EMSA RFP Additional Questions

Can you provide summaries of plan designs (SBCs) for all medical, dental, vision, life, disability and voluntary plans?

At this time, we are including the benefits guide only, which contains basic information and Team Member cost sharing for all of the benefits currently being offered by EMSA to its Team Members. There are not any plans to materially alter, add, or remove any of the offerings.

Are there any of your current structures or vendor partners that are a high priority to keep or move away from?

No.

Do you currently offer Retiree Medical?

No.

What are your top priorities for this RFP? (for example, cost containment, richer benefits, better service, employee experience, compliance support)?

Several priorities (in no particular order) include:

- An effective service model; account team experience, qualifications, and expertise; organizational capabilities; account management; client service responsiveness and service availability.
- Consulting approach, partnership approach, strategic planning, vision, and innovation.
- Broker compensation transparency, fee structure, and net cost.
- Fiduciary standing.
- Compliance expertise, self-funding expertise, cost containment, coordinated care strategies, network access strategies.
- Analytics, care gap strategies, reporting capabilities, actuarial capabilities,
- Information technology, HCM integration, implementation, and IT expertise, TPA and benefit plan designs.
- Analytics, reporting, benchmarking sources, and data-driven decision support

What is working well today that you would want to maintain as-is, and what are the biggest pain points with your current program?

EMSA welcomes a broad range of ideas, perspectives, and considerations.

What budget targets or renewal increase thresholds are you working against?

This will be discussed further with finalists.

Will you provide a current de-identified census.

At this time, the only census information being provided is that which is contained within the email thread.

Are claims experience and renewal figures available?

Yes. However, this topic will be discussed further with RFP finalists.

Which benefits administration or HRIS platform do you use?

UKG Pro and UKG Ready, along with UKG Tele-tracker

Can EMSA clarify the level of ad hoc data access expected? Is EMSA looking for direct self-service access to a data warehouse or dashboards, or consultant-prepared reports delivered upon request?

EMSA welcomes a broad range of ideas, perspectives, and considerations.

Section 3.5, Items 11 and 14 appear to ask the same question regarding wellness and preventive health analysis of members and claims experience. Please confirm whether this refers to two distinct deliverables.

Those items are duplicative. You may disregard the repeated item.

Can EMSA clarify the intended scope of "provider performance" benchmarking? Is EMSA seeking quality and outcomes-based metrics, cost and financial metrics, or both? Is there a preferred peer group for benchmarking, such as regional, national, or EMS and public sector specific?

EMSA welcomes a broad range of ideas, perspectives, and considerations.

Does EMSA require certified actuarial reporting, and if so, how often?

At this time, EMSA is fully insured for all benefits. Upon moving to self-funded, EMSA welcomes a broad range of ideas, perspectives, and considerations.

Can EMSA clarify the expected frequency and cadence of on-site enrollment meetings and benefit fairs at the Tulsa and Oklahoma City locations?

At a minimum, 1 to 2 days in both Tulsa and in OKC, one time per year, only during open enrollment.

Does EMSA require employee benefits communications, enrollment materials, or portal content to be available in languages other than English?

No.

Can you elaborate on your expectations regarding the broker's role in total rewards, and provide your definition of total rewards?

For purposes of this RFP, total rewards includes non-compensation related elements, such as: health and welfare benefits, programs, workplace experience initiatives, mental health support, financial well-being aspects, work-life programs, recognition, general wellness, career development, and the overall employee work experience; all of which are implemented to attract, motivate, engage, retain, grow and develop EMSA's Team Members. As for the broker's role in these aspects, EMSA welcomes a broad range of ideas, perspectives, and considerations.

Will the Board of Trustees or a benefits committee take part in the final decision? Which roles are on the evaluation committee?

The committee consists of EMSA's CFO, Director of Human Resources, and three board members with various experiences in law, healthcare, and business; along with consultation and concurrence with the CEO.

Will EMSA share the list of respondents after the November 3 opening?

This request will be considered and evaluated further.

Will all questions and answers be provided to all respondents?

Yes. Via this document.

Please list every line of coverage in scope (medical, pharmacy, dental, vision, life/AD&D, disability, voluntary, EAP, FSA/HSA/HRA, COBRA) with the current carrier or vendor.

At this time, we are including the benefits guide only, which contains basic information and Team Member cost sharing for all of the benefits currently being

offered by EMSA to its Team Members. There are not any plans to materially alter, add, or remove any of the offerings.

Is EMSA's medical plan a governmental (non-ERISA) plan?

Correct.

Which fiduciary standard does EMSA expect for the "fiduciary or co-fiduciary" question in Section 3.10, and which state's law applies?

