Tulsa International Airport

HELPING YOU UNDERSTAND
Your Benefit Choices

2026 New Hire Benefit Enrollment Guide

This is a high-level benefits guide of certain benefits your employer offers. The information in this booklet is intended as a general outline of the benefits offered under your employers benefits program and should not be considered legal, investment or other benefits advice. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail. Benefit plans are subject to change, amendment, or termination without notice to or the agreement of any employee/participant. All protected health information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

**This guide may or may not be applicable to union employees.*

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Your Benefit Period

JANUARY 1, 2026 – DECEMBER 31, 2026

READY TO ENROLL?

Go to https://plansource.com/login/

ENROLLMENT INSTRUCTIONS:

1. On the "Benefits" area (highlighted in the screen shot below), click on "Employees."

2. Username: Your username is the first letter of your first name, the first 6 letters of your last name, and the last 4 digits of your social security number. For example, employee John Hancock (social 123-45-6789) would have the following username: jhancoc6789. Employee Joe Smith's (social 987-65-4321) username would be: jsmith4321.

3. Password: Your password is your birth date in YYYYMMDD format. Someone with a birth date of January 7,1968 would have 19680107 for their password.

4. You will then be prompted to change your password. You will need to retain your new password, but your username will remain the same.

All employees MUST log in and ELECT or WAIVE benefit options. For additional information regarding your benefits, please go to PlanSource/ConnectSource for more information.

Helpful Tips To Consider Before You Enroll

1. **Do you plan to enroll an *eligible dependent(s)*?**
   If so, make sure to have their social security numbers and birthdates available. You cannot enroll your dependent(s) without this information.
2. **Have you recently been *married/divorced or had a baby*?**
   If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.
3. **Did any of your covered children reach their 26th birthday *this year*?**
   If so, they may no longer be eligible for benefits, unless they meet specific criteria.

ELIGIBILITY

RULES | REQUIREMENTS

EMPLOYEE ELIGIBILITY

You are eligible to participate if you are full-time and work a minimum of 40 hours per week. Your coverage will be effective 1st of the month following date of hire.

DEPENDENT ELIGIBILITY

You may also enroll eligible dependents for benefits coverage. A **'dependent'** is defined as the **legal spouse** and/or '**dependent child(ren)'** of the plan participant or the spouse.

The term 'child' refers to any of the following:

- A natural (biological) child;
- A stepchild;
- A legally adopted child;
- A foster child;
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse
- Disabled dependents may be eligible if requirements set by the plan are met.

The chart provided below explains who is eligible for coverage under each benefit plan type:

Line of Coverage	When coverage ends
Employees are eligible for Medical, Rx, Dental, Vision, Supplemental Life and AD&D, FSA, HSA, Disability, Accident, Critical Illness & Hospital Indemnity.	Coverage ends the last day of the calendar month of your termination date for Medical/Rx, Dental, Vision, Disability, Accident, Critical Illness, and Hospital Indeminity. For Supplemental Life and AD&D, coverage ends on the date of termination.
Spouses are eligible for Medical/Rx, Dental, Vision, Supplemental Life & AD&D, Accident, Critical Illness, and Hospital Indemnity when the employee signs up for coverage.	Coverage ends the last day of the calendar month for Medical/Rx, Dental, Vision, Accident, Critical Illness and Hospital Indemnity. For Supplemental Life and AD&D coverage ends on the employee's date of termination.
Child(ren) are eligible for Medical/Rx, Dental, Vision and Supplemental Life & AD&D, Accident, Critical Illness, and Hospital Indemnity when the employee signs up for coverage.	Coverage ends the last day of the calendar month the child turns age 26 for Medical/Rx, Dental, Vision, Accident, Critical Illness and Hospital Indemnity. For Supplemental Life & AD&D coverage ends on the employee's date of termination.

Qualifying Life Events

If you have a Qualifying Life Event and want to request a mid-year change, you must notify Human Resources and complete your election changes within 30 days following the event. Be prepared to provide documentation to support the Qualifying Life Event.

Common life events include; Marriage, Divorce, New Dependent, Loss/gain of available coverage by you or any of your dependents.

A full list of qualifying events can be found in the 'Required Notices' section of this benefits guide.

IMPORTANT

You cannot make changes to these elections during the year unless you experience a qualified family status change, which must be reported to Human Resources within 30 days of the event.

If you separate from employment, COBRA continuation of coverage may be available as applicable by law. COBRA Continuation details can be found in the notices section of this employee benefit guide.

HEALTH

MEDICAL | PRESCRIPTION DRUGS

COMMON INSURANCE TERMS

A **PREMIUM** is the amount you pay for insurance, using pre-tax or post-tax dollars.

A **COPAYMENT (COPAY)** is a fixed amount you pay to receive services. Your co-payment(s) will count towards your out-of-pocket maximum but not your deductible. (e.g., $30 for every visit to the doctor), while your insurance company pays the rest.

A **DEDUCTIBLE** is the amount of money you are responsible for paying each year before the plan begins to pay for covered services, with the exception of preventive care services, which are covered at 100% In-Network.

COINSURANCE This is your share of the expense of covered services after your deductible has been paid when the company plan is paying a percentage. The coinsurance rate is usually a percentage.

OUT-OF-POCKET (OOP) MAXIMUM is the most you pay per Plan Year for health care expenses and applies to deductibles, flat-dollar copays and coinsurance for all covered services – including cost-sharing amounts for prescription drugs.

Once this limit is met, the plan will cover all in-network services at 100% until the end of the plan year.

PPO | In-Network & Out-of-Network Benefits Available

The PPO option offers the freedom to see any provider when you need care. When you use providers from within the PPO network, you receive benefits at the discounted network cost. Most expenses, such as office visits, emergency room and prescription drugs are covered by a copay. Other expenses are subject to a deductible and coinsurance.

PPO HSA | In-Network & Out-of-Network Benefits Available

The HDHP is similar to the PPO Plan in that you have the option to choose any provider when you need care. However, in exchange for a lower per-paycheck cost, you must satisfy a higher deductible that applies to almost all health care expenses, including those for prescription drugs.

All expenses are your responsibility until the deductible is reached, with the exception of preventive care, which is covered at 100% when you visit a physician in the network. Once the deductible is met, you are responsible for coinsurance for medical expenses and a copay for prescription drug expenses.

Enrolling in this plan allows you to contribute tax free dollars to a health savings account (HSA). Any dollars that you (and your employer) wish to contribute can be used towards any eligible medical, Rx, dental and vision expenses that you may incur while covered under the plan. See HSA section of this guide for additional details.

NEW! BCBS Member Rewards Program

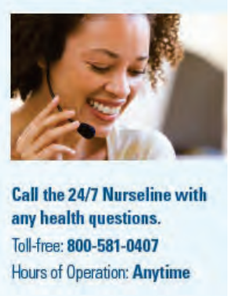
Use the Provider Finder tool to help you:

- Compare costs and find a reward-eligible location for a procedure or service
- Then get the procedure or service at the chosen reward-eligible location
- Member receives a cash reward by check, which will be mailed directly to your home after the claim is paid and the location is verified as reward-eligible.

NEW! FREE ComPsych EAP

Don't be afraid to reach out for help. Your health records are kept private from your employer, as required by law. All family members can use the EAP service - no copays or deductibles needed.

- Call: **844-222-9325**
- Online: **guidanceresources.com**
- App: **GuidanceNow**
- Web ID: **BCBSOKEAP**



Experience Wellness – wellontarget.com

Engage in Self-Management Programs, set goals, learn about nutrition, fitness, losing weight, quitting smoking and managing stress. Track progress as you move through each session. There is a library of Health and Well content, Tools and Trackers and Fitness Tracking.

Earn Blue Points for Healthy Living

Registered BCBS Members earn 2500 points for enrolling in the Fitness Program, 2500 points for completing a Health Assessment, and 2675 points for syncing your fitness device. The points are currently redeemed in the BCBS online shopping mall. The Well onTarget Blue Points merchandise mall will retire at the end of 2024 and will be replaced with digital gift cards in January 2025. The new redemption experience will be smoother with more flexible options including redemption amount(s) and embedded into both the Well onTarget portal and the AlwaysOn Wellness mobile app. Any unredeemed Blue Points from 2024 will roll over and be used towards digital gift cards in 2025.

Special Beginnings

Give your baby a healthy start. All 888-421-7781 to begin asking questions, get help with high-risk conditions and get a book about heaving a healthy pregnancy and baby.

