December 6, 2018

Welcome to Tulsa Public Schools, we are pleased to explain some of our medical plans for you. There is also a link to the benefits guide on our website under compensation and benefits, health benefits. Or you may view the benefits guide book directly online at www.healthchoiceok.com. Directions for doing so are listed below.

Here are the PPO plans that are offered for 2019:

- **HealthChoice High Deductible Health Plan (HDHP)**

The high deductible plan has a $1,750 deductible for individual; $3,500 family per year that must be met before it acts like an 80%/20% plan with a co-pay for doctor visits. You pay 100% of allowable charges both Medical and Pharmacy costs until deductible is met.

Since the premium is less than the amount paid by the district for the member's premium, the difference of $193.12 will be paid to you each month. If you select coverage for you and your dependents, the $193.12 will be applied to their premium.

You will be eligible to open a Health Savings Account (HSA) which can give you the ability to save you up to 20% - 35% on qualified medical expenses since the funds are not taxed and can be used at any time, even after you retire. The HSA funds can also be used for any tax dependents even if they are not on your insurance.

- **HealthChoice High Plan**

The high plan has a $750 deductible with a $100 deductible on pharmacy, for a family of 3 or more, it has a $2,000 deductible with a $300 deductible on pharmacy. There is a $30 co-pay for your primary care physician (PCP) office visits and a $50 co-pay for a specialist office visit.

For hospitalization, outpatient surgery, emergency room, lab work, x-rays etc. the plan pays 80% of allowable fees after your deductible has been met for the calendar year.

For the member, the premium is paid in full.

- **HealthChoice Basic Plan**

The basic plan has a $1000 deductible with a $100 deductible on pharmacy, for a family of 2 or more, it has a $1,500 deductible with a $300 deductible on pharmacy. This applies after the plan pays the first $500 of allowable fees. You will then pay 100% of the next $1,000 of allowable fees (deductible). After that you pay 50% of the next $6,000. Then the plan pays 100%.

Since the premium is less than the amount paid by the district for individual coverage, the difference of $128.48 will be paid to you each month. If you select coverage for you and your dependents, the $128.48 will be applied to their premium.

All Tulsa hospitals are in the HealthChoice Network.

Here are the HMO plans offered for 2019:

HMO plans are zip code driven, have co-pays with no deductibles and you must stay in network. You must have an in network primary care physician (PCP) that you select. If you do not select a PCP, the plan will select one for you. Your PCP can be changed at any time as long as they are in network. Currently, GlobalHealth is the only HMO that requires a referral to see a specialist. All other HMO plans allow members to self-refer to any specialist that is in Network.

The HMO plans participate with different Hospitals. If you already have a doctor, please make sure they participate with the state insurance plan you select.

- **Aetna St Johns** – is in network with St. Johns. They only have a select number of Providers.
- **BlueLincs** – is in network with St. Frances and Hillcrest affiliated hospitals.
- **CommunityCare** – is in network with St. Johns and St. Francis
- **GlobalHealth** – is in network with Hillcrest and their affiliated hospitals.

Information for the 2019 plans can be found at www.healthchoiceok.com

Once you have the site up, scroll down and select Members, next select Handbooks, finally select "Plan Year 2019 Employee Benefit Options Guide (pdf)". The benefits guide can be saved or printed at this point if you wish.

Please remember that you have 30 days from when your full time employment begins. We encourage employees to return their enrollment forms as soon as possible to ensure adequate time for processing for payroll purposes. Your insurance will begin the 1st of the month following your full time regular hire date. If you are hired late in the month, it is even more important to return your paper work in a timely manner. Waiting the full 30 days, may result in extra premiums being deducted once your paperwork is submitted.

If you have any questions or concerns please reach out to the benefits office at 918-746-6394 or benefits@tulsaschools.org.

Thank you,

TPS Benefits Team

CONTACT INFORMATION

Health Plans

Aetna INTEGRIS and Aetna St. John

800-459-7791
www.stateofok.aetna.com

BlueLincs

855-609-5684
www.bcbsok.com/state
www.bcbsok.com

CommunityCare

800-777-4890 or TDD 800-722-0353
state.ccok.com

GlobalHealth, Inc.

405-280-5600 or 877-280-5600
TDD 711
www.globalhealth.com

HealthChoice

Medical

800-323-4314
TTY 711 or 800-545-8279

Pharmacy

877-720-9375
TDD 711
www.healthchoiceok.com

Life Insurance

HealthChoice

800-323-4314
TTY 711 or 800-545-8279
www.healthchoiceok.com

Additional

EGID

405-717-8780 or 800-752-9475
TDD 405-949-2281 or 866-447-0436
omes.ok.gov

American Fidelity Health Services Administration

405-523-5699 or 866-326-3600
www.afhsa.com

Dental Plans

Cigna Prepaid Dental

800-244-6224
Hearing Impaired Relay 800-654-5988
www.cigna.com

Delta Dental

405-607-2100 or 800-522-0188
DeltaDentalOK.org/client/OK

HealthChoice

800-323-4314
TTY 711 or 800-545-8279
www.healthchoiceok.com

MetLife

855-676-9443
www.metlife.com/oklahoma
www.metlife.com/mybenefits

Sun Life

800-442-7742
www.sunlife.com

Vision Plans

Primary Vision Care Services (PVCS)

