2020 Benefits Guide

A New Perspective on Benefits

Oklahoma Higher Education Employee Interlocal Group

MESSAGE TO OKHEEI EMPLOYEES:

We are pleased to present our Employee Benefits Guide for the 2020 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

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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 ENROLLMET

Who is Eligible?

All regular, active, full-time employees working 30 or more hours per week, and their eligible dependent 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 providing 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 Children:

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?

1. 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:

2. 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

   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 experiencing 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 will be responsible for when utilizing your benefits.

All four plans promote wellness and offer preventive care and have unlimited lifetime maximums. Plans A, B, C and F have different office visit 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.

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 Sate University

Murray State College

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PRESCRIPTION DRUG BENEFITS

Plans A-C have the same prescription drug plan. Plan F is a High Deductible Health Plan with a Health Savings Account and, due to IRS regulations, this plan cannot have any prescription copays.

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 name, compose the drug list. 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 associated tiers. Specialty drugs are handled by a separate drug program administered through Prime.

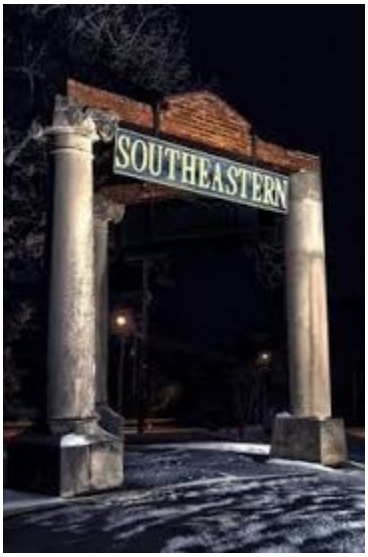
Blue Cross and Blue Shield's national preferred pharmacy network includes most national chains and independent pharmacies across the country. The Pharmacies participating in the preferred pharmacy network are below:

- 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-preferred pharmacies. If you fill a prescription at a non-preferred pharmacy, you may pay a higher copay or coinsurance.

When you fill your prescription drugs at a retail pharmacy, your copayment depends on the tier in which the drug has been classified. You will pay the cost up to the tier copay for a 30 day supply limit (120 pill maximum) or 90 quantity limit (360 pill maximum) per copay, whichever is less. 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 four plans:

- Plan A & C (Blue PreferredPPO)
- Plan B (BlueOptionsPPO)
- Plan F (Blue ChoicePPO)

Redlands Community College

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 various Blue Cross PPO networks 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 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.

Blue Preferred PPO

The Blue Preferred PPO network is a smaller network however it 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.

Blue Choice PPO

Blue Choice PPO is the largest network and 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.

Blue Options PPO

BlueOptions PPO gives you the flexibility to choose your provider and network at the time of service. Your choice of health care providers will 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.

- 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 ChoicePPO 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.

All plans offered also give you the flexibility to choose a non-PPO, “out-of-network” provider with whom BCB-SOK does not have a contract. Benefits provided by "out-of-network" providers are less robust and you will usually be required to pay more out of pocket for the services.

- 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.

BLUE CROSS BLUE SHIELD FREQUENTLY ASKED QUESTIONS

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

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

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

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 typically located in Oklahoma. You can search for providers in the online provider directory at **www.bcbsok.com**.

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

No. 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.

East Central University

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-pocketexpense.

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 out-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

2020 BlueCross BlueShield Medical Plans

	Plan A	Plan B	Plan C	Plan F
Network	**Preferred**	Preferred & Choice	Preferred	Choice
General Plan Information				**HSA ELIGIBLE Embedded Deductible**
Calendar Year Deductible (CYD)	$750 Ind / $2250 Family	$1250 Ind / $3750 Family	$1500 Ind / $4000 Family	$3000 Ind / $6000 Family
Calendar Year Out of Pocket Max Includes deductible and pharmacy/medical copays	$3000 Ind / $9000 Family	$3500 Ind / $10500 Family BP $4000 Ind / $12000 Family BC	$4000 Ind /$12000 Family	$6650 Ind / $13000 Family
Member Coinsurance	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD
Primary Office Visit Copay Specialty Office Visit Copay	$20 Copay $40 Copay	$25 BP/$35 BC Copay $40 BP/$50 BC Copay	$35 Copay $50 Copay	20% after CYD
Preventive Care Visits (Well Baby, Adult/Child Immunizations, Routine Health Screenings)	No Charge	No Charge	No Charge	No Charge
Diagnostics Lab/X-Ray	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD
In-Patient Hospitalization	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD
Out-Patient Surgery	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD
Allergy Treatment/Testing	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD
Emergency Room Urgent Care	$100 Copay; then 20% after CYD (waived if admitted) $40 Copay	$150 Copay, then 20%/30% after CYD (waived if admitted) $40 BP / $50 BC Copay	$150 Copay; then 20% after CYD (waived if admitted) $50 Copay	20% after CYD
Health Risk Assessment	HA deductible credit applies to 2020 plan year and must be completed between 01/01/2020 and 12/31/2020. HA must be completed and credited prior to claims payment. No retroactive claim adjustments will be allowed.			
Mental Health/Substance Abuse				
In-Patient	20% after CYD	20%/30% after CYD	20% after CYD	20% after CYD
Out-Patient	$20 Office Visit Copay 20% after CYD for other services	$25 BP / $35 BC Copay 20%/30% after CYD for other services	$35 Office Visit Copay 20% after CYD for other services	20% after CYD

2020 BlueCross BlueShield Medical Plans

	Plan A	Plan B	Plan C	Plan F
Network	**Preferred**	**Preferred** & Choice	**Preferred**	Choice
Rehabilitation Services: Outpatient: Separate 60 visit limits per benefit period for speech and occupational therapies.	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Habilitation Services: Inpatient: 30 day limit per benefit period. PA required.	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Physical and chiropractic Therapy (combined limited to 60 visits per CY)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Durable Medical Equipment (DME)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Skilled Nursing Facility (100 days per CY)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Home Health Care (100 days per CY)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Hospice (PA Required)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Pharmacy				
Generic Drugs	Retail: 25% of allowed amount; $25 Min / $50 Max Mail Order: 25% of allowed amount; $75 Min / $150 Max			20% after CYD
Preferred Brand Name Drugs	Retail: 25% of allowed amount; $25 Min / $50 Max Mail Order: 25% of allowed amount; $75 Min / $150 Max			20% after CYD
Non-Preferred Brand Name Drugs	Retail: 50% of allowed amount; $50 Min / $100 Max Mail Order: 50% of allowed amount; $150 Min / $300 Max			20% after CYD
Specialty Drugs	50% of allowed amount; $50 Min / $100 Max (Limited to 30 day supply Must be ordered through Prime Therapeutics (no mail order available)			20% after CYD
	30 Day Supply Limit retail. Up to 90 Day Supply of Maintenance drugs. Up to 90 Day Supply Mail, Network Only			

BlueCross BlueShield of Oklahoma

2020 Wellness Programs

natura)(yslim

Naturally Slim is a clinically-proven online program that taches participants how to lose weight and improve their health without dieting. There are no points to count or food groups to avoid. Instead, it's a mindful-eating program that teaches members how they can lose weight while still eating all foods. You must enroll when sessions are opened during the year. Limited participation per session.

