2024

Enrollment for Pre-Medicare Retirees (Under 65)

TULSA COMMUNITY COLLEGE

Table of Contents

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

Our Retiree Benefits Program

At Tulsa Community College, we value your past contributions to our success and want to provide you with a benefits package to protect your health and your financial security, now and in the future. We continually look for valuable benefits that support your needs during retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially. Retiree benefits available to you include:

- Medical Coverage
- Dental Coverage
- Vision Insurance
- Life Insurance
- Pet Insurance

This guide is an overview and does not provide a complete description of all benefit provisions. For detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs) found on TCC's Retiree Website at: www.tulsacc.edu/retiree. The plan benefit booklets determine how all benefits are paid. Tulsa Community College reserves the right to change, amend, or terminate these plans at any time.

A list of plan contacts is included at the back of this guide.

The benefits in this guide are effective:

January 1, 2024 – December 31, 2024

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 22-23 for more details.

Whom Can You Cover?

You are eligible to participate in the TCC's Retiree benefit plans if you are a TCC retiree and currently have health, dental, vision and/or life coverage.

Eligible Dependents

- Your legal spouse or domestic partner;
- Dependent children up to age 26, including biological and adopted children, stepchildren of your current marriage or children for whom you are the legal guardian; and
- Dependent children who cannot support themselves due to physical or mental handicap that began before they reached age 26.

Making Changes

Open Enrollment is the only time you can make changes to your benefit elections for any reason. Dependents can be added only if they experience a qualifying event.

During the year, if you experience a Qualifying Life Event notify Human Resources within 30 days and submit the appropriate required documentation to make changes to your current coverage. Qualifying Life Events include (but are not limited to):

- Birth or adoption of a child;
- Loss of other healthcare coverage;
- Eligibility for new healthcare coverage;
- Marriage, legal separation or divorce; or
- Death.

Should you or a dependent pass away, please contact the Tulsa Community College Human Resources immediately to manage insurance options.

Please Note: You cannot add or increase life insurance at retirement.

Enrollment for 2024

To enroll or change benefit elections, please complete an Enrollment Form that can be found on TCC's retiree website at: www.tulsacc.edu/retiree and return to:

Tulsa Community College
Human Resources
ATTN: Melyssa Hendrickson
909 S. Boston Ave.
Tulsa, OK 74119

Plan Premiums

Navia Benefit Solutions will continue as the retiree billing administrator for your Retiree Insurance Plans and will be collecting your monthly insurance premiums. At your initial enrollment and annually at the beginning of each calendar year, Navia Benefit Solutions will send you a Welcome Letter Packet with a premium payment statement included for your convenience to review your payments. Keep in mind, retiree coverage will continue to be an ACH authorized form of payment for your monthly premiums.

Retirement System Contribution To Your Monthly Insurance Premium

Oklahoma Teacher's Retirement may contribute a monthly subsidy toward your health insurance premiums. The premiums listed in this guide do not reflect any retirement system contribution.

Medical

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

All retirees will need to actively make elections to continue coverage, make changes or to cancel coverage for 2024. Effective January 1, 2024, a third plan will be added called the Blue Advantage $500 plan. The only differences between the Blue Advantage and the Blue Preferred plan are the provider network and the premium. The benefits are the same. Provider network information is listed in the below table. During open enrollment, you will need to complete the necessary paperwork and return to Human Resources by November 1, 2023.

