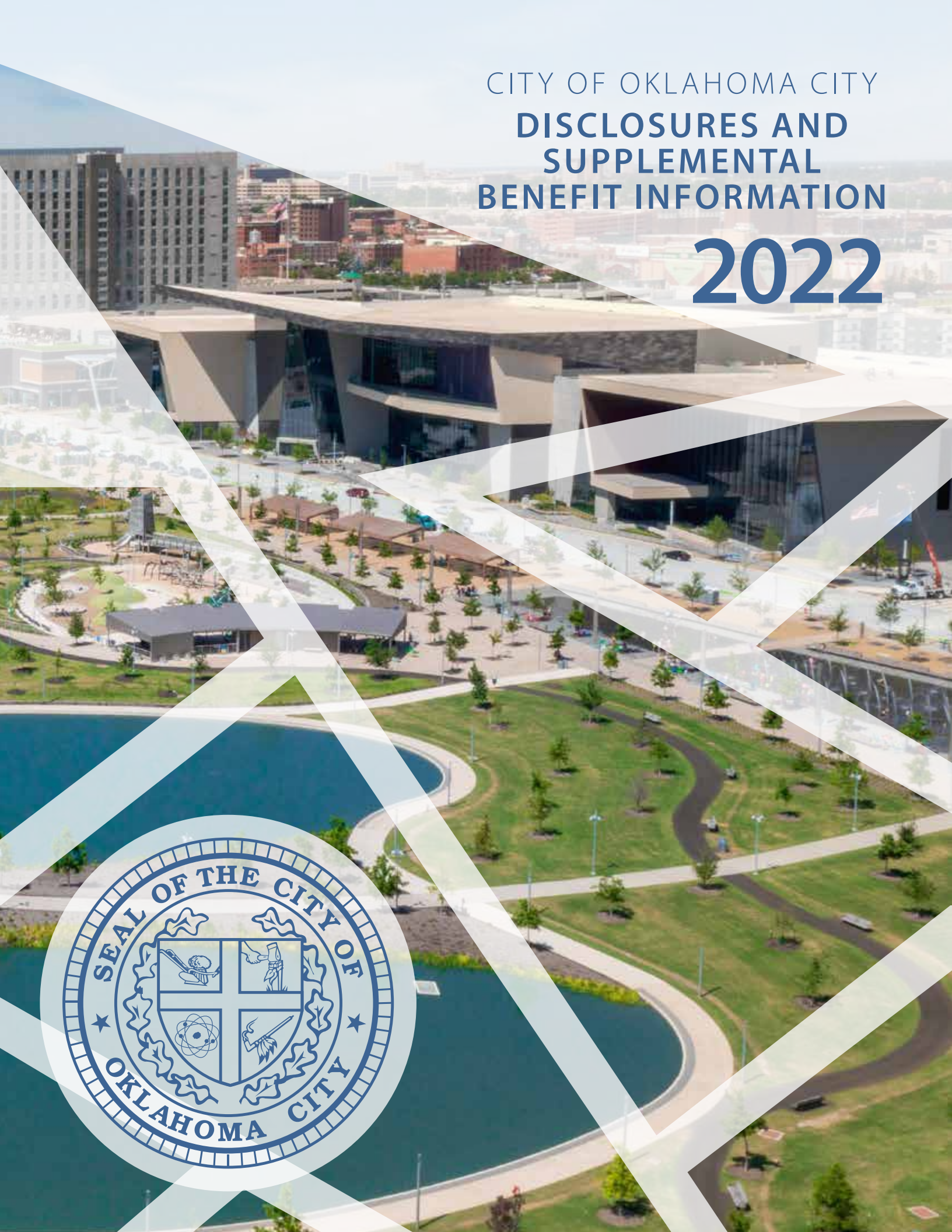
CITY OF OKLAHOMA CITY

DISCLOSURES AND SUPPLEMENTAL BENEFIT INFORMATION

2022



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Administrative Information

Clerical Error/Delay

Clerical error or delay will not invalidate coverage or cause coverage to be in force. Coverage is governed solely by terms and provisions of the Plans, and City policy. Additionally, payment or lack of payment of premiums will not cause coverage under a Plan to commence or terminate. However, upon discovery of clerical error or delay, which results in over or under collection of premiums, an adjustment will be made to reflect the correct amount of premiums. The City has the right to collect premiums owed by the employee and conversely, the employee will be reimbursed if an overpayment occurs. Additionally, if a clerical error results in the processing of claims against the Plan, any payments disbursed to providers will be invalidated and payment of services will be the responsibility of the employee.

