The University of Oklahoma Benefits Guide 2015

Norman – Oklahoma City – Tulsa
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**IMPORTANT NOTICE:** The Board of Regents of the University of Oklahoma reserves the right to change any benefit plans at any time. This document is only a summary of certain benefits and is not an expressed or implied promise or contract of any kind and should not be relied on for such purposes. For full details regarding these benefits, please see the plan description and policy booklet available through Human Resources.
Introduction

The University of Oklahoma 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 28 to reach Human Resources on your campus.

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

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

Full-time employees are required to participate in the medical insurance plan unless they can show proof of other coverage. If proof is provided, full-time employees receive a $50 per month opt-out credit. All employees are required to participate in the basic life insurance provided by the university. 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)
- Employee and Spouse Long-Term Care Insurance
- Flexible Spending Accounts

Enrollment

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

Full-Time, Benefits-eligible Employees - Full-time, benefits-eligible employees who fail to select benefits within the 31 day election period will be automatically enrolled in the core insurance benefits coverage which includes:

- Blue Options PPO (Medical Insurance)
- Basic Dental Plan
- Life Insurance (1.5 times annual base pay)
- Accidental Death and Dismemberment (AD&D) Insurance ($20,000 policy)

Part-Time, Benefits-eligible Employees - Part-time, benefits-eligible employees who hold a .74 FTE appointment or less cannot be automatically enrolled in the University's medical and dental plans and must enroll in the insurance plans 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 a designated period of time each year when current employees can evaluate their existing coverage and make changes in their benefits plan options according to the provisions of each plan. Benefits choices can be changed only during the annual enrollment period unless the employee experiences an applicable Qualifying Event (See Page 7) as defined by the IRS code section 125.
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 next plan 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.

**How to Enroll or Re-Enroll During Annual Enrollment**

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 2015; 2014 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 at [www.hr.ou.edu](http://www.hr.ou.edu). For enrollment assistance, please contact your campus Human Resources.
3. **Complete an additional insurance application** if you or your spouse choose optional Long-Term Care insurance.
4. **Complete an additional insurance application** if you request additional life insurance coverage as described below and if you request additional spouse life insurance coverage over $100,000:

   5. **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. However, 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. **Annual contribution limit for the FSA in 2015 will be $2500; as part of the Affordable Care Act.**

**NOTE:** Employees need to review current benefit elections in order to determine what, if any, changes need to be made for the next plan year. In order to enroll in the Dependent Day Care or Health Care Flexible Spending Accounts, you are required to re-enroll each year. Flexible Spending Accounts will not roll over. You have until March 15, 2016 to spend funds in your 2015 Health Care FSA account (NOTE: A prescription is required for over-the-counter drugs and medications. The deadline to file Health Care claims against your 2014 account is April 15, 2016. For the Dependent Care FSA, you have until December 31, 2015 to spend funds in your 2015 account and until April 15, 2016 to file claims.

**Pre-Tax Premiums**

Employees pay for medical, dental, life, AD&D, and vision with pre-tax dollars. Long-term disability may also be paid 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.
Waiver of Coverage Option

Proof of other current medical insurance coverage is required to waive participation in the University-provided medical insurance plan for all employees at .76 FTE or above. An employee who waives insurance coverage provided by the University receives those credits as taxable income ($50 a month in the case of medical insurance). Those credits can then be used to purchase additional pre-tax or after-tax benefits, at the employee’s discretion. A part-time employee who elects to waive medical insurance coverage but does not provide proof of other medical coverage will not receive the credit. Part-time employees who do show proof of other coverage receive a prorated credit based on their FTE status.

When Coverage Begins and When It Ends

Full-time Employees - Full-time benefits-eligible employees are covered the first day of the month following the 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 insurability requirements.

Part-Time Employees - Part-time, benefits-eligible employees who hold a .74 FTE (Full Time Equivalent) appointment or less cannot be automatically enrolled in the University's medical and dental plans and must enroll in the insurance plans before coverage will begin. Employees have 31 days from the first day of eligibility to make their benefits elections. Part-time employees are covered the first day of the month following the date of hire or the first day of the month following the date the employee becomes eligible for benefits. It is the employee’s responsibility to notify Human Resources when they have a status change.

When Coverage Ends - Coverage ends for most benefits 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. A Certificate of Credible Coverage for medical insurance will be mailed from the medical insurance provider to the employee's home address after coverage ends. Coverage for long-term disability and AD&D terminates on the last day of employment. See section on COBRA (page 10) in this guide.

Eligibility

Part-time, Benefits-eligible Employees who hold an 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 benefits-eligible.

**Dependent Coverage**

Benefits-eligible employees have the option to cover eligible dependents in certain University offered plans. Eligible dependents include the employee's spouse (as defined in the same manner as legally defined by the State of Oklahoma, which includes common-law spouses) and children up to age 26. Children are defined as children by birth, adoption or legal guardianship. Children may have extended coverage up to the end of the month in which they turn 26.

Children become eligible for coverage at birth or, in the case of adoption, on date of placement. To begin coverage for a newborn or a newly adopted child, employees must notify their local Human Resources office to add the child to the plan. A Benefits Change Form will be required for the newborn or newly adopted child. This must be done within **31 days** of the child’s birth or the date of placement of the adopted child. A disabled child is eligible for extended coverage. If the child is disabled, Human Resources must be notified within **31 days** after the child reaches age 26 for coverage to be continued.