Livongo®

Livongo has developed a new approach for diabetes, combining the latest technology with coaching, creating personalized experiences, and using data and clinical science that delivers positive health outcomes and lower costs. Livongo's diabetes management program includes digital and live coaching through a meter, phone, and the Livongo mobile app.

vivante HEALTH

*Better health, gut firs*t. Did you know many chronic and inflammatory conditions are tied to the digestive system? GIThrive® by Vivante Health is the digital program that brings together, in one easy-to-use app, everything you need for better gut health: personal nutrition, cutting-edge science, gut microbiome testing, 24/7 human Care Team support, smart food diaries, and even expert support for managing a chronic GI condition. To enroll in GIThrive, visit https://welcome.mygithrive.com/okheei or call 1.833.33MYGUT (1.833.336.9488)

DENTAL BENEFITS

As a participant and/or covered dependent of an OKHEEI employee, 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)

Services	Delta High			Delta Low			Delta Preventive
Network	PPO	Premier	OON	PPO	Premier	OON	PPO
Preventive/Diagnostic	100%	100%	100%	100%	100%	100%	100%*
Basic Restorative *(Endodonics, Periodontic & Oral Surgery)*	85%*^	70%*^	70%*^	75%*^	70%*^	70%*^	80%*
Major Restorative	60%*	50%*	50%*	60%*	50%*	50%*	N/A
Orthodontic	50% (Child Only to age 26)			N/A			N/A
Per Person Per Calendar Year Deductible	$50/$150			$100/$200			$50/$100
Annual Benefit Maximum	$2000 Per Person			$1000 Per Person			$750 Per Person
Orthodontic Benefit Maximum	Unlimited per Child (to age 26)			N/A			N/A

**Per Person Per Calendar Year Deductible Applies (not to exceed 3 individual deductibles).*
^Endodontics, Periodontics, and oral surgery only covered under the High and Low option plans.

Similar to the medical coverage, the annual deductible must first be reached for all covered Basic and Major Care (except for the Preventive Plan). The deductible does not apply to preventive care or orthodontia.

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 Employee 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 low out-of-pocket costs.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and low out-of-pocket costs.
- **High Quality Vision Care.** You'll get great care from a VSP network doctor, including a WellVision Exam℠—a comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—with the largest national network of private-practice doctors, plus participating retail chains, it's easy to find the in-network doctor who's right for you.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

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 preferred online eyewear store.

Enroll in VSP today.
You'll be glad you did.
Contact us. 800.877-7195
vsp.com

Your VSP Vision Benefits Summary

VSP Coverage Effective Date: 01/01/2020

Oklahoma Higher Education Employees and VSP provide you with a choice of affordable vision plans – choose the plan that's right for you.

Base Option — **VSP Provider Network: VSP Choice**

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$10
Prescription Glasses		$25
Frames	• $150 allowance of a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • Every calendar year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal and lines trifocal lenses • Polycarbonate lenses for dependent children • Every calendar year	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements • Every calendar year	$0 $95-$105 $150-$175
Contacts (Instead of glasses)	• $150 allowance for contacts, copay does not apply • 15% Discount Contact lenses exam (fitting and evaluation) • 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. • As needed.	$20

Enhanced Option — **VSP Provider Network: VSP Choice**

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$10
Prescription Glasses		$25
Frames	• $150 allowance of a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • Every calendar year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal and lines trifocal lenses • Polycarbonate lenses for dependent children • Every calendar year	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements • Every calendar year	$0 $95-$105 $150-$175
Contacts (Instead of glasses)	• $150 allowance for contacts, copay does not apply • 15% Discount Contact lenses exam (fitting and evaluation) • 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. • As needed.	$20
Additional Pairs of Eyewear		
Second Pair	• This enhancement allows you to get a second pair of glasses or contacts, subject to the same copays as your first pair benefit.	

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. Call Member Services for out-of-network plan details.	

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. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

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 insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible member's, or his or her dependent's, covered death. Basic Accidental Death and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by your institution.

Basic Life/AD&D Plan Features	
Definition of Member	Active employee of the institution and regularly working at least 40 hours each week. You are not a member if you are temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Class Definition	Class 1: Presidents Class 2: Vice Presidents, Finance Officers and Provosts Class 3: Members other than Presidents, Vice Presidents, Finance Offers and Provosts
Eligibility Waiting Period	If you are already a member on the date the group policy is effective, you are eligible on that date. If you become a member after the group policy effective date, you are eligible on the first day of the month that follows the date you become a member.
Benefits 2 times your annual earnings rounded to the next higher multiple of $1,000 if not already a multiple of $1,000. The minimum benefit amount is $10,000.	Class 1: $450,000 Class 2: $350,000 Class 3: $250,000
Age Reduction Formula	35% at age 65; By 50% at age 70; By 65% at age 75

Northwestern Oklahoma State University

LIFE/AD&D INSURANCE

Additional Life and AD&D

Life Insurance coverage can help your family meet daily expenses, maintain their standard of living, pay off debt, secure your children's education, and more in the event of your passing. AD&D insurance can provide you and your family with extra protection in the event of death or dismemberment as a result of a covered accident. Standard Insurance Company (The Standard) has developed this document to provide you with information about the elective coverage you may select through your institution.

Eligibility Requirements

Policy	• A minimum number of eligible employees must apply and qualify for the proposed plan before Additional Life Coverage can become effective
Employee	• You must be insured for Basic Life through The Standard • You must be an active employee of OKHEEI regularly scheduled to work 35 hours each week • Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible • You cannot be insured as both employee and a dependent
Dependent	• Spouse means a person to who you are legally married • Child means your child from live birth through age 25. Your child cannot be insured by more than one employee • Your spouse or children must not be full-time member(s) of the armed forces
Premium	• You pay 100% of the premium for this coverage through easy payroll deduction

Coverage Amount Guidelines

Within the coverage amount guidelines shown below, you select the amount of Additional Life an dependents Life insurance for which you are interested in applying.

	Minimum	Incremental Unit	Guarantee Issue Amount	Maximum
Employee	$10,000	$10,000	$300,000	$500,000*
Spouse	$5,000	$5,000	$50,000	$250,000
Child	$2,500	$2,500		$10,000

*but not to exceed 5 times your Annual Earnings or Basic & Vol Combined, not to exceed 7 times Annual Earning

Note:

- Amounts of coverage elected above the Guarantee Issue amount are subject to medical underwriting approval. To submit a medical history statement online, visit: http://www.standard.com/mybenefits/mhs_ho.html.
- All late applications (applying 31 days after becoming eligible), requests for coverage increases and reinstatements are subject to medical underwriting approval. Employees eligible but not insured under the prior life insurance plan are also subject to medical underwriting approval.
- The coverage amount for your spouse cannot exceed 100% of your combined Basic and Additional Life coverage.
- The coverage amount for your child(ren) cannot exceed 100% of your combined Basic and Additional Life coverage.

