



2025

**BENEFITS
ENROLLMENT**

MESSAGE TO OKHEEI EMPLOYEES:

We are pleased to present our Employee Benefits Guide for the 2025 plan year. OKHEEI is committed to providing a healthy environment including health care insurance for employees and dependents. The continual rising cost of health care has added challenges for consumers, employers, and the government. As we enter a new plan year, you'll see OKHEEI remains dedicated to offering an array of choices so you can balance cost and coverage in the way that best suits your needs and those of your family.

Preventive care and wellness benefits are important to promote well-being and to help limit the cost of health care. Our health care program with BlueCross BlueShield of Oklahoma offers insurance coverage and wellness programs to help us achieve and maintain a healthier lifestyle.

Whether you have just joined the OKHEEI team and are learning about your benefit options for the first time or you are a veteran employee who understands and appreciates our benefit programs, we are confident everyone will make good use of this informative reference guide.

We thank you for the many contributions you make to the success of OKHEEI. We encourage you to take advantage of all your available resources and work toward improving your overall health, making the next year your healthiest year ever.

Eligibility

Who is Eligible?

All regular, active, full-time employees working 30 or more hours per week, and their eligible dependent(s) are eligible for OKHEEI's benefit plans. Eligible dependents include:

- Current Legal Spouse
- Common Law Spouse
- Married and unmarried children up to age 26, including a newborn, adopted child, stepchild or other child for whom you or your spouse is legally responsible
- Children who are medically certified as disabled and dependent upon you or your spouse may be eligible for coverage. Please see OKHEEI Plan Document for details.

All dependents added to the plan will be verified by the institution for eligibility



Northern Oklahoma College—Enid Campus

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Seminole State College



MURRAY
STATE COLLEGE



This brochure provides only a brief summary of the benefits available under OKHEEI's plans. In the event of a discrepancy between this summary and the Plan Document, the Plan Document will prevail. OKHEEI retains the right to modify or eliminate these or any other benefits at any time and for any reason. More detailed information on a particular benefit plan may be found in the Summary Plan Description for that plan.

ENROLL IN BENEFITS



Go to MyOKHEEBenefits.com to get started and Register to begin your enrollment for 2025.

HAVE THE FOLLOWING INFORMATION HANDY— Provide eligible dependents' and beneficiaries':

- Full names
- Dates of Birth
- Social Security Number(s)

Verification is required for any dependents you add to any of the plans (document upload required)

MEDICAL BENEFITS



Administered by BlueCross BlueShield of Oklahoma



**BlueCross BlueShield
of Oklahoma**

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Oklahoma Higher Education Employee Interlocal Group.

Oklahoma Higher Education Employee Interlocal Group offers you a choice of one (1) HSA and three (3) PPO medical plans. With the PPO, you may select where you receive your medical services. If you use in-network providers, your costs will be less.

	PLAN A	PLAN B	PLAN C	PLAN F
	Blue Preferred	Blue Options*	Blue Preferred	Blue Options* — HSA HDHP
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Annual Deductible	\$750 single / \$2,250 family	\$1,250 single / \$3,750 family	\$2,000 single / \$5,000 family	\$3,500 single / \$7,000 family
Annual Out-of-Pocket Maximum	\$3,500 single / \$10,500 family	\$4,000 single / \$12,000 family	\$5,000 single / \$15,000 family	\$6,650 single / \$13,300 family
Coinsurance	20%	20%	20%	20%
DOCTOR'S OFFICE				
Primary Care Office Visit	\$20 copay per visit	\$25 copay per visit	\$35 copay per visit	20% after deductible
Specialist Office Visit	\$40 copay per visit	\$40 copay per visit	\$50 copay per visit	20% after deductible
Preventive Care (screening, immunization)	0%	0%	0%	0%
Diagnostic Test (x-ray, blood work)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
HOSPITAL SERVICES				
Emergency Room	\$100 copay per visit ** + 20% after deductible	\$150 copay per visit ** + 20% after deductible	\$150 copay per visit ** + 20% after deductible	20% after deductible
Inpatient	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Outpatient Surgery	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Urgent Care	\$40 copay per visit	\$40 copay per visit	\$50 copay per visit	20% after deductible
PRESCRIPTION DRUGS***				
Generic Drugs	Retail: \$30 copay Mail Order: \$90 copay			20% after deductible
Preferred Drugs	Retail: \$60 copay Mail Order: \$180 copay			20% after deductible
Non-Preferred Drugs	Retail: \$90 copay Mail Order: \$270 copay			20% after deductible
Specialty Drugs	Retail: \$150 copay, deductible does not apply Must be ordered through Prime Oklahoma Specialty Network (no mail order available)			20% after deductible
Supply Limits	Retail: 30 Day Supply Mail Order: 90 Day Supply			

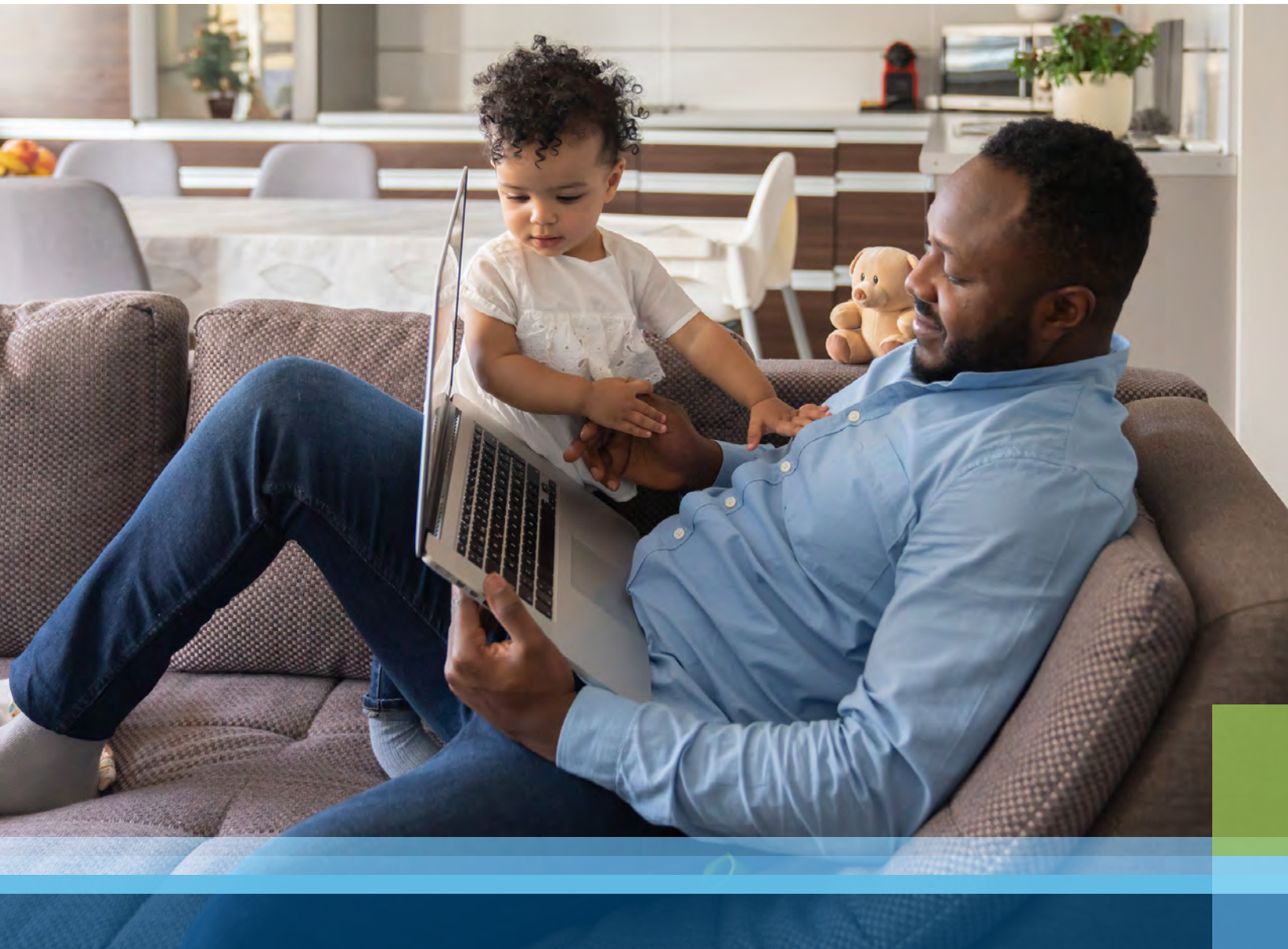
*Benefits for Blue Options includes both Blue Preferred and Blue Choice networks.

** Copay will be waived if admitted

***Listed copay is per prescription



BlueCross BlueShield of Oklahoma



Virtual Visits: Get 24/7 Care, Anywhere

Call your doctor's office first. They also may offer telehealth consultations by phone or online video.

With Virtual Visits, the doctor is always in. Get 24/7 non-emergency care from a board-certified doctor by phone, online video or mobile app from the privacy and comfort of your own home.

Don't risk crowded waiting rooms, expensive urgent care or ER bills, or waiting weeks or more to see a doctor, when you can speak with a Virtual Visits doctor within minutes.

Virtual Visits, provided by Blue Cross and Blue Shield of Oklahoma (BCBSOK) and powered by MDLIVE®, are a convenient alternative for treatment of more than 80 health conditions, including:

- Allergies
- Cold/Flu
- Fever
- Headaches
- Nausea
- Sinus infections

Virtual Visits with licensed behavioral health therapists are available by appointment. Get virtual care for:

- Anxiety
- Depression
- Stress management
- And more

Virtual Visit doctors can even send an e-prescription to your local pharmacy.



Activate your MDLIVE account today:

- Call MDLIVE at 888-970-4081
- Go to MDLIVE.com/bcbsok
- Text BCBSOK to 635-483
- Download the MDLIVE app

Virtual Visits may not be available on all plans. Non-emergency medical service in Montana and New Mexico is limited to interactive online video. Non-emergency medical service in Arkansas and Idaho is limited to interactive online video for initial consultation.

MDLIVE is a separate company that operates and administers Virtual Visits for Blue Cross and Blue Shield of Oklahoma. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

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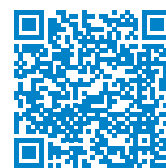


Your health at your fingertips

Get information about the cost of procedures, find a doctor or request an ID card. You can do it all – simply and securely – on Blue Access for MembersSM (BAMSM).

With BAM, you can:

- Find in-network doctors and hospitals.
- View your digital member ID, or order new or replacement IDs.
- Review your benefits and dependent coverage.
- Covered dependents age 18 and over can have their own BAM accounts.



Scan this QR code to visit bcbsook.com.

Let's get started

1. Go to **bcbsook.com**.
2. Click **Register Here**.
3. Use the information on your member ID card to complete the registration process.

Navigation has never been easier

- 1 Dashboard** – See your family's claims and health care spending at a glance, order an ID, navigate the site quickly and easily.
- 2 Claims** – View quick claims summaries or download your Explanation of Benefits (EOB).
- 3 Coverage** – See benefit highlights for your medical, dental and pharmacy plans.
- 4 Spending** – Keep track of your deductible and out-of-pocket expenses.
- 5 Find Care** – Find in-network doctors, hospitals and other health care providers quickly and easily.
- 6 Wellness** – Take control of your well-being with preventive care guidelines, information and health tips for managing health conditions and living a healthier life.
- 7 My Account** – Use this menu for everything else: View your health history, update your profile and preferences, sign up for electronic EOBs, find claim forms, manage privacy preferences and contact us.

