2018 Benefits Guide
THE UNIVERSITY OF OKLAHOMA - NORMAN PROGRAMS
The UNIVERSITY of OKLAHOMA
About This Guide

This benefit summary provides highlights of the employee benefits program for The University of Oklahoma – Norman Programs. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at The University of Oklahoma. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. The University of Oklahoma reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.

Confidentiality of Records

The university, its staff, and contracted companies are dedicated to maintaining the confidentiality of all benefits data. All employees’ records are protected by state and federal privacy laws. Only those individuals, internal or external, with a demonstrated need to know are allowed access to relevant records.
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<table>
<thead>
<tr>
<th>HUMAN RESOURCES / BENEFITS</th>
<th><a href="http://WWW.HR.OU.EDU">WWW.HR.OU.EDU</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Norman Campus</td>
<td></td>
</tr>
<tr>
<td><strong>Human Resources</strong></td>
<td></td>
</tr>
<tr>
<td>905 Asp Drive, Room 205</td>
<td></td>
</tr>
<tr>
<td>Norman, OK 73019</td>
<td></td>
</tr>
<tr>
<td><strong>P:</strong> 405-325-1826</td>
<td></td>
</tr>
<tr>
<td><strong>F:</strong> 405-325-7354</td>
<td></td>
</tr>
<tr>
<td>Tulsa Campus</td>
<td></td>
</tr>
<tr>
<td><strong>Human Resources</strong></td>
<td></td>
</tr>
<tr>
<td>4502 E. 41st Street, Room 2C11</td>
<td></td>
</tr>
<tr>
<td>Tulsa, OK 74135</td>
<td></td>
</tr>
<tr>
<td><strong>P:</strong> 918-660-3190</td>
<td></td>
</tr>
<tr>
<td><strong>F:</strong> 918-660-3200</td>
<td></td>
</tr>
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</table>

# HELPFUL RESOURCES

<table>
<thead>
<tr>
<th>PLAN</th>
<th>PROVIDER</th>
<th>PHONE NUMBER</th>
<th>WEBSITE</th>
</tr>
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<tbody>
<tr>
<td>Medical</td>
<td>Cigna</td>
<td>800-244-6224</td>
<td><a href="http://www.myCigna.com">www.myCigna.com</a></td>
</tr>
<tr>
<td>Health Savings Account (HSA)</td>
<td>Cigna / HSA Bank</td>
<td>800-244-6224</td>
<td><a href="http://www.myCigna.com">www.myCigna.com</a></td>
</tr>
<tr>
<td>Telemedicine</td>
<td>Cigna / MDLive</td>
<td>888-726-3171</td>
<td><a href="http://www.MDLive.com">www.MDLive.com</a></td>
</tr>
<tr>
<td></td>
<td>Cigna / Amwell</td>
<td>855-667-9722</td>
<td><a href="http://www.amwell.com">www.amwell.com</a></td>
</tr>
<tr>
<td>Nurse Line</td>
<td>Cigna</td>
<td>800-244-6224</td>
<td><a href="http://www.myCigna.com">www.myCigna.com</a></td>
</tr>
<tr>
<td>Dental</td>
<td>Delta Dental</td>
<td>800-522-0188</td>
<td><a href="http://www.DeltaDentalOK.org/client/ou">www.DeltaDentalOK.org/client/ou</a></td>
</tr>
<tr>
<td>Vision</td>
<td>VSP</td>
<td>800-877-7195</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
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<tr>
<td>Flexible Spending Accounts (FSA)</td>
<td>ConnectYourCare</td>
<td>855-907-3237</td>
<td><a href="http://www.ConnectYourCare.com">www.ConnectYourCare.com</a></td>
</tr>
<tr>
<td>Long-Term Disability</td>
<td>Lincoln Financial</td>
<td>800-423-2765</td>
<td><a href="http://www.LincolnFinancial.com">www.LincolnFinancial.com</a></td>
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<td>Short-Term Disability</td>
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<td>800-423-2765</td>
<td><a href="http://www.LincolnFinancial.com">www.LincolnFinancial.com</a></td>
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<tr>
<td>Travel Assistance</td>
<td>TravelConnect by UHC</td>
<td>800-527-0218</td>
<td><a href="http://www.Lincoln4Benefits.com">www.Lincoln4Benefits.com</a></td>
</tr>
<tr>
<td>ID Number: 322541</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Web ID: LifeKeys</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retirement &amp; Financial Planning</td>
<td>Fidelity</td>
<td>800-343-0860</td>
<td><a href="http://www.netbenefits.com/sooners">www.netbenefits.com/sooners</a></td>
</tr>
<tr>
<td>Employee Wellness (Norman)</td>
<td>OU Wellness</td>
<td>405-325-8435</td>
<td>ou.edu/wellness</td>
</tr>
</tbody>
</table>
EVERY EMPLOYEE plays an important role in the mission of the University of Oklahoma to provide the best possible educational experience for our students through excellence in teaching, research and creative activity, and service to the state and society.

As part of our employees’ total compensation, the university provides a range of benefit programs with both choice and value to meet the needs of our diverse workforce. We know that making benefits choices can be a bit overwhelming, so we have tools and information to help you make the right choices for you and your family.

This guide offers a comprehensive overview of your health and benefits options, including details about eligibility, enrollment and the plans available to you. It also explains how life changes and changes in your employment status can affect your benefits. Keep this booklet for future reference. You can also find benefits information on our website at: https://hr.ou.edu/Employees. If you have further questions after reviewing the options, please reach out to Human Resources on your campus (see page 4).

The University of Oklahoma offers a flexible benefits plan authorized by Section 125 of the Internal Revenue Code. Eligible employees receive an allowance of benefits credits, also called Sooner Credits. These credits represent the amount of money the university pays to provide benefits-eligible employees with the following core insurance benefits:

- Medical Insurance
- Basic Dental Insurance
- Life insurance (1.5 times annual base pay)
- Accidental Death and Dismemberment (AD&D) Insurance in the amount of $10,000 - $20,000

All employees are required to participate in the basic life insurance provided by the university. In addition to the core insurance benefits, employees and their dependents have the option to participate in other benefits available at the employee’s cost:

- Dependent Medical, Dental, Life, and AD&D Insurance
- Supplemental Employee Life and AD&D Insurance
- Employee and Dependent Vision Insurance
- Long-Term Disability Insurance (employee only)
- Short-Term Disability Insurance (employee only)
- Flexible Spending Accounts

Part-time, benefits-eligible employees who hold a full-time equivalent (FTE) of .74 or less will receive partial payment credits for core benefits. The employee will pay the difference between the total cost of the employee’s benefits and the amount contributed by the university. Part-time, benefits-eligible employees will receive a percentage of university-paid benefits in accordance with the following benefits payment table:

<table>
<thead>
<tr>
<th>FTE (Full Time Equivalent)</th>
<th>Percentage of Sooner Credits (employer share)</th>
</tr>
</thead>
<tbody>
<tr>
<td>.50 – .59</td>
<td>50%</td>
</tr>
<tr>
<td>.60 – .74</td>
<td>75%</td>
</tr>
<tr>
<td>.75 – 1.0</td>
<td>100%</td>
</tr>
</tbody>
</table>

Note: Employees holding the title of Adjunct are not benefit eligible.

