2018 BENEFITS ENROLLMENT GUIDE
BENEFIT BASICS

The University of Oklahoma Health Sciences Center provides a range of benefits programs to meet your needs. You should have a good understanding of your options after reading this guide. If you have further questions, use the contact information on page 31 to reach Human Resources on your campus.

BENEFITS BASICS

The University of Oklahoma Health Sciences Center (HSC) 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 $20,000

**Full-time employees** are employees who hold a FTE of .75 or more. In addition to the university provided core insurance benefits, employees and their dependents have the option to participate in other benefits available at the employee's cost. These include:

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

**Part-time, Benefits-eligible Employees** who hold a 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 university paid benefits the employee will receive</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-.99</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 by the State of Oklahoma) and children up to the age of 26. Children are defined as a child by birth, adoption or legal guardianship. 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 prior to the child’s 26th birthday for coverage to be continued. Insurance carriers may require additional documentation from attending physicians. 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 event to add the child to the plan.
ENROLLMENT BASICS

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) position.

**Benefits Eligible Employees** who fail to select benefits within the 31-day election period will be enrolled in the employer-paid insurance benefits coverage which includes:
- **Life Insurance** – Employer pays for benefit 1.5 times annual base pay
- **Accidental Death and Dismemberment (AD&D) Insurance** – Employer pays for $20,000 policy

**Part-Time, Benefits Eligible Employees** who hold a .74 FTE appointment or less must enroll in the insurance plan before coverage will begin. For more information about this issue, see the section on "Eligibility" in this guide.

ANNUAL ENROLLMENT

The annual enrollment period is the 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. Please take a moment to review the options and restrictions of each plan. Elections made during the annual enrollment period become effective January 1 of the following 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 4) as defined by the IRS code.

All current employees need to make elections only if they wish to add or drop current benefits. If you do not wish to make any changes you do not need to do anything. **Remember, if you wish to participate in a Flexible Spending Account you must re-enroll for 2018; 2017 elections will not roll over to the new plan year.**

**Helpful points 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. 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. **Establishing 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. New employees may elect to establish an FSA during their initial benefits enrollment. This initial FSA will be in effect for the remainder of 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 this option for Long-term disability premiums will result in a taxable monthly disability benefit.

WAIVER OF COVERAGE OPTIONS

Employees may waive coverage during their new hire benefits eligibility period or during annual open enrollment.

WHEN COVERAGE BEGINS AND WHEN COVERAGE 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. 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. For information regarding continuing coverage, see section regarding COBRA Continuing coverage (pages 21-23) in this guide.

Life, AD&D, Short and Long-term disability coverage terminate on the last day of employment. Life and AD&D coverage may be converted to an individual policy. For information regarding conversion, please refer to page 6.

QUALIFYING 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 when they have a status change. Human Resources must be notified within 31 days of the Qualifying Event. Employees must complete a Benefits Change Form and submit the form to Human Resources. Changes to benefit elections must be applicable and directly related to the Qualifying Event. Supporting documentation will be required.
SOONER CREDITS

PAYING FOR BENEFITS

Each plan year, the University of Oklahoma Health Sciences Center provides each benefits-eligible employee monthly benefits credits, also called Sooner Credits. The amount received is based on the employee's FTE (Full Time Equivalent) and salary. If you experience a change in FTE or salary during the year which moves you to another salary tier, your new Sooner Credits will be effective the first day of the month following the change. See link for a full listing of the credits and salary tiers: https://benefitsenrollment.ouhsc.edu/

<table>
<thead>
<tr>
<th>Plan</th>
<th>FTE .50-.59</th>
<th>FTE .60-.74</th>
<th>FTE .75-1.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical plans</td>
<td><a href="https://benefitsenrollment.ouhsc.edu/Benefit-Programs/Medical-Insurance">https://benefitsenrollment.ouhsc.edu/Benefit-Programs/Medical-Insurance</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/$1000</td>
<td>$0.035/$1000</td>
<td>$0.035/$1000</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>

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 required to pay their portion of the cost of the benefits, or benefits will be terminated.

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 must be provided to support the disability claim.

If approved, the employee’s life insurance benefit may be continued up to age 70, so long as the employee remains disabled. Ongoing disability 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.
CONTINUING COVERAGE

COVERAGE AFTER RETIREMENT

Qualifying for Coverage: Employees who meet the eligibility requirements for retirement from the University of Oklahoma may continue medical and dental coverage. To be eligible for this benefit, employees must meet at least one of the following criteria:

- Age 62 with at least 10 years of University of Oklahoma Health Sciences Center benefits-eligible service.
- “Rule of 80” in which the employee’s age plus years of benefits-eligible service (at least 10 years) equals or exceeds 80.
- 25 or more years of benefits-eligible service with the University of Oklahoma Health Sciences Center.