Coverage Amount Needed

Your family has a unique set of circumstances and financial demands. To help you figure out the amount of Additional Life insurance you may need to protect your loves ones, The Standard has created a Life Insurance Needs Calculator found at: http://www.standard.com/lifeneeds.

LIFE/AD&D INSURANCE

Additional Life and AD&D

Employee Rates (Monthly AD&D rate of $0.015 per $1,000 of AD&D benefit has been included in each of the below rates)

If you elect Additional Life with AD&D insurance, your monthly rate for this plan is indicated in the table below. Premiums for this coverage will be deducted directly from your paycheck.

Employee's Age (as of 1st day of the month following change in age)	**Rate*** (per $1,000 of Total Coverage
<30	$0.0.75
30-34	$0.095
35-39	$0.105
40-44	$0.145
45-49	$0.225
50-54	$0.335
55-59	$0.555
60-64	$0.685
65-69	$1.285
70-99	$2.075

To calculate your premium:

1. Amount Elected: Write this amount on the Additional Life with AD&D requested amount line on your Enrollment and Change Form. Line 1: _____

2. Line 1 divided by $1,000 = Line 2 Line 2: _____

3. Select your rate from the rate table and enter on Line 3 Line 3: _____

4. Line 2 multiplied by Line 3 - Your monthly cost Line 4: _____

Spouse Rates (Monthly AD&D rate of $0.015 per $1,000 of AD&D benefit has been included in each of the below rates)

If you elect Dependents Life with AD&D insurance for your spouse, your monthly rate for this plan is indicated in the table below. Premiums for this coverage will be deducted directly from your paycheck.

Employee's Age (as of 1st day of the month following change in age)	**Rate*** (per $1,000 of Total Coverage
<30	$0.0.75
30-34	$0.095
35-39	$0.105
40-44	$0.145
45-49	$0.225
50-54	$0.335
55-59	$0.555
60-64	$0.685
65-69	$1.285
70-99	$2.075

To calculate your premium:

1. Amount Elected: Write this amount on the Additional Life with AD&D requested amount line on your Enrollment and Change Form. Line 1: _____

2. Line 1 divided by $1,000 = Line 2 Line 2: _____

3. Select your rate from the rate table and enter on Line 3 Line 3: _____

4. Line 2 multiplied by Line 3 - Your monthly cost Line 4: _____

Child Rates (Monthly AD&D rate of $0.015 per $1,000 of AD&D benefit has been included in each of the below rates)

If you elect Dependents Life with AD&D insurance for your eligible child(ren), your monthly rate for this coverage is $0.23 per $1,000 of benefit regardless of the number of eligible children covered. Premiums for this coverage will be deducted directly from your paycheck.

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 The Standard. 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)	

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)	

DISABILITY INSURANCE

Voluntary Short Term Disability

Short Term Disability insurance pays a weekly benefit in the event you cannot work because of covered illness or injury. A STD benefit replaces a portion of your weekly income, providing funds directly to you to help pay your bills and living expenses

All late applications (applying 31 days after becoming eligible), and reinstatements are subject to a 60-day benefit waiting period for sickness and pregnancy during their first 12 months in the plan.

Benefit Amount and Duration	
Benefit Percentage	Your weekly STD benefit is 605 of the first $3,333 of your weekly insured Pre-disability earnings, reduced by deductible income
Maximum Weekly Benefit	$2,000
Minimum Weekly Benefit	$15
Maximum Benefit Period	STD Plan 1: 166 days for employees enrolled in the Base LTD plan STD Plan 2: 76 days for employees enrolled in the Enhanced LTD plan STD Benefits will end on the date Long Term Disability benefits become payable to you under a group plan provided by your employer, even if that occurs before the end of the Maximum Benefit Period.

STD benefits are NOT payable for any period when you are:

- Not under the ongoing care of a physician in the appropriate specialty as determined by The Standard
- Not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by The Standard, unless your disability prevents you from participating.
- Confined for any reason in a penal or correctional institution.
- Able to work and earn at least 20 percent of your pre-disability earnings in your own occupation, but you elect not to work
- Receiving sick-leave pay, annual or personal leave pay, or other salary continuation including donated amounts from your employer
- Eligible to receive benefits for your disability under a workers' compensation law or similar law.

To calculate your monthly payroll deduction, use the formula indicated below:

STD Plan 1 (rate per $10 of benefit)	STD Plan 2 (rate per $10 of benefit)		
		1. Enter your average monthly earnings on line 1	1.
$0.484	$0.341	2. Divide line 1 by 4.333 not to exceed $5000 and enter of line 2	2.
		3. Divide average weekly earnings by benefit % (60%) and enter of line 3	3.
		4. Select your rate from the r ate table and enter on line 4	4.
		5. Multiply line 3 by the amount entered on line 4 and enter on line 5	5.
		6. Divide the amount entered on Line 5 by 10 an enter on line 6. This will be your estimated monthly payroll deduction	6.

How to Save on Healthcare with an HSA Advantage™ Account

An HSA Advantage™ account is a special bank account. You own it. You may use it to put away money tax free for medical expenses not covered under your high deductible health plan.

Save Money by Contributing Tax Free

When you enroll in the HSA Advantage™ account you may contribute money directly from your pay - before taxes - for eligible medical, dental, and vision expenses not covered by your insurance plan. Before tax equals tax free which saves you an average of 30% annually.

Use your HSA Advantage™ Tax Free

You may withdraw your money to pay for eligible healthcare expenses - no taxes or penalties. The IRS has rules on what is considered eligible, so be sure to keep receipts and documentation for what you have spent. You may be asked to provide this information to the IRS if your tax return is audited.

Build a Healthcare Retirement "Nest Egg"

Once you have reached a certain balance in your account, you may choose from a variety of investments to maximize your savings over time. You can continue to use the money in your HSA Advantage™ account after you retire. The money you saved and the interest earned are always tax free when used for eligible expenses. No other savings plan offers so much tax free savings and growth.

Are You Eligible for a Health Savings Account?

If the following statements are true (not required for your spouse), you are eligible to enroll in HSA Advantage™:

- You are enrolled in a High Deductible Health Plan (HDHP) and are neither enrolled nor receiving benefits from another health plan*
- You do not have a disability rating from the VA and have not received medical benefits during the last three months
- You are not being claimed as a tax dependent by someone else

Keep Good Records
Save Your Receipts

The IRS may require you to prove that all money taken from your Health Savings Account was used for eligible expenses.