Coverage for dependents under the medical, dental and vision policies is available under the following categories:

- Employee / Spouse
- Employee / Child(ren)
- Employee / Family

**Changing Benefits Elections (Qualifying Event)**

Benefits elections cannot be changed during the plan year unless the employee has experienced an applicable Qualifying Event. Changes based on financial reasons alone are not allowed under IRS regulations. The employee must make a request for a change of benefits within **31 days** of the applicable Qualifying Event. “Applicable” means the change must be directly related to the individual experiencing the qualifying event. Dependents can be added or dropped from insurance plans, and FSA accounts can be changed. However, the employee cannot change medical care plans, for example, moving to the HMO from the Blue Options PPO plan. Examples of qualifying events include:

- A birth or an adoption;
- Marriage, divorce or legal separation;
- A death;
- Child loses eligibility because of age;
- Employee’s spouse gains or loses coverage through employment;
- Significant change in the financial terms of medical benefits provided through a spouse’s employer or another carrier.

**NOTE:** Coverage will terminate for dependents who turn 26 at midnight 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.
Except for coverage of a newborn or in the event of an adoption, all other changes in coverage begin the first day of the month following the Qualifying Event Date. If coverage is being dropped the effective date may be different. Coverage for the newborn is effective on the child's date of birth. Coverage for an adopted child is effective on the date of placement. No premium is due for newborns born on the second of the month or after or for adopted children placed on the second of the month or after for the initial month of coverage. To change benefits because of an applicable Qualifying Event, employees must complete a Benefits Change Form and submit it to their local campus Human Resources office within 31 days. Supporting documentation for the change is required.
Paying for Benefits

Each plan year, the University of Oklahoma 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.

http://www.hr.ou.edu/benefits/Rates.asp

<table>
<thead>
<tr>
<th>Monthly Benefits Credits (Sooner Credits) 2015 Plan Year</th>
<th>FTE (Full Time Equivalent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan</td>
<td>.50-.59</td>
</tr>
<tr>
<td>Medical Plans</td>
<td></td>
</tr>
<tr>
<td>Basic Dental Plan</td>
<td>$10.16</td>
</tr>
<tr>
<td>Life (1.5 times annual salary)</td>
<td>$0.095/$1000</td>
</tr>
<tr>
<td>AD&amp;D($20,000)</td>
<td>$.10</td>
</tr>
</tbody>
</table>

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

Norman Campus Only:

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

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

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

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 may be terminated.
Coverage When Disabled

If a benefits-eligible employee becomes totally disabled prior to age 60, they may apply to have life insurance continued without paying the premium. The employee will be required to provide medical documentation that indicates proof of disability.

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

Coverage 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 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.

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 that meet all other requirements for retirement may participate in all of the above referenced plans but will be required to pay the full premium.

NOTE:

If you elect to convert to an individual policy, you will be responsible for payments, which will be made directly to the company. Conversion forms are available by contacting the company at 800.378.4668. You may complete the following Request for Group Life Conversion Materials: http://www.standard.com/efoms/1598a.pdf. Please, reference the Group Policy number 641334.

NOTE: 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.
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 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.

Continuing Coverage After Termination - COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 is a federal law that allows individuals to continue medical, dental, vision or Health Care FSA coverage on an individual basis when they are no longer eligible for coverage under the employer’s group plan.

Covered dependents are also eligible to continue coverage on an individual basis when they are no longer eligible. Coverage may be extended up to 18 months for employees and up to 36 months for dependents.

A dependent is not eligible for more than 36 months of COBRA coverage. A dependent child who is born to or adopted by the employee covered by COBRA may be added to COBRA coverage for the length of time the employee is eligible to be covered. The COBRA period may be extended for 11 additional months (up to 29 total months) for employees who are disabled within the first 60 days following termination.

**NOTE:** “Disabled” is determined by the Social Security Administration’s definition of disability, and a copy of the Social Security notice is required to extend COBRA.

Upon termination, individuals will receive written notification of COBRA continuation rights from PayFlex Services, Inc. If an individual elects to continue coverage and fails to make premium payments within the specified time frame, coverage will be terminated.

The following are COBRA qualifying events:

**18-month events:**
- Voluntary or involuntary termination other than for gross misconduct.
- Reduction in hours under 50 percent FTE, causing a loss of coverage.

**36-month events:**
- Divorce or legal separation from a covered employee
- Dependent ceases to be eligible for coverage (age)
- Death of employee

It is the employee’s responsibility to notify Human Resources within **31 days** if dependents become ineligible for university coverage.
Flexible Spending Accounts (FSA)

Flexible Spending Accounts (health care flexible spending and dependent day care flexible spending accounts) make it possible for employees to use pre-tax income to pay for qualified expenses. The money deposited in a flexible spending reimbursement account is not considered taxable income and is therefore exempt from income taxes. Eligible employees can establish a flexible spending account by choosing this option in online enrollment or by completing the Benefits Change form.

It is important to take the time to understand the provisions of the plan before enrolling. Once a flexible spending account has been established, it cannot be changed during the plan year unless the employee has experienced an applicable Qualifying Event. Furthermore, IRS regulations require that any money not spent by the end of the plan year will be forfeited to the employer. Note different plan year end dates: December 31 for Dependent Day Care, March 15 of the following year for Health Care.