888-357-6912 or TDD 800-722-0353
www.pvcs-usa.com

Superior Vision

800-507-3800 or TDD 916-852-2382
www.superiorvision.com

Vision Care Direct

877-488-8900 or TDD 711
www.okstate.vision

VSP

800-877-7195 or TDD 800-428-4833
www.vsp.com

TULSA PUBLIC SCHOOLS
MONTHLY INSURANCE DEDUCTIONS
EFFECTIVE JANUARY 1, 2019-DECEMBER 31, 2019

Certified and support employees eligible for Flexible Benefit Allowance (FBA)
(Eligible employees are defined as those that work 6 hours or more on a regular contract)

Health Insurance Plans	Member Only	Member+ Child	Member+ Children	Member+ Spouse	Member+ Spouse+ Child	Member+ Spouse+ Children
HealthChoice High Deductible Health Plan (HDHP) *1	(193.12)	14.40	157.24	278.70	486.22	629.06
HealthChoice High & High Alternative	0.00	299.24	507.80	697.50	996.74	1,205.30
HealthChoice Basic & Basic Alternative *2	(128.48)	112.06	278.40	418.90	659.44	825.78
Aetna St. Johns HMO	303.00	904.60	1,265.52	1,775.24	2,376.84	2,737.76
BlueLincs HMO *3	(44.90)	252.26	440.34	767.00	1,064.16	1,252.24
Community Care HMO	299.42	754.90	1,028.20	1,602.10	2,057.58	2,330.88
Global HMO	28.28	384.16	609.44	948.16	1,304.04	1,529.32

***1- You will be paid $193.12 per month ($2,317.44 per year) if you choose the HealthChoice**
-High Deductible Health Plan (HDHP) and will be eligible to open a pre-tax Health Savings Account (HSA).
***2 - You will be paid $128.48 per month ($1,541.76 per year) if you choose either of the HealthChoice Basic plans.**
***3 - You will be paid $44.90 per month ($538.80 per year) if you choose BlueLincs HMO**

Dental Insurance Plans	Member Only	Member+ Child	Member+ Children	Member+ Spouse	Member+ Spouse+ Child	Member+ Spouse+ Children
Cigna Dental Care Plan (Prepaid)	0.00	4.20	9.46	6.18	10.38	15.64
Delta Dental PPO	24.84	56.02	103.70	60.66	91.84	139.52
Delta Dental PPO - Choice	4.68	40.50	91.64	40.24	76.06	127.20
HealthChoice Dental	28.12	59.70	109.22	67.24	98.82	148.34
MetLife High Classic Mac (MetLife Classic)	35.24	74.86	133.40	81.48	121.10	179.64
MetLife Low Classic Mac (MetLife Value MAC)	15.64	38.46	71.80	42.28	65.10	98.44
SunLife Preferred Active PPO (Assurant Freedom Preferred)	19.26	41.84	79.94	49.36	71.94	110.04

Vision Insurance Plans	Member Only	Member+ Child	Member+ Children	Member+ Spouse	Member+ Spouse+ Child	Member+ Spouse+ Children
Primary VisionCare Services (PVCS)	9.98	18.68	21.48	18.88	27.58	30.38
Superior Vision Services	7.62	14.80	22.36	15.20	22.38	29.94
Vision Care Direct	15.90	27.16	38.64	27.16	38.42	49.90
Vision Service Plan (VSP)	8.72	14.42	21.20	14.50	20.20	26.98

Support employees not eligible for Flexible Benefit Allowance (FBA)
(Eligible employees that work 25-29 hours per week)

Health Insurance Plans	Member Only	Member+ Child	Member+ Children	Member+ Spouse	Member+ Spouse+ Child	Member+ Spouse+ Children
HealthChoice High Deductible Health Plan (HDHP)	285.98	493.50	636.34	757.80	965.32	1,108.16
HealthChoice High & High Alternative	479.10	778.34	986.90	1,176.60	1,475.84	1,684.40
HealthChoice Basic & Basic Alternative	350.62	591.16	757.50	898.00	1,138.54	1,304.88
Aetna St. Johns HMO	782.10	1,383.70	1,744.62	2,254.34	2,855.94	3,216.86
BlueLincs HMO	434.20	731.36	919.44	1,246.10	1,543.26	1,731.34
Community Care HMO	778.52	1,234.00	1,507.30	2,081.20	2,536.68	2,809.98
Global HMO	507.38	863.26	1,088.54	1,427.26	1,783.14	2,008.42

*** Employees scheduled for 20-24 hours per week need to add an additional $57.90 to the premium**

Office of Management and Enterprise Services
Employees Group Insurance Division
INSURANCE ENROLLMENT FORM