About this Disclosure and Supplemental Guide

This guide is intended for informational purposes only. The actual benefits available and the full descriptions of these benefits are governed in all cases by the relevant plan document, insurance contracts, and Ordinances and Resolutions of The City of Oklahoma City, and where applicable, collective bargaining agreements. If there are discrepancies between the benefit guide and the actual plan documents, insurance contracts, and Ordinances and Resolutions, the documents, contracts, and Ordinances and Resolutions will govern.

This guide is not a contract, is not legally binding, and does not alter any original plan documents. Every effort has been made to ensure the accuracy of this information. However, the actual determination of your benefits is based solely on the plan documents and if statements in this description differ from the applicable plan documents, coverage documents or Summary Plan Descriptions, then the terms and conditions of those documents will prevail. Please check with your employer's Benefit's Office for further guidance.

Revisions to this guide will be posted on InsideOKC intranet and www.okc.gov/oe.

Dependent Eligibility Requirements

Eligible Dependents Include

- Spouse.
- Child(ren), under age 26, (or those who qualify as a dependent under the Internal Revenue Code).
- Child(ren) who are physically or mentally incapable of self support on the date coverage would otherwise end.

Disabled Child

A permanently and totally disabled child must meet all of the following tests:

- The child cannot engage in any substantial gainful activity because of a physical or mental condition;
- A doctor determines the condition has lasted or can be expected to last continuously for at least one year or can lead to death;
- The child is incapable of self-sustaining employment by reason of mental or physical disability, and is primarily dependent upon the employee for support and maintenance; and
- The employee provides proof of the continuance of such dependency upon request by the City. Evidence of the disability status will be required, at minimum, every two years.

Dependent Verification

Employees must provide official documentation establishing a legal relationship with dependents in order for the dependents to be eligible for coverage. Acceptable documentation must be received in the Employee Benefits Division of the Human Resources within 31 days of becoming eligible.

Dependent Child Age Limitations

Benefit Plan	
Group Indemnity Plan	Under age 26
HMO Plan	Under age 26
Dental Plan	Under age 26
Vision Plan	Under age 26
Group Term Life	Under age 23

Dependent Audit

Employee Benefits may audit employee benefit files to ensure proper documentation for dependents enrolled in the City's medical, dental, and vision plans have been provided. You may receive a verification letter requesting documentation and must comply with the request. Failure to do so may result in loss of coverage for your dependent(s). You do not need to contact Employee Benefits to inquire about your file. If documents are needed, you will receive a letter.

Dependent Documentation

Acceptable documents include but are not limited to copies of marriage certificate, state issued birth certificates, social security card, or court order establishing legal guardianship, legal custody or adoption. Supporting documentation must be provided in English. Additional information you need to have to add your dependent:

- Dependent's address, if different than yours;
- Dependent's telephone number, if different than yours; and
- Dependent's Primary Care Physician (if electing HMO).

Non-Eligible Dependents

- Ex-spouse, except as allowed under COBRA
- Domestic Partner
- Parents, grandparents, aunts, uncles, grandchild(ren), foster child, brother, sister, nephew, niece, unless such child(ren) are under your legal guardianship, legal custody or adopted as evidenced by court documents
- Step-child(ren), if the employee is divorced from the natural parent of the stepchild(ren), such child is no longer qualified as the employee's stepchild(ren), and is no longer eligible for coverage
- Dependents who do not meet the eligibility requirements outlined in this section
- Dependents cannot be covered by the same plan by more than one employee

Change in Dependent Status

If you divorce, or if your marriage is annulled, your ex-spouse is no longer an eligible dependent under the Plan. Divorce or annulment is a qualified event. You must remove an ex-spouse from your coverage, and remove other individuals including step-children that are no longer eligible dependents. It is your responsibility to provide notification to the Human Resources/Employee Benefits Division, of any change in your dependents eligibility within 31 days of the qualifying event.

NOTE: The Human Resources reserves the right to require proof of continued eligibility for dependents. Failure to provide the required documentation may result in termination of coverage Human Resources Policies Sections 717.02 and 717.03).

Dependent Eligibility Requirements

Common-Law Marriage Guidelines

A common-law marriage relationship is defined as two adults who present themselves as a married couple, have chosen to share their lives in an intimate and committed relationship, reside together and share mutual obligations of support for the basic necessities of life. To be recognized as a qualified common-law relationship, the two individuals must attest to the fact that they are (1) living together; (2) mutually responsible for the costs of basic living expenses (financially interdependent); (3) not related by blood to a degree that would prohibit marriage; and (4) are age 18 or older.

To document that the partners reside together, the parties must provide evidence such as: (1) a lease, deed, or mortgage showing both partners as parties to the transaction; (2) driver's licenses for both partners showing the same address; (3) utility bills showing the same address; and/or (4) passports for both partners showing the same address.

To document that the partners are financially interdependent, the partners must provide evidence such as: (1) joint checking account; (2) credit cards with the same account number in both names; (3) copy of the most recent tax year federal tax return filed as "married filing jointly" or "married filing separately" and/or (4) joint wills.