DEPENDENTS

Benefits-eligible employees have the option to cover eligible dependents under certain benefit plans. Eligible dependents include the employee’s spouse (as defined in the same manner as legally defined by the State of Oklahoma) and children up to the age of 26 (defined as a child by birth, adoption, or legal guardianship).

Children become eligible for coverage at birth or, in the case of adoption, on the date of placement. To begin coverage for a newborn or a newly adopted child, employees must notify their local Human Resources office within 31 days of the date of birth or date of placement.

A child’s coverage will terminate at midnight on the last day of the month in which they turn 26. The employee must notify Human Resources when a dependent is no longer eligible for coverage. A disabled child may continue coverage past age 26. Human Resources must be notified within 31 days after the child’s 26th birthday for coverage to be continued. Insurance carriers may require additional documentation from attending physicians.
NEW HIRE BENEFITS ENROLLMENT

Individuals have 31 days from the first day of employment to make their benefits elections. Full-time employees are benefits-eligible employees and receive 100% of the Sooner Credits provided by the university. Part-time employees are benefits-eligible if they are appointed to at least a .50 full-time equivalent (FTE). Part-time employees receive a portion of benefits credits (review the table on page 5).

Benefits-eligible employees who fail to select benefits within the 31-day election period will automatically waive coverage for Medical and Dental Insurance, and will automatically enroll in the following insurance benefits coverage:

- Life Insurance (1.5 times annual base pay)
- Accidental Death and Dismemberment (AD&D) Insurance ($10,000 - $20,000 policy)

ANNUAL ENROLLMENT

Annual enrollment is a designated period of time each year when current employees can evaluate their existing coverage and make changes in their benefits plan options according to the provisions of each plan. Before enrolling, employees should review the options and restrictions of each plan. Elections made during the annual enrollment period become effective January 1 of the next calendar year. If changes are not made during annual enrollment, the employee will have to wait until the next annual enrollment period to make any needed changes, unless the employee experiences an applicable Qualifying Event (see page 7) as defined by the IRS code section 125.

During a typical annual enrollment, all current benefits-eligible employees may elect to add, drop, or maintain their current benefits. Remember, if you are enrolled in a Flexible Spending Account (FSA) or the Health Savings Account (HSA), you must take action every year; FSA and HSA elections will not roll over to the new plan year.

Helpful tips for a successful benefits enrollment:

1. Review the benefits guide and select the desired benefits options.
2. Enroll Online. Current employees who wish to make changes to existing benefits may enroll online through Employee Self-Service during the annual enrollment period at benefitsenrollment.ou.edu/enroll. For enrollment assistance, please contact your campus Human Resources.
3. Complete an Evidence of Insurability form if you request additional life insurance coverage as described below and if you request additional spouse life insurance coverage over $100,000.
4. Consider a Flexible Spending Account (FSA). Health Care Flexible Spending Accounts and Dependent Day Care Flexible Spending Accounts are established during the open enrollment period to become effective the following January 1. However, new employees may elect to establish an FSA during their initial benefits enrollment during the plan year. Per IRS regulations, the 2018 maximum contribution for Health Care FSA is $2,650; Dependent Care FSA is $5,000.
PRE-TAX PREMIUMS
Employees pay for medical, dental, vision, life, and AD&D with pre-tax dollars. This means the cost of pre-tax benefits will be payroll deducted before federal and state taxes are calculated and deducted. Selecting this option lowers the amount of taxable income reported on the W-2 and reduces the amount of taxes withheld. Long-term disability may also be paid with pre-tax dollars. Please keep in mind choosing the option for Long-term disability premiums will result in a reduction of your monthly disability benefit.

WHEN COVERAGE BEGINS AND WHEN IT ENDS
Full-time Employees – Coverage begins the first day of the month following date of hire or the first day of the month following the date the employee becomes eligible for benefits.

Dependents of Employees – If dependent coverage is elected, the dependent will be covered the day the employee’s coverage begins. If dependent coverage is added or dropped during the year due to a qualifying event, the effective date is the first day of the month following the action. Some coverage is subject to evidence of insurability.

Part-Time Employees – Coverage begins the first day of the month following date of hire or the first day of the month following the date the employee becomes eligible for benefits.

When Coverage Ends – For most benefits, coverage terminates at midnight on the last day of the month in which the individual’s employment terminates, unless the employee or covered dependents qualify for continued coverage. Upon termination of medical coverage, a Certificate of Credible Coverage will be mailed from the medical insurance provider to the employee’s home address. Life, AD&D, and Longterm disability coverage terminates on the last day of employment. See section regarding *COBRA* (pages 20-21) in this guide.

QUALIFIED LIFE EVENTS
Generally, you may only change your benefit elections during the annual enrollment period. However, you may change your benefit elections during the year if you experience a life event such as:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of employee, spouse or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- Entitlement to Medicare or Medicaid

It is the employee’s responsibility to notify Human Resources within 31 days of the Qualified Life Event. Employees must submit a Benefits Change Form (found at hr.ou.edu) to Human Resources. Changes to benefit elections must be applicable and directly related to the Qualified Life Event. Supporting documentation will be required.
PAYING FOR BENEFITS

Each plan year, the University of Oklahoma contributes monthly benefits credits (or Sooner Credits) to each benefits-eligible employee. The amount of Sooner Credits received is based on the employee’s salary and FTE (Full Time Equivalent). If you experience a change in FTE or salary during the year that moves you to another salary tier, your new Sooner Credits will be effective the first day of the month following the change. Find a full listing of the rates, Sooner Credits, and salary tiers at: hr.ou.edu/Employees/Insurance/Insurance-Programs/Premium-Rates

<table>
<thead>
<tr>
<th>Plan</th>
<th>FTE .50 – .59</th>
<th>FTE .60 – .74</th>
<th>FTE .75 – 1.0</th>
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<tbody>
<tr>
<td>Medical Plans</td>
<td>See Appendix A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Dental Plan</td>
<td>$7.66</td>
<td>$11.49</td>
<td>$15.32</td>
</tr>
<tr>
<td>Basic Life Plan (1.5 times annual salary)</td>
<td>$0.035 / $1,000</td>
<td>$0.035 / $1,000</td>
<td>$0.035 / $1,000</td>
</tr>
<tr>
<td>Basic AD&amp;D Plan ($20,000)</td>
<td>$0.10</td>
<td>$0.15</td>
<td>$0.20</td>
</tr>
</tbody>
</table>

For employees who are paid monthly, benefits premium deductions will be taken from each monthly payroll check.