EMPLOYER INFORMATION (To be completed by insurance coordinator)

Group ID # 724001 **Division ID #** 0686 **Group Name** Tulsa Public Schools

☐ New Hire Enrollment ☐ Midyear Enrollment

EMPLOYEE INFORMATION (Please print)

SSN # _____ ☐ Married ☐ Single

Employee's Name (Please print)	**First Name**	**M I**	**Last Name**

Mailing Address _____

_____
City State ZIP Code

Primary Telephone # _____ Email Address _____

Residence State _____ Worksite State _____

Employee's Birth Date	Mo.	Day	Yr.	Sex
				☐M ☐F

Effective Date of Coverage	Mo.	Day	Yr.
		0 1	

EMPLOYEE HEALTH PLAN ELECTION

☐ Aetna HMO
☐ BlueLincs HMO
☐ CommunityCare HMO
☐ GlobalHealth HMO
☐ HealthChoice Basic
☐ HealthChoice High
☐ HealthChoice High Deductible Health Plan (HDHP)

Employee Primary Physician (HMO only): _____

☐ Current Patient ☐ New Patient

EMPLOYEE DENTAL PLAN ELECTION

☐ Cigna Dental Care Plan (Prepaid)
☐ Delta Dental PPO
☐ Delta Dental PPO – Choice
☐ HealthChoice Dental Plan
☐ MetLife Low Classic MAC
☐ MetLife High Classic MAC
☐ Sun Life Preferred Active PPO

Employee Primary Dentist (Prepaid only): _____

☐ Current Patient ☐ New Patient

EMPLOYEE VISION PLAN ELECTION

☐ Primary Vision Care Services
☐ Superior Vision
☐ Vision Care Direct
☐ Vision Service Plan

EMPLOYEE LIFE PLAN ELECTION

Basic and Supplemental Life can be added only during initial enrollment, during Option Period, or within 30 days of the loss of other group life insurance (with proof of loss). Guaranteed Issue (GI) Supplemental Life is equal to two times your annual salary rounded up to the next $20,000 unit. The maximum amount of Supplemental Life you can have in force at any time is $500,000.

To request amount above your GI, you must submit a Life Insurance Application for approval.

☐ **Basic Life (required for enrollment in Supplemental Life)** $ 20,000

☐ **Supplemental Life (in $20,000 units)** $ _____

Total Employee Life Insurance Requested (Basic and Supplemental) $ _____

Dependent Life

☐ Premier Option (spouse = $20,000, each child = $10,000)
☐ Standard Option (spouse = $10,000, each child = $5,000)
☐ Low Option (spouse = $6,000, each child = $3,000)

FOR EGID USE ONLY

☐ **HEALTHCHOICE DISABILITY** (Available only to certain county employees)

DEPENDENT INFORMATION

SPOUSE* ☐ Health ☐ Dental ☐ Vision ☐ Dependent Life

Name ____________ SSN ____________

Date of Birth ____________ ☐ Male ☐ Female

Primary Physician ____________ ☐ Current Patient ☐ New Patient

Primary Dentist ____________ ☐ Current Patient ☐ New Patient

***Does your spouse currently have health, dental and/or vision coverage through EGID?** ☐ **Yes** ☐ **No (If Yes, list name and SSN above)**

CHILD ☐ Health ☐ Dental ☐ Vision ☐ Dependent Life

Name ____________ SSN ____________

Date of Birth ____________ ☐ Male ☐ Female

Primary Physician ____________ ☐ Current Patient ☐ New Patient

Primary Dentist ____________ ☐ Current Patient ☐ New Patient

CHILD ☐ Health ☐ Dental ☐ Vision ☐ Dependent Life

Name ____________ SSN ____________

Date of Birth ____________ ☐ Male ☐ Female

Primary Physician ____________ ☐ Current Patient ☐ New Patient

Primary Dentist ____________ ☐ Current Patient ☐ New Patient

CHILD ☐ Health ☐ Dental ☐ Vision ☐ Dependent Life

Name ____________ SSN ____________

Date of Birth ____________ ☐ Male ☐ Female

Primary Physician ____________ ☐ Current Patient ☐ New Patient

Primary Dentist ____________ ☐ Current Patient ☐ New Patient

PLEASE USE THE DEPENDENT ATTACHMENT FORM TO LIST ADDITIONAL DEPENDENTS
(This form is available from your insurance coordinator)

I certify that all selections made on this form are true and in compliance with the Plan Guidelines for Insurance Enrollment. I agree to deliver documentation that authenticates this statement to the requesting entity.

Employee Signature ____________________ **Date** ____________

SPOUSE MUST SIGN IF COMMON-LAW OR EXCLUDED FROM HEALTH AND/OR DENTAL COVERAGE.