Because EMSA is not subject to ERISA and is considering Welfare Benefit Plan brokerage services, it is not seeking a discretionary fiduciary, investment manager, nor investment advisor. Rather, EMSA seeks a fiduciary advisor and/or co-fiduciary advisor, expecting its broker to act in the best interests of EMSA and its Team Members, providing objective and unbiased recommendations, disclosing all direct and indirect compensation and conflicts of interest, and maintaining a standard of care consistent with fiduciary principles of prudence, loyalty, and transparency. EMSA is an Oklahoma Public Trust.

Please provide 24 to 36 months of claims experience (total paid, large claimants, renewal history) along with the carrier's utilization reports for the same period. Please provide most recent 12 months of pharmacy claims.

At this time, the only census information being provided is that which is contained within the email thread.

Please provide current plan documents and enrollment by plan option and tier of coverage. Please provide the current benefits guide, the most recent renewal, and the employer and employee contributions by plan. Please provide the most recent bills for all ancillary lines (dental, vision, life, disability, voluntary) and the current EAP information to include pricing.

At this time, we are including the benefits guide only, which contains basic information and Team Member cost sharing for all of the benefits currently being offered by EMSA to its Team Members. There are not any plans to materially alter, add, or remove any of the offerings.

What does EMSA currently pay its broker each year in fees, and what does that cover?

This topic will be discussed further with RFP finalists.

Is there a budget range for consulting fees?

This topic will be discussed further with RFP finalists. However, EMSA welcomes a broad range of ideas, perspectives, and considerations.

Does EMSA require a credentialed actuary to sign off on funding and IBNR? Is an independent actuary already engaged?

At this time, EMSA is fully insured for all benefits. Upon moving to self-funded, EMSA welcomes a broad range of ideas, perspectives, and considerations.

Has anyone done a self-funding feasibility study? If so, can EMSA share it?

Not formally.

Please provide EMSA's fiduciary policies and any fiduciary file, the previous broker's meeting notes, and the notes or minutes from benefits-related meetings over the past two years.

This topic will be discussed further with RFP finalists.

Do collective bargaining or meet-and-confer obligations affect benefit design?

No.

What are the top three benefits priorities or concerns leadership wants the new firm to take on in the first 12 months?

A summary of overall priorities is discussed in an earlier question, and they are not timeframe determined at this point.

What is EMSA's biggest pain point in the employee benefits program as a whole, whether that's high-cost claims, limited data, administrative burden, or something else? What parts of the current program and service model does EMSA most want to keep through a transition? What would success look like three years from now, whether that's cost trend, recruiting and retention, or how well employees understand their benefits? Are there measurable targets?

EMSA welcomes a broad range of ideas, perspectives, and considerations.

When employees leave, what reasons come up in exit interviews?

This topic will be discussed further with RFP finalists.

Does EMSA track turnover that is tied to benefits?

2026 BENEFITS GUIDE

EMSA
EMERGENCY MEDICAL SERVICES AUTHORITY

Support for your physical, financial, and personal wellbeing.

Revised 10.29.25

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BENEFITS OVERVIEW

Emergency Medical Services Authority is proud to offer a comprehensive benefits package to eligible employees classified as full-time and also to part-time employees who work on average at least 30 hours per week during the standard measurement period. The complete benefits package is briefly summarized in this booklet. Plan booklets are available, which give you more detailed information about each of these programs.

You share the costs of some benefits (medical, dental and vision), and Emergency Medical Services Authority provides other benefits at no cost to you (life, accidental death & dismemberment). In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

2026 Benefit Options & Enrollment

Each year during Open Enrollment, you can choose your benefits for the upcoming year. It's your chance to make changes, add coverage, or confirm that your current selections still meet your needs. All benefit elections made during open enrollment will be effective January 1, 2026. During open enrollment you can enroll in coverage, add dependents, drop dependents, or drop coverage.

All New Hires must complete online benefit elections in UKG within 30 days of hire, even if you are declining all benefits. Your benefits begin the first of the month, following 30 days of employment. If you do not complete your enrollment, all benefits will be considered waived, and you will not have an opportunity to enroll again until the next annual open enrollment for benefits that start January 1st.

Benefits Offered

- Medical
- Dental
- Vision
- Flexible Spending Account (FSA)
- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D
- Short-Term Disability
- Long-Term Disability
- Employee Assistance Program
- First Responders Assistance Program
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance
- Legal Coverage
- Identity Theft Protection
- Pet Insurance

Who Can Enroll?

- Full-time employees are eligible for coverage
- Your legal spouse or registered domestic partner
- Your dependent children under the age of 26 and children who are permanently disabled and fully dependent on the employee for support.

Elections made during open enrollment or when during your initial eligibility period as a new hire will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying life event, you must make the changes in UKG within 30 days. Human Resources is available to assist you, if necessary

Qualifying Life Events

- Marriage
- Divorce
- Birth or adoption
- Death
- Loss of other coverage
- Military Leave (in certain scenarios)

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 33 for more details.