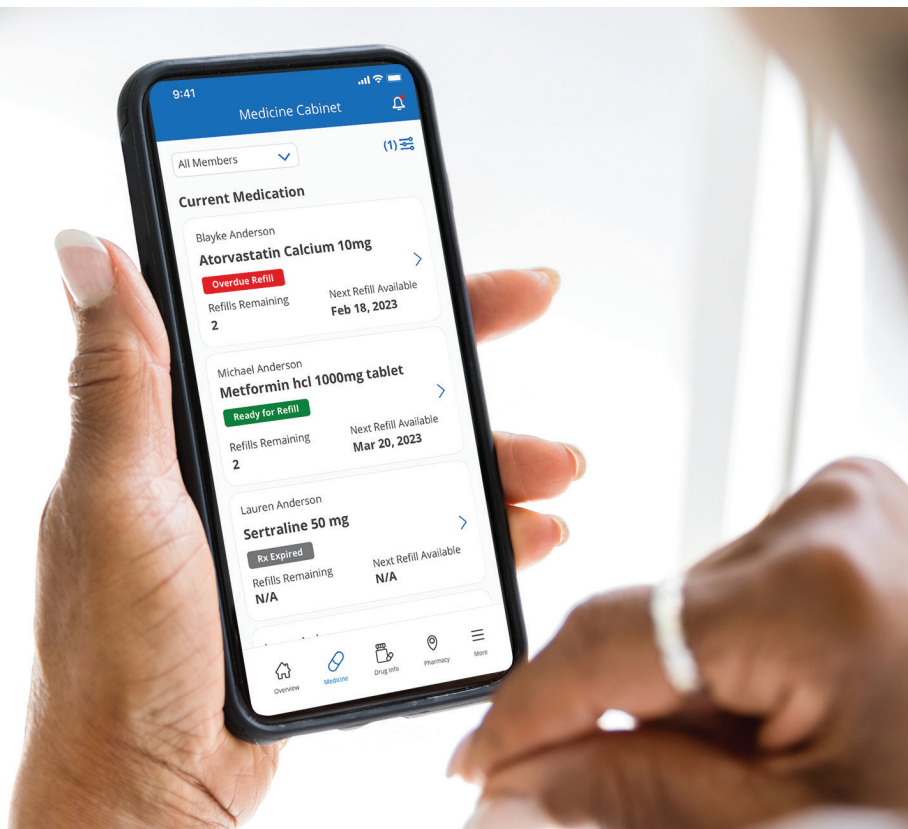
This material is only for illustration purposes. Your group's coverage types and benefits may be different.
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BlueCross BlueShield of Oklahoma

Your Virtual Medicine Cabinet Is Here



Save On Prescriptions With Just A few Clicks

MyBlueRxOK is a personalized pharmacy app for Blue Cross and Blue Shield of Oklahoma (BCBSOK) members. We're making it easy to understand and manage prescription drugs and out-of-pocket costs for yourself and your family.

How it works

This app puts your prescription drug information in your hands with features that allow you to:

- Compare drug costs at different pharmacies
- Find available lower-cost drug options
- Manage prescription drug care for your family*
- Access information about your prescription drugs, including medication details, claims history, coverage, pre-approvals and refills
- Get reminders when it's time to refill your prescription
- Search for and contact in-network pharmacies

* Who are listed as dependents on your BCBSOK plan. Adult children (age 18-26) and other dependents can download the app and create their own account.

Not all features are available for all plans

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

Scan a QR code to download the free app.

Use your Blue Access for MembersSM login, or create a new account to get started.



MyBlueRxOK (iOS)



MyBlueRxOK (Android)



Health Assessment

Would you like to reduce your annual medical deductible by \$250?*

All members enrolled in BlueCross BlueShield, including employees, spouses, and dependent children over the age of 18 are now eligible to take a health assessment for a \$250 credit EACH towards the annual medical calendar year deductible! This online assessment is completed through the member's Blue Access for Members, or BAM, account and **MUST be completed prior to incurring a claim that would go towards the deductible.**

Steps to set up a personal BCBS "BAM" account:

Go to: www.bcbsok.com/okheeil/ (also on the back of your medical card)

- In the "BlueAccess for Members" box click on the *Register Now*

Log into your BAM account with BCBS and take the Health Assessment. Each eligible member will have to create their own BAM account and complete the Health Assessment to receive the \$250 credit.

REMINDER: The Health Assessment may be taken anytime during the calendar year. It **MUST** be taken before a claim is incurred to receive the \$250 credit.

***HSA Enrollees (Plan F):** Enrollees are no longer eligible to receive the deductible credit.

After successfully completing your Health Assessment, your \$250 incentive will show up in your BAM account/Well onTarget/Incentives/History in approximately 10 business days. If you experience difficulties, then call the customer service number on the back of your BCBS ID card: 1-800-672-2567.

Once you have your personal online account set up with BCBS you will be able to access your claims information and *MyPrime* regarding prescription drugs. You will find articles on a variety of health topics and fitness programs, be able to request a new ID card, and find doctors and hospitals on your plan.



Northeastern State University

2025 Wellness Programs



BlueCross BlueShield
of Oklahoma



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FORMERLY NATURALLY SLIM



Livongo®

vivante
HEALTH



Hinge Health



The path to \$0 healthcare is simple

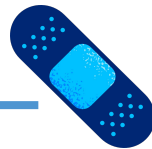


Talk To Your Doctor

When your doctor lets you know you need a specific procedure or service be sure to let them know **your health plan has a \$0 benefit** at certain providers

1

2



Get The Care You Need

You have access to **hundreds of providers** and **thousands of services** ranging from lab, advanced imaging, physical therapy, colonoscopies and even surgery

4



Choose Your Provider

Your Personal Health Assistant helps **find the provider that works best for you & handles all the details** and is always around to answer any questions you may have

3



Connect With ZERO

Connect with your own **Personal Health Assistant** at www.zero.health and chat live, reach out by phone at 855-816-0001 or email us at help@zero.health

5



Save Your Cash

You get access to the care you need without having to worry about things like deductibles, copays or coinsurance - **you always pay \$0.** For real. You always pay ZERO



BCBS Plan A	NEW MONTHLY MEDICAL COST	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$977.56	\$800.00	\$177.56
Employee + Children	\$1,688.42	\$800.00	\$888.42
Employee + Child	\$1,249.21	\$800.00	\$449.21
Employee + Spouse	\$1,903.06	\$800.00	\$1,103.06
Employee + Family	\$2,438.25	\$800.00	\$1,638.25

BCBS Plan B	NEW MONTHLY MEDICAL COST	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$853.52	\$800.00	\$53.52
Employee + Children	\$1,489.96	\$800.00	\$689.96
Employee + Child	\$1,096.74	\$800.00	\$296.74
Employee + Spouse	\$1,546.62	\$800.00	\$746.62
Employee + Family	\$2,025.76	\$800.00	\$1,225.76

BCBS Plan C	NEW MONTHLY MEDICAL COST	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$698.93	\$800.00	(\$101.07)
Employee + Children	\$1,295.30	\$800.00	\$495.30
Employee + Child	\$926.84	\$800.00	\$126.84
Employee + Spouse	\$1,344.87	\$800.00	\$544.87
Employee + Family	\$1,793.84	\$800.00	\$993.84

BCBS Plan F	NEW MONTHLY MEDICAL COST	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$667.67	\$800.00	(\$132.33)
Employee + Children	\$1,206.69	\$800.00	\$406.69
Employee + Child	\$851.81	\$800.00	\$51.81
Employee + Spouse	\$1,256.85	\$800.00	\$456.85
Employee + Family	\$1,732.60	\$800.00	\$932.60

Delta Dental High	Monthly Dental Cost	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$50.30		
Employee + Children	\$94.90		
Employee + Child	\$73.38		
Employee + Spouse	\$103.22		
Employee + Family	\$149.62		

Delta Dental Low	Monthly Dental Cost	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$36.88		
Employee + Children	\$62.22		
Employee + Child	\$54.22		
Employee + Spouse	\$79.10		
Employee + Family	\$110.88		

Delta Dental Preventative	Monthly Dental Cost	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$18.26		
Employee + Children	\$39.58		
Employee + Child	\$30.24		
Employee + Spouse	\$37.52		
Employee + Family	\$60.18		

VSP Vision Base	Monthly Vision Cost	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$6.54		
Employee + Children	\$14.00		
Employee + Child	\$12.82		
Employee + Spouse	\$13.10		
Employee + Family	\$22.36		

VSP Vision Buy-up	Monthly Vision Cost	Employer's Monthly Cost	Employee Monthly Cost
Employee Only	\$12.29		
Employee + Children	\$26.33		
Employee + Child	\$24.09		
Employee + Spouse	\$24.63		
Employee + Family	\$42.04		



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the **premium**) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-672-2567 or at www.bcbsok.com/member/policy-forms. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Network</u> : \$750 Individual / \$2,250 Family <u>Out-of-Network</u> : \$1,500 Individual / \$4,500 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Services that charge a <u>copay</u> , <u>prescription drugs</u> , and certain <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. Per occurrence: \$300 <u>Out-of-Network</u> inpatient admission. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Network</u> : \$3,500 Individual / \$10,500 Family <u>Out-of-Network</u> : \$5,000 Individual / \$15,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, <u>preauthorization</u> penalties, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.bcbsok.com or call 1-800-672-2567 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Telemedicine visits are available, please refer to your <u>plan</u> policy for more details.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Annual mammography <u>screening</u> and childhood immunizations are covered at No Charge <u>Out-of-Network</u> .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.bcbsok.com/member/prescription-drug-plan-information/pharmacy-prescription-plan-information	Generic drugs	\$30 retail \$90 mail order <u>copay/prescription</u> ; <u>deductible</u> does not apply	\$75 retail; <u>deductible</u> does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. Listed <u>copayments</u> are per prescription. Payment of the difference between the cost of a brand drug and a generic may also be required if a generic drug is available. <u>Specialty drugs</u> must be obtained from <u>In-Network</u> specialty pharmacy <u>provider</u> . Limited to 30-day supply. Mail order is not covered.
	Preferred brand drugs	\$60 retail \$180 mail order <u>copay/prescription</u> ; <u>deductible</u> does not apply	\$75 retail; <u>deductible</u> does not apply	
	Non-preferred brand drugs	\$90 retail \$270 mail order <u>copay/prescription</u> ; <u>deductible</u> does not apply	\$125 retail; <u>deductible</u> does not apply	
	<u>Specialty drugs</u>	\$150 <u>copay/prescription</u> ; <u>deductible</u> does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Elective abortion is not covered.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	Facility Charges: 20% <u>coinsurance</u> ER Physician Charges: 20% <u>coinsurance</u>	Facility Charges: 20% <u>coinsurance</u> ER Physician Charges: 20% <u>coinsurance</u>	Additional \$100 <u>copay</u> per visit; waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Additional \$300 <u>deductible Out-of-Network</u> . <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> /office visit; <u>deductible</u> does not apply 20% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	<u>Preauthorization</u> required for certain services.
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Additional \$300 <u>deductible Out-of-Network</u> . <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Additional \$300 <u>deductible Out-of-Network</u> . <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	100 visit limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	<u>Rehabilitation services</u>	Outpatient: No Charge; <u>deductible</u> does not apply Inpatient: 20% <u>coinsurance</u>	50% <u>coinsurance</u>	Outpatient: Separate 60 visit limit per benefit period for speech and occupational therapy subject to the benefit period <u>deductible</u> and <u>coinsurance</u> .
	<u>Habilitation services</u>	Outpatient: No Charge; <u>deductible</u> does not apply Inpatient: 20% <u>coinsurance</u>	50% <u>coinsurance</u>	Physical Therapy and Chiropractic 60 visit limit combined. Physical Therapy is covered at 100% for <u>in-network</u> services. Chiropractic is subject to the benefit period <u>deductible</u> and <u>coinsurance</u> . Muscle Manipulation is subject to the benefit period <u>deductible</u> and <u>coinsurance</u> . Chiropractic Office Visits are covered at 100% with no <u>copayment</u> . Inpatient: Additional \$300 <u>deductible</u> <u>Out-of-Network</u> . 30-day limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Additional \$300 <u>deductible</u> <u>Out-of-Network</u> . 100-day limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Medically necessary</u> rental or purchase at the <u>plan's</u> discretion.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Additional \$300 <u>deductible</u> <u>Out-of-Network</u> . <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)			
- Acupuncture - Cosmetic surgery - Dental care (Adult)	- Elective abortion (unless the life of the mother is endangered) - Hearing aids (limited coverage for children only) - Long-term care	- Routine eye care (Adult) - Routine foot care - Weight loss programs	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
- Bariatric surgery (limited coverage only) - Chiropractic care (60 visits per benefit period combined with physical therapy)	- Infertility treatment (diagnosis of infertility covered) - Non-emergency care when traveling outside the U.S.	Private-duty nursing (85 visits per year)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage contact the plan, Blue Cross and Blue Shield of Oklahoma at 1-800-672-2567 or visit www.bcbsok.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their state insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Oklahoma at 1-800-672-2567 or visit www.bcbsok.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Oklahoma Department of Insurance, Consumer Protection at 1-800-522-0071 or www.oid.ok.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Oklahoma at 1-800-672-2567 or visit www.bcbsok.com or contact the Oklahoma Department of Insurance, Consumer Protection at 1-405-521-2991 or www.oid.ok.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Oklahoma Department of Insurance's Consumer Health Assistance Program at 1-405-521-2991 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ok.html.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-672-2567.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-672-2567.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-672-2567.

Navajo (Dine): Dinekehgo shika a'ohwol ninisingo, kwijigo holne' 1-800-672-2567.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist</u> copayment	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,220

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist</u> copayment	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,000

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist</u> copayment	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,150



Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقى المساعدة اللغوية أو التواصل مجاًناً، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíik'eh bee náhaz'á. 1-866-560-4042 jì' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-672-2567 or at www.bcbsok.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$1,250 Individual / \$3,750 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Services that charge a <u>copay</u> , <u>prescription drugs</u> , ambulance, and certain <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. Per occurrence: \$300 <u>Out-of-Network</u> inpatient admission. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Blue Preferred (BP): \$4,000 Individual / \$12,000 Family Blue Choice (BC): \$4,000 Individual / \$12,000 Family <u>Out-of-Network</u> : \$7,000 Individual / \$14,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, <u>preauthorization</u> penalties, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.bcbsok.com or call 1-800-672-2567 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 BP/\$25 BC <u>copay/visit</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Telemedicine visits are available, please refer to your <u>plan</u> policy for more details.
	<u>Specialist</u> visit	\$40 BP/\$40 BC <u>copay/visit</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Annual mammography <u>screening</u> and childhood immunizations are covered at No Charge <u>Out-of-Network</u> .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.bcbsok.com/member/prescription-drug-plan-information/pharmacy-prescription-plan-information	Generic drugs	\$30 retail \$90 mail order <u>copay/prescription</u> ; <u>deductible</u> does not apply	\$75 retail; <u>deductible</u> does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. Listed <u>copayments</u> are per prescription. Payment of the difference between the cost of a brand drug and a generic may also be required if a generic drug is available. <u>Specialty drugs</u> must be obtained from <u>In-Network specialty pharmacy provider</u> . Limited to 30-day supply. Mail order is not covered.
	Preferred brand drugs	\$60 retail \$180 mail order <u>copay/prescription</u> ; <u>deductible</u> does not apply	\$75 retail; <u>deductible</u> does not apply	
	Non-preferred brand drugs	\$90 retail \$270 mail order <u>copay/prescription</u> ; <u>deductible</u> does not apply	\$125 retail; <u>deductible</u> does not apply	
	<u>Specialty drugs</u>	\$150 <u>copay/prescription</u> ; <u>deductible</u> does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	Elective abortion is not covered.
	Physician/surgeon fees	20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	Facility Charges: 20%/20% <u>coinsurance</u> ER Physician Charges: 20%/20% <u>coinsurance</u>	Facility Charges: 20%/20% <u>coinsurance</u> ER Physician Charges: 20%/20% <u>coinsurance</u>	Additional 150 <u>copay</u> per visit; waived if admitted.
	<u>Emergency medical transportation</u>	No Charge; <u>deductible</u> does not apply	No Charge; <u>deductible</u> does not apply	None
	<u>Urgent care</u>	\$40 BP/\$40 BC <u>copay/visit</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	Additional \$300 <u>deductible Out-of-Network</u> . <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	Physician/surgeon fees	20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 BP/\$25 BC <u>copay/office visit</u> ; <u>deductible</u> does not apply 20%/20% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	<u>Preauthorization</u> required for certain services.
	Inpatient services	20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	Additional \$300 <u>deductible Out-of-Network</u> . <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
If you are pregnant	Office visits	20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	Additional \$300 <u>deductible Out-of-Network</u> . <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	100 visit limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not <u>preauthorized Out-of-Network</u> .
	<u>Rehabilitation services</u>	Outpatient (BP/BC): No Charge; <u>deductible</u> does not apply Inpatient (BP/BC): 20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	Outpatient: Separate 60 visit limit per benefit period for speech and occupational therapy subject to the benefit period <u>deductible</u> and <u>coinsurance</u> . Physical Therapy and Chiropractic 60 visit limit combined. Physical Therapy is covered at 100% for <u>in-network</u> services. Chiropractic is subject to the benefit period <u>deductible</u> and <u>coinsurance</u> . Muscle Manipulation is subject to the benefit period <u>deductible</u> and <u>coinsurance</u> . Chiropractic Office Visits are covered at 100% with no <u>copayment</u> . Inpatient: Additional \$300 <u>deductible Out-of-Network</u> . 30-day limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not <u>preauthorized Out-of-Network</u> .
	<u>Habilitation services</u>	Outpatient (BP/BC): No Charge; <u>deductible</u> does not apply Inpatient (BP/BC): 20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	Additional \$300 <u>deductible Out-of-Network</u> . 100-day limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not <u>preauthorized Out-of-Network</u> .
	<u>Durable medical equipment</u>	20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Medically necessary</u> rental or purchase at the plan's discretion.
	<u>Hospice services</u>	20%/20% <u>coinsurance</u>	50% <u>coinsurance</u>	Additional \$300 <u>deductible Out-of-Network</u> . <u>Preauthorization</u> required; \$500 penalty if not <u>preauthorized Out-of-Network</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Elective abortion (unless the life of the mother is endangered)
- Routine eye care (Adult)
- Cosmetic surgery
- Hearing aids (limited coverage for children only)
- Routine foot care
- Dental care (Adult)
- Long-term care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (limited coverage only)
- Infertility treatment (diagnosis of infertility covered)
- Private-duty nursing (85 visits per year)
- Chiropractic care (60 visits per benefit period combined with physical therapy)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage contact the plan, Blue Cross and Blue Shield of Oklahoma at 1-800-672-2567 or visit www.bcbsok.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their state insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Oklahoma at 1-800-672-2567 or visit www.bcbsok.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Oklahoma Department of Insurance, Consumer Protection at 1-800-522-0071 or www.oid.ok.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Oklahoma at 1-800-672-2567 or visit www.bcbsok.com or contact the Oklahoma Department of Insurance, Consumer Protection at 1-405-521-2991 or www.oid.ok.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Oklahoma Department of Insurance's Consumer Health Assistance Program at 1-405-521-2991 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ok.html.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-672-2567.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-672-2567.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-672-2567.

Navajo (Dine): Dinekehgo shika a'ohwol ninisingo, kwijigo holne' 1-800-672-2567.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,250
■ <u>Specialist</u> copayment	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$1,250
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,620

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,250
■ <u>Specialist</u> copayment	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,120

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,250
■ <u>Specialist</u> copayment	\$40
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,300



Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجاناً، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinit's'á'góó, shá ata' hodooni nínízingo, t'áájí'eh bee náhaz'á. 1-866-560-4042 jį' hodiilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. **This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-672-2567 or at www.bcbsok.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Network</u> : \$2,000 Individual / \$5,000 Family <u>Out-of-Network</u> : \$2,500 Individual / \$7,500 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Services that charge a <u>copay</u> , <u>prescription drugs</u> , and certain <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. Per occurrence: \$300 <u>Out-of-Network</u> inpatient admission. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Network</u> : \$5,000 Individual / \$15,000 Family <u>Out-of-Network</u> : \$6,500 Individual / \$19,500 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, <u>preauthorization</u> penalties, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.bcbsok.com or call 1-800-672-2567 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Telemedicine visits are available, please refer to your <u>plan</u> policy for more details.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Annual mammography <u>screening</u> and childhood immunizations are covered at No Charge <u>Out-of-Network</u> .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.bcbsok.com/member/prescription-drug-plan-information/pharmacy-prescription-plan-information	Generic drugs	\$30 retail \$90 mail order <u>copay/prescription</u> ; <u>deductible</u> does not apply	\$75 retail; <u>deductible</u> does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. Listed <u>copayments</u> are per prescription. Payment of the difference between the cost of a brand drug and a generic may also be required if a generic drug is available. <u>Specialty drugs</u> must be obtained from <u>In-Network</u> specialty pharmacy <u>provider</u> . Limited to 30-day supply. Mail order is not covered.
	Preferred brand drugs	\$60 retail \$180 mail order <u>copay/prescription</u> ; <u>deductible</u> does not apply	\$75 retail; <u>deductible</u> does not apply	
	Non-preferred brand drugs	\$90 retail \$270 mail order <u>copay/prescription</u> ; <u>deductible</u> does not apply	\$125 retail; <u>deductible</u> does not apply	
	<u>Specialty drugs</u>	\$150 <u>copay/prescription</u> ; <u>deductible</u> does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Elective abortion is not covered.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	Facility Charges: 20% <u>coinsurance</u> ER Physician Charges: 20% <u>coinsurance</u>	Facility Charges: 20% <u>coinsurance</u> ER Physician Charges: 20% <u>coinsurance</u>	Additional \$150 <u>copay</u> per visit; waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$50 <u>copay/visit</u> ; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Additional \$300 <u>deductible Out-of-Network</u> . <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copay</u> /office visit; <u>deductible</u> does not apply 20% <u>coinsurance</u> for other outpatient services	40% <u>coinsurance</u>	<u>Preauthorization</u> required for certain services.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Additional \$300 <u>deductible Out-of-Network</u> . <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Additional \$300 <u>deductible Out-of-Network</u> . <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	100 visit limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	<u>Rehabilitation services</u>	Outpatient: No Charge; <u>deductible</u> does not apply Inpatient: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	Outpatient: Separate 60 visit limit per benefit period for speech and occupational therapy subject to the benefit period <u>deductible</u> and <u>coinsurance</u> .
	<u>Habilitation services</u>	Outpatient: No Charge; <u>deductible</u> does not apply Inpatient: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	Physical Therapy and Chiropractic 60 visit limit combined. Physical Therapy is covered at 100% for <u>in-network</u> services. Chiropractic is subject to the benefit period <u>deductible</u> and <u>coinsurance</u> . Muscle Manipulation is subject to the benefit period <u>deductible</u> and <u>coinsurance</u> . Chiropractic Office Visits are covered at 100% with no <u>copayment</u> . Inpatient: Additional \$300 <u>deductible</u> <u>Out-of-Network</u> . 30-day limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Additional \$300 <u>deductible</u> <u>Out-of-Network</u> . 100-day limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Medically necessary</u> rental or purchase at the <u>plan's</u> discretion.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Additional \$300 <u>deductible</u> <u>Out-of-Network</u> . <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (you will pay the least)	Out-of-Network Provider (you will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)			
• Acupuncture • Cosmetic surgery • Dental care (Adult)	• Elective abortion (unless the life of the mother is endangered) • Hearing aids (limited coverage for children only) • Long-term care	• Routine eye care (Adult) • Routine foot care • Weight loss programs	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (limited coverage only) • Chiropractic care (60 visits per benefit period combined with physical therapy)	• Infertility treatment (diagnosis of infertility covered) • Non-emergency care when traveling outside the U.S.	• Private-duty nursing (85 visits per year)

