WE CLAREMORE

2025 Employee Benefits Guide

July 1, 2025 – June 30, 2026

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

A Message to Our Employees

The Benefits Open Enrollment Period Is Here!

The City of Claremore values you as employees and public servants. Our goal is to provide the best benefits within the City's financial ability. We are happy to let you know that your benefit levels are not changing, nor are your costs AKA payroll deductions!

2025-2026 Benefit Plan Highlights

Medical – Edison Health

Dental – Guardian

- **DentalGuard Preferred**

Vision – Guardian

- VSP Network

Flexible Spending Account (FSA) – Flex Plan Admin

- Heath Care FSA or Dependent Care FSA

Medefy

- Telemedicine
- Virtual Mental Health

Basic Life and AD&D – Guardian

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

Voluntary Life – Guardian

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

Voluntary AD&D – Guardian

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

Voluntary Supplemental Benefits – American Fidelity

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

Employee Assistance Program (EAP) – CommunityCare

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

Benefits for You & Your Family

City of Claremore is pleased to announce our 2025-2026 benefits program, which is designed to help you stay healthy, feel secure, and maintain a work/life balance. Offering a competitive benefits package is just one way we strive to provide our employees with a rewarding workplace. Please read the information provided in this guide carefully. For full details about our plans, please refer to the summary plan descriptions. Listed below are the City of Claremore benefits available during open enrollment:

- Medical
- Dental
- Vision
- FSA
- Medefy
- Basic Life and AD&D
- Voluntary Life
- Voluntary AD&D
- Voluntary Supplemental Benefits
- Contacts
- Legal Notices

When is My Coverage Effective?

The effective date for your benefits is July 1, 2025 – June 30, 2026.

Who is Eligible?

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

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

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

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

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

Adding dependents:

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

When and How Do I Enroll?

Open enrollment will be conducted April 29, 2025 – May 8,2025. Open enrollment meetings will be held April 29, 2025 – May 1, 2025.

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

Changing Coverage During the Year

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

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

Benefits Cost

Cost of Benefits Coverage			
Coverage	Monthly Cost	Employer Biweekly Cost	Employee Biweekly Cost
Medical Plan – Edison Health			
Employee Only	$587.69	$293.85	$0.00
Employee & Spouse	$1,292.85	$505.39	$141.03
Employee & Child(ren)	$1,116.59	$452.52	$105.78
Family	$1,821.81	$664.08	$246.82
Dental Plan – Guardian			
Employee Only	$37.22	$18.61	$0.00
Employee & Spouse	$74.44	$29.89	$7.33
Employee & Child(ren)	$95.14	$36.21	$11.36
Family	$136.72	$48.85	$19.51
Vision Plan – Guradian VSP Choice Network			
Employee Only	$10.32	$0.00	$5.16
Employee & Spouse	$19.62	$0.00	$9.81
Employee & Child(ren)	$20.66	$0.00	$10.33
Family	$30.37	$0.00	$15.19
Basic Life and AD&D Plan -Guardian			
Employee Only	Employer Paid		
Depedent(s)	$1.10 monthly per unit		
Supplemental Life and AD&D Plan – Guardian			
Age-banded rates listed on page 15			

Medical Benefits Overview

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

Edison Health Benefit Coverage	
Maternity Services	
Office Visits (Primary / Specialist)	$25 / $50 copays per visit
Childbirth / Delivery Professional & Facility Services	Up to $500 copay per pregnancy, then 100% covered

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

Dental Insurance

Benefit Coverage	Guardian	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$50	$50
Family	$150	$150
Waived for Preventive Care	Yes	Yes
Waived for Orthodontia	Yes	Yes
Annual Maximum		
Per Person / Family	$1,500	$1,500
Preventive	100%	100%
Basic	100%	80%
Major	60%	50%
Claim Payment Basis	Neogtiated Fee Schedule	90th Percentile
Orthodontia		
Benefit Percentage	50%	50%
Adults (and Covered Full-Time Students, if Eligible)	Not covered	Not covered
Dependent Child(ren)	Covered up to age 26	Covered up to age 26
Lifetime Maximum	$1,500	$1,500
Maximum Rollover * Enhanced Benefit		
Threshold	$700	
Rollover Amount	$350	
In-Network only Rollover Amount	$500	
Account Limit	$1250	

Vision Insurance

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

Flexible Spending Account (FSA)

What is a Flexible Spending Account?