PHYSICAL HEALTH

MEDICAL BENEFITS

Administered by Blue Cross Blue Shield of Oklahoma

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way – especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Emergency Medical Services Authority offers you a choice between three PPO medical plans. One of the medical plans uses the BCBSOK Blue Preferred provider network, while the other two are based around the Blue Advantage provider network.

One plan is a Qualified High Deductible HSA medical plan. With all three PPO plans, you may select where you receive your medical services. If you use in-network providers, you'll receive the highest level of benefits and the lowest out-of-pocket costs. A referral is not required to see a specialist.

Your Pharmacy coverage features Participating pharmacies and Preferred pharmacies. You receive the highest level of benefits and the lowest copays for your prescription medications at Preferred Pharmacies. You can find Preferred pharmacies online at **www.bcbsok. com**, on the Blue Access for Members member portal or on the Blue Access for Members app on your smartphone.

Network:	Blue Preferred PPO $1,000 Plan	Blue Advantage PPO $2,500 Plan	Blue Advantage PPO $4,000 HDHP HSA Plan
	In-Network	In-Network	In-Network
Calendar Year Deductible	$1,000 single $3,000 family	$2,500 single $7,500 family	$4,000 single $8,000 family
Calendar Year Out-of-Pocket Maximum	$3,000 single $9,000 family	$6,000 single $12,000 family	$6,900 single $13,800 family
Coinsurance	20%	20%	20%
DOCTOR'S OFFICE			
Primary Care Office Visit	$20 copay per visit	$30 copay per visit	20% after deductible
Specialist Office Visit	$20 copay per visit	$50 copay per visit	20% after deductible
Urgent Care Visit	$50 copay per visit	$50 copay per visit	20% after deductible
Preventive Care (Covered screenings, immunizations)	0%	0%	0%
Covered Diagnostic Test (x-ray, lab work)	0%	0%	20% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	20% after deductible	20% after deductible
HOSPITAL SERVICES			
Emergency Room (Copayment waived if admitted)	$100 per occurrence deductible then, 20% after deductible	$200 per occurrence deductible then, 20% after deductible	20% after deductible
Inpatient	20% after deductible	$750 per occurrence deductible then, 20% after deductible	20% after deductible
Outpatient Surgery	20% after deductible	$250 per occurrence deductible then, 20% after deductible	20% after deductible
Ambulance Service	0%	0%	0%

Network:	Blue Preferred PPO $1,000 Plan	Blue Advantage PPO $2,500 Plan	Blue Advantage PPO $4,000 HDHP HSA Plan
	In-Network	In-Network	In-Network
MENTAL HEALTH SERVICES			
Inpatient Services	20% after deductible	$750 per occurrence deductible then, 20% after deductible	20% after deductible
Outpatient Services	Office visit: $20 copay; Other outpatient services: 20% after deductible	Office visit: $30 copay; Other outpatient services: 20% after deductible	20% after deductible
SUBSTANCE ABUSE SERVICES			
Inpatient Services	20% after deductible	$750 per occurrence deductible then, 20% after deductible	20% after deductible
Outpatient Services	Office visit: $20 copay; Other outpatient services: 20% after deductible	Office visit: $30 copay; Other outpatient services: 20% after deductible	20% after deductible
OTHER SERVICES			
Maternity Services	$20 copay for first prenatal visit	PCP: $30 copay; SPC: $50 copay for first prenatal visit	20% after deductible
All other maternity hospital/ physician services	20% after deductible	$750 per occurrence deductible then, 20% after deductible	20% after deductible
Chiropractic Muscle Manipulation Services	20% after deductible	20% after deductible	20% after deductible
Physical, Occupational and Speech Therapy Services 25 Visit Limit	20% after deductible	20% after deductible	20% after deductible
Skilled Nursing 30-day limit per benefit period	20% after deductible	20% after deductible	20% after deductible

Is My Doctor in Network?

To verify if your doctor is in network with the Blue Advantage PPO network ($2,500 PPO Plan or the $4,000 HDHP HSA Plan) or in network with the Blue Preferred PPO network ($1,000 PPO Plan) Blue Preferred PPO network, go to **bcbsok.com**, choose Find Care, Search as a Guest and use the ZIP code at your location to find in-network providers near you.