Check It Out

FIND a list of Eligible Expenses
www.chard-snyder.com

*Includes spousal plans, individual policies, Medicare, healthcare Flexible Spending Accounts and Health Reimbursement Arrangements (HRA). Both you and your spouse must have $0 in a healthcare Flexible Spending Account during a Grace period.

You Can Invest
Your HSA Advantage™ Savings

Grow your HSA Advantage™ account with self-directed mutual fund investments. Use the savings any time; even after you retire.

Decide how much you want to keep available in your interest-bearing account and set the threshold. You may set your threshold from $4,000 up.

If your interest-bearing account falls more than $100 above or below your threshold, HSA Advantage™ will sweep funds into or out of your interest-bearing account.

Your Chard Snyder Benefit Card may be used for amounts up to your threshold.

To set up your investments:

- Go to www.chard-snyder.com and log into your account
- Go to the *Accounts* tab and click on *Investments*
- Click on *Manage Investments* to get started

Transfer an Existing Health Savings Account To Your HSA Advantage™ Account

If you would like to transfer funds from another account in your name to HSA Advantage™, here's how:

1. Complete the benefit enrollment and bank application processes. Your HSA Advantage™ account must be open before you can deposit or access money
2. Decide if you want to move the entire balance. Your current bank may charge a fee to close your original account or a monthly service charge to keep it open
3. To complete the transfer, use the following process:
   - Request an HSA Advantage™ transfer form
   - Complete and forward the form to the original bank
   - The original bank issues a check for the amount you requested and sends it directly to HSA Advantage™ for deposit
   - Your funds are not available from either account for a period of 7-10 days. It may take up to 60 days to complete the entire process

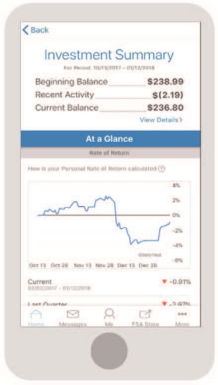
The original bank may choose not to close an account with a minimum or negative balance. Check with that bank for additional details.

You will receive tax documents from each bank that has held funds during the calendar year.

A small quarterly fee, calculated as a percentage of your total investments, will be charged to your account. The bank acts solely as custodian with any mutual funds being offered and sold through a registered broker-dealer by prospectus only. Past performance of investments is no indication or assurance of future performance. As with all investments, mutual funds involve risk. The investment return and principal value will fluctuate so that shares, when redeemed, may be worth more or less than their original cost. Read the prospectus carefully before you invest. Some funds have a redemption fee under certain circumstances. Mutual fund investments are not FDIC insured, and are not guaranteed by Chard Snyder or Healthcare Bank. The information contained in this publication is not, nor is it intended to be, legal or tax advice.

Check Out Our

Mobile App



Features

- **View investment summary**
- **View account balances and transactions**
- **Request reimbursements**
- **Scan products for eligibility** (Plan restrictions may apply)

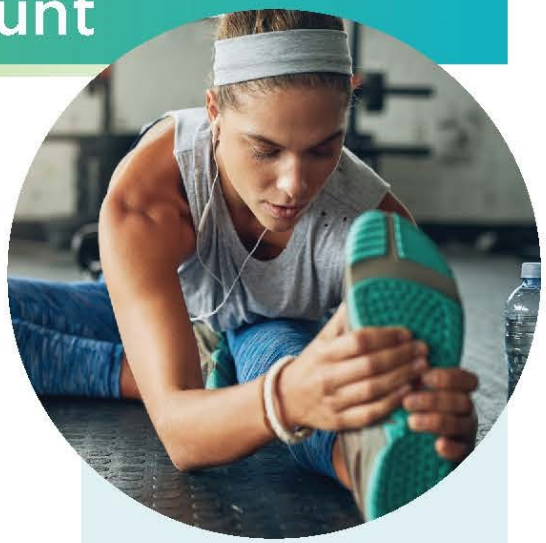
Download from the App Store or Google Play

CHARDSNYDER™ Benefit Solutions

800.982.7715 www.chard-snyder.com

HSA Advantage v8.18

How to Save on Healthcare with a Flexible Spending Account



This plan allows you to put aside tax-free money from your paycheck for eligible medical, vision and dental costs not paid for by insurance. You'll save on every dollar.

Lower Your Taxable Income

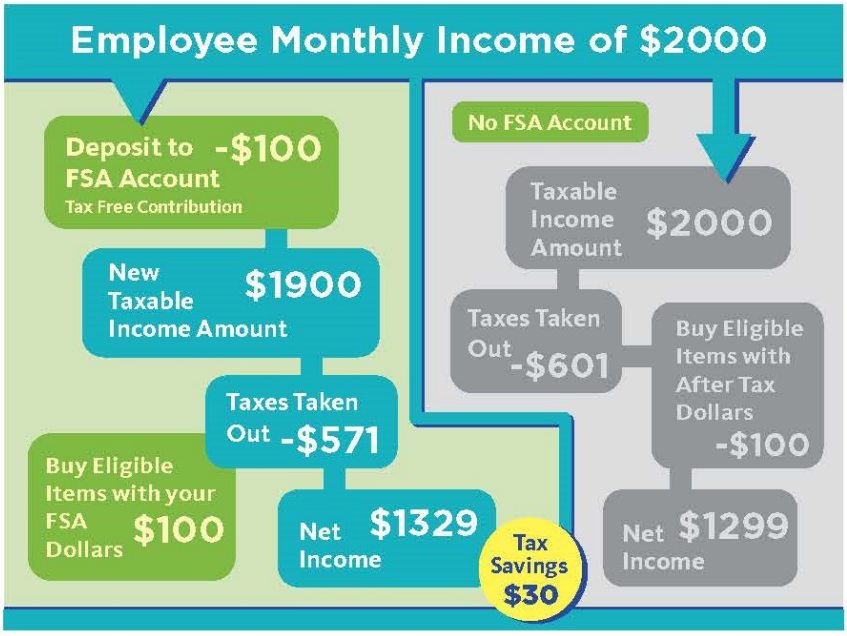
Save at least 30% on eligible expenses. It's smart and simple. During your benefits open enrollment period, add up how much you paid last year for medically necessary family health expenses not covered by insurance:

- **Co-insurance**
- **Co-pays**
- **Deductibles**
- **Prescriptions**
- **Vision**
- **Dental**

Include any new expenses you know you will have this year such as glasses or orthodontia. Now you have an idea of how much to have withheld from your pay when you enroll for the coming year.

You can spend all your annual healthcare account on one large expense the first day your plan is effective. Set your amount carefully. Any money you don't spend by the end of the year may be lost.

See How Much You Can Save



Savings will vary based on your tax bracket. Examples shown are calculated at 25% Federal, 7.65% Social Security and 5% state income tax savings. Divorced parents should check our website for special rules regarding the dependent daycare account. Your tax advisor can discuss how you might use this benefit with the child tax credit. Federal regulations may change plan features without notice at any time (see IRS Publication 503). Expense examples may not be reimbursable under your specific plan or restrictions may apply. Check your Summary Plan Description (SPD) for your plan's specifics. The information contained in this publication is not, nor is it intended to be, legal or tax advice.