Employees who are paid bi-weekly will have half of the monthly cost for all benefits deducted from each paycheck. However, please note there are two paychecks each year in which benefits deductions are not taken, except for long-term disability and flexible spending accounts, which will be taken from all paychecks. Note also that Sooner Credits are not given on those two paychecks.

Faculty who elect to be paid in nine months (9/9 faculty) will have deductions pro-rated for the plan year. In order to provide year-round coverage, 1.5 times the monthly premium will be deducted from September to December and January to April. No deductions for benefits will be taken on any summer appointments, since the annual premium is captured in the 8 months from September to April.

Note for 9/9 Faculty:
If you resign your position at the end of the spring semester and will not be returning to the university in the fall, any coverage paid by the employee will continue through June 30th. Arrangements must be made to pay premiums for July and August if you wish to extend the coverage through August 31st.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

For medical, dental, life and AD&D coverage, the university will continue to pay its share for benefits-eligible employees who take qualified leave under the Family and Medical Leave Act (FMLA). The employee is still required to pay their portion of the benefits rate, or benefits may be terminated.
Flexible Spending Accounts (FSAs) are designed to help you save money on taxes. Each pay period, funds are deducted from your paycheck before taxes are deducted, which lowers your taxable income and therefore lowers the amount of tax you pay. The FSA funds are then deposited to your Health Care and/or Dependent Care FSA. You then use your funds to pay for eligible health care or dependent care expenses. Our FSA vendor, ConnectYourCare™, includes a special debit card which:

- Works like a credit card and is linked directly to your Health Care Spending Account
- Will notify you to submit a receipt when more documentation is required

<table>
<thead>
<tr>
<th>Account Type</th>
<th>Eligible Expenses</th>
<th>Contribution Maximum</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care FSA</td>
<td>Medical, dental and vision care expenses like copays,</td>
<td>$2,650 per year</td>
<td>Reduces your taxable income; funds available to you on January 1st</td>
</tr>
<tr>
<td></td>
<td>coinsurance, deductibles, and eyeglasses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent Care FSA</td>
<td>Dependent care expenses so you and your spouse can work or attend school full-time such as day care, after school programs or elder care programs.</td>
<td>$5,000 per year $2,500 if married filing separate tax returns</td>
<td>Reduces your taxable income</td>
</tr>
</tbody>
</table>

**Important Information about FSA** Your FSA elections will be in effect from January 1st through December 31st. You can incur expenses through March 15th of the following plan year and submit claims for reimbursement no later than April 15th. Please plan your contributions carefully. Any money remaining in your account from the previous plan year will be forfeited. This is known as the "use it or lose it" rule governed by IRS regulations.

**The Advantages of an FSA** With an FSA, the money you contribute is never taxed—not when you put it in the account, not when you are reimbursed with the funds from the account, and not when you file your income tax return at the end of the year.

**Save on Your Taxes** Here is an example of how much you can save when you use your FSA to pay for your predictable health care and dependent care expenses:

<table>
<thead>
<tr>
<th>Example</th>
<th>With FSA</th>
<th>Without FSA</th>
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</thead>
<tbody>
<tr>
<td>Your Taxable Income</td>
<td>$50,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Pre-tax contribution to Health and Dependent Care FSA</td>
<td>$2,000</td>
<td>$0</td>
</tr>
<tr>
<td>Federal and Social Security taxes*</td>
<td>$11,701</td>
<td>$12,355</td>
</tr>
<tr>
<td>After-tax dollars spent on eligible expenses</td>
<td>$0</td>
<td>$2,000</td>
</tr>
<tr>
<td>Spendable income after expenses and taxes</td>
<td>$36,299</td>
<td>$35,645</td>
</tr>
<tr>
<td>Tax savings with Medical and Dependent Care FSA</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

*This is an example only. Your actual experience will vary. It assumes a 25% Federal income tax rate marginal rate and a 7.7% FICA marginal rate. State and local taxes vary, and are not included in this example. However, you will also save on any state and local taxes.

Note: FSA elections do not automatically continue from year to year; you must actively enroll each year.
If you enroll in the High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you cannot enroll in the Health Care FSA.
Medical Coverage

MEDICAL COVERAGE
The University of Oklahoma offers a choice of two medical plan options through Cigna so you can choose the plan that best meets the needs of you and your family. Your medical plan options are:

- Cigna PPO Plan
- Cigna HSA Plan

Each plan includes comprehensive health care benefits, including free preventive care services and coverage for prescription drugs. The plans also include in- and out-of-network coverage; individual and family deductibles; coinsurance; and out-of-pocket maximums. Note: The Cigna PPO Plan includes copays for physician visits and prescription drugs.

You must meet the annual deductible before the medical plan begins to cover your health care expenses, however, once the deductible is met, the medical plan begins to pay for a percentage of covered expenses (coinsurance), up to the out-of-pocket maximum.

Out-of-pocket maximums apply to both of the plans. This is the maximum amount you will pay for health care costs in a calendar year. Once you have paid the out-of-pocket maximum, the plan will cover your eligible medical expenses at 100% for the remainder of the plan year. If out-of-network providers are used, then you are responsible for charges that are above “reasonable and customary.”

Again, it is up to you to decide which plan will work best for you and the needs of your family. When making your decision, keep these few things in mind:

- monthly cost of coverage,
- annual deductibles, and
- annual out-of-pocket maximums.

Case Studies – Medical Plans

Cigna PPO Plan (Fred; Married; One child)
When comparing the medical plans offered by the university, Fred and his spouse look for the plan that provides the less out of pocket costs at time of service because Fred's spouse often needs the care of specialists. Having copays for these visits helps their financial stability. In addition, Fred’s son has allergies and also sees specialists. They would also benefit from Cigna PPO Plan’s 100% coverage for preventive care provision. Fred’s and his spouse’s salaries are adequate to cover the family deductible and they are also able to afford the monthly medical premiums. After comparing the plans, Fred decides the PPO plan is the best option for his family.