Blue365 – blue365deals.com/bcbsok

Save on eye exams and glasses through EyeMed and Davis Vision; savings on hearing tests and hearing aids through TruHearing, Belton and American Hearing Benefits; Dental Solutions, weight loss through Jenny Craig, Sun Basket and Nutrisystem and get a 20% discount on Fitbit devices.

Did You Know?

- ✓ **Preventive Services** are **covered at 100% In-Network** and copays & deductibles do not apply.
- ✓ You **pay less** out of pocket if you receive care from an **In-Network provider.**

How do I find an In-Network Provider?

In-Network providers can be found on your provider's website www.bcbsok.com under "Find a Doctor". Select Group Health Plans and choose the network based on the plan type you are choosing.

MEDICAL

HEALTH | PLAN COMPARISON

Tulsa Airports provides competitive and generous benefit options for you and your covered dependents. Eligible employees receive a benefit allowance to use toward your medical, dental, vision or supplemental options. The chart below shows the monthly medical cost as well as the allowance by month and annually.

IN-NETWORK BENEFITS	BLUE ADVANTAGE MOBAP1125 HDHP	BLUE ADVANTAGE MOBAP0035	BLUE ADVANTAGE MOBAP0115
DEDUCTIBLE			
Individual Deductible	$5,100	$2,600	$4,100
Family Deductible	$10,200	$7,800	$12,300
COINSURANCE *(applies after deductible is met)*			
Member Cost Share %	20%	20%	30%
MEMBER COPAYMENT(S)			
Primary Care (PCP) - Office Visit	D + C	$35 Copay	$35 Copay
Virtual Visit	D + C	$0 Copay	$0 Copay
Specialist - Office Visit	D + C	$60 Copay	$60 Copay
Urgent Care Facility	D + C	$50 Copay	$50 Copay
Emergency Room Visit	D + C	$300 + D + C	$400 Copay + D + C
OUT-OF-POCKET (OOP) MAXIMUM			
Individual Maximum	$7,750	$6,250	$7,250
Family Maximum	$15,500	$12,500	$14,500
	Select HDHP – HSA Preventive prescription drugs will be covered with no member cost share.		

BUDGETED ALLOWANCE	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD (REN)	EMPLOYEE + FAMILY
Annual	$9,470.40	$21,170.40	$16,710.96	$27,318.36
Monthly	$789.20	$1,764.20	$1,392.58	$2,276.53
Medical Insurance Waiver – Monthly Amount	$500	$500	$500	$500

MEDICAL MONTHLY RATES	BLUE ADVANTAGE MOBAP1125 HDHP	BLUE PREFERRED MOBAP0035	BLUE ADVANTAGE MOBAP0115
Employee Only	$572.79	$832.69	$753.21
Employee + Spouse	$1,287.23	$1,871.31	$1,692.67
Employee + Child (ren)	$996.77	$1,449.05	$1,310.71
Employee + Family	$1,634.69	$2,376.42	$2,149.56

BlueCross BlueShield of Oklahoma

Your health at your fingertips

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

With BAM, you can:

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

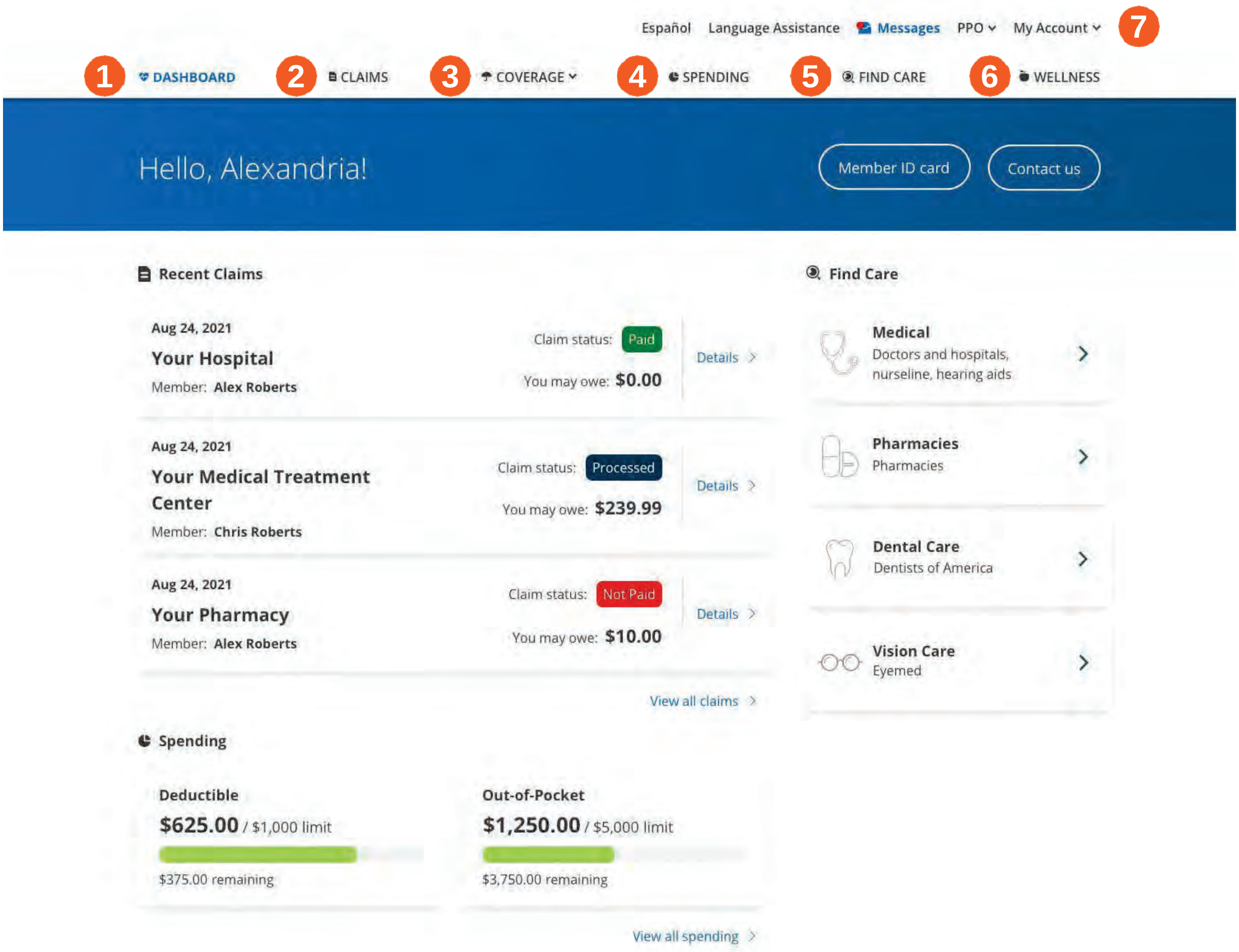
SCAN ME

Scan this QR code to visit bcbsok.com.

Let's get started

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

Navigation has never been easier



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

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

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PRESCRIPTION DRUGS

Rx | PLAN COMPARISON

TRADITIONAL DRUGS

Preferred Generic | Lowest copay: Most drugs in this category are generic drugs. Members pay the lowest copay for generics, making these drugs the most cost-effective option for treatment.

Non-Preferred Generic | Higher copay: This category includes preferred, brand name drugs that don't yet have a generic equivalent. These drugs are more expensive than generics, and a higher copay.

Preferred Brand | Highest copay: In this category are nonpreferred brand name drugs for which there is either a generic alternative or a more cost-effective preferred brand. These drugs have the highest copay. **Make sure to check for mail order discounts that may be available.**

SPECIALTY DRUGS

Non-Preferred Brand | Lowest specialty drug copay: Tier 4 specialty drugs are generally more effective and less expensive than nonpreferred specialty drugs in tier 5.

Specialty | Highest specialty drug copay: These drugs have the highest copay for specialty drugs, usually because there may be a more cost-effective generic or preferred brand available.