Eligible Expenses

Use your Flexible Spending Account funds to pay for a variety of expenses for you, your spouse, and your dependents, but keep in mind the IRS has specific rules about which expenses may be reimbursed by an FSA.

For more details on what expenses are eligible:

Check Out

www.chard-snyder.com — Go to *Benefits/Flexible Spending Account (FSA)* and click on *Healthcare Eligible Expenses*

www.fsastore.com — Go to *Eligibility List*. Items are listed alphabetically and there is a search feature

or

Contact Chard Snyder customer service if you have questions concerning eligible items

Use Your FSA to Save on Dependent Daycare

Use this account to pay for daycare, preschool or senior care needed while you and your spouse work, go to school full time, or look for work.

Tax-Free Dollars for Dependent Daycare Expenses

Save about one-third when you pay for dependent care while you work. You can use the dependent daycare account to pay for the care of children 12 years of age or younger or anyone you claim on your tax return who is not capable of self-care.

Eligible expenses include:

- Child in-home care or daycare centers
- Senior in-home care or daycare centers
- Nursery schools
- After-school and latchkey programs
- Summer activities provided while you work

Care while you are not working such as overnight camp is not eligible.

Money is deducted from each paycheck and added to your dependent daycare account. You may not be reimbursed more than the current balance. Family members who are not tax dependents may be eligible caregivers*.

How the Plans Work | Healthcare FSA and Dependent Daycare FSA

Decide how much to set aside and enroll

The amount you choose is deducted from your pay and added to your account(s)

Then

Use the Chard Snyder Benefit Card to pay for eligible expenses**

Or

Pay for eligible expenses and submit a claim

You may claim the entire balance of your healthcare account on the first day of the year but only the current balance in the dependent daycare account. Submit copies of itemized receipts, statements or Explanation of Benefits (EOB) with your claim. Receive your payment through direct deposit or check

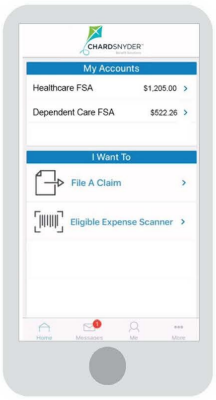
Or

Submit claims using the mobile app, website, email, fax or mail

You will never owe taxes on your Flexible Spending Account (Social Security, Federal and most state income taxes)

Check Out Our

Mobile App



Features

- View account balances and transaction details
- Submit and review claims
- Upload paperwork
- Scan products for eligibility (Plan restrictions may apply)

Download from the App Store or Google Play

CHARDSNYDER™ Benefit Solutions

800.982.7715 www.chard-snyder.com

*Check IRS Pub 503

**Check to see if your dependent daycare plan includes the Chard Snyder Benefit Card.

Critical Illness Insurance Plan Summary

COVERAGE OPTIONS

Critical Illness Insurance		
Eligible Individual	**Initial Benefit**	**Requirements**
Employee	$15,000 or $30,000	Coverage is guaranteed provided you are actively at work[3]
Spouse/Domestic Partner[1]	100% of the employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.[3]
Dependent Child(ren)[2]	100% of the employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.[3]

BENEFIT PAYMENT

Your **Initial Benefit** provides a lump-sum payment upon the first diagnosis of a Covered Condition. Your plan pays a Recurrence Benefit[4] for the following Covered Conditions: heart attack, stroke, coronary artery bypass graft, full benefit cancer and partial benefit cancer. A recurrence benefit is only available if an initial benefit has been paid for the covered condition. There is a benefit suspension period between recurrences.

The maximum amount that you can receive through your Critical Illness Insurance plan is called the **Total Benefit** and is 3 times the amount of your Initial Benefit. This means that you can receive multiple Initial Benefit and Recurrence Benefit payments until you reach the maximum of 300% or $45,000 or $90,000.

Please refer to the table below for the percentage benefit amount for each Covered Condition.

Covered Conditions	Initial Benefit	Recurrence Benefit
Full Benefit Cancer[5]	100% of Initial Benefit	100% of Initial Benefit
Partial Benefit Cancer[5]	25% of Initial Benefit	25% of Initial Benefit
Heart Attack	100% of Initial Benefit	100% of Initial Benefit
Stroke[6]	100% of Initial Benefit	100% of Initial Benefit
Coronary Artery Bypass Graft[7]	100% of Initial Benefit	100% of Initial Benefit
Kidney Failure	100% of Initial Benefit	Not Applicable
Alzheimer's Disease[8]	100% of Initial Benefit	Not Applicable
Major Organ Transplant Benefit	100% of Initial Benefit	Not Applicable
22 Listed Conditions	25% of Initial Benefit	Not Applicable

22 Listed Conditions

MetLife Critical Illness Insurance will pay 25% of the Initial Benefit Amount when a covered person is diagnosed with one of the 22 Listed Conditions. A Covered Person may only receive one payment for each Listed Condition in his/her lifetime. The Listed Conditions are Addison's disease (adrenal hypofunction); amyotrophic lateral sclerosis (Lou Gehrig's disease); cerebrospinal meningitis (bacterial); cerebral palsy; cystic fibrosis; diphtheria; encephalitis; Huntington's disease (Huntington's chorea); Legionnaire's disease; malaria; multiple sclerosis (definitive diagnosis); muscular dystrophy; myasthenia gravis; necrotizing fasciitis; osteomyelitis; poliomyelitis; rabies; sickle cell anemia (excluding sickle cell trait); systemic lupus erythematosus (SLE); systemic sclerosis (scleroderma); tetanus; and tuberculosis.

Example of Initial & Recurrence Benefit Payments
The example below illustrates an employee who elected an Initial Benefit of $15,000 and has a Total Benefit of 3 times the Initial Benefit Amount or $45,000.

Illness - Covered Condition	Payment	Total Benefit Remaining
Heart Attack - First diagnosis	Initial Benefit payment of $15,000 or 100%	$30,000
Heart Attack - second diagnosis, two years later	Recurrence Benefit payment of $15,000 or 100%	$15,000
Kidney Failure - first diagnosis, three years later	Initial Benefit payment of $15,000 or 100%	$0

In most states there is a pre-existing condition limitation. If advice treatment or care was sought, recommended, prescribed or received during the three months prior to the effective date of coverage, we will not pay benefits if the covered condition occurs during the first six months of coverage. The pre-existing condition limitation does not apply to occupational HIV, heart attack or stroke.

SUPPLEMENTAL BENEFITS

MetLife provides coverage for the Supplemental Benefits listed below. This coverage would be in addition to the Total Benefit Amount payable for the previously mentioned Covered Conditions.

