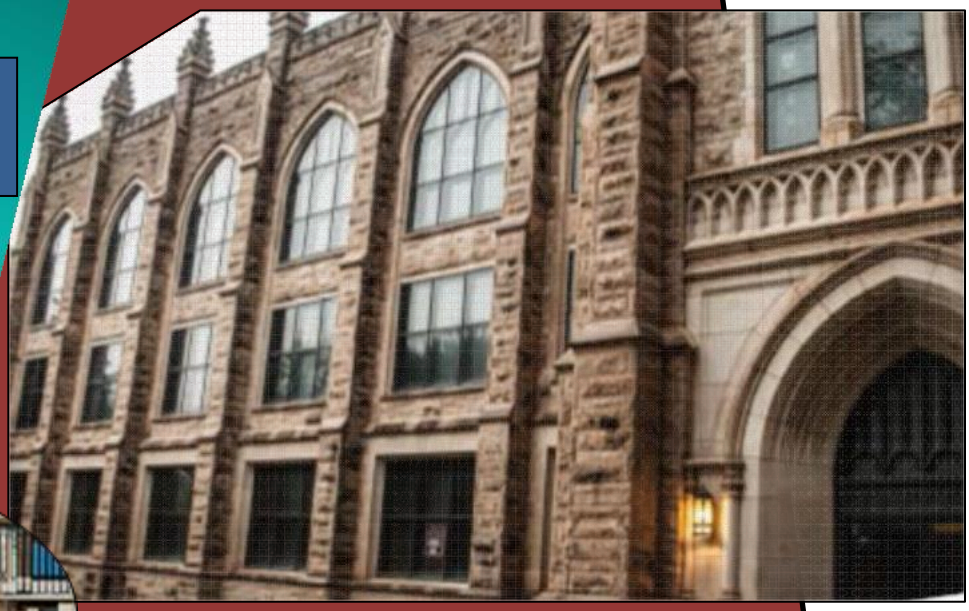
2017 Employee Benefits



OKLAHOMA HIGHER EDUCATION EMPLOYEE INSURANCE GROUP

OKHEEI

ECU · MSC · NOC · NSU · NWOSU · RCC · RSC · SE · SSC · SWOSU · UCO · WOSC · RUSO

MESSAGE TO OKHEEI EMPLOYEES:

We are pleased to present our Employee Benefits Guide for the 2017 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.

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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 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:

- 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 are eligible for coverage regardless of age. The plan reserves the right to request verification of dependent(s) with disabilities upon initial enrollment and from time-to-time thereafter as the plan may require.

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 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.

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 you travel outside the United States, PPO members have access to contracting providers in more than 200 countries through 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℠.)

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PRESCRIPTION DRUG BENEFITS

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

The two changes to the prescription drug benefit for 2017 include the following:

- Proton Pump Inhibitor prescription drugs are excluded from coverage (for example, Nexium, Prilosec, etc.). These drugs may be purchased over-the-counter.
- If a generic equivalent is available, members will be required to pay the difference in the cost of the medication between the brand name and the generic up to the brand name cost of the drug. This will apply if the member specifically requests the brand name drug.

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 formulary. The purpose of the formulary is to offer less costly medications. The drug formulary 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 formulary 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 pharmacy network includes most national chains and independent pharmacies across the country. When you fill your prescription drugs at retail, your pharmacy copayment depends on the formulary tier to 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.**

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℠)

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. The cost of services is usually lower and the benefits you receive higher if you use a PPO provider.

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 no referrals are 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 "Find a Doctor." 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℠

The White Plan is a BlueOptions℠ plan.

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.

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 BlueCard 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.

Your choice can affect the amount of benefits you receive. You will have the lowest out-of-pocket expense when you see providers in the Blue Preferred PPO℠ network. Keep in mind that out-of-pocket amounts vary depending on the network you choose. The out-of-pocket amounts update each other, which means that at one point during the year, you may have satisfied your Blue Preferred PPO℠ out-of-pocket, but still have more to satisfy for the Blue Choice PPO℠ network.

If you were to continue to see Blue Preferred PPO℠ providers, then your out-of- pocket is met. If you visit a Blue Choice PPO℠ (or out-of-network) provider, you will first have to satisfy the difference between the out-of- pocket for that network and the Blue Preferred PPO℠ out-of-pocket.

