WE CLAREMORE

2024 Employee Benefits Guide

July 1, 2024 – June 30, 2025

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This brochure summarizes the benefit plans that are available to City of Claremore eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits

A Message to Our Employees

The Benefits Open Enrollment Period Is Here!

As healthcare costs continue to rise due to inflation and increased government regulation, the cost to provide healthcare coverage has also increased. Additionally, City of Claremore has seen an increase in the occurrence as well as the severity of claims of healthcare costs. This has been a common scenario across the market as costs increase in an effort to keep pace with healthcare trends. City of Claremore is committed to providing a comprehensive benefits package to its employees for the following year and has no changes to its 2024-2025 offerings, other than an addition to Medefy resources and a change to the medical network.

2024-2025 Benefit Plan Highlights

Healthcare Benefit Resources – Medefy

- NEW! Virtual Mental Health Program
- MediOrbis Telemedicine

Medical – BCBS OK

- NEW! Blue Preferred PPO Network is now Blue Advantage PPO network. Network change, same benefits!
- NEW! McBride Ortho and/or Oklahoma Surgical Ortho Bundle
    - BCBS OK has partnered with McBride Orthopedic Hospital and Oklahoma Surgical Hospital to provide a bundled pricing program for hip and knee replacements. The program is offered at 100% no cost share on PPO plans, and includes charges for surgeon, facility, anesthesia, implant, and post-op care. This bundle does not include non-metal implants or complications.

Flexible Spending Account (FSA) – Flex Plan Admin

- Heath Care FSA or Dependent Care FSA

Dental – BCBS OK

- BlueCare PPO Network

Vision – Dearborn

- EyeMed Network

Basic Life and AD&D – Dearborn Life

- Company paid life insurance for employees.
- Employee paid life insurance for your spouse and/or child(ren).

Voluntary Life – Dearborn Life

- Employee paid additional life insurance for you, your spouse and/or child(ren).

Voluntary AD&D – Dearborn Life

- Employee paid additional AD&D insurance for you, your spouse and/or child(ren).

Voluntary Supplemental Benefits – American Fidelity

- Plan Options: Accident, Cancer, Critical Illness, Hospital Indemnity, Disability, Life

Employee Assistance Program (EAP) – CommunityCare

- Voluntary self-help available to you and your dependents.

Benefits for You & Your Family

City of Claremore is pleased to announce our 2024-2025 benefits program, which is designed to help you stay healthy, feel secure, and maintain a work/life balance. Offering a competitive benefits package is just one way we strive to provide our employees with a rewarding workplace. Please read the information provided in this guide carefully. For full details about our plans, please refer to the summary plan descriptions. Listed below are the City of Claremore benefits available during open enrollment:

- Medical
- FSA
- Dental
- Vision
- Basic Life and AD&D
- Voluntary Life
- Voluntary AD&D
- Voluntary Supplemental Benefits

When is My Coverage Effective?

The effective date for your benefits is July 1, 2024 – June 30, 2025.

Who is Eligible?

All regular full-time employees and their eligible dependents may participate in the City of Claremore benefits program.

Generally, for the City of Claremore benefits program, dependents are defined as:

- Your legal spouse or common law spouse.
- Dependent “child(ren)” up to age 26. “Child” is defined as the employee’s natural child, stepchild, legally adopted child, and child under your legal guardianship.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested, and disability has to have occurred prior to age 25.

If your child becomes ineligible for coverage, you must notify City of Claremore’s Human Resources Department.

To add a spouse or child to your benefit coverage, you must notify City of Claremore with 31 days of a qualifying event.

Adding dependents:

- Newborn children – add within 31 days of birth/adoption (newborns are not automatically enrolled)
- Natural children – show birth certificate, affidavit of birth, or baptismal certificate.
- Adopted children – show adoption papers.
- Stepchildren – show marriage certificate or tax return.
- Guardianship of minors – show court papers for guardianship.

When and How Do I Enroll?

Open enrollment will be conducted May 14, 2024 – May 31, 2024. Open enrollment meetings will be held May 14, 2024 – May 16, 2024.

If you have not enrolled by this date, then you will not be eligible to enroll for coverage until the next Annual Open Enrollment Period. All eligible employees are required to complete the enrollment process, even if you do not wish to make any changes to your benefits. Enrollment elections can be made online through AF Enroll.

Changing Coverage During the Year

You can change your coverage during the year when you experience a qualified change in status, such as marriage, divorce, birth, adoption, placement for adoption, or loss of coverage. The change must be reported to the Human Resources Department within 31 days of the event. The change must be consistent with the event.

For example, if your dependent child no longer meets eligibility requirements, you can drop coverage only for that dependent.

medefy | MediOrbis

$0 virtual mental health

Benefits navigation, meets personalized virtual care. We'll be here all day, literally.

Accessible

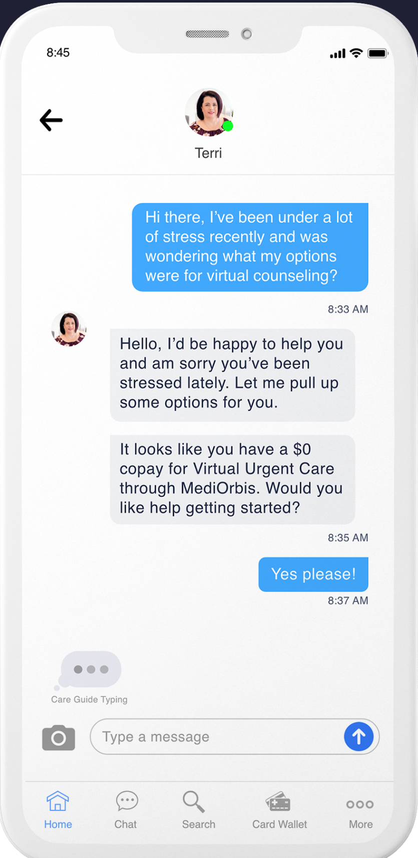
Mental health counselors that meet you where you are at, 24/7, all in one simple, easy-to-use app.

Confidential

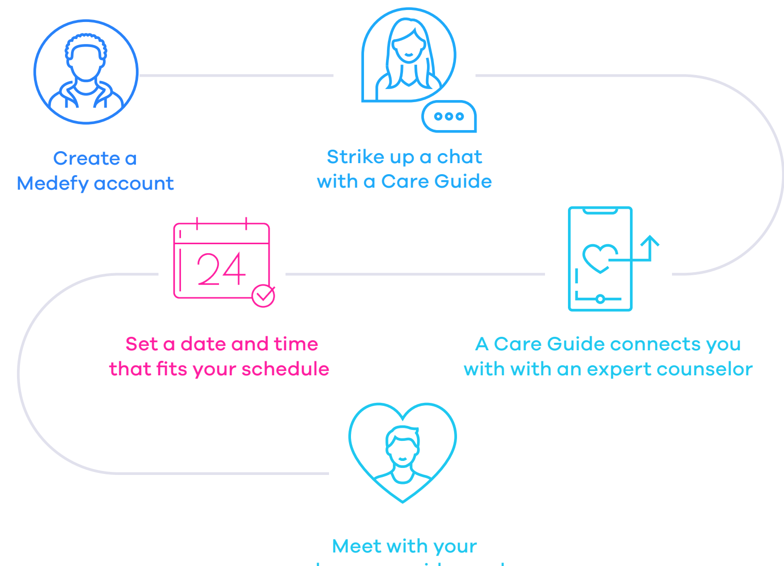
We keep things on lock, HIPAA style. Your medical records, video interaction, and in-app messages are all securely stored.

Convenient

Round-the-clock support from real human, experts – Care Guides for health plan navigation, and a dedicated health care team.



Access real-time virtual counseling in a few simple steps.



What our online counselors can help you with:

Without the telemedicine guessing game and benefits navigation maze. A one-stop-shop to clarity and care.

