



City of Oklahoma City

DISCLOSURES AND SUPPLEMENTAL
BENEFIT INFORMATION BENEFITS GUIDE

Table of Contents

Dependent Eligibility	4
Important Benefit Plan Information	6
Temporary Disability Income Protection Plan.....	9
Notices (including Medicare Disclosure	10
CHIP Notification.....	12
Health Care Reform Changes	14
Health Insurance Marketplace Exchange.....	16
Glossary.....	18

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.

OKC Open Enrollment can be found by scanning the QR code:



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
EPO 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; and
- Dependent's telephone number, if different than yours.

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 2017 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 2017 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 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.

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

Medicare Secondary Payer Laws

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.

Temporary Disability Income Protection

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.

Required Notices

Important Notice from City of Oklahoma City About Your Prescription Drug Coverage and Medicare under the United Healthcare of Oklahoma and BlueCross BlueShield of Oklahoma Plan(s)

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 Oklahoma City 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 Oklahoma City has determined that the prescription drug coverage offered by the United Healthcare of Oklahoma and BlueCross BlueShield of Oklahoma plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Oklahoma City coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may 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 Oklahoma City 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 at the end of these notices 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 Oklahoma City changes. You also may request a copy of this notice at any time.

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 Medicare Part D 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:	January 1, 2024
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

Notices

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources Employee Benefits Division at 405-297-2144.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources Employee Benefits Division at 405-297-2144.

HIPAA 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 later 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 towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- » Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- » Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- » Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- » Failing to return from an FMLA leave of absence; and
- » Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources Employee Benefits Division at 405-297-2144.

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 July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid

WEBSITE <http://myalhipp.com/>
PHONE 1-855-692-5447

ALASKA – Medicaid

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

WEBSITE <http://myarhipp.com/>
PHONE 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

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+)

WEBSITE Health First Colorado Website:
<https://www.healthfirstcolorado.com/>
PHONE Health First Colorado Member Contact Center:
1-800-221-3943 / State Relay 711
CHP+ WEBSITE <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>
CHP+ PHONE Customer Service: 1-800-359-1991 / State Relay 711
WEBSITE Health Insurance Buy-In Program (HIBI):
<https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>
PHONE HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

WEBSITE <https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>
PHONE 1-877-357-3268

GEORGIA – Medicaid

A 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

INDIANA – Medicaid

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)

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

KANSAS – Medicaid

WEBSITE <https://www.kancare.ks.gov/>
PHONE 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) Program
WEBSITE <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>
PHONE 1-855-459-6328
EMAIL KIHIPPPROGRAM@ky.gov
KCHIP WEBSITE <https://kidshealth.ky.gov/Pages/index.aspx>
KCHIP PHONE 1-877-524-4718
KENTUCKY MEDICAID WEBSITE <https://chfs.ky.gov>

LOUISIANA – Medicaid

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

ENROLLMENT WEBSITE <https://www.maine.gov/dhhs/ofi/applications-forms>
PHONE 1-800-442-6003 TTY: Maine relay 711
WEBSITE Private Health Insurance Premium
<https://www.maine.gov/dhhs/ofi/applications-forms>
PHONE 1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

WEBSITE <https://www.mass.gov/masshealth/pa>
PHONE 1-800-862-4840 TTY: 617-886-8102

CHIP Notice

MINNESOTA – 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

MISSOURI – Medicaid

WEBSITE <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
PHONE 573-751-2005

MONTANA – Medicaid

WEBSITE <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
PHONE 1-800-694-3084
EMAIL HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

WEBSITE <http://www.ACCESSNebraska.ne.gov>
PHONE 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

MEDICAID WEBSITE <http://dhcnp.nv.gov>
MEDICAID PHONE 1-800-992-0900

NEW HAMPSHIRE – Medicaid

WEBSITE <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
PHONE 603-271-5218
TOLL FREE FOR HIPPI PROGRAM 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

WEBSITE https://www.health.ny.gov/health_care/medicaid/
PHONE 1-800-541-2831

NORTH CAROLINA – Medicaid

WEBSITE <https://medicaid.ncdhhs.gov/>
PHONE 919-855-4100

NORTH DAKOTA – Medicaid

WEBSITE <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
PHONE 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

WEBSITE <http://www.insureoklahoma.org>
PHONE 1-888-365-3742

OREGON – Medicaid

WEBSITE <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
PHONE 1-800-699-9075

PENNSYLVANIA – Medicaid

WEBSITE <https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx>
PHONE 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

WEBSITE <http://www.eohhs.ri.gov/>
PHONE 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid

WEBSITE <https://www.scdhhs.gov>
PHONE 1-888-549-0820

SOUTH DAKOTA - Medicaid

WEBSITE <http://dss.sd.gov>
PHONE 1-888-828-0059

TEXAS – Medicaid

WEBSITE <http://gethipptexas.com/>
PHONE 1-800-440-0493

UTAH – Medicaid and CHIP

MEDICAID WEBSITE <https://medicaid.utah.gov/>
CHIP WEBSITE <http://health.utah.gov/chip>
PHONE 1-877-543-7669

VERMONT– Medicaid

WEBSITE <http://www.greenmountaincare.org/>
PHONE 1-800-250-8427

VIRGINIA – Medicaid and CHIP

WEBSITE <https://www.coverva.org/en/famis-select>
<https://www.coverva.org/en/hipp>
MEDICAID AND CHIP PHONE 1-800-432-5924

WASHINGTON – Medicaid

WEBSITE <https://www.hca.wa.gov/>
PHONE 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

WEBSITE <http://dhr.wv.gov/bms>
<http://mywhipp.com>
MEDICAID PHONE 304-558-1700
CHIP TOLL-FREE 1-855-MyWHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

WEBSITE <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
PHONE 1-800-362-3002

WYOMING – Medicaid

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 July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits
Security Administration
www.dol.gov/agencies/ebsa
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 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 2024, the Essential Health Benefits maximum in-network out-of-pocket limits for the City of Oklahoma City's plans are as follows:

Group Indemnity Plan (administered by BlueCross BlueShield of Oklahoma):

Medical and Prescription Benefit combined:

\$9,450 employee only coverage

\$18,900 family coverage

Exclusive Provider Organization - EPO plan administered by BlueCross BlueShield of Oklahoma

Medical and Prescription Benefit combined:

\$9,450 employee only coverage

\$18,900 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 2023 for coverage starting as early as January 1, 2024.

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 8.39% 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](https://www.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: **EB@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 26, 2023 - November 10, 2023 to be effective January 1, 2024.**
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? **EPO 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 complaint 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.