Retired employees may continue enrollment in the alternate dental plan and medical and dental coverage for their dependents by paying the required premiums. Group life insurance coverage may be continued to age 70 by paying the necessary premiums. In addition, a previously elected vision plan and Health Care Flexible Spending Account may be continued by paying the necessary premiums for a period of time specified by law. The vision plan may be continued for a period not to exceed 18 months from the date of retirement; the Health Care Flexible Spending Account may be continued only until the end of the calendar year in which the employee retires. Employees hired after 12/31/07 and who meet all other requirements for retirement may participate in all of the above referenced plans but will be required to pay the full premium.

COVERAGE FOR SURVIVING DEPENDENTS OF RETIREES

If a current retiree is covering dependents at the time of death, the dependents may continue coverage at their own expense. Surviving spouses may continue coverage until re-marriage. Surviving children may continue coverage until the age limit for coverage is reached.

COVERAGE FOR SURVIVING DEPENDENTS OF ACTIVE EMPLOYEES

If an active employee has been on the medical 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.

Note: If you elect to convert your life insurance to an individual policy, you will be responsible for payments which may be made directly to the company. Conversion forms are available by contacting Lincoln Financial at 800-423-2765. You may complete the following Request for Group Life Conversion Materials: https://www.lfg.com/public/employersorganizations. Please refer to group reference ID UNIVEROK2.

To be eligible for medical and dental insurance after retirement, eligible employees must have at least five years of continuous participation in the university medical plan immediately prior to retirement.
Flexible Spending Accounts (FSAs) are designed to help you save money on taxes. Each pay period, funds are deducted from your pay on a pre-tax basis and are 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

### Account Type | Eligible Expenses | Contribution Maximums | Benefit |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care FSA</td>
<td>Medical, dental and vision care expenses like copays, coinsurance, deductibles, and eyeglasses.</td>
<td>$2,650 per year</td>
<td>Reduces your taxable income; funds available to you on January 1st</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 per household</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 March 31st. 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.

**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 Medical FSA.

**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>
</tr>
</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-dollars spent on eligible expenses</td>
<td>$0</td>
<td>$2000</td>
</tr>
<tr>
<td>Spendable income after expenses and taxes</td>
<td>$36,299</td>
<td>$35,645</td>
</tr>
<tr>
<td><strong>Tax savings with Medical and Dependent Care FSA</strong></td>
<td><strong>$654</strong></td>
<td><strong>N/A</strong></td>
</tr>
</tbody>
</table>

*This is an example only. Your actual experience will vary. It assumes a 25% Federal Income tax rate and 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 or local taxes.
MEDICAL COVERAGE

The University of Oklahoma Health Sciences Center offers a choice of two medical plan options through Blue Cross Blue Shield (BCBS) so you can choose the plan that best meets your needs and those of your family. Your medical plan options are:

- **BCBS PPO Blue Options Plan**
- **BCBS HSA Blue Edge 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:** Unlike the BCBSOK PPO HSA plan, the BCBSOK PPO plan includes copays for physician visits and prescription medications. The BCBSOK PPO HSA plan requires all physician visits all prescription medications (other than preventive prescription medications) are subject to the deductible and out-of-pocket maximum.

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, 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

CASE STUDIES: MEDICAL PLANS

**BCBS 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 least 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 BCBS 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 Blue Options PPO plan is the best option for his family.

**BCBS HSA (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 Choice Fund PPO 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 $1,000 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 Choice Fund PPO HSA’s 100% coverage for preventive care provision. Lee weighs all of his options and decides the BCBS Blue Edge HSA provides the best benefit for his needs.
### MEDICAL PLANS