**NOTE (Norman Campus Hourly Staff):** Payroll deductions for an FSA will be subtracted from all 26 bi-weekly payrolls.

**The Enrollment Period.** Current employees may establish the FSA that will be in effect for the following year during the annual enrollment period each fall. Health Care and Dependent Day Care FSA plans have different expense years. Please **NOTE:** Health Care FSA expenses can be incurred through March 15 of the following year. In effect, the Health Care FSA is a fourteen and one half-month plan. The Dependent Day Care FSA expenses can be incurred through December 31 of the calendar year. The Dependent Day Care FSA is a true twelve-month plan.

**New Employee Enrollment Period.** 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 expense year (see Enrollment Period section above). Employees wishing to maintain an FSA during the following year will need to establish an FSA during each annual enrollment period.

**Amount of Contribution.** Employees should plan to contribute what they will need for the expense year. According to current policies, total contribution to a health care flexible spending account or a dependent day care flexible spending account cannot exceed $2,500 per account.

**PayFlex™ Card.** The **PayFlex™ Card** is a debit card that electronically accesses an employee’s healthcare account to pay for eligible expenses. The card can be used at qualifying merchant locations wherever MasterCard® is accepted. Qualified merchants include physician and dental offices, vision providers and merchants who have implemented an inventory information approval system (IIAS). The card allows employees to pay for eligible expenses at the point of service. Employees who use the PayFlex™ Card take advantage of four key benefits:

1. Immediate payment of expenses from the employee’s healthcare account;
2. Increases personal cash flow;
3. No claim filing due to point-of-sale approval;
4. Ease of use of pre-tax funds.

Using the PayFlex™ Card is a great way to help relieve employees of filing claims; however **it is important that the employee keep all itemized documentation for the entire plan year** in the event the information is requested by PayFlex™ to comply with IRS regulations.
Flexible Spending Accounts - Health Care

Accounting Issues - Expenses must be incurred in the current calendar year or the first two and one half months of the following calendar year, up to March 15. Participants have until April 15 to submit all claims. There is a $2,500 maximum contribution limit per expense year. The requested amount to be reimbursed will be paid as long as it does not exceed total annual contribution, less prior payments.

Reimbursements cannot be requested for expenses that have already been paid or will be paid by another source, such as an insurance company or another employer. Medical expenses that have been reimbursed through a health care flexible spending account cannot be credited against an income tax return.

Participants no longer employed by the University may continue to submit reimbursement requests for eligible expenses incurred during the plan year prior to their date of termination or may continue to make after-tax contributions to the account under federal COBRA regulations.

NOTE: If you terminate employment and you have unspent money in your Health Care Flexible Spending Account, you can claim reimbursement only for service dates up to the last day of your termination month. The claims filing deadline is the same as for active employees. You can protect your unspent balance by extending your Health Care Flexible Spending Account through COBRA and continuing your contributions through the end of the calendar year. If you elect to continue your Health Care Flexible Spending Account through COBRA, the plan will terminate at the end of the current calendar year subject to the same service deadline and claims filing deadline as the active employee plan.

Non-Eligible Expenses - Examples of non-eligible expenses are:

- Over-the-Counter Items
- Custodial Care in an Institution
- Health Club Fees
- Cosmetic Surgery (unless to correct a deformity)
- Funeral and Burial Expenses
- Vitamins and herbal supplements
- Insurance Premiums

NOTE: Employees must obtain a prescription from their physician for non-eligible expenses (OTC items or vitamin and herbal supplements); otherwise, the non-eligible expense cannot be claimed on the Health Care Flexible Spending Account. Consult your local campus Human Resources for further clarification.

Eligible Reimbursable Expenses - Examples of eligible expenses are:

- Artificial Teeth
- Birth Control Pills
- Chiropractor
- Contact Lenses
- Co-payments
- Crutches
- Flu Shots
- Hearing Aides
- Insulin
- Immunizations
- Lab Fees You Pay
- Physical Therapy
- Prescription Drugs
- Psychiatric Care
- Equipment Rental
- Surgeon Fees
- Vision Care
- Well Baby Care
Flexible Spending Accounts - Day Care

Accounting Issues - There is a $5,000 maximum contribution limit per calendar year. Working couples can contribute a combined total of $5,000 to this account. Deductions cannot exceed the earned gross income of the lower-paid spouse unless the spouse is a full-time student or is disabled. Reimbursements cannot exceed the amount that is in the account when the request is made. Participants have 106 days after the end of the plan year to submit all claims. For dependent care, the service deadline remains December 31 of the plan year; expenses must be incurred within the current calendar year. Kindergarten is not an eligible expense.

NOTE: The plan year is different than the Health Care FSA.

Eligibility - Employees who need custodial care for an eligible dependent so the employee and spouse can work (or go to school full-time) qualify for a dependent day care reimbursement account. If married, the spouse must work or be a full-time student. The annual amount submitted for reimbursement cannot exceed the amount earned by the lower-paid spouse. For a full-time student, an income of $200 per month for one dependent, $400 for two or more, is assumed.

Legitimate Expenses - Expenses must be for the care of a dependent that is 12 years old or younger when the care was provided, a spouse who was not physically or mentally able to care for him/herself and lived with you more than half of the year, or a person who was not physically or mentally able to care for him/herself, lived with you more than half of the year and either: (a) was your dependent, or (b) would have been your dependent except that: (i) he or she received a gross income of $3,650 or more, (ii) he or she filed a joint return, or (iii) you, or your spouse if filing jointly, could be claimed as a dependent on someone else’s prior year tax return. For more information please refer to IRS Publication 503, Child and Dependent Care Expenses. Expenses for services needed to run the home by a housekeeper or maid are covered if they are partly responsible for the wellbeing and protection of the dependent. Expenses for food, clothing, education or entertainment for the dependent are not covered.