- ✓ Stress
- ✓ Anxiety
- ✓ Depression
- ✓ Mood swings
- ✓ Trauma and PTSD
- ✓ Negative thought patterns
- ✓ Medication Presciptions
- ✓ Relationship conflicts
- ✓ Marriage issues

Scan to download the app in the Apple Store or Google Play

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Medefy App Overview

All the moving pieces of your health benefits plan in one tidy, easy-to-access, easy-to-use app hub.

An app hub with hustle

Search 'Medefy' in the app store. We're available on both Apple and Android devices. Once downloaded, open the app and tap 'Create Account.'

Live Care Guides, 24/7

Human help is here. Actual in-app experts that quickly help you navigate your health benefits plan, and find care in a snap.

Tools for every step of the way

Access all of your health benefits ID cards, open enrollment documents, and benefits plan information all in the app- anytime, anywhere.

Download the Medefy App to get started today.

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Benefits Cost

Cost of Benefits Coverage			
Coverage	Monthly Cost	Employer Biweekly Cost	Employee Biweekly Cost
Medical Plan – BCBS Blue Advantage PPO			
Employee Only	$587.69	$293.85	$0.00
Employee & Spouse	$1,292.85	$505.39	$141.03
Employee & Child(ren)	$1,116.59	$452.52	$105.78
Family	$1,821.81	$664.08	$246.82
Dental Plan – BCBS BlueCare PPO			
Employee Only	$37.22	$18.61	$0.00
Employee & Spouse	$74.44	$29.89	$7.33
Employee & Child(ren)	$95.14	$36.21	$11.36
Family	$136.72	$48.85	$19.51
Vision Plan – Dearborn EyeMed			
Employee Only	$10.32	$0.00	$5.16
Employee & Spouse	$19.62	$0.00	$9.81
Employee & Child(ren)	$20.66	$0.00	$10.33
Family	$30.37	$0.00	$15.19
Basic Life and AD&D Plan - Dearborn			
Employee Only	Employer Paid		
Depedent(s)	$1.10 monthly per unit		
Supplemental Life and AD&D Plan - Dearborn			
Age-banded rates listed on page 20			

Medical Benefits Overview

Benefit Coverage	BlueCross BlueShield of Oklahoma Blue Advantage PPO Plan Group # 275396	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$2,000	$5,000
Family	$4,000	$10,000
Coinsurance (you pay / plan pays)	20% / 80%	40% / 60%
Maximum Out-of-Pocket		
Individual	$4,000	$10,000
Family	$8,000	$20,000
Physician Office Visit		
Preventive Care	No charge	30% after deductible
Primary Care	$25 copay per visit	30% after deductible
Specialty Care	$50 copay per visit	30% after deductible
Mental Health – Counseling	$25 copay per visit	30% after deductible
Chiropractic (20 visit limit)	$25 copay per visit	30% after deductible
Diagnostic Services		
X-ray and Lab Tests	No charge	No charge
Complex Radiology (CT/PET scans, MRIs, etc.)	$200 copay per visit	30% after deductible
Sleep Study	$200 copay	30% after deductible
CPAP	$200 copay then 20% deductible waived	40% after deductible
Allergy Testing	$50 copay	30% after deductible
Allery Shots	20% deductible waived	30% after deductible
Urgent Care Facility	$50 copay per visit	30% after deductible
Emergency Room Facility Charges	20% after deductible	20% after deductible
Emergency Medical Transportation	20% after deductible	20% after deductible
Inpatient Hospital Care	20% after deductible	40% after deductible
Outpatient Hospital Care and Services	20% after deductible	40% after deductible
Recovery Needs		
Home Health Care / Private Duty Nursing (30 day limit)	20% after deductible	40% after deductible
Hospice Services	20% after deductible	40% after deductible
Inpatient Rehabilitation (30 day limit)	20% after deductible	40% after deductible
Occupational Therapy (20 visit limit)	20% after deductible	40% after deductible
Physical Therapy (20 visit limit)	$50 copay per visit	40% after deductible

Benefit Coverage	BlueCross BlueShield of Oklahoma Blue Advantage PPO Plan Group # 275396	
	In-Network Benefits	Out-of-Network Benefits
Durable Medical Equipment (prosthetics, orthotic devices)	20% after deductible	40% after deductible
Maternity Services		
Office Visits (Primary / Specialist)	$25 / $50 copays per visit	30% after deductible
Childbirth / Delivery Professional & Facility Services	Up to $500 copay per pregnancy, then 100% covered	40% after deductible

Pharmacy Benefit Coverage		
Retail Pharmacy (30 Day Supply)		
	In-Network Benefits	Out-of-Network Benefits
Generic (Tier 1)	$15 copay	$15 copay
Preferred (Tier 2)	$45 copay	$45 copay
Non-Preferred (Tier 3)	$95 copay	$95 copay
Preferred Specialty (Tier 4)	$300 copay	$300 copay
Mail Order Pharmacy (90 Day Supply)		
	In-Network Benefits	Out-of-Network Benefits
Generic (Tier 1)	$30 copay	Not covered
Preferred (Tier 2)	$90 copay	Not covered
Non-Preferred (Tier 3)	$190 copay	Not covered
Preferred Specialty (Tier 4)	Not covered	Not covered

CVS is not a participating pharmacy.

BlueCross BlueShield of Oklahoma

24/7 Nurseline

Nurses available anytime you need them.

Health happens – good or bad, 24 hours a day, seven days a week. That is why we have registered nurses waiting to talk to you whenever you call our 24/7 Nurseline*.

Our nurses can answer your health questions and try to help you decide whether you should go to the emergency room or urgent care center or make an appointment with your doctor. You can also call the 24/7 Nurseline whenever you or your covered family members need answers to health questions about:

- Asthma
- Dizziness or severe headaches
- Cuts or burns
- Back pain
- High fever
- Sore throat
- Diabetes
- A baby's nonstop crying
- And much more

Plus when you call, you can access an audio library of more than 1,000 health topics – from allergies to surgeries – with more than 500 topics available in Spanish.

So, put the 24/7 Nurseline phone number in your contacts today, because health happens 24/7.

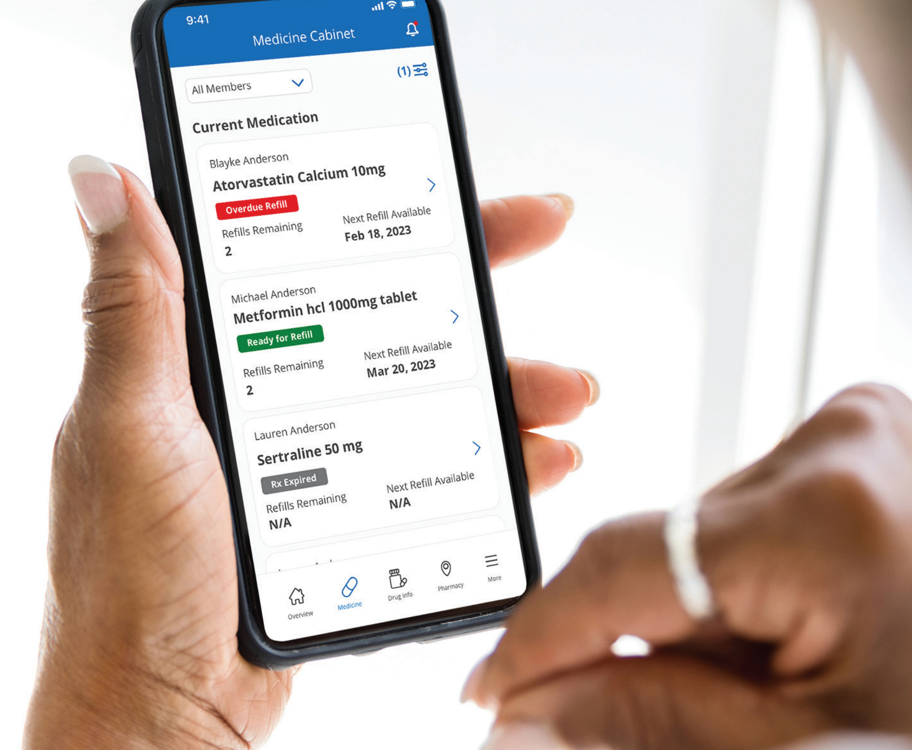
Call 800-581-0407 to reach the 24/7 Nurseline and talk to a nurse. Hours of Operation: Anytime

*24/7 Nurseline is not available to HMO members. For medical emergencies, call 911.
This program is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

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

BlueCross BlueShield of Oklahoma

Your Virtual Medicine Cabinet Is Here



Save On Prescriptions With Just A few Clicks

MyBlueRxOK is a personalized pharmacy app for Blue Cross and Blue Shield of Oklahoma (BCBSOK) members. We're making it easy to understand and manage prescription drugs and out-of-pocket costs for yourself and your family.