	Blue Advantage PPO $500 Plan		**Blue Preferred PPO $500 Plan**		**BlueLincs HMO $250 Plan**
Network:	**Blue Advantage**		**Blue Preferred**		**BlueLincs HMO**
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network ONLY**
Annual Deductible	$500 individual $1,500 family	$1,500 individual $4,500 family	$500 individual $1,500 family	$1,500 individual $4,500 family	$250 individual $750 family
Coinsurance	20% Blue Advantage	50%	20% Blue Preferred	50%	20%
Annual Out-of-Pocket Max	$5,000 individual $10,000 family	$10,000 individual $20,000 family	$5,000 individual $10,000 family	$10,000 individual $20,000 family	$5,000 individual $10,000 family
Preventive Services	Covered in full	Plan pays 70% after deductible	Covered in full	Plan pays 70% after deductible	Covered in full
Office Visit					
Primary Provider	$35 copay	Plan pays 70% after deductible	$35 copay	Plan pays 70% after deductible	$30 copay
Specialist	$40 copay	Plan pays 70% after deductible	$40 copay	Plan pays 70% after deductible	$60 copay
Virtual Visits	$0 copay – medical $0 copay – behavioral health	N/A	$0 copay – medical $0 copay – behavioral health	N/A	N/A
Lab and X-ray Advanced Imaging	Covered in full Plan pays 80% after deductible	Plan pays 50% after deductible	Covered in full Plan pays 80% after deductible	Plan pays 50% after deductible	Covered in full Plan pays 80% after deductible
Therapy: Occupational, Physical, and Speech	$40 copay per visit in- network 30 visit max – Occupational, Physical and Speech	Plan pays 70% after deductible 30 visit max – Occupational, Physical and Speech	$40 copay per visit in- network 30 visit max – Occupational, Physical and Speech	Plan pays 70% after deductible 30 visit max – Occupational, Physical and Speech	Plan pays 80% after deductible 60 visit combined max
Chiropractic	$40 copay 30 visit max	Plan pays 70% after deductible 30 visit max	$40 copay 30 visit max	Plan pays 70% after deductible 30 visit max	Plan pays 80% after deductible
Urgent Care	$50 copay	Plan pays 70% after deductible	$50 copay	Plan pays 70% after deductible	$50 copay
Emergency Room	$250 copay plus deductible and coinsurance	$250 copay plus deductible and coinsurance	$250 copay plus deductible and coinsurance	$250 copay plus deductible and coinsurance	$250 copay plus deductible and coinsurance
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 80% after deductible
Inpatient Hospitalization	Plan pays 80% after deductible	Plan pays 50% after deductible	Plan pays 80% after deductible	Plan pays 50% after deductible	$100 per day for 1st 5 days

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. The following are the prescription drug benefits that are included with our medical plans:

Pharmacy Network - All Plans: Preferred Network	Blue Advantage PPO $500 Plan	Blue Preferred PPO $500 Plan	BlueLincs HMO $250 Plan
	In-Network ONLY	In-Network ONLY	In-Network ONLY
Pharmacy			
Generic / Non-preferred Generic	$10 / $20 copay	$10 / $20 copay	$0 / $10 / $20 copay
Preferred Brand	$45 / $65 copay	$45 / $65 copay	$35 / $55 copay
Non-preferred Brand	$75 / $95 copay	$75 / $95 copay	$75 / $95 copay
Specialty Preferred	$100 copay	$100 copay	$150 copay
Specialty Non-Preferred	$100 copay	$100 copay	$250 copay
Supply Limit	30 days	30 days	30 days
Mail Order			
Generic	$30 copay	$30 copay	$0 / $30 copay
Preferred Brand	$135 copay	$135 copay	$105 copay
Non-preferred Brand	$225 copay	$225 copay	$225 copay
Specialty	Limited to 30 day supply	Limited to 30 day supply	Limited to 30 day supply
Supply Limit	90 days	90 days	90 days

All medical plans include retail and mail order prescription drug coverage. There is no annual deductible for prescription drugs under the medical plan options and you begin paying copayments with your first prescription purchase. Specialty drugs are available in a 30-day supply only.

To determine if a particular drug is included in our plan, view a list of generic options for a brand name drug or calculate your estimated cost for 30-day or 90-day supply of a covered drug, visit www.bcbsok.com, login to Blue Access for Members. Click on Prescription Drugs in the Quick Links box. This will take you to MyPrime.com where you can manage your pharmacy benefits further including order a 90-day supply of medications.

Note: If you or your physician request a brand-name drug when a generic equivalent is available, you will be responsible for paying the applicable copay PLUS the difference in cost between the generic price and the brand-name price.

BlueCross BlueShield of Oklahoma Resources

Blue Access For Members

When you enroll in a BCBS medical plan, you have access to the Blue Access for Members website. There you will find a number of tools at your fingertips to help you make the most of your plan, manage your medical costs and stay on top of your health.