Payment for Services - Payment for services cannot be made to a person who is claimed as a dependent or to a child if the child is under age 19. The provider can be a relative who is not a dependent, even if the provider lives in the employee’s home. If the services are provided for a disabled spouse or dependent outside the employee’s home, the disabled spouse or dependent must spend at least eight hours each day in the employee’s home. A provider who cares for dependents who are under age 13 and who care for more than six individuals must comply with all state and local laws at the provider’s location.

Types of Day Care Providers - Eligible types of day care providers are:

- Licensed day care centers
- Private preschool programs
- Home-based licensed day cares
- Public or private before-school and after-school programs
- Private sitter in your home or theirs
- Public or private summer day camps
- Nursery schools
• Adult day care centers
  In order to claim expenses as a tax credit, the social security number or federal tax number of the provider must be submitted.

**NOTE:** Church-sponsored day care centers are not required to provide a tax number. Dependent day care expenses must satisfy eligible criteria for a dependent day care flexible spending reimbursement account as outlined in Section 129 of the IRS code.
Medical Care and Dental Options

Medical Care - The University medical plan provides coverage to employees and their dependents. Three medical plans are available:

- Blue Options PPO
- BlueLincs HMO
- Blue Edge Consumer-Driven Health Care Plan

Case Studies – Medical Plans

Blue Options PPO Option (Fred, married, one child)

When comparing the medical plans offered by the University, Fred and his spouse look for the plan that provides the most flexibility in choosing a physician. Fred’s spouse often needs the care of specialists. Two of the specialists she sees are not network providers, but on the Blue Options PPO plan she would be able to continue receiving services from these specialists through the out-of-network benefit. In addition, Fred’s son has allergies and also sees specialists. With the Blue Options PPO plan, they would not be required to obtain referrals to be treated. Fred’s and his spouse’s salaries are adequate to cover the family deductible. After comparing the plans, Fred decides the Blue Options PPO plan is the best option for his family.

BlueLincs HMO

(Jennifer, married, no children)

Jennifer and her spouse know they will choose the HMO option offered through the University because they like the fact they will be responsible for flat dollar amount co-pays and a low deductible when needing medical services. They both have doctors who accept Blue Cross Blue Shield’s HMO and know they would have no problems obtaining a referral for a specialist should they ever need one. Jennifer and her spouse are both fairly healthy, seeing their doctors only a few times a year, and neither sees any specialists. Jennifer decides to enroll both herself and her spouse in the HMO option.

BlueEdge HCA Option - Consumer-Driven Health Care Plan (Lee, single, no children)

Lee is in good health and rarely has to go to the doctor. Lee reviews his medical expenses from past years and notes he has not exceeded $500 in expenses during those years. While studying the medical plans offered by the University, Lee sees the BlueEdge HCA option which provides a $500 fund 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 would also benefit from BlueEdge HCA’s $250 preventive care provision. Lee weighs all of his options and decides the HealthFund provides the best benefit for his needs.

The University provides coverage for full-time employees under the Blue Options PPO option. For a comparison of the medical plans, see the Blue Cross Medical plan guide from the “Documents and Forms” link on the HR website: www.hr.ou.edu. Rates for the 2014 plan year are shown in Appendix A.
Dental - The University dental plan provides coverage to employees and their dependents. The dental plan provides 2 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 www.hr.ou.edu/benefits/dental.asp. Dental Rates can be found using the following link: Dental Rates

Case Studies – Dental Options

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 herself and their children on the dental plan offered through her employment. Jason is not covered by his spouse’s dental plan and knows he will need extensive dental work in the coming year. He compares the plan designs of the basic and alternate dental plans offered through the University and weighs the premium costs of the alternate plan against the plan’s benefits (lower deductible, lower coinsurance amounts and a higher annual maximum benefit). He decides the alternate plan would provide a better benefit for his circumstance.

Life Insurance

Employee Life Insurance- The University provides Basic Life Insurance for all benefits-eligible employees, as part of the core benefits package in the amount of 1.5 times the employee's annual base salary. A $50,000 option is also available for employees earning $33,000 or more. There are no imputed income or tax issues for the first $50,000 of group term life insurance coverage provided by an employer.
For example, the University-provided life insurance for an individual with a base salary of $20,000 annually will be $30,000. New Employees may purchase Supplemental Life Insurance up to an additional 3.0 times their annual salary (Basic and Supplemental Life not to exceed 4.5 times annual salary) or $450,000 without providing proof of insurability. To purchase more than four and one half times annual salary or more than $450,000, employees must complete an evidence of insurability application about their medical history before coverage is approved. The maximum total employee life coverage is 6.0 times your annual salary or $1,500,000, whichever is less. The cost for Supplemental Life Insurance greater than 1.5 times salary is based on the individual’s age. During open enrollment, you may only increase your life insurance by one level each calendar year, without an evidence of insurability application as long as the coverage amount is under the GI (Guaranteed Issue) limits listed above.

NOTE (For Norman campus faculty members): Annual base pay consists of the contracted nine-month salary plus any earnings paid by the University of Oklahoma for the previous summer.