☐ **COMMON-LAW SPOUSE CERTIFICATION:** I certify that the person listed as my spouse and I have an actual and mutual agreement between ourselves to be married; that this is a permanent relationship, and that our relationship is exclusive, as proven by our cohabitation as spouses; and do hereby hold ourselves out publicly as married. **I am aware that this relationship can be dissolved only by legal divorce.**

☐ **SPOUSE EXCLUSION CERTIFICATION** (required only if children are covered and spouse is not): I certify I am aware **I am being excluded from health and/or dental coverage as indicated on this form.** I am also aware that an employee who elects to cover all eligible dependent children and NOT their spouse will not have the opportunity to enroll their spouse until either the next annual Option Period or a midyear qualifying event occurs.

Spouse Signature ____________________ **Date** ____________

I certify this enrollment is in compliance with the provisions of the employer's Section 125 Plan or, if no 125 Plan is offered, is in compliance with new hire or allowed midyear coverage enrollments as defined by Title 26, Section 125, of the Internal Revenue Codes (as amended) and pertinent regulations. I further certify that on this date, this employee's annual salary listed below (if required) is correct to the best of my knowledge.

Employee's Annual Salary (Required for Supplemental Life in excess of $20,000) $____________

Insurance Coordinator's Signature ____________________ **Date** ____________
(Must be signed by insurance coordinator to be valid)

TULSA
PUBLIC SCHOOLS

Tulsa Public Schools

Benefit Election Confirmation / Enrollment Form

For Plan Year January 01, 2019 through December 31, 2019

Name:
Address:
City, State, Zip
Social Security Number:
Home Phone Number:
Number of Pay Periods: Site:
Email:

Section 125 Flexible Benefit Enrollment

A Section 125 Plan allows employees to have eligible insurance premiums taken out of their paycheck before taxes. Eligible insurance benefits include medical, dental, vision, and Life Insurance.

☐ **I elect to have the premiums for my eligible insurance benefits checked below contributed by salary reduction under the Section 125 Plan (before-tax).**

☐ Medical $_____	☐ Dental $_____	☐ Vision $_____	☐ Group Life $_____

☐ **I elect to waive my participation for eligible insurance benefits under the Section 125 Plan.**

Terms and Conditions

I authorize the above payroll reductions as my contribution to my Employer's Section 125 Cafeteria Plan. I understand that:

1. Changes in the cafeteria plan elections (other than with respect to Health Savings Accounts) can only be made at the end of the plan year unless due to and consistent with a valid status change (e.g., change in legal marital status; change in number of dependents; change in employment status; dependent satisfies or ceases to satisfy dependent eligibility requirements; residence change, cost or coverage changes) and such other events as would permit a revocation or change of election under IRC 125 regulations. Participation in this plan will automatically cease upon termination of employment. In most cases NO change may be made in the Medical Expense Reimbursement Account except for termination of participation of employment. For special rules affecting your plan, please contact your employer. FICA taxes are not paid on Section 125 salary reduction. Therefore, your social security benefits at retirement may be reduced. Unused funds remaining in the flex spending accounts at the end of the current plan year will be forfeited.
2. Execution of this benefit election/salary reduction agreement does not automatically institute insurance coverage; in most instances an application for insurance must be completed. Premiums charged for insurance coverage may be adjusted by the carrier issuing the contract and my "take-home" pay may be higher or lower depending on the selections made.

This authorization replaces any previous authorization I have made. This Election Form shall remain in effect until the earlier of the following dates: the date the Participant terminates participation in the Plan; or, the effective date of a subsequently filed Election Form electing or changing any or all of the benefits listed on this form.

Employee Signature: _____ **Date:** _____

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

I HAVE READ AND UNDERSTAND THE INFORMATION REGARDING COBRA CONTINUATION COVERAGE RIGHTS. I FURTHER UNDERSTAND THAT MY ELIGIBLE DEPENDENT SPOUSE (if any) MUST ALSO SIGN THIS ACKNOWLEDGMENT.

Employee Name (please print) Social Security Number

Employee Signature Date

Spouse Signature Date

Employing Agency

FEDERAL LAW REQUIRES THIS FORM BE KEPT ON FILE. RETURN THIS SIGNED FORM TO YOUR EMPLOYER.

PLAN GUIDELINES FOR INSURANCE ENROLLMENT

Please Detach and Keep for Your Records

IMPORTANT! YOU MUST READ THE FOLLOWING GUIDELINES BEFORE COMPLETING THIS FORM
Signatures on your form certify that you have read this page and that all of your elections meet the Plan guidelines.
Refer to Title 74 O. S., 2012 § 1323, Penalties for Knowingly Making False Statements

Enrolling yourself and your dependents:

New Hire Enrollment – You can enroll yourself and your dependents in any or all coverage in which your employer participates. Your dependents are not eligible for any coverage in which you are not enrolled. You must make your elections and sign the Insurance Enrollment Form within 30 days of your employment date.

Midyear Enrollments – To be eligible for a midyear enrollment after your initial employment date (other than Option Period), you must have lost other verifiable coverage (some exceptions apply). You can enroll yourself and your dependents only in the specific coverage that you lost. You must make your elections and sign the Insurance Enrollment Form or Insurance Change Form within 30 days of the qualifying event (the date the loss occurred).

