varies the terms for dependent coverage of children based on age.

When did the Law Become Effective?

The extension of dependent coverage provision took effect for plan years beginning on or after Sept. 23, 2010, though some plans and issuers extended coverage to adult children before this date. All plans and issuers should now be in compliance with the age 26 dependent coverage requirement.

What if State Laws Differ from Federal Law?

More than two-thirds of states have passed laws that require insured group health plans to cover dependents after they turn 18 years old, often into their mid to late 20s and in some cases later. For example, in New Jersey, unmarried children can stay on a parent's plan until they are 31 years old. These state mandates, to the extent they require coverage past age 26, will continue to apply to insured health coverage.

What are the Tax Effects of the extended dependent coverage?

Under federal tax law, employers can offer tax-free health coverage to employees' adult children through the end of the year in which the children turn age 26. It does not matter whether the children are tax dependents for federal income tax purposes. All states have passed tax laws conforming to the federal tax law.

Often, adult children that obtain coverage pursuant to state law are not tax dependents for federal income tax purposes. In the event state laws mandate coverage past age 26, federal tax law generally requires employers to impute the fair market value of the dependent coverage as income to employees for tax years after the children turn age 26, unless employees pay for the coverage on an after-tax basis.

More Information

Additional information on ACA's young adult coverage requirement is available at:

www.healthcare.gov/law/features/choices/young-adult-coverage/index.html.

The interim final regulations on the young adult coverage requirement, as published in the Federal Register on May 13, 2010, are available at: www.gpo.gov/fdsys/pkg/FR-2010-05-13/pdf/2010-11391.pdf

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 10, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

HIPAA Basics
Your Right to Privacy

In April 2003, the final regulations that place restrictions on how personally identifiable health information may be used and disclosed by certain organizations became effective.

These regulations (the Privacy Rules) implement the privacy requirements contained within the Administrative Simplification subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

While some states have laws that protect health information, the HIPAA Privacy Rules establish a uniform, minimum level of privacy protections for all health information.

In summary, the HIPAA Privacy Rules:

- ☐ Set limits on how health information may be used and disclosed;
- ☐ Require that individuals be told how their health information will be used and disclosed;
- ☐ Provide individuals with a right to access, amend or copy their medical records;
- ☐ Give individuals a right to receive an accounting of disclosures, to request special restrictions, and to receive confidential communications; and
- ☐ Impose fines where the requirements contained within the regulations are not met.

Restrictions on Use & Disclosure

The rules allow health care providers, health plans, and health care clearinghouses (Covered Entities) to use and disclose your personally identifiable health information for purposes of treatment, payment, or health care operations.

For example, your health care provider may submit your health information to a health insurance company in order to seek payment for the treatment provided to you. Your primary care physician can share your health information with a specialist that he or she recommends you consult. In these cases, your written permission to disclose your health information is not required.

In general, any use or disclosure not considered treatment, payment, or a health care operation requires your written authorization, unless an exception applies. For example, your physician may not share your health information with your employer or a life insurance carrier without your written permission.

However, disclosure of health information is permitted for certain purposes specifically listed in the HIPAA Privacy Rules, such as national security, law enforcement and public health issues. If you authorize release of your health information to a third party, the information released may no longer be protected by HIPAA.

Notice of Privacy Practices

You are entitled to receive an explanation of how your personally identifiable health information will be used and disclosed.

For example, a physician or hospital is required to provide you with a Notice of Privacy Practices at your first visit. You will be required to sign an acknowledgement indicating that you received the Notice of Privacy Practices.

If you have health insurance coverage, the insurance company or health plan will also provide you with a Notice of Privacy Practices immediately after you are enrolled in the plan. It is important that you read the Notice of Privacy Practices in order to understand your rights and know who to contact if you feel your privacy rights have been violated.

Right to Access, Amend, or Copy

You have a right to view and copy your medical records. You may be charged a fee for the cost of reproduction. If you believe that information within your medical records is incorrect or if important information is missing, you have a right to request that your medical records be amended.

Right to an Accounting of Disclosure

You also have a right to a list of uses and disclosures made of your medical records where the use or disclosure was not for purposes of treatment, payment, health care operations, or pursuant to your written authorization.

Right to Request Restrictions

You may request in writing that a health care provider or health plan not use or disclose information for treatment, payment, or other administrative purposes unless specifically authorized by you, when required by law, or in emergency circumstances. Health care providers and health plans must consider your request, but are not legally obligated to agree to those restrictions.

Confidential Communications

You have a right to receive confidential communications containing your health information. Health care providers and health plans are required to accommodate your reasonable requests. For example, you may ask that a physician contact you at your place of employment or send communications regarding treatment to an alternate address.

