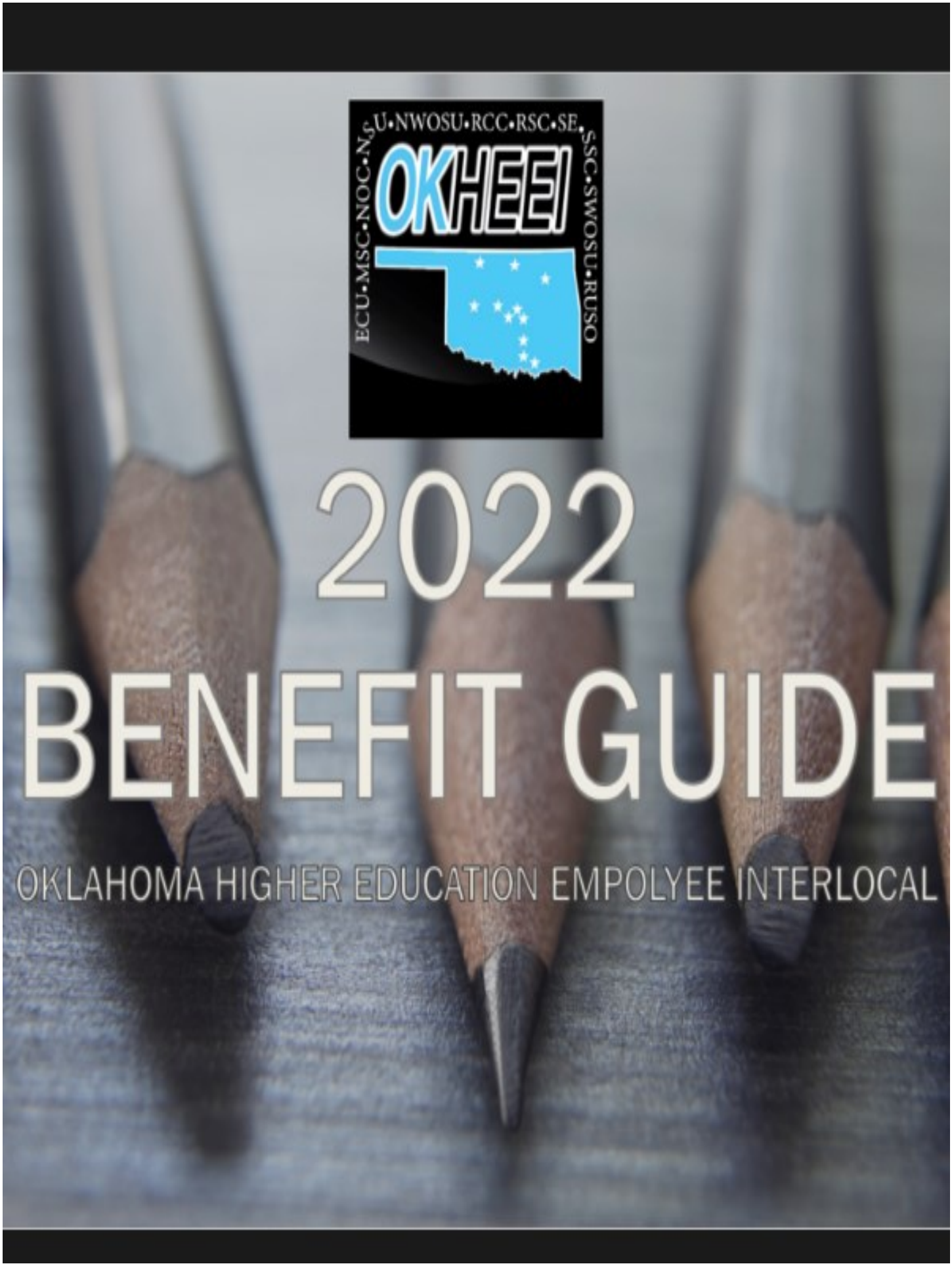
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OKHEEI
2022
BENEFIT GUIDE
OKLAHOMA HIGHER EDUCATION EMPOLYEE INTERLOCAL

MESSAGE TO OKHEEI EMPLOYEES:

We are pleased to present our Employee Benefits Guide for the 2022 plan year. OKHEEI is committed to providing a healthy environment including health care insurance for employees and dependents. The continual rising cost of health care has added challenges for consumers, employers, and the government. As we enter a new plan year, you'll see OKHEEI remains dedicated to offering an array of choices so you can balance cost and coverage in the way that best suits your needs and those of your family.

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

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

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

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

EMPLOYEE BENEFITS OPEN ENROLLMET

Who is Eligible?

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

Northern Oklahoma College—Enid Campus

- 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. The employee must prove eligibility of insurance by providing the following acceptable documentation:

Spouse:

Documentation must support the current spousal relationship and include the date of marriage. Submit one of the following documents:

- Copy of presently valid legal or religious marriage certificate, which must include the date of marriage.
- Copy of presently valid and notarized common law marriage affidavit (see HR/benefits for a copy of the affidavit).

Dependent Children:

Documentation must support the parental relationship and provide the child's date of birth. Submit any one (or a combination) of the following documents:

- Copy of the child's legal or hospital birth certificate naming you or your spouse as the child's parent.
- Copy of a final court order (divorce decree/custody agreement) naming you or your spouse as the child's parent. All documents must include the following information: names of the child and parent, official signature and/or court seal/stamp.
- Copy of legal adoption papers issued by the courts naming you or your spouse as the adoptive parent. All documents must include the following information: names of the child and parent, official signature and/or court seal/stamp.

- Copy of legal guardianship papers issued by the courts naming you or your spouse as the child's guardian. All documents must include the following information: names of the child and guardian, official signature and/or court seal/stamp.
- Copy of an order naming you or your spouse as the child's foster parent. All documents must include the following information: names of the child and foster parent, official signature and/or court seal/stamp.
- Copy of a Qualified Medical Child Support Order (QMCSO) showing you're required to provide medical coverage for the child. Documentation must state your current employer's name and include the names of the child and parent.

How to Make Changes?

1. During the open and new member enrollment period, you can add or drop dependents from your health care coverage without a qualifying event. The enrollment period is the time to make sure all of your eligible dependents are enrolled and that Human Resources has all of the correct information about your dependents on file.

   The health care plan options you select during the enrollment period will remain in effect during the calendar year. In order to change benefit elections outside of the enrollment period, the employee must have:

2. Experience an Applicable Qualifying Event, as defined by the Internal Revenue Service (IRS). Changes based on financial reasons alone are not allowed under the current IRS regulations.

   AND

   The request for a change of benefits must be made within 31 days of the Applicable Qualifying Event. Within the context of changing benefits, "Applicable" refers to a change that is directly related to the individual experiencing the qualifying event.

   A qualifying event includes:

   - A birth or adoption
   - Marriage, divorce or legal separation
   - Death
   - Child loses eligibility because of age
   - Employee's spouse gains or loses coverage through employment
   - Significant change in the financial terms of health benefits provided through a spouse's employer or another carrier

Except for coverage of a newborn or adopted child, all other changes in coverage begin the first day of the month following the qualifying event. Coverage for the newborn is effective on the child's date of birth. Coverage for an adopted child is effective on the date of placement. In both instances, the employee must initiate and complete the appropriate paperwork within 30 days.

Changes in provider networks (for example, your doctor leaving the network) are not considered acceptable reasons for you to be able to change your product election outside of the enrollment period.

CHOOSING A PLAN

Benefit design – There are notable differences between the plans which impact the coverage and the out-of-pocket costs you will be responsible for when utilizing your benefits.

All four plans promote wellness and offer preventive care and have unlimited lifetime maximums. Plans A, B, C and F have different office visit copays, deductibles, coinsurance and out-of-pocket maximums.

Premium cost – It's important to compare the rates of each plan, while keeping in mind the benefits that come with each plan.

Provider access – The Blue Choice PPO network is Blue Cross Blue Shield of Oklahoma's largest network in the state. The Blue Preferred PPO network is BCBSOK's second largest network. BlueOptions offers a unique tiered structure that allows you the flexibility to see providers in the Blue Choice PPO, Blue Preferred PPO, or Blue Traditional networks. However, you will have the lowest out-of-pocket costs when you see providers in the Blue Preferred PPO network. You can verify that your current physicians are in the network for the plan you are considering by checking the provider listing on www.bcbsok.com.

All PPO members have nationwide access to contracting providers through the BlueCard® program when you or your covered family members live, work, or travel anywhere in the country. Additionally, when traveling outside the United States, PPO members have access to contracting providers in more than 200 countries through BCBS Global Core formerly BlueCard WorldWide®.

Flexibility – All four plans and their networks give you flexibility since you have coverage for both in-network and out-of-network providers. Keep in mind that you will always receive your highest level of benefits and lowest out-of-pocket costs when choosing an in- network provider. (For BlueOptions, you will have the lowest out-of-pocket costs when you see providers in the Blue Preferred PPO network.)

Southwestern Oklahoma Sate University

Murray State College

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PRESCRIPTION DRUG BENEFITS

Plans A-C have the same prescription drug plan. Plan F is a High Deductible Health Plan with a Health Savings Account and, due to IRS regulations, this plan cannot have any prescription copays.

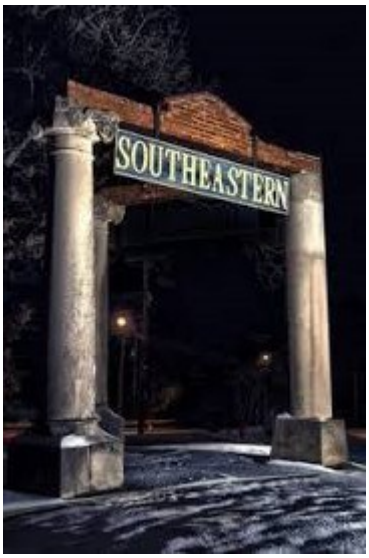
In order to provide greater discounts, Blue Cross and Blue Shield of Oklahoma has negotiated discounts with drug companies. A list of prescription drugs, both generic and brand name, compose the drug list. The drug list is divided into three tiers: tier 1 includes generic drugs, tier 2 includes preferred brand drugs and tier 3 includes non-preferred brand drugs. Visit **www.myprime.com** to view the drug list and associated tiers. Specialty drugs are handled by a separate drug program administered through Prime.