Getting started on the site is easy. Go to www.bcbsok.com, click on "Log In/Register," and then either register if this is your first time to use the site or login if you are already registered. Once you are in the site, there are many different resources:

- Compare cost estimates based on your specific plan and BCBS's provider rates;
- Download Explanation of Benefits (EOBs) and request ID cards;
- Order maintenance and/or specialty medication refills, set up mail order service, check an order's status and view your prescription history;
- Access detailed claims information anytime;
- View your personal health record; and
- Take a health assessment and use online health coaching.

When you are on the go, you can download the BCBS Mobile App for Android or iPhone giving you convenient access to your secure member information – anytime or anywhere. To download the app simply go to the App Store or to Google Play or you can text BCBSOKAPP to 33633.

Virtual Visits – MDLIVE

If you enrolled in the Blue Advantage PPO or the Blue Preferred PPO, you have access to the doctors through BCBS virtual visit solution, MDLIVE. Instead of going to a doctor's office, employees can talk to a doctor on a virtual visit while at home, work or many other places. You can visit with a doctor virtually through your mobile app, online video or by phone – 24 hours a day, 7 days a week. MDLIVE's doctors can treat many non-emergency medical and behavioral health conditions, such as:

- General Health (allergies, asthma, sinus infections);
- Pediatric Care (cold/flu, pink eye, ear infections); and
- Behavioral Health – by appointment (online counseling, child behavioral/learning issues, stress management).

Physicians will write and send prescriptions to your nearby in-network pharmacy. To use MDLIVE, go to Blue Access for Members and sign-up.

Please note: Virtual Visits – MDLIVE is not available to those enrolled in the BCBS BlueLincs HMO $250 Plan.

For details regarding your medical plan and to determine what may be covered, check your Summary of Benefits Coverage documents. These documents can be located at www.tulsacc.edu/retiree.

BCBS Discount Program

Blue365 is just one more advantage you have by being a BCBS member. With this program you may save money on health and wellness products and services from top retailers that are not covered by insurance.

Below are some examples of discounted services offered through Blue365:

- Vision Exams, Eyewear and Laser Surgery;
- Hearing Exams and Hearing Aids;
- Dental Discounts; and
- Healthy Eating and Wellness Savings.

To discover and take advantage of the many discounts available, visit the BCBS website at www.blue365deals.com/bcbsok.

Livongo®
by Teladoc Health

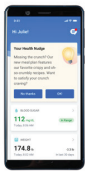
Real people, real results

Livongo helps 700,000+ members worry less about managing diabetes.

> "Livongo keeps me aware of my glucose levels without the worry of running out of supplies."
>
> **Livongo member**

With Livongo, you'll get:

A smart blood glucose meter
to guide your journey



A connected app
that tracks numbers so you don't have to

Access to expert coaches
for advice on diet, lifestyle and more

Enroll Today!

Text **"GO BCBSOK-HEALTH"** to 85240 to learn more and enroll

You can also enroll by visiting **join.livongo.com/BCBSOK-HEALTH/hi**
or call **800-945-4355** and use registration code: **BCBSOK-HEALTH**

The program is provided to you and your family members with diabetes and coverage through Blue Cross and Blue Shield of Oklahoma (BCBSOK).

Members must have primary insurance coverage through the Blue Cross and Blue Shield of Oklahoma plan offering the Livongo program.

Livongo® by Teladoc Health

High blood pressure management, simplified

$0 cost to you

An advanced blood pressure monitor, support you need and your employer or health plan is covering 100% of the costs.

Program benefits

- Advanced blood pressure monitor
- Personalized insights
- One-on-one coaching
- Easy-to-use app & dashboard
- Guidance on healthy habits

Get started

Text **"GO WELL-BCBSOK-LARGEHTN"** to 85240 to learn more and join

You can also join by visiting **Ready.Livongo.com/WELL-BCBSOK-LARGEHTN/register**
or call **800-945-4355** and use registration code: **WELL-BCBSOK-LARGEHTN**

Las comunicaciones del programa Livongo están disponibles en español. Al inscribirse, podrá configurar el idioma que prefiera para las comunicaciones provenientes del medidor y del programa. Para inscribirse en español, llame al 800-945-4355 o visite hola.livogo.com/WELL-BCBSOK-LARGEHTN
The program is provided to you and your family members with high blood pressure and coverage through Blue Cross and Blue Shield of Oklahoma (BCBSOK).
Members must have primary insurance coverage through the Blue Cross and Blue Shield of Oklahoma plan offering the Livongo program.