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. For full details, including exclusions and limitations, consult the plan booklet available online at [www.hr.ou.edu/benefits/life.asp](http://www.hr.ou.edu/benefits/life.asp). Life Insurance Policy.

Beneficiaries - Life insurance coverage requires a named beneficiary. Employees may name one or more primary beneficiaries. They may also name contingent beneficiaries who would receive the benefit if none of the primary beneficiaries survive the employee. When electing dependent life insurance, the employee is the beneficiary for the spouse’s and children’s insurance. It is the employee's responsibility to keep the beneficiary information updated. Participants in this plan may change, add, or delete beneficiaries at any time by completing the Designation of Beneficiary Form found online at [www.hr.ou.edu](http://www.hr.ou.edu). Some situations that may call for a change to the beneficiary declaration may be a divorce or a marriage. Changes to the beneficiary declaration section will take effect on the date the signed form is delivered to the local campus Human Resources office.

Life Insurance rates can be found using the following link:

[Life Insurance Rates](http://www.hr.ou.edu/benefits/life.asp)

**Dependent Life Insurance** - Dependent life insurance pays benefits in the event the employee's covered spouse or dependent child dies. Dependent life insurance (spouse and children) can only be purchased with after-tax dollars. During the annual enrollment period or within 31 days of a change in family status, an employee may increase or decrease coverage.

**NOTE**: The employee must be enrolled in life insurance in order to cover any dependents.

**Spouse Life Insurance** – The University’s contract with the life insurance company does not allow spouse life insurance to exceed one half of the amount of life insurance elected by the employee. Maximum coverage allowed for a spouse is one half the employee coverage up to $350,000. Evidence of insurability, a medical history questionnaire, is required for coverage over $100,000 or 2.25 times the employee’s annual salary. During annual enrollment, spouses may only increase life insurance by one level. Evidence of insurability is required if spouse life insurance is added during annual benefits enrollment.
Life Insurance Options (Spouse)

<table>
<thead>
<tr>
<th>Options</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – .75 x employee's annual salary</td>
<td>&lt;24</td>
</tr>
<tr>
<td>2 – 1.5 x employee's annual salary</td>
<td>25-29</td>
</tr>
<tr>
<td>3 – 2.25 x employee's annual salary</td>
<td>30-34</td>
</tr>
<tr>
<td>4 – 3 x employee's annual salary</td>
<td>35-39</td>
</tr>
<tr>
<td>5 – No Coverage</td>
<td>40-44</td>
</tr>
<tr>
<td></td>
<td>45-49</td>
</tr>
<tr>
<td></td>
<td>50-54</td>
</tr>
<tr>
<td></td>
<td>55-59</td>
</tr>
<tr>
<td></td>
<td>60-64</td>
</tr>
<tr>
<td></td>
<td>65-69</td>
</tr>
<tr>
<td></td>
<td>70+</td>
</tr>
</tbody>
</table>

Child Life Insurance - The number of children covered under the child life option does not affect the cost. The premium is the same whether the employee covers one child or more than one child. Only the children listed on the insurance enrollment form will be eligible for benefits. It is the employee’s responsibility to enroll any children during the annual enrollment period or within 31 days of the birth or adoption of a child. It is the employee’s responsibility to advise Human Resources when a dependent is no longer eligible.

Life Insurance Options (Child)

<table>
<thead>
<tr>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - $5,000 per child</td>
</tr>
<tr>
<td>2 - $10,000 per child</td>
</tr>
<tr>
<td>3 - No Coverage</td>
</tr>
</tbody>
</table>

Case Studies – Life Insurance

Mark, married, no children, earns $85,000 per year.

Mark and his spouse have recently purchased a home and have acquired substantial debt. Mark wants to make sure his spouse is not left with this financial burden should anything happen to him. Mark opts to apply for the maximum level of life insurance available (6x his annual salary). Because his spouse also wants to provide financial help should something happen to her, she also applies for the maximum amount of life insurance available to her (1/2 the amount Mark chose to a maximum of $350,000).

Sarah, married, 2 children, earns $25,000 per year.

Sarah’s spouse carries life insurance for her through his employer. However, since the University provides life insurance at 1.5x her annual salary at no cost to her, Sarah accepts the coverage as an added benefit for her family. Sarah had not considered providing life insurance for her children, but because of the reasonable rates offered through the University, she opts to take the maximum amount offered for child life insurance ($10,000).
Accidental Death and Dismemberment (AD&D)

**Employee AD&D** - The University core benefits package provides $20,000 in AD&D insurance for full-time employees, which is the default enrollment option. This policy pays a benefit only if the employee dies or is dismembered as a result of an accident. Employees may purchase additional AD&D coverage up to $250,000 in increments of $50,000. Employees can change the amount of coverage each year during the annual enrollment period or anytime they experience an applicable Qualifying Event.

**Beneficiaries** - AD&D insurance coverage requires a named beneficiary. Employees may name one or more primary beneficiaries. They may also name contingent beneficiaries who would receive the benefit if none of the primary beneficiaries survive the employee. The employee is considered the beneficiary for the spouse’s and children’s insurance. **It is the employee's responsibility to keep the beneficiary information updated.** Participants in this plan may change, add, or delete beneficiaries at any time by completing the Designation of Beneficiary Form found online at [www.hr.ou.edu](http://www.hr.ou.edu). Some situations that may call for a change to the beneficiary declaration are a divorce or a marriage. Changes to the beneficiary declaration will take effect on the date the signed form is delivered to the local campus Human Resources.