How it works

This app puts your prescription drug information in your hands with features that allow you to:

- Compare drug costs at different pharmacies
- Find available lower-cost drug options
- Manage prescription drug care for your family*
- Access information about your prescription drugs, including medication details, claims history, coverage, pre-approvals and refills
- Get reminders when it's time to refill your prescription
- Search for and contact in-network pharmacies

Scan a QR code to download the free app.

Use your Blue Access for Members℠ login, or create a new account to get started.

MyBlueRxOK (iOS)

MyBlueRxOK (Android)

* Who are listed as dependents on your BCBSOK plan. Adult children (age 18-26) and other dependents can download the app and create their own account.

Not all features are available for all plans

Hip and Knee Replacement Surgeries -

Keep Your Out-of-Pocket Expenses in Check

Policy Benefit Information

Hip and Knee Replacement Surgeries

Prices for medical procedures can vary widely depending on the provider and where the procedure is performed. With your current employee health coverage, using designated hospitals for hip and knee replacement surgeries gives you 100% coverage with no deductible, no coinsurance, and no surprise billing.*

What is included:

- Surgeon
- Facility
- Anesthesia
- Implant
- Post-op care

By utilizing our designated hospitals, you can get the procedure you need while keeping your out-of-pocket expenses in check.**

Designated hospitals currently include:

- McBride Orthopedic Hospital in Oklahoma City
- Oklahoma Surgical Hospital in Tulsa

If you have any questions about this or any other BCBSOK benefit, please call the number on the back of your ID card.

*With HDHP/HSA plans, this 100% benefit is available after deductible, per IRS guidelines.

**Patients can choose in-network facilities not listed on this flier for hip and knee replacement procedures. However, additional costs will apply.

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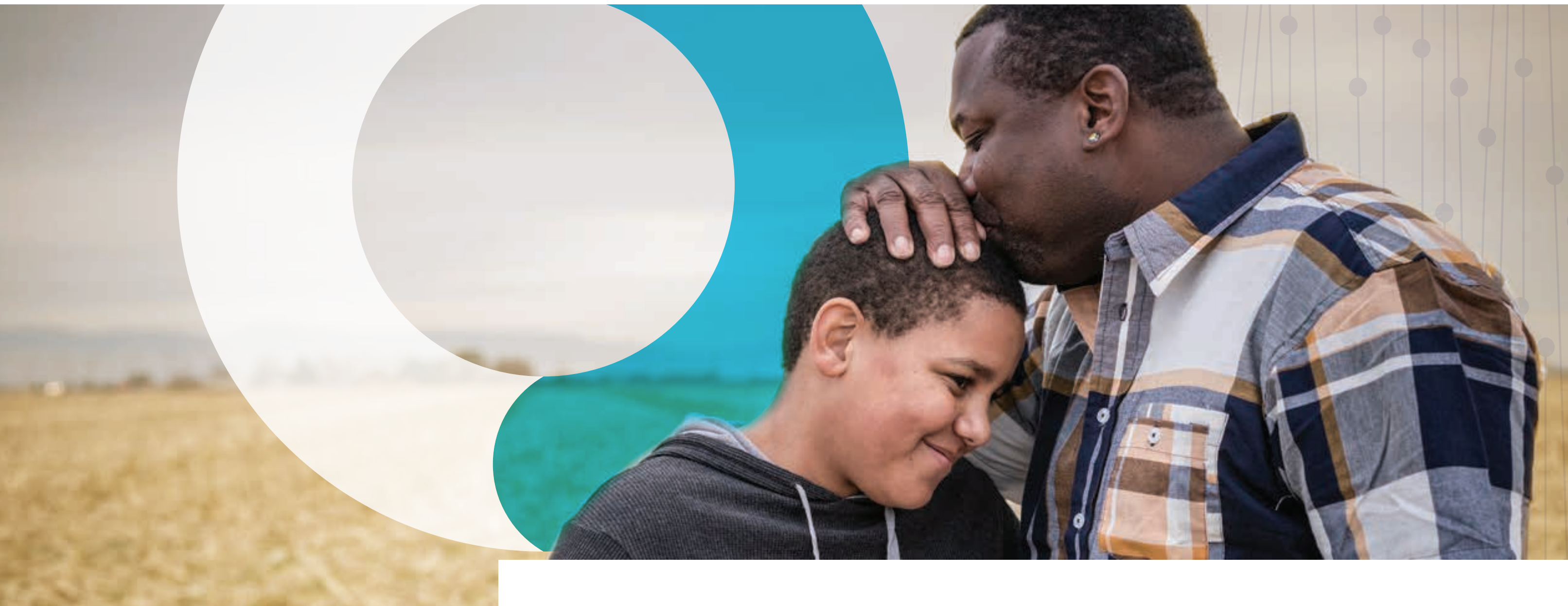
An integrated approach to managing multiple chronic conditions



Three solutions, each designed around the needs of a distinct population, deliver meaningful medical cost savings[1].

DIABETES MANAGEMENT PLUS

Medical savings: $180 PPPM

- Hypertension
- Dyslipidemia
- Weight Management
- Mental Health

HYPERTENSION MANAGEMENT PLUS

Medical savings: $76 PPPM

- Dyslipidemia
- Weight Management
- Mental Health

PREDIABETES MANAGEMENT PLUS

Medical savings: $76 PPPM

- Hypertension
- Dyslipidemia
- Weight Management
- Mental Health

Chronic conditions don't exist in isolation, and co-occurring conditions often lead to exponentially higher costs.

The Livongo Chronic Condition Management Plus solution from Teladoc Health offers Blue Cross and Blue Shield of Oklahoma members a complete virtual care strategy to address chronic conditions.

Our connected devices and personalized, timely, actionable outreach help people achieve lasting behavior change—improving how they manage conditions such as diabetes, hypertension and mental health challenges.

Livongo solutions are offered at no cost to members.

Member benefits

- Lifestyle behavior change
- Medication optimization
- Individualized health coaching
- Provider coordination
- Cellular-connected devices

Employer benefits

- A simple, streamlined enterprise experience
- Single implementation for multiple condition needs at no additional cost
- Real-time eligibility, claims-based billing, streamlined reporting and outcomes analysis

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The majority of people living with one chronic condition also live with or are at risk for other chronic conditions.[2]

PEOPLE WITH DIABETES

6% of adults

- 85% weight
- 56% hypertension
- 33% dyslipidemia
- 21% mental health

PEOPLE WITH HYPERTENSION RISK

14% of adults

- 65% weight
- 33% dyslipidemia
- 22% mental health

PEOPLE WITH PREDIABETES

34% of adults

- 38% hypertension
- 33% dyslipidemia
- 18% mental health

By recognizing the impact of one condition on overall health and well-being, our Chronic Condition Management Plus solution drives sustainable clinical outcomes.

DIABETES

0.8pt

AVERAGE HbA1c REDUCTION[3]

HYPERTENSION

10mmHg

AVERAGE SYSTOLIC BLOOD PRESSURE REDUCTION[3]

WEIGHT MANAGEMENT

5.5%

YEAR 1 AVERAGE WEIGHT LOSS[3]

DEPRESSION

55%

PATIENTS WITH MEASURED CLINICAL IMPROVEMENT ON AVERAGE[3]

For more information, contact your Blue Cross and Blue Shield of Oklahoma account representative today.