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Dental

Regular visits to your dentist can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Did You Know... For every $1 spent on preventive oral healthcare, as much as $50 is saved on future emergency and restorative services?

You have a choice of two dental plans with comprehensive coverage through BlueCross BlueShield of Oklahoma (BCBS).

If you use an out-of-network provider, you will not receive a contracted rate and could pay more for your dental care. To find a BCBS provider near you visit www.bcbsok.com or call 888.381.9727.

	BCBS Low Plan	BCBS High Plan
	In-Network / Out-of-Network	In-Network / Out-of-Network
Calendar Year Deductible	$50 individual $150 family	$50 individual $150 family
Annual Plan Maximum	$1,000 per covered member	$3,000 per covered member
Diagnostic and Preventive	Plan pays 100%	Plan pays 100%
Basic Services Fillings General anesthesia	 Plan pays 70% after deductible Plan pays 70% after deductible	 Plan pays 80% after deductible Plan pays 80% after deductible
Major Services Root canals Oral surgery Crowns Dentures, implants	 Plan pays 40% after deductible Plan pays 40% after deductible Plan pays 40% after deductible Plan pays 40% after deductible	 Plan pays 50% after deductible Plan pays 50% after deductible Plan pays 50% after deductible Plan pays 50% after deductible
Orthodontic Services Orthodontia Lifetime Maximum	 Not covered Not covered	 Adult / Child $3,000

Vision

Routine vision exams can help correct vision and may detect more serious health conditions. If you use an out-of-network provider, you will not receive a contracted rate and will pay more for vision care and materials. To find an in-network provider, go to www.metlife.com/mybenefits or call 855.638.3931.

	MetLife Low Plan	MetLife High Plan	Out-of-Network
	In-Network	**In-Network**	**Applies to both plans**
Examination – Every calendar year	$10 copay	$10 copay	Reimbursed up to $45
Frames – Every calendar year	Up to $150 allowance + 20% off additional cost	Up to $170 allowance + 20% off additional cost	Reimbursed up to $70
Lenses – Every calendar year Single Vision Lens Bifocal Lens Trifocal Lens	 $25 copay $25 copay $25 copay	 $25 copay $25 copay $25 copay	 Reimbursed up to $30 Reimbursed up to $50 Reimbursed up to $65
Lens Enhancements Progressive Standard Progressive Premium Progressive Custom Anti-Reflective Coating Scratch-Resistant Coating Tints/Photochromic	 $55 copay $95 – $105 copay $150 – $175 copay $41 – $85 copay $17 – $33 copay $47 – $82 copay	 Covered in full Covered in full Covered in full Covered in full Covered in full Covered in full	Reimbursed up to $50
Contacts – In Lieu of Glasses Exam and Fitting – Every calendar year	Covered up to $150 allowance Up to $60 copay	Covered up to $170 allowance Up to $60 copay	Reimbursed up to $105 Reimbursed up to $105
Laser Vision Correction By contracted providers only.	Average 15% discount off regular price or 5% off promotional price	Average 15% discount off regular price or 5% off promotional price	N/A

Voluntary Life Insurance

Retiree Voluntary Life Insurance

You can keep, reduce or drop life coverage you have in place at the time you leave active employment. The election must be made within 30 days of leaving active employment. You cannot add or increase life insurance at retirement.

Life insurance continued at retirement does not include Accidental Death and Dismemberment benefits.

Age Band	Retiree Rate Per $1,000
Below 20-64	$0.77
65-69	$0.84
70-74	$1.31
75-79	$2.24
80-84	$4.10
85-89	$7.41
90 and above	$13.20

Life Insurance Beneficiary

If you continue life insurance coverage when you leave active employment, it is very important to keep your beneficiary information current. To ensure we have your current beneficiary designation on file, you are required to complete the information on the enrollment form inside your packet. Please contact the TCC Human Resources team to update your beneficiary.