Rx Copays	Blue Advantage MOBAP1125 HDHP	Blue Advantage MOBAP0035	Blue Advantage MOBAP0115
Pharmacy	Retail/Participating	Retail/Participating	Retail/Participating
Preferred Generic	D + 10% / 20%	$0 or $10	$0 or $10
Non-Preferred Generic	D + 10% / 20%	$10 or $20	$10 or $20
Preferred Brand	D + 20% / 30%	$50 or $70	$50 or $70
Non-Preferred Brand	D + 30% / 40%	$100 or $120	$100 or $120
Preferred/ Non-Preferred Specialty	D + 40% / D + 50%	$250 / $350	$250 / $350
Mail Order	Select HDHP-H.S.A. Preventive prescription drugs will be covered with no member cost share.	3x Copay for 90- day supply	3x Copay for 90- day supply

WHERE CAN I FIND A DRUG LIST?

Typically, a full listing of covered drugs is found on your provider's website. A drug list, also called a formulary, is a list of generic and brand-name drugs covered by a health plan. Although a drug may be on the drug list, it might not be covered under every plan. Review the plan materials for details on specific benefits.

You can use drug lists to see if a medication is covered by your health insurance plan. You can also find out if the medication is available as a generic, needs prior authorization, has quantity limits and more.

Save Money With Generic (Tier 1) Drugs

Ask your doctor if it's appropriate to use a generic drug rather than a brand.

Generic drugs are less expensive, and according to the FDA, they contain the same active ingredients and are identical in dose, form and administrative method as a brand name.

Helpful Rx Cost Savings Tools & Tips:

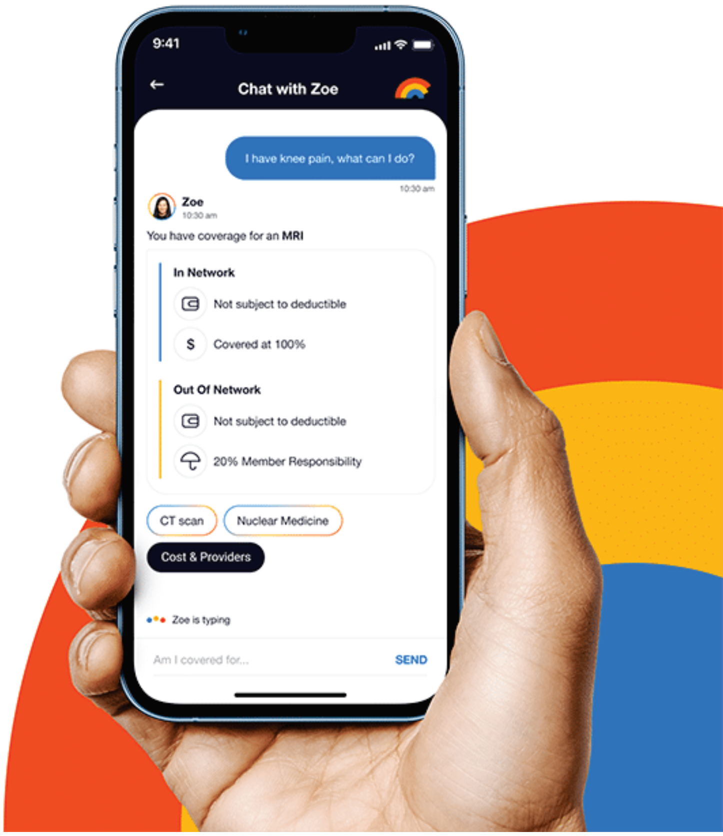
MAIL ORDER - Many drugs are available in a 90-day supply, rather than the 30-day retail supply. Typically, you will pay less if you choose to get a mail order 90-day supply.

GOOD Rx - There are many tools online that you can use in order to save on prescription costs. One being GoodRx.com, an online Rx database that allows you to find what pharmacy is the cheapest for your specific prescription. Additionally, you may be able to find a coupon that will greatly reduce your cost. It is important to remember that many of the coupons can only be used outside of your plan (will not count towards your maximums).

ASK YOUR DOCTOR – Make sure to ask if there are cost savings alternatives to the prescription they are providing. Many times, there are generic or different manufacturers that will save you money at the pharmacy.

HEALTH

HEALTHCARE BENEFIT NAVIGATOR



Healthee is an employee benefit and healthcare guidance app provided to you at no cost by Tulsa Airport. The app is personalized for you and includes several tools to help you make better decisions, save time and money as well as to have an overall better healthcare experience.   Below are a few features:

- Find out how much you'll need to pay for any of your healthcare needs
- Free virtual care 24/7
- Easily navigate through your health benefits
- Quickly find in-network healthcare providers

Watch this short video to see how it works. https://www.youtube.com/watch?v=WVANYTH8MRQ

ONLINE HEALTHCARE

24/7 | VIRTUAL DOCTOR VISITS

BlueCross BlueShield of Oklahoma

Virtual Visits: Get Cost-Effective, 24/7 Care

With Virtual Visits powered by MDLIVE®, the doctor is always in. This Blue Cross and Blue Shield of Oklahoma (BCBSOK) benefit gives you access to 24/7 non-emergency care from a board-certified doctor or therapist by phone, online video or mobile app from almost anywhere.

Skip expensive ER bills and waiting to see a doctor. You can speak with a Virtual Visits doctor within minutes.

Services are available in both English and Spanish with translation services available in other languages.

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

Powered by MDLIVE

ONLINE HEALTHCARE

24/7 | VIRTUAL DOCTOR VISITS

Why Virtual Visits?

- 24/7 access to an independently contracted, board-certified doctor or therapist
- Access via phone, online video or mobile app from almost anywhere
- Average wait time of less than 20 minutes
- Doctors can send e-prescriptions to your local pharmacy

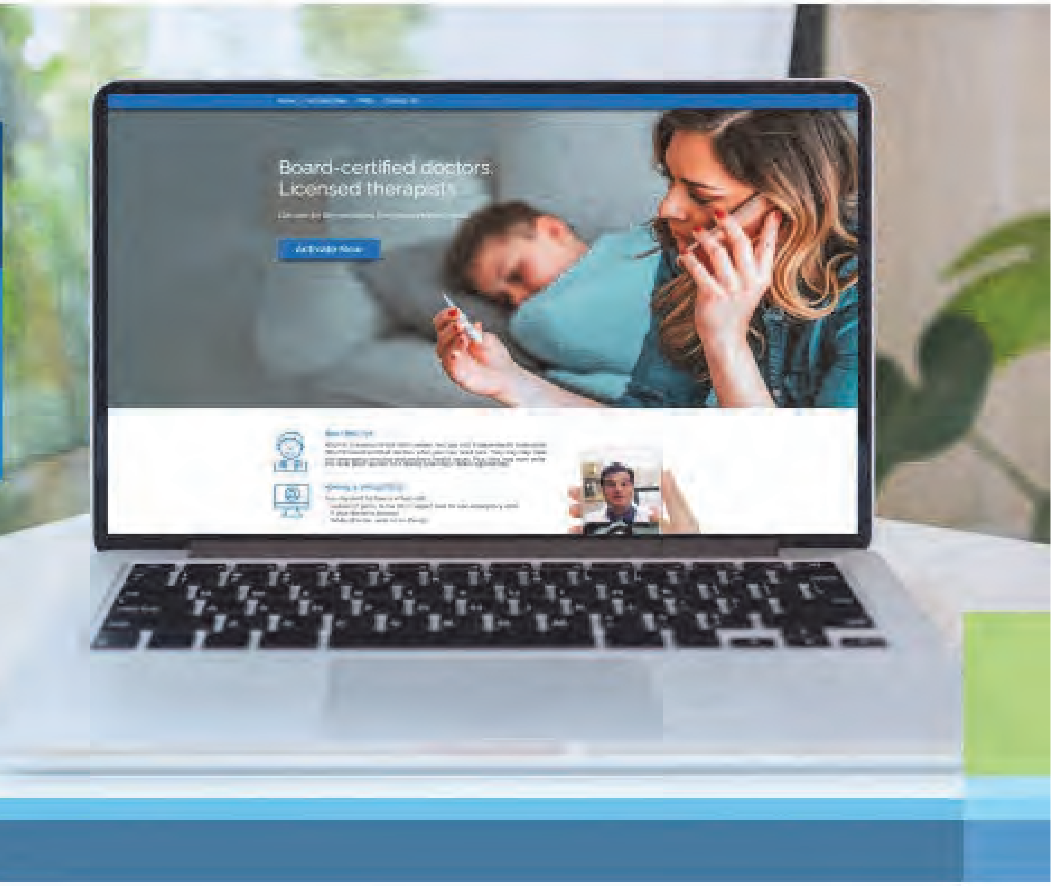
The Virtual Visits benefit is a convenient alternative for treatment of more than 80 health conditions, including:

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

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

- Depression
- Eating disorders
- ADHD
- Substance use disorders
- Trauma and PTSD
- Autism spectrum disorder

First, call your doctor's office; they may also offer telehealth consultations by phone or online video. If you have any questions about this or any other BCBSOK benefit, please call the number on the back of your ID card.