Oklahoma recognizes common law through case law as opposed to statute. The employee applicant and the partner must also sign and have notarized an official Statement for Common-Law Marriage available from the Human Resources/Employee Benefits Division.

Employees may add common-law partners during the annual open enrollment period, upon initial employment with the City of Oklahoma City, or within 31 days of the date you entered into a common-law marriage. The Employee Benefits Manager or designee will review all applications and approve or deny based on the documentation the employee has provided.

Disciplinary Action for Failure to Notify the Employee Benefits Division

It is a fraudulent act to knowingly add or maintain ineligible dependents on the City's benefit plans. If the information provided to the Employee Benefits Office of the Human Resources is determined to be false or misleading, you may be subject to disciplinary action up to and including termination from employment. Failure to notify the Human Resources, Employee Benefits Division, in writing of any change in marital status and/or change in dependent status that results in the improper extension of health and welfare benefits, may result in disciplinary action, up to and including termination and/or further legal action against the employee. You must notify the Employee Benefits Division within 31 days of a qualifying event (Human Resources Policies Sections 717.02 and 717.03).

Important Benefit Plan Information

Court Ordered Benefits

When the Employee Benefits Division receives a qualified medical support order or other court order, as defined by ERISA and/or applicable federal law, to enroll your child under the Plan, the Employer will enroll your child at any time without regard to open enrollment limits and shall provide the benefits of the plan in accordance with the applicable requirements of such order. The qualified medical support order or other court order may require the Employee Benefits Division to add additional coverage that may have been previously waived or change medical plans in order to comply with the requirements of such order.

Once the child has been enrolled in benefits, as a result of the medical support order or other court order, the employee will receive confirmation of the child's enrollment and a copy of the order received. A child's coverage under this provision will not extend beyond any Dependent Age Limit of the Plan. Any claims payable under the Plan will be paid, at the Plan's discretion, to the child or the child's custodial parent or legal guardian. The Administrator, on behalf of the Employer, will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to the Employer and Administrator directly. Any questions in regard to the qualified medical support order or other court order should be directed to the issuing agency of the order.

Can a court order be modified once the coverage is started as a result of the qualified child support order?

The court order obligates the City to provide benefits of the plan in accordance with the applicable requirements of such order regardless if the child is covered under another plan. Employee Benefits can only make changes if the issuing agency sends a modification of the qualified medical support order or other court order. Any questions in regard to the qualified medical support order or other court order should be directed to the issuing agency of the order.

Please Note: You may be able to remove the child from another plan within 31 days of the date you gain coverage. Please contact the plan administrator of your other insurance for more information.

Why did the City change my medical plan?

If you are enrolled in an HMO and the custodial parent lives outside the HMO service area, Employee Benefits is obligated to change your medical coverage to a plan that will provide coverage for the child in order to satisfy the applicable requirements of the qualified medical support order or other court order.

Why did the City enroll me in coverage I had previously waived or never elected?

In order to comply with the applicable requirements of the qualified medical support order or other court order, Employee Benefits may have to elect additional coverage for yourself and child. For example, if the order states to enroll the child in "any available coverage", then Employee Benefits is required to enroll you and your child in any coverage offered, which would include medical, dental, and vision.

Can I add other dependents to coverage?

No. The qualified medical support order or other court order is not considered a qualifying event to add additional dependents. You may add additional dependents at Open Enrollment or if a qualifying event occurs, such as loss of other coverage.

I believe the qualified child support order Employee Benefits received is inaccurate, what should I do?

Any questions in regards to the qualified medical support order or other court order should be directed to the issuing agency of the order. Employee Benefits can only make changes if the issuing agency sends a modification of the qualified medical support order or other court order.

How long is the qualified child support order or court order valid?

The qualified medical support order or other court order remains valid until the date specified in the order, the child reaches the age of majority (age 18). or a modification of the original order is received by Employee Benefits. An employee may elect to continue coverage for the dependent up to age 26. Employees must provide supporting documentation, a state issued birth certificate and Social Security card, for the dependent to be eligible for coverage after the court order expires.

Important Benefit Plan Information

Family Medical Leave Act (FMLA)

Any employee will continue to be eligible for group rate benefits while they are on an approved FMLA leave. The employee must continue to pay his/her share of the premiums during the leave period. Failure to pay the required premium will result in cancellation of the employee's coverage. Termination of benefits, if necessary, are date sensitive and will vary on an individual basis. For additional information regarding FMLA, please refer to Personnel Service Bulletin 05-02.

What happens to my group benefits while I'm on paid Family Medical Leave?

While on a paid FMLA status, City and employee contributions for health and welfare benefits will continue to be paid to the same extent as they would be if the employee were in an active employment status.