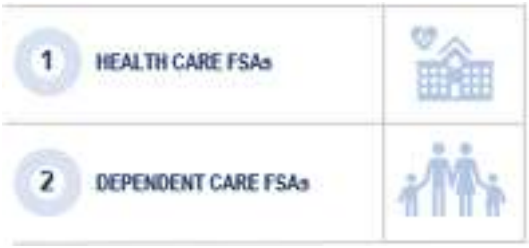
A Flexible Spending Account (FSA) is a special type of account you (and sometimes your employer) put money into to pay for certain out-of-pocket health care expenses. Your contributions to this account are not taxed, so you will save the amount that would have been paid in taxes on this money. Your FSA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

"Use it or Lose it" Rule

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

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

If your plan has a carry-over provision, you may carry over up to $660 (in 20254) of unused funds to next year. Plans can't have both a grace period and a carry-over. Check with your HR or FSA vendor to see if your plan has either of these provisions.



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

Health FSAs

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

How much can I contribute to my health FSA?

The IRS sets a maximum contribution for the year. For 2025, the IRS maximum is $3,300. Your plan may have a lower contribution maximum. FSA funds are available up front, at the beginning of the plan year, even if you haven't fully funded the account yet. You cannot change your contribution amount outside open enrollment unless you experience a qualifying life event.

How do I use my health FSA?

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

What is considered a qualified medical expense?

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

• Prescription medicine

• Over-the-counter medicine

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

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

Dependent Care FSAs

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

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

How much can I contribute to my Dependent Care FSA?

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

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

How do I use my Dependent Care FSA?

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

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

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

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

Medefy

How to Access Physician Care

- Your plan participates in the HealthSmart physician-only network (PON)
- Call Edison Health at (844) 212-3035 for providers who participate in the HealthSmart PON, or use the Medefy chat feature

How to Access Hospital Care

- You are part of an open network for hospital care
- This means all hospital facilities are eligible to provide services to you and your dependents
- If the front desk has any questions about your insurance that you are unable to answer, advise them to call Edison Health at (800) 967-2077. Edison Health's phone number can be located on the back of your ID card.

What Happens if I Receive a Balance Bill?

- Call Edison Health at (844) 212-3035 to confirm you have a balance bill.
- Edison Health will confirm and then transfer you to your personal member advocate at Fairos.
- You will know your Fairos Advocate's name and have direct access to them via phone and email
- Your Advocate will set you up on the Fairos portal so you can track the status of your balance bill.
- Expect frequent updates from your Fairos Advocate at a minimum of every 15 calendar days until it's resolved.

For more information about your benefit plan contact Edison Health at (844) 212-3035.

Medefy App Overview

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

An app hub with hustle

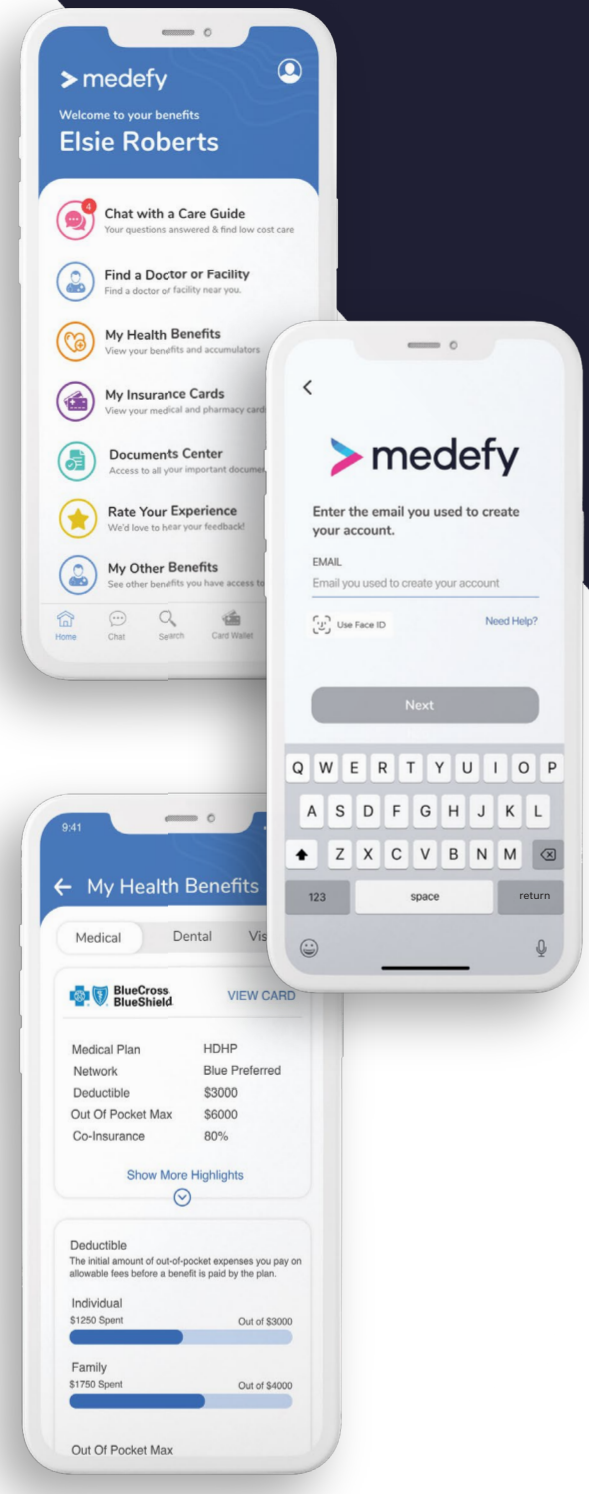
Search 'Medefy' in the app store. We're available on both Apple and Android devices. Once downloaded, open the app and tap 'Create Account.'

Live Care Guides, 24/7

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

Tools for every step of the way

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



medefy®

Download the Medefy App to get started today.

GET IT ON Google Play

Download on the App Store

Life and AD&D Insurance

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

Guardian Basic Life and AD&D (Employer Paid)	
You Employee (Company Paid)	
Benefit Maximum	$25,000
Guaranteed Issue	$25,000
AD&D Benefit	$25,000
Age Reduction Schedule	Reduces to 50% at age 70
Your Spouse or Domestic Partner (Employee Paid)	
Benefit Maximum	$5,000 not to exceed 50% of employee benefit amount
Your Child(ren) (Employee Paid)	
Benefit Maximum	$2,000 (Birth to age 26, Infant age birth to 14 days)
Waiver of Premium	
Elimination Period	6 months
Benefit Duration	Age 65
Eligibility	Employee is totally disabled prior to age 60
Accelerated Death Benefit (ADB)	
Benefit Amount	75% of employee benefit amount
Eligibility	Employee has been examined and diagnosed by a doctor as having a medically determined condition that is expected to result in death within 12 months of this claim benefit being received by the carrier
Other Benefits	
Portable	Yes, both employees and spouses / domestic partners.
Convertible	Yes

Voluntary Life and AD&D Insurance

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

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

Guardian Supplemental Life and AD&D (Employee Paid)	
You Employee	
Benefit Increments	$10,000
Guaranteed Issue	$100,000
Benefit Maximum	$200,000
AD&D Benefit	$10,000 to $200,000 in increments of $10,000
Age Reduction Schedule	Reduces to 50% at age 70
Your Spouse or Domestic Partner	
Benefit Increments	$5,000
Guaranteed Issue	$100,000
Benefit Maximum	$50,000 not to exceed 100% of employee benefit amount
AD&D Benefit	60% of employee AD&D amount if no covered child(ren) 40% of employee AD&D amount if covered child(ren)
Age Reduction Schedule	Reduces to 50% at age 70
Your Child(ren)	
Benefit Increments	$5,000
Benefit Maximum	$500 (birth to 14 days) $10,000 (age 14 days to 26 years
AD&D Benefit	20% of employee AD&D amount if no covered spouse 10% of employee AD&D amount if covered spouse
Waiver of Premium	
Elimination Period	6 months
Benefit Duration	Age 65
Eligibility	Employee is totally disabled prior to age 60
Accelerated Death Benefit (ADB)	
Benefit Amount	75% of employee benefit amount
Eligibility	Employee has been examined and diagnosed by a doctor as having a medically determined condition that is expected to result in death within 12 months of this claim benefit being received by the carrier
Other Benefits	
Portable	Yes, both employees and spouses / domestic partners.
Convertible	Yes

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

Voluntary Supplemental Benefits

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

Accident

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

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

Cancer

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

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

Critical Illness

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

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

Hospital Indemnity

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

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

Disability

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

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

Life

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

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

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

Contacts

Have Questions? Need Help?

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

Carrier Customer Service

BENEFITS PLAN	CARRIER	CONTACT INFO
Human Resources	City of Claremore	918-341-1325 x102 or x101
Medical PPO	Edison Health Solutions	844-212-3035 members@edisonehs.com
Dental PPO	Guardian Life Insurance Company	800-541-7846
Vision	Vision Service Plan (VSP) Guardian Life Insurance Company	800-877-7195 www.vsp.com
FSA	Flex Plan Administrators	918-524-6350 flexplanadmin.com
Health Plan Navigation	Medefy	Download the app on the Apple App Store or Google Play
Life and AD&D	Guardian Life Insurance Company	800-525-4542 Group_life_claims@glic.com
Voluntary Life	Guardian Life Insurance Company	800-525-4542 Group_life_claims@glic.com
Voluntary AD&D	Guardian Life Insurance Company	800-525-4542 Group_life_claims@glic.com
Voluntary Supplemental Benefits	American Fidelity	800-450-3506 americanfidelity.com
Employee Assistance Program (EAP)	CommunityCare EAP	800-221-3976 ccok.com/eap

WE CLAREMORE

104 Muskogee

Claremore, Oklahoma 74017

City of Claremore

Important Legal Notices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 29 for more details.

IMPORTANT NOTICE: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.

Important Legal Notices Affecting Your Health Plan Coverage

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

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $2,000 Individual / $4,000 Family Deductible - $4,000 Individual/ $8,000 Family - Out of Pocket Maximum.

NEWBORNS ACT DISCLOSURE – FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

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

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

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

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

PATIENT PROTECTION MODEL DISCLOSURE

BlueCross BlueShield generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the BlueCross BlueShield at www.bcbsok.com.

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

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

STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce your Rights

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

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

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

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Ashley Hickman
Oklahoma, United States
918-341-1325
ahickman@claremorecity.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully****.*
Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

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

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

Get a list of those with whom we’ve shared information

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

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

Pay for your health services

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

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

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

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

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

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

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

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

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

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

Changes to the Terms of this Notice

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

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

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

Important Notice from City of Claremore About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. City of Claremore has determined that the prescription drug coverage offered by the Edison Health Solutions Plan for the plan year 2025 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, the following options may apply:

- You may stay in the Edison Health Solutions Plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose Edison Health Solutions Plan creditable coverage.
- You may stay in the Edison Health Solutions Plan and also enroll in a Medicare prescription drug plan. Edison Health Solutions Plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Edison Health Solutions Plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Edison Health Solutions Plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Claremore and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information.

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	04/16/2025
Name/Entity of Sender:	City of Claremore
Contact Position/Office:	Ashley Hickman- HR Director
Address:	104 Muskogee, Claremore, OK 74017
Phone Number:	918-341-1325

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, 2024. 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+)

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

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

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.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/
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: HHSHIPPProgram@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://dhcfp.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 number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

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: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
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, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[2]

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

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

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

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

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

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

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

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

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

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

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

    All employees

  - [ ] Some employees. Eligible employees are:

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

    All lawful dependents including spouses, domestic partners, and children up to age 26

  - [ ] We do not offer coverage.

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

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

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