BlueCross BlueShield of Oklahoma

BlueLincs
Blue Cross and Blue Shield of Oklahoma

1400 South Boston, Tulsa, OK 74119

Renewal Addendum to Benefit Program Application ("Renewal Addendum")
Applicable to 151+ Fully Insured Group Accounts

Blue Cross and Blue Shield of Oklahoma (herein called "BCBSOK")

BlueLincs HMO (herein called "BlueLincs")

THIS RENEWAL ADDENDUM is incorporated into and made a part of the Benefit Program Application ("BPA") last entered into between the parties as of this Renewal Addendum's Effective Date and the corresponding Group Administration Document, currently in effect between the parties. This Renewal Addendum is intended to renew the foregoing as of the Effective Date of Coverage noted below and, except as modified and amended and/or re-attested herein pursuant to this renewal, the provisions, conditions, and terms of such BPA and Group Administration Document shall remain in full force and effect.

Employer's Legal Name: City of Oklahoma City by and through the Oklahoma City Municipal Facilities Authority (OCMFA)
Employer Account Number (6-digits): 019574 Group Number(s): K19574
Section Number(s): all
Renewal Addendum Effective Date of Coverage: 01/01/2025
Primary Mailing Address: Number, Street, City, State, Zip 420 W. Main Street, Suite 110, Oklahoma City, OK 73102-4435
Physical Address (required if different from primary): Number, Street, City, State, Zip _____
Billing Address (if different from primary – If more than one, please list within Additional provisions): Number, Street, City, State, Zip _____
Name and Title of Authorized Company Official: Jason Long, Total Rewards Manager Email and Phone Number 405-297-3372
Billing to the attention of: Jason Long Fax Number: 405-297-2565
The Blue Access for Employers℠ ("BAE℠") contact person is the Employee authorized by the Employer to access and maintains its account/Employee information via BAE. An email address is required to access and maintain BAE. Name and title of BAE contact person: Jason Long, Total Rewards Manager Telephone Number of BAE contact person: 405-297-3372 E-Mail address of BAE contact person: jason.long@okc.gov
Subsidiary / Affiliated Companies to be covered (If more than one, please list within Additional provisions): Name and Address Number, Street, City, State, Zip _____

The **Employee Retirement Income Security Act of 1974 (ERISA)** is a federal law that sets minimum standards for employee benefit plans in the private industry. In general, **all** employer groups, insured or ASO, are subject to ERISA provisions except for governmental entities, such as municipalities, and public school districts, and "church plans" as defined by the Internal Revenue Code.

ERISA Regulated Group Health* Plan ☐ Yes ☒ No

If Yes, is your ERISA Plan Year* a period of twelve (12) months beginning on the Anniversary Date specified above? ☐ Yes ☐ No

If No, please specify your ERISA Plan Year (mm/dd/yyyy): Beginning Date: ____/____/____ End Date: ____/____/____

ERISA Plan Administrator *: _____

Plan Administrator's Address: _____

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

☐ Federal Governmental plan e.g., the government of the United States or agency of the United States)
☒ Non-Federal Governmental plan (e.g., the government of the State, an agency of the state, or the government of a political subdivision, such as a county or agency of the State)
☐ Church plan
☐ Other; please specify: _____

Is your Non-ERISA Plan Year a period of twelve (12) months beginning on the Anniversary Date specified above? ☒ Yes ☐ No

If No, please specify your Non-ERISA Plan Year (mm/dd/yyyy): Beginning Date: __/__/____ End Date: __/__/____

For more information regarding ERISA, contact your Legal Advisor.
*All as defined by ERISA and/or other applicable law/regulations.

Are you applying for Insure Oklahoma? ☐ Yes ☒ No
If Yes, effective date must be the first (1st) of the month to receive subsidies.

Blue Directions℠ Purchased: ☐ Yes ☒ No
(if Yes, the Blue Directions Addendum is attached and made a part of the Group Contract.)