[1]Average per member per month medical saving ROI from Livongo data on file (DS-4266).
[2]Livongo data on file for diabetes, hypertension and mental health prevalence (DS-4266). Note: mental health prevalence is based on medical claims. The 2017 National Survey on Drug Use and Health found that prevalence of mental health conditions was 25% for clinical conditions and an additional 35% for sub-clinical conditions. Overweight and dyslipidemia prevalence from Kaiser Family Foundation 2018 and 2017 State Health Facts, respectively. Overweight prevalence for people with diabetes from CDC.
[3]Livongo data from 2019 S1 for diabetes, hypertension, and depression. Weight management from Livongo data on file (DS-3547).

LEARN MORE: Engage@Livongo.com

Livongo is part of Teladoc Health. Teladoc Health is transforming the healthcare experience and empowering people everywhere to live healthier lives. Recognized as the world leader in whole-person virtual care, Teladoc Health leverages more than a decade of expertise and data-driven insights to meet the growing virtual care needs of consumers and healthcare professionals.

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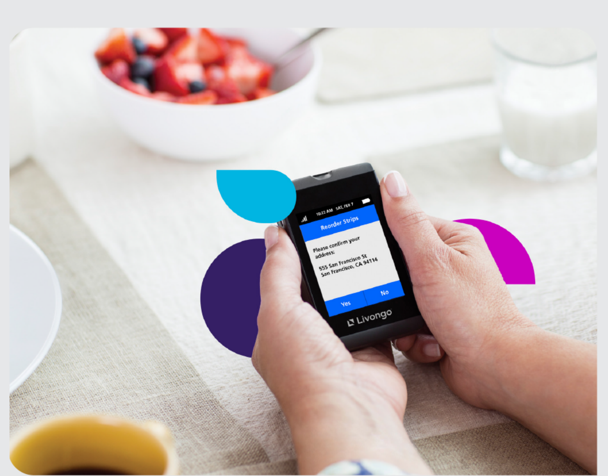
Diabetes Management: What to know about this benefit



Did you know people who have been diagnosed with diabetes spend about $17,000 each year on medical expenses? Out of that $17,000, over $9,500 is for diabetes treatment.[1]

The Diabetes Management program that is part of our benefits can help you save this money because you do not have to pay for anything. You get support for your diabetes with smart devices, expert coaches and easy-to-follow, personalized plans.

In 2019, diabetes was the seventh-leading cause of death in the U.S.[2]
Through our benefit, you could qualify for help with your diabetes at no cost to you. The Diabetes Management program gives you personalized tools and support to track your blood sugar levels and develop healthier lifestyle habits.

- **What is the program?** The Diabetes Management program supports people diagnosed with type 1 or type 2 diabetes and helps make living with diabetes easier. The program team works with you to provide personalized plans so you can live your healthiest life possible.

- **What resources do you receive?** The program gives you a connected meter and Unlimited strips and lancets. If members of the program team see that your glucose levels go out of range, they'll reach out to you within 15 minutes to get you the support you need. You also have the option to work with a certified health coach for more guidance. If you prefer to receive support in Spanish, this option is available to you.

- **How can you get started?** Getting registered for the Diabetes Management program is easy and only takes a few minutes. You can either download the Livongo app, call 800-945-4355 or visit the website by scanning the QR code below. You will start the process by answering a few simple questions about your health to see if you qualify for the program. If you do qualify, you will be mailed a Welcome Kit with instructions on how to get started.

Call 800-945-4355

Visit
Join.Livongo.com/BCBSOK-HEALTH
Download the app |

[1]https://www.diabetes.org/about-us/statistics/cost-diabetes
[2]https://www.diabetes.org/about-us/statistics/about-diabetes

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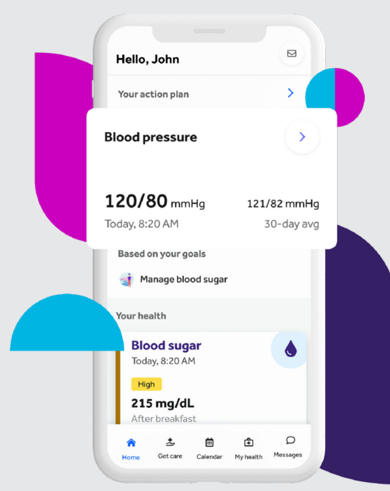
Hypertension Management: What to know about this benefit



Did you know people with high blood pressure or hypertension pay almost double for outpatient medical expenses compared to people who do not have hypertension?[1]
The Hypertension Management program that is part of our benefits can help you save this money because you do not have to pay for anything. You get support for your high blood pressure with smart devices, expert coaches and easy-to-follow, personalized plans.

If high blood pressure or hypertension is not managed in the right way, it could lead to stroke, vision loss, heart failure, heart attack, kidney disease/failure or even sexual dysfunction.[2]
The Hypertension Management program is available at no cost to you. Through daily tracking and support, the program helps you discover lifestyle changes that can reduce your blood pressure.

- **What is the program?** The Hypertension Management program helps make living with high blood pressure easier. Members of the program team work with you to provide personalized plans so you can live your healthiest life possible.
- **What resources do you receive?** The program provides you with a connected blood pressure monitor. This gives you access to personalized information to help you manage your condition better. You also have the option to work with a coach for more guidance. If you prefer to receive support in Spanish, this option is available to you.
- **How can you get started?** To get started, you can either download the Livongo app, call 800-945-4355 or visit the website by scanning the QR code below. You will start the process by answering a few simple questions about your health to see if you qualify for the program. If you successfully enroll, you will be mailed a Welcome Kit with instructions on how to get started.

Call 800-945-4355

Visit
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Download the app |

[1]https://newsroom.heart.org/news/adults-with-high-blood-pressure-face-higher-healthcare-costs?preview=72e1
[2]https://www.heart.org/en/health-topics/high-blood-pressure/find-high-blood-pressure-tools--resources/blood-pressure-fact-sheets

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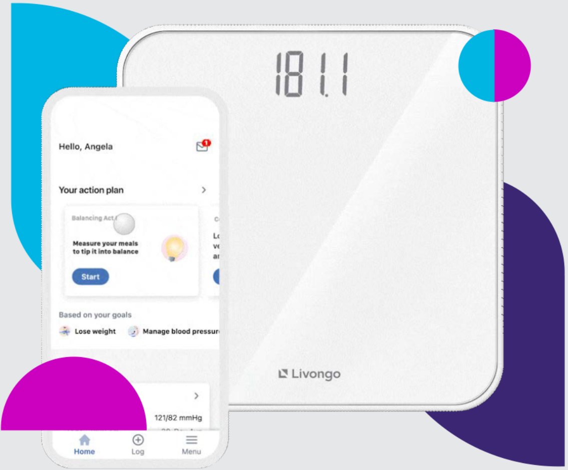
Diabetes Prevention Program: What to know about this benefit



Did you know that, on average, people who have been diagnosed with diabetes have to pay over twice as much in medical costs than if they did not have diabetes?[1]

Your benefit can help you avoid those costs through the Diabetes Prevention Program. You get support with smart devices, expert coaches and easy-to-follow, personalized plans.

133 million Americans live with diabetes or prediabetes, but 84% of them don't know they have it yet.[2]

The Diabetes Prevention Program is available to you through our benefits and can help if you might be at risk of getting type 2 diabetes. The program lets you get ahead of diabetes with medically certified content, activity tracking and ongoing coaching.

- **What is the program?** The Diabetes Prevention Program is for people who are at risk of getting type 2 diabetes and is based on clinical standards of care from the Centers for Disease Control and Prevention (CDC).
- **What resources do you receive?** The program doesn't cost you anything and provides personalized plans so you can live your healthiest life possible. It helps you lose weight and provides you with a connected scale to automatically track your progress. You also have the option to work with a certified health coach for more guidance. If you prefer to receive support in Spanish, this option is available to you.
- **How can you get started?** You can either download the Livongo app, call 800-945-4355 or visit the website by scanning the QR code below. You will start the process by answering a few simple questions about your health to see if you qualify. After you join, you will be mailed a Welcome Kit with instructions on how to get started.