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, and include 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

MEDICAL PLAN SUMMARY 2017

BlueCross BlueShield of Oklahoma

	RED PLAN		WHITE PLAN				BLUE PLAN	
	Blue Choice PPO℠		BlueOptions℠				Blue Choice PPO℠	
	In Network	Out of Network	Blue Preferred℠	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 per member then member responsibility	
General Payment Level	80% after CYD	50% after CYD					50% after CYD	
Calendar Year Deductible (CYD)	$1,000 Ind. / $3,000 Family	$1,000 Ind. / $3,000 Family	$1,250 Ind. / $3,750 Family	$1,250 Ind. / $3,750 Family	$1,250 Ind. / $3,750 Family	$1,250 Ind. / $3,750 Family	$500 Ind. / $1,000 Family	$500 Ind. / $1,000 Family
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 Family	$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	
Primary Care Office	$25 copay	50% after CYD	$25 copay	$35 copay	60% after CYD	50% after CYD	50% after CYD	
Visit Specialist Office	$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%	100%	100%	70% after CYD	100%	70% after CYD
Adult Immunizations	100%	70% after CYD	100%	100%	100%	70% after CYD	100%	70% after CYD
Routine Health Exams	100%	70% after CYD	100%	100%	100%	70% after CYD	100%	70% after CYD
Childhood	100%	100%	100%	100%	100%	100%	100%	
Routine Mammograms	100%	100%	100%	100%	100%	100%	100%	
Allergy Treatment/Testing	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 2017 plan year and must be completed between 01/01/2017 and 12/31/2017. HA must be completed and credited prior to claims payment. No retroactive claim adjustments will be allowed.							
Mental Health and	**RED PLAN**		**WHITE PLAN**				**BLUE PLAN**	
Inpatient*	80% after CYD	Additional $300 deductible, then 50% after CYD	80% after CYD	70% after CYD	60% after CYD	Additional $300 deductible, 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	
Other Covered Services								
	In Network	Out of Network	Blue Preferred℠	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	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	100% after copay	60% after CYD	50% after CYD	50% after CYD	
Hearing Aids	Covered as DME up to age 18							

PRESCRIPTION DRUG BENEFITS SUMMARY

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	

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.

For the 2017 Plan Year, OKHEEI made the decision to change from BCBS Dental to Delta Dental of Oklahoma. Out of the dentists that the OKHEEI group utilizes, more dentists are in-network with Delta Dental's Premier network while offering better benefits for a lower premium. OKHEEI is also offering employees and their eligible dependents the opportunity to enroll in Delta Dental's Preventive Only Plan.

The Preventive Only Plan through Delta Dental is a low-cost alternative that covers preventive and basic care for all enrollees. This plan is great for those individuals who mainly utilize the dentist for preventive care and the occasional filling and/or extraction!

The High and Low Options through Delta Dental duplicate the plans that OKHEEI offered through BCBS with the exception of a couple of enhanced orthodontia benefits under the high plan (the low plan does not offer orthodontia).

- No longer a waiting period for orthodontia
- Dependent children up to age 26 can now utilize the orthodontia benefit, rather than just to age 19

Similar to medical coverage, with your dental coverage through Delta Dental, the annual deductible must first be reached for all necessary Basic and Major Care (except for Preventive Plan that doesn't cover Major Care). Once the deductible is met, the copay will then go into effect.

Preventive Care Includes:

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

Routine cleanings, exams, and bitewing x-rays are covered twice in a benefit period. There is no charge for topical fluoride application up to age 16.

Basic Care Includes:

- Fillings
- Extractions
- Endodontics
- Periodontics

Major Care Includes:

- Crowns
- Bridges
- Dentures

Orthodontia:

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

	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%
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 deductibl	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 Summary Plan Description. The information is not designed to serve as Evidence of Coverage for this program and is subject to the provisions of the Summary Plan Description. For an accurate description of your benefits, see the Summary Plan Description 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.

VISION BENEFITS

A vision program available through VSP.

Value and Savings. You'll get great benefits on your exam and eyewear at an affordable price.

Personalized Care. You'll get quality care that focuses on your eyes and overall wellness with a WellVision Exam from a VSP doctor. When you see a VSP doctor, you'll get the most out of your benefit and have lower out-of-pocket costs. Plus, you'll be 100% happy with your eyecare and eyewear from a VSP doctor or VSP will make it right.

Eyewear. Choose the eyewear that's right for you and your budget.

Choice of Providers. The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider.

To find a VSP doctor, visit www.vsp.com or call 800-877-7195. For information specific to OKHEEI's plans, visit http://okheeigro.vspforme.com.

Your Coverage with a VSP Provider			
Benefit	**Description**	**Copay**	**Frequency**
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	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/special offers 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 Provider		
Visit www.vsp.com for details, if you plan to see a provider other than a VSP network provider.		
Exam: Up to $45	Single Vision Lenses: Up to $30	Progressive Lenses: Up to $50
Frame: Up to $70	Bifocal Lenses: Up to $50	Trifocal Lenses: Up to $65
Contacts: Up to $105	Progressive Lenses: Up to $50	
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.		