Beneficiary Resources

Your life insurance benefits include services for grief, legal and financial counseling for beneficiaries, funeral planning and online legal library including templates to create a will and other legal documents.

Pet Insurance

Tulsa Community College has partnered with Nationwide to provide employees the option of purchasing pet insurance for most furry friends. To shop the options and enroll in the direct bill program, please visit the Nationwide website directly at: benefits.petinsurance.com/tulsacc. Employees will not see a payroll deduction for this benefit program through payroll.

Protecting your four-legged family members in an uncertain world isn't always easy. Nationwide® pet insurance helps you provide for your pets—and protect your pocketbook—by reimbursing you for eligible veterinary bills related to accidents, illnesses, preventive care and more.

Best of all, you'll receive preferred pricing when you sign up at work, making this peace-of-mind protection even more affordable. Plans are available for dogs, cats, birds and exotic pets, and our members are free to use any veterinarian—even specialists and emergency care providers.

Nationwide is the nation's oldest and largest pet health insurance provider, and is the #1 choice in America for pet insurance.

- Employee preferred pricing
- Visit any vet, anywhere
- Choose from 70% and 50% reimbursement
- Low $250 annual deductible
- Save more on pet prescriptions with Nationwide® PetRxExpress
- Easy online claim submission
- Unlimited 24/7 pet health advice from experts at vethelpline®

Visit https://benefits.petinsurance.com/tulsacc or call 877.738.7874 for a fast, no obligation quote, today!

Travel Services

Your life insurance benefits include assistance while traveling to help with unexpected plans that may take place. Services include emergency medical assistance, financial, legal and communication assistance, and access to other critical services and resources available via the internet.

To access your services available under the BCBS life insurance plan call: 800.872.1414 or email: medservices@assistamerica.com

Premiums

Monthly Premiums

MEDICAL	Blue Advantage PPO $500 Plan	Blue Preferred PPO $500 Plan	BlueLincs HMO $250 Plan
Employee Only	$698.70	$765.50	$754.54
Employee + Spouse	$1,257.68	$1,377.94	$1,358.18
Employee + Child	$1,332.18	$1,459.56	$1,438.66
Employee + Children	$1,769.70	$1,938.90	$1,911.08
Employee + Family	$2,165.98	$2,373.10	$2,339.06

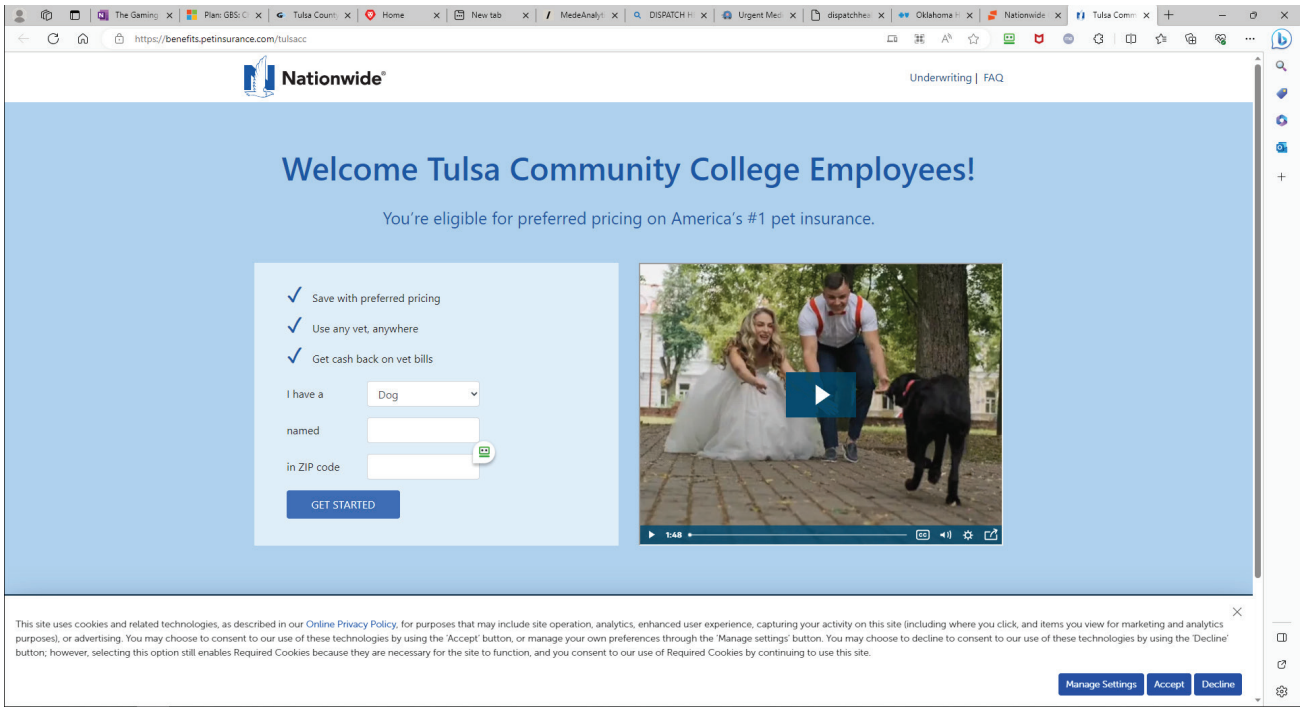
DENTAL	BlueCare Low Plan	BlueCare High Plan
Employee Only	$19.38	$38.46
Employee + Spouse	$38.78	$76.84
Employee + Children	$51.38	$100.30
Employee + Family	$78.12	$152.96