Activate your Virtual Visits account today:

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

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HEALTH SAVINGS ACCOUNT

HSA | TAX SAVING VEHICLE

ENROLLED IN A HSA ELIGIBLE HEALTH PLAN?

Take charge of your health care spending with a Health Savings Account (HSA). Contributions to an HSA are tax-free, and no matter what, the money in the account is yours!

A Health Savings Account (HSA) is a tax-free savings account is owned by you, is 100% vested from day one, and let's you build up savings for future needs. The funds may be used to pay for qualifying healthcare expenses not covered by insurance or any other plan for yourself, your spouse, or tax dependents. You decide how much you would like to contribute, when and how to spend the money on eligible expenses, and how to invest the balance.

UNDERSTANDING YOUR HSA

- Pre-tax contributions are deducted through payroll and deposited into your HSA account;
- You can use your HSA available funds to pay for qualified medical expenses tax-free;
- HSA funds can be used for non-eligible expenses but will be subject to regular income taxes and a 20% excise tax penalty.
- Unused funds remain in your account for future use and roll over each calendar year;
- HSAs remain with you even if you change health plans or companies. If you open an HSA and later become ineligible to make contributions, you can still use your remaining funds; and
- You can change your HSA contribution at any time during the plan year for any reason.

2026 | HSA FUNDING LIMITS

Each year, the IRS places a limit on the maximum amount that can be contributed to HSA accounts.

HSA Contribution Limits	
Employee	**$4,400**
Two Person/Family	**$8,750**
HSA "Catch-Up" Contributions	
Age 55 or older	**$1,000 a year**

Source: IRS, Rev. Proc. 2020-30

FLEXIBLE SPENDING ACCOUNT

FSA | TAX SAVING VEHICLE

Flexible Spending Accounts (FSA) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses* for yourself, your spouse and your dependent children.

In order to participate in the FSA, you must enroll each year. Your annual contribution stays in effect during the entire year **(January 1st through December 31st)**. The only time you can change your election is during the enrollment period or if you experience a change-in-status event. Also, you must elect this benefit within **30 days** of your hire date or first date of benefits eligibility.

ELIGIBLE EXPENSES

- A full list of qualified FSA expenses can be found in IRS Publication 502 at **www.irs.gov**.
- You can learn more about FSA qualified expenses and also make purchases by visiting the FSA Store at www.**fsastore.com.**

HEALTH CARE FSA

MAXIMUM ANNUAL CONTRIBUTION | $3,400

All eligible health care expenses – such as deductibles, medical and prescription copays, dental expenses, and vision expenses – can be reimbursed from your general-purpose FSA account.

With the Health Care FSA, you can spend up to the full amount of your annual election as soon as your account has been set up.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax-free dollars so that you and your spouse can work or attend school FT.

Unlike the Health Care FSA, funds in a Dependent Care FSA are only available once they have been deposited into your account and you cannot use the funds ahead of time.

- You may set aside up to **$7,500** annually in pre-tax dollars, or **$3,750** if you are married and file taxes separately from your spouse.
- If you participate in a Dependent Care FSA, you cannot apply the same expenses for a dependent care tax credit when you file your income taxes.
- TAIT will match up to $2,500 for Dependent Day Care FSA.

IMPORTANT FSA RULES

HEALTH CARE FSA ROLLOVER

Health Care FSA's have a $680 rollover feature, which allows any of $680 or less remaining in your account at the end of the plan year to roll over into the new plan year.

At the end of each plan year, you may use these funds left over from the current year FSA balance to pay for eligible expenses incurred in the first 60 days of the following year. Any unused funds beyond the 60-day run-outt period will be forfeited.

TAIT matches 100% of your Dependent Care FSA contribution up to $2,500.

**ELIGIBLE DEPENDENT CARE EXPENSES INCLUDE:*

1. **'Care'** for your dependent child who is under the age of 13 that you can claim as a dependent on your federal tax return;
2. **'Care'** for your dependent child who resides with you and who is physically or mentally incapable of caring for themselves; or
3. **'Care'** for your spouse, parent or grandparent who is physically or mentally incapable of caring for themselves and spends at least eight hours a day in your home.

'Care' is defined as: In-home baby-sitting services (not by an individual you claim as a dependent); care of a preschool child by a licensed nursery or day care provider; before and after-school care; summer day camp (provided it is not overnight); and in-home dependent day care.

FLEXIBLE SPENDING ACCOUNT

FSA | TAX SAVING VEHICLE

HERE'S HOW IT WORKS

An employee earning $30,000 elects to place $2,650 into a Health Care FSA. The payroll deduction is $110.42 based on a 24 pay period schedule. As a result, the insurance premiums and health care expenses are paid with tax-free dollars, giving the employee a tax savings of $574.

		Without FSA	With FSA
Gross Income		$30,000	$30,000
FSA Contributions		$0	-$2,650
TAXABLE INCOME		**$30,000**	**$27,350**
Estimated Taxes			
	Federal	$3,090*	-$2,817*
	State	$1,104**	$1,006**
	FICA	$2,295	$2,092
AFTER TAX EARNINGS		**$23,511**	**$21,435**
Eligible Out-Of-Pocket Expenses		$2,650	$0
AVAILABLE/SPENDABLE INCOME		**$20,861**	**$21,435**

That's a savings of $574 for the year!

This example is for illustrative purposes only. Every situation varies and it is recommended you consult a tax advisor for all tax advice.

**Varies, assumes 10.30%;*
***Varies, assumes 3.68%*

OVER-THE-COUNTER (OTC) MEDICATION REMINDER

Effective for purchases on or after January 1, 2020, thousands of items, including pain relievers, cold and flu medications, antacids, acne remedies, and allergy medicines are now reimbursable from an FSA, Section 213 HRA, or HSA without a prescription.

In addition to eliminating the prescription requirement on OTC drugs and medicine, the new CARES Act has added hundreds of menstrual products to the list of approved expenses, including tampons, pads, liners, cups, sponges and similar items. As was the case prior to the passage of the ACA, vitamins and supplements will continue to require a physician's "prescription" indicating that they are being taken to treat a diagnosed medical condition (e.g., anemia) rather than for general health and wellness.

ELIGIBLE HEALTH FSA EXPENSES*

- Acupuncture
- Alcoholism treatment
- Artificial teeth/dentures
- Blood pressure monitors
- Braces
- Braille-books & magazines
- Breast pumps & lactation supplies
- Chiropractors
- Co-insurance, co-pay & deductibles
- Cost of operations & related treatments
- Crutches
- Diabetic supplies
- Drug addiction treatment
- Eye exams, eyeglasses, contacts
- Hearing devices & batteries
- Hospital services
- Operations
- Pregnancy tests
- Radial keratotomy & Lasik eye surgery
- Smoking cessation programs
- Speech therapy
- Surgical fees
- Vaccines
- Walkers & wheelchairs
- X-rays and more.

A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov.

IMPORTANT: PAYING FOR ELIGIBLE SERVICES & EXPENSES

Visit the FSA Store at **www.FSAstore.com,** where you can purchase FSA-eligible products without a prescription online.

Although you do not need to file for reimbursement when using your FSA debit card, you may be required to submit documentation, so be sure to save your receipts.

If you use a personal form of payment to pay for eligible expenses out-of-pocket, you can submit an FSA claim form along with your original receipts for reimbursement.

DENTAL
COVERAGE OVERVIEW

BlueCross BlueShield of Oklahoma

You have the freedom to select the dentist of your choice; however, when you visit a participating in-network dentist, you will have lower out-of-pocket costs, no balance billing, and claims will be submitted by your dentist on your behalf.