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

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 that you reach a new age band.** You must purchase Voluntary life Insurance for yourself to purchase Voluntary Life insurance for your spouse and child(ren).

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 age 70	N/A

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
Under 30	$0.08	$0.80	$1.60	$3.20	$4.00	$8.00	$12.00	$16.00	$24.00
30-34	$0.10	$1.00	$2.00	$4.00	$5.00	$10.00	$15.00	$20.00	$30.00
35-39	$0.11	$1.10	$2.20	$4.40	$5.50	$11.00	$16.50	$22.00	$33.00
40-44	$0.15	$1.50	$3.00	$6.00	$7.50	$15.00	$22.50	$30.00	$45.00
45-49	$0.23	$2.30	$4.60	$9.20	$11.50	$23.00	$34.50	$46.00	$69.00
50-54	$0.34	$3.40	$6.80	$13.60	$17.00	$34.00	$51.00	$68.00	$102.00
55-59	$0.56	$5.60	$11.20	$22.40	$28.00	$56.00	$84.00	$112.00	$168.00
60-64	$0.69	$6.90	$13.80	$27.60	$34.50	$69.00	$103.50	$138.00	$207.00
65-69*	$1.29	$6,500	$13,000	$26,000	$32,500	$65,000	$97,500	$130,000	$195,000
		$8.39	$16.77	$33.54	$41.93	$83.85	$125.78	$167.70	$251.55
70-74*	$2.08	$5,000	$10,000	$20,000	$25,000	N/A	N/A	N/A	N/A
		$10.40	$20.80	$41.60	$52.00	N/A	N/A	N/A	N/A
75-99*	$2.08	$3,500	$7,000	$14,000	$17,500	N/A	N/A	N/A	N/A
		$7.28	$14.56	$29.12	$36.40	N/A	N/A	N/A	N/A

Due to rounding, your actual payroll deduction amount may vary slightly.
*Age reductions apply

Example:
Use this formula to calculate premium costs for supplemental life benefit coverage amounts not shown in the illustration above.

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

.

Monthly Premium for Dependent Life and Child Options			
Spouse and Child - Life Only		Spouse and 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	$13.01 per family unit

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

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 DISABILTIY 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 Buy-Up LTD benefit

A. Annual Earnings =	$30,000	A. Annual Earnings =	$
B. Monthly Earnings = *(A divided by 12)*	$2,500	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 multiplied by 0.080 – Buy-Up)*	$2.00 monthly	D. Estimated Monthly Contribution *(C multiplied by 0.080 – Buy-Up)*	$

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.

BlueCross BlueShield of Oklahoma

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 a Blue Distinction Center® 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 and your estimated out-of-pocket share of the cost?
- Do you want to find savings by comparing costs?
- How do you choose where to go for medical services?

Provider Finder with Benefit Accumulator

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.

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

Well onTarget®

Take Your Health Personally. Take the Health Assessment!

What do you take personally in life? Your family? Your work? Sports? A hobby? Add your health to the list by taking the Well onTarget Health Assessment (HA).

Just a few minutes and a few personal details—how you eat, how you sleep, how you live your life—can give you a personalized map to your best health. You can know your risks and your best options to avoid them. Your customized Personal Wellness Report can tell you how to go from good to better.

The new Health Assessment consists of nine modules that can be completed all at once or by section. These modules include questions regarding your:

- Diet
- Tobacco use
- Physical activity
- Emotional health
- Health at work and on the road

It would be helpful—but not a must—to have a few more personal details on hand when you begin the HA:

- Current height and weight
- Systolic (top number) and Diastolic (bottom number) of your blood pressure reading
- Total cholesterol level
- HDL cholesterol level
- Triglyceride level
- Blood sugar level
- Waist measurement in inches

The new onmyway™* Health Assessment is available at wellontarget.com.

Log in today and earn 2,500 Life Points for taking your HA.

wellontarget.com

Registered mark of Health Care Service Corporation, a Mutual Legal Reserve Company

* onmyway is registered mark of Onlife Health.

BlueCross BlueShield of Oklahoma

Well onTarget®

Live Well with the Well onTarget Member Wellness Portal

The Well onTarget Member Wellness Portal brings you 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 on to your portal, you will find:

- onmyway™ Health Assessment
- onmytime Self-directed Courses
- Health Trackers
- Trusted news and content

See Your Stats in a Flash!