VISION	MetLife Low Plan	MetLife High Plan
Employee Only	$8.06	$13.62
Employee + Spouse	$16.14	$27.28
Employee + Children	$17.24	$29.16
Employee + Family	$27.56	$46.60

* Oklahoma Teacher's Retirement may contribute a monthly subsidy toward your health insurance premiums. The premiums listed in this guide do not reflect any retirement system contribution.

Pet Insurance Rates

Please visit for https://benefits.petinsurance.com/tulsacc or call 877.738.7874 for rate information.



Plan Contacts

If you need to reach to our plan providers, here are their contact information:

Plan Type	Provider	Phone Number	Website
Medical	BCBS of Oklahoma	1.800.942.5837	www.bcbsok.com
Dental	BCBS of Oklahoma	888.381.9727	Email: ancillaryquestionsOK@bcbsok.com Website: www.bcbsok.com/ancillary
Vision	MetLife	855.638.3931	www.metlife.com/mybenefits
Benefit Payment	Navia Benefit Solutions	800.669.3539	www.naviabenefits.com
Life and AD&D	BCBS of Oklahoma	888.381.9727	Email: ancillaryquestionsOK@bcbsok.com Website: www.bcbsok.com/ancillary
Pet Insurance	Nationwide	877.738.7874	benefits.petinsurance.com/tulsacc
Benefit Advocate	Gallagher Benefit Services	918.779.5005	Email: christie_kennedy@ajg.com
TCC Human Resources	Tulsa Community College Benefits	918.595.7856	Email: benefits@tulsacc.edu Website: tulsacc.edu/retiree
Virtual Visits	MDLIVE	800.970.4081	MDLIVE.com/bcbsok

Glossary of Terms You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if you understand the most common terms, explained below in plain English.

MEDICAL

OUT-OF-POCKET COST – A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

DEDUCTIBLE – The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

COINSURANCE – After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY – A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK – Doctors, hospitals, labs, etc. that have contracted with your health plan to charge lower fees to plan members are considered "in-network." Out-of-network providers can cost you more because the providers are under no obligation to cap their fees. With some plans, such as HMOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM – The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan out- of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRIMARY CARE PHYSICIAN (PCP) – Physician (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions and refers patients to specialists as necessary.

SPECIALIST – A physician who has specialized training in a particular branch.

PRESCRIPTION DRUG

BRAND NAME DRUGS – A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

GENERIC DRUGS – A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

FORMULARY – A drug formulary is a list of prescription drugs, both generic and brand name, used by practitioners to identify drugs that offer the greatest overall value. A committee of physicians, nurse practitioners, and pharmacists maintain the formulary.

MAIL ORDER PHARMACY – Mail order pharmacies generally provide a 90-day supply of a prescription medication conveniently shipped directly to your door.