	BlueCare Dental PPO Low Plan – DONLR36	BlueCare Dental PPO High Plan – DONHR32
PLAN FEATURES		
Network Details	Blue Traditional National Network	Blue Traditional National Network
Benefit Period	Calendar Year	Calendar Year
DEDUCTIBLE		
Individual	$50	$50
Family	$150	$150
When does it apply?	When receiving Basic or Major services (Does not apply for Preventive services)	
COVERED SERVICES		
CLASS I: Preventive Services *Routine oral exams and cleanings, x-rays (bitewing), sealants & fluoride treatments*	Covered at 100%	Covered at 100%
CLASS II: Basic Services *Fillings, & Non-Surgical Extractions*	Covered at 80%	Covered at 80%
CLASS III: Major Services *Prosthodontics, crowns, inlays/onlays, dentures & bridges*	Covered at 50%	Covered at 50%
ORTHODONTIA *Adult coverage & dependent children to age 19*	N/A	*Covered at 50%* *$2,000 Lifetime maximum per participant*
ANNUAL MAXIMUM		
Maximum Benefit *Allowed per Benefit Period*	$1,000 per covered individual	$2,000 per covered individual

DENTAL MONTHLY RATES	LOW PLAN	HIGH PLAN
Employee Only	$29.83	$39.41
Employee + Spouse	$59.66	$78.83
Employee + Child (ren)	$71.50	$98.41
Employee + Family	$110.90	$151.38

This dental plan offers deeper discounts when you visit a provider that is In-Network. In-Network providers can be found on Find a Dentist www.bcbsok.com/find-care/providers-in-network/find-a-dentist. Choose the network based on the plan type you are choosing.

COMMON TERMS

PRE-TREATMENT ESTIMATE
If your dental care is extensive and you want to plan ahead for the cost, you can ask your dentist to submit a pre-treatment estimate. While it is not a guarantee of payment, a pre-treatment estimate can help you predict your out-of-pocket costs.

DUAL COVERAGE
You might have benefits from more than one dental plan, which is called dual coverage. In this situation, the total amount paid by both plans can't exceed 100% of your dental expenses. And in some cases, depending on the specifics of the plans, your coverage may not total 100%.

LIMITATIONS AND EXCLUSIONS
Dental plans are intended to cover part of your dental expenses, so coverage may not extend to your every dental need. A typical plan has limitations such as the number of times you can receive a cleaning each year. In addition, some procedures may be not be covered under your plan, which is referred to as an exclusion.

PREVENTION FIRST!

Your dental health is an important part of your overall health. Make sure you take advantage of your preventive dental visits.

Preventive care services are covered at 100% if you visit an In-Network provider. They are also not subject to the annual deductible.

VISION
COVERAGE OVERVIEW

Under this plan, you may use the eye care professional of your choice. However, when you visit a participating in-network EyeMed provider, you receive higher levels of coverage. If you choose to receive services from an out-of-network provider, you will be required to pay that provider at the time of service and submit a claim form for reimbursement.

EyeMed Network

PLAN FEATURES	LOW PLAN	MIDDLE PLAN	HIGH PLAN
Vision Exam	**$20** copay	**$10** copay	**$0** copay
COVERED SERVICES – LENSES / FRAMES			
Single Lenses	**$20** copay	**$25** copay	**$0** copay
Bifocals	**$20** copay	**$25** copay	**$0** copay
Trifocals	**$20** copay	**$25** copay	**$0** copay
Frames	**$120** retail allowance	**$130** retail allowance	**$150** retail allowance
COVERED SERVICES			
Contact Lenses	In full if medically necessary; $120 allowance for elective.	In full if medically necessary; $130 allowance for elective.	In full if medically necessary; $150 allowance for elective.
BENEFIT FREQUENCY			
Exams	Once every 12 Months	Once every 12 Months	Once every 12 Months
Lenses	Once every 12 Months	Once every 12 Months	Once every 12 Months
Frames	Once every 24 Months	Once every 24 Months	Once every 12 Months
Contacts	Once every 12 Months *(contacts in lieu of frames/lenses)*	Once every 12 Months *(contacts in lieu of frames/lenses)*	Once every 12 Months *(contacts in lieu of frames/lenses)*

VISION MONTHLY RATES	LOW PLAN	MIDDLE PLAN	HIGH PLAN
Employee Only	$6.16	$7.43	$9.24
Employee + Spouse	$11.87	$14.31	$17.78
Employee + Child (ren)	$10.37	$12.51	$15.12
Employee + Family	$16.07	$19.40	$23.62

Did you know your eyes can tell an eye care provider a lot about you?

In addition to eye disease, a routine eye exam can help detect signs of serious health conditions like diabetes and high cholesterol. This is important, since you won't always notice the symptoms yourself and since some of these diseases cause early and irreversible damage.

Need to locate a participating In-Network provider?

Visit www.mutualofomaha.com/vision

Search by location, doctor name, or office name.

TERM LIFE INSURANCE
COVERAGE OVERVIEW

BENEFICIARY(IES)

It's very important to designate beneficiaries. Taking a few minutes to designate your beneficiaries now will help ensure that your assets will be distributed according to your direction.

A Beneficiary is the person you designate to receive your life insurance benefits in the event of your death. It is important that your beneficiary designation is clear so there is no question as to your intentions.

It is also important that you name a **Primary** and **Contingent Beneficiary.** A contingent beneficiary will receive the benefits of your life insurance if the primary beneficiary cannot. You can change beneficiaries at any time.

You should review your beneficiary elections on a regular basis to ensure they are updated as life changes. Even if you are single, your beneficiary can use your Life Insurance to pay off your debts, such as: credit cards, mortgages, and other expenses.

**You designate your beneficiary(ies) when enrolling for your benefits.*

TERM LIFE INSURANCE

Life insurance is an important part of your financial security. Life insurance helps protect your family from financial risk and sudden loss of income in the event of your death. AD&D insurance is equal to your Life benefit in the event of your death being a result of an accident and may also pay benefits for certain injuries sustained.

Company Paid Benefit - Provided to you at no cost	
Coverage Amount	Flat **$50,000** Benefit
Accidental Death and Dismemberment (AD&D)	The Principal Sum Amount is equal to the amount of your life insurance benefit.
Benefit Reduction Schedule	Your insurance will reduce to: – At age 65, amounts reduce to 65% – At age 70, amounts reduce to 50%

ADDITIONAL PLAN PROVISIONS

Conversion	If your employment or class membership ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.

WHAT WILL MY BENEFICIARY RECEIVE?

In The Event That Death Occurs:

- Your Basic Life insurance is paid to your beneficiary.
- **If death occurs from an accident:** 100% of the AD&D benefit would be payable to your beneficiary(ies) in addition to your Basic Life insurance.

VOLUNTARY TERM LIFE & AD&D

COVERAGE OPTIONS FOR YOU & THE FAMILY

VOLUNTARY TERM **LIFE INSURANCE**

Employees have the opportunity to enroll in supplemental Life insurance. If you choose to enroll in employee coverage, this will be in addition to your employer provided Basic Life coverage. Coverage is also available for your spouse and/or child dependents. It is typically required that you elect coverage for yourself in order to be eligible for coverage on your dependents.

PLAN OPTIONS			
Cost of Coverage	Premiums are based on age-rated tables and paid by the employee every pay period through a payroll deduction. These premiums are post-tax and benefits payable are tax-free.		
Coverage Options	**Employee Coverage** $500,000, in increments of $10,000, but no more than 5 tines annual salary.	**Spouse Coverage** 100% of employee's benefit, in increments of $5,00, up to $100,000.	**Dependent Coverage** 100% of employee's benefit, in increments of $1,000, up to $10,000.
Do I have to take a health exam to get coverage?	If you and your dependents enroll in coverage at your initial eligibility date, you may apply for up to the Guaranteed Issue amounts without medical questions.		
Guaranteed Issue	**Employee** 5 times annual salary, up to $150,000	**Spouse** 100% of employee's benefit up to $50,000.	**Dependent** 100% of employee's benefit.

PLAN PROVISIONS		
Cost Calculation	Age Rated Benefit (Spouse Life based on employee's age)	
Benefit Reduction Schedule	**Employee Coverage Will Reduce To:** – 65% of the original amount at age 65 – 50% of the original amount at age 70	**Spouse Coverage Will Reduce By:** The same amount and at the same time your coverage reduces
Portability	If your employment ends or you retire, you may be eligible to continue your term insurance at group rates.	
Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.	

*Guaranteed Issue (GI) and Evidence of Insurability (EOI)

When you are first eligible (at hire) for Voluntary Life and AD&D, you may purchase up to the Guaranteed Issue (GI) for yourself and your spouse without providing proof of good health (EOI). Annually, you are able to increase elections 1 increment up to GI without proof of good heath.