ELIGIBILITY INFORMATION

1. **Eligible Person (please check all boxes that apply)**:
- ☒ A full-time Employee of the Employer.
- ☐ A part-time Employee of the Employer.
- ☐ An Eligible Person may also include a retiree of the Employer. (please specify): _____
- ☐ Other (please specify): _____

2. Employer has determined Employees must routinely work 30 (minimum of thirty (30)) hours per week and who is on the permanent payroll of Employer in order to be eligible for health/dental coverage under this Group Contract.

3. **Domestic Partners covered**? ☐ Yes ☒ No
If yes: A Domestic Partner, as defined in the Certificate Booklet, shall be considered eligible for coverage. The Employer is responsible for providing notice of possible tax implications to those covered Employees with Domestic Partners. An Employer may only elect or change Domestic Partner Coverage on the Group Contract Effective Date or Group Contract Anniversary Date.
If yes, are Dependents of Domestic Partners eligible for coverage? ☐ Yes ☐ No

If yes, the Limiting Age for covered children of Domestic Partners means twenty-six (26) years, regardless of presence or absence of a child's financial dependency, residency, student status, employment, marital status, or any combination of those factors.

Continuation coverage for Domestic Partners: If Employer elects coverage for Domestic Partners, a Domestic Partner is eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) if an eligible Employee elects COBRA coverage.

Employer may also elect whether to provide continuation coverage for Domestic Partners on an independent basis from the Employee. Please indicate your election below:

☐ Yes, Employer elects to offer continuation coverage to Domestic Partners on an independent basis from an Employee's election of COBRA.

☐ No, Employer does not elect to offer continuation coverage to Domestic Partners on an independent basis from an Employee's election of COBRA (Domestic Partners are not independently eligible for continuation coverage)

☐ Other: _____

4. The Effective Date of coverage for a newly Eligible Employee who becomes effective after the Employer's initial enrollment date is:

If a person is added to the Group Contract and it is later determined that the Group reported a coverage date earlier than what would apply to the Employee or Dependent, based on the Waiting Period and eligibility conditions the Group provided to BCBSOK, BCBSOK reserves the right to retroactively adjust the coverage date for such person.

☐ The date of employment.

☐ The first (1st) billing cycle following the date of employment.

☐ The first (1st) billing cycle following select one days of continuous employment.

☐ The first (1st) billing cycle following select one months of continuous employment.

☐ The select one day of employment

☒ Other (please specify): first of the month following date of hire

5. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person will be the end of the coverage period (billing cycle) during which the person ceases to meet the definition of Eligible Person.

☐ Other (please specify): _____

6. Limiting Age for covered children: Dependent children are eligible for coverage until their twenty-sixth (26th) birthday. Dependent Child, used hereafter, means a natural child, a stepchild, an eligible foster child, an adopted child or child placed for adoption (including a child for whom the Employee or his/her spouse or Domestic Partner, if Domestic Partner coverage is elected), is a party in a legal action in which the adoption of the child is sought), under twenty-six (26) years of age, 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. A child not listed above who is legally and financially dependent upon the Employee or spouse (or Domestic Partner, if Domestic Partner coverage is elected) is also considered a Dependent child under the Group Health Plan, provided proof of dependency is provided with the child's application.

☐ Other. Indicate maximum age (age twenty-six (26) and over are available options) and explain any limitations or requirements for extension of coverage beyond the minimum required age of twenty-six (26): _____

Termination of coverage upon reaching the Limiting Age: Coverage is terminated at the end of the coverage period (billing cycle) during which the Dependent child ceases to be eligible, subject to any applicable federal or state law.

7. Disabled Dependent: Disabled Dependent means a child who is medically certified as disabled and dependent upon the Employee or his/her spouse (or Domestic Partner if Domestic Partner coverage is elected). Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered as a dependent under the Plan or as a

dependent child under another employer plan before the child attains the limiting age with no break in coverage. To administer medical certification of disabled Dependents, you may select option (a) standard rules or (b) custom rules. 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 may continue coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26). A disabled Dependent may add coverage beyond the limiting age, provided the disability began before the child attained the age of twenty-six (26), and proof of coverage as a disabled Dependent is provided.

