January 9, 2018

Employees Group Insurance Division (EGID) doesn't print Guide Books any more. The book is online at www.healthchoiceok.com. You will go to the member tab and then to handbooks. The handbook is in PDF format.

Here are the PPO plans offered by EGID:

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

It has a $1,750 deductible for individual; $3,500 family per year that must be met before it acts like the 80%/20% plan with co-pay for doctor visit. 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 individual coverage, the difference of $193.12 will be refunded to you each month in your pay.

The premium for family coverage is $3,474 to $7,203 less than the premium for the HealthChoice plan.

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 never taxed and can be used any time in your life. The HSA funds can also be used for any tax dependents even if they are not on your insurance.

- **HealthChoice High Plan**

It has a $750 deductible + $100 pharmacy, $2,000 family (3 or more) deductible + $300 pharmacy, per year and a $100 pharmacy deductible. The only time you have to pay the deductible up front is hospitalization, outpatient surgery, emergency room, Urgent Care, etc.

Other than that it is $30 for PCP and $50 for Specialist. For blood work, X-rays etc. the plan pays 80% you pay 20%.

The District pays the premium for an individual.

- **HealthChoice Basic Plan**

They pay the first $500 of allowable fees. You pay 100% of the next $1,000 of allowable fees. After that you pay 50% of the next $6,000. Then the plan pays 100%.

Pharmacy: $100 pharmacy deductible, with a $300 maximum deductible per family.

Since the premium is less than the amount paid by the district for individual coverage, the difference of $128.48 will be refunded to you each month in your pay.

All Tulsa hospitals are in the HealthChoice Network.

Here are the HMO plans offer by the EGID:

HMO's is copay driven and zip code driven. You have a primary care physician (PCP) that you assign yourself to or one that they assign you too.

Should there be a need for you to go to a specialist you have to go through you PCP for a referral.

The HMO plans go to different Hospitals.

- **Aetna St Johns** - is in network with St Johns. They only have a select number of Providers.
- **CommunityCare** - is in network with St. Johns and Saint Francis
- **GlobalHealth** - is in network with Hillcrest, Hillcrest South, OSU Medical, Bailey Medical Center in Owasso, Hillcrest Hospital Claremore, Tulsa Spine, Oklahoma Surgical and Wagoner Community Hospital.

Information on the plans for 2018 can be found at www.healthchoiceok.com

Click on the Member tab

And go to 2018 Handbook (it is in PDF format)

Information Contact:

Sharon Izett @ izettsh@tulsaschools.org or 918-746-6350

Contact Information

Health Plans

Aetna INTEGRIS and Aetna St. John

800-459-7791
www.stateofok.aetna.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

405-416-1800 or 800-782-5218
TDD 405-416-1525 or 800-941-2160

Pharmacy

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

Life Insurance

HealthChoice

405-416-1800 or 800-782-5218
TDD 405-416-1525 or 800-941-2160
www.healthchoiceok.com

Additional

EGID

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

American Fidelity Health Services Administration

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

Dental Plans

Assurant Inc. Dental

PPO Freedom Preferred 800-442-7742
Prepaid Heritage Plans 800-443-2995
www.assurantemployeebenefits.com

CIGNA Prepaid Dental

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

Delta Dental

405-607-2100 or 800-522-0188
www.DeltaDentalOK.org

HealthChoice

405-416-1800 or 800-782-5218
TDD 405-416-1525 or 800-941-2160
www.healthchoiceok.com

MetLife

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

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 877-488-8900
www.visioncaredirect.com/oklahoma

VSP

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

Monthly Insurance Deductions Tulsa Public Schools
Effective January 1, 2018 - December 31, 2018

All Certified Employees and Support Employees Eligible for FBA (Working 6 hrs or more on a regular contract)

Health Insurance Plan		*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	419.42	659.96	826.30
Aetna HMO		80.72	533.38	533.38	1,188.50	1,641.16	1,641.16
Community Care HMO		287.40	736.76	1,006.38	1,572.58	2,021.94	2,291.56
Global HMO	*3	(1.54)	319.00	521.90	874.32	1,194.86	1,397.76

***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 $1.54 per month ($18.48 per year) if you choose Global HMO.

TRICARE Supplement	*Member*	*Member +1*	*Member +2 or more*
	60.50	119.50	160.50

Support Employees Not Eligible for FBA (Employees Scheduled For 25-29 Hours Per Week)*