NON-FORMULARY – Drugs that are not included in the list of preferred medications that a committee of pharmacists and doctors deems to be the safest, most effective and most economical. They are drugs not included in the drug list approved by the health plan.

PREFERRED DRUGS – Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

DENTAL

BASIC SERVICES – Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTICS AND PREVENTIVE SERVICES – Generally includes routine cleanings, oral exams, x- rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES – Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

ADDITIONAL TERMINOLOGY

EVIDENCE OF INSURABILITY – Also known as "evidence of good health" is the process by which the insurance company determines if you are healthy enough to be considered eligible for the amount of insurance coverage for which you are seeking.

FLEXIBLE SPENDING ACCOUNT (FSA) – A special account you put money into that you use to pay for certain out of pocket healthcare costs. You don't pay taxes on this money.

GUARANTEED ISSUE (GI) – The amount of coverage that an insurance company will offer an applicant regardless of health status.

Legal Notices

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply: Plan 1: Blue Preferred PPO $500 Plan (Individual: 20% coinsurance and $500 deductible; Family: 20% coinsurance and $1,500 deductible) Plan 2: BlueLincs HMO $250 Plan: (Individual: $250 deductible and 20% coinsurance; Family: $750 deductible and 20% coinsurance.)

If you would like more information on WHCRA benefits, please call TCC Human Resources at 918.595.7856 or benefits@tulsacc.edu.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are **not** currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877.KIDS.NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

IIf you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075

PENNSYLVANIA – Medicaid and CHIP
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669

VERMONT – Medicaid
Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Tulsa Community College is committed to the privacy of your health information. The administrators of the Tulsa Community College Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices.

You may receive a copy of the Notice of Privacy Practices by contacting Human Resources at 918.595.7856.

HIPAA Special Enrollment Rights

Tulsa Community College Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Tulsa Community College Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan – your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for ourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan.

However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact TCC Human Resources at 918.595.7856 or benefits@tulsacc.edu.

Notice of Creditable Coverage

Important Notice from Tulsa Community College

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Tulsa Community College and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Tulsa Community College has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two

(2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Tulsa Community College coverage will not be affected. You can keep this coverage if you elect part D. If you do decide to join a Medicare drug plan and drop your current Tulsa Community College coverage, be aware that you and your dependents will be able to get this coverage back during the annual open enrollment period.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 1, 2023
Name of Entity/Sender:	Tulsa Community College Benefits
Contact:	Human Resources
Office Address:	909 S. Boston Ave. Tulsa, OK 74119
Phone Number:	918.595.7856

Cobra General Notice

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get 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 and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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 costs on your monthly premiums and lower 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 doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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 under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan 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 becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying event the parent-employee dies;

- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources.

How is COBRA continuation coverage provided?

Once the Plan Administrator 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 an independent right to elect 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 COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a 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 COBRA continuation coverage.

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 get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan 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, Medicare, Medicaid, Children's Health Insurance Program (CHIP), 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/.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

1 https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in

Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan 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 (ERISA), 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, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Tulsa Community College
Human Resources
909 S. Boston Ave.
Tulsa, OK 74119

918.595.7856

Patient Protection Disclosure

The Tulsa Community College BlueLincs HMO group health plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, BlueLincs will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BlueLincs at 1.800.942.5837.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from BlueLincs or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact BlueLincs at 1.800.942.5837.

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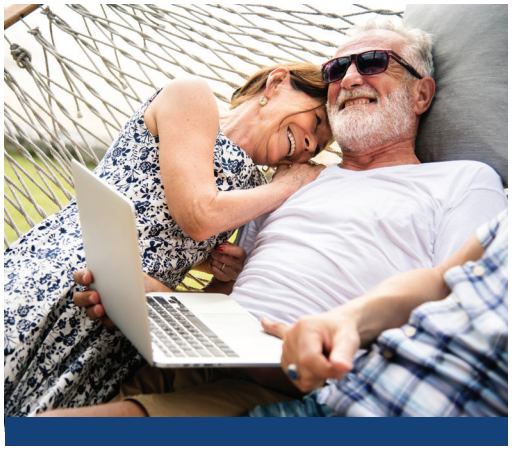

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting