

## Benefit Program Application ("ASO BPA")

### Applicable to Administrative Services Only (ASO) Group Accounts

administered by Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation,  
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, hereinafter referred to as "Claim  
Administrator" or "BCBSOK"

Group Status: Renewing ASO Account

Employer Account Number (6-digits): 019574

Group Number(s): 019574 (PPO) , 293447 (EPO)

Section Number(s): All

Legal Employer Name: City of Oklahoma City by and through the Oklahoma City Municipal Facilities Authority (OCMFA)  
(Specify the Employer or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must be  
named below. AN EMPLOYEE BENEFIT PLAN MAY NOT BE NAMED)

**ERISA Regulated Group Health Plan\***: ☐ Yes ☒ No

Is your ERISA Plan Year\* a period of 12 months beginning on the Effective Date of Coverage specified below? ☐ Yes

If not, please specify your ERISA Plan Year\*: Beginning Date \_\_\_/\_\_\_/\_\_\_ End Date \_\_\_/\_\_\_/\_\_\_ (month/day/year)

ERISA Plan Administrator\*:

Plan Administrator's Address:

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:

Non-Federal - Municipality ; if applicable, specify other:

Is your Non-ERISA Plan Year\* a period of 12 months beginning on the Anniversary Date specified below? ☐ Yes

If not, please specify your Non-ERISA Plan Year\*: Beginning Date 01 / 01 / 2024 End Date 12 / 31 / 2024  
(month/day/year)

**For more information regarding ERISA, contact your Legal Advisor.**

\*All as defined by ERISA and/or other applicable law/regulations

Effective Date of Coverage: (Month/day/Year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Anniversary Date: (Month/Day/Year) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Retiree-Only Plan(s) Identification:**

For more information regarding Retiree-only plans, contact your Legal Advisor.

Do you have one or more Retiree-only plan(s)? ☐ Yes ☒ No

If yes, please provide Benefit Agreement number, or group and section numbers of the Retiree-only plan(s):

#### Account Information

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): 9532

Employer Identification Number (EIN): 731031504

Address: 420 W. Main Street, Suite 110

City: Oklahoma City

State: OK

ZIP: 73102-4435

Administrative Contact: Jason Long

Title: Total Rewards Manager

Email Address: jason.long@okc.gov

Phone Number: 405-297-3372

Fax Number: 405-297-  
2565

Wholly Owned Subsidiaries to be covered:

Affiliated Companies to be covered: Oklahoma City Public Property Authority (OCPPA), Central Oklahoma Parking and  
Transportation Authority (COPTA), Oklahoma City Employee Retirement System (OCERS), McGee Creek Authority

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disclosure.**

Employer Identification Number (EIN): OCPPA 73-1334810, COPTA 73-0758089, OCERS 73-6096475, McGee Creek Authority 73-1323531

(Affiliated Companies must be required or permitted to be aggregated per IRS Guidelines. Employer hereby confirms that Employer, Subsidiaries and Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), or (c), or (m) or (o), or under applicable law.)

Blue Access for Employers<sup>SM</sup> ("BAE<sup>SM</sup>") Contact: Jason Long

(The BAE Contact is the Employee authorized by the Employer to access and maintain the Employer's account in BAE.)

Email Address: jason.long@okc.gov

Phone Number: 405-297-3372

Fax Number: 405-297-2565

☐ The Employer or other company listed in this BPA is a public entity or governmental agency/contractor

### Producer of Record Information

☒ NO CHANGES

☐ SEE ADDITIONAL PROVISION

Effective: 4.1.23

If applicable, the below-named producer(s) or agency(ies) is/are recognized as the Employer's Producer of Record (POR) to act as a representative in negotiations with and to receive commissions from BCBSOK, or Claim Administrator's corporate subsidiaries, as applicable, for procuring Claim Administrator's claims administration services for Employer's employee benefit program(s). This statement rescinds any and all previous POR appointments for the Employer. The POR is authorized to perform membership transactions on behalf of the Employer. This appointment will remain in effect until withdrawn or superseded in writing by Employer.

Are commissions to be paid? ☒ Yes ☐ No

**Producer or Agency to whom commissions are to be paid\*:** Lockton Companies LLC.

Oklahoma Producer#: 30174000

NPN: 002709000

Address: 6900 Dallas Parkway, Suite 450

City: Plano

State: TX

ZIP: 75024

Phone: 972-204-9564

Fax:

Email: Morgan.Young@lockton.com

Is Producer/Agency appointed with BCBSOK in Oklahoma? ☒ Yes ☐ No

Commissions:

☐ PCPM \$ Does a Monthly Cap Apply ☐ Yes ☐ No \$ (If cap is annual, divide by twelve)

☒ Flat \$10,000 annual pharmacy commissions Does a Monthly Cap Apply ☒ Yes ☐ No \$8,333.33

(If cap is annual, divide by twelve)

☒ Percentage of Stop Loss: 5%

ADDITIONAL COMMISSIONS:

\* The Producer or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

### Schedule of Eligibility

☒ NO CHANGES

☐ SEE ADDITIONAL PROVISIONS

Employer has made the following eligibility decisions:

#### 1. Eligible Person means:

- ☒ A full-time employee of the Employer.
- ☐ A full-time employee of the Employer who is a member of: (name of union)
- ☐ A part-time employee of the Employer.
- ☐ A retiree of the Employer. Define criteria:
- ☐ Other:

Are any classes of employees to be excluded from coverage? ☐ Yes ☒ No

If yes, please identify the classes and describe the exclusion:

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**2. Employee definition:****Full-Time Employee means:**

- ☒ A person who is regularly scheduled to work a minimum of 30 hours per week and who is on the permanent payroll of the Employer.
- ☐ Other:

**Part-Time Employee means:**

- ☐ A person who is regularly scheduled to work a minimum of \_\_\_\_\_ hours per week and who is on the permanent payroll of the Employer.
- ☐ Other:

**3. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person:**

- ☐ The date such person ceases to meet the definition of Eligible Person.
- ☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
- ☐ Other:

**4. Select an effective date rule for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan (the effective date must not be later than the 91st calendar day after the date that a newly eligible person becomes eligible for coverage, unless otherwise permitted by applicable law).**

- ☐ The date of employment.
- ☐ The \_\_\_\_\_ day of employment.
- ☐ The \_\_\_\_\_ day of the month following \_\_\_\_\_ month(s) of employment.
- ☐ The \_\_\_\_\_ day of the month following \_\_\_\_\_ days of employment.
- ☐ The \_\_\_\_\_ day of the month following the date of employment.
- ☒ Other: first of the month following date of hire

Is the waiting period requirement to be waived on initial group enrollment? ☐ Yes ☐ No

Are there multiple new hire waiting periods? ☐ Yes ☒ No

**If yes**, please attach eligibility and contribution details for each section.

**5. Domestic partners covered:** ☐ Yes ☒ No

**If yes**, a domestic partner is eligible to enroll for coverage.

**If yes**, are domestic partners eligible for continuation of coverage?

☐ Yes ☐ No

**If yes**, are dependents of domestic partners eligible to enroll for coverage?

☐ Yes ☐ No

**If yes**, are dependents of domestic partners eligible for continuation of coverage?

☐ Yes ☐ No

The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for domestic partners.

**6. Limiting Age for covered children:** Twenty-six (26) years, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. Other: \_\_\_\_\_**7. Termination of coverage upon reaching the Limiting Age:**

- ☐ The last day of coverage is the day prior to the birthday.
- ☒ The last day of coverage is the last day of the month in which the limiting age is reached.
- ☐ The last day of coverage is the last day of the billing month.
- ☐ The last day of coverage is the last day of the year (12/31) in which the limiting age is reached.
- ☐ The last day of coverage is the day prior to the Employer's Anniversary Date.

Automatically cancel dependents when they reach the day their coverage terminates? ☐ Yes ☒ No

*\*Automatically canceling dependents is not recommended for accounts with automated eligibility*

Will coverage for a child who is medically certified as disabled and dependent on the employee terminate upon reaching the Limiting Age even if the child continues to be both disabled and dependent on the employee?

☐ Yes ☒ No

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*However, such coverage shall be extended in accordance with any applicable federal or state law and the Disabled Dependent provisions of this BPA. The Employer will notify BCBSOK of such requirements.*

- 8. Disabled dependent:** A disabled dependent means a dependent child who is medically certified as disabled and dependent upon the Employee or his/her spouse. A child is a disabled child when the child is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, per Internal Revenue Code Section 22(e)(3).

*To administer medical certification of disabled dependents, you may select option (a) Standard Rules or (b) Custom Rules. BCBSOK will administer its standard process for administration of disabled dependent coverage if (a) below is selected by Employer, or at the Employer's direction memorialized below, BCBSOK will follow a customized process if Employer selects (b). If (b) is selected there are additional selections regarding age, proof of prior coverage, certification review, forms, and previous medical certification approvals.*

- (a) ☐ Disabled dependent administration will follow **Standard Rules**.

A disabled dependent is eligible to **continue** coverage beyond the limiting age, provided the disability began before the child attained the age of 26. A disabled dependent is eligible to **add** coverage beyond the limiting age, provided the disability began before the child attained the age of 26, and proof of coverage as a disabled dependent is provided. Administration of certification review is administered by BCBSOK; a disabled dependent certification form must be submitted to BCBSOK.

- (b) ☒ Disabled dependent Administration will follow **Custom Rules**. Please make the following sections:

**Age:** *Please select one option regarding age of when the disability began.*

- ☐ The disability must have begun before the child attained the age of 26.  
☒ All disabled dependents are covered regardless of when the disability began.

**Proof of prior coverage:** *Please select required or not required below:*

When **adding** coverage, proof of prior coverage as a disabled dependent is ☐ required ☒ not required.

**Certification review:** *Please select one option regarding the administration of certification review.*

- ☐ Certification review is administered by BCBSOK; a disabled dependent certification form must be submitted to BCBSOK.  
☒ Certification review is administered by the Employer; there are no disabled dependent certification form requirements.

**If certification review is administered by BCBSOK, please select one option regarding forms:**

- ☐ Utilize BCBSOK disabled dependent certification forms.  
☐ Utilize custom/other disabled dependent certification forms.

**If Certification Review is administered by BCBSOK, please select allowed or not allowed below:**

A disabled dependent approved certification from a prior insurance carrier is ☐ allowed ☐ not allowed.  
A disabled dependent approved certification from a prior BCBS policy is ☐ allowed ☐ not allowed.

- 9. Will extension of benefits due to temporary layoff, disability or leave of absence apply?**

- ☐ Yes (specify number of days below) ☒ No  
Temporary Layoff:            days      Disability:            days      Leave of Absence:            days

*However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law. The Employer will notify BCBSOK of such requirements.*

## 10. Enrollment:

**Special Enrollment:** An Eligible Person may apply for coverage, family coverage or add dependents within thirty-one

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(31) days of a Special Enrollment qualifying event if he/she did not previously apply prior to his/her Eligibility Date or when otherwise eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to marriage or termination of previous coverage, then no later than the first day of the Plan Month following the date of receipt of the person's application of coverage.

An Eligible Person may apply for coverage within sixty (60) days of a Special Enrollment qualifying event in the case either of a loss of coverage under Medicaid or a state Children's Health Insurance program, or eligibility for group coverage where the Eligible Person is deemed qualified for group coverage assistance under a state Medicaid or CHIP premium assistance program.

**Open Enrollment:** An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when otherwise eligible to do so, during the Employer's annual Open Enrollment Period. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period. Specify Open Enrollment Period:

**Late Enrollment:** An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when otherwise eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer.

**Select one of the provisions below:**

- ☒ Open Enrollment – Late applicants may only apply during Open Enrollment.  
☐ Late Entrant – Late applicants may apply at any time – coverage effective date is determined by the receipt date and the rules governing off-cycle enrollments.

**11. \* Does COBRA Auto Cancel apply? ☐ Yes ☒ No**

*Member's COBRA/Continuation of coverage will be automatically cancelled at the end of the member's eligibility period.*

*\*Not recommended for accounts with automated eligibility*

## CURRENT EMPLOYEE ELIGIBILITY INFORMATION

Current number of eligible subscribers at onboarding and/or annual renewal 4750.

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Lines of Business (Check all applicable services)	<input type="checkbox"/> NO CHANGES <input checked="" type="checkbox"/> See Additional Provisions
<p><b><u>Medical Plan Services:</u></b></p> <p><input type="checkbox"/> Blue Choice PPO</p> <p><input type="checkbox"/> BlueOptions</p> <p><input checked="" type="checkbox"/> Blue Preferred</p> <p><input type="checkbox"/> NativeBlue</p> <p><input type="checkbox"/> Blue High Performance Network<sup>SM</sup> (BlueHPN<sup>SM</sup>)</p> <p><input type="checkbox"/> Blue Advantage PPO<sup>SM</sup></p> <p><input type="checkbox"/> <b>Out of Area</b> (Traditional)</p> <p><b><u>Additional Services:</u></b></p> <p><input checked="" type="checkbox"/> Wellbeing Management</p> <p><input type="checkbox"/> Wellness Incentives</p> <p><input type="checkbox"/> Health Advocacy Solutions</p> <p><input type="checkbox"/> Mercer Health Advantage</p> <p><input type="checkbox"/> Custom Care Management Unit</p> <p><input type="checkbox"/> Blue Directions<sup>SM</sup> (Private Exchange) <i>(If selected, the Blue Directions Addendum is attached and made a part of the parties' Administrative Services Agreement.)</i></p> <p><input type="checkbox"/> Limited Fiduciary Services for Claims and Appeals</p> <p><input type="checkbox"/> Other Select Product</p> <p><input type="checkbox"/> Other Select Product</p> <p><input type="checkbox"/> Other Select Product</p> <p><input type="checkbox"/> Other Select Product</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Other</p>	<p><b><u>Consumer Driven Health Plan:</u></b></p> <p><input type="checkbox"/> Blue Edge<sup>SM</sup> (HCA) <i>(If selected, complete separate HCA BPA)</i></p> <p><input type="checkbox"/> HSA (Preferred Vendor: Select Vendor)* If HealthEquity, Inc. is selected, BCBSOK to send HSA enrollment to HealthEquity, Inc</p> <p style="margin-left: 20px;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Non-Preferred Vendor:</p> <p><input type="checkbox"/> FSA (Preferred Vendor: Select Vendor)*</p> <p>Non-Preferred Vendor:</p> <p><input type="checkbox"/> HRA (Preferred Vendor: Select Vendor)*</p> <p>Non-Preferred Vendor:</p> <p><b><u>Prescription Drugs:</u></b> <i>(If selected, the PBM Fee Schedule Addendum must be attached and is part of this BPA)</i></p> <p>Pharmacy Network (Select one):</p> <p><input type="checkbox"/> Traditional Select Network</p> <p><input checked="" type="checkbox"/> Advantage Network</p> <p><input type="checkbox"/> Preferred Network</p> <p><input type="checkbox"/> Elite Network</p> <p><input type="checkbox"/> Network on PBM Fee Schedule Addendum</p> <p>Drug List: Select Drug List</p> <p>Other (please specify):</p> <p style="margin-top: 20px;">PPO/HSA Preventive Drug List:</p> <p>Please specify: Select Option</p> <p>Other RX programs: Select Program</p> <p><b><u>Ancillary Services:</u></b></p> <p><input checked="" type="checkbox"/> Dental Plan Services</p> <p><input type="checkbox"/> Vision Insurance <i>(if selected, complete a separate application)</i></p> <p><input checked="" type="checkbox"/> Stop Loss Coverage <i>(if selected, complete separate Exhibit to the Stop Loss Coverage Policy)</i></p> <p><input checked="" type="checkbox"/> Life, Disability, Critical Illness, Accident or Hospital Indemnity Insurance <i>(if selected, complete a separate application for those coverages)</i></p> <p><input type="checkbox"/> COBRA Administrative Services <i>(if selected, complete separate COBRA Administrative Services Addendum)</i></p>

\*A HSA must be paired with a qualified high deductible health plan (HDHP) and follow strict requirements set forth by the Internal Revenue Service (IRS). Employer Groups should seek advice from their independent tax advisor, legal counsel, or other professional counselor, to ensure their proposed benefit strategy with respect to HSAs, FSAs, HRAs, or other benefit arrangements does not conflict with current IRS requirements.

Mercer Health Advantage is offered by Mercer, an independent company, and is administered by Blue Cross and Blue Shield of Oklahoma.

Custom Care Management Unit is offered by Willis Towers Watson, an independent company, and is administered by Blue Cross and Blue Shield of Oklahoma.

Medical and Dental benefits and services are administered by Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Life, Disability, Critical Illness, Accident, Hospital Indemnity and Vision products are issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Oklahoma is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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**FEE SCHEDULE**

Employer shall pay amounts Claim Administrator bills Employer for benefit claims Claim Administrator processes on Employer's behalf as well as administrative fees as set forth in this Fee Schedule.

<b>Payment Specifications</b>		<input checked="" type="checkbox"/> NO CHANGES <input type="checkbox"/> SEE ADDITIONAL PROVISIONS			
<b>Employer Payment Method:</b> <input type="checkbox"/> Online Bill Pay <input checked="" type="checkbox"/> Electronic <input type="checkbox"/> Auto Debit <input type="checkbox"/> Check					
<b>Employer Payment Period:</b> <input checked="" type="checkbox"/> Weekly (cannot be selected if Check is selected as payment method above) <input type="checkbox"/> Semi Monthly (cannot be selected if Check is selected as payment method above) <input type="checkbox"/> Monthly					
<b>Claim Settlement Period:</b> <input checked="" type="checkbox"/> Weekly <input type="checkbox"/> Monthly					
<b>Run-Off Period:</b> Employer payments are to be made for <u>12</u> months following end of Fee Schedule Period. <i>Standard is twelve (12) months.</i>					
<b>Fee Schedule Period:</b> To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: _____ months.					
<b>Administrative Per Employee per Month (PEPM) Charges</b>		<input checked="" type="checkbox"/> NO CHANGES <input type="checkbox"/> SEE ADDITIONAL PROVISIONS			
	2024	2025	2026	2027	
Administrative Fee	\$50.45	\$51.46	\$52.49	\$53.84	
Dental	\$	\$	\$	\$	
Claims Fiduciary	\$	\$	\$	\$	
Advanced Payment Review	25% \$included in the admin fee	% \$	% \$	% \$	
*Medical Drug Rebate Credit	\$(2.50)	\$(TBD)	\$(TBD)	\$(TBD)	
*Rebate Credit for the Prescription Drug Program	\$(219.77)	\$(244.76)	\$(264.55)	\$(TBD)	
Telehealth (Virtual Visits)	\$0.52	\$	\$	\$	
Wellbeing Management	\$4.95	\$	\$	\$	
Health Advocacy Solutions	\$	\$	\$	\$	
Commissions: _____	\$	\$	\$	\$	
Commissions: _____	\$	\$	\$	\$	
Commissions: _____	\$	\$	\$	\$	
Other: Select Service Category List Service: _____	\$	\$	\$	\$	
Other: Select Service Category List Service: _____	\$	\$	\$	\$	
Other: Select Service Category List Service: _____	\$	\$	\$	\$	
Miscellaneous: _____	\$	\$	\$	\$	
Miscellaneous: _____	\$	\$	\$	\$	

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<b>Total</b>	<b>\$(166.35)</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>
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\*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no right to, or legal interest in, any portion of the rebates, either under the pharmacy benefit or the medical benefit, actually provided by the Pharmacy Benefit Manager ("PBM") or a pharmaceutical manufacturer to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator by the PBM or expected to be provided. Rebate Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any Rebate Credit provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

<b>Administrative Line Item Charges</b>	<b>Frequency</b>	<b>Amount</b>
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	_____ %
<b>Total:</b>		<b>\$ _____</b>

<b>Other Service and/or Program Fee(s)</b> <input checked="" type="checkbox"/> <b>NO CHANGES</b> <input type="checkbox"/> <b>SEE ADDITIONAL PROVISIONS</b>
<b>NSA Fees</b> In connection with the claims, items, and services that are subject to the No Surprises Act ("NSA") and disputed by a Provider, Employer agrees to pay Claim Administrator the following fees: <ul style="list-style-type: none"> <li>Fifty dollars (\$50) for each claim that is the subject of informal negotiation with a Provider (this fee will be charged in the event the Provider, in its sole discretion, determines that it will not accept the initial payment amount); and</li> <li>An additional seventy-five dollars (\$75) per claim for each independent dispute resolution process ("IDR") where Claim Administrator represents Plan (this fee will be charged in the event the Provider, in its sole discretion, determines that it will initiate IDR after the informal negotiation period); and</li> </ul> All costs imposed by the IDR entity or any state, federal or local government entity in connection with an IDR.
<b>Not applicable to Grandfathered Plans</b> <b>External Review Coordination:</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes</b> , coordination fee: \$700 for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer's Plan. Employer elects for external reviews to be performed under the Affordable Care Act external review process.

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**If no**, provide name and address of administrator(s) of external review coordination and indicate if administering medical claims and/or pharmacy claims:

**Administrator:** Medical claims: ☐ Pharmacy claims: ☐ Name: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

**Administrator:** Medical claims: ☐ Pharmacy claims: ☐ Name: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

**Advanced Payment Review (APR):** ☒ Yes ☐ No

APR is a suite of payment integrity offerings. Refer to the Matrix. If Employer elects APR, indicate APR Savings Program or PEPM below:

☒ APR Savings Program

☐ PEPM

**For APR capabilities other than Reimbursement Services:** If Employer elects APR Savings Program, Claim Administrator will invoice the percentage indicated in the Fee Schedule of any savings amounts identified by Claim Administrator or third-party vendor.

**Reimbursement Services:** ☒ Yes ☐ No If yes, Claim Administrator will retain twenty-five percent (25%) of any recovered amounts made on third-party liability claims other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

**Third-Party Law Firms Provisions (other than Reimbursement Services):**

Employer will pay no more than 35% of any recovered amount made by Claim Administrator's third-party law firm or up to 35% of any recovered amount will be deducted from the amount distributed according to established allocation processes.

**FlexAccess™:** ☐ Yes ☒ No

As part of its plan design, Employer has directed Claim Administrator to administer claims, copay and coinsurance requirements for Covered Persons enrolled in the FlexAccess program, including (i) adjusting Covered Persons' copayment amounts to the amount of the manufacturer copay assistance, (ii) applying such manufacturer assistance to reduce Covered Persons' out of pocket costs, and (3) not applying the manufacturer assistance to Covered Persons' deductibles and out of pocket maximum accumulators. Employer agrees that FlexAccess is a plan design decision of Employer and is consistent with Employer's plan design and supported by plan documents. Employer further agrees it is solely responsible for, and will, to the extent permitted by law, hold Claim Administrator harmless for, the legal and regulatory compliance of the Plan and its plan design.

Claim Administrator will assess a program fee equal to 20% of the total shared savings. Total shared savings is calculated as follows:

The difference between Employer responsibility without the FlexAccess Program and Employer responsibility with the FlexAccess Program. The Employer responsibility with the FlexAccess Program is the cost of the drug minus: (1) the manufacturer copay assistance dollars that are allocated to the cost of the drug and (2) the member's cost share for the member enrolled in the program. The Employer responsibility without the FlexAccess Program is the cost of the drug minus the member cost share if the member was not enrolled in the program.

**FLEXACCESS™ QUALIFIED HDHP:** ☐ Yes ☒ No

Claim Administrator will assess a fee equal to 20% of program savings for administrative fees. Program savings (shared savings) will be calculated based on the manufacturer copay assistance dollars that are allocated to the cost of the drug minus the member's estimated cost share (copay or coinsurance) that would have been paid if they were not enrolled in the program.

The difference between Employer Responsibility for claims utilizing FlexAccess Qualified HDHP and not utilizing FlexAccess Qualified HDHP includes as follows:

**WITH FLEXACCESS QUALIFIED HDHP:** Cost of drug – amount manufacturer copay assistance used – Member out-of-pocket cost (if any) up to Deductible... Copay assistance reversed from deductible. Plan pays no portion.

**WITHOUT FLEXACCESS QUALIFIED HDHP:** Cost of drug – member out-of-pocket cost - Non-FlexAccess Qualified HDHP coupon... Copay assistance applied to Deductible. Plan may pay portion of claim after deductible met

**Proprietary and Confidential Information of Claim Administrator.** Claim Administrator acknowledges that Employer is a municipality subject to the Oklahoma Open Records Act (the "Act").

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator or as required by applicable provisions of the Act, with notice to Claim Administrator prior to disclosure.

**Alternative Compensation Arrangements:** Employer acknowledges and agrees that Claim Administrator has Alternative Compensation Arrangements with contracted Providers, including but not limited to Accountable Care Organizations and other Value Based Programs. Further information concerning Employer's payment for Covered Services under such Arrangements is described in the Administrative Services Agreement between the Claim Administrator and the Employer.

**Virtual Visits Program:** ☒ Yes ☐ No **If yes,** Covered Persons would be able to obtain certain Covered Services remotely via interactive video and/or interactive audio/video (where available) capability from Virtual Visits powered by MDLIVE.

MDLIVE® is a separate company that operates and administers Virtual Visits for persons with coverage through Blue Cross and Blue Shield of Oklahoma. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

### Termination Administrative Charge

The Termination Administrative Charge applicable to the Run-Off Period shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category (*per Covered Employee per individual or family composite*) during the three (3) months immediately preceding the date of termination by the appropriate factors shown below. In the event of a partial termination, the Termination Administrative Charge shall be the sum of the amount obtained by multiplying three (3) times the total number of terminated Covered Employees by the appropriate factors shown below.

Service				
Medical Run-off Administration Charge	\$	\$	\$	\$
Dental Run-off Administration Charge	\$	\$	\$	\$
Miscellaneous	\$	\$	\$	\$
Miscellaneous	\$	\$	\$	\$
<b>Total:</b>	\$	\$	\$	\$

### Other Provisions

☐ NO CHANGES ☒ SEE ADDITIONAL PROVISIONS

#### 1. Summary of Benefits & Coverage:

a. Will Claim Administrator create Summary of Benefits and Coverage (SBC)?

☒ Yes. (Please answer question b. The SBC Addendum is attached.)

☐ No. (If No, then skip question b and refer to the Administrative Services Agreement for further information.)

b. Will Claim Administrator distribute the (SBC) to Covered Persons?

☒ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Administrative Services Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to Covered Persons (or hire a third party to distribute) as required by law.

☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Administrative Services Agreement) and distribute SBC plan to participants and beneficiaries via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is one dollar and fifty cents (\$1.50) per package.

#### 2. Massachusetts Health Care Reform Act:

Does the Employer direct Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act? ☒ Yes ☐ No

**Proprietary and Confidential Information of Claim Administrator.** Claim Administrator acknowledges that Employer is a municipality subject to the Oklahoma Open Records Act (the "Act").

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator or as required by applicable provisions of the Act, with notice to Claim Administrator prior to disclosure.

**If no:** The Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue if required by the Massachusetts Health Care Reform Act.

**3. Alternative Care Management Program** (applicable to the purchased medical management program):

☐ Yes ☒ No

*The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, including but not limited to Behavioral Health, and other health care management programs.*

**4. Prior Authorization** (applicable to the purchased medical management program): Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which Prior Authorization (also called pre-notification or preauthorization) is required.

**5. Essential Health Benefits ("EHB") Election:**

**Employer elects EHBs based on the following:**

1. ☒ EHBs based on a Claim Administrator state benchmark:  
☐ Illinois ☐ Montana ☐ New Mexico ☒ Oklahoma ☐ Texas
2. ☐ EHBs based on benchmark of a state other than IL, MT, NM, OK and TX  
 If so, indicate the state's benchmark that Employer elects: \_\_\_\_
3. ☐ Other EHB, as determined by Employer

In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the Oklahoma benchmark plan.

**6. This ASO BPA is binding on both parties and is incorporated into and made a part of the Administrative Services Agreement between the parties with both such documents to be referred to collectively as the "Administrative Services Agreement" unless specified otherwise.**

**7. Producer/Consultant Compensation:**

The Employer acknowledges that if its POR acts on its behalf for purposes of purchasing services in connection with the Employer's Plan under the Administrative Services Agreement to which this ASO BPA is attached, the Claim Administrator may pay the Employer's POR a commission and/or other compensation in connection with such services under the Administrative Services Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid to the POR by the Claim Administrator in connection with services under the Administrative Services Agreement, the Employer should contact its POR.

**8. Independent Dispute Resolution Process:**

Employer authorizes and directs Claim Administrator to offer an amount not to exceed the greater of the Qualifying Payment Amount (QPA) or the amount allowed on the initial notice of payment or denial of a claim on behalf of the Employer during negotiations under the federal IDR process.

**Additional Provisions:** Renewing ASO account to administer Self - Funded Indemnity and EPO plans. These plans do not include any Medicare Advantage plans. OCMFA and OCEPBT will be an additional funding source of the ASO. Prime Therapeutics is a partially owned subsidiary providing Pharmacy Benefit Manager (PBM) administration.

Credits

• Employer will be provided \$1,200,000 in a Transition Credit for 2024 on their 1/1/24 ASO Invoice. This will NOT require any receipts but will be a credit that appears on the invoice at the end of February. The City will determine how they will use the funds.

• If Employer terminates during the period of 01/01/2024 - 12/31/2024, that Transition Credit will be due 100% of the credit (\$1,200,000) to BCBSOK within 30 days of the effective date of cancellation.

• If Employer terminates during the period of 01/01/2025 - 12/31/2025, that Transition Credit will be due 75% of the credit (\$900,000) to BCBSOK within 30 days of the effective date of cancellation.

• If Employer terminates during the period of 01/01/2026 - 12/31/2026, that Transition Credit will be due 50% of the credit (\$600,000) to BCBSOK within 30 days of the effective date of cancellation.

• All credits will be paid directly to the group only through the BCBSOK billing system

**Proprietary and Confidential Information of Claim Administrator.** Claim Administrator acknowledges that Employer is a municipality subject to the Oklahoma Open Records Act (the "Act").

**Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator or as required by applicable provisions of the Act, with notice to Claim Administrator prior to disclosure.**

**Proprietary and Confidential Information of Claim Administrator. Claim Administrator acknowledges that Employer is a municipality subject to the Oklahoma Open Records Act (the "Act").**

**Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator or as required by applicable provisions of the Act, with notice to Claim Administrator prior to disclosure.**



**Signature**

Cassie Cramer



Sales Representative

405/093

Ph 405-316-7133 and Fax 405-549-3331

District

Phone & FAX Numbers

Morgan Young

Producer Representative

Lockton Companies, LLC.

Producer Firm

6900 Dallas Parkway, Suite 450

Plano, TX 75024

Producer Address

972-204-9654

Producer Phone & FAX Numbers

Morgan.Young@lockton.com

Producer Email Address

002709000

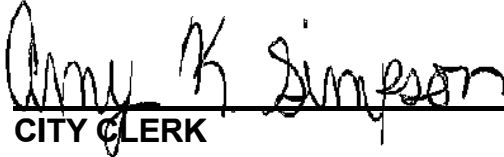
Tax I.D. No.

**Proprietary and Confidential Information of Claim Administrator. Claim Administrator acknowledges that Employer is a municipality subject to the Oklahoma Open Records Act (the "Act").**

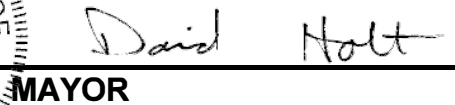
**Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator or as required by applicable provisions of the Act, with notice to Claim Administrator prior to disclosure.**

**ADOPTED** by the Council and **SIGNED** by the Mayor of The City of Oklahoma City this  
30TH day of JANUARY, 2024.

**ATTEST: (Seal)**

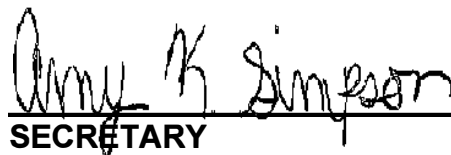
  
CITY CLERK



  
MAYOR

**ADOPTED** by the Trustees and **SIGNED** by the Chairman of the Oklahoma Municipal Facilities Authority this 30TH day of JANUARY, 2024.

**ATTEST: (Seal)**

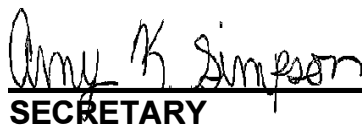
  
SECRETARY



  
CHAIRMAN

**RATIFIED** by the Trustees and **SIGNED** by the Chairman of the Oklahoma City Post-Employment Benefits Trust this 12TH day of FEBRUARY, 2024.

**ATTEST: (Seal)**

  
SECRETARY



  
CHAIRMAN

**REVIEWED** for form and legality

  
Assistant Municipal Counselor

Proprietary and Confidential Information of Claim Administrator. Claim Administrator acknowledges that Employer is a municipality subject to the Oklahoma Open Records Act (the "Act").

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator or as required by applicable provisions of the Act, with notice to Claim Administrator prior to disclosure.

**PROXY**

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members is scheduled to be held each year in the HCSC corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less than thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until either revoked in writing by the undersigned at least twenty (20) days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

From time to time, HCSC pays indemnification or advances expenses to its directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

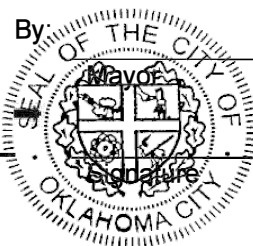
☐ Intentionally left blank by the Employer

Group No.: 019574,  
293447

By: DAVID HOLT

ATTEST: (Seal)

Amy K Simpson  
City Clerk



David Holt

Group Name: City of Oklahoma City

Address: 420 W. Main Street, Suite 110

City: Oklahoma City State: OK ZIP: 73102-4435

Dated this 30TH day of JANUARY, 2024  
Month Year

**REVIEWED** for form and legality

Richard E. Mahoney  
Assistant Municipal Counselor

**Proprietary and Confidential Information of Claim Administrator.** Claim Administrator acknowledges that Employer is a municipality subject to the Oklahoma Open Records Act (the "Act").

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**BlueCross BlueShield  
of Oklahoma**

## APPLICATION AND POLICY SCHEDULE FOR STOP LOSS COVERAGE

**Employer Group Name:** City of Oklahoma City by and through the Oklahoma City Municipal Facilities Authority (OCMFA)  
**Employer Group Address:** 420 West Main Street, Suite 110  
**City:** Oklahoma City **State of Situs:** OK **Zip Code:** 73102-4435  
**Account Number:** 019574  
**Employer Group Number(s):** 019574, 293447  
**Original Effective Date of Stop Loss Policy:** 01/01/2013  
**Current Policy Effective Date:** 01/01/2024  
**Current Policy Period** The specifications set forth in this Application are for the Policy Period commencing on January 1, 2024 and ending on December 31, 2024.

The specifications below shall become effective on the first date of the Policy Period specified above and shall continue in full force and effect until the earliest of the following dates: (1) The last day of the Policy Period; (2) The date the Policy terminates; or (3) The date this Application is superseded in whole or in part by a later executed Application.

**A. Covered Employees:**

Number of Single Coverage Units: 4,750 subscribers  
 Number of Family Coverage Units: 10,488 total members

**B. Individual Stop Loss Coverage:**

1. New Coverage ☐ Renewal of Existing Coverage ☒

2. Stop Loss coverage during the Current Policy Period

☒ **Paid**

Coverage for Claims incurred from \_\_\_\_\_ to \_\_\_\_\_ and Claims paid from \_\_\_\_\_ to \_\_\_\_\_.

For new coverage only, if a run-in contract as explained in the Stop Loss Policy e.g. (24/12, 18/12, or 15/12 coverage period) is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

☒ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

3. Covered Expenses includes:

- ☒ Medical Claims:
- ☒ Prescription Drug Claims with: Prime (Preferred PBM) \_\_\_\_\_
- ☐ For **Hospital Employer Groups only**: Excludes \_\_\_\_\_ % of Home Hospital Medical claims
- ☐ Other (for example Dental/Vision): \_\_\_\_\_.

**4. Individual Stop Loss Provisions**

- a. Individual Stop Loss Deductible: \$300,000  
Applies per Covered Person for the Employer Group's Current Policy Period.
- b. Aggregating Specific Deductible (if applicable): \$\_\_\_\_\_
- c. Lasered Individuals with Individual Stop Loss Deductible (if applicable):  
Individual identifier, alternate Individual Stop Loss Deductible:  
\_\_\_\_\_
- d. Lasered Individuals excluded from Stop Loss Coverage (if applicable):  
Individual identifier:  
\_\_\_\_\_
- e. If a run-in contract (24/12, 18/12, or 15/12 coverage period) is purchased, per Item 2. above, run-in claims are covered with a maximum liability of: \$\_\_\_\_\_ per Covered Person.

**5. Terminal Liability Option (TLO) (does not apply to Employer Groups with 12/15, 12/18, or 12/24 contracts):**

☐ Yes ☒ No

The following applies if the answer to item above is "Yes" (Terminal Liability Option):

Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months of the Current Policy Period multiplied by three times pre-termination Individual Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill. Claims will accumulate and be combined under one Individual Stop Loss Deductible specified in item B.4.a above for the Current Policy Period and Terminal Period. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

**6. Individual Stop Loss Premium**

Monthly Individual Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:

\$70.40 Composite; or  
\$\_\_\_\_\_ for each Single Coverage Unit  
\$\_\_\_\_\_ for each Family Coverage Unit

**C. Aggregate Stop Loss Coverage:** Yes ☒ No ☐  
If yes, complete Items 1. through 5. Below:

1. New Coverage ☒ Renewal of Existing Coverage ☐

2. Stop Loss Coverage during the current Policy Period

☒ 12/12

Coverage for Claims incurred from \_\_\_\_\_ to \_\_\_\_\_ and Claims paid from \_\_\_\_\_ to \_\_\_\_\_.

For new coverage only, if a run-in contract as explained in the policy e.g. (24/12, 18/12, or 15/12 coverage period) is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

☐ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

**3. Covered Expenses:**

- ☒ Medical Claims  
     ☐ Claim Administrator's Provider Access Fees  
☒ Prescription Drug Claims with: Prime (Preferred PBM) \_\_\_\_\_  
☐ For **Hospital Employer Groups only**: Excludes \_\_\_\_\_% of Home Hospital Medical claims  
☐ Other (for example Dental/Vision): \_\_\_\_\_

**4. Aggregate Claim Liability**

- a. Attachment Factor 120% of the Average Claim Value  
 b. Aggregate Claim Factors:

Group Number:	_____	_____	_____	_____
Composite; or	\$ _____	\$ _____	\$ _____	\$ _____
For each Single Coverage Unit	\$ _____	\$ _____	\$ _____	\$ _____
For each Family Coverage Unit	\$ _____	\$ _____	\$ _____	\$ _____

- c. Minimum Aggregate Point of Attachment: \$103,941,112

**5. Terminal Liability Option (TLO) (does not apply to Employer Groups with 12/15, 12/18, or 12/24 contracts):**  
☐ Yes ☒ No

The following applies if the answer to item above is "Yes" (Terminal Liability Option):

Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months multiplied by three times pre-termination Aggregate Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill.

The Final Settlement Point of Attachment shall equal the sum of the Employer's Aggregate Claim Liability amount for the Policy Period plus 15% of the Aggregate Claim Factor multiplied by 12, and then multiplied by the average enrollment for the last two (2) months of the Current Policy Period immediately preceding termination. Furthermore, for the Final Settlement Period, the Minimum Aggregate Point of Attachment shall be the Minimum Aggregate Point of Attachment in item C.4.c. above increased by 15%. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

**6. Aggregate Stop Loss Premium:**

- ☒ Monthly Premium  
 Monthly Aggregate Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:  
     \$0.68 Composite; or  
     \$ \_\_\_\_\_ for each Single Coverage Unit  
     \$ \_\_\_\_\_ for each Family Coverage Unit

- ☐ Annual Premium (Due on the first day of the Current Policy Period): \$ \_\_\_\_\_

**D. Additional Provisions (if elected):**

1. Retirees Covered (select if included):  
 Pre-65: ☒ or Post-65: ☐
2. Home Hospital Employer Groups Only: Home Hospital Provider Number(s) subject to exclusion percentage per Item B.3. & C.3.: \_\_\_\_\_
3. Monthly Aggregate Accommodation: ☐ Yes ☒ No

Additional information: Pre-65 Dependents of Post -65 Retirees are covered under stoploss.

**Fraud Notice:** Any person who knowingly, with intent to injure, defraud or deceive any insurance company submits an application containing any false, incomplete, or misleading information, may be subject to prosecution and may be found guilty of a felony under state law and subject to punishment, including fines and/or imprisonment. Submission of false information in connection with this application may also constitute a crime under federal laws. All appropriate legal remedies will be pursued in the event of insurance fraud, including prosecution under Federal Mail or Wire Fraud statutes, and/ or the Federal Racketeer Influenced and Corrupt Organizations Act. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

The undersigned person represents that he/she is authorized and responsible for purchasing Stop Loss Coverage on behalf of the Employer Group. It is understood that the actual terms and conditions of coverage are those contained in this Application and the Stop Loss Coverage Policy into which this Application shall be incorporated at the time of acceptance by Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"). Upon acceptance, HCSC shall issue a Stop Loss Coverage Policy to the Employer Group. Upon acceptance of this Application and issuance of the Stop Loss Coverage Policy, the Employer Group shall be referred to as the "Policyholder".

DocuSigned by:

CASSIE CRAMER

Cassie Cramer

C2C0B596A291409

Sales Representative

**ADOPTED by the Council and SIGNED by the Mayor of The City of Oklahoma City this**  
**30TH day of JANUARY, 2024**

**ATTEST: (Seal)**

*Amy K Simpson*  
CITY CLERK



**THE CITY OF OKLAHOMA CITY**

*David Holt*  
MAYOR

**ADOPTED by the Trustees and SIGNED by the Chairman of the Oklahoma Municipal Facilities Authority this**  
**30TH day of JANUARY, 2024.**

**ATTEST: (Seal)**

*Amy K Simpson*  
SECRETARY



**OKLAHOMA CITY MUNICIPAL FACILITIES AUTHORITY**

**SEAL**

**CHAIRMAN**

*David Holt*

**RATIFIED by the Trustees and SIGNED by the Chairman of the Oklahoma City Post-Employment Benefits Trust this**  
**12TH day of FEBRUARY 2024.**

**ATTEST: (Seal)**

*Amy K Simpson*  
SECRETARY



**OKLAHOMA CITY POST-EMPLOYMENT BENEFITS TRUST**

**CHAIRMAN**

*Ben B.*

**REVIEWED for form and legality**

*Richard E. Mahoney*  
Assistant Municipal Counselor





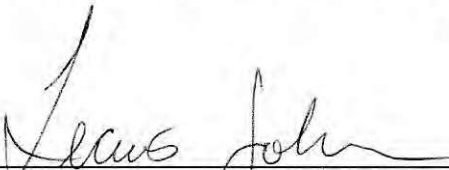
**BlueCross BlueShield**  
of Oklahoma

1400 South Boston  
PO Box 3283  
Tulsa, Oklahoma 74102-3283

December 19, 2023

Dear Amy K, Simpson, City Clerk of City of Oklahoma City,

This letter is to serve as verification that Cassie Cramer, Strategic Account Executive is authorized to sign contracts among The City, the OCMFA, OCPEBT and BCBS and her signature will bind BCBS to the agreements in said contracts.

  
\_\_\_\_\_  
Travis Johnson  
Vice President Sales and Account Management

12/19/23  
\_\_\_\_\_  
Date

State of Oklahoma }

County of Tulsa }

The foregoing instrument was acknowledged before me on Dec. 19, 2023 [Date] by  
TRAVIS JOHNSON [Name(s) of Person(s)].



  
\_\_\_\_\_  
Notary Signature

My Commission Expires: June 22, 2025



# NON-COLLUSION AFFIDAVIT

The undersigned, of lawful age, being duly sworn, upon oath, deposes and says: That the undersigned has the lawful authority to execute the within and foregoing proposal/bid for, and on behalf of, the Proposer/Bidder; that the Proposer/Bidder has not, directly or indirectly, entered into any agreement, express or implied, with any Proposer/Bidder, having for its object the controlling of the price or amount of such proposal/bid, the limiting of the proposals/bids or the Proposers/Bidders, the parceling or farming out to any Proposer/Bidder or other persons, of any part of the Agreement or any part of the subject matter of the proposal/bid, or of the profits thereof, and that Proposer/Bidder has not and will not divulge the sealed proposal/bid to any person whomsoever, except those having a partnership or other financial interest with the Proposer/Bidder in the said proposal/bid, until after the said sealed proposals/bids are opened.

The undersigned further states that the Proposer/Bidder has not been a party to any collusion: among Proposer/Bidders in restraint of freedom of competition, by any agreement to bid at a fixed price or to refrain from proposing; or with any City/Trust official, City/Trust employee or City/Trust agent as to the quantity, quality, or price in the prospective Agreement, or any other terms of the said prospective Agreement; or in any discussions between the Proposers/Bidders or City/Trust official, City/Trust employee or City/Trust agent concerning the exchange of money or other thing of value for special consideration in the letting of Agreement. The Proposer/Bidder states that it has not paid, given or donated or agreed to pay, give or donate to any City/Trust official, officer or employee of the City or awarding agency, any money or other thing of value, either directly or indirectly, in the procuring of the award of Agreement pursuant to this Proposal/Bid.

Witness the hands of the parties hereto:

The undersigned states that the Proposer/Bidder will be bound by its proposal/bid, the specification, the terms and conditions of the Agreement, and the Requirements for Proposer/Bidders.

→ THIS FORM TO BE COMPLETED BY THE PROPOSER/BIDDER PRIOR TO AGREEMENT APPROVAL ←

Cassie Cramer Strategic Acct Exec  
Type Name of Authorized Agent/Representative Title

Cassie Cramer  
Signature

Blue Cross Blue Shield of Oklahoma  
Company Name

3817 NW Expressway, Ste. 300, Oklahoma City, OK 73112  
Address Zip Code

405-316-7133  
Telephone Number and Fax Number, if any

## TO BE COMPLETED BY THE NOTARY:

State of \* Oklahoma

County of \* Canadian

[\*State and County where notarized must be written in for bid/proposal to be considered.]

Signed and sworn to before me on this 7<sup>th</sup> day of December, 2023 by Cassie Cramer  
[Day] [Month] [Year] [Print the name of the agent/representative who signed above.]

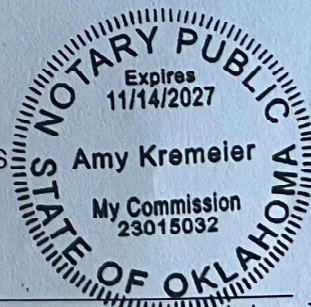
My Commission Number: 23015032  
[Oklahoma]

My Commission Expires: 11/14/2027  
[Date/Year]

Amy Kremeier  
Type Name of Notary Public

[Signature]  
Signature of Notary Public

[49 Okla. Stat. 2011 §119]





## NON-DISCRIMINATION STATEMENT

The Proposer agrees, in connection with the performance of work under this Agreement/Contract:

a. That the Proposer will not discriminate against any employee or applicant for employment, because of race, creed, color, sex, age, national origin, ancestry or disability. The Proposer shall take affirmative action to insure that employees are treated without regard to their race, creed, color, age, national origin, sex, ancestry or disability. Such actions shall include, but not be limited to, the following: employment, promotion, demotion or transfer, recruitment, advertising, lay-off, termination, rates of pay or other forms of compensation and selection for training, including apprenticeship. The Proposer agrees to post, in a conspicuous place available to employees and applicants for employment, notices to be provided by the City Clerk/Secretary of the Contracting Entity setting forth the provisions of this section, and;

b. That the Proposer agrees to include this non-discrimination clause in any subcontracts connected with the performance of this Agreement/Contract.

c. In the event of the Proposer's non-compliance with the above non-discrimination clause, this Agreement/Contract may be canceled or terminated by the Contracting Entity. The Proposer may be declared by the Contracting Entity ineligible for further Agreement[s]/Contract[s] with the Contracting Entity until satisfactory proof of intent to comply is made by the Proposer.

### THIS FORM MUST BE COMPLETED BY THE PROPOSER PRIOR TO AGREEMENT/CONTRACT AWARD

Sign Here x  
Signature of Individual

*Cassie Cramer*

*Strategic Acct Exec*  
Title

*Cassie Cramer*

Printed Name of Individual

*BCBS OK , 3817 NW Expressway, ste. 300, Oklahoma City, ok*  
Company Name and Address

Zip Code *73112*

*405-316-7133*

Telephone Number and Fax Number if any