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 selections:

Age: Please select one (1) option regarding age of when the disability began.

☐ The disability must have begun before the child attained the age of twenty-six (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 (1) option regarding 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 (1) option regarding forms:

☐ BCBSOK's Disabled Dependent Certification Form will be utilized.

☐ A custom/other Disabled Dependent Certification Form will be utilized.

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

An approved disabled Dependent medical certification from a prior carrier is ☐ allowed ☐ not allowed.

An approved disabled Dependent medical certification from a prior BCBS policy is ☐ allowed ☐ not allowed.

8. Other Eligibility Provisions (Please explain):

_____

CURRENT ELIGIBILITY INFORMATION

Total number of Employees (Please indicate the total number of actual Employees, not enrollees):

1. On payroll _____
2. On COBRA continuation coverage _____
3. With retiree coverage (if applicable) _____
4. Who work part-time and are not eligible _____
5. Serving the new hire probationary waiting period (if not waived) _____
6. Declining because of other coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) _____
7. Declining coverage (not covered elsewhere) _____

RATES (Per Benefit Agreement if different)							
Select rate structure: ☐ **2-Tier** ☒ **3-Tier** ☐ **4-Tier** ☐ **5-Tier**							
PRODUCT/COVERAGE	**EE**	**EE/SP**	**EE/CH**	**Family**	_____	**Medicare Carve-Out**	
						EO	**ES**
Blue Advantage PPO℠	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Blue Choice PPO℠	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Blue Preferred PPO℠	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Blue Options PPO℠	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Blue Traditional®	$_____	$_____	$_____	$_____	$_____	$_____	$_____
BlueLincs HMO℠	$_____	$_____	$_____	$_____	$_____	$_____	$_____
HSA Blue℠ (Vendor: **Select Vendor)**	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Blue Options HSA℠ (Vendor: **Select Vendor)**	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Blue Preferred℠ HSA (Vendor: **Select Vendor)**	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Dental	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Vision	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Custom Benefits	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Preferred FSA Vendor: **Select Vendor** **Non-Preferred Vendor** _____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Preferred Health Reimbursement Account (HRA) Vendor: **Select Vendor** **Non-Preferred Vendor:** _____	$_____	$_____	$_____	$_____	$_____	$_____	$_____
Blue Care Dental High option	$36.03 EE	$_____	$_____	$115.25 EE+ Fam	$72.03 EE+1	$_____	$_____
Blue Care Dental Low option	$24.43 EE	$_____	$_____	$78.19 EE+Fam	$48.90 EE+1	$_____	$_____
_____	$_____	$_____	$_____	$_____	$_____	$_____	$_____

The above initial monthly premium rates shall be in effect beginning on 01/01/2025, and are subject to change by BCBSOK/BlueLincs after the premium rates are in effect for a period of at least 12 months and/or there is a substantial change in the number of covered Employees.

Preferred HSA Vendor:**Select Vendor**
If HealthEquity, Inc. is selected, BCBSOK to send HSA enrollment to HealthEquity, Inc.: ☐ **Yes** ☐ **No**

Non-Preferred Vendor: _____

An 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.

OTHER PROVISIONS:

1. **Summary of Benefits and Coverage ("SBC"):** BCBSOK will create the SBC (only for benefits BCBSOK insures under the Group Contract) and provide the SBC to the Employer in electronic format. If the Employer approves of the content, Employer will then distribute the SBC to participants and beneficiaries (or hire a third party to distribute) as required by law. If the Employer would like changes to the SBC, it will promptly notify BCBSOK. BCBSOK will also distribute the SBC to participants and beneficiaries via regular hardcopy mail or electronically in response to occasional requests received directly from individuals. All other distribution is the responsibility of the Employer.