Health Insurance Plan	*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	898.52	1,139.06	1,305.40
Aetna HMO	559.82	1,012.48	1,012.48	1,667.60	2,120.26	2,120.26
Community Care HMO	766.50	1,215.86	1,485.48	2,051.68	2,501.04	2,770.66
Global HMO	477.56	798.10	1,001.00	1,353.42	1,673.96	1,876.86

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

Dental Insurance Plan	*Member Only*	*Member + Child*	*Member + Children*	*Member + Spouse*	*Member + Spouse + Child*	*Member + Spouse + Children*
Assurant Freedom Preferred	19.26	41.84	79.94	49.36	71.94	110.04
Assurant Heritage Plus withSBA (Prepaid)	0.74	8.34	15.94	9.60	17.20	24.80
Assurant Heritage Secure (Prepaid)	0.00	5.20	10.38	5.98	11.18	16.36
Cigna Dental Care Plan (Prepaid)	0.00	4.08	9.18	6.00	10.08	15.18
Delta Dental PPO	22.64	51.90	96.68	56.26	85.52	130.30
Delta Dental PPO Plus Premier	33.52	72.30	131.58	78.04	116.82	176.10
Delta Dental PPO - Choice	4.06	38.50	87.66	38.24	72.68	121.84
HealthChoice Dental	28.12	59.70	109.22	67.24	98.82	148.34
MetLife Classic	25.98	57.66	104.76	62.96	94.64	141.74
MetLife Value MAC	16.24	39.58	74.26	43.48	66.82	101.50
MetLife Value PDP	18.48	43.72	81.28	47.96	73.20	110.76

Vision Insurance Plan	*Member Only*	*Member + Child*	*Member + Children*	*Member + Spouse*	*Member + Spouse + Child*	*Member + Spouse + Children*
Primary VisionCare Services (PVCS)	9.36	17.36	20.36	17.36	25.36	28.36
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)	8.02	13.30	19.60	13.38	18.66	24.96

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

EMPLOYER INFORMATION (To be completed by insurance coordinator)

Group ID # 724001 Division ID # 0686 Group Name TPS

☐ New Hire Enrollment ☐ Midyear Enrollment

EMPLOYEE INFORMATION (Please print)

SSN # _____ ☐ Married ☐ Single

Employee's Name (Please print)	First Name	MI	Last Name

Mailing Address _____

City State ZIP Code

Home Telephone # _____ Email Address _____

Residence State _____ Worksite State _____

Employee's Birth Date	Mo.	Day	Yr.	Sex

Effective Date of Coverage	Mo.	Day	Yr.
		01	

EMPLOYEE HEALTH PLAN ELECTION

HealthChoice ☐ High ☐ Basic ☐ High Deductible Health Plan (HDHP)

☐ Aetna HMO ☐ CommunityCare HMO ☐ GlobalHealth HMO

Employee Primary Physician (HMO only): _____ ☐ Current Patient ☐ New Patient

EMPLOYEE DENTAL PLAN ELECTION

☐ Assurant Freedom Preferred
☐ Assurant Heritage Plus w/SBA (Prepaid)
☐ Assurant Heritage Secure (Prepaid)
☐ CIGNA Dental Care Plan (Prepaid)
☐ Delta Dental PPO
☐ Delta Dental PPO – Choice
☐ Delta Dental PPO Plus Premier
☐ HealthChoice Dental Plan
☐ MetLife Classic
☐ MetLife Value MAC
☐ MetLife Value PDP

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)

Revised 10/12/2016

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 EGID upon request.

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)

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 (CS). The CS 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.

TULSA PUBLIC SCHOOLS

Benefit Election Confirmation / Enrollment Form and Interest Form
For Plan Year January 1, 2017 through December 31, 2017

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, life, Cancer Insurance, Accident Only Insurance and Disability Income Insurance.

I elect to have the premiums for my eligible insurance benefits checked below under the Section 125 Plan (before-tax).

☐ Medical	$_____	☐ Dental	$_____	☐ Life	$_____	☐ Group Life	$_____
☐ Cancer**	$_____	☐ Disability*	$_____	☐ Accident	$_____		

Flexible Spending Accounts

This part of Section 125 allows employees to set aside pre-tax dollars for unreimbursed medical expenses and dependent care expenses. However, any expense dollars not used for expenses incurred during the period of coverage are forfeited. This is known as the "use or lose" rule. It is very important you be conservative and accurate when estimating your expenses for the year.