What happens to my group benefits while I'm on unpaid Family Medical Leave?

When an employee enters an unpaid status, they will be afforded the opportunity to pay premiums due through the end of the month that their FMLA entitlement ends. If the employee does not pay premiums, benefits will be terminated retroactively to the first day of the month following the last full month of paid premiums.

What happens to my voluntary benefits while I'm on Family Medical Leave?

Deductions for voluntary services/products, which may include flexible spending accounts, deferred compensation, union dues, etc., will not cease, unless the employee requests cancellation, and may continue to accrue in your absence. Once you have returned to an active employment status, the accrued premiums will be deducted through the payroll system.

What happens when I return to work?

When an employee returns to work after an FMLA status, the employee must meet with an Employee Benefits staff member within 31 days to restore his or her benefits. Any terminated benefits must be restored to the plan and tiers in effect prior to the FMLA leave. The only exceptions to this rule are when an open enrollment has passed or if there was a qualifying event during the unpaid leave which makes the employee eligible to change benefits plans or tiers. Should money be owed to any plan for missed deductions while on leave, collection will be made through the payroll system upon employees return to work.

How does non-payment of premium affect my COBRA rights?

If benefits are terminated due to non-payment of premiums, the termination is considered voluntary and all qualified beneficiaries will become ineligible for COBRA continuation of coverage.

Leave Without Pay

If you are on leave without pay for any reason, excluding an approved FMLA leave or military leave, for one or more pay periods, you are eligible to continue your group coverage for a specific period of time subject to premium payment. The employee must continue to pay his/her share of the premiums during the leave period. Failure to pay the required premium will result in cancellation of the employee's coverage. Termination of benefits, if necessary, are date sensitive and will vary on an individual basis. Contact a representative of the Employee Benefits Division for detailed information.

What happens to my group benefits while I'm in an unpaid status?

When an employee enters an unpaid status, they will be afforded the opportunity to pay premiums due for group benefits through the end of the month of the second unpaid pay period. If the employee pays the premiums due, the employee will be offered COBRA continuation coverage the first of the following month. If the employee does not pay premiums, benefits will be terminated retroactively to the first day of the month following the last full month of paid premiums.

What happens to my voluntary benefits while I'm in an unpaid status?

Deductions for voluntary services/products, which may include flexible spending accounts, deferred compensation, union dues, etc., will not cease, unless the employee request cancellation and may continue to accrue in your absence. Once you have returned to an active employment status, the accrued premiums will be deducted through the payroll system.

What happens when I return to work?

When an employee returns to work after an unpaid status, the employee must meet with an Employee Benefits staff member within 31 days to restore his or her benefits. Any terminated benefits must be restored to the plan and tiers in effect prior to the unpaid status. The only exceptions to this rule are when an open enrollment has passed or if there was a qualifying event during the unpaid leave which makes the employee eligible to change benefits plans or tiers. Should money be owed to any plan for missed deductions while on leave, collection will be made through the payroll system upon employees return to work.

How does non-payment of premium affect my COBRA rights?

If benefits are terminated due to non-payment of premiums, the termination is considered voluntary and all qualified beneficiaries will become ineligible for COBRA continuation of coverage.

Important Benefit Plan Information

Military Leave

While an employee is in a military leave status, they will continue to be eligible for group rate benefits for up to 12 months after they enter an unpaid status. The employee will continue to pay his/her share of the premiums during the leave period. Failure to pay the required premium will result in cancellation of the employee's coverage. Termination of benefits, if necessary, are date sensitive, and will vary on an individual basis. For additional information regarding military leave, please refer to Personnel Service Bulletin 05-05 and City Council Resolution.

What happens to my group benefits while I'm on paid military leave?
Unless instructed by the employee, their attorney in fact or agent to terminate benefits, City and employee contributions for health and welfare benefits will continue to be paid to the same extent as they would be if the employee were in an active employment status.

What happens to my group benefits while I'm in an unpaid military status?
When an employee enters an unpaid military status, they will be afforded the opportunity to pay premiums due for group benefits for an additional 12 months. If the employee pays the premium due, the employee will be offered COBRA continuation coverage the first of the month following the 12th month of unpaid status. If the employee does not manually pay premiums, benefits will be terminated retroactively to the first day of the month following the last full month of paid premiums.

What happens to my voluntary benefits while I'm in an unpaid military status?
Deductions for voluntary services/products, which may include flexible spending accounts, deferred compensation, individual term life, cancer plan, union dues, credit union, etc., will not cease and may continue to accrue in your absence. When an employee enters an unpaid military status, the Employee Benefits Division will mail information to the employee regarding continuation and/or reinstatement of voluntary benefits when the employee returns to a paid status.

What happens when I return to work?
When an employee returns to work after an unpaid military status, it will be their responsibility to meet with a representative of the Employee Benefit Division within 31 days to re-establish any terminated benefits. In the event an open enrollment has passed or if there was a qualifying event during the unpaid leave which makes the employee eligible to change benefit plans or tiers, they will have that option. Should money be owed to any plan for missed deductions while on leave, collection will be made through the payroll system upon employees return to work.

How does non-payment of premium affect my COBRA rights?
If benefits are terminated due to non-payment of premiums, the termination is considered voluntary and all qualified beneficiaries will become ineligible for COBRA continuation of coverage.

Special Enrollment Rights

Loss of Coverage
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in one of the plans offered, provided that you request enrollment within 31 days after your other coverage ends. 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, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
29 CFR 2590.701-6(c)

Loss of Medicaid or SCHIP
Employee or dependents will be allowed to enroll mid-year if they lose Medicaid or the State Children's Health Insurance Program (SCHIP) coverage, as a result of losing eligibility, or becoming eligible for Medicaid or SCHIP assistance with the group health plan premiums. An employee will be given 60 days after the event to request enrollment in one of the City's health plans. To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date the employee or dependent become eligible for premium assistance under Medicaid or SCHIP or the date you or your dependent's Medicaid or state-sponsored SCHIP coverage ends.

Temporary Disability Income Protection

City of Oklahoma City

Temporary Disability Income Protection Plan *(For Management Employees Only)*

This plan is provided by the City of Oklahoma City and is designed for management employees who are temporarily disabled and are expected to return to work. This program is not intended as a long-term disability, or salary continuance plan.

Definition of Management Employees

- All full-time management and executive pay plan employees
- All full-time City Council appointees
- All full-time employees in the City Auditor's pay plan
- All full-time employees in the Municipal Counselor's pay plan

Effective Date

All qualified employees are covered by the Plan on their first day on the job. It is not necessary to complete enrollment paperwork for this program.

Benefits

A benefit in the amount equal to 60% of the employee's basic earnings is payable monthly to an eligible employee. The maximum amount of benefits payable to any employee is $3,000 per month and the maximum benefit period is 36 months.

For additional details, refer to the Temporary Disability Income Protection Plan booklet or contact an Employee Benefits representative.

Notice of Health Laws

Certificate of Creditable Coverage

A certificate of creditable coverage will be provided upon request or automatically upon loss of coverage and a COBRA qualifying event. Certificates provide evidence of health coverage and may be needed if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. § 701(e); 29 CFR 2590.701-5

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in one of the plans offered, provided that you request enrollment within 31 days after your other coverage ends. 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, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. 29 CFR 2590.701-6(c)

No Surprises Act (New for 2022)

The No Surprises Act protects individuals from surprise medical bills for emergency services, all ambulance services provided by out of network providers, and non emergency services provided by out of network providers at in-network facilities in certain circumstances. Provisions include:

- Bans surprise billing for emergency services. Emergency Services, regardless of where they are provided, must be treated on an in-network basis without requirements for prior authorization.
- Bans high out of network cost-sharing for emergency and non-emergency services. Patient cost-sharing, such as co-insurance or a deductible, cannot be higher than if such services were provided by an in-network doctor, and any coinsurance or deductible must be based on in-network provider rates.
- Bans out-of-network charges for ancillary care (like an anesthesiologist or assistant surgeon) at an in-network facility in all circumstances.
- Bans other out-of-network charges without advance notice. Health care providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.

These provisions will provide patients with financial peace of mind while seeking emergency care as well as safeguard them from unknowingly accepting out-of-network care and subsequently incurring surprise billing expenses. Contact the medical plan provider with any additional questions regarding how the No Surprises Act affects your individual services provided.

Affordable Care Act

Beginning January 1, 2014, as part of the Affordable Care Act legislation, most Americans are required to purchase health insurance coverage that meets a certain minimum standard. The health plans offered by the City of Oklahoma City do qualify as minimum essential coverage, as do governmental plans (like Medicare, Medicaid, CHIP and TRICARE). Another key part of the health care law to take effect in 2014 is a new way to buy health insurance: the Health insurance Marketplace, also referred to the Marketplace Exchange. More information about these changes are on www.healthcare.gov.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under Federal or State 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 and State law generally do 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 or State 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).

In addition, under State law group health plans and health insurance issuers shall provide for one home visit within 48 hours of childbirth by a licensed health care provider whose scope of practice includes providing postpartum care, following a vaginal delivery when childbirth occurs at home or in a licensed birthing center.
§711(d); 29 CFR 2520.102-3(u) and §36-6060.3 of Oklahoma Statutes.

Women's Health and Cancer Rights Act of 1998

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 states 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. Refer to your plan documents for applicable deductibles and coinsurance amounts. § 713(a)

Continuation of Coverage (COBRA)

COBRA Continuation of Coverage

Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise would be terminated.