Violations of Privacy Rights

If you believe that your privacy rights have been violated, you may contact the Privacy Officer for the organization that you feel has violated your right to privacy. The name of the Privacy Officer should be included in the Notice of Privacy Practices provided to you by that organization.

If the Privacy Officer does not adequately resolve your concerns, you may contact the Department of Health and Human Services — Office of Civil Rights (OCR). OCR is responsible for enforcing the HIPAA Privacy Rules. Its Web site contains instructions on how to file a complaint www.hhs.gov/ocr/privacy/hipaa/complaints and a complaint form

www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaintpackage.pdf

Penalties for Noncompliance

The HIPAA Privacy Rules do not provide individuals with a private right to sue, although methodologies for allowing a portion of civil penalties to be paid to affected individuals must be established by February 17, 2012.

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Currently, health care providers, health plans, and health care clearinghouses that do not comply with the HIPAA Privacy Rules may be subject to civil money penalties ranging from $100 to $50,000 per violation, with maximum penalties ranging from $25,000 per year to $1.5 million per year.

Criminal violations of the HIPAA Privacy Rules may also be referred to the Department of Justice for enforcement. Criminal penalties for such violations include:

State Attorneys General (AG) may also bring suit against Covered Entities to enjoin further violations and obtain damages on behalf of residents of their states, if HHS has not already taken action. The AG may seek damages of up to $100 per violation, with a maximum of $25,000 per year for identical violations.

HIPAA Privacy Resources

- Office of Civil Rights (HHS) www.hhs.gov/ocr/
- Health Privacy Project www.healthprivacy.org

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact your institution’s Benefits Department.

INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE FOR USE ON OR AFTER APRIL 1, 2011

Important Notice from Oklahoma Higher Education Employee Interlocal Group About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Oklahoma Higher Education Employee Interlocal Group and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Oklahoma Higher Education Employee Interlocal Group has determined that the prescription drug coverage offered by the Blue Cross Blue Shield Plan of Oklahoma is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Oklahoma Higher Education Employee Interlocal Group coverage will not be affected. If you decide to join a Medicare drug plan, your existing Oklahoma Higher Education Employee Interlocal Group coverage will not be affected. You may keep this coverage, and benefits will be coordinated with Part D Coverage.

If you do decide to join a Medicare drug plan and drop your current Oklahoma Higher Education Employee Interlocal coverage, be aware that you and your dependents may not be able to get this coverage back except during the Open Enrollment time period or unless you are an active employee
with a Qualifying Life Event.

You should also know that if you drop or lose your current coverage with OKHEEI and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Oklahoma Higher Education Employee Interlocal Group and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact your institutions Benefits Department for more information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Oklahoma Higher Education Employee Interlocal Group changes. You also may request a copy of this notice at any time.

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There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

3. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

4. Oklahoma Higher Education Employee Interlocal Group has determined that the prescription drug coverage offered by the UnitedHealthCare MedicareRx is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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If you decide to join a Medicare drug plan, your current Oklahoma Higher Education Employee Interlocal Group coverage will not be affected. If you decide to join a Medicare drug plan, your existing Oklahoma Higher Education Employee Interlocal Group coverage will not be affected. You may keep this coverage, and benefits will be coordinated with Part D Coverage.

If you do decide to join a Medicare drug plan and drop your current Oklahoma Higher Education Employee Interlocal coverage, be aware that you and your dependents may not be able to get this coverage back except during the Open Enrollment time period or unless you are an active employee
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For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact your institutions Benefits Department for more information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Oklahoma Higher Education Employee Interlocal Group changes. You also may request a copy of this notice at any time.

Lifetime and Annual Limits

PPACA generally prohibits group health plans, and group and individual health insurance issuers, from imposing lifetime or annual limits on the dollar value of health benefits, effective for plan years beginning on or after Sept. 23, 2010. Although annual limits are generally prohibited, "restricted annual limits" are permitted for essential health benefits for plan years beginning before Jan. 1, 2014.

Restricted Annual Limits

The interim final rules establish a three-year phased approach for restricted annual limits. Annual limits may not be less than the following amounts for plan years beginning Jan. 1, 2014.

- $750,000 for plan years beginning on or after Sept. 23, 2010, but before Sept. 23, 2011;
- $1.25 million for plan years beginning on or after Sept. 23, 2011, but before Sept. 23, 2012; and
- $2 million for plan years beginning on or after Sept. 23, 2012, but before Jan. 1, 2014

These are minimums for plan years; plans may use higher annual limits or impose no limits. The limits apply on an individual- by-individual basis, so that any annual limit on benefits applied to families cannot cause an individual to be denied the minimum annual benefit for the plan year.