<table>
<thead>
<tr>
<th>Plan Provisions</th>
<th>BCBS Blue Options PPO Plan</th>
<th>BCBS Blue Edge HSA Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td></td>
<td>Blue Preferred</td>
<td>Blue Choice</td>
</tr>
<tr>
<td></td>
<td>Blue Choice</td>
<td></td>
</tr>
<tr>
<td><strong>Network</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Employer HSA Contribution</strong></td>
<td>$500 / $1,000</td>
<td>$1,500 / $3,000</td>
</tr>
<tr>
<td>Annual Deductible Individual / Family</td>
<td>$500 / $1,000</td>
<td>$1,500 / $3,000</td>
</tr>
<tr>
<td></td>
<td>$1,000 / $2,000</td>
<td>$2,500 / $5,000</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>90% / 10%</td>
<td>85% / 15%</td>
</tr>
<tr>
<td>Individual / Member</td>
<td>80% / 20%</td>
<td>60% / 40%</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$4,000 / $8,000</td>
<td>$3,000 / $6,000</td>
</tr>
<tr>
<td>Individual / Family</td>
<td>$5,000 / $10,000</td>
<td>$6,000 / $12,000</td>
</tr>
<tr>
<td></td>
<td>$6,000 / $12,000</td>
<td>$6,000 / $12,000</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Preventative Care</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Plan pays 50% after deductible</td>
<td>Plan pays 50% after deductible</td>
<td>Plan pays 50% after deductible</td>
</tr>
<tr>
<td>Office Visits</td>
<td>$20 / $30</td>
<td>$30 / $40</td>
</tr>
<tr>
<td>Primary / Specialist</td>
<td>Plan pays 50% after deductible</td>
<td>Plan pays 85% after deductible</td>
</tr>
<tr>
<td>Diagnostic X-rays / Labs</td>
<td>Covered 100%</td>
<td>Covered 100% of allowed amount</td>
</tr>
<tr>
<td>Plan pays 50% after deductible</td>
<td>Plan pays 85% after deductible</td>
<td>Plan pays 50% after deductible</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 80% after deductible</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 80% after deductible</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Plan pays 90% after deductible</td>
<td>Plan pays 80% after deductible</td>
</tr>
<tr>
<td><strong>Retail Prescriptions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Generic</strong></td>
<td>$10 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td><strong>Preferred Brand</strong></td>
<td>$30 copay</td>
<td>$60 copay</td>
</tr>
<tr>
<td><strong>Non-Preferred Brand</strong></td>
<td>$60 copay</td>
<td>$120 copay</td>
</tr>
</tbody>
</table>
| 30-Day Supply                    | Plan pays 70% after deductible plus copays | After Deductible: Plan pays 85% 
|                                 | Plan pays 85%              | Plan pays 85%            |
| Retail Prescriptions             | 90-Day Supply              | 90-Day Supply           |
| **Generic**                      | $20 copay                  | N/A                     |
| **Preferred Brand**              | $60 copay                  | After Deductible: Plan pays 85% 
| **Non-Preferred Brand**          | $120 copay                 | Plan pays 85%            |
|                                 | N/A                        |                         |

**Important Notes:**
- 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 BCBS benefits summaries for the full scope of coverage located on the benefits portal at bcbsok.com.
HEALTH SAVINGS ACCOUNT

CONSUMER DRIVEN HEALTH PLAN (CDHP): BCBS 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.
- Function 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.

MONEY IS YOURS TO KEEP!

Money deposited belongs to you. It’s all yours! 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.

Our HSA is administered through HSA Bank. When you enroll in the BCBS Blue Edge HSA medical plan, an HSA will be opened up 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.

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 through HSAbank.com. Remember, as long as funds are used for eligible expenses, they are never taxable.

2018 IRS ANNUAL MAXIMUMS-- HEALTH SAVINGS ACCOUNT

<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>

For more specific information about IRS guidelines, please visit HSAbank.com and click on “Health Savings Account” under Product Overview.
DENTAL PLAN

DENTAL COVERAGE

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 most tooth decay and periodontal disease, and is an important part of maintaining your medical health.

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.

<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>Class I: Diagnostic and Preventative Services</td>
<td>Basic Plan</td>
<td>90%</td>
<td>75%</td>
</tr>
<tr>
<td>Exams, cleanings, x-rays</td>
<td>Alt Plan</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Class II: Basic Services</td>
<td>Basic Plan</td>
<td>80%</td>
<td>75%</td>
</tr>
<tr>
<td>Endodontics, periodontics, oral surgery</td>
<td>Alt Plan</td>
<td>90%</td>
<td>80%</td>
</tr>
<tr>
<td>Class III: Major Services</td>
<td>Basic Plan</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Inlays, onlays, crowns, dentures</td>
<td>Alt Plan</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Class IV: Orthodontic Services</td>
<td>Basic Plan</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Adults and child(ren)</td>
<td>Alt Plan</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual / Family</td>
<td>$50 / $100</td>
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<td>$50 / $100</td>
</tr>
<tr>
<td>Annual Maximum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual / Family</td>
<td>$1,000</td>
<td>$2,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Class IV Lifetime Maximum</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 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 weights 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

VISION COVERAGE

The vision plan covers routine eye exams and also 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, contact your local Human Resources, 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.