Any amount elected over the GI will require EOI. If you elect optional life coverage, and are required to complete an EOI, it is your responsibility to complete the EOI and send to the provider (address will be listed on your form). In addition, your spouse will need to provide EOI to be eligible for coverage amounts over GI, or if coverage is requested at a later date.

DISABILITY

VOLUNTARY SHORT-TERM | LONG-TERM

SHORT-TERM DISABILITY (STD)

Everyday illnesses or injuries can interfere with your ability to work. Even a few weeks away from work can make it difficult to manage household costs.

Short Term Disability coverage provides financial protection for you by paying a portion of your income, so you can focus on getting better and worry less about keeping up with your bills.

LONG-TERM DISABILITY (LTD)

Serious illnesses or accidents can come out of nowhere. They can interrupt your life, and your ability to work for months – even years.

Long Term Disability provides financial protection for you by paying a portion of your income, so you have financial support to manage your disability and your household.

PLAN FEATURES	SHORT-TERM DISABILITY (STD)	LONG-TERM DISABILITY (LTD)
Cost of Coverage	**Voluntary Benefit** Employee is responsible for 100% of the cost	**Voluntary Benefit** Employee is responsible for 100% of the cost
Elimination Period	8th day of disabling injury or illness.	180 days
Maximum Benefit Period	**Up to 25 weeks.**	If you become disabled prior to age 62, benefits are payable to age 65, your Social Security Normal Retirement Age or 3.5 years, whichever is longest. At age 62 (and older), the benefit period will be based on a reduced duration schedule.
Coverage Amount	Your benefit is equivalent to 60% of your before-tax weekly earnings, not to exceed the plan's maximum weekly benefit amount less other income sources.	Your benefit is equivalent to 60% of your before-tax monthly earnings, not to exceed the plan's maximum monthly benefit amount less other income sources.
What's covered?	**A variety of conditions and injuries.** Typical claims would include pregnancy, injuries, joint, back and digestive disorders.	**A variety of conditions and injuries.** Typical claims would include cancer, back disorders, injuries and poison, cardiovascular, joint disorders.
Definition of Earnings	**Base Salary** *(excludes commissions and bonuses)*	**Base Salary** *(excludes commissions and bonuses)*
ADDITIONAL PLAN PROVISIONS		
Benefit Payment Frequency	**Weekly benefit** may be reduced or offset by other sources of income.	**Monthly benefit** may be reduced or offset by other sources of income.
Cost Calculation	Age Rated	Age Rated
Pre-Existing Condition Limitation	Your plan is subject to a pre-existing condition limitation. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 3/6 which means any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 6 months of coverage, would not be covered.	Your plan is subject to a pre-existing condition limitation. A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to your effective date of coverage. The pre-existing condition under this plan is 12/12 which means any condition that you receive medical attention for in the 12 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.

Certain exclusions and any pre-existing condition limitations may apply. Please refer to the Provider's detailed benefit summary for details.

SUPPLEMENTAL BENEFIT RATES

SHORT-TERM, LONG-TERM AND VOLUNTARY TERM LIFE

Calculating Short Term (STD) Disability Rates

To calculate your weekly premium, take your weekly earnings, multiply by 0.60, then multiply the rate from the rate table, and divide by 10. This amount is your estimated monthly premium. Take your monthly premium and multiply by 12 months and then divide by 24 pay periods. This amount is your estimated bi-weekly premium.

STD Example: Loretta is 36 years old and earns $660 per week.

$660 X 0.60 X 0.677 ÷ 10 = $26.81 p/month

$26.81 × 12 months ÷ 24 pay periods = $13.41 p/paycheck

Your Age (as of January 1)	Rate per $10 of weekly benefit
<30	$0.677
30-34	$0.677
35-39	$0.677
40-44	$0.677
45-49	$0.733
50-54	$0.890
55-59	$1.214
60-64	$1.409
65+	$1.464

Calculating Long Term (LTD) Disability Rates

To calculate your premium, take your monthly earnings, multiply by the rate and divide by 100. This amount is your estimated monthly premium. Take your monthly premium and multiply by 12 months and then divide by 24 pay periods. This amount is your estimated bi-weekly premium.

LTD Example: Angel is 40 years old and earns $5,000 per month.

$5,000 X 0.570 ÷ 100 = $28.50 p/month

$28.50 × 12 months ÷ 24 pay periods = $14.25 p/paycheck

Your Age (as of January 1)	Rate
<35	$0.28
35-39	$0.36
40-44	$0.57
45-49	$0.77
50-54	$1.26
55-59	$2.16
60-64	$2.85
65+	$2.50

Employee & Spouse Age	Premium for Voluntary Term Life & AD&D (24 Payroll Deductions Per Year) Employee & Spouse Coverage				
	$10,000	$20,000	$30,000	$50,000	$100,000
0-29	$0.59	$1.18	$1.77	$2.95	$5.90
30-34	$0.69	$1.38	$2.07	$3.45	$6.90
35-39	$0.84	$1.68	$2.52	$4.20	$8.40
40-44	$1.04	$2.08	$3.12	$5.20	$10.40
45-49	$1.44	$2.88	$4.32	$7.20	$14.40
50-54	$2.19	$4.38	$6.57	$10.95	$21.90
55-59	$3.74	$7.48	$11.22	$18.70	$37.40
60-64	$5.14	$10.28	$15.42	$25.70	$51.40
65-69	$9.14	$18.28	$27.42	$45.70	$91.40
70+	$16.19	$32.38	$48.57	$80.95	$161.90
Child (ren) Rates		$1,000	$3,000	$5,000	$10,000
		$0.14	$0.42	$0.71	$1.41

SUPPLEMENTAL BENEFITS

ACCIDENT | CRITICAL ILLNESS

Accident Insurance

A serious injury can cost you a lot of money – not only in medical bills but in things like income from lost work hours. Some injuries are minor, but others are debilitating and require significant medical care. If you get hurt, accident insurance pays you money that you can use to cover personal expenses, bills, and out-of-pocket medical costs.

Who Gets Paid?

You get paid. When you have a covered accident or injury, your health insurance company pays your doctor or hospital, but your accident insurance company pays you.

What's Covered?

Not all accidents are "qualifying injuries." The kinds of accidents that are covered can vary by plan, but accident insurance plans typically cover things like:

If you have a covered injury, accident insurance can help you pay for things like:

- Emergency Room Visits
- Ambulance Transportation
- Hospital Admissions & Per Diem Charges
- Intensive Care &Rehabilitation Unit Care
- Diagnostic Exams
- Follow-up Treatments
- Physical Therapy

What is the Cost of Accident Insurance?

Depending on if you cover only yourself or other dependents.

What it Doesn't Cover

Accident insurance will not typically cover things like check-ups or hospitalization due to illness. Accident insurance will not cover you for injuries suffered before you purchased the plan.

$50 WELLNESS BENEFIT
Per Covered Individual

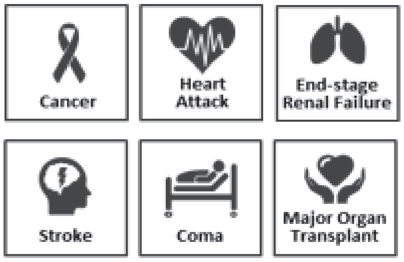
ACCIDENT SEMI-MONTHLY RATES (24 Payroll Deductions Per Year)	
Employee Only	$5.14
Employee + Spouse	$8.34
Employee + Child (ren)	$9.02
Employee + Family	$12.22

Critical Illness Insurance

How would you pay your bills if you were suddenly diagnosed with cancer and couldn't work? Critical illness insurance doesn't' pay your medical bills. It pays you if you're diagnosed with a covered illness. The benefit is paid directly to you and is your choice how to spend it.

What's Covered?

Critical illness can vary widely from one another. Some may focus on a single specific diagnosis, while others may provide you with coverage for a range of possible diagnoses, such as:



COVERAGE OPTIONS	**Employee:** Choose up to $30,000 in $5,000 increments. **Guaranteed issue:** $30,000 **Spouse:** Choose up to $30,000 in $5,000 increments, up to $30,000. Cannot exceed 100% of employee's principal sum. **Guaranteed issue:** $30,000 **Child (ren):** 25% of employee's principal sum up to $6,000. **Guaranteed issue:** $5,000
Benefit Reduction Schedule	Your insurance will reduce on the policy anniversary following your birthdate: – 50% of the original amount at age 70

What is the Cost of Critical Illness Insurance?