Blue Cross and Blue Shield's national preferred pharmacy network includes most national chains and independent pharmacies across the country. The Pharmacies participating in the preferred pharmacy network are below:

- Walgreens
- Walmart (Including Sam's Club Pharmacy)
- Pharmacy Providers of Oklahoma, Inc. (PPOk - a group of independent pharmacies)
- Access Health (a group of independent pharmacies)

Please note CVS and Target pharmacies are no longer included in the preferred pharmacy network and are considered non-preferred pharmacies. If you fill a prescription at a non-preferred pharmacy, you may pay a higher copay or coinsurance.

When you fill your prescription drugs at a retail pharmacy, your copayment depends on the tier in which the drug has been classified. You will pay the cost up to the tier copay for a 30 day supply limit (120 pill maximum) or 90 day quantity limit (360 pill maximum) per copay, whichever is less. Blue Cross and Blue Shield also offers a mail order pharmacy program and an extended supply network that may provide discounts for maintenance drugs. For more information about PrimeMail or to view a list of maintenance drugs, visit **www.myprime.com.**



Southeastern Oklahoma State University

AVAILABLE MEDICAL PLANS

With OKHEEI, you may select one of four plans:

- Plan A & C (Blue Preferred PPO)
- Plan B (BlueOptions PPO)
- Plan F (Blue Choice PPO)

Redlands Community College

You will want to consider the plan best suited for you and your family. There are important differences between the plans that should be considered. Details of the benefits and plans are listed on the following pages for easy comparison. You have access to an extensive network of providers and hospitals throughout the country, including therapists, chiropractors, behavioral health professionals and other specialists.

You are not required to select a Primary Care Physician and referrals are not required. You can select any covered provider for care within the various Blue Cross PPO networks or outside the network. When you receive care from in-network providers, you receive the highest level of benefits. When you receive care from out-of-network providers, you not only receive a lower level of benefits, but you may also be subject to out-of-pocket costs for amounts the provider charges that are above the maximum allowable charge.

Finding out which network your providers are located in is easy! Simply visit www.bcbsok.com and click on your plan type in the Find a Doctor section. You can search for a doctor by name, location, network, or specialty, such as dermatology or cardiology.

Blue Preferred PPO

The Blue Preferred PPO network is a smaller network however it provides the biggest discount and pays your benefits at the highest level, which means you will have the lowest out-of-pocket costs when you use providers in the Blue Preferred PPO network.

Blue Choice PPO

Blue Choice PPO is the largest network and has negotiated discounts with medical providers to reduce the cost of health care. The discount is applied before there is any payment for services from you or from BCBSOK.

Blue Options PPO

BlueOptions PPO gives you the flexibility to choose your provider and network at the time of service. Your choice of health care providers will affect the level of health care benefits (including copayment and coinsurance amounts) – based on the network your provider is in. With the BlueOptions plan, you can choose from different networks each time you need health care.

- The Blue Preferred PPO network provides the biggest discount and pays your benefits at the highest level, which means you will have the lowest out-of-pocket costs when you use providers in the Blue Preferred PPO network.

- The Blue ChoicePPO network will pay your benefits at the second highest level, although some aspects of coverage are the same with the Blue Preferred PPO and Blue Choice PPO networks.

All plans offered also give you the flexibility to choose a non-PPO, “out-of-network” provider with whom BCBSOK does not have a contract. Benefits provided by "out-of-network" providers are less robust and you will usually be required to pay more out of pocket for the services.

- The Blue Traditional network will pay your benefits at the third highest level
- If you see out-of-network providers, you will receive no discounts and your benefits will be paid at the lowest allowed amount.

BLUE CROSS BLUE SHIELD FREQUENTLY ASKED QUESTIONS

How do I find a doctor in the Blue Preferred PPO or Blue Choice PPO network?

Go www.bcbsok.com and use the provider directory, or call BCBSOK customer service.

How do my benefits work when I am out-of-state?

Members have nationwide access to contracting providers through the BlueCard Program when you or your covered family members live, work, or travel anywhere in the country. Your benefits will generally be paid at the Blue Choice PPO benefit level, since Blue Preferred PPO providers are typically located in Oklahoma. You can search for providers in the online provider directory at **www.bcbsok.com**.

Do I need a referral from my doctor to see a specialist?

No. You can see any doctor at any time without a referral. If you see a specialist who is part of the Blue Preferred PPO network, your benefits will be paid at the highest level and your out-of-pocket costs will be lowest.

East Central University

Can my doctor be a part of both networks?

Be sure to ask your provider which network(s) they are in. They may be in more than one network. If that is the case, your benefits will be applied at the highest network level. For example, your doctor is in the Blue Preferred PPO and Blue Choice PPO network. If you visit your doctor, your benefits will be applied for the Blue Preferred PPO network, which means that you will have the lowest out-of-pocket expense.

Can I see providers in both the Blue Preferred PPO and Blue Choice PPO networks?

Yes, with BlueOptions, you have the freedom to see any doctor you choose at any time. You can choose different networks for different health care services and/or for different members of your family. For example, you can see a physician in the Blue Preferred PPO network while your spouse and children see a physician in the Blue Choice PPO network. Your benefits are determined at the point of service, which means that your copayment and out-of-pocket amounts depend on which network you choose.

Keep in mind that out-of-pocket amounts vary depending on the network you choose and while they do cross apply, you may have more to satisfy if you use a different network. This means it is possible that you may have satisfied your Blue Preferred PPO out-of-pocket, but still have more to satisfy for the Blue Choice PPO network.

Can I see a doctor or use a service that is out-of-network?

Yes. However, the amount your plan pays for covered services is based on the allowed amount described in your Certificate of Benefits. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

WHAT'S NOT COVERED

Your plan options do not cover all health care expenses including exclusions and limitations. You should refer to plan-specific documents to determine which health care services are covered and to what extent.

The following is a partial list of services and supplies that are generally not covered.

- Charges above the allowed amount for out-of-network services
- Services that BCBSOK determines are experimental/investigational
- Custodial care such as sitters' or homemakers' services, care in a place that serves you primarily as a residence when you do not require skilled nursing, or for rest cures
- Reverse sterilization
- Compounded medications
- Acupuncture, whether for medical or anesthesia services

2022 BlueCross BlueShield Medical Plans

	Plan A	Plan B	Plan C	Plan F
Network	**Preferred**	**Preferred & Choice**	**Preferred**	**Choice**
General Plan Information				**HSA ELIGIBLE Embedded Deductible**
Calendar Year Deductible (CYD)	$750 Ind / $2250 Family	$1250 Ind / $3750 Family	$1500 Ind / $4000 Family	$3000 Ind / $6000 Family
Calendar Year Out of Pocket Max Includes deductible and pharmacy/medical copays	$3000 Ind / $9000 Family	$3500 Ind / $10500 Family BP $4000 Ind / $12000 Family BC	$4000 Ind /$12000 Family	$6650 Ind / $13000 Family
Member Coinsurance	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD
Primary Office Visit Copay Specialty Office Visit Copay	$20 Copay $40 Copay	$25 BP/$35 BC Copay $40 BP/$50 BC Copay	$35 Copay $50 Copay	20% after CYD
Preventive Care Visits (Well Baby, Adult/Child Immunizations, Routine Health Screenings)	No Charge	No Charge	No Charge	No Charge
Diagnostics Lab/X-Ray	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD
In-Patient Hospitalization	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD
Out-Patient Surgery	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD
Allergy Treatment/Testing	20% after CYD	20% after CYD BP 30% after CYD BC	20% after CYD	20% after CYD
Emergency Room Urgent Care	$100 Copay; then 20% after CYD (waived if admitted) $40 Copay	$150 Copay, then 20%/30% after CYD (waived if admitted) $40 BP / $50 BC Copay	$150 Copay; then 20% after CYD (waived if admitted) $50 Copay	20% after CYD
Health Risk Assessment	HA deductible credit applies to 2022 plan year and must be completed between 01/01/2022 and 12/31/2022 HA must be completed and credited prior to claims payment. No retroactive claim adjustments will be allowed.			HA $200 deductible Credit. Same rules as Plans A, B & C.
Mental Health/Substance Abuse				
In-Patient	20% after CYD	20%/30% after CYD	20% after CYD	20% after CYD
Out-Patient	$20 Office Visit Copay 20% after CYD for other services	$25 BP / $35 BC Copay 20%/30% after CYD for other services	$35 Office Visit Copay 20% after CYD for other services	20% after CYD

2022 BlueCross BlueShield Medical Plans

	Plan A	Plan B	Plan C	Plan F
Network	**Preferred**	**Preferred** & Choice	**Preferred**	Choice
Rehabilitation Services: Outpatient: Separate 60 visit limits per benefit period for speech and occupational therapies.	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Habilitation Services: Inpatient: 30 day limit per benefit period. PA required.	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Physical and chiropractic Therapy (combined limited to 60 visits per CY)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Durable Medical Equipment (DME)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Skilled Nursing Facility (100 days per CY)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Home Health Care (100 days per CY)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Hospice (PA Required)	20% after CYD	20% / 30% after CYD	20% after CYD	20% after CYD
Pharmacy				
Generic Drugs	Retail: 25% of allowed amount; $25 Min / $50 Max Mail Order: 25% of allowed amount; $75 Min / $150 Max			20% after CYD
Preferred Brand Name Drugs	Retail: 25% of allowed amount; $25 Min / $50 Max Mail Order: 25% of allowed amount; $75 Min / $150 Max			20% after CYD
Non-Preferred Brand Name Drugs	Retail: 50% of allowed amount; $50 Min / $100 Max Mail Order: 50% of allowed amount; $150 Min / $300 Max			20% after CYD
Specialty Drugs	50% of allowed amount; $50 Min / $100 Max (Limited to 30 day supply Must be ordered through Prime Therapeutics (no mail order available)			20% after CYD
	30 Day Supply Limit retail. Up to 90 Day Supply of Maintenance drugs. Up to 90 Day Supply Mail, Network Only			

BlueCross BlueShield of Oklahoma

Virtual Visits: Speak with a doctor—anytime, anywhere

Getting sick after hours or on weekends used to mean a long, costly trip to the emergency room or urgent care center. But with your virtual visits benefit, provided by Blue Cross and Blue Shield of Oklahoma (BCBSOK) and powered by MDLIVD, the doctor is in 24/7/365. And you don't have to leave the comfort of your own home.

Virtual visits allows you to consult a doctor for non-emergency situations by phone, mobile app or online video anytime, anywhere. Speak to a doctor or schedule an appointment at a time that works best for you.