Cigna HSA Plan (Lee; Single; No children)
Lee is in good health and rarely has to go to the doctor. Lee reviews his medical expenses from past years and notes he has not exceeded $500 in the past. While studying the medical plans offered by the university, Lee sees the HSA Plan option, which provides a $500 fund to a Health Savings Account for medical expenses. Although he realizes he would have to pay the next $1,250 in expenses should he exhaust the fund, he does not expect to pay more than he has in past years. He also can take advantage of the tax savings he receives by contributing pre-tax earnings to his Health Savings Account to save for potential future medical expenses. He would also benefit from HSA’s 100% coverage for preventive care provision. Lee weighs all of his options and decides the Cigna HSA provides the best benefit for his needs.
### Important Notes:

- Employer HSA contributions are split over several payroll periods and pro-rated based on date of hire.
- Out-of-Pocket Maximum includes deductibles and copays.
- This is a synopsis of coverage only; the benefits summary contains exclusions and limitations that are not shown here. Please refer to the Cigna benefits summaries for the full scope of coverage located in the Plan & Rx Information on the Medical Insurance page: hr.ou.edu/Employees-Insurance/Insurance-Programs/Medical
Cigna HSA Plan

CONSUMER DRIVEN HEALTH PLAN (CDHP):
CIGNA AND HSA BANK
A Consumer Driven Health Plan CDHP combines a High Deductible Health Plan (HDHP) with a federal tax favored savings account known as a Health Savings Account (HSA)

What’s so great about HSA?
► Funds can be used to pay your annual deductible, coinsurance, and any other qualified medical expenses.
► Functions similar to a 401(k) or IRA. However, withdrawals for qualified medical expenses are not taxed, regardless of your age.
► Funds placed, as well as the interest which accrues, may continue to grow without federal taxation over the years.
► Unused funds roll over from year to year.
► Funds pass along to a surviving spouse or other beneficiary upon death.
► Funds are also portable to another HSA.

HSA MONEY IS YOURS TO KEEP!
Money deposited in your HSA belongs to you and is yours to keep. Should you leave the university, you take the account with you, even if you decide not to remain enrolled in an HSA qualified plan. HSA plans are not “use it or lose it”; funds rollover from year-to-year. You can continue to make contributions up to the IRS annual limit as long as you are enrolled in a qualified medical plan.

Cigna’s HSA plan is administered through HSA Bank. When you enroll in the HSA medical plan, an HSA will be opened in your name. A debit card will be mailed to you once your account is established so you can access the money in your HSA Bank account. Your debit card may be used at an ATM, as credit, or debit with your PIN.

Use myCigna.com to manage your HSA account, facilitate reimbursements to yourself, maintain receipts and keep track of expenses for future reimbursement, and even import expenses from a personal credit or debit card. Remember, as long as funds are used for eligible expenses, they are never taxable.

2018 IRS ANNUAL MAXIMUMS – HEALTH SAVINGS ACCOUNTS

<table>
<thead>
<tr>
<th>Status</th>
<th>IRS Annual Max</th>
<th>Annualized Employer Contribution</th>
<th>Employee Contribution Annual Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$3,450</td>
<td>$500</td>
<td>$2,950</td>
</tr>
<tr>
<td>Family</td>
<td>$6,900</td>
<td>$1,000</td>
<td>$5,900</td>
</tr>
<tr>
<td>Catch-Up Contribution Age 55+</td>
<td>$1,000</td>
<td>For more specific information about IRS guidelines, please visit HSAbank.com and click on “Health Savings Account” under Product Overview.</td>
<td></td>
</tr>
</tbody>
</table>
The university dental plan provides coverage to employees and their dependents. The dental plan provides two choices of coverage for benefits-eligible employees—the Basic plan and the Alternate plan. For full details including exclusions and limitations, consult the dental insurance web page at hr.ou.edu/Employees/Insurance/Insurance-Programs/Dental.

Regular dental exams can help you and your dentist detect problems in the early stages when treatment is more basic and costs are much lower. Keeping your teeth and gums clean and healthy will help prevent tooth decay and periodontal disease. Good dental hygiene is an important part of maintaining your medical health.

<table>
<thead>
<tr>
<th>Plan Option</th>
<th>PPO Network</th>
<th>Premier Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Basic Plan</td>
<td>Alt Plan</td>
<td>Basic Plan</td>
</tr>
<tr>
<td>Class I: Diagnostic and Preventive Services</td>
<td>90%</td>
<td>100%</td>
<td>75%</td>
</tr>
<tr>
<td>Exams; cleanings; xrays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class II: Basic Services</td>
<td>80%</td>
<td>90%</td>
<td>75%</td>
</tr>
<tr>
<td>Endodontics; periodontics; oral surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class III: Major Services</td>
<td>50%</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Inlays; onlays; crowns; dentures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class IV: Orthodontic Services</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Adult and child(ren)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>$50 / $100</td>
<td>$25 / $75</td>
<td>$50 / $100</td>
</tr>
<tr>
<td>Individual / Family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>$1,000</td>
<td>$2,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Per covered person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class IV Lifetime Max</td>
<td>$1,500</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

Case Studies – Dental Plans

**Basic Option** *(Donna; Single; No children)*
Donna hasn't needed dental services other than preventive care for several years. She knows she will not need any major work in the coming year. After comparing the premiums and coinsurance amounts of the two plans offered by the university, she chooses to take the basic dental plan for which the university pays 75% of the premium rather than taking the higher premium alternate dental plan.

**Alternate Option** *(Jason; Married; Two children)*
Jason's spouse covers himself and their children on the dental plan offered through her employment. Jason is not covered by his spouse's dental plan and knows he will need extensive dental work in the coming year. He compares the plan designs of the basic and alternate dental plans offered through the university and weighs the premium costs of the alternate plan against the plan's benefits (lower deductible, lower coinsurance amounts and a higher annual maximum benefit). He decides the alternate plan would provide a better benefit for his circumstance.
Vision Plan

The vision plan covers routine eye exams and pays for all or a portion of the cost of glasses or contact lenses if you need them. There are no claims for you to file when you go to a participating vision specialist. Simply pay your copay and, if applicable, any amount over your allowance at the time of service.