About the Contact Lens Allowance

This allowance is in addition to the 15% discount on the contact lens exam. The allowance 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</th>
<th>Standard</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
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<td>$5 copay</td>
</tr>
<tr>
<td>Hardware</td>
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<td>$15 copay</td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam</td>
<td>Once every:</td>
<td>Once every:</td>
</tr>
<tr>
<td>Lenses</td>
<td>12 months</td>
<td>12 months</td>
</tr>
<tr>
<td>Frames</td>
<td>12 months</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></td>
<td></td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>100% after copay</td>
<td>100% after copay</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>100% after copay</td>
<td>100% after copay</td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>100% after copay</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>Up to $120 no copay, 15% off balance</td>
<td>Up to $150 no copay, 15% off balance</td>
</tr>
</tbody>
</table>

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) INSURANCE COVERAGE

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 Health Sciences Center 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 Health Sciences Center provides you with the opportunity to purchase additional Supplemental Life insurance coverage for you and your family over the above amount paid on your behalf by The University of Oklahoma Health Sciences Center. 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:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
</table>
| 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                                |

Please refer to https://benefitsenrollment.ouhsc.edu/Benefit-Programs/Life-Insurance for additional information and

SUPPLEMENTAL AD&D INSURANCE COVERAGE

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
</table>
| 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.  
• Choice of $50,000 increments  
• Maximum amount $250,000 |
| Spouse     | • Choice of $10,000 increments up to $40,000                                 |
| Child(ren) | • Live birth to 26 years: $5,000 or $10,000                                |

*Important:* Keep Your Beneficiary Information Up-to-Date.
BENEFICIARY DESIGNATION

BENEFICIARIES—LIFE AND AD&D INSURANCE

Naming someone as a beneficiary means the money can go straight to him or her, 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

• If you are in a community property state (i.e. 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 (i.e. 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 (i.e., 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.

Things You SHOULD NOT Do in Naming Your Beneficiaries

• Don’t use 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”.
• You should not name your estate as beneficiary, since that opens up all the probate problems (i.e. taxes, delays, legal questions, debts) life insurance is meant to avoid.
• You also may not want to name minor children (under the age of 18 or 21, depending on where you live) as beneficiaries in Oklahoma, 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.
DISABILITY BENEFITS

SHORT-TERM DISABILITY INSURANCE

The Short-Term Disability Plan is an optional insurance plan offered through Lincoln Financial which is fully paid for by the employee. Employees enrolled in this plan that become ill or injured and are not able to work may be eligible to receive continued income. Because employees may customize a short-term disability plan to meet their unique needs, the plan will require employees to apply for coverage and provide medical information to determine eligibility. The plan is offered as an after-tax deduction only. 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. To apply for coverage and for premium information, employees must contact Lincoln directly at 800-423-2765.

LONG-TERM DISABILITY INSURANCE

The Long-Term Disability (LTD) Plan is an optional insurance plan which is 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. For additional information on reduced benefits you can review the LTD policy at:

Three Options

There are three plan options from which to choose. When choosing an option, consider the costs and benefits of each. For Long-Term Disability rates please see below.

- **Option 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) OUHSC Retirement Plan when disability occurs, the carrier will continue to make contributions.

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

- **Option 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.

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

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 through 64</td>
<td>5 years</td>
</tr>
<tr>
<td>65 through 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 Option 2 (50%), and they want to increase the coverage and elect Option 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 Option 2, and the one-year pre-existing condition will apply.
IMPORTANT NOTICE FROM THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Applies to Participants covered on the BCBS 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 OUHSC 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.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. OUHSC has determined that the prescription drug coverage offered by the Creditable Plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered “creditable” prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.
ENROLLING IN MEDICARE -- GENERAL RULES

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

LATE ENROLLMENT AND THE LATE ENROLLMENT POLICY

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D’s annual enrollment period, which runs each year from October 15th through December 7th. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period, you go 63 continuous days or longer without “creditable” prescription drug coverage (that is, prescription drug coverage that’s at least as good as Medicare’s prescription drug coverage), your monthly Part D premium may go up by at least 1% of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go nineteen months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