☐ Medical Expense Reimbursement: Total Plan Year Election: $ _____ (min $120, max $2,500)

☐ Dependent Care Expense Reimbursement: Total Plan Year Election: $ _____ (min $120, max $5,000)

American Fidelity Insurance Benefits Available

If you would like additional information, please check the appropriate box(es).

☐ Disability Income Insurance*	☐ 403b/457****	☐ Cancer**
☐ Long Term Care***	☐ Life Insurance***	☐ Accident Only
☐ Hospital GAP PLAN®	☐ Hospital Indemnity**	☐ Health Savings Account

☐ *Please Contact Me! I would like additional information or wish to make a change.* With my signature on the back of this form, I consent to being contacted, including by phone, regardless of my status on any Do-Not-Call list.]

* This benefit will result in taxable income if selected on a before-tax basis.
** When indemnity premiums are pre-taxed, benefits paid in excess of the medical expenses incurred could be taxable.
*** Not available under Section 125 plan.
**** Annuity elections shown above are for informational purposes only. This form is not an authorization to reduce salary for 403(b) and 457(b) plans. A 403(b) or 457(b) salary reduction form must be completed and submitted to the employer. Annuities are not eligible under Section 125.

SIGNATURE REQUIRED ON BACK

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.

[If I have elected the Health Savings Account benefit, I certify that I have met all the Health Savings Account eligibility requirements, which have been separately disclosed to me, and that I will notify the Employer immediately in writing if I cease to meet any of the conditions for Health Savings Account eligibility during any month of the plan year.]

[I will have {___} days after a qualifying event to make an election change.]

This authorization replaces any previous authorization I have made. [My participation in this Plan terminates on the last day of the Plan year. Before the beginning of each Plan year, I will be offered the opportunity to change my election for the following Plan year.] [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.]

[FLEXIBLE SPENDING ACCOUNTS - REIMBURSEMENT RULES FOR PARTICIPATION

As a part of my benefit election for the plan year, I have elected participation in the expense reimbursement account(s) as indicated above. I have received a summary of the terms of participation in the reimbursement accounts and understand the terms and conditions of participation in that portion of the Section 125 plan.

- I understand that if the dollars allocated to be reimbursed to me under the provisions of this plan are not used for such benefits, the balance of the unused amounts must be forfeited to my Employer ("Use or lose").
- Medical expenses reimbursed under this plan are not eligible as tax deductions on my federal income tax return.
- Medical expenses for reimbursement include certain expenses incurred during the period of coverage plan year for the diagnosis, cure, mitigation, treatment, or prevention of disease for which there has been no other reimbursement through insurance, damages, or otherwise. Certain cosmetic surgery expenses and medical insurance premiums are not eligible for reimbursement.
- I understand that during an unpaid leave of absence, in order to continue participation, contributions to the medical expense reimbursement account must be made on an after-tax-basis just like any insurance premiums. When I return to work, the pre-tax contribution will resume. For special rules affecting your plan, please contact your employer.
- If I terminate my employment and do not elect to continue my medical expense account payments on an after-tax basis, only expenses incurred during the period of coverage will be reimbursed. Coverage under the reimbursement account ceases when the payments cease.
- Dependent care expenses reimbursed under this plan are not eligible for the dependent care tax credit on my federal income tax return.
- Dependent care expenses eligible for reimbursement must be provided by third parties meeting both applicable state law requirements and federal tax law requirements. Claims may only be made for dependent care that has already been provided. The amount allocated by federal tax law is $5,000 (or $2,500 each if married and filing separately) for the calendar year.
- Instructions on how to acquire expense vouchers will be provided to the participant. The expense voucher must be completed and submitted with proper documentation in order for the participant to be reimbursed for any expense on a timely basis. The Employer will establish a cut-off date ("runoff period") for submission of vouchers.
- I understand that I must submit documentation as requested by American Fidelity for all expenses reimbursed under this plan.
- I understand that no reimbursement will be made until the first contribution is received and posted to my account.
- I agree to notify my Employer if there is reason to believe that any item for which reimbursement has been made is not allowable under the terms of the Plan.
- The Employer may allow for a grace period on the medical expense reimbursement account. The grace period is an additional length of time after the plan year ends during which the participant can incur and submit claims for reimbursement (not all Employers allow for the grace period; please contact your Employer to verify if this applies to your plan).]