**OBTAINING SERVICES FROM VSP DOCTORS**

Call a VSP doctor to make an appointment. For details on how to locate VSP doctors, call VSP at 800-877-7195 or visit their web site at www.vsp.com. The VSP doctor will contact VSP to verify the employee's eligibility, plan coverage and authorization for services and materials. VSP will pay the doctor directly for covered services and materials.

When an exam and/or materials are received from VSP doctors, there will be no out-of-pocket expense other than the co-payment, unless optional items are selected. Optional items include, but are not limited to, oversize lenses (61mm or larger), coated lenses, no-line multifocal lenses, treatments for cosmetic reasons, or a frame that exceeds the plan allowance.

**CONTACT LENS ALLOWANCE**

This allowance is in addition to the 15% discount on the contact lens exam and is applied to both the contact lens exam (fitting and evaluation) and the contact lenses. Any costs exceeding this allowance are the patient's responsibility. The contact lens exam is a special exam for ensuring proper fit of your contacts and evaluating an individual's vision with the contacts. Medically necessary contact lenses must be prescribed by your doctor (as required for certain medical conditions) and approved by VSP. For more information, contact VSP member services support at 800-877-7195, or visit VSP's web site at www.vsp.com.

<table>
<thead>
<tr>
<th>Plan Option</th>
<th>Standard</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>$15 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td>Hardware</td>
<td>$25 copay</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam</td>
<td>Once every: 12 months</td>
<td>Once every: 12 months</td>
</tr>
<tr>
<td>Lenses</td>
<td>12 months</td>
<td>12 months</td>
</tr>
<tr>
<td>Frames</td>
<td>every other calendar year</td>
<td>12 months</td>
</tr>
<tr>
<td>Frames</td>
<td>$130 to $150 after copay, 20% off balance</td>
<td>$150 to $170 after copay, 20% off balance</td>
</tr>
<tr>
<td>Lenses</td>
<td>100% after copay</td>
<td>100% after copay</td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td></td>
<td>100% after copay</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td></td>
<td>100% after copay</td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td></td>
<td>100% after copay</td>
</tr>
<tr>
<td>Medically Necessary Contacts</td>
<td>100% no copay</td>
<td>100% no copay</td>
</tr>
<tr>
<td>Disposable Contacts</td>
<td>$50 / $100</td>
<td>$25 / $75</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td>Up to $120 no copay, 15% off balance</td>
<td>Up to $150 no copay, 15% off balance</td>
</tr>
</tbody>
</table>

Case Study – Standard Vision

**Bob, married, 3 children**

Bob wears eyeglasses, and his spouse has contact lenses. Two of his children also wear corrective lenses. The co-pay for an exam with a VSP provider is $15 and $25 for materials (lenses and frames). In addition, the plan provides an allowance for contact lenses which would benefit Bob’s spouse and children. After comparing premiums and costs of services and supplies, Bob finds the premiums will likely be less than his vision care expenses. Bob decides to enroll his family in VSP.
Life Insurance

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D): LINCOLN FINANCIAL

Life insurance is an important part of your financial security, especially if others depend on you for support. Accidental Death & Dismemberment (AD&D) insurance is designed to provide a benefit in the event of accidental death or dismemberment.

The University of Oklahoma provides Basic Life and AD&D Insurance to all eligible employees at no cost to you. There are two benefit options to choose from:

**Basic Life:** Flat $50,000 (employees earning $33,000 per year or more), or 1.5 times base annual salary

**AD&D:** $10,000 to $40,000 (depending on class and basic life benefit choice)

There are no imputed income or tax issues for the first $50,000 of group term life insurance coverage provided by an employer. IRS Section 79 states that employer-paid employee life insurance over $50,000 will generate imputed income (a dollar amount added to your gross pay based on age and amount of coverage over $50,000), which will be subject to federal, state and FICA taxes.

SUPPLEMENTAL LIFE INSURANCE COVERAGE

The University of Oklahoma provides you with the opportunity to purchase supplemental life insurance coverage for you and your family over the amount paid on your behalf by The University of Oklahoma. Evidence of Insurability (EOI) may be required if you elect a coverage amount above the guaranteed issue amount at your initial eligibility, or if you elect any amount of coverage after your initial eligibility. The cost of this benefit is determined by your age and the amount of coverage you elect. This means that as you age, the premium amount per pay period may change. You must elect Supplemental Life coverage for yourself in order to cover your spouse and/or children. Please refer to the chart below for available coverage information.

**SUPPLEMENTAL AD&D INSURANCE COVERAGE**

Employee • The amount of Basic AD&D insurance you elect is 100% employer paid; and is included in the amount of Stand Alone AD&D insurance you elect, which is 100% employee paid.

Spouse • Choice of $50,000 increments

Child(ren) • Live birth to 26 years: $5,000 or $10,000

Please refer to hr.ou.edu/employees/insurance/insurance-programs/life for additional information and rates.

Employee • An amount equal to 1.5, 3 or 4.5 times annual salary up to $1,500,000 (when combined with basic life)  
• Initial eligibility Guaranteed Issue amount combined with basic life: $450,000 or 4.5 times annual salary, whichever is less  
• Benefits terminate at retirement.

Spouse • An amount equal to .75, 1.5, 2.25, 3 or 3.5 times annual salary up to 50% of combined employee's basic and supplemental life amount  
• Initial eligibility Guaranteed Issue amount: $100,000 or 2.25 times annual salary, whichever is less  
• Benefits terminate at employee’s retirement

Child(ren) • Live birth to 26 years: $5,000 or $10,000
Beneficiary Designation

**Beneficiaries – Life and AD&D Insurance**

Naming someone as a beneficiary means the money can go straight to him or her in the event of your death, rather than through your estate; thus avoiding potential probate taxes, expenses, and legal battles. The beneficiary you designate can be any legally competent person or an entity—spouse, children, other friends and relatives; or a trust, a charity, a church, etc. It is important that you name a beneficiary and do it properly to make sure the money ends up where you intended it to go.

Having a will is not sufficient. You need to designate a beneficiary for your life insurance policy proceeds (the money or death benefit). Insurance policies and proceeds have nothing to do with your will. A will only applies to your “probate estate,” which includes assets other than life insurance (i.e. investments, savings, or real estate).

Your probate estate is subject to taxes, creditors (debt such as loans and credit cards), and other expenses that might greatly lower the amount of money your spouse, children, or other heirs receive. The probate process can take many months. If your spouse or other heirs have no money while your estate is in probate, they might not be able to pay household expenses and maintain their quality of life. This is what life insurance is meant to prevent. The money goes directly to the beneficiary, without going through probate.