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Download the app |

[1]https://www.diabetes.org/about-us/statistics/cost-diabetes
[2]https://www.diabetes.org/newsroom/official-statement/2022/ada-statement-regarding-updated-data-national-statistics-report

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Flexible Spending Account (FSA)

What is a Flexible Spending Account?

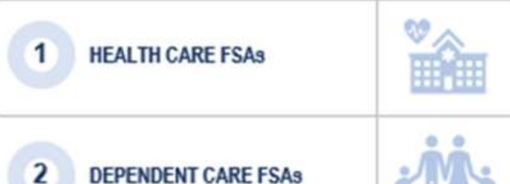
A Flexible Spending Account (FSA) is a special type of account you (and sometimes your employer) put money into to pay for certain out-of-pocket health care expenses. Your contributions to this account are not taxed, so you will save the amount that would have been paid in taxes on this money. Your FSA is administered by Benefit Resource, Inc.

"Use it or Lose it" Rule

FSAs are subject to a "use or lose" rule, as required by the IRS. This means that the money in the account must be spent by the end of the plan year and can't be carried over to the next year. When choosing your contribution for the year, you should be careful to choose an amount that is enough to cover expected expenses, but not so much that you may forfeit it if you don't incur enough eligible expenses over the course of the year.

Some plans may have a grace period or carry-over. A grace period, which can be up to two and a half months past the plan year, allows you to submit any qualified medical expenses incurred during the grace period using money left in the account. If your plan ended 12/31 and had a two-and-a-half-month grace period, you would have until 3/15 to spend the money in your FSA.

If your plan has a carry-over provision, you may carry over up to $640 (in 2024) of unused funds to next year. Plans can't have both a grace period and a carry-over. Check with your HR or FSA vendor to see if your plan has either of these provisions.



There are two different types of FSAs: health care FSAs and dependent care FSAs. You can have both types of accounts at the same time and contribute to both. The money in the two types of the accounts are separate and money in one account cannot be used for reimbursement of the other type of expense.

Health FSAs

Health care FSAs may only be used to reimburse qualified medical expenses. A list of what is considered a qualified expense is available in IRS Publication 502.

How much can I contribute to my health FSA?

The IRS sets a maximum contribution for the year. For 2024, the IRS maximum is $3,200. Your plan may have a lower contribution maximum. FSA funds are available up front, at the beginning of the plan year, even if you haven't fully funded the account yet. You cannot change your contribution amount outside open enrollment unless you experience a qualifying life event.

How do I use my health FSA?

First, note that FSAs can only be used for expenses that have already been incurred—you can't use them for future or anticipated expenses. After paying for the qualified products or services, you will submit a claim to the FSA through your employer. The claim needs to include proof of the medical expense and a statement that it has not been covered by your costs. For more detailed information about how to use your specific FSA, reach out to your HR or FSA vendor.

What is considered a qualified medical expense?

• Deductibles and copays for your medical plan (not premiums)

• Prescription medicine

• Over-the-counter medicine

• Some medical equipment like crutches, or diagnostic devices like blood sugar test kits

See IRS publication 502 for more detailed information on what is covered.

Dependent Care FSAs

Dependent Care FSAs may be used to reimburse expenses for the care of a qualifying individual to enable you (and your spouse) to work or actively look for work. It is also sometimes called a Dependent Care Assistance Program (DCAP). Common eligible expenses include:

- Day care or after school care for a child under age 13
- Elder care for dependent parents
- Summer day camps for a child under age 13
- Care for a disabled spouse or dependent incapable of self-care.

How much can I contribute to my Dependent Care FSA?

Generally, the maximum amount that may be contributed to the Dependent Care FSA is $5,000 and determined on a calendar year basis. Lower limits may apply if the employee is married and filing separately or when the spouse earns less than $5,000 per year or is a full-time student.

Amounts contributed to the Dependent Care FSA are subject to the “use or lose” rule. This means any unused contributions remaining at the end of the plan year are lost, unless the plan includes a grace period (which provides up to 2.5 months to access unused contributions following the end of the plan year). Review your plan documents to understand whether a grace period is available.

How do I use my Dependent Care FSA?

The Dependent Care FSA may only be used for eligible expenses that have been provided and the services were rendered during the plan year. You can’t seek reimbursement for future or anticipated expenses. For example, a claim for dependent care services for the month of June cannot be reimbursed until June has ended.

After paying for the eligible services, you will submit a claim to the Dependent Care FSA through your administrator. You will need to substantiate the claim, which will include the provider, date of service and the amount. Unlike the Health FSA, only amounts actually contributed to the dependent care FSA are available for reimbursement.

You cannot be reimbursed for expenses which for which you claim the dependent care tax credit.

See IRS Publication 503, Child and Dependent Care Expenses for more information on eligible expenses.

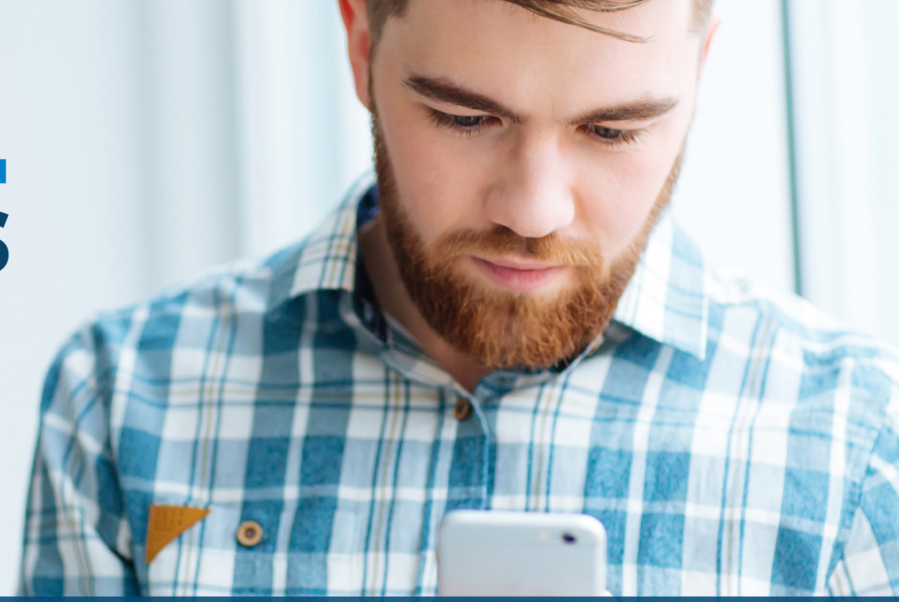
Dental Insurance

Benefit Coverage	BlueCross BlueShield of Oklahoma BlueCare PPO Plan Group # 237834	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$50	$50
Family	$150	$150
Waived for Preventive Care?	Yes	Yes
Waived for Orthodontia?	Yes	Yes
Three Month Carryover?	Yes	Yes
Annual Maximum		
Per Person / Family	$1,500	$1,500
Preventive	100%	100%
Basic	100%	80%
Major	60%	50%
Claim Payment Basis	Neogtiated Fee Schedule	90th Percentile
Orthodontia		
Benefit Percentage	50%	50%
Adults (and Covered Full-Time Students, if Eligible)	Not covered	Not covered
Dependent Child(ren)	Covered up to age 26	Covered up to age 26
Lifetime Maximum	$1,500	$1,500

BlueCross BlueShield of Oklahoma

VIRTUAL DENTAL VISITS 24/7

Powered by



At Blue Cross and Blue Shield of Oklahoma (BCBSOK), we know how important access to dental care is to you and your family. Now if an urgent dental issue occurs after hours or when your own dentist is unavailable, you can schedule a virtual dental visit, powered by Teledentistry.com.