COBRA contains provisions giving certain employees, former employees, retirees, spouses and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available in specific instances. Coverage for COBRA participants is usually more expensive than coverage for active employees, since usually the employer formerly paid a part of the premium.

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary generally is any individual covered by a group health plan on the day before a qualifying event. A qualified beneficiary may be an employee, the employee's spouse and dependent children, and in certain cases, a retired employee, the retired employee's spouse and dependent children.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

Is COBRA continuation coverage available to a retiree?

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

How long will continuation coverage last?

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

Continuation of Coverage (COBRA)

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

- Any required premium is not paid on time;
- A qualified beneficiary becomes covered under another group health plan that does not impose a pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
- A qualified beneficiary enrolls in Medicare after electing continuation coverage; or
- The employer ceases to provide any group health plan for its employees.

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

General Notice

You will receive a General Notice of your COBRA Continuation of Coverage Rights when you initially become covered under a group health or dental group plan. The notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage. Additionally, the notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

Election Notice

You will receive an Election Notice when you or one of your qualified beneficiaries lose coverage under a qualified plan. The Election Notice contains the election form that must be returned in order to participate in COBRA, along with the COBRA rate sheet and other information about your rights under COBRA. You or your qualified beneficiaries will receive an Election Notice for any of the following reasons:

1) Termination (for reasons other than gross misconduct) or a reduction in work hours
2) A child's loss of dependent status
3) A divorce or legal separation
4) Employee eligibility for Medicare
5) Military leave, after the 12-month benefit extension expiration
6) Death of an employee

For More Information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the COBRA Administrator. You can get a copy of your summary plan description from:

The City of Oklahoma City
Human Resources / Employee Benefits Division
Attn: COBRA Administrator
420 W. Main, Suite 110
Oklahoma City, OK 73102
Phone: 405-297-2144

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Address Updated

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer.

Medicare Disclosure

Important Notice from the City of Oklahoma City 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 one of the City's sponsored health plans, that include UnitedHealthcare or the City's self-insured Group Indemnity Health Plan, 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. The City of Oklahoma City has determined that the prescription drug coverage offered by all of our health plans, that includes the HMO Plan and the Group Indemnity Health Plan are, 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 through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to enroll in Medicare prescription drug plan (Medicare Part D), **you and your dependents will automatically be disenrolled from your current health and prescription coverage.** Once you are disenrolled (or dropped) from one of the City's sponsored health plans (UnitedHealthcare or the City of Oklahoma City's Group Indemnity Health Plan) and enroll in a Medicare prescription drug plan, **you will not be able to get this coverage back later.**

Before enrolling in Medicare Part D, make an informed decision about what is best for you. Compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

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 one of the City of Oklahoma City's sponsored health plans 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 I% 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.

Your Medicare Secondary Payer Responsibility

In order to comply with Medicare Secondary Payer (MSP) laws, it is very important that you promptly and accurately complete any requests for information from the City or the Claims Administrator (UnitedHealthcare or BlueCross BlueShield of Oklahoma) regarding the Medicare eligibility of you, your spouse and covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed. Please contact the City or your group administrator promptly to ensure that your claims are processed in accordance with applicable MSP laws.

Medicare Disclosure

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 one of the City's sponsored health plans which include UnitedHealthcare HMO or the Group Indemnity Health Plan, changes. You may also request a copy of this notice at any time.

Contact an Employee Benefits Representative at (405) 297-2144.

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 **800-MEDICARE (800-633-4227)**.
- TTY users should call **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 800-772-1213 (TTY 800-325-0778).

Date:	July 1, 2022
Name of Entity/Sender:	City of Oklahoma City
Contact--Position/Office:	Human Resources Employee Benefits Division
Address:	420 West Main, Suite 110 Oklahoma City, OK 73102
Phone Number:	405-297-2144

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).

CHIP Notification

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

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can 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, you can contact your State Medicaid or CHIP office or dial 877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

OKLAHOMA – Medicaid
Web site: https://okhca.org/individuals.aspx
Phone: 888-365-3742

Health Care Reform Changes

A Summary of Impacts on Employees

The impact of health care reform requires you to take action — enroll yourself in minimum essential coverage or pay a penalty.

The Patient Protection and Affordable Care Act, also known as health care reform or the Affordable Care Act, was enacted on March 23, 2010. In its current form, the law has resulted in a steady stream of regulations and guidance as various governmental entities clarified employers' requirements under the law over the past three years.

As your employer, we continue to implement provisions to comply with the requirements of the health care reform law. This summary focuses on the changes that affect you as an individual, as well as changes in the benefit programs we offer. We encourage you to pay careful attention to your health care benefits.

ACA Individual Mandate

Beginning in 2019, the Tax Cuts and Jobs Act (TCJA) repeals the penalty tax associated with the individual mandate under the Affordable Care Act.