**Important Things to Know About Beneficiaries**

If you are in a community property state (e.g. Arizona, California, Idaho, Nevada, New Mexico, Texas, Washington, or Wisconsin), your spouse is legally entitled to half of everything.

If you give someone a power of attorney (the legal right to act for you), be sure to mention if the insurance policy is within his or her authority.

Don’t forget to review your beneficiary designations periodically and especially after major life events (e.g. births, deaths, weddings, divorces, graduations, and retirements).

**Who to Name as Beneficiary and How to Do It**

Think carefully about whom to name as beneficiary and be sure to name a secondary (contingent) beneficiary, too. The contingent beneficiary will get the money if the first person you name (primary beneficiary) dies before you or maybe at the same time (e.g. in a car accident). While it is common to name family members as beneficiaries, this is not required. The most important thing is to think about your beneficiary decisions while keeping in mind the big picture of all your assets and financial planning. It may help to talk to an estate planner, accountant, or attorney.

When designating a beneficiary (or beneficiaries - you can name as many as you want, and the money can be divided among them), you have to do it correctly. Spelling out people’s full names and their relationship to you is important. Using their Social Security numbers removes all doubt about your intentions so you can be sure your wishes are carried out.

The beneficiary designation is also the place to indicate how you want the money divided. This can get complicated if a spouse has children from another marriage, or if one of your children dies before you, leaving grandchildren, etc. This is why it is extremely important for you to be specific in your beneficiary designation.
Beneficiary Designation

Things to Consider When Naming Your Beneficiaries

- Using exact dollar amounts, which can get outdated. Instead, use percentages, such as 50% (be sure they add up to 100%) or terms such as “evenly divided among”.
- Naming your estate as beneficiary, as that may lead to probate problems that life insurance is meant to avoid (i.e. taxes, delays, legal questions, debts).
- Naming minor children (under the age of 18 or 21, depending on where you live) as beneficiaries, since they will need a legal guardian appointed by the court to manage their money.

Using a Legal Trust as Beneficiary

You can use a trust as beneficiary. A trust is a legal document that transfers money from one person (the grantor) to another person (the trustee) or institution (such as a bank) to be managed for the benefit of a third person (the beneficiary). Trusts are particularly useful if you want to provide for minor children, disabled relatives, or people who might be legally incompetent to manage money themselves.

Two key types of trusts are living trusts, which you create during your lifetime, and testamentary trusts, which are part of your will and don’t take effect until after you die. For life insurance purposes, a living trust is best since it avoids the probate process your will and other assets must go through. If you decide to name a trust as beneficiary, be sure an actual legal trust document has been drawn up for you by a lawyer, or the insurance proceeds (money) cannot be paid to the trust.

Important:
Keep your beneficiary information up to date in Employee Self-Service (hr.ou.edu/self-service).
Disability Benefits

SHORT-TERM DISABILITY INSURANCE
The Short-Term Disability (STD) Plan is an optional insurance plan fully paid for by the employee as an after-tax payroll deduction. Employees enrolled in this plan that become ill or injured and are not able to work may be eligible to receive continued income. The weekly benefit is 60% of your weekly salary up to a maximum of $1,500 per week. The benefit begins on the first day of an accident (or on the fifteenth day of an illness) with a maximum duration of 26 weeks. The STD plan is guaranteed issued during open enrollment, but does have a pre-existing condition clause. This means you may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date until you have been covered under the policy for 6 months.

LONG-TERM DISABILITY INSURANCE
The Long-Term Disability (LTD) Plan is an optional insurance plan fully paid for by the employee. Participants in this plan who become ill or injured and are not able to work for 180 days (six months) may be eligible to receive continued income. After the employee has been ill or injured and unable to return to work for 180 days (6 months), they may become eligible to receive Long-Term Disability payment.

Paying with Pre-Tax vs. After-Tax Dollars
Participants who elect to pay with pre-tax dollars will be subject to income tax on all disability income received from this policy. Participants who elect to pay with after-tax dollars should not be subject to taxes on income received from this policy at the time it is received.

Reduced Benefit Possible
The benefit the employee receives may be reduced so the total amount of disability payments received from all other sources (Social Security, workers’ compensation and other group disability insurance, including OTRS) will not exceed the percentage of the employee’s monthly base salary for the option selected. Payment of LTD Benefits is limited to 24 months during your entire lifetime for a Disability caused or contributed to by mental disorders or substance abuse. However, if you are confined in a hospital solely because of a mental disorder at the end of the 24 months, this limitation will not apply while you are continuously confined.

Three Options for Long-Term Disability
Eligible employees can choose from three plan options. When choosing an option, consider the costs and benefits of each. For Long-Term Disability options please see below.

Plan 1: 66 2/3 % of pre-disability earnings up to $5,000 per month.
Several additional benefits: Participants can receive a cost-of-living adjustment of up to four percent per year. If the employee participates in the 401(a) OU Retirement Plan when disability occurs, the carrier will continue to make contributions.

Plan 2: 50% of pre-disability earnings up to $2,000 per month.

Plan 5: 66 2/3 of pre-disability earnings up to $15,000 per month. Available to individuals who earn $70,000 or more annually. See the plan summary for the details of this plan.

Maximum Benefit Period
The maximum benefit period for this long-term disability coverage is determined by the employee’s age at the time of disability. Maximum benefit periods are as follows:

<table>
<thead>
<tr>
<th>Age</th>
<th>Maximum Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>59 or younger</td>
<td>To age 65</td>
</tr>
<tr>
<td>60 thru 64</td>
<td>5 years</td>
</tr>
<tr>
<td>65 thru 68</td>
<td>To age 70</td>
</tr>
<tr>
<td>69 or older</td>
<td>1 year</td>
</tr>
</tbody>
</table>

Changing Options
If a participant previously elected Plan 2 (50%), and they want to increase the coverage and elect Plan 1 (66 2/3%) during annual enrollment, a one-year pre-existing condition will apply to the increased benefit amount. If the individual previously elected no coverage during annual enrollment, he or she may only elect Plan 2, and the one-year pre-existing condition will apply.

Note: Under Plans 1 and 5, contributions made by this policy to the 401(a) OU Retirement Plan will end when a distribution from the plan is made to the employee.
Continuing Coverage

**COBRA CONTINUATION OF COVERAGE**

Employees of the University of Oklahoma who are covered by the university’s medical, dental, vision, or healthcare Flexible Spending reimbursement account, have the right to choose COBRA Continuation Coverage if the employee loses coverage because of a reduction in hours of employment or the termination of employment for reasons other than gross misconduct.