Supersede Enrollment – You have 30 days following your employment date to make any additions or changes to the coverage you elected. In order to make changes, you must submit a new Insurance Enrollment Form with *SUPERSEDE* written across the top. This will alert EGID that no qualifying event is required because the change is being made within 30 days of your employment date. Any changes made to your original coverage are effective the first day of the month following the date you sign the *supersede* form.

Elections – You must elect health coverage to be eligible for dental and life coverage through EGID. You can exclude health coverage if you have other verifiable group health coverage. You may be asked to provide proof of that coverage. Failure to provide proof when requested will result in termination of all coverage.

Dependent children must be under 26 years of age to be eligible for enrollment.

If you cover one eligible dependent, you must cover all of your eligible dependents. You can elect not to cover dependents who do not reside with you, are married, are not financially dependent on you for support, have other verifiable group coverage, or are eligible for Indian or military benefits. You may be asked to provide proof of other coverage. Failure to provide proof when requested will result in termination of your dependents' coverages.

You can cover your children and exclude your spouse from health and/or dental coverage. If you choose this option, your spouse must sign and date the Spouse Exclusion Certification section of this form.

You can cover your children and exclude your spouse from vision and/or life coverage only if your spouse has other verifiable group vision and/or life coverage. You may be asked to provide proof of that coverage. Failure to provide proof when requested will result in termination of all coverage.

Once publicly declared, a common-law relationship can be dissolved only by legal divorce.

You must enroll in Basic Life in order to enroll in Supplemental Life and/or enroll your dependents in Dependent Life.

When you enroll, you will be provided a confirmation statement, which lists the coverage you are enrolled in, the effective date of your coverage, and the premium amounts. The CS allows you to review your coverage so that any errors can be identified and corrected. **Corrections should be submitted to your insurance coordinator or EGID within 60 days of the election.** Corrections reported to your insurance coordinator or EGID after 60 days will be effective the first of the month following notification.

Notification Time Limits – The deadlines for submitting this form to EGID are strictly enforced. Forms not received within the specified time periods will not be processed.

New hire enrollment: Your form must be received by EGID within 40 days of your initial employment date.
Midyear election enrollment: Your form must be received by EGID within 40 days of the qualifying event.

OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES
EMPLOYEES GROUP INSURANCE DIVISION
GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

You are receiving this notice because you have recently become covered under a group health, dental and/or vision plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage through EGID. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** When you become eligible for COBRA you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the *Consolidated Omnibus Budget Reconciliation Act* of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered through EGID when they would otherwise lose their group coverage. For additional information about your rights and obligations through EGID and under federal law, you should review your plan handbook or contact EGID.

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse and your dependent children could become qualified beneficiaries if coverage is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage through EGID because of the following qualifying events:

- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee (or former employee), you will become a qualified beneficiary if you lose your coverage through EGID because of the following qualifying events:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse (former employee) becomes entitled to Medicare benefits (Part A, Part B, or both).
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage because of the following qualifying events:

- You die.

- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.
- You become entitled to Medicare benefits (Part A, Part B, or both).
- You and your spouse divorce or legally separate.
- The child stops being eligible for coverage under the plan as a dependent child.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the Unites States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered through EGID, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage.

When is COBRA continuation coverage available?

EGID will offer COBRA continuation coverage to qualified beneficiaries only after they have been notified in writing that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, your death, commencement of a proceeding in bankruptcy with respect to the employer, or you become entitled to Medicare benefits (Part A, Part B, or both), the employer must notify EGID of the qualifying event.

You must give notice of some qualifying events.

For all other qualifying events (divorce or legal separation of you and your spouse or a dependent child losing eligibility for coverage as a dependent child), you must notify EGID within 30 days after the qualifying event occurs. You must provide this notice to the insurance/benefits coordinator at your employing agency. The notification must be in writing; a telephone call is not sufficient. You may also be required to provide documentation or other required information.

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events or a second qualifying event during the initial period of coverage may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage
If you or anyone in your family covered EGID is determined by the Social Security Administration to be disabled and you notify EGID within 60 days of the SSA determination and before the end of the first 18 months of continuation coverage, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the Social Security disability determination must be sent to EGID, P.O. Box 58010, Oklahoma City, OK. 73157-8010 before the expiration of the 18 months of COBRA, and within 60 days from the later of:

1. The date of the Social Security Administration disability determination.
2. The date of the qualifying event.
3. The loss of coverage date.
4. The date the qualified beneficiary is informed of the obligation to provide the disability notice.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to EGID. This extension may be available to your spouse and any dependent children receiving continuation coverage if you die, become entitled to Medicare benefits (Part A, Part B or both), get divorced or legally separated, or if the dependent child stops being eligible as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage through EGID had the first qualifying event not occurred.

Are there other coverage options besides COBRA continuation coverage?

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

If you have questions

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

Keep your plan informed of address changes

To protect your family's rights, keep EGID informed of any changes in the addresses of family members. You should also keep a copy of any notices you send to EGID.