Employee Signature: **Date:**

RULES OF PARTICIPATION AND AUTHORIZATION OF DEDUCTION
FLEX DEBIT CARD

I understand that:

- the primary benefit of using the Flex Debit Card is that I do not have to pay out-of-pocket for my eligible medical expenses at the time payment is rendered for the expense and then wait to be reimbursed from my Health Flexible Spending Account.
- usually, when I use the Flex Debit Card, I will still need to keep and submit documentation to American Fidelity Assurance Company ("American Fidelity") for the transaction in order to verify the eligibility of the expense.
- the Flex Debit Card may only be used at qualified medical providers.
- if the medical provider does not accept the Flex Debit Card, the card user will need to pay the expense and submit the claim for reimbursement to American Fidelity manually by mail or fax.
- if I do not respond to American Fidelity's request for receipts in a timely manner, access to the Flex Debit Card will be blocked and will not be unblocked, even in the following plan year, until I pay back the amount of the expense by either check or money order.
- if the Flex Debit Card is used to pay for an ineligible expense, I will be required to pay back the amount of the expense when requested by American Fidelity, by either check or money order.
- if I do not pay back the plan in a timely manner when requested to do so, my employer will be notified. My employer may make an after tax deduction or adjust my W-2 at the end of the tax year to make this correction.
- if the expense is greater than the amount available on the Flex Debit Card, the card swipe will be denied.
- there may be a fee charged to participate in the debit card program and, if so, I authorize my employer to payroll deduct this fee.
- a new Flex Debit Card will not be issued each year. Each subsequent year I (and my dependent(s)) participate, the election amount for the new plan year will be loaded to the existing card. The Flex Debit Card will expire 3 years from the date of issue.

If applicable, I certify that the additional Flex Debit Card will be provided to a person(s) who is:

- my eligible tax dependent or adult child as defined by the Internal Revenue Service, who is at least age 18 as of the first day of the plan year and who has not reached age 27 by the end of the tax year; or,
- my spouse.

When a dependent loses dependent status, I understand that I must notify American Fidelity immediately.

I am authorizing that an additional Flex Debit Card be issued in my dependent's name which will be used in conjunction with my Health Flexible Spending Account (Unreimbursed Medical Account) offered by my employer. Dependents that have the additional Flex Debit Card will have access to my account information, including protected health information.

Employer Name: _____ Date: _____

Print Name: _____ Signature: _____

Social Security Number: _____

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.

Revised 12/06/2012

IMPORTANT INFORMATION
COBRA Continuation Coverage and other Health Coverage Alternatives

(Please read carefully and retain for future reference)

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or former employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including Option Period Enrollment rights.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits, or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. The *COBRA Continuation Coverage Notice* shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- the required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Office of Management and Enterprise Services Employees Group Insurance Division of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has 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 SSA's determination must be sent to the Office of Management and Enterprise Services Employees Group Insurance Division within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan in writing within 30 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the election form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary will be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in the *COBRA Continuation Coverage Notice*. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you will also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov. Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage will not limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage. To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

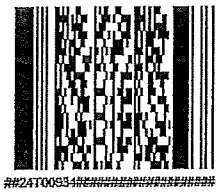
If I elect COBRA continuation coverage, can I switch to coverage in the Marketplace? What if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you elect COBRA continuation coverage you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also terminate your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through a "special enrollment period." If you terminate your COBRA continuation coverage early without another qualifying event you will have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

Once you have exhausted your COBRA continuation coverage and the coverage expires you will be eligible to enroll in Marketplace coverage through a special enrollment period even if Marketplace open enrollment has ended. If you elect Marketplace coverage instead of COBRA continuation coverage you cannot switch to COBRA continuation coverage under any circumstances.

American Fidelity
Health Services Administration
a different opinion

P.O. Box 258886
Oklahoma City, OK 73125
Toll Free: (866) 326-3600
Local: (405) 523-5699
Fax: (844) 560-6754
Website: www.afhsa.com
Email: afhsa_receipts@alegeus.com



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 www.afhsa.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 Million
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	$_____	$_____	☐ Monthly ☐ Bi-monthly ☐ Weekly ☐ Bi-weekly
Individual	$_____	$_____	
Catch-up Contribution	$_____	$_____	

[2016] Maximum Annual Contribution: Individual = [$3,350] Family = [$6,750]

[2017] Maximum Annual Contribution: Individual = [$3,400] Family = [$6,750]

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

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

American Fidelity
Health Services Administration
a different opinion

P.O. Box 258886
Oklahoma City, OK 73125
Toll Free: (866) 326-3600
Local: (405) 523-5699
Fax: (844) 560-6754
Website: www.afhsa.com
Email: afhsa_receipts@alegeus.com

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 Health Services Administration - 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 www.afhsa.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 _____