Health Screening Benefit[10] MetLife will provide an annual benefit of $100 per calendar year for taking one of the eligible screening/prevention measures. MetLife will pay only one health screening benefit per covered person per calendar year. Eligible screening/prevention measures may include:

Eligible screening/prevention measures may include:

• Annual physical exam	• Flexible sigmoidoscopy
• Biopsies for cancer	• Hemoccult stool specimen
• Blood test to determine total cholesterol	• Hemoglobin A1C
• Blood test to determine triglycerides	• Human papillomavirus (HPV) vaccination
• Bone marrow testing	• Lipid panel
• Breast MRI	• Mammogram
• Breast ultrasound	• Oral cancer screening
• Breast sonogram	• Pap smears or thin prep pap test
• Cancer antigen 15-3 blood test for breast cancer (CA 15-3)	• Prostate-specific antigen (PSA) test
• Cancer antigen 125 blood test for ovarian cancer (CA 125)	• Serum cholesterol test to determine LDL and HDL levels
• Carcinoembryonic antigen blood test for colon cancer (CEA)	• Serum protein electrophoresis
• Carotid Doppler	• Skin cancer biopsy
• Chest x-rays	• Skin cancer screening
• Clinical testicular exam	• Skin exam
• Colonoscopy	• Stress test on bicycle or treadmill
• Digital rectal exam (DRE)	• Successful completion of smoking cessation program
• Doppler screening for cancer	• Tests for sexually transmitted infections (STIs)
• Doppler screening for peripheral vascular disease	• Thermography
• Echocardiogram	• Two hour post-load plasma glucose test
• Electrocardiogram (EKG)	• Ultrasounds for cancer detection
• Endoscopy	• Ultrasound screening of the abdominal aorta for abdominal aortic aneurysms
• Fasting blood glucose test	• Virtual colonoscopy
• Fasting plasma glucose test	•

This is a brief summary of benefits. You will need to review the plan certificate for full coverage which can be found on your TBX online enrollment portal.

Accident Insurance Plan Summary

Benefit Type[1]	Low Plan MetLife Accident Insurance Pays YOU	High Plan MetLife Accident Insurance Pays YOU
Injuries		
Fractures[2]	$100 — $6,000	$150 — $9,000
Dislocations[2]	$100 — $6,000	$150 — $9,000
Second and Third Degree Burns	$100 — $10,000	$150 — $15,000
Concussions	$400	$600
Cuts/Lacerations	$50 — $400	$75 — $600
Eye Injuries	$300	$400
Medical Services & Treatments		
Ambulance	$300 — $1,000	$400 — $1,200
Emergency Care	$50 — $100	$100 — $150
Non-Emergency Care	$50	$50
Physician Follow-Up	$100	$200
Therapy Services (including physical therapy)	$25 - $60	$35 - $60
Medical Testing Benefit	$200	$300
Medical Appliances	$100 — $1,000	$200 — $1,500
Inpatient Surgery	$200 — $2,000	$300 — $3,000
Hospital[3] Coverage (Accident)		
Admission	$1,000 (non-ICU) — $2,000 (ICU) per accident	$2,000 (non-ICU) — $3,000 (ICU) per accident
Confinement	$200 a day (non-ICU) —up to 31 days $400 a day (ICU) — up to 31 days	$400 a day (non-ICU) — up to 31 days $600 a day (ICU) — up to 31 days
Inpatient Rehab — per accident	$200 a day — up to 15 days	$300 a day — up to 15 days
Accidental Death		
Employee receives 100% of amount shown, spouse receives 50% and children receive 20% of amount shown.	$40,000 $200,000 for common carrier[5]	$60,000 $300,000 for common carrier[5]
Dismemberment, Loss & Paralysis		
Dismemberment, Loss, & Paralysis	$500 — $50,000 per injury	$1,000 — $100,000 per injury
Other Benefits		
Lodging[6] — Pays for lodging for companion up to 30 nights per calendar year	$200 per night, up to 30 nights	$300 per night, up to 30 nights
Health Screening Benefit (Wellness)[7] benefit provided if the covered insured takes one of the covered screening/prevention tests	$100 ***Payable 1x per calendar year***	$100 ***Payable 1x per calendar year***

Accident Insurance

MetLife

BENEFIT PAYMENT EXAMPLE

Kathy's daughter, Molly, plays soccer on the varsity high school team. During a recent game, she collided with an opposing player, was knocked unconscious and taken to the local emergency room by ambulance for treatment. The ER doctor diagnosed a concussion and a broken tooth. He ordered a CT scan to check for facial fractures too, since Molly's face was very swollen. Molly was released to her primary care physician for follow-up treatment, and her dentist repaired her broken tooth with a crown. Depending on her health insurance, Kathy's out of pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Group Accident Insurance payments can be used to help cover these unexpected costs.

Covered Event[1]	**Benefit Amount**[8]
Ambulance (ground)	$400
Emergency Care	$150
Physician Follow-Up ($200 x 2)	$400
Medical Testing	$300
Concussion	$600
Broken Tooth (repaired by crown)	$400
Benefits paid by MetLife Group Accident Insurance	$2,250

This is a brief summary of benefits. You will need to review the plan certificate for full coverage which can be found on your TBX online enrollment portal.

Hospital Indemnity Insurance Plan Summary

MetLife

HOSPITAL INDEMNITY INSURANCE BENEFITS

With MetLife, you'll have a choice of two comprehensive plans which provide payments in addition to any other insurance payments you may receive. Here are just some of the covered benefits/services, when an accident or illness puts you in the hospital.[1]

Benefit Type[2]	Low Plan MetLife Hospital Indemnity Insurance Pays YOU	High Plan MletLife Hospital Indemnity Insurance Pays YOU
Hospital Coverage (Accident)		
Admission Must occur with 180 days after the accident	$500 per accident (non-ICU) $1,000 per accident (ICU)	$1,000 per accident (non-ICU) $2,000 per accident (ICU)
Confinement Must occur within 180 days after the accident	$100 a day (non-ICU) for up to 10 days $200 a day (ICU) for up to 10 days	$200 a day (non-ICU) for up to 10 days $400 a day (ICU) for up to 10 days
Hospital Coverage (Sickness)[3]		
Admission Payable 1x per calendar year	$500 (non-ICU) $1,000 (ICU)	$1,000 (non-ICU) $2,000 (ICU)
Confinement Paid per sickness	$100 a day (non-ICU) for up to 10 days $200 a day (ICU) for up to 10 days	$200 a day (non-ICU) for up to 10 days $400 a day (ICU) for up to 10 days

BENEFIT PAYMENT EXAMPLE

Susan wakes up in the middle of the night experiencing chest pain. An ambulance takes her to the emergency room (ER) at a local hospital. Upon arrival, the doctor examines Susan and advises that she requires immediate admission to the Intensive Care Unit for further evaluation and treatment. After 1 day in the Intensive Care Unit, Susan moves to a standard room and spends 2 additional days recovering in the hospital. Susan was released to her primary care physician for follow-up treatment and observation. Her primary doctor is now keeping a close watch over Susan's overall health. Depending on her health insurance, Susan's out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Group Hospital Indemnity Insurance payments can be used to help cover these unexpected costs or in any other way Susan sees fit.