Virtual dental visits are an option with your current BlueCare Dental PPO℠ plan. You and your covered dependents can use these visits when you:

- Have an urgent dental issue and can't see your dentist
- Need access to a dentist after business hours
- Want to consult a dentist without leaving home, or while traveling

What can a virtual dentist do for you?

- Address tooth pain due to things like cavities, gum disease, impacted wisdom teeth
- Assess trauma, such as a chipped tooth
- Prescribe appropriate medications*

How does it work?

Simply call 1-866-256-2054 and provide some required information. You will be connected to a dentist via video conference within 10-15 minutes and the average consult only takes 3-5 minutes!**

Is it covered?

Yes, the virtual visit will be paid the same as if you were visiting your dentist office for the same service. If you need follow-up care and don't have a regular dentist, Teledentistry.com can help you find a dentist. If you follow up with your regular dentist, they can send them a report regarding the virtual visit.

Call 1-866-256-2054 to connect with a dentist for your virtual visit.

*No opioids or narcotics

**Average times from Teledentistry.com

Virtual visits may not be available on all plans.

Teledentistry.com is an independent company that operates and administers the virtual dental visits program for Blue Cross and Blue Shield of Oklahoma. Teledentistry.com is solely responsible for its operations and for those of its contracted providers. Teledentistry.com® and the Teledentistry.com logo are registered trademarks of Teledentistry.com, and may not be used without permission.

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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

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Vision Insurance

Benefit Coverage	Dearborn Life Insurance Company EyeMed Vision Plan Group # F022633	
	In-Network Benefits	Out-of-Network Benefits
Copays		
Routine Exams (Annual)	$10 copay	Up to $30
Materials (Lenses and Frames)	$10 copay	Reimbursement schedule
Benefit Frequencies		
Exams	12 months	
Lenses	12 months	
Frames	12 months	
Contacts	12 months	
Lenses		
Single	$10 copay	Up to $25
Bifocal	$10 copay	Up to $40
Trifocal	$10 copay	Up to $55
Lenticular	$10 copay	Up to $55
Frames		
Frames	$0 copay, up to $150 allowance	Up to $75
Contacts		
Medically Necessary	$0 copay, paid in full	Up to $210
Elective (Conventional and Disposable)	$0 copay, up to $150 allowance	Up to $120

Life and AD&D Insurance

City of Claremore provides Basic Life and AD&D benefits to eligible employees. The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

Dearborn Life Insurance Company Basic Life and AD&D) Group # F022633	
You Employee (Company Paid)	
Benefit Maximum	$25,000
Guaranteed Issue	$25,000
AD&D Benefit	$25,000
Age Reduction Schedule	Reduces to 50% at age 70
Your Spouse or Domestic Partner (Employee Paid)	
Benefit Maximum	$5,000 not to exceed 50% of employee benefit amount
Your Child(ren) (Employee Paid)	
Benefit Maximum	$2,000 (Birth to age 21, or age 30+ if full-time student)
Waiver of Premium	
Elimination Period	6 months
Benefit Duration	Age 65
Eligibility	Employee is totally disabled prior to age 60
Accelerated Death Benefit (ADB)	
Benefit Amount	75% of employee benefit amount
Eligibility	Employee has been examined and diagnosed by a doctor as having a medically determined condition that is expected to result in death within 12 months of this claim benefit being received by the carrier
Other Benefits	
Portable?	Yes, both employees and spouses / domestic partners.
Convertible?	Yes

Voluntary Life and AD&D Insurance

In addition to the employer paid Basic Life and AD&D coverage, you have the option to purchase additional voluntary life insurance to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc. Your election, however, could be subject to medical questions and evidence of insurability.

You may purchase additional Life insurance and AD&D insurance with Dearborn Life Insurance Company if you want more coverage. Your contributions will depend on your age and the amount of coverage you elect.

Dearborn Life Insurance Company Supplemental Life and AD&D (Employee Paid) Group # F022633	
You Employee	
Benefit Increments	$10,000
Guaranteed Issue	$100,000
Benefit Maximum	$200,000
AD&D Benefit	$10,000 to $200,000 in increments of $10,000
Age Reduction Schedule	Reduces to 50% at age 70
Your Spouse or Domestic Partner	
Benefit Increments	$5,000
Guaranteed Issue	$50,000
Benefit Maximum	$50,000 not to exceed 100% of employee benefit amount
AD&D Benefit	60% of employee AD&D amount if no covered child(ren) 40% of employee AD&D amount if covered child(ren)
Age Reduction Schedule	Reduces to 50% at age 70
Your Child(ren)	
Benefit Increments	$1,000
Benefit Maximum	$1,000 (birth to 6 months) $10,000 (age 6 months to 21 years, or 30+ years if full-time student)
AD&D Benefit	20% of employee AD&D amount if no covered spouse 10% of employee AD&D amount if covered spouse
Waiver of Premium	
Elimination Period	6 months
Benefit Duration	Age 65
Eligibility	Employee is totally disabled prior to age 60
Accelerated Death Benefit (ADB)	
Benefit Amount	75% of employee benefit amount
Eligibility	Employee has been examined and diagnosed by a doctor as having a medically determined condition that is expected to result in death within 12 months of this claim benefit being received by the carrier
Other Benefits	
Portable?	Yes, both employees and spouses / domestic partners.
Convertible?	Yes

Employee Monthly Rates Per $1,000	
Supplemental Life Plan	
Employee / Spouse Age	Rate
Under 30	$0.10
30-34	$0.12
35-39	$0.15
40-44	$0.18
45-49	$0.32
50-54	$0.49
55-59	$1.13
60-64	$1.16
65-69	$1.44
70-74	$5.09
75-99	$5.74
Child(ren)	$0.10
Supplemental AD&D Plan	
Individual (employee only)	$0.03
Family (employee, spouse, child(ren))	$0.04

Beneficiary Resource Services™

Benefits Beyond a Check

When a loved one dies, families often face complex issues ranging from estate planning, legal questions, funeral planning and coping with grief and financial uncertainties. That's why we offer Beneficiary Resource Services, a program that combines family wellness and security at the most difficult of times. Services include grief and financial counseling, funeral planning, legal support and online will preparation. Beneficiary Resource Services is provided by Morneau Shepell.

Beneficiary Resource Services™

Counseling:
800-769-9187

BeneficiaryResource.com
Username: beneficiary

BlueCross BlueShield of Oklahoma

Services for Insureds and Their Families

Online Will Preparation

You and your family have access to a full legal library with many estate planning documents, including an online will. You can create your own will online in a safe and secure way, right from your home. The will can be saved and updated as family situations change. Creating a will provides security and peace of mind for several reasons:

- Appoints a guardian for children
- Controls where property and assets go
- Provides family security

Online Funeral Planning

You have access to an online funeral planning site that features a variety of helpful tools and information, such as:

- A downloadable funeral planning guide to document vital information your loved ones will need when making final arrangements
- Calculators to estimate and compare expenses for various types of funeral arrangements
- Information on funeral requirements and various religious customs
- Directories to locate funeral homes and cemeteries in your area

Services for Beneficiaries and Their Families

The following services are available after a life claim or for those who qualify for an accelerated death benefit:

Face-to-Face Working Sessions*

Five face-to-face working sessions are available to you or your beneficiaries. All five sessions may be used with one grief counselor or legal advisor, or they may be split among the two types of counselors or advisors in geographically accessible locations. A one-hour financial consultation on the phone is also available.

Unlimited Phone Contact

Available for up to one year with a grief counselor, legal advisor or financial planner.

Referrals and Support Services

Morneau Shepell maintains a comprehensive directory of qualified and accessible grief counselors and legal and financial consultants.

Follow Up

Counselors will initiate follow-up calls when necessary for up to one full year from the date of initial contact.

Morneau Shepell's network of experienced professionals can offer counseling for those facing emotional, financial or legal issues. Morneau Shepell's counselors are available 24 hours a day, 365 days a year. All calls are completely confidential.