AD&D rates can be found using the following link: [AD&D Rates](#)

<table>
<thead>
<tr>
<th>Option/ Coverage</th>
<th>AD&amp;D Rates (Full-Time Employee)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>$20,000</td>
</tr>
<tr>
<td>04</td>
<td>$50,000</td>
</tr>
<tr>
<td>09</td>
<td>$100,000</td>
</tr>
<tr>
<td>14</td>
<td>$150,000</td>
</tr>
<tr>
<td>19</td>
<td>$200,000</td>
</tr>
<tr>
<td>24</td>
<td>$250,000</td>
</tr>
<tr>
<td>25</td>
<td>Waived Coverage</td>
</tr>
</tbody>
</table>

**Spouse AD&D** - This coverage provides benefits if a spouse dies or is dismembered as a result of an accident. Spouse AD&D insurance can only be purchased with after-tax dollars.

<table>
<thead>
<tr>
<th>Option/ Coverage</th>
<th>AD&amp;D Rates (Spouse)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>$10,000</td>
</tr>
<tr>
<td>05</td>
<td>$20,000</td>
</tr>
<tr>
<td>13</td>
<td>$30,000</td>
</tr>
<tr>
<td>10</td>
<td>$40,000</td>
</tr>
<tr>
<td>15</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>

**AD&D for Child(ren)** - This coverage provides benefits if the child(ren) dies or is dismembered as a result of an accident. The premium is the same for one or more children. Only the children listed on the enrollment form will be eligible for benefits. It is the employee’s responsibility to enroll any children born during the benefit year and to notify Human Resources when a dependent is no longer eligible.

<table>
<thead>
<tr>
<th>Option/ Coverage</th>
<th>AD&amp;D Rates (Child)</th>
</tr>
</thead>
<tbody>
<tr>
<td>05</td>
<td>$5,000</td>
</tr>
<tr>
<td>10</td>
<td>$10,000</td>
</tr>
<tr>
<td>11</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>
Case Study – AD&D

Alicia, Married, three children, earns $60,000 per year.

Alicia is the main supporter for her family. Although she buys a high level of life insurance, she feels her family might need additional money if she were to die in an accident. A prolonged illness would give her husband time to find a job and provide some transition, but an accident is sudden. Also, the dismemberment benefit would be important to family finances if she lost a limb, eyesight, speech or hearing and had to be off work for a prolonged period of time or changed jobs. In regards to her children, Alicia feels an AD&D benefit would be helpful to pay funeral and/or medical costs. If her husband were to be dismembered or killed, she would need to work more hours, thus requiring a caretaker for her children. Since the AD&D coverage is inexpensive, Alicia opts for the maximum coverage, which is $250,000 for herself, $40,000 for her spouse, and $10,000 for her children.

NOTE: The employee must be enrolled in life insurance in order to cover any dependents.

Beneficiaries for 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 About Beneficiary Designations

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, 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.

Vision Care Plan

The vision care plan provides coverage to the employee and dependents. Two plans are available. This is a University-sponsored optional insurance coverage that is fully paid by the employee. A summary of the plans is provided below. For full details including exclusions and limitations, consult the VSP summary, found at www.hr.ou.edu/benefits/vision.asp.

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. The VSP doctor is responsible for communicating to the employee if he or she is not currently eligible for services. 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.

VSP doctors offer valuable savings including a 20 percent discount on non-covered pairs of prescription glasses (lenses and frame). These services must be received within 12 months from the same VSP doctor who provided the employee’s last covered eye exam. Individuals can also save 15 percent on the cost of contact lens exam when the covered individual receives contact lens service from VSP. This discount does not apply to the contact lens materials.

Obtaining Services Out-of-Network - Services and materials obtained from an out-of-network provider will be reimbursed up to amounts on the above schedule, less any copayments. For out-of-network reimbursement, the covered individual will first need to pay the entire bill, and then send the itemized receipts, along with full patient and member information, to VSP, Out-of-Network Provider Claims, PO Box 997100, Sacramento, CA, 95899, or file their claim online via the VSP website. Claims must be submitted to VSP within six months from your date of service.

Laser Vision Correction - VSP’s Laser Vision Care program is also available to those covered under VSP Well Vision Plan. It is designed to provide members with a discount on laser surgery when obtained through VSP contracted doctors, surgeons, and laser centers. This program includes the two most common laser vision correction procedures, laser-assisted-in-situ keratomileusis (LASIK) and photorefractive keratectomy (PRK).
About the Contact Lens Allowance - This allowance is in addition to the 15 percent 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.

Case Studies - Vision

Bob, married, 3 children.
Bob wears eyeglasses, and his spouse has contact lenses. Two of his children also wear corrective lenses. The co-pay for an exam with a VSP provider is $15 and $25 for materials (lenses and frames). In addition, the plan provides an allowance for contact lenses which would benefit Bob's spouse and children. After comparing premiums and costs of services and supplies, Bob finds the premiums will likely be less than his vision care expenses. Bob decides to enroll his family in VSP.

Amanda, single, no children.
Amanda has excellent vision. She gets her eyes checked every two years just to be sure no problems are developing. This is her year for a checkup. Since Amanda can get an eye exam through her BCBS medical plan, and the co-pay is far less than the premiums for VSP, she decides not to enroll in VSP. If it turns out she needs lenses, she can pay that cost out-of-pocket and enroll in future plan years.