For more information, visit hr.ou.edu/Employees/Insurance/COBRA-Continued-Benefits-Coverage.

**COVERAGE WHEN DISABLED**

If a benefits-eligible employee becomes totally disabled prior to age 60, they may apply for Waiver of Premium. The employee will be required to provide medical documentation indicating proof of disability.

If approved, the employee’s life insurance benefit may be continued up to age 70, so long as the employee remains disabled. Eligibility is reviewed annually by the life insurance company. This benefit is not available for dependent life insurance. Currently, employees who have at least 10 years of benefits-eligible service with the university may apply for university disability retirement. If approved, the employee will receive the medical and dental coverage that is paid by the university for the duration of his or her disability. Medical documentation must be provided to support the disability claim.

**COVERAGE FOR SURVIVING DEPENDENTS OF ACTIVE EMPLOYEES**

If an active employee has been on the plan for five consecutive years and is on the plan at time of death as an active employee, any dependents covered by the employee at time of death may continue coverage at their own expense until re-marriage for a spouse or until the age limit for coverage is reached for children.
Important Notice from the University of Oklahoma about your Prescription Drug Coverage and Medicare

Applies to Participants covered on the Cigna PPO Plan:

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The University of Oklahoma 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. The University of Oklahoma has determined that the prescription drug coverage offered by the Cigna Traditional PPO Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current The University of Oklahoma coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current The University of Oklahoma coverage, be aware that you and your dependents will be able to get this coverage back.

What 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 The University of Oklahoma 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
For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed at the beginning of this notice for further information. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The University of Oklahoma 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).

Notice on Prescription Drug Coverage for Medicare Participants covered on the Cigna HSA Plan
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The University of Oklahoma 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. The University of Oklahoma has determined that the prescription drug coverage offered by the Cigna High Deductible Health Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Cigna High Deductible Health Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from The University of Oklahoma. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
Since the coverage under the Cigna High Deductible Health Plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug...
plan but didn’t join, if you go 63 continuous days or longer without prescription drug coverage that’s creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

If you decide to join a Medicare drug plan, your current The University of Oklahoma coverage or will not be affected. If you do decide to join a Medicare drug plan and drop your current The University of Oklahoma coverage, be aware that you and your dependents will be able to get this coverage back.

**For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact the person listed at the beginning of this notice for further information. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through The University of Oklahoma 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).

**HIPAA SPECIAL ENROLLMENT NOTICE**

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 or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as 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.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children’s Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

To request special enrollment or obtain more information, call your plan administrator at the number listed at the beginning of this document.
WOMEN’S HEALTH AND CANCER RIGHTS ACT NOTICES
Did you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? If you would like more information on WHCRA benefits, call your plan administrator at the number listed at the beginning of this document.

NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
If you gain coverage under a group health plan (the Plan), this notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

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

If you’re an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
• Your hours of employment are reduced, or
• Your employment ends for any reason other than your gross misconduct.
If you’re the spouse of an employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
• Your spouse dies;
• Your spouse’s hours of employment are reduced;
• Your spouse’s employment ends for any reason other than his or her gross misconduct;
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
• You become divorced or legally separated from your spouse.
Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
• The parent-employee dies;
• The parent-employee’s hours of employment are reduced;
• The parent-employee’s employment ends for any reason other than his or her gross misconduct;
• The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); or
• The parents become divorced or legally separated; or
• The child stops being eligible for coverage under the Plan as a “dependent child.”
When is COBRA continuation coverage available?

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

• The end of employment or reduction of hours of employment;
• Death of the employee; or
• The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?

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

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

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

**Disability extension of 18-month period of COBRA continuation coverage**

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions about COBRA

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified at the beginning of these notices. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

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

The effective date of this Notice of Cigna Health Information Privacy Practices (the “Notice”) is January 1, 2018.

Cigna (the “Plan”) provides health benefits to eligible employees of The University of Oklahoma (the “Company”) and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits.

For ease of reference, in the remainder of this Notice, the words “you,” “your,” and “yours” refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including employees, and COBRA qualified beneficiaries, if any, and their respective dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

Your “Protected Health Information” (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected health information includes information of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of the Plan’s duties and privacy practices with respect to your PHI, and is doing so through this Notice. This Notice describes the different ways in which the Plan uses and discloses PHI. It is not feasible in this Notice to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this Notice describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by the terms of this Notice until it is replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to the terms of this Notice, the Plan will revise and re-distribute this Notice according to the Plan’s distribution process. Accordingly, the Plan can change the terms of this Notice at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

The Plan is distributing this Notice, and will distribute any revisions, only to participating employees and COBRA qualified beneficiaries, if any. If you have coverage under the Plan as a dependent of an employee, or COBRA qualified beneficiary, you can get a copy of the Notice by requesting it from the contact named at the end of this Notice.

Please note that this Notice applies only to your PHI that the Plan maintains. It does not affect your doctor’s or other health care provider’s privacy practices with respect to your PHI that they maintain.

Receipt of Your PHI by the Company and Business Associates

The Plan may disclose your PHI to, and allow use and disclosure of your PHI by, the Company and Business Associates without obtaining your authorization.

Plan Sponsor: The Company is the Plan Sponsor and Plan Administrator. The Plan may disclose to the Company, in summary form, claims history and other information so that the Company may solicit premium bids for health benefits, or to modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Company and receive similar information from the Company. If the Company agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Company a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Notice.

The Plan may disclose your PHI to the Company for plan administration functions performed by the Company on behalf of the Plan, if the Company certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

Example: The Company reviews and decides appeals of claim denials under the Plan. The Claims Administrator provides PHI regarding an appealed claim to the Company for that review, and the Company uses PHI to make the decision on appeal.

Business Associates: The Plan and the Company hire third parties, such as a third party administrator (the “Claims Administrator”), to help the Plan provide health benefits. These third parties are known as the Plan’s “Business Associates.” The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Plan or the Company to assist or carry out the terms of the Plan. In addition, these Business
Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. The Plan and the Company must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this Notice, all actions of the Company and the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. So, when this Notice refers to the Plan taking various actions with respect to health information, those actions may be taken by the Company or a Business Associate on behalf of the Plan.

How the Plan May Use or Disclose Your PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. And, with only limited exceptions, we will send all mail to you, the employee. This includes mail relating to your spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Your Health Care Treatment: The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

Example: If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.

Example: The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist’s reference in determining whether a new prescription may be harmful to you.

Making or Obtaining Payment for Health Care or Coverage

The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

Example: The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.