Plan contact information

Please contact the insurance coordinator at your employer. If you have additional questions about COBRA, send questions to the Office of Management and Enterprise Services EGID Member Services at 3545 N.W. 58th St., Ste. 110, Oklahoma City, OK, 73112, call 405-717-8780 or toll-free 800-752-9475, TDD users call 405-949-2281 or toll-free 866-447-0436, or visit the website at www.sib.ok.gov.

AMERICAN FIDELITY
a different opinion

P.O. Box 258886
Oklahoma City, OK 73125
Toll Free: (800) 662-1113
Fax: (844) 560-6754
Website: americanfidelity.com
Email: HSA-Support@americanfidelitly.com

##24T00934##########

HEALTH SAVINGS ACCOUNT
Application and Custodial Agreement

PLEASE NOTE: Do not use a coversheet if faxed. Fax will go into secured inbox. Bar code must be visible on first page for processing.

PERSONAL INFORMATION					
Name				SSN	
Physical Address				DOB (mm/dd/yyyy)	
City, State, Zip				Marital Status	☐ Single ☐ Married
Mailing Address (if different)				Driver's License #	
City, State, Zip				Issuing State	
Home Phone		Work Phone		Cell Phone	
Email address					

Important Information about Procedures for Opening a New Account:

To help the government fight the funding of terrorism and money laundering activities, Federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. What this means for you: When you open an account, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

HEALTH PLAN INFORMATION					
☐ Yes ☐ No	Are you covered by an HSA qualified high deductible plan (HDHP)? (If you answer no, you are not eligible to establish an HSA.)			☐ Yes ☐ No	Are you covered by any other non-permitted health plan? (See americanfidelity.com for definitions & examples)
Carrier Name				☐ Yes ☐ No	Are you covered by Medicare?
Effective date of HDHP	_____	Yearly Deductible	$_____	☐ Yes ☐ No	Are you claimed as a dependent on another person's tax return?
Type of Coverage	☐ Individual ☐ Family			(If you answered yes to any of the questions above, you are not eligible to establish an HSA. See IRS Publication 969 for specific information.)	

EMPLOYER INFORMATION (if you are establishing the HSA separate from your employer, this information does not need to be completed)			
Company Name	Tulsa Public Schools	Contact	Kylie Wagner
Address	3027 S New Haven Ave	Telephone Number	918-746-6357
City, St, Zip	Tulsa OK 74114	Date of Employment	

CONTRIBUTION INFORMATION

Requested effective date for the HSA: _____

(The requested effective date cannot be sooner than the date this application is signed, effective date of coverage under the HDHP or the date you are eligible to contribute to an HSA.)

Contribution	Annual	Per Pay Period	Pay Period (if applicable)
Employer	$0.00	$0.00	☐ Monthly ☐ Bi-monthly ☐ Weekly ☐ Bi-weekly
Individual	$_____	$_____	
Catch-up Contribution	$_____	$_____	

[2018] Maximum Annual Contribution: Individual = [$3,450] Family = [$6,900]

[2019] Maximum Annual Contribution: Individual = [$3,500] Family = [$7,000]

For additional information on what may affect your annual allowable contribution(s), please visit americanfidelity.com.

Account owners age 55+ may make an additional contribution of $1,000/year.

AMERICAN FIDELITY
a different opinion

REQUEST FOR ADDITIONAL DEBIT CARD (Optional)			
Would you like a second debit card for use by an authorized user – either a spouse or an eligible dependent*- at no additional fee? ☐ Yes ☐ No *Dependent must be 18 years or older.			
Name		Relationship	
Social Security #		DOB (mm/dd/yyyy)	
☐ Check this box if you would like to list the above person as a signatory on your HSA.			
A MasterCard will automatically be mailed to your home address shown above. The debit card can be used with merchants with a valid medical merchant code. By requesting a secondary debit card, you are agreeing that the secondary debit card is subject to the HSA custodial agreement, all other conditions of the account, and all law governing HSA accounts.			

BENEFICIARY INFORMATION					
Name		Relationship		☐	Primary
Address		DOB		☐	Contingent
City, St, Zip				____%	Percent
Name		Relationship		☐	Primary
Address		DOB		☐	Contingent
City, St, Zip				____%	Percent
Name		Relationship		☐	Primary
Address		DOB		☐	Contingent
City, St, Zip				____%	Percent

Back-Up Withholding Certificate

I hereby certify under penalties of perjury that: The social security number shown on this form is my correct taxpayer identification number, I am a U.S. person (including a U.S. resident alien), and that (please check the appropriate box):

☐ I am not subject to withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

☐ I am subject to backup withholding.

This application, when signed by me and accepted by American Fidelity - Administrator/Record keeper, constitutes my adoption of this application/ Custodial Agreement. By signing this agreement, I acknowledge and certify that I have received either in print or electronically (available anytime at americanfidelity.com), read and agree to the terms in the HSA Custodial Agreement, HSA Interest & Fee Schedule and Terms and Conditions of my Account and any amendments thereof.