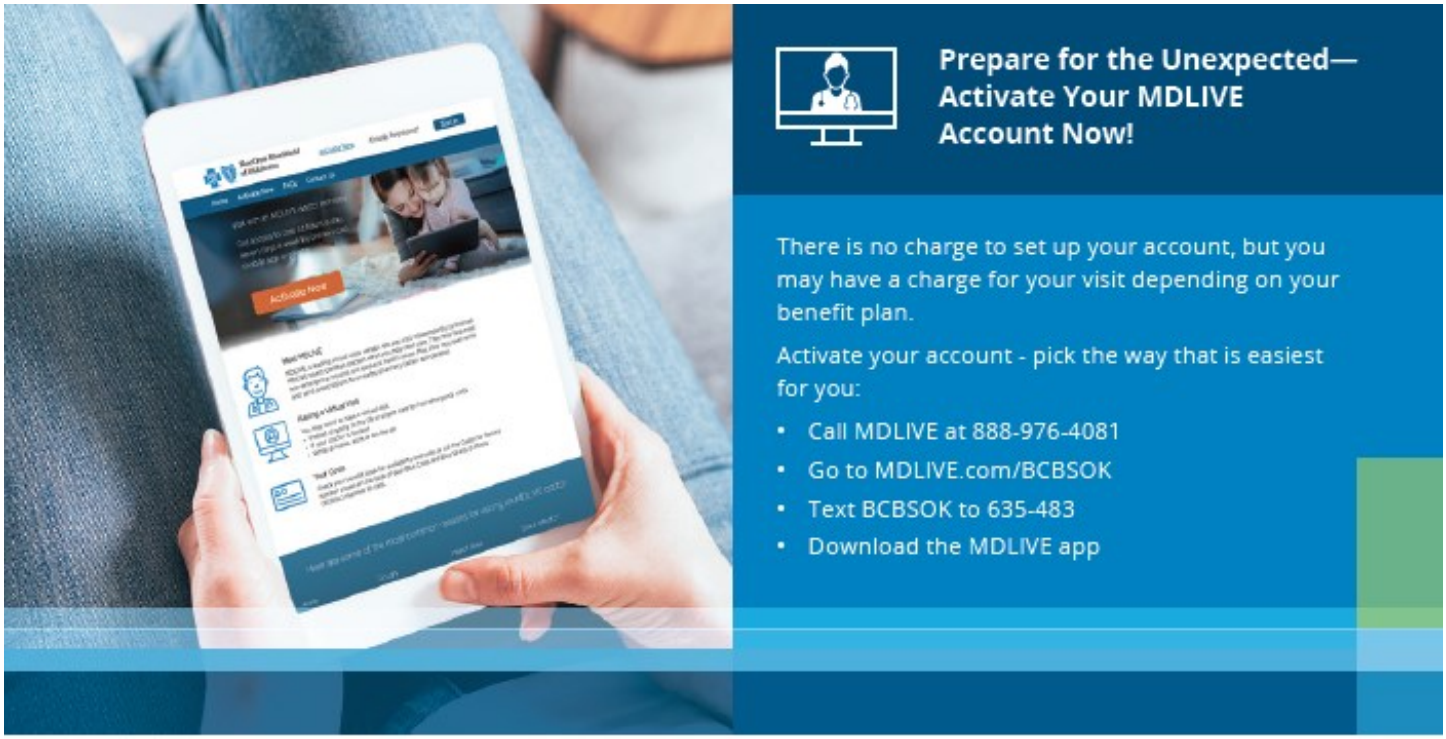
Powered by MDLIVE

Why virtual visits?

- **24/7 access to an independently contracted, board-certified MDLIVE doctor**
- **Access via phone, online video or mobile app from almost anywhere**
- **Average wait time of less than 20 minutes**
- **If needed, get a prescription sent to your local pharmacy**

MDLIVE doctors can treat a variety of non-emergency conditions, including:

- **Allergies**
- **Asthma**
- **Cold/flue**
- **Ear infections (age 12+)**
- **Fever (age 3+)**
- **Headache**
- **Insect bites**
- **Nausea**
- **Pink Eye**
- **Rash**
- **Sinus infections**



Virtual visits doctors may also send an e-prescription to your local pharmacy if necessary.

Virtual visits may not be available on all plans. Virtual visits are subject to the terms and conditions of your benefit plan, including benefits, limitations and exclusions. Non-emergency medical service in Idaho, Montana, and New Mexico is limited to interactive audio/video (video only). Non-emergency medical service in Arkansas is limited to interactive audio/video (video only) for initial consultation. Service availability depends on location at the time of consultation.

MDLIVE, a separate company, operates and administers the virtual visit program for Blue Cross and Blue Shield of Oklahoma and is solely responsible for its operations and that of its contracted providers.

BlueCross BlueShield of Oklahoma

2022 Wellness Programs

Wondr is a clinically-proven online program that taches participants how to lose weight and improve their health without dieting. There are no points to count or food groups to avoid. Instead, it's a mindful-eating program that teaches members how they can lose weight while still eating all foods. You can sign up any time during the year. Sign up today at: www.wondrhealth.com/okheei or download the mobile app.

Livongo is another program that is available to all employees at no charge. This program is developed for diabetics and blook pressure management, and it has combined the latest technology with coaching, creating personalized experiences and using data and clinical science to deliver positive health outcome and lower costs. The program includes digital and live coaching though a meter, phone and the Livongo mobile app. To enroll, go to join.livongo.com/OKHEALTH/hi or call 800-945-4355. Use Registration code OKHEALTH. When you are part of the program, you will receive free strips and lancets as needed at no charge.

*Better health, gut firs*t. Did you know many chronic and inflammatory conditions are tied to the digestive system? GIThrive® by Vivante Health is the digital program that brings together, in one easy-to-use app, everything you need for better gut health: personal nutrition, cutting-edge science, gut microbiome testing, 24/7 human Care Team support, smart food diaries, and even expert support for managing a chronic GI condition. To enroll in GIThrive, visit https://welcome.mygithrive.com/okheei or call 1.833.33MYGUT (1.833.336.9488)

We are so excited to offer another wellness program called Hinge Health which is designed to help members with musculoskeletal pain management. Benefits include a personalized exercise therapy phase of 12 weeks followed by an ongoing program that builds on learned behaviors. The program includes a tablet that is pre-installed with the Hinge Health app, wearable motion sensors, charging units and a carrying case. Check it out at www.hingehealth.com.

Go to **MyOKHEEIBenefits.com** to get started and Register to begin your enrollment for 2022.

Click on *REGISTER*. Enter *First, Last Name; Date of Birth and Social Security or Employee ID* - click *NEXT*

Add a new User ID (work email address for example)

Create a new password with a least: eight characters, one letter, one number, one symbol (i.e. *&+#$)

Set a security question and answer (at least six characters in case you forget your password) - click *NEXT*

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

Full names; Dates of Birth; and Social Security Numbers

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

Get Ready to Enroll for Your Benefits!

When you log in you'll see a pending event screen—Click *Continue* and Begin on *My Information*. Follow the prompts in each step. When finished, do not forget to **SUBMIT** or no elections will be saved.

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)

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 *(Endodonics, 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.

Get access to the best in eye care and eyewear with Oklahoma Higher Education Employee Interlocal Group and VSP® Vision Care.

Why enroll in VSP? As a member, you'll receive access to care from great eye doctors, quality eyewear, and the affordability you deserve, all at low out-of-pocket costs.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and low out-of-pocket costs.
- **High Quality Vision Care.** You'll get great care from a VSP network doctor, including a WellVision Exam℠—a comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—with the largest national network of private-practice doctors, plus participating retail chains, it's easy to find the in-network doctor who's right for you.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Enroll in VSP today.
You'll be glad you did.
Contact us. 800.877-7195
vsp.com

Using your VSP benefit is easy.

- **Create an account at vsp.com**. Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** Visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe, CALVIN KLEIN, Cole Haan, Flexon℠, Lacoste, Nike, Nine West, and more.[1] Visit **vsp.com** to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.[2] Prefer to shop online? Check out all of the brands at **eyeconic.com**℠, VSP's preferred online eyewear store.

Your VSP Vision Benefits Summary

VSP Coverage Effective Date: 01/01/2022

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 — **VSP Provider Network: VSP Choice**

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$10
Prescription Glasses		$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
Lenses	• Single vision, lined bifocal and lines trifocal lenses • Polycarbonate lenses for dependent children • Every calendar year	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
Contacts (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

Enhanced Option — **VSP Provider Network: VSP Choice**

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every calendar year	$10
Prescription Glasses		$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
Lenses	• Single vision, lined bifocal and lines trifocal lenses • Polycarbonate lenses for dependent children • Every calendar year	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
Contacts (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
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.	

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.

LIFE/AD&D INSURANCE

Basic Life/AD&D

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 Offers 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	35% at age 65; By 50% at age 70; By 65% at age 75

Northwestern Oklahoma State University

LIFE/AD&D INSURANCE

Additional Life and AD&D

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	• You must be insured for Basic Life through The Standard • You must be an active employee of an employer covered through OKHEEI • Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible • You may be insured as both an employee and a dependent
Dependent	• Spouse means a person to who you are legally married • Child means your child from live birth through age 25 • Your child may be insured by more than on employee • Your spouse or children must not be full-time member(s) of the armed forces
Premium	• 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 eof 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 loves 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.

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, 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.

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, Evidence of Insurability will be waived in you apply for up to 2 increments of $5,000 for a max benefit of $1,000. However, Evidence Of Insurability is required for any amount that exceeds $10,000.

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.

LIFE/AD&D INSURANCE

Additional Life and AD&D

Employee Rates (Monthly AD&D rate of $0.015 per $1,000 of AD&D benefit has been included in each of the below rates)

If you elect Additional Life with AD&D insurance, your monthly rate for this plan is indicated in the table below. Premiums for this coverage will be deducted directly from your paycheck.

Employee's Age (as of 1st day of the month following change in age)	**Rate*** (per $10,000 of Total Coverage
<30	$0.75
30-34	$0.95
35-39	$1.05
40-44	$1.45
45-49	$2.25
50-54	$3.35
55-59	$5.55
60-64	$6.85
65-69	$12.85
70-99	$20.75

To calculate your premium:

1. Amount Elected: Write this amount on the Additional Life with AD&D requested amount line on your Enrollment and Change Form. Line 1: _____

2. Line 1 divided by $10,000 = Line 2 Line 2: _____

3. Select your rate from the rate table and enter on Line 3 Line 3: _____

4. Line 2 multiplied by Line 3 - Your monthly cost Line 4: _____

Spouse Rates (Monthly AD&D rate of $0.015 per $1,000 of AD&D benefit has been included in each of the below rates)

If you elect Dependents Life with AD&D insurance for your spouse, your monthly rate for this plan is indicated in the table below. Premiums for this coverage will be deducted directly from your paycheck.