2. **EHB Election:** Employer elects EHBs based on the Oklahoma benchmark.

3. ☐ **Wellbeing Management (WBM)**

4. **Transition Credit:** BCBSOK will provide a one-time transition credit of _____ for the twelve (12) month period beginning on the Group Contract Effective Date to be used to cover costs and expenses associated with transitioning medical, prescription, ancillary health or other coverage to BCBSOK and/or costs and expenses associated with transitioning to a new product design with BCBSOK. If Employer cancels before the expiration of the Group Contract period, Employer will be responsible for refunding to BCBSOK the full amount of the transition credit.

5. **Massachusetts Health Care Reform Act:** If elected below, BCBSOK will provide required written statements of Minimum Creditable Coverage ("MCC") to Subscribers residing in Massachusetts and submit applicable electronic reporting to the Massachusetts Department of Revenue. Information transmitted will be exclusively based on information provided to BCBSOK by Employer and coverage under the Plan(s) during the term of the Group Contract. By electing to have BCBSOK transmit these creditable coverage reports on Employer's behalf, Employer hereby certifies that, to the best of its knowledge, such coverage under the Plan(s) is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. Employer acknowledges that BCBSOK is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this service. Employer or its Subscribers should seek advice from their legal or tax advisors as necessary. If not elected, Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

   ☐ Employer consents to BCBSOK transmitting MCC reports on its behalf. Further, Employer attests that the information submitted is true and compliant with all relevant MCC Regulations.

   ☐ Employer will transmit MCC reports, and any other documentation as may be required to comply with the Massachusetts Health Care Reform Act.

6. **Wellness Credit:** BCBSOK will provide a one-time wellness credit of _____ for the twelve(12) month period beginning on the Group Contract Effective Date to be used to cover costs and expenses associated with the implementation of a new or to operate an existing wellness program for the benefit of Members. If Employer cancels before the expiration of the Group Contract period, Employer will be responsible for refunding to BCBSOK the full amount of the wellness credit.

7. **Communication Credit:** BCBSOK will provide a one-time communication credit of _____ for the twelve (12) month period beginning on the Group Contract Effective Date to be used to cover costs and expenses associated with

Member communications and other communication costs associated with electing coverage through BCBSOK. If Employer cancels before the expiration of the Group Contract period, Employer will be responsible for refunding to BCBSOK the full amount of the communication credit.

8. **Reimbursement:** It is understood and agreed that in the event BCBSOK makes a recovery on a third-party liability claim, BCBSOK will retain twenty-five percent (25%) of any recovered amounts, other than recovery amounts received as a result of, or associated with, any Workers' Compensation Law.

9. **Third-Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services)**: BCBSOK engages with third party-recovery vendors and law firms on a post-pay basis to identify and/or recover any potential overpayments that may have been made to Providers.

10. ☐ **Medical and Ancillary Package Pricing:** The rates shown in this Group Contract reflect a volume-based discount in an amount up to three percent (3%) of the medical premium for the twelve (12) month period beginning on the Group Contract Effective Date. If any of the qualifying ancillary coverage (BlueCare Dental, Basic Life, Short-Term Disability, Long-Term Disability, Accident, Critical Illness, Hospital Indemnity and/or Vision product(s)) lapses during this twelve (12) month period, BCBSOK reserves the right to remove the volume-based discount attributable to the lapsed product on medical premium. In such event, upon sixty (60) days prior written notice to Employer, the premium payment will be adjusted to reflect the removal of the discount attributable to the lapsed product.