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Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-672-2567.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-672-2567.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-672-2567.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-672-2567.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> copayment	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,170

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> copayment	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,220

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> copayment	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,200



Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجاً، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinit's'á'góó, shá ata' hodooni nínízingo, t'áájíik'eh bee náhaz'á. 1-866-560-4042 jì' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-672-2567 or at www.bcbsok.com/member/policy-forms. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>Network</u> : \$3,500 Individual / \$7,000 Family <u>Out-of-Network</u> : \$5,000 Individual / \$10,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Network preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost sharing and before you meet your deductible. See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	<u>Network</u> : \$6,650 Individual / \$13,300 Family <u>Out-of-Network</u> : \$10,000 Individual / \$20,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges, <u>preauthorization</u> penalties, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.bcbsok.com or call 1-800-672-2567 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Telemedicine visits are available, please refer to your <u>plan</u> policy for more details.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Annual mammography <u>screening</u> and childhood immunizations are covered at No Charge <u>Out-of-Network</u> .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.bcbsok.com/member/prescription-drug-plan-information/pharmacy-prescription-plan-information	Generic drugs	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. Some <u>preventive</u> medications may be covered at No Charge, <u>deductible</u> waived. Please refer to the HSA <u>Preventive</u> Drug list for details. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. <u>Specialty drugs</u> must be obtained from <u>In-Network</u> specialty pharmacy <u>provider</u> . Limited to 30-day supply. Mail order is not covered.
	Preferred brand drugs	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Non-preferred brand drugs	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Specialty drugs</u>	20% <u>coinsurance</u>	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Elective abortion is not covered.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	Facility Charges: 20% <u>coinsurance</u> ER Physician Charges: 20% <u>coinsurance</u>	Facility Charges: 20% <u>coinsurance</u> ER Physician Charges: 20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required for certain services.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	100 visit limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Outpatient: Separate 60 visit limit per benefit period for speech and occupational therapy subject to the benefit period <u>deductible</u> and <u>coinsurance</u> . Physical Therapy and Chiropractic 60 visit limit combined. Physical Therapy is covered at 100% for <u>in-network</u> services. Chiropractic is subject to the benefit period <u>deductible</u> and <u>coinsurance</u> . Muscle Manipulation is subject to the benefit period <u>deductible</u> and <u>coinsurance</u> . Chiropractic Office Visits are covered at 100% with no <u>copayment</u> . Inpatient: 30-day limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	100-day limit per benefit period. <u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Medically necessary</u> rental or purchase at the plan's discretion.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required; \$500 penalty if not preauthorized <u>Out-of-Network</u> .
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|-----------------------|---|----------------------------|
| • Acupuncture | • Elective abortion (unless the life of the mother is endangered) | • Routine eye care (Adult) |
| • Cosmetic surgery | • Hearing aids (limited coverage for children only) | • Routine foot care |
| • Dental care (Adult) | • Long-term care | • Weight loss programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|---|--|---|
| • Bariatric surgery (limited coverage only) | • Infertility treatment (diagnosis of infertility covered) | • Private-duty nursing (85 visits per year) |
| • Chiropractic care (60 visits per benefit period combined with physical therapy) | • Non-emergency care when traveling outside the U.S. | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage contact the plan, Blue Cross and Blue Shield of Oklahoma at 1-800-672-2567 or visit www.bcbsok.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their state insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Oklahoma at 1-800-672-2567 or visit www.bcbsok.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Oklahoma Department of Insurance, Consumer Protection at 1-800-522-0071 or www.oid.ok.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Oklahoma at 1-800-672-2567 or visit www.bcbsok.com or contact the Oklahoma Department of Insurance, Consumer Protection at 1-405-521-2991 or www.oid.ok.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Oklahoma Department of Insurance's Consumer Health Assistance Program at 1-405-521-2991 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ok.html.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-672-2567.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-672-2567.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-672-2567.

Navajo (Dine): Dinekehgo shika a'ohwol ninisingo, kwijigo holne' 1-800-672-2567.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,360

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,920

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<u>Cost sharing</u>	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800



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If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>
Complaint Forms: <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

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Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	للتلقي المساعدة اللغوية أو التواصل مجاناً، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínizingo, t'áájiik'eh bee náhaz'á. 1-866-560-4042 jil' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.

DENTAL BENEFITS



As a participant, and/or covered dependent of an OKHEEI employee, your dental benefits program allows payment for eligible services performed by any properly licensed dentist. However, maximum savings are achieved when treatment is provided by a Delta Dental participating dentist through the PPO network.



OKHEEI offers three different dental plan options through Delta Dental of Oklahoma to all eligible employees and dependents. These include:

- High Option (PPO and Premier Network)
- Low Option (PPO and Premier Network)
- Preventive Option (PPO Network ONLY)

Redlands Community College offers Dental High Plan ONLY

Services	Delta High			Delta Low			Delta Preventive
Network	PPO	Premier	OON	PPO	Premier	OON	PPO
Preventive/Diagnostic	100%	100%	100%	100%	100%	100%	100%*
Basic Restorative (Endodontics, Periodontic & Oral Surgery)	85% [^]	70% [^]	70% [^]	75% [^]	70% [^]	70% [^]	80%*
Major Restorative	60%*	50%*	50%*	60%*	50%*	50%*	N/A
Orthodontic	50% (Child Only to age 26)			N/A			N/A
Per Person Per Calendar Year Deductible	\$100/\$300			\$100/\$200			\$50/\$100
Annual Benefit Maximum	\$2000 Per Person			\$1000 Per Person			\$750 Per Person
Lifetime Orthodontic Benefit Maximum	\$2000 per Child (to age 26)			N/A			N/A

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

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

The information contained herein is an example of benefits and not intended as a Dental Care Certificate. The information is not designed to serve as Evidence of Coverage for this program and is subject to the provisions of the Dental Care Certificate. For an accurate description of your benefits, see the Dental Care Certificate or contact Delta Dental of Oklahoma as some benefits are subject to limitations such as age of patient, frequency of procedure, exclusions, plan changes, etc. Out-of-Network - Members may be balanced billed by the provider for charges over the allowable amount and/or services that are not covered.

VISION BENEFITS



VSP Coverage Effective Date: 01/01/2025

VSP Provider Network: VSP Choice



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

		Base Option	Enhanced Option
Benefit	Description	Copay	Copay
Your Coverage with a VSP Provider			
WellVision Exam	- Focuses on your eyes and overall wellness - Every calendar year	\$10	\$10
Prescription Glasses		\$25	\$25
Frames	\$150 allowance of a wide selection of frames \$170 allowance for featured frame brands 20% savings on the amount over your allowance - Every calendar year	Included in Prescription Glasses	Included in Prescription Glasses
Lenses	- Single vision, lined bifocal and lines trifocal lenses - Polycarbonate lenses for dependent children - Every calendar year	Included in Prescription Glasses	Included in Prescription Glasses
Lens Enhancements	- Standard progressive lenses - Premium progressive lenses - Custom progressive lenses - Average savings of 20-25% on other lens enhancements - Every calendar year	\$0 \$95-\$105 \$150-\$175	\$0 \$95-\$105 \$150-\$175
Contact (Instead of glasses)	\$150 allowance for contacts, copay does not apply 15% Discount Contact lenses exam (fitting and evaluation) - Every calendar year		
Diabetic Eyecare Plus Program	- Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. - As needed.	\$20	\$20
Additional Pairs of Eyewear			
Second Pair	This enhancement allows you to get a second pair of glasses or contacts, subject to the same copays as your first pair benefit	NA	Included

Extra Savings	Glasses and Sunglasses - Extra \$20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.
	Retinal Screening No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam.
	Laser Vision Correction Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.
Your Coverage with Out-of-Network Providers	
Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.	

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

1. Brands/Promotion subject to change.

2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

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LIFE/AD&D INSURANCE



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

The cost of this insurance is paid by your institution.

Basic Life/AD&D Plan Features

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



VOLUNTARY LIFE/AD&D INSURANCE

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



Eligibility Requirements

- | | |
|-----------|--|
| Employee | <ul style="list-style-type: none">You must be insured for Basic Life through The StandardYou must be an active employee of an employer covered through OKHEEITemporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligibleYou may be insured as both an employee and a dependent |
| Dependent | <ul style="list-style-type: none">Spouse means a person to who you are legally marriedChild means your child from live birth through age 26Your child may be insured by more than one employeeYour spouse or children must not be full-time member(s) of the armed forces |
| Premium | <ul style="list-style-type: none">You pay 100% of the premium for this coverage through easy payroll deduction |

Coverage Amount Guidelines

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

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

Note:

- Amounts of coverage elected above the Guarantee Issue amount are subject to evidence of insurability. To submit a medical history statement online, visit standard.com/mhs.
- All late applications (applying 31 days after becoming eligible), requests for coverage increases and reinstatements are subject to evidence of insurability, except as indicated in the following **Annual Enrollment** section. Employees eligible but not insured under the prior life insurance plan are also subject to evidence of insurability, except as indicated in the following **Annual Enrollment** section. The coverage amount for your spouse cannot exceed 100% of your combined Basic and Additional Life coverage.
- The coverage amount for your spouse cannot exceed 100% of your combined Basic and Additional Life coverage.
- The coverage amount for your child(ren) cannot exceed 100% of your combined Basic and Additional Life coverage.

Coverage Amount Needed

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

Employee Coverage Effective Date

To become insured, you must satisfy the eligibility requirements listed above, serve an eligibility waiting period, receive medical underwriting approval (if applicable), agree to pay premium, and be actively at work (able to perform all normal duties of your job) on the day before the scheduled effective date of insurance.

If you are not actively at work on the day before the scheduled effective date of insurance, your insurance will not become effective until the day after you complete one full day of active work as an eligible employee.

Please contact your human resources representative for more information regarding these requirements that must be satisfied for your insurance to become effective.

This plan contains an exclusion for death resulting from suicide or other intentionally self-inflicted injury. The amount payable will exclude amounts that have not been continuously in effect for at least two years on the date of death. This is subject to state variations.

VOLUNTARY LIFE/AD&D INSURANCE

Additional Life And AD&D Coverage Highlights
Oklahoma Higher Education Employee Interlocal

Annual Enrollment

Allow increases to occur for Member and Spouse during Annual Enrollment, even if prior increase occurred:

- For you:
- If insured for Plan 2 (additional) Life Insurance for an amount less than the Guarantee issue Amount, Evidence of Insurability will be waived if you apply for an increase of up to 2 increments of \$10,000 in your Plan 2 (additional) Life Insurance up to the Guarantee Issue Amount during the Annual Enrollment Period. However, Evidence of Insurability is required for any amount that exceeds the Guarantee Issue Amount.
 - If you became eligible for Plan 2 (additional) Life Insurance and did not elect coverage within 31 days from the date you became eligible, you will have one more chance to apply at the next Annual Enrollment Period to apply and Evidence of Insurability will be waived if you apply for up to 2 increments of \$10,000 for a max benefit of \$20,000. However, Evidence of Insurability is required for any amount that exceeds \$20,000. If you again choose not to apply for Plan 2 (additional) Life Insurance, then during future Annual Enrollments any amount you apply for will require Evidence of Insurability
- For your spouse:
- If your Spouse is Insured for Dependents Life for an amount less than the Guarantee Issue Amount, Evidence of Insurability will be waived if you apply for an increase of up to 2 increments of \$5,000 in your Dependents Life Insurance for your Spouse up to the Guarantee Issue Amount.
 - If you became eligible to insure your Spouse for Dependent Life and did not elect coverage within 31 days from the date you became eligible, you will have one more chance at the next Annual Enrollment Period to apply for Dependent Life Insurance for your Spouse and Evidence of Insurability will be waived if you apply for up to 2 increments of \$5,000 for a max benefit of \$10,000. However, Evidence Of Insurability is required for any amount that exceeds \$10,000. If you again choose not to apply for Dependent Life Insurance for your Spouse, then during future Annual Enrollments any amount you choose for your Spouse will require Evidence of Insurability.
- Family Status Change:
- In the event of a Family Status Change certain Evidence of Insurability requirements will be waived with respect to Plan 2 (additional) Life Insurance and Dependents Life Insurance.
- If you are eligible be not insured for Plan 2 (additional) Life Insurance, requirements a. and c. above will be waived for you if you apply for an amount of Plan 2 (additional) Life Insurance up to the Guarantee Issue Amount within 31 days of a Family Status Change.
 - If you are insured for an amount of Plan 2 (additional) Life Insurance less than the Guarantee Issue Amount, requirement f. above will be waived for you if you apply for an increase in your Plan 2 (additional) Life Insurance up to the Guarantee Issue Amount within 31 days of a Family Status Change. However, Evidence of Insurability is required to become insured for any Plan 2 (additional) Life Insurance Benefit that exceeds the Guarantee Issue Amount.
 - If your Spouse is eligible but not insured for Dependents Life Insurance, requirements a. and c. above will be waived for your Spouse if you apply for Dependents Life Insurance for your Spouse up to the Guarantee Issue Amount within 31 days of a Family Status Change.
 - If your Spouse is insured for an amount of Dependents Life Insurance less than the Guarantee Issue Amount, requirement f. above will be waived for your Spouse if you apply for an increase in Dependents Life Insurance for your Spouse up to the Guarantee Issue Amount within 31 days of a Family Status Change. However, Evidence of Insurability is required to become insured for any Dependents Life Insurance Benefit for your Spouse that exceeds the Guarantee Issue Amount.

Life Insurance Features and Benefits

Please see your human resources representative for additional information about the features and benefits below.

- Waiver of Premium** If you become totally disabled while insured under this plan and under age 60, and complete a waiting period of 180 days, your Basic and Additional Life insurance may continue without premium payment until age 65 provided you give us satisfactory proof that you remain totally disabled. Waiver of Premium does not apply to AD&D insurance.
- Accelerated Benefit** If you become terminally ill, you may be eligible to receive up to 80 percent of your combined Basic and Additional Life benefit to a maximum of \$800,000.
- Portability** If your insurance ends because your employment terminates, you may be eligible to buy portable group insurance coverage.
- Conversion** If your insurance ends or reduces, you may be eligible to convert your life insurance to an individual life insurance policy without submitting proof of good health.

LONG TERM DISABILITY

Long Term Disability Insurance protects your income if you become partially or totally disabled for a long period of time off the job.

If you elect to buy-up your coverage at any time other than initial eligibility, you will be required to submit proof of health which is subject to approval by The Standard. Any election amount will not be effective until EOI is reviewed and approved.



LONG TERM DISABILITY PLAN FEATURES		
	Core Plan	Buy-Up Plan
Benefits Begin	180 days	90 days
Percentage of Income Replaced	60% of the first \$13,333 of Your Pre- disability Earnings	60% of the first \$13,333 of Your Pre-disability Earnings
Maximum Monthly Benefit	\$8,000	\$8,000
Minimum Monthly Benefit	\$100	\$100
Pre-Existing Conditions	Sickness or accidental injury in which you received medical treatment, care or service within 3 months of the effective date and you have been Actively at Work for less than 12 consecutive months after the effective date	
Mental Nervous Illness/Substance Abuse	Lesser of 24 months or your Maximum Benefit Period	

LTD Example: Monthly Calculation for LTD **CORE** Benefit

A. Annual Earnings =	\$30,000.00	A. Annual Earnings =	
B. Monthly Earnings = (A divided by 12)	\$2,500.00	B. Monthly Earnings = (A divided by 12)	
C. Value Per \$100 = (B divided by \$100)	\$25.00	C. Value Per \$100 = (B divided by \$100)	
D. Estimated Monthly Contribution = (C multiplies by 0.135)	\$3.37	D. Estimated Monthly Contribution = (C multiplies by 0.135)	

LTD Example: Monthly Calculation for LTD **BUY-UP** Benefit

A. Annual Earnings =	\$30,000.00	A. Annual Earnings =	
B. Monthly Earnings = (A divided by 12)	\$2,500.00	B. Monthly Earnings = (A divided by 12)	
C. Value Per \$100 = (B divided by \$100)	\$25.00	C. Value Per \$100 = (B divided by \$100)	
D. Estimated Monthly Contribution = (C multiplies by 0.08)	\$2.00	D. Estimated Monthly Contribution = (C multiplies by 0.08)	

SHORT TERM DISABILITY



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

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

Benefit Amount and Duration	
Benefit Percentage	Your weekly STD benefit is 60% of the first \$3,333 of your weekly insured Pre-disability earnings, reduced by deductible income
Maximum Weekly Benefit	\$2,000
Minimum Weekly Benefit	\$15
Maximum Benefit Period	STD Plan 1: 166 days for employees enrolled in the Base LTD plan STD Plan 2: 76 days for employees enrolled in the Enhanced LTD plan STD Benefits will end on the date Long Term Disability benefits become payable to you under a group plan provided by your employer, even if that occurs before the end of the Maximum Benefit Period.

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

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

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

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

Get reimbursed for out-of-pocket healthcare and child/aged adult day care expenses with tax free dollars!

MAXIMIZE YOUR INCOME!

Flexible Spending Accounts (FSAs) allow you to pay certain health-care and dependent care expenses with pre-tax money. You will not pay any Federal, State or FICA taxes on funds placed in the Plan. You will save approximately \$27.65 to \$37.65 on every \$100 you place in the Plan. The amount of your savings will depend on your Federal tax bracket.

ELIGIBILITY

Participation in the plan begins on January 1, 2025 and ends on December 31, 2025. You will be eligible to join the Plan if you are a full-time employee working at least 30 hours or more per week on the first of the month following your date of hire. Those employees having a qualifying event are eligible to enroll within 30 days of the qualifying event. Deductions begin on the first pay period following your Plan start date. You must complete an enrollment to participate in the Flexible Spending Accounts each year during the enrollment period. If an enrollment is not completed during open enrollment, you will not be enrolled in the Plan and you will not be able to join until the next Plan Year or if you have a qualifying event.

ELECTION CHANGES

Election changes are only allowed if you experience one of the following qualifying events:

- Marriage or divorce
- Birth or adoption
- Involuntary loss of spouse's medical or dental coverage
- Death of dependent (child or spouse)
- Unpaid FMLA or Non-FMLA leave
- Change in dependent care providers

REIMBURSEMENT SCHEDULE

All manual or paper claims received in the office of Flexible Benefit Administrators, Inc. will be processed within one week via check or direct deposit. You may also use your Benefits Card to pay for expenses. Please refer to the Benefits Card section for details.

ONLINE ACCESS

Flexible Benefit Administrators, Inc. provides online account access for all FSA participants. Please visit their website at:

<https://fba.wealthcareportal.com/> to view the following features:

- **FSA Login** – View account transactions, create account alerts and download participation forms.
- **FSA Educational Tools** – FSA calculator: estimate how much you can save by utilizing an FSA.

THE HEALTHCARE ACCOUNT IS A PRE-FUNDED ACCOUNT

This means that you can submit a claim for medical expenses on the first day of the Plan Year and you will be reimbursed your total claim amount up to your annual election. The funds that you are pre-funded will be recovered as deductions which are taken from your paycheck on a pre-tax basis.

Contribution Limits: The maximum you may place in this account for the Plan Year is \$3,050.

HEALTHCARE REIMBURSEMENT

With this account, you can pay for your out-of-pocket healthcare expenses for yourself, your spouse and all your tax dependents for healthcare services that are incurred during your Plan Year and while an active participant. Eligible expenses are those incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for affecting any structure or function of the body.

EXAMPLES OF ELIGIBLE HEALTH CARE EXPENSES

Fees/Co-Pays/Deductibles For:

- | | | |
|--|---|------------------------------|
| • Acupuncture | • Surgery | • Take-home screening kits |
| • Prescription eyeglasses/reading glasses/Contact lens and supplies/ | • Dental/Orthodontic fees | • Diabetic supplies |
| Eye exams/ | • Obstetrician | • Routine physicals |
| Laser eye surgery | • X-Rays | • Oxygen |
| • Physician | • Eye exams | • Physical therapy |
| • Ambulance | • Prescription drugs | • Hearing aids and batteries |
| • Psychiatrist | • Artificial limbs & teeth | • Medical equipment |
| • Psychologist | • Orthopedic shoes/inserts | • Antacids |
| • Anesthetist | • Therapeutic care for drug and alcohol addiction | • Pain relievers |
| • Hospital | • Vaccinations & immunizations | • Allergy & Sinus Medication |
| • Chiropractor | • Mileage | |
| • Laboratory/diagnostic | | |
| • Fertility treatments | | |

OVER-THE-COUNTER EXPENSES

Examples of medications and drugs that may be purchased in reasonable quantities with a prescription:

- | | |
|------------------|----------------------|
| • Acne Treatment | • Herbal Supplements |
| • Humidifiers | • Baby Formula |
| • Multivitamins | • Fiber Supplements |

DAY CARE/AGED ADULT CARE REIMBURSEMENT

The Day Care/Aged Adult Care FSA allows you to pay for day care expenses for your qualified dependent with pre-tax dollars. Eligible Dependent Care expenses are expenses you must pay for the care of an eligible dependent so that you and your spouse can work. Eligible dependents, as revised under Section 152 of the Code by the Working Families Tax Act of 2005, are defined as either dependent children or dependent relatives that you claim as dependents on your taxes. Refer to the Employee Guide for more details. Eligible dependents are further defined as:

- Under age 13
- Physically or mentally unable to care for themselves such as:
 - Disabled spouse
 - Children who became disabled prior to age 19.
 - Elderly parents that live with you

Contribution Limits: The annual maximum contribution may not exceed the lesser of the following:

- \$5,000 (\$2,500 if married filing separately) per household
- Your wages for the year or your spouse's if less than above
- Maximum is reduced by spouse's contribution to a Day Care/Aged Adult Care FSA

ELIGIBLE DAY CARE/AGED ADULT CARE EXPENSES

- Au Pair
- Nannies
- Before and After Care
- Day Camps
- Babysitters
- Daycare for an Elderly Dependent
- Daycare for a Disabled Dependent
- Nursery School
- Private Pre School
- Sick Child Center
- Licensed Day Care Centers

Ineligible Expenses

- Overnight camps
- Babysitting for social events
- Food expenses (if separate from dependent care expenses)
- Care provided by children under 19 (or by anyone you claim as a dependent)
- Days your spouse doesn't work (though you may still have to pay the provider)
- Kindergarten expenses are ineligible as an expense because it is primarily educational, regardless if it is half or full day, private, public, state mandated or voluntary.
- Transportation, books, clothing, food, entertainment and registration fees are ineligible if these expenses are shown separately on your bill.
- Expenses incurred while on a leave of absence or vacation.

HOW TO RECEIVE REIMBURSEMENT

To obtain a reimbursement from your Flexible Spending Account, you must complete a Claim Form. This form is available to you on our website. You must attach a receipt or bill from the service provider which includes all the pertinent information regarding the expense:

- Date of service
- Patient's name
- Amount charged
- Provider's name
- Nature of the expense
- Amount covered by insurance (if applicable)

Canceled checks, bankcard receipts, credit card receipts and credit card statements are NOT acceptable forms of documentation. You are responsible for paying your healthcare or dependent care provider directly.

HOW THE FLEXIBLE BENEFIT PLAN WORKS

	Without Flex Benefits	With Flex Benefits
Gross Monthly Income	\$ 2,500.00	\$ 2,500.00
Eligible Pre-Tax employer medical insurance	\$ 0.00	\$ 200.00
Eligible Pre-Tax Medical Expenses	\$ 0.00	\$ 100.00
Eligible Pre-Tax Dependent Child Care Expenses	\$ 0.00	\$ 300.00
Taxable Income	\$ 2500.00	\$ 1900.00
Federal Tax (15%)	\$ 375.00	\$ 285.00
State Tax (5.75%)	\$ 143.75	\$ 109.25
FICA Tax (7.65%)	\$ 191.25	\$ 145.35
After-Tax employer medical insurance	\$ 200.00	\$ 0.00
After-Tax medical expenses	\$ 100.00	\$ 0.00
After-Tax dependent child care expenses	\$ 300.00	\$ 0.00
Monthly Spendable Income	\$ 1190.00	\$ 1360.40

By taking advantage of the Flexible Benefit Plan this employee was able to increase his/her spendable income by \$170.40 every month! This means an annual tax savings of \$2,044.80. Remember, with the FLEXIBLE BENEFIT PLAN, the better you plan the more you save!

FORFEITING FUNDS

Plan carefully! Unused funds will be forfeited back to your employer as governed by the IRS's "use-it-or-lose-it" rule. Your employer has elected to add the \$610 roll-over provision to the Medical FSA. Please see the Employee Guide for more information.

HOW TO ENROLL IN OUR FSA PLAN

Step 1

Carefully estimate your eligible Healthcare and Day Care/Aged Adult Care expenses for the upcoming Plan Year. Then use our online FSA Educational Tools located at <https://fba.wealthcareportal.com/> to help you determine your total expenses for the Plan Year.

Step 2

Complete your enrollment during the open enrollment period, which instructs payroll to deduct a certain amount of money for your expenses. This amount will be contributed on a pre-tax basis from your paychecks to your FSA. Remember the amount you elect will be set aside before any Federal, State, and FICA taxes are calculated.

BENEFITS CARD

The Benefits Card can be used as a direct payment method for eligible expenses incurred at approved service providers and merchants. Using your card allows you instant access to your funds with no out-of-pocket expense. Please keep all your itemized receipts. Flexible Benefit Administrators, Inc. may request documentation to substantiate Benefits Card transactions to determine eligibility of an expense. Benefits Cards are available upon request of the account holder for dependents over the age of 18. Please contact Flexible Benefit Administrators, Inc. to order additional cards.





HSA **fact** sheet: Easy to understand answers to common HSA questions

Here are some of the questions most often asked about healthcare savings accounts (HSAs), along with plain-language answers.

Is an HSA the same as an FSA?

No. An HSA is a tax-deductible savings account that lets you save every year toward healthcare expenses. There's no use-it-or-lose-it rule, and you can grow your account through interest and investments. And it's portable, so you take it with you if you ever leave the company. To maintain an HSA, you must be enrolled in a high deductible health plan (HDHP).

Will I lose the money in my HSA if I don't spend it?

No. There's no use-it-or-lose-it rule with an HSA, so every dollar that goes into it becomes available for your use.

How much can I contribute to my HSA?

For 2025, single taxpayers can contribute up to \$4,300; families can contribute up to \$8,550. Anyone over age 55 can contribute an additional \$1,000.

How does an HSA save me money on taxes?

Three ways:

- You pay no tax on the money you or your employer put into your HSA, up to the IRS limits.
- You pay no taxes on interest and investment returns earned in your HSA.
- You pay no tax on HSA money when you use it to pay eligible healthcare expenses.

When is my HSA funded?

You or your employer can add money to your HSA at any time during the year. There's no enrollment period. Most employees fund their HSAs through payroll deduction.

Who owns my HSA?

You own it outright. If you leave the company for any reason, you own the account, including any interest earned.

What expenses are eligible for my HSA?

Eligible expenses include many out-of-pocket costs not covered by your insurance plan, including copayments, coinsurance and prescriptions. Costs for many healthcare products and services are also eligible.

Where can I get more information about enrolling in an HSA?

Visit our website. It has everything you need to know—including a video library, tools and calculators, enrollment forms and other details.

Accident Insurance



Group Name: Oklahoma Higher Education Employees Interlocal
Group Number: 722316
Class: Full-Time Employees

Cleaning the gutters. Yoga class. Soccer practice. Life offers plenty of opportunities for accidental injuries. When an injury happens, Accident Insurance can help. This document includes expanded cost and benefit information for Accident Insurance. As you explore, keep in mind:



No medical questions or tests are required for Accident coverage.



Employees get an annual Wellness Benefit of \$100 for completing an eligible health screening test.



Benefit payments go directly to you. Use them how you'd like!

Accident Insurance doesn't replace your medical coverage; instead, it complements it. **The benefit payments don't go out to pay for medical bills or treatments you may need, instead they come in—directly to you—to be used however you'd like.** Choose this supplemental health insurance product for added protection if one of the following covered conditions comes your way.

Accident Insurance is a limited benefit policy. It is not health insurance, and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

ReliaStar Life Insurance Company
a member of the Voya® family of companies

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What's covered?

Accident Insurance provides a benefit payment after a covered accident that results in the specific injuries and treatments listed in this document. To be eligible, the accident must happen outside of work. Some of the most common treatments and conditions we pay benefits for include:



ER treatment



X-rays



Physical therapy



Stitches



Follow-up doctor treatment(s)



Hover your cell phone camera over the QR code, or type the following URL into your browser:
<https://presents.voya.com/EBRC/Home/OKHEE1>

What else is included? The Accident Insurance available through your employer also features the following:

Wellness Benefit



\$100 to use however you'd like

- Complete an eligible health screening test (such as an annual physical) or experience a covered stay in a hospital, and receive a benefit payment.
- Your annual benefit amount is \$100. Your spouse's benefit amount is \$100.
- Children receive 50% of your benefit amount per child, with an annual maximum of \$200 for all children



Keep coverage during a leave of absence

Continuation of Insurance

Continuation allows you to maintain your current Accident Insurance coverage for yourself, your spouse and children during an employer-approved leave of absence.

For a list of standard exclusions and limitations, please refer to the end of this document. For a complete description of your available benefits, exclusions and limitations, see your certificate of insurance and any riders. This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of insurance and riders. All coverage is subject to the terms and conditions of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. To keep coverage in force, premiums are payable up to the date of coverage termination. Accident Insurance is underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. Policy Form #RL-ACC3-POL-16; Certificate Form #RL-ACC3-CERT-16; and Rider Forms: Spouse Accident Rider Form #RL-ACC3-SPR-16, Children's Accident Rider Form #RL-ACC3-CHR-16, Wellness Benefit Rider Form #RL-ACC3-WELL-16, Accidental Death & Dismemberment (AD&D) Rider Form #RL-ACC3-ADR-16, Catastrophic Accident Rider Form #RL-ACC3-CAR-16, Off Job Accident Disability Income Rider form #RL-ACC3-DIR-16, Sickness Hospital Confinement Rider Form #RL-ACC3-HCR-16, Waiver of Premium Rider form #RL-ACC3-WOP-16, Continuation of Insurance Rider form #RL-ACC3-CNT-16. Form numbers, provisions and availability may vary by state and employer's plan.

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ACC2 Only

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Schedule of Benefits

The following list is a summary of the benefits provided by Accident Insurance. You may be required to seek care for your injury within a set amount of time. Note that there may be some variations by state. For a list of standard exclusions and limitations, go to the end of this document.

- ✓ **Your coverage includes a Sport Accident Benefit.** This means that if your accident occurs while participating in an organized sporting activity (as defined in the certificate of coverage); the benefit amounts in the accident hospital care, accident care or common injuries sections below will be increased by 25%; to a maximum additional benefit of \$1,000.

Accident hospital care	Low	High
Surgery open abdominal, thoracic	\$2,000	\$3,000
Surgery exploratory or without repair	\$175	\$350
Blood, plasma, platelets	\$600	\$650
Hospital admission	\$2,000	\$3,000
Hospital confinement per day, up to 365 days	\$250	\$400
Critical care unit confinement per day, up to 15 days	\$450	\$600
Rehabilitation facility confinement per day, up to 90 days	\$200	\$300
Coma duration of 14 or more days	\$17,000	\$20,000
Transportation per trip, up to three per accident	\$750	\$840
Lodging per day, up to 30 days	\$200	\$300
Accident care	Low	High
Initial doctor visit	\$75	\$100
Urgent care facility treatment	\$150	\$200
Emergency room treatment	\$150	\$200
Ground ambulance	\$360	\$600
Air ambulance	\$1,500	\$2,500
Follow-up doctor treatment	\$75	\$100
Medical equipment	\$200	\$500
Physical or occupational therapy up to six per accident	\$45	\$55
Speech therapy up to 6 per accident	\$45	\$55
Prosthetic device (one)	\$750	\$1,500
Prosthetic device (two or more)	\$1,200	\$2,400
Major diagnostic exam	\$250	\$400
Outpatient surgery (one per accident)	\$225	\$300
X-ray	\$75	\$100
Common injuries	Low	High
Burns second degree, at least 36% of the body	\$1,250	\$1,750
Burns third degree, at least nine but less than 35 square inches of the body	\$7,500	\$10,000

Burns third degree, 35 or more square inches of the body	\$15,000	\$22,000
Skin grafts	50% of the burn benefit	50% of the burn benefit
Emergency dental work: crown	\$350	\$480
Extraction	\$90	\$180
Eye injury removal of foreign object	\$100	\$120
Eye injury surgery	\$350	\$420
Torn knee cartilage surgery with no repair or if cartilage is shaved	\$225	\$280
Torn knee cartilage surgical repair	\$800	\$1,000
Laceration ¹ treated no sutures	\$50	\$75
Laceration ¹ sutures up to 2"	\$100	\$150
Laceration ¹ sutures 2" – 6"	\$240	\$480
Laceration ¹ sutures over 6"	\$480	\$960
Ruptured disk surgical repair	\$800	\$1,000
Tendon/ligament/rotator cuff exploratory arthroscopic surgery with no repair	\$425	\$720
Tendon/ligament/rotator cuff one, surgical repair	\$825	\$1,020
Tendon/ligament/rotator cuff two or more, surgical repair	\$1,225	\$1,520
Concussion	\$400	\$600
Paralysis - paraplegia	\$16,000	\$20,000
Paralysis - quadriplegia	\$24,000	\$30,000
Dislocations	Non-surgical/ surgical repair²	Non-surgical/ surgical repair²
Hip joint	\$3,850/\$7,700	\$5,000/\$10,000
Knee	\$2,400/\$4,800	\$3,000/\$6,000
Ankle or foot bone(s) other than toes	\$1,500/\$3,000	\$1,800/\$3,600
Shoulder	\$1,600/\$3,200	\$2,200/\$4,400
Elbow	\$1,100/\$2,200	\$1,500/\$3,000
Wrist	\$1,100/\$2,200	\$1,500/\$3,000
Finger/toe	\$275/\$550	\$350/\$700
Hand bone(s) other than fingers	\$1,100/\$2,200	\$1,500/\$3,000
Lower jaw	\$1,100/\$2,200	\$1,500/\$3,000
Collarbone	\$1,100/\$2,200	\$1,500/\$3,000
Partial dislocations	25% of the non-surgical repair amount	25% of the non-surgical repair amount
Fractures	Non-surgical/ surgical repair³	Non-surgical/ surgical repair³
Hip	\$3,000/\$6,000	\$6,000/\$12,000
Leg	\$2,500/\$5,000	\$2,800/\$5,600
Ankle	\$1,800/\$3,600	\$2,500/\$5,000
Kneecap	\$1,800/\$3,600	\$2,500/\$5,000
Foot excluding toes, heel	\$1,800/\$3,600	\$2,500/\$5,000
Upper arm	\$2,100/\$4,200	\$2,750/\$5,500
Forearm, hand, wrist except fingers	\$1,800/\$3,600	\$2,500/\$5,000

Finger, toe	\$240/\$480	\$400/\$800
Vertebral body	\$3,360/\$6,720	\$4,200/\$8,400
Vertebral processes	\$1,440/\$2,880	\$2,000/\$4,000
Pelvis except coccyx	\$3,200/\$6,400	\$4,000/\$8,000
Coccyx	\$400/\$800	\$500/\$1,000
Bones of face except nose	\$1,200/\$2,400	\$1,400/\$2,800
Nose	\$600/\$1,200	\$750/\$1,500
Upper jaw	\$1,500/\$3,000	\$1,750/\$3,500
Lower jaw	\$1,440/\$2,880	\$2,000/\$4,000
Collarbone	\$1,440/\$2,880	\$2,000/\$4,000
Rib or ribs	\$400/\$800	\$600/\$1,200
Skull – simple except bones of face	\$1,400/\$2,800	\$1,750/\$3,500
Skull – depressed except bones of face	\$3,000/\$6,000	\$5,000/\$10,000
Sternum	\$360/\$720	\$500/\$1,000
Shoulder blade	\$1,800/\$3,600	\$2,500/\$5,000
Chip fractures	25% of the closed reduction amount	25% of the closed reduction amount

Laceration benefits are a total of all lacerations per accident.

² Non-surgical repair of a completely separated joint may be referred to in your policy documentation as a “closed reduction.” Surgical repair of a completely separated joint may be referred to in your policy documentation as an “open reduction.”

³ Non-surgical repair of a fracture may be referred to in your policy documentation as a “closed reduction.” Surgical repair of a fracture may be referred to in your policy documentation as an “open reduction.”

Accidental Death & Dismemberment

Your coverage also includes Accidental Death & Dismemberment benefits. This means that if you are severely injured or pass away due to an accident, additional benefits may apply. See the chart below for more details. A “common carrier” is commercial transportation that operates on a regular schedule, between predetermined points or cities (such as a bus or airline route).

Accidental Death Benefits	Low	High
Common carrier accident		
Employee	\$200,000	\$300,000
Spouse	\$100,000	\$150,000
Children	\$50,000	\$75,000
Other accident		
Employee	\$40,000	\$60,000
Spouse	\$20,000	\$30,000
Children	\$8,000	\$12,000
Accidental Dismemberment Benefits		
Loss of both hand or both feet or sight in both eyes	\$50,000	\$100,000
Loss of one hand or one foot AND the sight of one eye	\$37,500	\$75,000
Loss of one hand AND one foot	\$37,500	\$75,000
Loss of one hand OR one foot	\$20,500	\$37,500
Loss of two or more fingers or toes	\$3,125	\$6,250
Loss of one finger or one toe	\$2,080	\$3,750

How much does it cost?

This table shows your rates for Accident Insurance. The cost provided below includes Accident Insurance premium and a fee for Voya Travel Assistance.

Low Plan Monthly Rates			
Employee	Employee and Spouse	Employee and Children	Family
\$10.37	\$18.53	\$21.20	\$29.36

High Plan Monthly Rates			
Employee	Employee and Spouse	Employee and Children	Family
\$15.12	\$27.30	\$30.01	\$42.19

Your spouse will be covered for the same Accident benefits as you. "Spouse" may include domestic partners or civil union partners as defined by your employer's plan.

If you have coverage on yourself, your natural children, stepchildren, adopted children or children for whom you are legal guardian can be covered up to age 26. Your children will be covered for the same benefit amounts as you. One premium amount covers all of your eligible children.

Sample payment amounts

If one of these events happens to you, and your claim is approved, you'd receive a benefit payment in the amount listed below. Use it however you'd like:

Accident-related treatment	Low	High
Emergency room treatment	\$150	\$200
X-ray	\$75	\$100
Physical or occupational therapy (up to six per accident)	\$45	\$55
Stitches (for lacerations, up to 2")	\$100	\$150

Critical Illness Insurance



Group Name: Oklahoma Higher Education Employees Interlocal
Group Number: 722316
Class: Full-Time Employees

There are more than just medical bills to pay after a heart attack, stroke, or other unexpected covered medical condition. Critical Illness Insurance provides a benefit payment that can help. This document includes expanded cost and benefit information for Critical Illness Insurance. As you explore, keep in mind:



No medical questions or tests are required for coverage.



Employees get an annual Wellness Benefit of \$100 for completing an eligible health screening test.



Benefit payments go directly to you. Use them however you'd like!

Critical Illness Insurance doesn't replace your medical coverage; instead, it complements it. **The benefit payments don't go out to pay for medical bills or treatments you may need, instead they come in—directly to you—to be used however you'd like.** Choose this supplemental health insurance product for added protection if one of the following covered conditions comes your way.

Critical Illness Insurance is a limited benefit policy. It is not health insurance, and does not satisfy the requirement of minimum essential coverage under the Affordable Care Act.

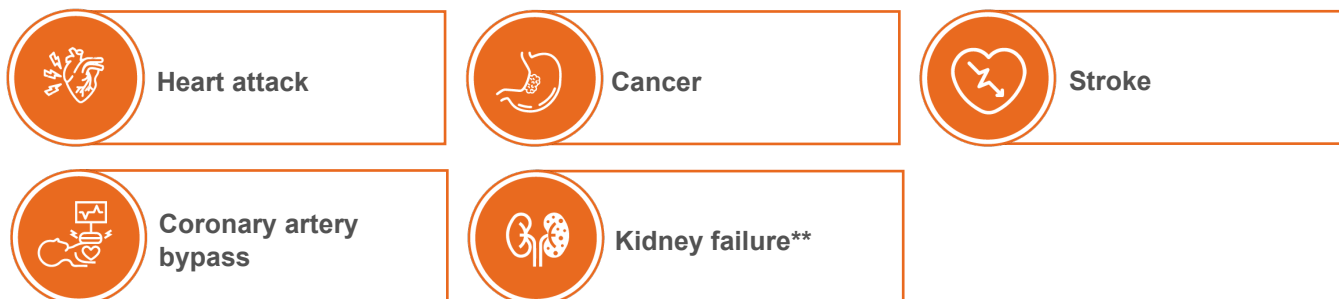
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What's covered by Critical Illness Insurance?

Critical Illness Insurance provides benefits for the covered medical conditions and diagnoses shown below. The most common conditions we pay claims for include:



If one of these common events happens on or after your coverage effective date, and your claim is approved, benefits are payable at 100% of the Critical Illness benefit amount shown above unless otherwise stated. Use your benefit payment however you'd like:

Covered Condition	% of Benefit
Heart attack*	100%
Cancer	100%
Stroke	100%
Kidney failure**	100%
Coronary artery bypass	100%

* A sudden cardiac arrest is not in itself considered a heart attack.

** Listed in the certificate of coverage as "major organ transplant," which means the irreversible failure of your heart, lung, pancreas, entire kidney or liver, or any combination thereof, determined by a physician specialized in care of the involved organ.

This is only a small preview of the benefits available to you.

What else is included?

The Critical Illness Insurance available through your employer includes the following additional benefits:

**Receive
\$100 to use
however
you'd like**

Wellness Benefit

Complete an eligible health screening test, and we'll send you a benefit payment to use however you'd like.

- Employees receive an annual benefit payment of \$100.
- Spouses receive an annual benefit payment of \$100.
- Children receive 50% of your benefit amount per child, with an annual maximum of \$200 for all children

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of insurance and riders. All coverage is subject to the terms and conditions of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. To keep coverage in force, premiums are payable up to the date of coverage termination. Critical Illness Insurance is underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. Policy form #RL-CI4-POL-16; Certificate form #RL-CI4-CERT-16; Spouse Critical Illness Rider form #RL-CI4-SPR-16; Children's Critical Illness Rider form #RL-CI4-CHR-16; Wellness Benefit Rider form #RL-CI4-WELL-16; Waiver of Premium Rider form #RL-CI4-WOP-16. Form numbers, provisions and availability may vary by state and employer's plan.

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Schedule of Benefits

The table below outlines a more detailed list of what's covered. Please note that the covered condition/diagnosis must happen on or after your coverage effective date. Benefits are payable at 100% of the Critical Illness benefit amount unless otherwise stated. For a complete description of benefits, exclusions and limitations, refer to your certificate of insurance and riders.

Covered Condition	% of Benefit
Heart attack*	100%
Cancer	100%
Stroke	100%
Major organ transplant**	100%
Coronary artery bypass	100%
Carcinoma in situ	25%
Benign brain tumor	100%
Skin cancer	10%
Bone marrow transplant	25%
Stem cell transplant	25%
Permanent paralysis	100%
Loss of sight, hearing or speech	100%
Coma	100%
Multiple sclerosis	25%
Amyotrophic lateral sclerosis (ALS)	25%
Parkinson's disease	25%
Advanced dementia, including Alzheimer's disease	100%
Huntington's disease	25%
Muscular dystrophy	25%
Infectious disease (hospitalization requirement)***	25%
Addison's disease	10%
Myasthenia gravis	25%
Systemic lupus erythematosus (SLE)	25%
Systemic sclerosis (scleroderma)	10%

* A sudden cardiac arrest is not in itself considered a heart attack.