Essential Health Benefits Maximum Out-of-Pocket Limits

The Affordable Care Act (ACA) establishes a maximum annual out-of-pocket amount for in-network Essential Health Benefits (EHBs).
The categories of essential health benefits are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Copayments, coinsurance and deductibles for all in-network plan benefits generally apply toward the out-of-pocket limits.

For plan year 2022, the Essential Health Benefits maximum in-network out-of-pocket limits for the City of Oklahoma City's plans are as follows:

<u>Group Indemnity Plan (administered by BlueCross BlueShield of Oklahoma):</u>
Medical and Prescription Benefit combined:
$8,700 employee only coverage
$17,400 family coverage

<u>United Healthcare (HMO) Plan</u>
Medical and Prescription Benefit combined:
$8,700 employee only coverage
$17,400 family coverage

Health Care Reform Changes

A Summary of Impacts on Employees

Do I have to take the coverage my employer offers me?
No. But you should be aware that in most cases, the election you make is considered irrevocable and cannot be reversed if you change your mind. If you decide not to take employer-sponsored coverage, you should purchase coverage elsewhere, such as through a health insurance exchange, discussed next.

In some cases you could experience either a HIPAA special enrollment right or qualifying event that would allow you to enroll in our coverage midyear. Examples might include if you get married, have a baby or adopt a child midyear, qualify for premium assistance through CHIP or lose coverage (through Medicaid or another employer-sponsored plan). If the plan we offer is a non-calendar year plan, we may elect to include an optional Section 125 qualifying event to allow you to enroll or drop our coverage midyear. Importantly, not paying premiums for an individual policy or having a change in financial condition will not allow you to join our plan midyear. Ask your Employee Benefits representative for more information about this. In all cases, we are not permitted to retaliate against you for choosing to enroll in coverage somewhere other than our plan.

Where can I get coverage if I do not want my employer's coverage?
The federal government and states set up online public health insurance exchanges. You may hear these referred to as marketplaces. There are also many private exchanges and marketplaces. Some states have already created marketplaces.

Importantly, the public exchanges set up and administered by the federal government and the states are the only avenue for qualifying employees to receive assistance with paying premiums and reducing other cost-sharing normally associated with health insurance (including deductibles, co-payments and co-insurance) in the form of advance tax credits and subsidies. These are not available in private exchanges. Income parameters and other eligibility requirements apply to qualify for a tax credit or subsidy. To qualify for subsidies, an employee must have household income of between 100 percent and 400 percent of the federal poverty line. Plus, the cost of health insurance premiums must exceed 9.86 percent of household income.

What should I consider when deciding whether to enroll in coverage offered through my employer versus an exchange?
Employer-sponsored coverage is generally subsidized by the employer offering the coverage. This means the cost to you is most likely less than it would be if you purchased it on your own. In many cases, the amount of the employer contribution is more than the federal subsidy or tax credit that you would qualify for through a public exchange. Another reason to consider keeping employer-sponsored coverage is the tax implications of paying for coverage on your own. Coverage purchased through a public exchange cannot be paid on a pre-tax basis. However, paying for coverage offered through your employer can be done on a pre-tax basis. Depending on the amount of premiums paid and your individual effective tax rate, you may see a significant savings in your taxes by paying for employer-sponsored coverage on a pre-tax basis. Finally, allowing us, as your employer, to handle the design choices and narrow down the network of providers, as well as issue the required tax filings, can relieve you of many of the tasks that are inherent when purchasing coverage on your own.

Health Insurance Marketplace Exchange

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Key parts of the health care law took effect in 2014. There is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment ¬based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 2021 for coverage starting as early as January 1, 2022.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.56% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact City of Oklahoma City, Employee Benefits at 405-297-2144

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.

Health Insurance Marketplace Exchange

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 Oklahoma City**
4. Employer Identification Number (EIN) : **736005359**
5. Employer address: **420 W. Main St. Ste 110**
6. Employer phone number: **405-297-2530**
7. City: **Oklahoma City** 8. State: **Oklahoma** 9. ZIP code: **73102**
10. Who can we contact about employee health coverage at this job? **Employee Benefits**
11. Phone number (if different from above) **405-297-2144**
12. Email address: **employee.benefits@okc.gov**

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

- As your employer, we offer a health plan to: regular, full-time active employee, or in one of the following categories:

  1) An employee on paid disability leave due to an on-the-job injury or illness who was a regular, full-time active employee on the date the disabling injury or illness occurred;

  2) An elected official of the City;

  3) The City Auditor or a regular, full-time active employee of the City Auditor's office;

  4) The Municipal Counselor or a regular, full-time active employee of the Municipal Counselor's office; or

  5) A full-time active Oklahoma City Municipal Judge.