Example: The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan’s use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others.

• Obtaining payments required for coverage under the Plan
• Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication
• Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts)
• Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing
• Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges
• Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services

The Plan also may disclose your PHI for purposes of assisting other health plans (including other health plans sponsored by the Company), health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

Example: If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.

Example: If claims you submit to the Plan indicate that the stop-loss coverage that the Company has purchased in connection with the Plan may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.
The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes.

- Quality assessment and improvement activities
- Disease management, case management and care coordination
- Activities designed to improve health or reduce health care costs
- Contacting health care providers and patients with information about treatment alternatives
- Accreditation, certification, licensing or credentialing activities
- Fraud and abuse detection and compliance programs

The Plan also may use or disclose your PHI for purposes of assisting other health plans (including other plans sponsored by the Company), health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

- The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others.
  - Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan
  - Planning and development, such as cost-management analyses
  - Conducting or arranging for medical review, legal services, and auditing functions
  - Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set

The Plan also may use or disclose your PHI for purposes of assisting other health plans for which the Company is the plan sponsor, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

**Limited Data Set:** The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number and certain other identifying information.

**Legally Required:** The Plan will use or disclose your PHI to the extent required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

**Health or Safety:** When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.

**Law Enforcement:** The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of the Plan. The Plan also may disclose your PHI for limited law enforcement purposes.

**Lawsuits and Disputes:** In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

**Workers’ Compensation:** The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers’ compensation or other similar programs.

**Emergency Situation:** The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

**Personal Representatives:** The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: 1) you have been or may be a victim of domestic abuse by your personal representative; or 2) recognizing such person as your personal representative may result in harm to you; or 3) it is not in your best interest to treat such person as your personal representative.
Public Health: To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product’s quality, safety or effectiveness to a person subject to FDA jurisdiction.

Health Oversight Activities: The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

Coroner, Medical Examiner, or Funeral Director: The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director’s duties.

Organ Donation: The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

Specified Government Functions: In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

Research: The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

Disclosures to You: When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

Authorization to Use or Disclose Your PHI
Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this Notice. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, we will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to sell means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

The Plan May Contact You
The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.

You should note that the Plan may contact you about treatment alternatives or other health-related benefits and services that may be of interest to you.

Your Rights With Respect to Your PHI
Confidential Communication by Alternative Means: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this Notice. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.
Request Restriction on Certain Uses and Disclosures: You may request the Plan to restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan’s agreement. To request a restriction, please submit your written request to the contact person identified at the end of this Notice. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan’s use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on our use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this Notice. Notwithstanding this policy, the plan will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

Right to Be Notified of a Breach: You have the right to be notified in the event that the plan (or a Business Associate) discovers a breach of unsecured protected health information.

Electronic Health Records: You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009.

The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

Paper Copy of This Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you received this Notice previously, or have agreed to receive this Notice electronically. To obtain a paper copy please call or write the contact person named at the end of this Notice.

Right to Access Your PHI: You have a right to access your PHI in the Plan’s enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the contact person named at the end of this Notice. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

Right to Amend: You have the right to request amendments to your PHI in the Plan’s records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan’s records should be made in writing to the contact person named at the end of this Notice. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan’s records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan’s records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan’s records, and a description of how you may complain to Plan or the Secretary of Health and Human Services.

Accounting: You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the contact person named at the end of this Notice. Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Personal Representatives: You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.
Complaints
If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the contact person named at the beginning of this Notice. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Notice of Availability Cigna Notice of Privacy Practices
THIS NOTICE DESCRIBES HOW YOU MAY OBTAIN A COPY OF THE PLAN’S NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES THE WAYS THAT THE PLAN USES AND DISCLOSES YOUR PROTECTED HEALTH INFORMATION.

Cigna (the “Plan”) provides health benefits to eligible employees of The University of Oklahoma (the “Company”) and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan’s duties and privacy practices with respect to covered individuals’ protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan’s Notice of Privacy Practices you can reach this contact person at the number provided at the beginning of these notices.

NOTICE OF EXTENDED COVERAGE TO PARTICIPANTS COVERED UNDER A GROUP HEALTH PLAN
Cigna (the “Plan”) currently permits an employee to continue a child’s coverage past the child’s 26th birthday until the child’s 28th birthday if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution’s registration and/or attendance policies. Michelle’s Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle’s Law extension of eligibility applies to a particular child:

- **Dependent child** means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.

- **Medically necessary leave of absence** means a leave of absence or any other change in enrollment:
  - of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury
  - which is medically necessary
  - and which causes the dependent child to lose student status under the terms of the Plan

For the Michelle’s Law extension of eligibility to apply, a dependent child’s treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle’s Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- One year after the first day of the leave of absence
- The date that Plan coverage would otherwise terminate (for reasons other than failure to be a fulltime student)

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle’s Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.
Brand Name Drugs — Drugs that have trade names and are protected by patents. Brand name drugs are generally the costliest choice. Non-preferred brand drugs are available but fall under tier 3 and require a higher copay.

Coinsurance — The percentage of a covered charge paid by the plan.

Copayment (Copay) — A flat dollar amount you pay for medical or prescription drug services regardless of the actual amount charged by your doctor or health care provider.

Deductible — The annual amount you and your family must pay each year before the plan pays benefits.

Generic Drugs — Generic drugs are less expensive versions of brand name drugs that have the same intended use, dosage, effects, risks, safety and strength. The strength and purity of generic medications are strictly regulated by the Federal Food and Drug Administration.

High Deductible Health Plan (HDHP) — A medical plan that may be used in conjunction with a health savings account (HSA).

Health Savings Account (HSA) — A fund you can use to help pay for eligible medical costs not covered by your medical plan. Both employers and employees may contribute to this fund; employees do so through pre-tax payroll deductions.

In-Network — Use of a health care provider that participates in the plan’s network. When you use providers in the network, you lower your out-of-pocket expenses because the plan pays a higher percentage of covered expenses.

Out-of-Network — Use of a health care provider that does not participate in a plan’s network.

Mail Order Pharmacy — Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.

Inpatient — Services provided to an individual during an overnight hospital stay.

Outpatient — Services provided to an individual at a hospital facility without an overnight hospital stay.

Out-of-Pocket Maximum — The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year, except for prescriptions under all medical plans except the HSA Plan.

Primary Care Physician (PCP) — A physician (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions and refers patients to specialists as necessary.

Specialist — A physician who has specialized training in a particular branch of medicine (e.g., a surgeon, gastroenterologist or neurologist).