Employee's Age (as of 1st day of the month following change in age)	**Rate*** (per $5,000 of Total Coverage
<30	$0.38
30-34	$0.48
35-39	$0.53
40-44	$0.725
45-49	$1.13
50-54	$1.68
55-59	$2.78
60-64	$3.43
65-69	$6.43
70-99	$10.375

To calculate your premium:

1. Amount Elected: Write this amount on the Additional Life with AD&D requested amount line on your Enrollment and Change Form. Line 1: _____

2. Line 1 divided by $5,000 = Line 2 Line 2: _____

3. Select your rate from the rate table and enter on Line 3 Line 3: _____

4. Line 2 multiplied by Line 3 - Your monthly cost Line 4: _____

Child Rates (Monthly AD&D rate of $0.015 per $1,000 of AD&D benefit has been included in each of the below rates)

If you elect Dependents Life with AD&D insurance for your eligible child(ren), your monthly rate for this coverage is $2.30 per $10,000 of benefit regardless of the number of eligible children covered. Premiums for this coverage will be deducted directly from your paycheck.

DISABILITY INSURANCE

Long Term Disability

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

If you elect to buy-up your coverage at any time other than initial eligibility, you will be required to submit proof of health which is subject to approval by 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)	$3.70	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)	

DISABILITY INSURANCE

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

Employee FAQ:

Health Savings Accounts

What is a health savings account (HSA)?

An HSA is a tax-advantaged person savings account that can be used to pay for medical, dental, vision and other qualified expenses now or later in life. To contribute to an HSA you must be enrolled in a qualified high-deductible health plan (HDHP) and your contributions are limited annually. The funds can even be invested, making it a great addition to your retirement portfolio.

Why should I participate in an HSA?

Funds contributed to an HSA are triple-tax-advantaged.

1. **Money goes in tax-free**. Most employers offer a payroll deduction through a Section 125 Cafeteria Plan, allowing you to make contributions to your HSA on a pre-tax basis. The contribution is deposited I not your HSA prior to taxes being applied to your paycheck, making your savings immediate. You can also contribute to your HSA post-tax and recognize the same tax savings by claiming the deduction when filing your annual taxes.
2. **Money comes out tax-free**. Eligible healthcare purchases can be made tax-free when you use your HSA. Purchases can be made directly from your HSA account, either by using your benefits debit card, ACH, online bill-pay, or check—or, you can pay out-of-pocket and then reimburse yourself from your HSA.
3. **Earn interest, tax-free**. The interest on HSA funds grows on a tax-free basis. And, unlike most savings accounts, interest earned on an HSA is not considered taxable income when the funds are used for eligible medical expenses.

What expenses are eligible for reimbursement?

Health plan co-pays, deductibles, co-insurance, vision, dental care, and certain medical supplies are covered. The IRS provides specific guidance regarding eligible expenses. (See IRS Publication 502).

Am I eligible to participate?

In order to contribute, you must be enrolled in a qualified HDHP, not covered under a secondary health insurance plan, not enrolled in Medicare, and not another person's dependent. There are no eligibility requirements to spend previously-contributed HSA funds.

What is a high-deductible health plan?

A HDHP is a health insurance plan with deductible amounts that are greater than $1,400 for individual or $2,800 for family coverage and have an out-of-pocket maximum that does not exceed $7,000 for individual or $14,000 for family coverage for 2021.

How do I contribute money to my HSA?

Payroll deduction is most likely offered by your employer. Your annual contribution will be divided into equal amounts and deducted from your payroll before taxes. Direct contributions can also be made from your personal checking account and can be deducted on your personal income tax return.

Can I change my contributions to my HSA during the year?

Yes. You will not be subject to the change-in-status rules applicable to other benefit accounts. You will e able to make changes in your contributions by providing the applicable notice of change provided by your employer.

How much can I contribute to my HSA?

Contributions can be made by the eligible employee, their employer, or any other individual. Annual contributions from all sources may not exceed $3,650 for singles or $7,300 for families in 2022. Individuals aged 55 and over may make an additional $1,000 catch-up contribution.

Do I have to spend all my contributions by the end of the plan year?

No. HSA money is your to keep. Unlike a flexible spending account (FSA), unused money in your HSA isn't forfeited at the end of the year, it continues to grow, tax-deferred.

What happens if my employment is terminated?

HSAs are portable and move with you if you change employment. Your HSA belongs to you, not your employer, just like your personal checking account.

How do I access the funds in my HSA?

Your HSA is similar to a checking account. You are responsible for ensuring the money is spent on qualified purchases only and maintaining records to withstand IRS scrutiny. Payments can be made via check, ACH, online bill-pay, or debit card, depending on what is available to you.

When must contributions be made to an HSA for a taxable year?

Contributions for the taxable year can be made in one or more payments at any time after the year has begun and prior to the individual's deadline (without extensions) for filing the eligible individual's federal income tax return for that year. For most taxpayers, the deadline is April 15 of the year following the year for which contributions are made.

What happens to the money in my HSA if I no longer have HDHP coverage?

Once you discontinue coverage under an HDHP and/or get secondary health insurance coverage that disqualifies you from an HSA, you can no longer make contributions to your HSA. However, since you own the HSA, you can continue to use the remaining funds for future healthcare expenses.

Is tax reporting required for an HSA?

Yes. IRS form 8889 must be completed with your tax return each year to report total deposits and withdrawals from your account. You do not have to itemize to complete this form.

Ca I still deduct healthcare expenses on my tax return?

Yes, but not the same expenses for which you have already been reimbursed from you HSA.

Can I withdraw the money for a non-healthcare purchases?

Yes. If you withdraw the money for an unqualified expense prior to age 65, you'll pay a 20% excise tax. You can withdraw the money for any reason without penalty after age 65, but are subject to applicable income taxes.

Can I roll over or transfer funded from my HSA or Medical Savings Account (or Archer MSA) into an HSA?

Yes. Pre-existing HSA funs or MSA monies may be rolled into an HSA and will continue their tax-free status.

Can I control how the funs are invested?

Yes. Once your HSA cash account balance reaches the minimum amount required by the custodian, you can transfer funds to an HSA investment account. You can choose from a selection of mutual funds and setup and allocation model for future transfers like you would for a 401k plan.

Can I transfer funds between the cash and investment accounts?

Yes. You can transfer money between your HSA cash and HSA investment account at any time.

For more information, call 800-437-3539

FlexibleBenefit ADMINISTRATORS

P.O. Box 8188 • Virginia Beach, VA 23450 • www.flex-admin.com

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 2022, single taxpayers can contribute up to $3,650; families can contribute up to $7,300. Anyone over age 55 can contribute an additional $1,000.

How does an HSA save me money on taxes?

Three ways:

A. You pay no tax on the money you or your employer put into your HSA, up to the IRS limits.

B. You pay no taxes on interest and investment returns earned in your HSA.

C. You pay no tax on HSA money when you sue 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 service 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.

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HSA_Myths_Facts_0116

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Oklahoma Higher Education Employee Interlocal

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, 2022 and ends on December 31, 2022. 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 $2,750.

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

OVER-THE-COUNTER EXPENSES

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

- Acne Treatment
- Humidifiers
- Multivitamins
- Herbal Supplements
- Baby Formula
- 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

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!

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.

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 $550 roll-over provision to the Medical FSA. Please see the Employee Guide for more information.

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 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.

FlexibleBenefit ADMINISTRATORS

P.O. Drawer 8188 • Virginia Beach, VA 23450 • Toll Free (800) 437-3539 • Phone (757) 340-4567 • Fax (757) 431-1155
www.flex-admin.com

FlexibleBenefit ADMINISTRATORS

Oklahoma Higher Education Employee Interlocal

With the Limited Purpose FSA, get reimbursed for out-of-pocket dental, vision, and preventative care expenses with tax free dollars

MAXIMIZE YOUR INCOME!

Limited Purpose Flexible Spending Accounts (FSAs) allow you to pay certain dental, vision and/or preventative care expenses with pre-tax money. You will not pay any Federal, State or Social Security taxes on funds placed in the Plan. You will save between approximately $27.65 and $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, 2022 and ends on December 30, 2022. 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. You must also be enrolled in a High-Deductible Health Plan (HDHP). 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

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 on-line account access for all FSA participants. Please visit their website at:

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

- FSA Login – View balances, check status and view claims history-download participation forms.
- FSA Educational Tools – FSA calculator: Estimate how much you can save by utilizing an FSA.

THE LIMITED FSA ACCOUNT IS A PREFUNDED ACCOUNT

This means that you can submit a claim for dental and/or vision 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 Limit: The maximum you may place in this account for the Plan Year is $2,750.

BENEFITS OF USING A LIMITED PURPOSE FSA WITH AN HSA

With this account, you can pay for your out-of-pocket dental, vision, and preventative care expenses for yourself, your spouse and all your dependents for services that are incurred during your Plan Year and while an active participant. Funds contributed to your Health Savings Account (HSA) can also cover these expenses, so why would someone choose to make a second contribution to a Limited FSA along with an HSA? Below are a few key reasons to contribute to both to get the most out of your HSA.

You will likely have dental and/or vision expenses early in the Plan Year.

A Limited Purpose FSA is prefunded at the beginning of the Plan Year while HSA funds are only available as they are deposited into your account. For this reason, if you are planning on incurring dental and/or vision expenses early in the Plan Year, a Limited Purpose FSA is a great way to pay for those expenses. With the Limited FSA, you can use your full election as soon as you need it. Since it acts like a tax-free, interest free loan. This is particularly useful for those who have just opened their HSA and/or who haven't been able to build up a balance in their HSA account.

You want to use your HSA contributions primarily for medical expenses.

Since you are covered by a High-Deductible Health Plan, you know you may be required to pay higher amounts for medical expenses you incur. If you know you'll use most of your HSA contributions for these medical expenses, it makes sense to set aside separate contributions to cover any vision or dental expenses.

You wish to use your HSA as a retirement or investment account.

HSAs offer a triple-tax advantage, meaning you get a tax advantage towards your contributions, distributions (if used for eligible expenses), and any interest you earn from your HSA. Medicare expenses for those 65 years and older can easily add up to $200,000 for a couple over the course of 20 years. This does not include dental, vision, hearing aids, and out-of-pocket drugs. By using funds from a Limited Purpose FSA, you can allow more money to remain in your HSA to gain interest while still getting the same tax advantage on your vision and dental expenses.