SPECIAL ENROLLMENT PERIOD EXCEPTIONS TO THE LATE ENROLLMENT PENALTY

There are “special enrollment periods” that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes “creditable” prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

COMPARE COVERAGE

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. See the Plan’s summary plan description for a summary of the Plan’s prescription drug coverage. If you don’t have a copy, you can get one by contacting us at the telephone number or address listed at the beginning of the Required Notices section of this guide.
COORDINATING OTHER COVERAGE WITH MEDICARE PART D

Generally speaking, if you decide to join a Medicare drug plan while covered under the OUHSC Plan due to your employment (or someone else’s employment, such as a spouse or parent), your coverage under the OUHSC Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan’s summary plan description or contact Medicare at the telephone number or Web address listed at the end of this notice.

If you do decide to join a Medicare drug plan and drop your prescription drug coverage with The University of Oklahoma Health Sciences Center, be aware that you and your dependents will be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan’s eligibility and enrollment rules. You should review the Plan’s summary plan description to determine if and when you are allowed to add coverage.

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 Health Sciences Center changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

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

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

REMEMBER: KEEP THIS CREDITABLE COVERAGE NOTICE. IF YOU DECIDE TO JOIN ONE OF THE MEDICARE DRUG PLANS, YOU MAY BE REQUIRED TO PROVIDE A COPY OF THIS NOTICE WHEN YOU JOIN TO SHOW WHETHER OR NOT YOU HAVE MAINTAINED CREDITABLE COVERAGE AND, THEREFORE, WHETHER OR NOT YOU ARE REQUIRED TO PAY A HIGHER PREMIUM (A PENALTY).
2018 ANNUAL NOTICES

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents’) right to coverage under the Plan is determined solely under the terms of the Plan.

APPLIES TO PARTICIPANTS COVERED ON THE BCBS BLUE EDGE 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 Health Sciences Center 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 Health Sciences Center has determined that the prescription drug coverage offered by the BCBS 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 BCBS 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 Health Sciences Center. 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 BCBS 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 Health Sciences Center coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current The University of Oklahoma Health Sciences Center 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 Health Sciences Center 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:

- 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](http://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.

Note: The 60 day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30 day period applies to most special enrollments. To request special enrollment or obtain more information, call your plan administrator at the number listed at the beginning of this document.
NOTICE OF AVAILABILITY OF SUMMARY OF BENEFITS AND COVERAGE (SBC)

As an employee or retiree, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. OUHSC offers a series of health coverage options. Choosing your health insurance coverage is an important decision.

To help you make an informed choice, OUHSC makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about your health coverage options in a standard format, to help you compare. The SBCs are only a summary. You should consult the OUHSC’s Summary Plan Descriptions and/or Medical Benefit Booklet to determine the governing contractual provisions of the coverage. A paper copy is also available, free of charge, by contacting your Plan Administrator.

WOMEN’S HEALTH AND CANCER RIGHTS NOTICE (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator.

NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

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

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

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

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. Each qualified beneficiary has 60 days to choose whether or not to elect COBRA coverage, beginning from the later of the date the election notice is provided, or the date on which the qualified beneficiary would otherwise lose coverage under the Plan due to a qualifying event. To learn more about COBRA and your rights under COBRA, please refer to your Summary Plan Description.

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](http://www.healthcare.gov).

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified 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](http://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](http://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.
2018 ANNUAL NOTICES

NOTICE OF BCBS 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. This Notice is provided to you on behalf of the company about the plan. It pertains only to health care coverage provided under the plan. Please review it carefully.

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

The Plan’s Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered “Protected Health Information” (“PHI”). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources Department, or contact the Plan’s HIPAA Privacy Official).

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan’s uses and disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations

• Treatment: Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it’s important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

• Payment: Of course, the Plan’s most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse’s plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

• Health care operations: The Plan may use and disclose your PHI in the course of its “health care operations.” For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.
Other Uses and Disclosures of Your PHI Not Requiring Authorization

The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as OUHSC) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan’s provision of benefits.

- **To the Plan’s Service Providers:** The Plan may disclose PHI to its service providers (“business associates”) who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.

- **Required by law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.

- **For public health activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.

- **For health oversight activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.

- **Relating to descendants:** The Plan may disclose PHI relating to an individual’s death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.

- **For research purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.

- **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

- **For specific government functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and

Uses and Disclosures Requiring Authorization

For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI.