To access these valuable resources, call or visit:

800-769-9187

BeneficiaryResource.com
Username: beneficiary

Beneficiary Resource Services™

Counseling:
800-769-9187

BeneficiaryResource.com
Username: beneficiary

BlueCross BlueShield of Oklahoma

Blue Cross and Blue Shield of Oklahoma is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association.

*May include face-to-face sessions, over-the-phone sessions or time taken for research or document preparation.

For employee use. Beneficiary Resource Services is provided by Morneau Shepell. Morneau Shepell is an independent organization that does not provide Blue Cross and Blue Shield of Oklahoma (BCBSOK) or Dearborn Life Insurance Company products or services. Morneau Shepell is solely responsible for the products and services described in this flier. Legal services will not be provided for court proceedings or for the preparation of briefs for legal appearances or actions or for any action against any party providing Beneficiary Resource Services. Legal services provided under Beneficiary Resource Services are not intended for adversarial matters. May include face-to-face sessions, over-the-phone sessions or time taken for research or document preparation. Neither Morneau Shepell, BCBSOK nor Dearborn Life Insurance Company are responsible or liable for care or advice rendered by any referral resources.

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Voluntary Supplemental Benefits

You may purchase additional voluntary benefits to help you cover out-of-pocket costs for unexpected medical events. These benefits are available through American Fidelity. More information, including pricing, can be found at **americanfidelity.com** or by meeting with an American Fidelity benefits counselor.

Accident

Limited benefit accident only insurance may help manage out-of-pocket expenses to treat injuries resulting from a covered accident. This plan pays benefits directly to you, helping you cover any unplanned medical expenses.

- 24-hour Coverage – on and off the job coverage
- Accidental Injuries – twisted ankles, burns, bee stings, spider bites and more
- Wellness / Screening Benefit – annual benefit for being proactive
- Over 25 Treatments Covered – fractures, lacerations, physical therapy and more

Cancer

Limited benefit cancer insurance is designed to help ease the financial pressures of cancer treatment, so you can focus on recovery. Benefit payments are made directly to you, helping you pay for expenses like copayments, inpatient stays, and house and care payments.

- More than 25 Benefits – chemotherapy, radiation, surgery and more
- Diagnostic and Prevention – annual benefit for a covered diagnostic test or screening
- Transportation and Lodging Expenses – helps pay for qualified transportation and boarding
- Coverage Options – you, your spouse and children under age 26

Critical Illness

Limited benefit critical illness insurance pays a lump-sum benefit upon diagnosis of certain covered life-altering illnesses. The policy can help with expenses not covered by your major medical insurance, allowing you to use the funds towards house payments, lost income or groceries.

- Coverage Options – choose the coverage amount that suits your needs
- Covered Health Conditions – heart attack, stroke, paralysis, major organ failure and end stage renal failure
- Screening Benefit – annual benefit for covered health screenings
- Recurrent Diagnosis – upon 2nd occurrence of certain illnesses, benefit pays 50% of the amount previously paid

Hospital Indemnity

Limited benefit hospital indemnity insurance is designed to help pay for out-of-pocket expenses, likes an inpatient stay, while also providing tax benefits and potential savings from a Health Savings Account (HSA).

- Routine Screening Benefit – take care of yourself and get rewarded
- Hospital Benefit – help pay for your stay
- Critical Illness Benefit – financial protection for high-dollar illnesses
- Accident Benefit – prepare for the unexpected

Disability

Disability income insurance can help protect your finances by providing a percentage of your gross monthly earnings to help pay for expenses if you are unable to work due to a covered disability.

- Salary Protection – help protect your income for you and your loved ones
- Return-to-Work Benefit – partial benefit for part-time work
- Coverage Options – benefit amount and elimination periods that meet your needs
- Employee Assistance Program – life coaching, legal assistance and more

Life

Life insurance may help ensure your family is financially protected in the event of a loss and may help provide peace of mind knowing it can help take care of your family after you/re gone. Plus, you own the policy, so you can take it with you to a different job or into retirement.

- Coverage Options – select Term Life, Whole Life, or both, whatever fits your needs
- 3 Health Questions* – no required medical exams; minimal health questions
- Immediate Coverage – no waiting periods; death benefit coverage begins at the time of application
- Riders Available – plans include additional benefits to enhance your coverage at an additional cost

**Issuance of the policy will depend on the answer to these questions.*

Travel Resource Services™

Your Ticket to Safe and Worry-Free Travel

Our Travel Resource Services provider, Assist America, offers around-the-clock emergency and information services that can help you access emergency assistance when you are traveling 100 or more miles away from home.

Medical Emergency Assistance

- Medical referral
- Medical monitoring
- Emergency medical evacuation
- Foreign hospital admission assistance
- Medical repatriation
- Prescription assistance

Travel Emergency Assistance

- Compassionate visit
- Care of minor children
- Evacuation transport for family members
- Return of mortal remains
- Other services include:
  - Return of vehicle
  - Legal & interpreter referrals
  - Pre-trip information

Download the Mobile App!

Access a wide range of global emergency assistance services from your phone by downloading the FREE Assist America Mobile App. Enter your Assist America Reference Number to set up the App:
01-AA-TRS-12201

Tap for Help
One-touch call to Assist America's 24/7 Operations Center

Voice Over Internet Protocols (VoIP)
Avoid international phone charges by calling Assist America using a Wi-Fi connection

Pre-Trip Information
Access detailed country-specific information to prepare your trip

Embassy & U.S. Pharmacy Locator
Locate the nearest embassy/consulate of 23 countries and pharmacies near you (U.S. pharmacies only)

Travel Alerts
Receive alerts on urgent global situations that may impact travel

Travel Status Indicator
A GPS feature letting you know when you are eligible for services

Mobile ID Card
Your Assist America ID card is conveniently stored within the app

Available in 7 languages
The app is available in English, Spanish, Arabic, Mandarin, Thai, Bahasa, and French

How to Activate Services

If you are traveling more than 100 miles away from home, or in a foreign country, and require assistance, contact Assist America's 24/7 Operations Center:

Your Assist America Reference Number is: **01-AA-TRS-12201**

TAP FOR HELP
On the Mobile App

800-872-1414
(Toll Free within the U.S.)

+1-609-986-1234
(outside the U.S.)

medservices@
assistamerica.com

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148.

Medical Emergency Assistance

Medical Referral:
Assist America's 24/7 Operations Center is staffed by trained, multilingual assistance personnel who can make immediate recommendations for any emergency situation.

Medical Monitoring:
Assist America maintains regular communication with members, their families and attending medical staff, closely monitoring the quality and course of treatment.

Emergency Medical Evacuation:
If a member becomes ill or injured where an adequate medical facility is not available, Assist America will arrange to transport the member under medical supervision, if required, to the nearest medical facility capable of providing the required care.

Foreign Hospital Admission Assistance:
Assist America fosters prompt hospital admission by validating the member's health insurance or advancing funds as needed to the hospital.

Medical Repatriation:
When the member has been stabilized to the satisfaction of Assist America's consulting physicians and the attending physician, and is medically cleared for travel, we will arrange and pay for transportation via commercial carrier back home or to a rehabilitation facility with medical supervision, if required.

Prescription Assistance:
When a prescription is lost or left behind, Assist America works with the prescribing physician and a local pharmacy to replace the member's medicine.

Travel Emergency Assistance

Compassionate Visit:
Assist America will arrange and pay for a family member or a friend to join a member who is traveling alone and is expected to be hospitalized for more than seven days.

Care of Minor Children:
If an injured member has minor children left unattended, Assist America will pay for them to return home to a family member or will arrange childcare locally or at home.

Evacuation Transport for Family Members:
If a member is evacuated, Assist America will arrange and pay for either the return of the immediate family members (spouse, children, parents) home or the transportation to the location where the member is evacuated.

Return of Mortal Remains:
In the event that a member passes away, Assist America will arrange and pay for the required documents, preparation of the remains and transport to a funeral home near the member's place of residence.