Covered Benefit	Benefit
Admission—Intensive Care Unit Cover-	$2,000
Confinement for 1 day—Intensive Care	$400
Confinement for 2 Days—Hospital Cov-	$400
Benefit paid by MetLife Group Hospital	$2,800

This is a brief summary of benefits. You will need to review the plan certificate for full coverage which can be found on your TBX online enrollment portal.

How it Works

Everything you need to know to start saving money right away!

Step 1

Your doctor says you need a specific service or procedure. This could be lab work, an MRI or even a surgical procedure. You can always see your regular doctor because he or she will often let you know exactly what you need.

Step 2

Just call or email us to see if what you need is covered. Once you know exactly what you need we can see what is available. We don't cover everything but we are always adding new providers and services.

Step 3

We will hook you up. Once we talk to you we will send a referral to the provider you chose and they will contact you to schedule an appointment time that works for you. If it takes too long or you just have a question you can alway reach back out to us.

Step 4

You pay $0. That's right, your health plan will cover the cost of everything. You never have to worry about copays or deductibles. No more bills and no more surprises.

Pretty awesome, right? If you've got any questions or concerns, just ask!

855-816-0001

Not the ask-in-person type? Feel free to reach out to us by email at help@thezerocard.com

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.

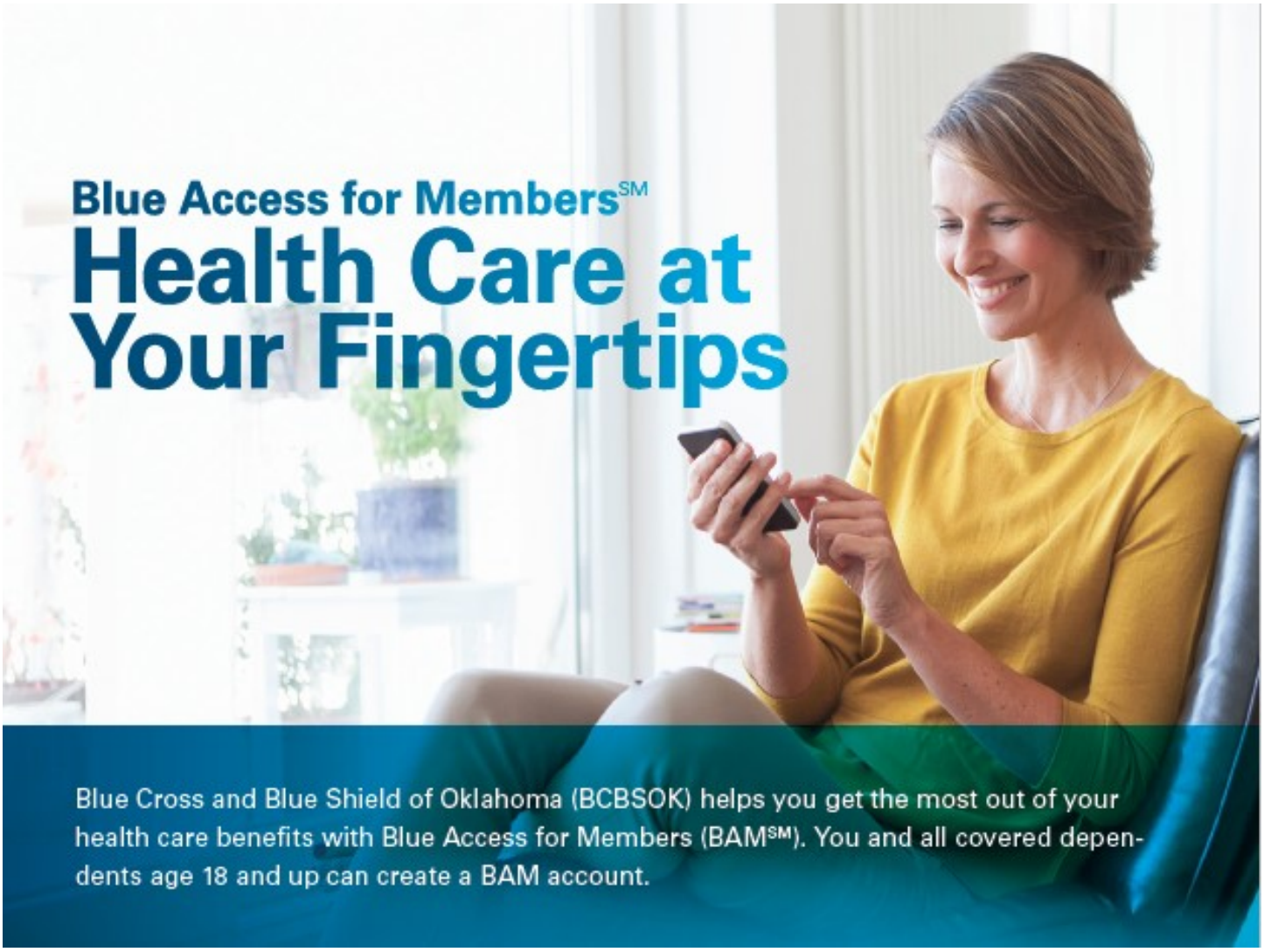
How do I know what providers are covered?

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



With BAM, you can:

- Use our Provider Finder tool to search for a health care provider, hospital or pharmacy
- Request or print your ID card
- Check the status or history of a claim
- View or pint Explanation of Benefits statements
- Use our Cost Estimator tool to find the price of hundreds of tests, treatments and procedures
- Download our app
- Sign up for text or email alerts

It's Easy to Get Started!

1. Go to bcbsok.com/member
2. Click Log Into My Account
3. Use the information on your BCBGSOK ID card to sign up

Or, text* BCSOKAPP to 33633 to get the BCBSOK App that lets you use BAM while you're on the go.

*Message and data rates may apply

BlueCross BlueShield of Oklahoma

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 the *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 reference

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.

***Exclusion: The Health Assessment deductible credit is not available to members enrolled in the HSA plan (Plan E).**

How to take the assessment:

1. Log into your BAM account at BCBS
2. Under the Quick Links on the right 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, then call the customer service number on the back of your BCBS ID card: 1-800-672-2567.

Once you have your personal online account set up with BCBS will you 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-Management Programs
- 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.1 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.

BLUE POINTS[SM] PROGRAM[2]

Small rewards may 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. [3] You can also earn points when you achieve milestones in the Self-Management Programs. Redeem your Blue Points in the online shopping mall, which offers a wide variety of merchandise.[4]

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 trackers that 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-MANAGEMENT PROGRAMS

These programs consist of:

1. Interactive programs with learning activities and content that focus on behavioral changes to reinforce healthier habits.
2. Educational programs that inform about symptoms, treatment options and lifestyle changes.