The restricted annual limits are designed to ensure that individuals would have access to needed services with a minimal impact on premiums. However, they could affect limited benefit plans or "mini-med" plans that generally have limits significantly below the permitted limits. The regulations provide that the restricted annual limits could be waived by the Department of Health and Human Services (HHS) if compliance with the restrictions would result in a significant decrease in access to benefits or a significant increase in premiums.

HHS granted a number of waivers and then closed the waiver program to new applications effective Sept. 22, 2011. Waivers and/or extensions received before that date could be effective until plan years beginning on or after Jan. 1, 2014, when all annual limits for essential health benefits will be prohibited.

As a condition to receiving a waiver, a group health plan or health insurance issuer must provide a notice informing each participant that the plan or policy does not meet the restricted annual limits for essential benefits because it has received a waiver of that requirement. Waiver recipients must also provide annual updates to HHS regarding plan information and benefits.

Covered Plans

The prohibition on lifetime and annual limits applies to both new and grandfathered group health plans. However, it does not apply to grandfathered individual policies. The restrictions on annual limits do not apply to account-based plans like health flexible spending arrangements (health FSAs), medical savings accounts (MSAs) and health savings accounts (HSAs).

Essential Health Benefits

PPACA specifically provides that plans may impose annual or lifetime per-individual limits on specific covered benefits that are not "essential health benefits." Each state will set its own definition of essential health benefits, but it will include at least the following general categories of items and services:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;

- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services, including chronic disease management; and

Until standards are issued, plans can use a good faith effort to comply with a reasonable interpretation of essential health benefits and must apply it consistently.

The interim final rules clarify that a plan can still exclude all benefits for a condition. Such exclusion will not be considered an annual or lifetime limit as long as no benefits are provided for the condition.

Enrollment Opportunities

Under the interim final rules, individuals who reached a lifetime limit prior to the date the regulations were effective and are otherwise eligible for plan coverage must have been given a notice that the lifetime limit no longer applies. They must have been permitted to re-enroll in the plan if they were no longer enrolled. The notices and enrollment opportunity must have been provided no later than the first day of the first plan year beginning on or after Sept. 23, 2010. Anyone who was eligible for the enrollment opportunity must have been treated as a special enrollee eligible to enroll in all of the benefit packages available to similarly situated individuals upon initial enrollment.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Part A: General Information

Form Approved OMB No. 1210-0149
(expires 5-31-2020)

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance : the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lo wers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or:

Whitney Popchoke
RUSO / OKHEEI Benefits Coordinator
Oklahoma Higher Education Employee Interlocal Group
3555 N. W. 58th St. Suite 320
Oklahoma City, OK 73112
405-942-8817

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marke tplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Part B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Oklahoma Higher Education Employee Interlocal Group	4. Employer Identification Number (EIN) 73-6017987	
5. Employer address 3555 NW 58th St., Suite 320	6. Employer phone number (405) 942-8817	
7. City Oklahoma City	8. State OK	9. ZIP code 73112
10. Who can we contact about employee health coverage at this job? Whitney Popchoke		
11. Phone number (if different from above)	12. Email address wpopchoke@ruso.edu	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  X All employees. Eligible employees are:
  Active full-time employees working 30 or more hours per week,

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  X We do offer coverage. Eligible dependents are:

  ☐ We do not offer coverage.

X If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

* An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NOTICE REGARDING WELLNESS PROGRAM

Oklahoma Higher Education Employee Interlocal Group is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which may include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of a $250 deductible credit. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the deductible credit.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Whitney Popchoke, RUSO / OKHEEI Benefits Coordinator at 405-942-8817.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Oklahoma Higher Education Employee Interlocal Group may use aggregate information it collects to design a program based on identified health risks in the workplace, OKHEEI will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are healthcare personnel such as nurses, doctors, and members their support team in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact: Whitney Popchoke, RUSO / OKHEEI Benefits Coordinator at 405-942-8817.

Patient Protection

Oklahoma Higher Education Employee Interlocal Group generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your institutions Benefits Department.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Oklahoma Higher Education Employee Interlocal Group or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please contact your institutions Benefits Department.

Mental Health Parity and Addiction Equity Act of 2008

Under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements and treatment limits that group health plans and health insurance issuers apply to mental health or substance use disorder benefits generally cannot be more restrictive than those applicable to medical and surgical benefits. The MHPAEA supplemented the Mental Health Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. The MHPAEA also extended the parity requirements to substance use disorder benefits.