Signature of Depositor _____ Date _____ Signature of Custodian _____ Date _____

Standard Insurance Company

Enrollment and Change

To Be Completed By Talent Management

Group Number	Division	Billing Category	TPS ID	Date of Employment
755591				

To Be Completed By Applicant

☐ Apply for Coverage ☐ Beneficiary Change *Complete Beneficiary Section below.* ☐ Name Change

☐ Add or ☐ Delete Dependent Date of add/delete _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	☐ Male ☐ Female
Your Address		City	State / ZIP
Former Name (Last, First, Middle) *Complete only if name change*			Phone Number
Employer Name: **Independent School District No. 1, Tulsa County**			Job Title/Occupation
Hours Worked Per Week	Earnings $_____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year		

Coverage ***Check with your Talent Management Department about coverage options available to you and Evidence Of Insurability requirements.***

Life Insurance

☒ Basic Life with AD&D (Employer Paid)

Additional Life with AD&D ☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ Other $_____

Spouse Life with AD&D ☐ $5,000 ☐ $15,000 ☐ $25,000 ☐ Other $_____

Child Life with AD&D ☐ $10,000

Beneficiary ***This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.***

Primary – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit*

Contingent – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. *if known*	Relationship	% of Benefit*

****Total must equal 100%***

Signature I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____

Return completed form to your Talent Management Department.

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:

  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.

  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.

  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

Standard Insurance Company
Additional Life and AD&D Coverage Highlights
Independent School District No. 1, Tulsa County

Additional Life and Accidental Death and Dismemberment (AD&D) Insurance

Life insurance coverage can help your family meet daily expenses, maintain their standard of living, pay off debt, secure your children's education, and more in the event of your passing. AD&D insurance can provide you and your family with extra protection in the event of death or dismemberment as a result of a covered accident. Standard Insurance Company (The Standard) has developed this document to provide you with information about the elective coverage you may select through Independent School District No. 1, Tulsa County.

Eligibility Requirements

Employee

- You must be insured for Plan 1 (basic) Life through The Standard
- You must be an active employee of Independent School District No. 1, Tulsa County working at least 20 hours each week
- Temporary and seasonal employees, full-time members of the armed forces, leased employees and independent contractors are not eligible
- You cannot be insured as both an employee and a dependent

Dependent

- You must elect Plan 2 (additional) Life insurance for yourself in order to elect Dependents Life insurance
- Spouse means a person to whom you are legally married
- Child means your child from live birth through age 25
- Your child cannot be insured by more than one employee
- Your spouse or children must not be full-time member(s) of the armed forces

Premium

- You pay 100 percent 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 Plan 2 (additional) Life and Dependents Life insurance for which you are interested in applying.

-OR-

	Minimum	Incremental Unit	Guarantee Issue Amount	Maximum
Employee	$10,000	$10,000	Lesser of $150,000 or 3 times your Annual Earnings	$350,000*
Spouse	$5,000	$5,000	$25,000	$150,000
Child	$10,000			

*but not to exceed 5 times your Annual Earnings

Note:

- Amounts of coverage elected above the Guarantee Issue amount are subject to medical underwriting approval. To submit a medical history statement online, visit: http://www.standard.com/mybenefits/mhs_ho.html.
- All late applications (applying 31 days after becoming eligible), requests for coverage increases and reinstatements are subject to medical underwriting approval. Employees eligible but not insured under the prior life insurance plan are also subject to medical underwriting approval.
- The coverage amount for your spouse cannot exceed 100 percent of your Plan 2 (additional) Life coverage.
- The coverage amount for your child(ren) cannot exceed 100 percent of your Plan 2 (additional) Life coverage.

Coverage Amount Needed

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

Employee Coverage Effective Date

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

If you are not actively at work on the day before the scheduled effective date of insurance including Dependents Life 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.

Life and AD&D Age Reductions

Under this plan, your coverage amount reduces by your age as follows: by 35 percent at age 65, by 55 percent at age 70, by 70 percent at age 75, and by 80 percent at age 80.

If you are age 65 or over, ask your human resources representative for the amount of coverage available.

Life Insurance Exclusions

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.

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 the date you reach Social Security Normal Retirement Age (SSNRA) 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 $600,000.
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.

Additional AD&D Insurance Benefit Schedule

The amount of the Additional AD&D benefit for loss of your, or your dependents, life is equal to the amount payable for your Additional Life or your Dependents Life benefit on the date of the accident. The amount of the Additional AD&D benefit for other covered losses is a percentage of the amount payable for the Additional AD&D benefit on the date of the accident as shown below.