Uses and Disclosures Requiring You to Have an Opportunity to Object

The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).
Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To request restrictions on uses and disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.

- **To choose how the Plan contacts you:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.

- **To inspect and copy your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.

- **To request amendment of your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan’s or vendor’s records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- **To find out what disclosures have been made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

**How to Complain about the Plan’s Privacy Practices**

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed on the first page of these notices. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

**Notification of a Privacy Breach**

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.
Contact Person for Information, or to Submit a Complaint
If you have questions about this Notice please contact the Plan’s Privacy Official or Deputy Privacy Official(s) (see first page). If you have any complaints about the Plan’s privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official or an authorized Deputy Privacy Official.

Organized Health Care Arrangement Designation
The Plan participates in what the federal privacy rules call an “Organized Health Care Arrangement.” The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

HIPAA Notice of Special Enrollment Rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents’ other coverage).

Loss of eligibility includes but is not limited to:
• Loss of eligibility for coverage as a result of ceasing to meet the plan’s eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
• Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
• Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
• Failing to return from an FMLA leave of absence; and
• Loss of coverage under Medicaid or the Children’s Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment by the HIPAA Special Enrollment Deadline after your or your dependent’s(s’) other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment by the HIPAA Special Enrollment Deadline, after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator. Note: Additional information may be required if the plan requires that persons declining coverage under the plan state, in writing, the reason(s) for declining coverage.

CHIP Special Enrollment Provision – Premium Assistance Eligibility
If you or your children are eligible for Medicaid or the Children’s Health Insurance Program (CHIP) and you’re eligible for health coverage from your employer, OUHSC may have a premium assistance program that can help pay for coverage using funds from the state’s Medicaid or CHIP programs. If you or your dependent(s) are eligible for premium assistance under Medicaid or CHIP, as well as eligible for health insurance coverage through OUHSC, your employer must allow you to enroll in the OUHSC plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. In addition, you may enroll in the OUHSC plan if you or your dependent’s Medicaid or CHIP coverage is terminated as a result of loss of eligibility. An employee must request this special enrollment within 60 days of the loss of coverage.
NOTICE OF EXTENDED COVERAGE TO PARTICIPANTS COVERED UNDER A GROUP HEALTH PLAN

OUHSC 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 full-time 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.

NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT

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

GINA WARNING AGAINST PROVIDING GENETIC INFORMATION

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request. “Genetic information” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please do not include any family medical history or any information related to genetic testing, genetic services, and genetic counseling or genetic diseases for which an individual may be at risk.
GLOSSARY OF MEDICAL TERMS

**Brand Name Drugs** — Drugs that have trade names and are protected by patents. Brand name drugs are generally the most costly 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 not under patent protection 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.

**Primary Care Physician (PCP)** — 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).
## HELPFUL RESOURCES

<table>
<thead>
<tr>
<th>Plan</th>
<th>Who to Call</th>
<th>Phone Number</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>BCBS</td>
<td>855-649-9614</td>
<td><a href="http://www.bcbsok.com">www.bcbsok.com</a></td>
</tr>
<tr>
<td>Health Savings Account (HSA)</td>
<td>HSA Bank</td>
<td>(800) 357-6246</td>
<td><a href="http://www.HSAbank.com">www.HSAbank.com</a></td>
</tr>
<tr>
<td>Employee Assistance Program (EAP)</td>
<td>Magellan Health</td>
<td>800-327-5043</td>
<td><a href="http://www.magellanassist.com">www.magellanassist.com</a></td>
</tr>
<tr>
<td>Dental</td>
<td>Delta Dental</td>
<td>800-522-0188</td>
<td><a href="http://www.DeltaDentalOK.org/ou">www.DeltaDentalOK.org/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>
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<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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<tr>
<td>Short-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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<tr>
<td>401(a) Retirement Savings Plan</td>
<td>Fidelity Investments</td>
<td>800-343-0860</td>
<td><a href="https://nb.fidelity.com/public/nb/Soonersthome">https://nb.fidelity.com/public/nb/Soonersthome</a></td>
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<tr>
<td>Benefits Enrollment Portal</td>
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<td><a href="https://benefitsenrollment.ouhsc.edu/">https://benefitsenrollment.ouhsc.edu/</a></td>
</tr>
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### 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.
### ABOUT THIS GUIDE

This benefit summary provides selected highlights of The University of Oklahoma Health Sciences Center employee benefits program. 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 Health Sciences Center. 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 Health Sciences Center 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.