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: http://hr.ou.edu/Documents/Files/LTD_Cert_7_21_2010.pdf
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 percent of pay) offers several additional benefits: participants can receive a cost-of-living adjustment of up to four percent per year. If the employee participates in the 401(a) OU Retirement Plan when disability occurs, the carrier will continue to make contributions.

Option 2 (50 percent of pay) does not offer the cost-of-living adjustment or the 401(a) OU Retirement Plan benefit.

Option 5 (66 2/3 percent of pay) is for 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) OU 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 percent of pay), and they want to increase the coverage and elect Option 1 (66 2/3 percent of pay) 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.

Case Study – Long-Term Disability

Eric, married, one child, earns $40,000 per year.

Eric is the primary breadwinner for his family. His wife works full-time and puts half of her earnings into a college fund for their son. The family could not pay their monthly bills if they lost Eric’s income. While Eric believes he is healthy, he knows an accident or serious illness could force him to miss work for a prolonged period. While paid leave and extended sick leave would continue his income for a while, he knows those would eventually run out, leaving his family in trouble. The LTD plan, together with other disability benefits, would provide a monthly benefit of $2,222.23 (66 2/3% of annual salary option). Along with his wife’s income, that would be enough to pay the bills. Eric also likes that with the 66 2/3% option, the University would continue to make contributions to his retirement plan. He enrolls in the LTD coverage option.
NOTE: An employee who has a salary increase during the year resulting in an annual salary of $70,000 or more may change from Option 1 or 2 to Option 3 without providing Evidence of Insurability, a medical history questionnaire, at the first annual enrollment period after the increase or within 31 days of first becoming eligible for the increased benefit.

<table>
<thead>
<tr>
<th>Options</th>
<th>Minimum Benefit</th>
<th>Maximum Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>66 2/3 % of pay For Rates – see link below</td>
<td>$100/month</td>
</tr>
<tr>
<td>2</td>
<td>50% of pay</td>
<td>$100/month</td>
</tr>
<tr>
<td>3</td>
<td>66 2/3 % of pay</td>
<td>$100/month</td>
</tr>
</tbody>
</table>

http://hr.ou.edu/Documents/Files/2015RateSheet.pdf

* In addition to the monthly cash payments to the employee, Options 1 and 3 will also pay into the employee’s 401(a) account.

Short-Term Disability

The Short-Term Disability Plan is an optional insurance plan offered through AFLAC 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. To apply for coverage and for premium information, employees must contact AFLAC directly at 1-800-462-3522 or (405) 259-9983.
Long-Term Care Insurance

The Long-Term Care (LTC) Plan is an optional insurance plan through C.N.A. Independent Solutions Group Long-Term Care Insurance which is fully paid by the employee. It provides coverage, with a $150 daily maximum benefit, for nursing home and community-based care (which includes home health care) in the event the participant becomes disabled and can no longer care for him or herself on a day-to-day basis.

Premiums may only be made on an after-tax basis and are based on the employee’s age at the time approval is received. A separate enrollment form must be completed and approved by the insurance carrier before coverage will begin. Once enrolled in long-term care insurance, the participant is locked into the age rate bracket at which they are initially approved. As long as the participant continues to make the scheduled payments and does not have a break in coverage, the premium will not go up.

If you enroll in Long-Term Care Insurance when you first become a benefits-eligible employee, you are automatically accepted without satisfying evidence of insurability for coverage. Employees who wish to enroll at a later date can do so during the annual enrollment period, but you will be required to complete an Evidence of Insurability, a medical history questionnaire, and submit it for medical review by the insurance provider before coverage can be considered. Once enrolled, the employee may continue coverage after termination by making payments directly to the insurance provider.

Spouses, retirees, retiree spouses, parents, in-laws, and grandparents can apply for long-term care insurance by completing and submitting a medical questionnaire. If approved, the premium for spouse may also be paid by the employee through after-tax payroll deduction. All others would be billed directly by the company.

<table>
<thead>
<tr>
<th>Benefits Features</th>
<th>Independent Solutions Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Eligibility Triggers</td>
<td>2 of 6 Activities of Daily Living: Eating, Dressing, Toileting, Bathing, Transferring, Continence</td>
</tr>
<tr>
<td>Daily Maximum Benefit (DMB) – Facility Care Benefit is 100% of DMB</td>
<td>$150</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>1,500 times DMB</td>
</tr>
<tr>
<td>Home Care Benefit; Home Health, Adult Day Care, Assisted Living, Adult Foster Care</td>
<td>60% of DMB</td>
</tr>
<tr>
<td>Benefit Waiting Period</td>
<td>90/15 Service Days - must be satisfied once per lifetime OR 90 Calendar Days</td>
</tr>
<tr>
<td>Respite Benefit</td>
<td>Up to 14 days per year</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Included</td>
</tr>
<tr>
<td>Pre-existing Condition Exclusion</td>
<td>None</td>
</tr>
<tr>
<td>Mental and Nervous Disorders</td>
<td>Included</td>
</tr>
<tr>
<td>Alternate Plan of Care</td>
<td>Included</td>
</tr>
<tr>
<td>Caregiver Training</td>
<td>Up to 3 times the DMB</td>
</tr>
<tr>
<td>Bed Reservation Benefit</td>
<td>Up to 21 days per year</td>
</tr>
<tr>
<td>Home Medical Technology</td>
<td>Covers a full range of assistive devices or home modifications – benefit up to $1,000 per year</td>
</tr>
<tr>
<td>Waiver of Premium</td>
<td>Premiums waived while on claim and until the first of the month following the end of claimant’s Plan of Care ends</td>
</tr>
<tr>
<td>Inflation Protection</td>
<td>Guaranteed Benefit Increase – offered every 3 years to current insured</td>
</tr>
<tr>
<td>Return of Premium at Death - Optional</td>
<td>Refunds premiums paid if the insured person dies before age 75. If death occurs at or before age 65, 100% of premium is refunded – less any benefits received. After age 65, the amount refunded declines by 10% each year.</td>
</tr>
</tbody>
</table>

QUESTIONS? - If you have any questions about your options, please call C.N.A.’s Customer Service Center: 1-800-528-4582, Monday - Friday, 8:00 a.m. to 6:00 p.m. (EST).

Long Term Care Rates can be found using the following link: Long-Term Care Rates
Case Study – Long-Term Care

Steve, single, no children, age 25.

Steve previously thought he was too young to worry about things like long-term care. But as he has gotten older, he has seen more instances of people who needed home health or nursing home care and could not afford it. Steve may never need long-term care, but the premiums are low at his age, and he knows the possibility is always there. He also knows if he were to leave employment with the University, he can take this policy with him and continue to pay the premium to the company. The premium will remain at the amount at which he locked in, as long as he does not have a break in coverage. He enrolls in coverage and sends information to his parents so they can look into long-term care coverage as well.

Women’s Health and Cancer Rights Act

On October 21, 1998, a federal law (H.R. 4328) known as the Women’s Health and Cancer Rights Act of 1998 (Women’s Health Act) was enacted requiring group medical plans and insurance companies that provide coverage for mastectomies to provide certain mastectomy-related benefits or services to plan participants or beneficiaries. Under the new law, a group medical plan participant or beneficiary who is receiving benefits in connection with a mastectomy is entitled to coverage for:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.
- Coverage for these benefits or services will be provided in a manner determined in consultation with the participant’s or beneficiary’s attending physician.
- If you are a covered member of the University-provided medical insurance and are currently receiving, or in the future will receive, benefits under any contract in connection with a mastectomy, you are entitled to coverage for the benefits and services described above in the event you elect breast reconstruction. Your qualified dependents are also entitled to coverage for those benefits or services.
- Coverage for the mastectomy-related services or benefits required under the Women’s Health Law will be subject to the same deductibles and coinsurance or co-payment provisions that apply with respect to other medical or surgical benefits provided under the applicable medical plan.
On Aug. 3, 2011, federal regulatory agencies published regulations requiring that certain preventive services for women be provided without cost-sharing as part of guidelines supported by the Health Resources and Services Administration (HRSA).

The guidelines include the following types of services:

- well-woman visits
- screening for diabetes which develops during pregnancy
- testing for HPV -- the virus that can cause cervical cancer -- for women at least 30 years old
- counseling for sexually transmitted infections
- screening and counseling for HIV -- the virus that can cause AIDS
- FDA-approved contraception methods and counseling
- breastfeeding support, supplies and counseling
- interpersonal and domestic violence screening and counseling

Coverage for certain preventive health services will be provided without cost-sharing (such as copayment, coinsurance or deductible) when you use an in-network provider. Your coverage without cost-sharing includes contraceptive services when using an in-network provider.

- Prescription – One or more products within the categories approved by the FDA for use as a method of contraception
- Over-the-counter – Contraceptives available over-the-counter approved by the FDA for women (foam, sponge, female condoms) when prescribed by a physician
- The morning after pill
- Medical devices such as IUD, diaphragm, cervical cap and contraceptive implants
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.

Contact Information

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Norman Campus
Payroll and Employee Services
(405) 325-2961 - Fax: (405) 325-7354
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(918) 660-3190 - Fax: (918) 660-3200
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Blue Cross Blue Shield of Oklahoma
BlueChoice PPO, BlueLincs HMO, BlueEdge HCA
P.O. Box 3283
Tulsa, OK 74102-3283
Member Services: (888) 881-4648
www.bcbsok.com/ou

Delta Dental
P.O. Box 54709
Oklahoma City, OK 73154-1709
Member Services: (800) 522-0188
OKC Metro: (405)607-2100
Hours: 7:30 AM to 5:00 PM CST
www.deltadentalok.org/client/ou

Vision Care Plan
VSP
P.O. Box 997105
Sacramento, California 95899
Customer Service: (800) 877-7195
Website: www.vsp.com

Life Insurance Plan
Standard Insurance Company
P.O. Box 2800
Portland, Oregon 97208
Customer Service: (800) 368-1135
www.thestandard.com

Long-Term Disability Plan
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Customer Service: (800) 368-1135

Short-Term Disability Plan
AFLAC
(800) 462-3522
(405) 259-9983
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AD&D Insurance
Standard Insurance Company
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Long-Term Care Plan
CNA
P.O. Box 946760
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Flexible Spending Accounts
PayFlex™ Systems USA, Inc.
Flex Department
P.O. Box 3039
Omaha, NE 68103-3039
(800) 284-4885
www.mypayflex.com
THE 2015 RATE SHEET WILL BE INSERTED HERE AFTER THE DOCUMENT IS CONVERTED TO A PDF.

*Hourly Employees – Divide the Employee Cost by \( \frac{1}{2} \) to determine the amount paid per check. 9/9 Employees – Multiple the Employee Cost by 1.5 to determine the amount paid per check