Loss:	**Percentage Payable:**
Loss of Life[1]	100%
One hand or one foot[2]	50%
Sight in one eye, speech, or hearing in both ears	50%
Two or more of the losses listed above	100%
Thumb and index finger of the same hand[3]	25%
Quadriplegia	100%
Hemiplegia	50%
Paraplegia	50%
Uniplegia	25%
Coma[4]	5%

[1] Including loss of life by accidental exposure to adverse weather conditions or disappearance if the disappearance is caused by an accident that could have reasonably resulted in your death.
[2] Even if the severed part is surgically re-attached. This benefit is not payable if an Additional AD&D benefit is payable for Quadriplegia, Hemiplegia, Paraplegia, or Uniplegia involving the same hand or foot.
[3] This benefit is not payable if an Additional AD&D benefit is payable for the loss of the entire hand.
[4] 5% per month of the remainder of the AD&D Insurance Benefit payable for Loss of life after reduction by any AD&D Insurance Benefit paid for any other Loss as a result of the same accident. Payment for coma will not exceed a maximum of 12 months.

The loss must be caused solely and directly by an accident and occurs independently of all other causes, within 365 days after the accident. Loss of life must be evidenced by a certified copy of the death certificate. All other losses must be certified by a physician in the appropriate specialty as determined by The Standard. No more than 100 percent of the AD&D benefit will be paid for all losses resulting from one accident.

Additional AD&D Insurance Exclusions

Subject to state variations, AD&D benefits are not payable for death or dismemberment caused or contributed to by:

- War or act of war, declared or undeclared, whether civil or international, and any substantial armed conflict between organized forces of a military nature
- Suicide or other intentionally self-inflicted injury
- Committing or attempting to commit an assault or felony, or actively participating in a violent disorder or riot
- Voluntary use or consumption of any poison, chemical compound, alcohol or drug, unless used or consumed according to the directions of a physician
- Sickness or pregnancy existing at the time of the accident
- Heart attack or stroke
- Medical or surgical treatment for any of the above
- Boarding, leaving or being in or on any kind of aircraft, unless you are a fare paying passenger on a commercial aircraft

When Insurance Ends

Coverage ends automatically on the earliest of the following:

- The last date the last period ends for which a premium was paid
- The last day of the calendar month in which your employment terminates
- The date you cease to meet the eligibility requirements (coverage may continue for limited periods under certain circumstances)
- The date the group policy, or your employer's coverage under the group policy, terminates
- For each elective insurance coverage, the date that coverage terminates under the group policy
- For Plan 2 (additional) AD&D insurance for you, the date your Plan 2 (additional) life insurance ends

In addition to the above requirements, your Dependents Life with AD&D coverage ends automatically on the date your dependent ceases to meet the eligibility requirements for a dependent.

For more details on when insurance ends, contact your human resources representative.

Group Insurance Certificate

If coverage becomes effective, and you become insured, you will receive a group insurance certificate containing a detailed description of the insurance coverage including the definitions, exclusions, limitations, reductions and terminating events. The controlling provisions will be in the group policy. Neither the information presented in this summary nor the certificate modifies the group policy or the insurance coverage in any way.

Employee 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 first paycheck following change in age)	Rate* (Per $1,000 of Total Coverage)
<30	$0.08
30-34	$0.10
35-39	$0.11
40-44	$0.13
45-49	$0.18
50-54	$0.26
55-59	$0.49
60-64	$0.72
65-69	$1.37
70-74	$2.21
75+	$2.21

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 $1,000 = 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: _____

*** Monthly AD&D rate of $0.02 per $1,000 of AD&D benefit has been included in each of the above rates.**

Spouse Rates

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

Employee's Age (as of first paycheck following change in age)	Rate* (Per $1,000 of Total Coverage)
<30	$0.074
30-34	$0.094
35-39	$0.104
40-44	$0.124
45-49	$0.174
50-54	$0.254
55-59	$0.484
60-64	$0.714
65-69	$1.364
70-74	$2.204
75+	$2.204

To calculate the premium for your spouse:

1. Amount Elected: Write this amount on the Spouse Life with AD&D requested amount line on your Enrollment and Change Form. Line 1: _____
2. Line 1 divided by $1,000 = 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: _____

*** Monthly AD&D rate of $0.014 per $1,000 of AD&D benefit has been included in each of the above rates.**

Child Rates

If you elect Dependents Life with AD&D insurance for your eligible child(ren), your monthly rate for this coverage is $0.14* regardless of the number of eligible children covered. Premiums for this coverage will be deducted directly from your paycheck.

*** Monthly AD&D rate of $0.04 per $1,000 of AD&D benefit has been included in the above rate.**

Standard Insurance Company

For more than 100 years we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. We have earned a national reputation for quality products and superior service by always striving to do what is right for our customers.

Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group Disability, Life, Dental and Vision insurance and Individual Disability insurance. We provide insurance to more than 24,800 groups, covering over 8 million employees nationwide.* Our first group policy, written in 1951 and still in force today, stands as a testament to our commitment to building long-term relationships.

To learn more about products from The Standard, Contact your human resources department or visit us at **www.standard.com.**

* As of June 30, 2013, based on internal data developed by Standard Insurance Company.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

GP190-LIFE/S399, GP399-LIFE/TRUST,
GP899-LIFE, GP190-LIFE/A997/S399