ADDITIONAL PROVISIONS:

A. **Grandfathered Health Plans:** Employer shall provide BCBSOK/BlueLincs with written notice prior to renewal (and during the plan year, at least sixty (60) days advance written notice) of any changes in its Contribution Rate Based on Cost of Coverage or Contribution Rate Based on a Formula towards the cost of any tier of coverage for any class of Similarly Situated Individuals as such terms are described in the Affordable Care Act and applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by BCBSOK/BlueLincs to the terms and conditions of coverage. In no event shall BCBSOK/BlueLincs be responsible for any legal, tax or other ramifications related to any benefit package of any group health insurance coverage (each hereafter a "plan") qualifying as a "grandfathered health plan" under the Affordable Care Act and applicable regulations or any representation regarding any plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference and made part of the Large Employer Benefit Program Application and Group Contract, and Employer represents and warrants that such Form is true, complete, and accurate. If Employer fails to timely provide BCBSOK/BlueLincs with any requested grandfathered health plan information, BCBSOK/BlueLincs may make retroactive and/or prospective changes to the terms and conditions of coverage, including changes for compliance with state or federal laws or regulations or interpretations thereof.

B. **Retiree Only Plans and/or Excepted Benefits:** If the Large Employer Benefit Program Application includes any retiree only plans and/or excepted benefits, then Employer represents and warrants that one (1) or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by BCBSOK/BlueLincs to the terms and conditions of coverage. In no event shall BCBSOK/BlueLincs be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's past, present and future exempt plan status.

C. Employer shall indemnify and hold harmless BCBSOK/BlueLincs and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought or asserted against BCBSOK/BlueLincs in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any directions, actions and interpretations of the Employer, (d) any provision of inaccurate information, (e) the SBC and/or (f) Employer's selection of Essential Health Benefit ("EHB") definition for the purposes of the Patient Protection and Affordable Care Act ("ACA"). Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Notwithstanding anything in the Group Contract or Renewal(s) to the contrary, BCBSOK/BlueLincs reserves the right to revise our charge for the cost of coverage (premium or other amounts) at any time if any local, state or federal legislation, regulation, rule or guidance (or amendment or clarification thereto) is enacted or becomes effective/implemented, which would require BCBSOK/BlueLincs to pay, submit or forward, on its own behalf or on the Employer's behalf, any additional tax, surcharge, fee, or other amount (all of which may be estimated, allocated or pro-rated amounts).

The provisions of paragraphs A-C (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of coverage and/or administrative services between the parties.

Summary of Benefits & Coverage as noted above does not apply to the Fully Insured Voluntary Dental Plans.

Employer acknowledges and agrees that unless a change is indicated on this Renewal Addendum, Employer's instructions, acknowledgements and agreements in the BPA and the Group Contract (both as defined above) shall remain in full force and effect.

Cassie Cramer		
Sales Representative		
405/093	918-549-3331	405-316-7133
District	Fax No.	Phone No.
Morgan Young		
Producer Representative		
Lockton Companies, LLC.		
Producer Firm		
6900 Dallas Parkway, Suite 450 Plano, TX 75024		
Producer Address		
002709000		
BCBSOK Producer No.		

APPROVED by the Council and **SIGNED** by the Mayor of The City of Oklahoma City this 5TH day of NOVEMBER, 2024.

ATTEST:

City Clerk

Vice Mayor

APPROVED by the Trustees and **SIGNED** by the Chairman of the Oklahoma Municipal Facilities Authority this 5TH day of NOVEMBER, 2024.

ATTEST: (Seal)

OKLAHOMA CITY MUNICIPAL FACILITIES AUTHORITY

SECRETARY

VICE **CHAIRMAN**

APPROVED by the Trustees and **SIGNED** by the Chairman of the Oklahoma City Post-Employment Benefits Trust this 13TH day of NOVEMBER, 2024

ATTEST: (Seal)

OKLAHOMA CITY POST-EMPLOYMENT BENEFITS TRUST

SECRETARY

CHAIRMAN

REVIEWED for form and legality

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)].

CHERYL TROUT NOTARY No. 17005775 Expires 22 Jun 2025 PUBLIC STATE OF OKLAHOMA

Cheryl Trout
Notary Signature

My Commission Expires: June 22, 2025