Depending on your age, and how much coverage you want, the cost of critical illness insurance can vary significantly.

Age	Premium for Critical Illness (24 Payroll Deductions Per Year)				
	$10,000	**$15,000**	**$20,000**	**$25,000**	**$30,000**
0-24	$2.15	$3.23	$4.30	$5.38	$6.45
25-29	$2.30	$3.45	$4.60	$5.75	$6.90
30-34	$3.25	$4.88	$6.50	$8.13	$9.75
35-39	$4.75	$7.13	$9.50	$11.88	$14.25
40-44	$7.45	$11.18	$14.90	$18.63	$22.35
45-49	$11.60	$17.40	$23.20	$29.00	$34.80
50-54	$17.65	$26.48	$35.30	$44.13	$52.95
55-59	$25.60	$38.40	$51.20	$64.00	$76.80
60-64	$37.70	$56.55	$75.40	$94.25	$113.10
65-69	$57.70	$86.55	$115.40	$144.25	$173.10
70+	$85.70	$128.55	$171.40	$214.25	$257.10

Hospital Indemnity Insurance

Hospital Indemnity insurance will pay a scheduled benefit for hospital confinement that occurs while insurance is in effect. Additional benefits for certain services or treatments may also be available, as described.

Covered Events	Illness or Injury
Pregnancy	Eligible Same as Illness
Hospital Admission	$1,500 per admission. Admission benefits are payable up to a combined total of 1 day per policy year.
ICU Admission	$2,000 per admission. Admission benefits are payable up to a combined total of 1 day per policy year.
Hospital Confinement	$100 per day. Confinement benefits are payable up to a combined total of 30 days per policy year unless otherwise noted and are not payable on the same day as Hospital/ICU admission benefits.
Critical Care Confinement	$200 per day. Confinement benefits are payable up to a combined total of 30 days per policy year unless otherwise noted and are not payable on the same day as Hospital/ICU admission benefits.
Wellness Benefit	$50 per Employee per calendar year
Pre-Existing	See below for exclusions & limitations

Pre-Existing Condition Limitation: Benefits for a pre-existing condition (defined as a sickness or injury, or symptoms of one, whether diagnosed or not, for which you received medical treatment, consultation, care or services, including diagnostic measures, took prescribed drugs or medicine, or had been prescribed medicine or drugs to be taken in the 3 months prior to your effective date) will not be paid during the first 12 months the policy is in force.

Hospital Indemnity Semi-Monthly Rates (24 Pay Periods Per Year)	
Employee Only	$7.97
Employee + Spouse	$17.83
Employee + Child (ren)	$13.40
Employee + Family	$23.27

$50 WELLNESS BENEFIT
Per Covered Individual

For Screenings such as: blood tests, Chest X-rays, Stress tests, Colonoscopies, Mammograms, and other tests listed in your policy. Up to six (6) per family per calendar year.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Tulsa Airports provides an Employee Assistance Program (EAP) that is available to assist you and your immediate dependents (spouse or children) in the identification and resolution of personal problems or concerns that may have a negative impact on your personal or professional lives. Personal problems or concerns include, but not limited to martial, family, alcohol, drug, emotional, and stress.

EAP SERVICES INCLUDE:

- Confidential FREE Assessment/Referral/Follow-Up Services
- 24-Hour, 365-Day Access for Emergency Situations
- Face-to-Face Assessment Interview
- Master-Level Licensed Counselors
- Referrals to Community-Based and/or Benefit Covered Resources

BENEFITS TO EMPLOYEES:

- EAP is benefit available at no cost to the employee and immediate dependents
- EAP is an objective resource available to assist in problem identification and resolution
- EAP is confidential for all individuals who self-refer

CommunityCare EAP
Williams Center Tower II
Two West Second Street
Plaza Level
Tulsa, Oklahoma 74103

In Tulsa:
918-594-5232

Toll Free Outside of Tulsa:
800-221-3976

Fax:
918-879-4310

Visit our Web Site:
www.ccok.com/EAP

Personal problems and concerns affect us all throughout our lives. Most of the time we can handle these problems ourselves, but when that is not possible, the EAP is an option. An objective third party can assist you with problem solving or with additional care. Treatment success is often dependent upon how early treatment is sought. Seeking assistance to resolve problems before they have a severe impact on your family, job or life is a sign of strength that helps you gain control of the situation. If you need assistance, call the EAP at **918-594-5232 or 800-221-3976.**

ADDITIONAL BENEFITS

idwatchdog from Equifax

idwatchdog from Equifax

No one is immune to identity theft.

Better Protect What Matters Most.

Identity theft can affect anyone—from infants to seniors. Each generation has habits that savvy criminals know how to exploit—resulting in over $43 billion lost to identity fraud in the U.S. in 2022.[1] Take action with award-winning ID Watchdog identity theft protection.

Awarded Best in Class Identity Protection Service Provider for Consumers

Greater Peace of Mind

With ID Watchdog® as an employee benefit, you have a more convenient and affordable way to help better protect and monitor your identity. You'll be alerted to potentially suspicious activity and enjoy greater peace of mind knowing you don't have to face identity theft alone.

Why Choose ID Watchdog?

Advanced Identity Theft Detection

We scour billions of data points—public records, transaction records, social media and more—to search for signs of potential identity theft.

Greater Protection & Control

We've got you covered with lock features for added control over your credit report(s) to help keep identity thieves from opening new accounts in your name.

Dedicated Identity Resolution Specialists

If you become a victim, you don't have to face it alone. One of our certified resolution specialists will personally manage the case for you until your identity is restored.

Extensive Family Coverage

Our family plan helps you better protect your loved ones[2] with personalized accounts for adult family members, family alert sharing, and exclusive features for children.

Our U.S.-based, customer care team is **here for you 24/7/365 at 866.513.1518**

Monthly Rates
Employee: $0 – Employer Paid
Family: $6.90

[1] Javelin Strategy & Research, "2023 Identity Fraud Study: The Butterfly Effect", Mar 2023.
[2] Refer to your employer or ID Watchdog for family plan eligibility.

ADDITIONAL BENEFITS

MetLife Legal Plans

Cover the costs on a wide range of common legal issues with a Legal Plan.

Access experienced attorneys to help with estate planning, home sales, tax audits and more.

Powerful legal protection on your side

Quality legal assistance can be pricey. And it can be hard to know where to turn to find an attorney you can trust. With MetLife Legal Plans, you have access to the expert guidance and tools you need to navigate a broad range of personal legal needs. Whether you're buying or selling a home, starting a family, or caring for aging parents, the benefit provides protection at every step.

Reduce the out-of-pocket cost of legal services with MetLife Legal Plans.

How it works

Our service is tailored to your needs. With network attorneys available in person, by phone or by email and online tools to do-it-yourself — we make it easy to get legal help. And, you will always have a choice in which attorney to use. You can choose one from our network of prequalified attorneys, or use an attorney outside of our network and be reimbursed some of the cost.[1]

Best of all, you have unlimited access to our attorneys for all legal matters covered under the plan. For a monthly fee conveniently paid through payroll deduction, an expert is on your side as long as you need them.

Estate planning at your fingertips

Our website provides you with the ability to create wills, living wills and powers of attorney online in as little as 15 minutes. Answer a few questions about yourself, your family and your assets to create these documents instantly. In states where available, you also have access to sign and notarize your documents online through our video notary feature.[2]

How to use the plan

1. Find an attorney

Create an account at **members.legalplans.com** to see your coverages and select an attorney for your legal matter. Or, give us a call at **800-821-6400** for assistance.

2. Make an appointment

Call the attorney you select and schedule a time to talk or meet.

3. That's it!

There are no copays, deductibles or claim forms when you use a network attorney for a covered matter.

ADDITIONAL BENEFITS

MetLife Legal Plans

Helping you navigate life's planned and unplanned events.

Tulsa Airports Improvement Trust

For $24.00 per month for our high plan, or for $14.80 per month for our low plan, you, your spouse and dependents get legal assistance for some of the most frequently needed personal legal matters — with no waiting periods, no deductibles and no claim forms when using a network attorney for a covered matter.