ELIGIBLE VISION AND DENTAL EXPENSES

The Limited FSA allows you to pay for dental and vision expenses for you and your eligible dependents with pre-tax dollars. Eligible dental expenses include dental procedures that are not for cosmetic purposed and not covered by your insurance such as those listed below.

Examples of Eligible Dental Expenses:

- Orthodontia (Braces)
- Crowns
- Fillings
- Checkups

For orthodontia expenses, you can use funds in your Limited FSA to either be reimbursed for a payment made in full on the first orthodontic visit (up to your annual election). If you pay for your orthodontia treatments over the span of multiple plan years, you can pay the monthly payment directly to your orthodontist, then send a claim form in each month to be reimbursed or you can pay your monthly payments with your Benefits Card and send FBA a copy of your orthodontic contract to keep on file so that we can setup a recurring expense on your account.

Examples of Eligible Vision Expenses:

- Eyeglasses
- Prescription Sunglasses
- Routine Eye Exam
- Lasik Eye Surgery
- Contact Lenses
- Diagnostic Services

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	$ 60.00
Eligible Pre-Tax Dental and Vision Expenses	$ 0.00	$ 150.00
Taxable Income	$ 2500.00	$ 2090.00
Federal Tax (15%)	$ 375.00	$ 313.50
State Tax (5.75%)	$ 143.75	$ 120.18
FICA Tax (7.65%)	$ 191.25	$ 159.89
After-Tax employer medical insurance	$ 200.00	$ 0.00
After-Tax Medical expenses	$ 60.00	$ 0.00
After-Tax Dental and Vision expenses	$ 150.00	$ 0.00
Monthly Spendable Income	$ 1380.00	$ 1496.43

By taking advantage of the Limited FSA to cover dental and vision expenses and the HSA to cover their Medical expenses, this employee was able to increase his/her spendable income by $116.43 every month! This means an annual tax savings of $1,397.16. Remember, with the FLEXIBLE BENEFIT PLAN, the better you plan the more you save!

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 dental and vision provider directly.

FORFEITING FUNDS

Plan carefully! Unused funds will be forfeited as governed by the IRS's "use-it-or-lose-it" rule. Your employer has elected to add the $550 roll-over provision to the Limited FSA. Please see the Employee Guide for more info.

ELIGIBLE PREVENTATIVE CARE EXPENSES

In order for an expense to be considered "preventative care" you will need to acquire a prescription or Letter of Medical Necessity from your medical provider that specifically states that the treatment is for the prevention of the onset of an illness. Once you are officially diagnosed with a condition, any expenses used towards treating the condition would not be eligible. Below are two examples of preventative care to prevent the onset of illnesses.

Diabetes

Your doctor may write you a letter of medical necessity stating that they recommend you get a gym membership and exercise in order to prevent the onset of Type II Diabetes.

High Blood Pressure

If you have a family history of high blood pressure, your doctor may write you a prescription for blood pressure medication preventing high blood pressure.

Other eligible "preventative care" expenses include tobacco cessation programs, cancer screening, heart and vascular care screenings, substance abuse screenings, routine prenatal care, and child and adult immunizations.

Please refer to IRS Notice 2004-23 for a more comprehensive list of preventative care expenses.

HOW TO ENROLL IN OUR FSA PLAN

Step 1

Carefully estimate your eligible dental, vision and/or preventative 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, social security, and state 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.

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Employee FAQ:

Dependent Care FSA

What is a dependent care FSA (DCA)?
A DCA is a flexible spending account that allows you to contribute a portion of your paycheck before taxes are taken out to pay for qualified dependent care expenses so that you can work or look for work.

Why should I participate?
Since contributions to the account are deducted from your paycheck before income taxes are assessed, your taxable income is reduced. Participants enjoy a 30% average tax savings on the total amount they contribute to the account.

How do I contribute money to my DCA?
Once you make your annual election during open enrollment, your employer will deduct this amount from your paycheck before taxes are assessed in equal amounts throughout the year.

How much can I contribute?
The IRS limits annual contributions to $5,000 on income tax returns for single or married filing jointly, and $2,500 for married filing separately.

Who qualifies as a dependent?
You can use your DCA to pay for care for children under age 13 that you claim as dependents, as well as adults or other relatives that are incapable of caring for themselves (if you provide more than 50% of their support).

What type of care is eligible?
Eligible expenses must be for the purpose of allowing you to work or look for work. Services may be provided at a child or adult care center, nursery, preschool, after-school, summer day camp, or a nanny in your home.

What type of care is not eligible?
Care expenses that are not eligible to be paid with DCA funds include care for a child over age 13, overnight camp, babysitting that is not work related, school fees for kindergarten and higher grades, and long-term care services.

Do I have access to my entire DCA election amount at the beginning of the year?
No, you will only have access to DCA funds that have already been deducted from your paycheck.

Are there any rules about who can care for my dependents?
Yes. You can not use funds to pay for care provided by a spouse, a person you list as a dependent for income tax purposes, or one of your children under the age of 19.

How do I use the funds in my account?
If you have a benefits debit card and your care provider accepts MasterCard®, you may pay directly from your account. Otherwise, pay out-of-pocket and then file a reimbursement claim with your expense documentation.

What happens if I don't spend all of my DCA funds by the end of the plan year?
It is essential to estimate conservatively during elections. Any unused funds at the end of the plan year are forfeited, also called the use-it-or-lose-it rule.

Can I change my election amount mid-year?
Typically, you cannot change your contribution mid-year. However, if you experience a qualifying event, such as the birth of a new child, or if your child care provider significantly increases their rates, you may be eligible to adjust your contribution.

What happens to my account if my employment is terminated?
Participation in the plan is also terminated. This means that only expenses that were incurred prior to your termination date are eligible for reimbursement.

Can I still deduct dependent care expenses on my tax return?
Yes, but not the same expenses for which you have already been reimbursed. If your total expenses were $7,000 and you were reimbursed $5,000 from your DCA, you may only claim the $2,000 difference.

For more information, please call 800-437-3539

What is the benefit of participating in the DCA versus claiming a tax credit on my tax return?

Generally speaking, those with less than a 15% tax bracket will be better served by the Dependent Care Tax Credit. IRS Publication 503 "Child and Dependent Care Expenses" provides full information about this tax credit and offers worksheets and aids for performing the calculations.

- If you are earning a moderate to high income, and particularly if you are filing taxes as "Married, Filing Jointly" (combining incomes with a spouse), the Dependent Care FSA is may be more advantageous. Reasons: Your tax bracket may be higher than 15%, the threshold generally regarded as the dividing point between the Dependent Care Tax Credit (best for those earning LESS) and the Dependent Care FSA (best for those earning MORE).
- Logically, if you have 1 child, the $5000 available through the Dependent Care FSA may be more generous than the credit arising from the $3000 limit imposed by the Dependent Care Tax Credit.
- Finally, the FSA saves not only income taxes (federal and state), but social security taxes as well. There are no social security tax savings offered by the Dependent Care Tax Credit. (Note: Your social security benefits could be slightly reduced by paying less social security taxes.)

Based on the average US income and average US Child Care Costs, here is an example of why participating in the Dependent Care FSA is a smart option.

Average US Salary is roughly $44,000.
Average cost for Day Care in the US is roughly $10,000 per child.
Average cost of After School Care (for older children) is roughly $7,700 in the US.

Here is the breakdown for claiming a credit on your tax return:

You can claim up to $3,000 on your tax return for child care costs if you have one child. If you have two or more children, you can claim up to $6,000. At the average salary of $44,000, 20% of those costs of child care you can be claimed in credit - **meaning you can get a maximum of $600 in credit for one child and $1,200 in credit for two or more children.**

Here is how much you save by setting aside the maximum $5,000 in your Dependent Care Account pre-tax versus paying out of pocket after tax:

Paying for Dependent Care After Tax
Earning $44,00 per year

Federal Tax (15%):	-$6,600
FICA Tax (7.76%):	-$3,366
State Tax (5.75%):	-$2,530
After Tax Dependent Care Cost:	-$5,000
Bring Home Salary Per Year:	$26,504

Paying for Dependent Care Before Tax
Earning $44,000, but taxed on $39,000
(since $5,000 is set aside before taxes are taken)

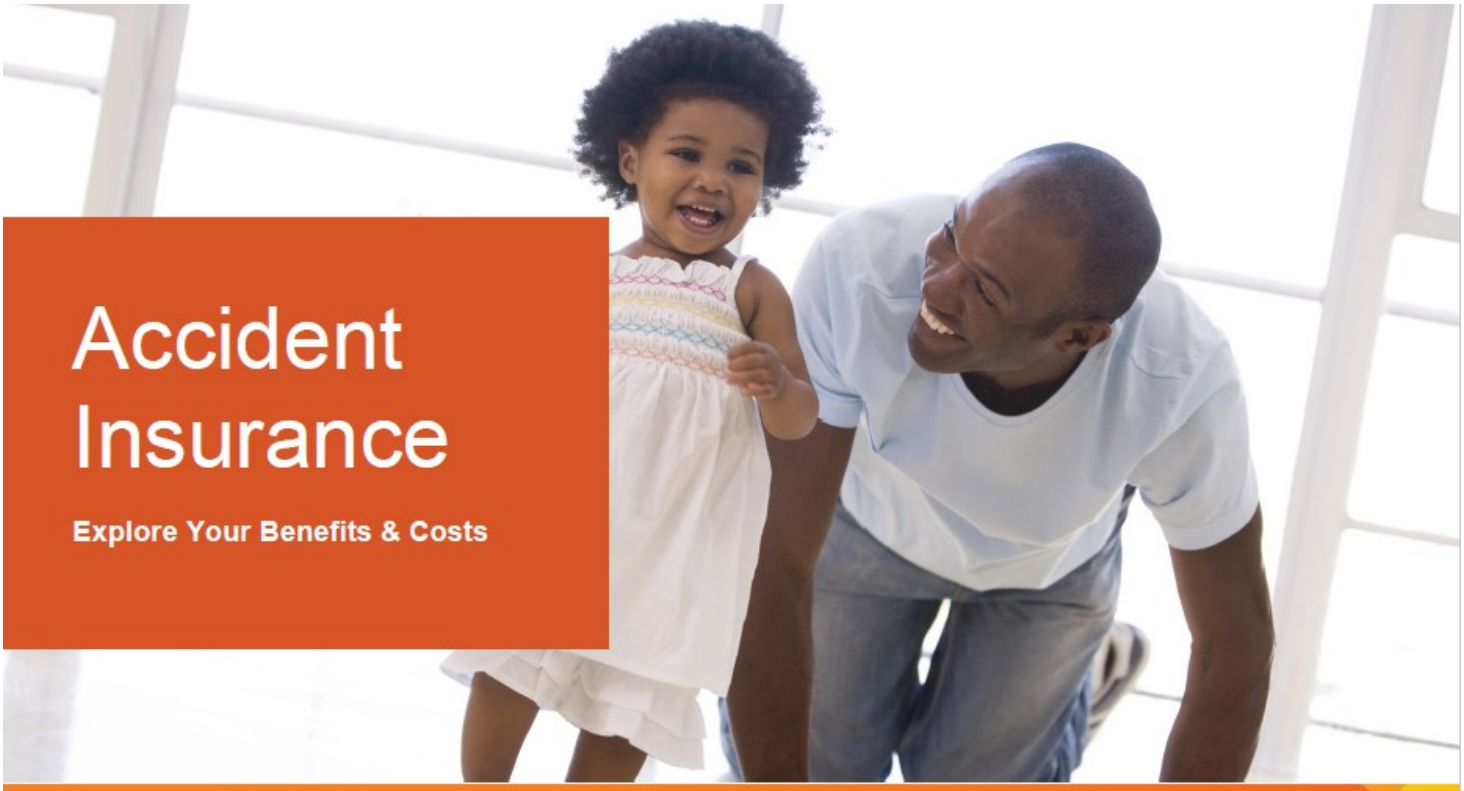
Federal Tax (15%):	-$5,850
FICA Tax (7.76%):	-$2,983.50
State Tax (5.75%)	-$2,530
Bring Home Salary Per Year:	$27,924

The average person saves $1,420 for the year in taxes by setting aside the full $5,000 pre-tax!

To top this off - the average person also has spends $10,000 per year in Day Care costs for one child, so they could still claim the maximum $3,000 on their tax return, **since you can still claim any additional cost over what you set aside pre-tax**. For someone who spends $20,000+ for Day Care costs for two or more children, they could still claim the maximum $6,000 on their tax return.

Participating in the Dependent Care Flex Plan allows you to stretch your hard-earned dollars!

For more information, call 800-437-3539 P.O. Box 8188 • Virginia Beach, VA 23450 • www.flex-admin.com



Accident Insurance

Explore Your Benefits & Costs

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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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.

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)

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

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Follow-up doctor treatment	$75	$100
Hospital admission	$2,000	$3,000
Hospital confinement (per day, up to 365 days)	$250	$400

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

See the full Schedule of Benefits toward the end of this document.

What else is included?

The Accident Insurance available through your employer also features the following:

$100 to use however you'd like

Wellness Benefit

- 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.
- The benefit for child coverage is 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.

Additional non-insurance service(s)

Access extra support next time you travel

Voya Travel Assistance

When traveling more than 100 miles from home, Voya Travel Assistance offers enhanced security for your leisure and business trips. You and your dependents can take advantage of four types of services: pre-trip information, emergency personal services, medical assistance services and emergency transportation services.

Voya Travel Assistance services are provided by Europ Assistance USA, Bethesda, MD.

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Critical Illness Insurance

Explore Your Benefits & Costs

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.

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

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How much coverage is available?

You have the option to enroll in coverage in the amount(s) below.

	Coverage Amount
For you	Choice of $15,000 or $30,000
Your spouse	100% of Employee elected amount
Your children*	100% of Employee elected amount

*Child(ren) up to age 26.

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:

Sample benefit amounts

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.

See the full Schedule of Benefits toward the end of this document.

PLAN | INVEST | PROTECT

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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.

Wellness Benefit

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

- Employee receives 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

Benefits for insured children

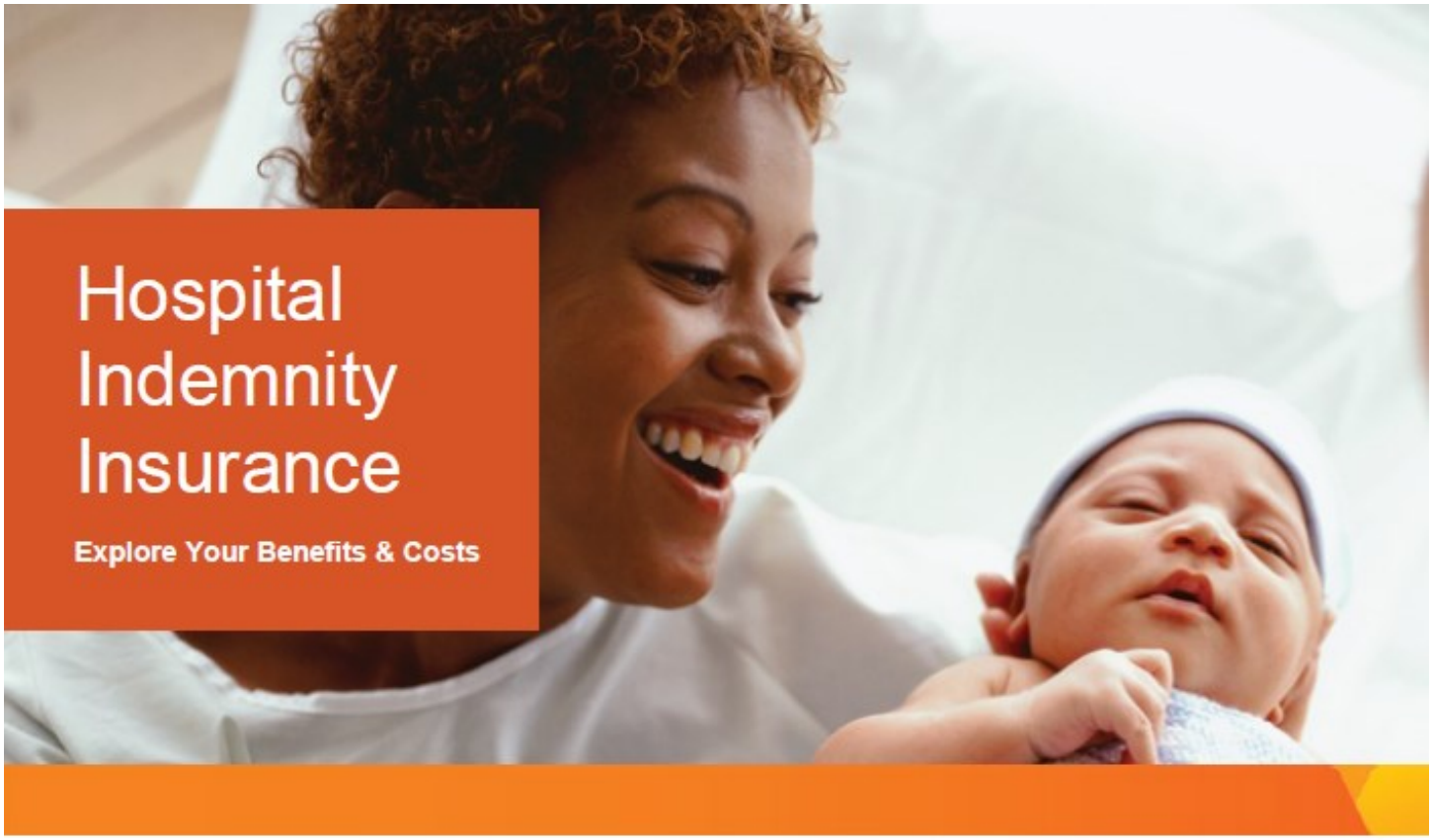
In addition to the covered conditions mentioned above, coverage for your insured children includes:

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.



Hospital Indemnity Insurance

Explore Your Benefits & Costs

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

Out-of-pocket costs from a stay in a hospital or other medical facility can be overwhelming. As expenses add up, **Hospital Indemnity Insurance can help.** This document includes cost and benefit information for Hospital Indemnity Insurance. As you explore, keep in mind:

- No medical questions or tests are required for coverage.
- Simplified claims process has limited paperwork and can be submitted/tracked online.
- Benefit payments go directly to you. Use them however you'd like!

Hospital Indemnity 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 should a covered hospitalization occur.

Hospital Indemnity 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

PLAN
INVEST
PROTECT

VOYA® FINANCIAL

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

*Child(ren) birth to age 26; no limit to the number of children per family.

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.

If you add a child to your family

Hospital Indemnity Insurance benefits apply if you have employee or spouse coverage and are hospitalized for childbirth. In addition, your newborn child(ren) may be covered as well. See below for more details and for a complete description of your available benefits, exclusions and limitations, see your certificate of insurance and any riders.

If child coverage is effective before the child is born

- Benefits will apply just as they would for any other child.

If child coverage is NOT effective before the child is born

- A one-time benefit of $100 is payable for the newborn child's birth.
- No admission benefit is payable.

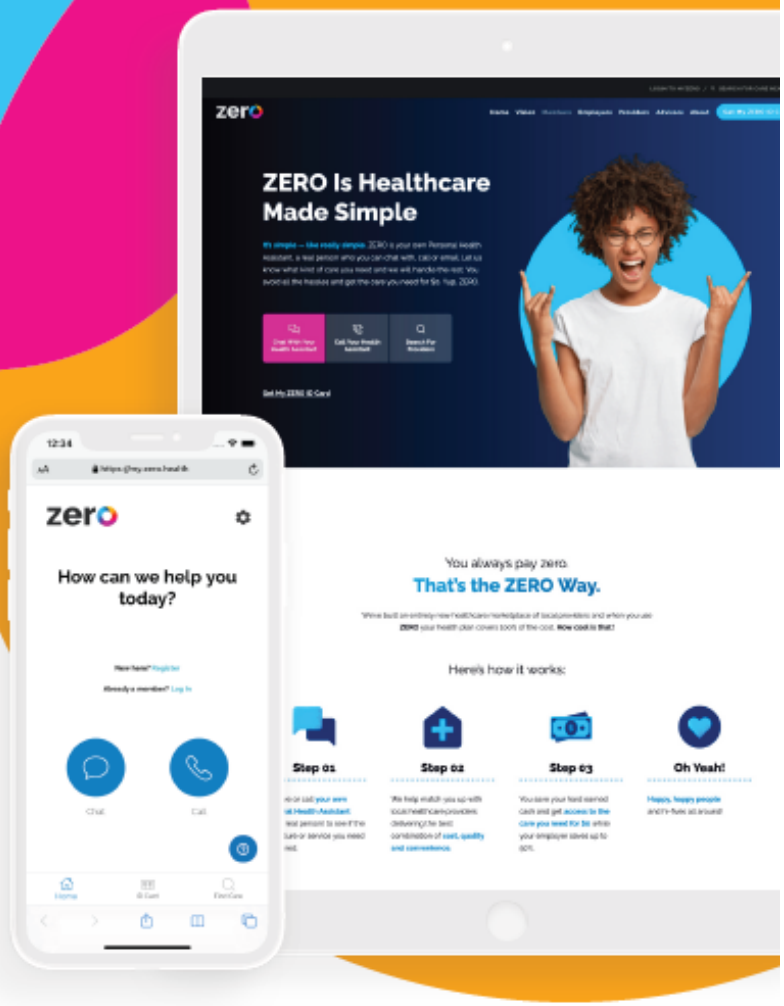
zero

No Deductibles.

No Co-Pays.

No Co-Insurance.

You Always Pay ZERO.



Step 01

Connect with your Personal Health Assistant to see if the service or procedure you need is covered.

Step 02

ZERO will help you find the healthcare provider that works best for you and we will take care of all the details.

Step 03

You save your hard earned cash and get the care you need for ZERO.

Yep, ZERO.

That's It. It's that easy.

Welcome to Simplicity

Welcome to ZERO

Chat Live
www.zero.health

Give Us A Shout
855-816-0001

Drop Us A Line
help@zero.health

my

Your own personal

Member Site!

Access your digital lab ID card, chat live with a PHA & search for care.

Signup now at my.zero.health

Welcome to Simplicity

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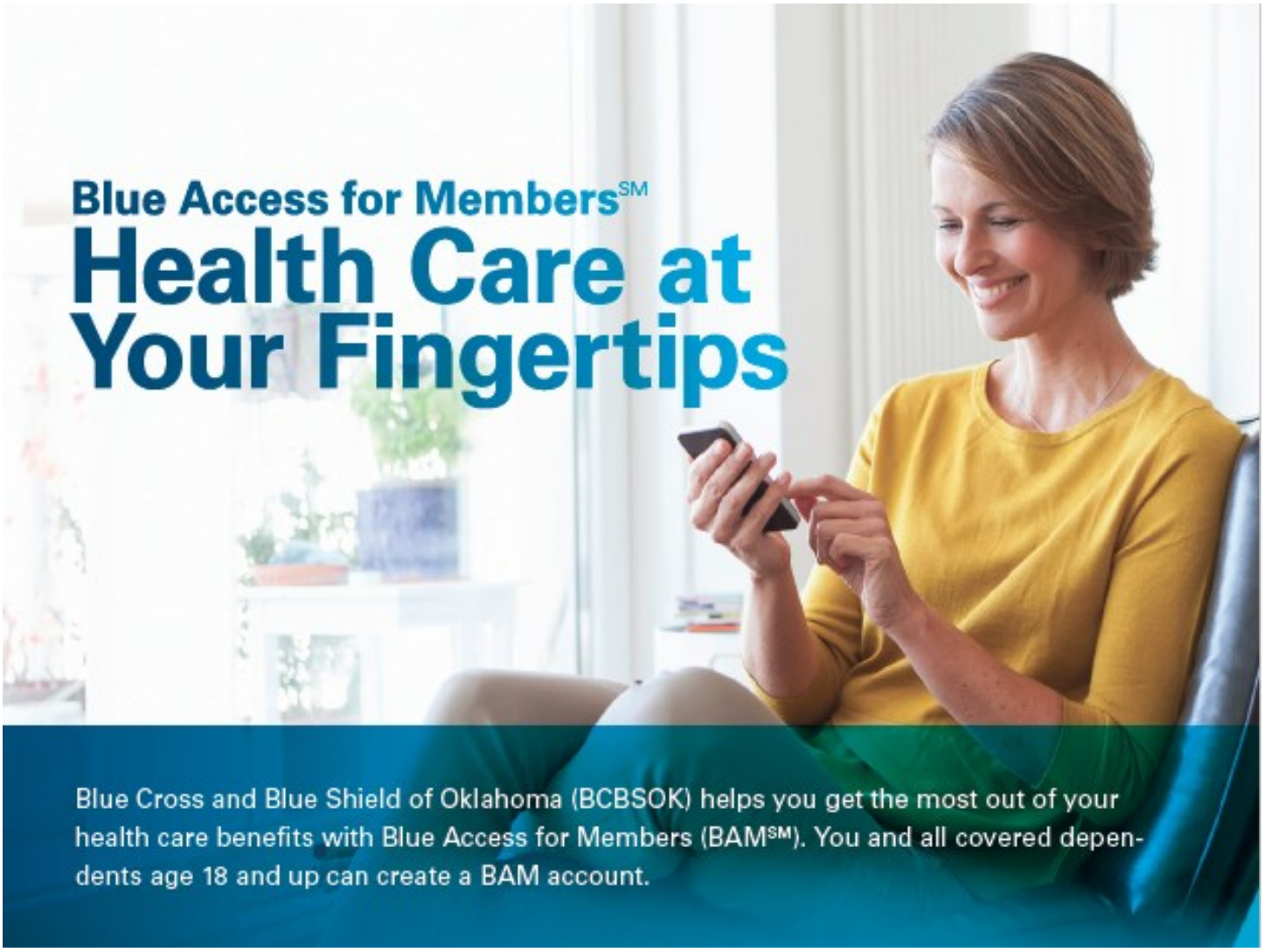


With BAM, you can:

- Use our Provider Finder tool to search for a health care provider, hospital or pharmacy
- Request or print your ID card
- Check the status or history of a claim
- View or pint Explanation of Benefits statements
- Use our Cost Estimator tool to find the price of hundreds of tests, treatments and procedures
- Download our app
- Sign up for text or email alerts

It's Easy to Get Started!

1. Go to bcbsok.com/member
2. Click Log Into My Account
3. Use the information on your BCBGSOK ID card to sign up

Or, text* BCSOKAPP to 33633 to get the BCBSOK App that lets you use BAM while you're on the go.

*Message and data rates may apply

BlueCross BlueShield of Oklahoma

Health Assessment

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

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

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

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

- In the "BlueAccess for Members" box click on the *Register Now*
- Follow steps to set up account with BCBS:
  - Complete Member information
  - Complete Plan information (numbers found on your card)
  - Complete Security information
  - "Agree" with the Terms of Use
  - Access your e-mail account to validate your e-mail address with BCBS
  - Make note of your log-in and password for future reference

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

REMINDER: The Health Assessment may be taken anytime during the calendar year; however, it must be taken before a claim is incurred to receive the $250 credit.

***HSA Enrollees (Plan F): The Health Assessment deductible credit is $200 and you'll receive a $50 deposit into your HSA.**

How to take the assessment:

1. Log into your BAM account at BCBS
2. Under the Quick Links on the left side of the screen, click *Take Your Health Assessment*

After successfully completing your Health Assessment, your $250 incentive will show up in your BAM account/My Coverage/Incentives in approximately 10 business days. If you experience difficulties, 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 will you 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.

BlueCross BlueShield of Oklahoma

Blue Points℠ — Rewards for Healthy Living

Well onTarget® understands how hard it can be to maintain a healthy lifestyle. Sometimes, you may need a little motivation. That's why we offer the Blue Points[1] program. This program may help you get on track — and stay on track — to reach your wellness goals.

With the Blue Points program, you will be able to earn points for regularly participating in many different healthy activities. You can redeem these points in the online shopping mall, which provides a wide variety of merchandise.

Created with your needs in mind, the Blue Points program has many convenient, user-friendly, personalized and flexible features:

Earn Points Instantly

The program gives you points immediately, so you can start using them right away.[2]

Get Extra Points

Don't have enough points yet for that reward you really want? No problem! You can apply the points you have and use a credit card to pay the remaining balance.

Easily Manage Your Points

The interactive Well onTarget portal, available at **wellontarget.com**, uses the latest user-friendly technology. This makes it easy to find out how many points are available for you to earn. You can also track the total number of points you've earned year-to-date. All of your points information will appear on one screen.

Well onTarget®

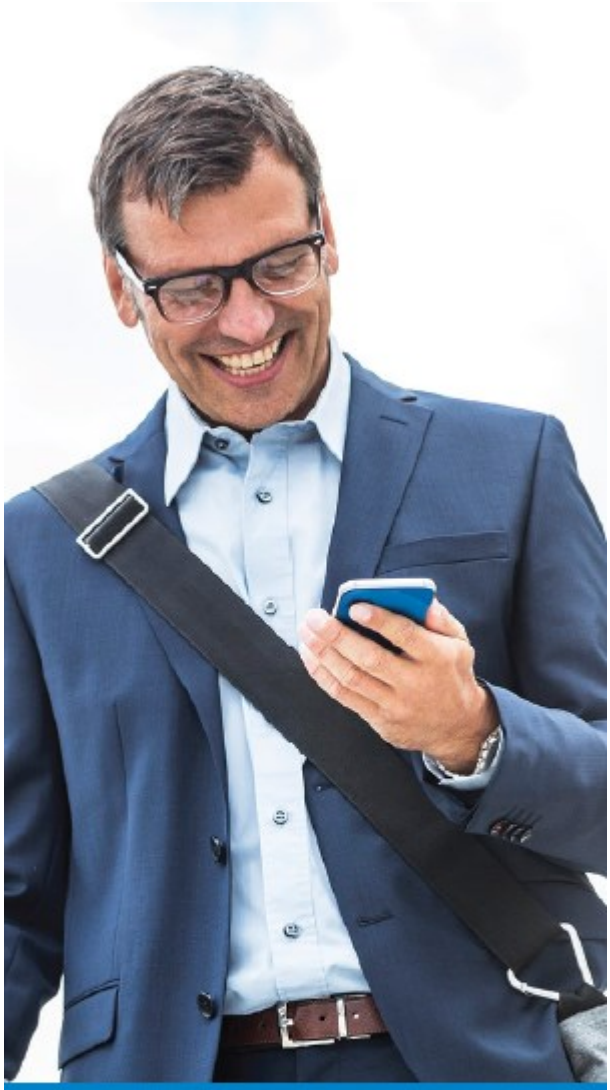
Choose from a Large Selection of Rewards

Redeem your points in our expanded online shopping mall. Reward categories include apparel, books, health and personal care, jewelry, electronics, music and sporting goods. You'll also find discounted items on electronics, games, luggage and other merchandise.[3]

Participate in Activities That Match Your Goals

Look how quickly your Blue Points can add up! Here are some sample activities you can complete to earn Blue Points:

Activities	Potential Blue Points Amounts
Completing the Health Assessment every six months[4]	2,500 points every six months
Complete a Self-management Program	1,000 points per quarter
Using the trackers to track your progress toward your goals	10 points, up to a maximum of 70 points per week
Enrolling in the Fitness Program	2,500 points
Adding weekly Fitness Program center visits to your routine	Up to 300 points each week
Completing Progress Check-ins	Up to 250 points per month
Connecting a compatible fitness device or app to the portal	2,675 points
Tracking progress using a synced fitness device or app	55 points per day



Log on to **wellontarget.com** today to find all the interactive tools and resources you need to start racking up Blue Points. Keep yourself motivated to earn more points by heading over to the online shopping mall and checking out all the rewards you can earn for adopting — and continuing — healthy habits.