** Major organ transplant means the irreversible failure of your heart, lung, pancreas, entire kidney or liver, or any combination thereof, determined by a physician specialized in care of the involved organ.

*** Diagnosis of a severe infectious disease by a Doctor, including COVID-19, when a diagnosis occurs on or after the group's coverage effective date; AND Confinement to a Hospital for 5 or more consecutive days, or in a transitional facility for 14 or more consecutive days.

Benefits for insured children

In addition to the covered conditions mentioned above, coverage for your insured children includes:

Covered Condition	% of Benefit
Cerebral palsy	100%
Congenital birth defects	100%
Cystic fibrosis	100%
Down syndrome	100%
Gaucher disease, type II or III	100%
Infantile Tay-Sachs	100%
Niemann-Pick disease	100%
Pompe disease	100%
Type IV glycogen storage disease	100%

Multiple benefit payments

You may receive a benefit payment up to 100% of the Critical Illness benefit amount for each different diagnosis, up to the total maximum benefit. (A definition of “different diagnosis” is provided in the certificate of coverage).

Total maximum benefit: The total maximum benefit amount is 5 times the Critical Illness benefit amount for each covered condition. Once the total maximum benefit for a covered condition has been paid, no further benefits are payable for that same covered condition.

How much does Critical Illness Insurance cost?

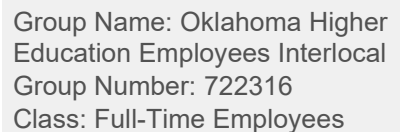
The table below shows how much you'll pay for Critical Illness Insurance. Rates are dependent on your age and amount of coverage selected.

Monthly									
Employee: \$15,000					Spouse: \$15,000				
Non-Tobacco User					Tobacco User				
Attained Age	EE Only	EE+SP	EE+CH	Family	Attained Age	EE Only	EE + SP	EE + CH	Family
Under 25	\$5.55	\$10.80	\$9.75	\$15.00	Under 25	\$6.60	\$12.90	\$10.80	\$17.10
25-29	\$6.00	\$11.40	\$10.20	\$15.60	25 - 29	\$7.05	\$13.50	\$11.25	\$17.70
30-34	\$6.90	\$13.35	\$11.10	\$17.55	30 - 34	\$9.30	\$17.55	\$13.50	\$21.75
35-39	\$9.00	\$16.80	\$13.20	\$21.00	35 - 39	\$13.20	\$23.40	\$17.40	\$27.60
40-44	\$13.35	\$22.65	\$17.55	\$26.85	40 - 44	\$18.75	\$33.00	\$22.95	\$37.20
45-49	\$17.85	\$30.30	\$22.05	\$34.50	45 - 49	\$28.50	\$46.05	\$32.70	\$50.25
50-54	\$27.00	\$43.05	\$31.20	\$47.25	50 - 54	\$40.35	\$67.65	\$44.55	\$71.85
55-59	\$32.25	\$55.35	\$36.45	\$59.55	55 - 59	\$51.45	\$91.05	\$55.65	\$95.25
60-64	\$44.85	\$76.65	\$49.05	\$80.85	60 - 64	\$59.70	\$118.05	\$63.90	\$122.25
65-69	\$50.70	\$100.35	\$54.90	\$104.55	65 - 69	\$63.15	\$125.55	\$67.35	\$129.75
70+	\$66.60	\$131.85	\$70.80	\$136.05	70 +	\$88.50	\$175.35	\$92.70	\$179.55

Monthly									
Employee: \$30,000					Spouse: \$30,000				
Non-Tobacco User					Tobacco User				
Attained Age	EE Only	EE+SP	EE+CH	Family	Attained Age	EE Only	EE + SP	EE + CH	Family
Under 25	\$11.10	\$21.60	\$19.50	\$30.00	Under 25	\$13.20	\$25.80	\$21.60	\$34.20
25-29	\$12.00	\$22.80	\$20.40	\$31.20	25 - 29	\$14.10	\$27.00	\$22.50	\$35.40
30-34	\$13.80	\$26.70	\$22.20	\$35.10	30 - 34	\$18.60	\$35.10	\$27.00	\$43.50
35-39	\$18.00	\$33.60	\$26.40	\$42.00	35 - 39	\$26.40	\$46.80	\$34.80	\$55.20
40-44	\$26.70	\$45.30	\$35.10	\$53.70	40 - 44	\$37.50	\$66.00	\$45.90	\$74.40
45-49	\$35.70	\$60.60	\$44.10	\$69.00	45 - 49	\$57.00	\$92.10	\$65.40	\$100.50
50-54	\$54.00	\$86.10	\$62.40	\$94.50	50 - 54	\$80.70	\$135.30	\$89.10	\$143.70
55-59	\$64.50	\$110.70	\$72.90	\$119.10	55 - 59	\$102.90	\$182.10	\$111.30	\$190.50
60-64	\$89.70	\$153.30	\$98.10	\$161.70	60 - 64	\$119.40	\$236.10	\$127.80	\$244.50
65-69	\$101.40	\$200.70	\$109.80	\$209.10	65 - 69	\$126.30	\$251.10	\$134.70	\$259.50
70+	\$133.20	\$263.70	\$141.60	\$272.10	70 +	\$177.00	\$350.70	\$185.40	\$359.10

A close-up photograph of a woman with curly brown hair, smiling warmly at a newborn baby she is holding. The baby is wearing a white cap and a blue patterned blanket. The background is softly blurred, showing what appears to be a hospital setting with white linens. An orange rectangular box is overlaid on the left side of the image, containing the text 'Hospital Indemnity Insurance' in white.

Hospital
Indemnity
Insurance



How does it work?

With Hospital Indemnity Insurance, you'll receive a fixed daily benefit if you have a covered stay in a hospital intensive care unit*, or rehabilitation facility that occurs on or after your coverage effective date. Benefit amounts are listed below and depend on the type of facility and number of days of confinement. Any combination of facility confinement and admission benefits payable includes a limit, please see your certificate for further confirmation. And for a complete description of your available benefits, exclusions and limitations, see your certificate of insurance and any riders. For a list of standard exclusions and limitations, go to the end of this document.

When your stay begins

When you are admitted to a covered medical facility, you become eligible for an admission benefit for the first day of confinement. This benefit is payable once per confinement, up to a maximum of 8 admission(s) per calendar year:

Type of Admission	Benefit Amount Low Plan	Benefit Amount High Plan
Hospital Admission	\$600	\$1,200
Intensive Care Unit* Admission	\$1,200	\$2,400

As your stay continues

Beginning on Day 2 of your confinement, for each day that you have a stay in a covered facility, you'll be eligible for a fixed daily benefit payment. The benefit amount and maximum number of days per confinement varies by facility:

Type of Facility	Daily Benefit Low Plan	Daily Benefit High Plan
Hospital (10 day maximum per confinement)	\$100	\$200
Intensive Care Unit* (10 day maximum per confinement)	\$200	\$400
Rehabilitation Facility (10 day maximum per confinement)	\$50	\$100

*An Intensive Care Unit may be referred to as a "Critical Care Unit" in your certificate of coverage. An ICU Transitional Care Unit may be referred to as a "CCU Step-Down Unit" in your policy documentation. Refer to your policy documentation for complete definitions and descriptions of each facility type.

Exclusions and limitations

The standard exclusions and limitations are listed below. For a complete description of your available benefits, exclusions and limitations, see your certificate of insurance and any riders. (These may vary by state and/or your employer's plan.)

Benefits are not payable for any loss caused in whole or directly by any of the following:

- Participation or attempt to participate in a felony or illegal activity.
- Operation of a motorized vehicle while intoxicated. Intoxication means the covered person's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.
- Suicide, attempted suicide or any intentionally self-inflicted injury, while sane or insane.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism).
- Loss that occurs while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Misuse of alcohol or taking of drugs, other than under the direction of a doctor. Exception: This exclusion does not apply to a confinement in an eligible hospital or rehabilitation facility for the purpose of treatment for alcoholism or drug addiction.
- Elective surgery, except when required for appropriate care as determined by a doctor as a result of the covered person's injury or sickness.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

The definition of "hospital" does not include an institution or any part of an institution used as: a hospice unit, including any bed designated as a hospice or swing bed; a convalescent home; a rest or nursing facility; a free-standing surgical center; an extended care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care for the aged. "Critical care unit" and "rehabilitation facility" is also defined in the certificate.

*See the certificate and any riders for a complete description of benefits, exclusions and limitations.

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of insurance and riders. All coverage is subject to the terms and conditions of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. To keep coverage in force, premiums are payable up to the date of coverage termination. Hospital Confinement Indemnity Insurance is underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. Policy form RL-HI2-POL-18; Certificate form RL-HI2-CERT-20; Spouse Hospital Confinement Indemnity Rider form RL-HI2-SPR-18; Children's Hospital Confinement Indemnity Rider form RL-HI2-CHR-18; Continuation of Insurance Rider form RL-HI2-CNT-18; Diagnostic Test Benefit Rider form RL-HI2-DGR-18; Wellness Benefit Rider form RL-HI2-WELL-18; Accident Benefit Rider form RL-HI2-ACD-18; Critical Illness Rider form RL-HI2-CIR-18; and Waiver of Premium Rider form RL-HI2-WOP-18. Form numbers, provisions and availability may vary by state and by your employer's plan.

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HI2 Only

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How much does Hospital Indemnity Insurance cost?

This table shows your rates for Hospital Indemnity Insurance.

Low Plan	Daily Benefit	Monthly Rate
Employee	\$100	\$8.96
Employee + Spouse	\$100	\$17.83
Employee + Children	\$100	\$14.59
Employee + Family	\$100	\$23.46

High Plan	Daily Benefit	Monthly Rate
Employee	\$200	\$17.59
Employee + Spouse	\$200	\$35.32
Employee + Children	\$200	\$28.84
Employee + Family	\$200	\$46.57

CONTACT INFORMATION



BENEFIT	ADMINISTRATOR	PHONE	WEBSITE/EMAIL
Medical	BCBSOK	800.672.2567	www.bcbsok.com/okheeji
Pharmacy	Prime Therapeutics	855.457.0007	www.MyPrime.com
Dental	Delta Dental Oklahoma	800.522.0188 or 405.607.2100	www.deltadentalok.org or customerservice@deltadentalok.org
Vision	Vision Service Plan	800.877.7195	www.vsp.com
Life & AD&D and Voluntary Life AD&D	Standard Insurance Company	888.937.4783	www.standard.com
Disability Income Benefits (LTD, STD)	Standard Insurance Company	888.937.4783	www.standard.com
FSA/HSA	Flexible Benefit Administrators	800.437.3539	www.flex-admin.com
COBRA Administration	Flexible Benefit Administrators	800.437.3539	www.flex-admin.com
Retiree Billing	Flexible Benefit Administrators	800.437.3539	www.flex-admin.com
Oklahoma Teacher's Retirement		877.738.6365	www.ok.gov/trs or mail@trs.ok.gov
Enrollment Platform	Empyrean	888.965.4334	MyOKHEEIBenefits.com
Accident, Critical Illness, Hospital Indemnity	VOYA	877.236.7564	Voya.com/claims

This benefit summary prepared by



Gallagher

Insurance

Risk Management

Consulting

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.