	High Plan		Low Plan
Money Matters	• Debt Collection Defense • Identity Theft Defense • Negotiations with Creditors • Promissory Notes • Tax Collection Defense	• Personal Bankruptcy • Tax Audit Representation	• Debt Collection Defense • Identity Theft Defense • Negotiations with Creditors • Promissory Notes • Tax Collection Defense
Home & Real Estate	• Boundary or Title Disputes • Deeds • Eviction Defense • Foreclosure • Home Equity Loans • Mortgages	• Security Deposit Assistance • Tenant Negotiations • Property Tax Assessments • Refinancing & Home Equity Loan • Sale or Purchase of Home • Zoning Applications	• Deeds • Eviction Defense • Foreclosure • Mortgages • Security Deposit Assistance • Tenant Negotiations
Estate Planning	• Codicils • Complex Wills • Healthcare Proxies • Living Wills • Powers of Attorney (Healthcare, Financial, Childcare, Immigration) • Simple Wills	• Revocable & Irrevocable Trusts	• Codicils • Complex Wills • Healthcare Proxies • Living Wills • Powers of Attorney (Healthcare, Financial, Childcare, Immigration) • Simple Wills
Family & Personal	• Affidavits • Conservatorship • Demand Letters • Garnishment Defense • Guardianship • Name Change • Personal Property Protection • Protection from Domestic Violence • Review of ANY Personal Legal Document • School Hearings	• Adoption • Immigration Assistance • Juvenile Court Defense, Including Criminal Matters • Parental Responsibility Matters • Prenuptial Agreement	• Affidavits • Conservatorship • Demand Letters • Garnishment Defense • Guardianship • Name Change • Personal Property Protection • Protection from Domestic Violence • Review of ANY Personal Legal Document • School Hearings
Civil Lawsuits	• Administrative Hearings • Disputes Over Consumer Goods & Services • Incompetency Defense	• Civil Litigation Defense • Pet Liabilities • Small Claims Assistance	• Administrative Hearings • Disputes Over Consumer Goods & Services • Incompetency Defense • Small Claims Assistance
Elder-Care Issues	Consultation & Document Review for Issues Related to Your Parents: • Deeds • Leases • Medicaid • Medicare	• Notes • Nursing Home Agreements • Powers of Attorney • Prescription Plans • Wills	• Same as High Plan
Traffic & Other Matters	• Defense of Traffic Tickets[3] • Driving Privileges Restoration	• License Suspension Due to DUI • Repossession	• Same as High Plan

To learn more about your coverages, view our attorney network or grant your dependents access, create an account.

Your account will also give you access to our self-help document library to complete simple legal forms. The forms are available to you, regardless of enrollment.

Create an account at **members.legalplans.com** or scan the QR code.

Questions? Call the **MetLife Legal Plans Client Service Center** at **800-821-6400** Monday—Friday, 8:00 a.m. to 8:00 p.m., ET.

1. The Participant will be reimbursed according to the set fee schedule, the lesser of the maximum reimbursement amount or the attorney's actual charge. You will be responsible to pay the difference, if any, between the plan's payment and the non-plan attorney's charge for services. MetLife Legal Plans is not responsible for legal work performed by out-of-network attorneys.
2. Digital notary and signing is not available in all states.
3. Does not cover DUI.

MetLife

MetLife Legal Plans | 1111 Superior Avenue, Suite 800 | Cleveland, OH 44114

GLOSSARY OF TERMS

Dependent Verification Services (DVS) – Service used to verify dependent proof of relationship when adding dependents to benefit plans.

Beneficiary – A person designated by you, the participant of a benefit plan, to receive the benefits of the plan in the event of the participant's death.

- **Primary Beneficiary –** A person who is designated to receive the benefits of a benefit plan in the event of the participant's death
- **Contingent Beneficiary** – A person who is designated to receive the benefits of a benefit plan in the event of the Primary Beneficiary's death

Charges – The term "charges" means the actual billed charges. It also means an amount negotiated by a provider, directly or indirectly, if that amount is different from the actual billed charges.

Coinsurance – The percentage of charges for covered expenses that an insured person is required to pay under the plan (separate from copayments)

Deductible – The amount of money you must pay each year to cover eligible expenses before your insurance policy starts paying.

Dependents – Dependents are your:

- Lawful spouse through a marriage that is lawfully recognized.
- Dependent child (married or unmarried) under the age of 26 including stepchildren and legally adopted children.

Proof of relationship documentation will be required in order to add dependents to your plan(s). Employees will receive request for documentation.

Emergency Services – Medical, psychiatric, surgical, hospital, and related health care services and testing, including ambulance service, that are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.

The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital, or the final diagnosis – whichever reasonably indicated an emergency medical condition – will be the basis for the determination of coverage provided such symptoms reasonably indicate an emergency.

Evidence of Insurability (EOI) – Proof that you are insurable based on the requirements of the insurance carrier. *For example, the results of a blood test or a doctor's signature on a form may be required for you to be covered by/for Optional Life insurance.*

Explanation of Benefits — The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs are your responsibility.

Health Reimbursement Account (HRA) – The Health Reimbursement Account (HRA) is an employer-funded account that reimburses you for eligible out-of-pocket medical expenses. The HRA is only available to employees who are enrolled in the HRA Plan.

In-Network – The term "in-network" refers to health care services or items provided by your Primary Care Physician (PCP) or services/items provided by another participating provider and authorized by your PCP or the review organization. Authorization by your PCP or the review organization is not required in the case of mental health and substance abuse treatment other than hospital confinement solely for detoxification.

Emergency Care that meets the definition of "emergency services" and is authorized as such by either the PCP or the review organization is considered in-network.

Out-of-Network - The term "out-of-network" refers to care that does not qualify as in-network.

Maximum Out of Pocket — The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Medically Necessary/Medical Necessity – Required to diagnose or treat an illness, injury, disease, or its symptoms; in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site, and duration; not primarily for the convenience of the patient, physician, or other health care provider; and rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Participating Provider – A hospital, physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

Post-Tax – An option to have the payment to your benefits deducted from your gross pay after your taxes have been withheld. Therefore, your tax contributions will be calculated based on a higher amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a higher amount.

Pre-Tax – An option to have the payment to your benefits deducted from your gross pay before your taxes have been withheld. Therefore, your tax contributions will be calculated based on a lesser amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a lesser amount.

Primary Care Dentist (PCD) – The term "Primary Care Dentist" means a dentist who (a) qualifies as a participating provider in general practice, referrals, or specialized care; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for dental care for you or any of your insured dependents.

Primary Care Physician (PCP) – The term "Primary Care Physician" means a physician who (a) qualifies as a participating provider in general practice, obstetrics/gynecology, internal medicine, family practice, or pediatrics; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any of your insured dependents.

Proof of Relationship Documentation – Documents that show a dependent is lawfully your dependent. Documents can include marriage certificates, birth certificates, adoption agreements, previous years' tax returns, court orders, and/or divorce decrees showing your or your spouse's responsibility for the dependent.

IMPORTANT CONTACT INFORMATION

	PROVIDER	CONTACT INFORMATION
	Blue Cross Blue Shield of Oklahoma Medical	(800) 942-5837 www.bcbsok.com Group #: 254533
	BlueCross BlueShield of Oklahoma Dental Group #302852	(800) 942-5837 www.bcbsok.com Group #: 254533
	Mutual of Omaha | EyeMed Vision Network	(833) 279-4358 Group #: 60436 www.MutualofOmaha.com/vision
	MDLive | Virtual Visits	(888) 676-4204 www.MDLIVE.com/bcbstx
	Mutual of Omaha Basic Life, STD, LTD, Voluntary Supplemental Life	(800) 866-679-3054 www.mutualofomaha.com Group #: G000C7LS
	Mutual of Omaha Accident, Critical Illness & Hospital	(800) 228-7104 www.mutualofomaha.com Group #: G000C7LS
	FSA, HSA, Dependent Care FSA, Limited FSA WEX Health	(866) 451-3399 customerservice@wexhealth.com
	CommunityCare Employee Assistance Plan (EAP)	(800) 221-3976 www.ccok.com/EAP
	MetLife Legal Plans	(800) 821-6400
	Identity Theft Idwatchdog from Equifax	(866) 513-1518
	Human Resources Director	Amanda Bryson (918) 838-5019 amandabryson@flytulsa.com
	HR Generalist	Tara McCloud (918) 838-5020 taramccloud@flytulsa.com
	NFP Service Team	
	Robyn Setzer Senior Account Executive (918) 282-3517 Robyn.Setzer@nfp.com	Hailye Vaughn Account Manager II (918) 978-7759 Hailye.Vaughn@nfp.com

Tulsa International Airport

This Benefit Enrollment Guide Is Provided By:

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