The MHPAEA generally applies to plans sponsored by employers with more than 50 employees, including self-insured plans and fully insured arrangements. The MHPAEA generally became effective for plan years beginning on or after Oct. 3, 2009 (Jan. 1, 2010 for calendar year plans).

The MHPAEA does not require a plan to provide mental health or substance use disorder benefits. However, if a plan provides medical and surgical benefits and mental health and substance use disorder benefits, it must comply with the federal parity requirements.

The MHPAEA contains the following parity requirements:

- The financial requirements (such as deductibles, copayments, coinsurance and out-of-pocket limits) applicable to mental health and substance use disorder benefits cannot be more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits.
- Treatment limitations (such as frequency of treatment, number of visits, days of coverage or other similar limits on the scope or duration of coverage) must also comply with the MHPAEA's parity requirements. Non-quantitative treatment limitations (such as medical management standards, formulary design and determinations of usual, customary or reasonable amounts) are subject to a separate parity requirement.
- If medical and surgical benefits are offered on an out-of-network basis, a plan or issuer must also offer mental health and substance use disorder benefits on an out-of-network basis.

In addition, the MHPAEA requires plans to make certain information available with respect to mental health and substance use disorder benefits, such as the criteria for medical necessity determinations and the reason for any denial of reimbursement or payment for mental health or substance use disorder services.

The Departments of Health and Human Services, Labor and Treasury (Departments) issued interim final rules to implement the MHPAEA and to demonstrate how the MHPAEA applies to group health plans and health insurance issuers. The rules became applicable for plan years beginning on or after July 1, 2010.

A plan's coverage or mental health and substance use disorder benefits may be affected by the health care reform law. The health care reform law is very broad and its specific effect on mental health and substance use disorder benefits is still somewhat unclear. Additional regulatory guidance would be helpful.

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

☆ You ensure that your employer receives advance written or verbal notice of your service;
☆ You have five years or less of cumulative service in the uniformed services while with that particular employer;
☆ You return to work or apply for reemployment in a timely manner after conclusion of service; and you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

☆ are a past or present member of the uniformed service;
☆ have applied for membership in the uniformed service; or
☆ are obligated to serve in the uniformed service;

An employer may not deny you any of the following because of this status:

☆ Initial employment;
☆ Reemployment;
☆ Retention in employment;
☆ Promotion; or any benefit of employment

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.

☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.
☆ If you file a complaint with VETS and VETS is unable to resolve the complaint, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address:
http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor 1-866-487-2365
U.S. Department of Justice Office of Special Counsel 1-800-336-4590

Publication Date — April 2017

Women's Health and Cancer Rights Act (WHCRA) of 1998

Common questions and answers

The benefits related to mastectomies changed quite a bit with the Women's Health and Cancer Rights Act (WHCRA) of 1998. This article will answer some of the common questions patients have about the WHCRA.

What does WHCRA cover?

If you are enrolled in a health plan that covers the medical and surgical costs of a mastectomy, the WHCRA states that your plan must also cover the costs of certain reconstructive surgery and other post-mastectomy benefits, including:

- ☐ All stagesof reconstruction of the breast on which the mastectomy was performed
- ☐ Surgery and reconstruction of the other breast to produce a symmetrical appearance
- ☐ External breast forms that fit into your bra for before or during reconstruction
- ☐ Treatment of any physical complications of the mastectomy, including lymphedema

I had a mastectomy due to non-cancer related health issues. Am I covered under WHCRA?

Yes. These rights are not limited to cancer patients. If your plan covers mastectomies, WHCRA rights apply.

My job does not offer a group health plan. Does WHCRA apply to my individual health insurance policy?

Yes. WHCRA applies to group health plans that are provided by an employer or union as well as to individual health insurance policies that are not based on employment.

I receive health benefits through my church. Am I still covered under WHCRA?

There are certain "church" and "governmental" plans that are not subject to this law. Generally, though, any plan that provides coverage for mastectomies must also comply with WHCRA. Check with your provider for information specific to your plan.

Will my co-pay for reconstructive surgery be more expensive than my co-pay for other health conditions?

No. If your health plan requires a co-payment for other health conditions, the co-pay for your mastectomy benefits must be the same. For example, it is a violation of WHCRA for your plan to cover 90 percent of hip replacement surgery but to only cover 70 percent of breast reconstruction.

Is my health plan required to inform me of my rights under WHCRA?

Yes. Your health plan must provide you with a notice of your rights under WHCRA when you first enroll in the health plan, and then annually after that.

Women's Health and Cancer Rights Act Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your institution's Benefits Department for more information.

The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996, if you have any questions about your Guide, contact Human Resources.

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