1. Blue Points Program Rules are subject to change without prior notice. See the Program Rules on the Well onTarget Member Wellness Portal for more information.
2. This does not apply to points you earn for completing Fitness Program activities.
3. Member agrees to comply with all applicable federal, state and local laws, including making all disclosures and paying all taxes with respect to their receipt of any reward.
4. Well onTarget is a voluntary wellness program. Completion of the Health Assessment is not required for participation in the program.
   The Fitness Program is provided by Tivity Health®, an independent contractor that administers the Prime Network of fitness centers. The Prime Network is made up of independently owned and operated fitness centers.

BlueCross BlueShield of Oklahoma

Because Your Health Counts

It's Important to Know Where to Go When You Need Care

Sometimes it's easy to know when you should go to an emergency room (ER), at other times, it's less clear. You have choices for receiving in-network care that will work with your schedule and also give you access to the kind of care you need. Know when to use each for non-emergency treatment.

Your Doctor's Office

Your own doctor's office may be the best place to go for non-emergency care, such as health exams, routine shots, colds and minor injuries. Your doctor knows your health history and the medicine you take and can decide if you need tests or specialist care. Your doctor can also help you with care for chronic health issues, such as asthma or diabetes.

Retail Health Clinic

When you can't get to your regular doctor, walk-in clinics – available in many retail stores – can be a lower-cost choice for care. Many stores have a physician assistant or nurse practitioner who can help treat ear infections, rashes, minor cuts and scrapes, allergies and colds.

Urgent/Immediate Care Clinic

These facilities can treat you for more serious health issues, such as when you need an X-ray or stitches. You will probably have a lower out-of-pocket cost than at a hospital ER, and you may have a shorter wait.

Hospital Emergency Room

Any life-threatening or disabling health problem is a true emergency. You should go to the nearest hospital ER or call **911**. When you use the ER for true emergencies, you help keep your out-of-pocket costs lower.

Knowing where to go for care can make a big difference in cost and time. Here's how your options compare:[†]

	Average Costs	Average Wait Times	Examples of Health Issues	
Your Doctor's Office Your doctor knows your medical history best	$	18 minutes*	• Fever and colds • Sore throat • Minor burns • Stomach ache	• Ear or sinus pain • Physicals • Shots • Minor allergic reactions
Retail Health Clinic Convenient, low-cost care in stores and pharmacies	$	15 minutes	• Infections • Fever and colds • Minor injuries or pain • Shots	• Flu shots • Sore and strep throat • Skin problems • Allergies
Urgent Care Clinic Immediate care for issues that are not life-threatening	$$	16 - 24 minutes**	• Migraines or headaches • Cuts that need stitches • Abdominal pain • Sprains or strains	• Urinary tract infection • Animal bites • Back pain
Hospital Emergency Room For serious or life-threatening conditions	$$$	4 hours, 7 minutes***	• Chest pain, stroke • Seizures • Head or neck injuries • Sudden or severe pain	• Fainting, dizziness, weakness • Uncontrolled bleeding • Problem breathing • Broken bones

[†]Relative costs described are for independently contracted network providers. Costs for out-of-network providers may be higher.

* Vitals Annual Wait Time Report, 2017.

** Wait Time Trends in Urgent Care and Their Impact on Patient Satisfaction, 2017.

*** Emergency Department Pulse Report 2010 Patient Perspectives on American Health Care. Press Ganey Associates.

Urgent Care or Freestanding Emergency Room

Urgent care centers and freestanding ERs can be hard to tell apart. Freestanding ERs often look a lot like urgent care centers. They treat most major injuries, except for trauma, but costs may be higher. Unlike urgent care centers, freestanding ERs are often out of network and may charge patients up to 10 times more for the same services.[1] Here are some ways to know if you are at a freestanding ER.

Freestanding ERs:

- Look like urgent care centers, but include EMERGENCY or ER in facility names.
- Are open 24 hours a day, seven days a week.
- Are physically separate from a hospital.
- Are staffed by board-certified ER doctors and are subject to the same ER member share which may include a copay, coinsurance and applicable deductible.

Find urgent care centers[2] near you by texting[3] **URGENTOK** to **33633**.

Need help deciding where to go for care?

On hand 24 hours a day, seven days a week; bilingual nurses available.

Call the 24/7 Nurseline[4] at **800-581-0407** for help identifying some options when you or a family member has a health problem or concern.

Need help finding a network provider?

Use Provider Finder® at **bcbsok.com** or call the Customer Service number on the back of your member ID card. If you need emergency care, call **911** or seek help from any doctor or hospital right away.

[1]The Texas Association of Health Plans.

[2]The closest urgent care center may not be in your network. Be sure to check Provider Finder to make sure the center you go to is in-network.

[3]Message and data rates may apply. Read terms, conditions and privacy policy at bcbsok.com/mobile/text-messaging.

[4]24/7 Nurseline is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

OTHER RESOURCES TO HELP YOU

Blue Cross and Blue Shield of Oklahoma also provides other health and wellness information.

Preventive Health Care Guidelines are published each year and made available via www.bcbsok.com/okheei/. This is a good source of information on preventive care guidelines, which are based on recommendations set by national health agencies and medical associations. You can learn about recommended screenings, and immunizations and doctor visits for all ages, from prenatal care and infancy through the senior years.

Be Smart. Be Well.® Is our website dedicated to raising awareness of largely preventable health and safety issues. You'll find in-depth information on a variety of issues, including traumatic brain injuries, drug interactions and mental health at www.besmartbewell.com.

Glucose Meters help members with diabetes manage their condition and can be ordered at no charge. For information on the meters that are available, call customer service at 800-672-2567.

Blue Access for Members - Go to www.bcbsok.com/okheei/ to register. You will be able to:

- Check the status or history of a claim
- Locate a doctor or hospital in your plan's network
- Request a new ID card or print a temporary one
- Access to health and wellness information
- Find Cost Estimates
- Compare providers
- Estimate Out-of-Pocket expenses for common procedures

Start your journey to wellness today!

HOW TO REDUCE YOUR PHARMACY COSTS

Everyone is looking for ways to reduce medical costs. One of the most effective ways to do this is to manage your pharmacy costs. Here are some tips to make your medical dollars go further:

- Choose generic medications over brand name counterparts. Generic drugs are Food and Drug Administration-approved and are as safe and effective as their brand name equivalents. There was a time when people questioned generics, but most doctors and patients embrace them today. The FDA mandates that generics are made with the same active ingredients and are available in the same strength and dosage as their competitors. Most generics are dramatically cheaper than brand name drugs and many are manufactured by the same companies that make the original brand name drug.
- Step therapy is a pharmacy policy based on the concept of comparative effectiveness. Comparative effectiveness examines forms of treatment to determine which is best in a given situation. Many assume that the most expensive option is the best, but as generics prove, this is not always the case. Ask your doctor to explore less expensive treatments before resorting to more expensive drug therapies. If the first treatment fails, then the next will be explored, and so on.
- And as always, prevention is the best medicine. Taking care of yourself, eating well, exercising and general preventive health care will help keep your need for prescription drugs down overall.

BCBSOK ONLINE BENEFIT RESOURCES

RESOURCE	PURPOSE	HOW TO ACCESS
Online Enrollment System	• Completing your benefit elections	MyOKHEEIBenefits.com
BCBSOK Website for OKHEEI	• Log in to Blue Access for Members to access the Well on Target portal or view claims • View/print benefit brochures • Locate a doctor or hospital	www.bcbsok.com/okheei/
Blue Access for Members	• Ability to print a temporary member ID card and order a new card • View claim status and Explanation of Benefits (EOB) • Find a doctor or hospital • View wellness rewards points • Access to Well on Target	Go to www.bcbsok.com/okheei/ or visit www.blue365deals.com/BCBSOK • Enter Blue Access for Members user ID and password • If you do not have a user ID and password, then click "Register Now".
Blue Points	Earn points, redeemable for rewards, for health-related activities	Go to BAM at www.bcbsok.com/okheei/ Click on Well on Target
Locate a Health Care Provider	Find a doctor, specialist, or hospital in your area	Go to www.bcbsok.com/okheei/ or visit www.blue365deals.com/BCBSOK Click "Find a Doctor"
OKHEEI Benefits Website	Find benefit related information	www.okheei.org/
Pharmacy	• Compare Drugs • Find generic alternatives • Obtain cost estimates • View drug list	www.myprime.com

Vendor Contact Information

Medical and Prescription Drug Benefits:	Carrier Name:	BCBSOK
	Customer Service Phone Number:	800-672-2567
	Website:	www.bcbsok.com/okheei
Dental Benefits:	Carrier Name:	Delta Dental Oklahoma
	Customer Service Phone Number:	800-522-0188 or 405-607-2100
	Email:	customerservice@deltadentalok.org
	Network:	PPO or Premier
	Website:	www.deltadentalok.org
Vision Benefits:	Carrier Name:	Vision Service Plan
	Customer Service Phone Number:	800-877-7195
	Network:	Choice
	Website:	www.vsp.com
Life & AD&D and Voluntary Life AD&D:	Carrier Name:	Standard Insurance Company
	Customer Service Phone Number:	888-937-4783
	Website:	www.standard.com
Disability Income Benefits (Long Term Disability):	Carrier Name:	Standard Insurance Company
	Customer Service Phone Number:	888-937-4783
	Website:	www.standard.com
COBRA Administration:	Carrier Name:	Flexible Benefit Administrators
	Customer Service Phone Number:	
	Email:	
Retiree Billing:	Carrier Name:	Flexible Benefit Administrators
	Customer Service Phone Number:	
Oklahoma Teacher's Retirement:	Customer Service Phone Number:	877-738-6365
	Email:	mail@trs.ok.gov
	Website:	www.ok.gov/trs
Online Enrollment System:	Website: Empyrean	MyOKHEEIBenefits.com
Accident, Critical Illness, Hospital Indemnity:	Carrier Name:	VOYA
	Customer Service Phone Number Website:	877-236-7564 Voya.com/claims