  6) An eligible employee of a participating public trust.

- With respect to dependents: We do offer coverage. Eligible dependents are:
  - Spouse/Common Law Partners
  - Child(ren)
  - Legally adopted children
  - Child(ren) under Legal Guardianship
  - Step-Child(ren)

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.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months: **Yes, eligible employees are those currently classified as a regular, full-time active employee as defined previously on this form. Open Enrollment to add or change coverage is October 15, 2021-October 31, 2021 to be effective January 1, 2022.**
14. Does the employer offer a health plan that meets the minimum value standard*? **Yes**
15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee: How much would the employee have to pay in premiums for this plan? **HMO plan: $66.89 per pay period (24 pay periods)**

* An employer-sponsored 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Glossary

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expenses, payment allowance, or negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference.

Annual Open Enrollment: The annual period during which you may choose to change your medical and/or dental coverage level or switch plans for the next plan year.

Annual Out–of–Pocket Maximum: The maximum amount of coinsurance you pay for covered medical expenses in any single calendar year. Once you have paid the out-of-pocket maximum, the Plan pays 100% of expenses (except for plan copays, which are still required). Prescription copays do not count toward your out-of-pocket maximum.

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Auto-adjudication: This process allows the Flexible Benefits Plan Administrator to immediately recognize that an expense is eligible for reimbursement under your employer's plan and IRS regulations. These transactions eliminate the need for you to send documentation to the Administrator for your expense.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Beneficiary: Person(s) named by the employee or retiree in an insurance policy to receive any benefits provided by the plan if the participant dies.

Brand-name drugs: Prescription drugs that carry a trademark or brand name. Brand-name drugs may be significantly higher in cost than generic drugs, even though, by law, both must have the equivalent active ingredients.

Coinsurance: The percent (for example, 10%) you pay of the allowed amount for covered health care services to providers. Network coinsurance usually costs less than non-network coinsurance. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 10% would be $10. The health insurance or plan pays the rest of the allowed amount.

Contingent Beneficiary: Person(s) named to receive policy benefits if the primary beneficiary is deceased.

Coordination of Benefits: Typically, coordination of benefits is the insurance industry standard practice used to share the cost of care between two or more carriers when a member is covered by more than one benefit plan. When someone is covered under two plans at the same time, the benefits received under those plans will be coordinated so that the participant will receive a benefit that is not greater than either one of the plans would pay under its own terms. In order to accomplish this, one plan is designated as "primary" and the other is designated as "secondary".

If you are covering your spouse as a dependent, and he or she also receives coverage elsewhere, for your spouse the City's benefit plan will always be secondary and the other plan will always be primary. Likewise, if you cover yourself as an employee on our plan, and your spouse covers you under his or her plan, our plan is primary and his or her plan would be secondary with respect to your benefits.

Copay: A fixed amount (for example, $15) you pay for a covered health care services to providers, usually when you receive the service. Network copayments are usually less than non-network copayments.

Deductible: The amount you owe for health care services that your health insurance or plan covers before your health insurance begins to pay. For example, if your deductible is $1,250, your plan won't pay anything until you've met your $1,250 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Glossary

Explanation of Benefits (EOB): A detailed statement from your health plan that explains which procedures and services were given, how much they cost, how much your plan pays, and how much you pay.

Formulary Drugs: Listing of prescription medications which are approved for use and/or coverage by the plan and which will be dispensed through participating pharmacies to covered enrollees. Formularies are subject to change without notice.

Grievance: A compliant that you communicate to your health insurer or plan.

Generic Drugs: Prescription drugs that meet the standards for safety, purity, strength, and quality as their brand-name counterparts. These drugs, however, bear only a chemical or general-classification name — not a brand name.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient services.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Health Maintenance Organization (HMO): A pre-paid medical plan that provides a comprehensive predetermined medical care benefit package.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Inpatient Hospitalization: A hospital stay (usually 24 hours or more) for which a room and board charge is made by the hospital.

Managed (Closed) Formulary: A listing of drugs on a plan approved list intended to include a large enough range of medications and sufficient information about them to enable health practitioners to prescribe treatment that is medically appropriate.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Medicare: The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD). Part A, Hospital Insurance, pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care. Part B, Supplementary Medical Insurance, helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A. Enrollment in Part B is voluntary and available for a small premium. (You are required to be enrolled in Part B if you are enrolled in any of the City's health plans.)

Network Provider: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Formulary Drugs: Prescription medications not on a plan-approved list.

Non-Network Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Open Formulary: A relatively unrestricted listing of drug medications and sufficient information about them to enable health practitioners to prescribe treatment that is medically appropriate.

Outpatient (Hospital) Care: Care in a hospital, clinic, or health facility that usually doesn't require an overnight stay.

Physician Services: Health care services a licensed medical physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.