Other services include:
- Return of vehicle
- Legal & interpreter referrals
- Emergency cash & bail bond coordination
- Pre-trip information

For employee use. Travel Resource Services is administered by Assist America, Inc. Assist America is an independent organization that does not provide Blue Cross and Blue Shield of Oklahoma or Dearborn Life Insurance Company products or services. Assist America is solely responsible for the products and services associated with Travel Resource Services. Usage of the Assist America mobile app may be subject to additional terms and conditions.

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Conditions and Exclusions

All travel transportation services must be arranged by Assist America. Claims for reimbursement will not be accepted under the Assist America Global Emergency Assistance program. Assist America is not medical insurance. Medical bills are the responsibility of the member or the health insurance as applicable.

Upon verification of your eligibility, Assist America will arrange and pay for the following services:

- Emergency Medical Evacuation and Medical Repatriation: $150,000 Combined Single Limit
- Repatriation of Mortal Remains: Up to $15,000
- Care of Minor Children: Up to $5,000
- Return of Vehicle: Up to $2,500
- Compassionate Visit: Up to $5,000

Assist America will not provide services in the following instances:

- Suicide or attempted suicide; intentionally self-inflicted injuries;
- The transfer from one medical facility to another of similar capabilities which provides the same level of care.
- Occurrence of mild lesions, simple injuries such as sprains, simple fractures or mild sickness which can be treated by local doctors that do not prevent the continuation of travel.
- Participation in any war, invasion, acts of foreign enemies, hostilities between nations (whether declared or not) or civil war, rebellion, revolution, and insurrection, military or usurped power;
- Participation in any military maneuver or training exercise;
- Traveling against the advice of a physician;
- Traveling for the purpose of obtaining medical treatment;
- Traveling in any country in which the U.S. State Department issued travel restrictions prior to such travel.
- Piloting or learning to pilot or acting as a member of the crew of any aircraft;
- Mental or emotional disorders, unless hospitalized;
- Being under the influence of drugs or intoxicants unless prescribed by a physician;
- Commission or the attempt to commit a criminal act;
- Participation as a professional in athletics or underwater activities;
- Participating in bodily contact sports; skydiving; hang gliding; parachuting; mountaineering; any race; bungee cord jumping; speed contests; spelunking or caving, heli-skiing, extreme skiing;
- Dental treatment except as a result of accidental injury to sound, natural teeth;
- Any non-emergency treatment or surgery, routine physical examinations, hearing aids, eyeglasses or contact lenses;
- Pregnancy and childbirth (except for complications of pregnancy prior to the 28th week of the pregnancy).
- Curtailment or delayed return for other than covered reasons;
- Services not shown as covered; trips exceeding 90 days in length from primary legal residence..

The services described above currently are available in every country of the world. Due to political and other situations in certain areas of the world, Assist America may not be able to respond in the usual manner. Assist America also reserves the right to suspend, curtail or limit its services in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strikes, nuclear accidents, Acts of God or refusal of authorities to permit Assist America to fully provide services.

Assist America is not responsible and cannot be held liable for any malpractice performed by a local physician or attorney who is not an employee of Assist America; or for any loss or damage to your vehicle during the return of vehicle; or for any loss or damage to any personal belongings.

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BlueCross BlueShield of Oklahoma

Go Ahead. Make Your Day!

Use Your Health and Wellness Programs to Help You Live Better

Taking one, small, first step can set you on a path to better health throughout your life. Whether you need support for a specific health issue or you're looking to boost your overall wellbeing, you'll have help along the way. Here are a few things you can do with the tools included with your Blue Cross and Blue Shield of Oklahoma plan:

- Improve your mental health with digital programs for stress, depression, panic, resiliency and more
- Get help to manage your pre-diabetes, diabetes, high blood pressure or joint and spine pain
- Join a weight-loss program
- Download apps for support with fertility, pregnancy and parenting issues
- Talk with a nurse, any time, day or night
- Complete online programs to help reach your wellness goals
- Earn rewards for healthy activities
- Access a nationwide network of fitness centers*

Learn more about your health and wellness programs:

1. Go to bcbsok.com.
2. Register for Blue Access for Members℠.
3. Click the Wellness tab.

These programs do not replace the care of a doctor. Talk to your doctor about any health questions or concerns.

* Fees apply. Individuals must be at least 18 years old to purchase a membership. The Fitness Program is provided by Tivity Health™, an independent contractor that administers the Prime Network of fitness centers. The Prime Network is made up of independently owned and operated fitness centers.

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

9100678.0922

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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 this plan. Therefore, the following deductibles and coinsurance apply: BCBCOK Medical Blue Advantage PPO Plan: $2,000 individual / $4,000 family deductibles; 80% coinsurance

NEWBORNS ACT DISCLOSURE - FEDERAL

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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, 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 dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

MICHELLE'S LAW DISCLOSURE

MICHELLE'S LAW DISCLOSURE

Under the ACA, dependent children are covered by the group health plan until age 26. City of Claremore group health plan extends dependent coverage beyond the ACA requirements, to age 26, so long as the child is covered as a student. If your child has extended coverage as a student but loses their student status because they take a medically necessary leave of absence from school your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This is available if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

To obtain more information, contact person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting

your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Ashley Hickman
104 Muskogee
Claremore, OK 74017
918-341-1325
ahickman@claremorecity.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html**.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases we never share your information unless you give us written permission:
  Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- Effective date: 07/01/2024
- City of Claremore
  Ashley Hickman – HR Director
  ahickman@claremorecity.com
  918-341-1325

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from City of Claremore 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 City of Claremore 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. **City of Claremore has determined that the prescription drug coverage offered by the Health and Welfare 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 City of Claremore coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current City of Claremore coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Claremore and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Claremore changes. You also may request a copy of this notice at any time.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

OMB 0938-0990

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

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:	07/01/2024
Name of Entity/Sender:	City of Claremore
Contact--Position/Office:	Ashley Hickman – HR Director
Address:	104 Muskogee, Claremore, OK 74017
Phone Number:	918-341-1325

CMS Form 10182-CC **Updated April 1, 2011**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 **1-877-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 **1-866-444-EBSA (3272)**.

If 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 January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**

Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

CHIP Phone: 1-800-986-KIDS (5437)	
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: 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/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office

of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[12]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health

insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer Name City of Claremore	4. Employer Identification Number (EIN) 73-6005143	
5. Employer address 104 Muskogee	6. Employer phone number 918-341-1325	
7. City Claremore	8. State OK	9. ZIP code 74017
10. Who can we contact about employee health coverage at this job? Ashley Hickman		
11. Phone number (if different from above) N/A	12. Email address ahickman@claremorecity.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are:

    All employees
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    All lawful dependents including spouses, domestic partners and children up to age 26
  - [ ] We do not offer coverage.

[x] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid–year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? ______________ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

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16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Contacts

Have Questions? Need Help?

Additional information regarding benefit plans can be found on Medefy. Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

Carrier Customer Service

BENEFITS PLAN	CARRIER	CONTACT INFO
Human Resources	City of Claremore	918-341-1325 x102 or x101
Medical PPO	BlueCross BlueShield of Oklahoma	888-466-5359 bcbsok.com
FSA	Flex Plan Administrators	918-524-6350 flexplanadmin.com
Dental PPO	BlueCross BlueShield of Oklahoma	888-381-9727 bcbsok.com
Vision EyeMed	Dearborn Life Insurance Company	855-856-4402 eyemedvisioncare.com/bcbsok
Life and AD&D	Dearborn Life Insurance Company	800-348-4512 dearbornnational.com
Voluntary Life	Dearborn Life Insurance Company	800-348-4512 dearbornnational.com
Voluntary AD&D	Dearborn Life Insurance Company	800-348-4512 dearbornnational.com
Voluntary Supplemental Benefits	American Fidelity	800-450-3506 americanfidelity.com
Employee Assistance Program (EAP)	CommunityCare EAP	800-221-3976 ccok.com/eap

104 Muskogee

Claremore, Oklahoma 74017