Everything you want to see quickly is on My Dashboard. The dashboard shows all of the Well onTarget programs you are involved in. See where you are today compared to where you started. You can also get the latest health news and check your activity progress.

onmyway Health Assessment

The Health Assessment asks you questions about your health and habits. You then get a Personal Wellness Report. The report shows you how you might make positive lifestyle changes. Your Personal Wellness Report can tell you which program to start first to get the most benefit. You can also print a Provider Report to share with your doctor.

The Well onTarget Member Wellness Portal, available at wellontarget.com, offers you the tools and resources you need to reach your wellness goals.

wellontarget.com

Blue Points* Program

Small rewards can help you to make changes to meet your goals. With Well onTarget, you can earn Blue Points for making healthy choices. If you enroll in the Fitness Program or take your Health Assessment, you earn points. You can also earn points when you achieve milestones in the Self-directed Courses. Redeem your Blue Points for a large selection of rewards in the online Shopping Mall.

Health Tools and Trackers

Tracking what you eat and how much you work out each day can help you reach your goals. But keeping track of all that you do can be time-consuming. To make it easy, the Well onTarget portal has an interactive Food and Exercise Diary. You can track all your nutrition and fitness data in one place. The diary will track your progress toward your goals. You can record how many glasses of water you drink. An online pedometer measures the steps you take.

Other health trackers are sleep, stress, blood pressure and cholesterol.

The portal also offers a Symptom Checker. When you don't feel well, this feature can help you decide if you should see a doctor.

onmytime Self-directed Courses

These 12-week courses allow you to study on your own time. Taking these courses helps 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 Self-directed Courses at a time.

Through the "Progress Check-In" feature on the Dashboard, you can fill out Milestone Assessments. This feature will help check your progress in each course you've joined. You can then view a personalized report with actionable recommendations.

Fitness Tracking

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

Your Well onTarget Member Wellness Portal experience is personalized for you based on your answers to the Health Assessment.

wellontarget.com

*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. Your company may have additional reward programs in place to encourage you to take advantage of certain preventive care and wellness activities or for making healthy changes. Check your employee benefits.

73423.0815

Condition Management

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®

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

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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 formulary	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 or 405-607-2100
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

DISABILITY INCOME BENEFITS (LONG TERM DISABILITY):

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

Important Legal Notices Affecting Your Health Plan Coverage

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Important Notice from *Oklahoma Higher Education Employees Insurance 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 Insurance Group (OKHEEI) 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 have 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. OKHEEI 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 existing OKHEEI 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 OKHEEI 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.

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 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.

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 moths without creditable cover, 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 the Blue Cross Blue Shield Customer Service department for further information at 1-800-942-5837 (Option 4). **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 OKHEEI changes. You may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage:

More detailed information about Medicare Plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778)

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	August 23, 2016
Name of Entity/Sender:	OKHEEI
Contact:	Whitney Popchoke
Address:	3555 NW 58th St, Ste 320 Oklahoma City, OK 73112
Phone:	(405) 942-8817

Important Notice from *Oklahoma Higher Education Employee Insurance 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 Insurance Group (OKHEEI) 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. OKHEEI has determined that the prescription drug coverage offered by the UnitedHealthcare MedicareRx for Groups 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 another stand-alone Medicare Part D drug plan or a medical plan that includes prescription drug coverage, you will be unenrolled from your OKHEEI plan.

If you do decide to join a Medicare drug plan and drop your current OKHEEI 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.

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 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.

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 UnitedHealthcare Medicare Solution at (800) 698-0822. **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 OKHEEI changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov

- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	August 23, 2016
Name of Entity/Sender:	OKHEEI
Contact:	Whitney Popchoke
Address:	3555 NW 58th St, Ste 320 Oklahoma City, OK 73112
Phone:	(405) 942-8817

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE - FEDERAL

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).

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 toward 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).

In addition, 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.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 30 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Whitney Popchoke
3555 NW 58th St., Suite 320
Oklahoma City, OK 73112
405-942.8817
wpopchoke@ruso.edu

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 July 31, 2016. 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.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid	NEVADA – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	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
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

RHODE ISLAND – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300	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
SOUTH CAROLINA – Medicaid	**WASHINGTON – Medicaid**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA - Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
TEXAS – Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
UTAH – Medicaid and CHIP	**WYOMING – Medicaid**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VERMONT– Medicaid	
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	

To see if any other states have added a premium assistance program since July 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 1-31-2017)

PART A: General Information

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 lowers 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.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace 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.

[1] 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.

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 Insurance 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:
  - ☒ 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:
  - ☒ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

☒ 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)

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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