These two learning methods allow you to study on your own time and may help you get to the next level of wellness. Topics include nutrition, weight management, physical activity, stress management, tobacco cessation and more.

FITNESS TRACKING

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

1. Well onTarget is a voluntary wellness program. Completion of the Health Assessment is not required for participation in the program.
2. Blue Points Program Rules are subject to change without prior notice. See the Program Rules on the Well onTarget Member Wellness Portal for more information.
3. This does not apply to points you earn for completing Fitness Program activities.
4. Member agrees to comply with all applicable federal, state and local laws., including making all disclosures and paying all taxes with respect to their receipt of any reward.

The Fitness Program is provided by Tivity Health®, an independent contractor that administers the Prime Network of fitness centers. The Prime Network is made up of independently owned and operated fitness centers.

Blue Cross and Blue Shield of Oklahoma, a Dvision of Health Care Service Corporateion, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Sheild Association

BlueCross BlueShield of Oklahoma

Because Your Health Counts

It's Important to Know Where to Go When You Need Care

Sometimes it's easy to know when you should go to an emergency room (ER), at other times, it's less clear. You have choices for receiving in-network care that will work with your schedule and also give you access to the kind of care you need. Know when to use each for non-emergency treatment.

Your Doctor's Office

Your own doctor's office may be the best place to go for non-emergency care, such as health exams, routine shots, colds and minor injuries. Your doctor knows your health history and the medicine you take and can decide if you need tests or specialist care. Your doctor can also help you with care for chronic health issues, such as asthma or diabetes.

Retail Health Clinic

When you can't get to your regular doctor, walk-in clinics – available in many retail stores – can be a lower-cost choice for care. Many stores have a physician assistant or nurse practitioner who can help treat ear infections, rashes, minor cuts and scrapes, allergies and colds.

Urgent/Immediate Care Clinic

These facilities can treat you for more serious health issues, such as when you need an X-ray or stitches. You will probably have a lower out-of-pocket cost than at a hospital ER, and you may have a shorter wait.

Hospital Emergency Room

Any life-threatening or disabling health problem is a true emergency. You should go to the nearest hospital ER or call **911**. When you use the ER for true emergencies, you help keep your out-of-pocket costs lower.

Knowing where to go for care can make a big difference in cost and time. Here's how your options compare:[†]

	Average Costs	Average Wait Times	Examples of Health Issues	
Your Doctor's Office Your doctor knows your medical history best	$	18 minutes*	• Fever and colds • Sore throat • Minor burns • Stomach ache	• Ear or sinus pain • Physicals • Shots • Minor allergic reactions
Retail Health Clinic Convenient, low-cost care in stores and pharmacies	$	15 minutes	• Infections • Fever and colds • Minor injuries or pain • Shots	• Flu shots • Sore and strep throat • Skin problems • Allergies
Urgent Care Clinic Immediate care for issues that are not life-threatening	$$	16 - 24 minutes**	• Migraines or headaches • Cuts that need stitches • Abdominal pain • Sprains or strains	• Urinary tract infection • Animal bites • Back pain
Hospital Emergency Room For serious or life-threatening conditions	$$$	4 hours, 7 minutes***	• Chest pain, stroke • Seizures • Head or neck injuries • Sudden or severe pain	• Fainting, dizziness, weakness • Uncontrolled bleeding • Problem breathing • Broken bones

[†]Relative costs described are for independently contracted network providers. Costs for out-of-network providers may be higher.

* Vitals Annual Wait Time Report, 2017.

** Wait Time Trends in Urgent Care and Their Impact on Patient Satisfaction, 2017.

*** Emergency Department Pulse Report 2010 Patient Perspectives on American Health Care. Press Ganey Associates.

Urgent Care or Freestanding Emergency Room

Urgent care centers and freestanding ERs can be hard to tell apart. Freestanding ERs often look a lot like urgent care centers. They treat most major injuries, except for trauma, but costs may be higher. Unlike urgent care centers, freestanding ERs are often out of network and may charge patients up to 10 times more for the same services.[1] Here are some ways to know if you are at a freestanding ER.

Freestanding ERs:

- Look like urgent care centers, but include EMERGENCY or ER in facility names.
- Are open 24 hours a day, seven days a week.
- Are physically separate from a hospital.
- Are staffed by board-certified ER doctors and are subject to the same ER member share which may include a copay, coinsurance and applicable deductible.

Find urgent care centers[2] near you by texting[3] **URGENTOK** to **33633**.

Need help deciding where to go for care?

On hand 24 hours a day, seven days a week; bilingual nurses available.

Call the 24/7 Nurseline[4] at **800-581-0407** for help identifying some options when you or a family member has a health problem or concern.

Need help finding a network provider?

Use Provider Finder® at **bcbsok.com** or call the Customer Service number on the back of your member ID card. If you need emergency care, call **911** or seek help from any doctor or hospital right away.

[1]The Texas Association of Health Plans.

[2]The closest urgent care center may not be in your network. Be sure to check Provider Finder to make sure the center you go to is in-network.

[3]Message and data rates may apply. Read terms, conditions and privacy policy at bcbsok.com/mobile/text-messaging.

[4]24/7 Nurseline is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

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
Online Enrollment System	• Completing your benefit elections	my.tbx360.com/okheei
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	• 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, then click "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 "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

Medical and Prescription Drug Benefits:	Carrier Name:	BCBSOK
	Customer Service Phone Number:	800-672-2567
	Website:	www.bcbsok.com/okheei
Dental Benefits:	Carrier Name:	Delta Dental Oklahoma
	Customer Service Phone Number:	800-522-0188 or 405-607-2100
	Email:	customerservice@deltadentalok.org
	Network:	PPO or Premier
	Website:	www.deltadentalok.org
Vision Benefits:	Carrier Name:	Vision Service Plan
	Customer Service Phone Number:	800-877-7195
	Network:	Choice
	Website:	www.vsp.com
Life & AD&D and Voluntary Life AD&D:	Carrier Name:	Standard Insurance Company
	Customer Service Phone Number:	888-937-4783
	Website:	www.standard.com
Disability Income Benefits (Long Term Disability):	Carrier Name:	Standard Insurance Company
	Customer Service Phone Number:	888-937-4783
	Website:	www.standard.com
COBRA Administration:	Carrier Name:	TBX COBRA
	Customer Service Phone Number:	800-328-4337
	Email:	csr@tbxsupport.com
Retiree Billing:	Carrier Name:	Chard-Snyder
	Customer Service Phone Number:	888-993-4646
Oklahoma Teacher's Retirement:	Customer Service Phone Number:	877-287-1605
	Email:	mail@trs.ok.gov
	Website:	www.ok.gov/trs
Online Enrollment System:	Website:	my.tbx360.com/okheei
Accident, Critical Illness, Hospital Indemnity:	Carrier Name:	MetLife
	Customer Service Phone Number	1-800-GET-MET8 (1-800-438-6388)
	Website:	www.metlife.com/mybenefits