- When searching for the networks, you want to make sure they match exactly like the verbiage below:

  » The network for the Blue Advantage PPO is: Blue Advantage PPO [BVP]
  » The network for the Blue Preferred PPO is: Blue Preferred PPO [EPP]

- Need more help? Call **800.810.BLUE (2583)**

Network:	Blue Preferred PPO $1,000 Plan	Blue Advantage PPO $2,500 Plan	Blue Advantage PPO $4,000 HDHP HSA Plan
	In-Network	In-Network	In-Network
PRESCRIPTION DRUGS			
Retail			
Preferred Generic Drugs (30-day supply)	Preferred: $0 Participating: $10 copay	Preferred: $0 Participating: $10 copay	Preferred: 10% after deductible Participating: 20% after deductible
Non-Preferred Generic Drugs (30-day supply)	Preferred: $10 copay Participating: $20 copay	Preferred: $10 copay Participating: $20 copay	Preferred: 20% after deductible Participating: 30% after deductible
Preferred Brand Drugs (30-day supply)	Preferred: $35 copay Participating: $55 copay	Preferred: $50 copay Participating: $70 copay	Preferred: 20% after deductible Participating: 30% after deductible
Non-Preferred Brand Drugs (30-day supply)	Preferred: $75 copay Participating: $95 copay	Preferred: $100 copay Participating: $120 copay	Preferred: 30% after deductible Participating: 40% after deductible
Specialty Drugs (30-day supply)	Preferred: $150 copay Non-Preferred: $250 copay	Preferred: $150 copay Non-Preferred: $250 copay	Preferred: 40% after deductible Non-Preferred: 50% after deductible
MAIL ORDER			
Preferred Generic Drugs (90-day supply)	$0	$0	10% after deductible
Non-Preferred Generic Drugs (90-day supply)	$30 copay	$30 copay	20% after deductible
Preferred Brand Drugs (90-day supply)	$105 copay	$30 copay	20% after deductible
Non-Preferred Brand Drugs (90-day supply)	$225 copay	$300 copay	30% after deductible

*Refer to page 9 for information on finding preferred pharmacies, for a list of the preferred formulary, and for information about the mail order program.

MEDICAL PLAN TYPES

What is a PPO plan?

- Traditional health insurance plan
- In-network and Out-of-Network Benefits
- In-network benefits are paid at the highest level.
- Copays at in network doctor's office visits
- Copays for prescriptions drugs
- In-network preventive services covered at 100%
- Annual deductible for other services (labs, imaging, surgery, ER visits, etc.)
- No referral needed to see a specialist

What is a HDHP with HSA?

- A high-deductible health plan with a health savings account
- You pay 100% of charges for services until you meet your deductible.
- This includes office visits and prescriptions.
- Only in-network preventive services are covered at 100% before meeting the deductible.
- Deductible must be met before the plan begins to pay
- You deposit pre-tax dollars into the HSA account to pay for health expenses. This reduces your taxable income.
- HSA funds are yours to keep and remain in your account year after year, just like a normal savings account.
- Money can only be used for qualified medical expenses.

Consider which plan features are most important to you. Do you want to:	Blue Preferred PPO $1,000	Blue Advantage PPO $2,500	Blue Advantage PPO $4,000 HSA
Open and contribute to a tax-free HSA, which has no "use it or lose it" rule and offers the opportunity to invest money for future			X
Pay the lowest premium cost, which may make it the least expensive option if you expect to have low healthcare usage?			X
Balance your out-of-pocket and paycheck costs with a moderate deductible and premium cost?		X	
Pay the highest premium cost in order to keep your out-of-pocket costs as low as possible when you need care?	X		
Pay the highest premium cost in order to have the most robust provider network?	X		

STAYING WELL

Preventive Care at No Cost on all Plan Options

What's Covered?

- Annual wellness visits – includes specific cancer and disease screenings depending on your age and gender. Well checks identify early stages of disease and prevent future problems.
- Annual flu shot; annual Covid-19 vaccine(s)
- Well-child visits including required immunizations
- ALL Free to you: Coverage provided in-network at 100% with no copay, no deductible.

Virtual Visits MDLIVE

Getting to the doctor when you're sick is never easy. That's why EMSA offers telemedicine through BCBSOK and MDLIVE.

- Whether you're at home or traveling, access to an independently contracted, board-certified doctor is available 24/7.
- You can connect with a U.S. board-certified doctor 24 hours a day, seven days a week on the mobile app, online video, or by phone.
- You can speak to an MDLIVE doctor immediately or schedule an appointment for a time that works for you.
- MDLIVE doctors can help treat many non-emergency conditions.
- A virtual visit may be a better alternative to the emergency room or urgent care center
- Call MDLIVE at **888.970.4081** if you have a minor physical condition like a cold or fever.
- To get started, visit **MDLIVE.com/bcbsok** and register with your CARRIER member ID number (found on the back of your medical ID card).
- MDLive physicians can prescribe medications when appropriate.

BCBSOK TOOLS & RESOURCES

Blue Access for Members (BAM)

Save time with self-service support tools and health and wellness resources available through a convenient and secure website on your computer or through the App on your smart phone. Go to **bcbsok.com** to log in or create an account on BAM.

Through BAM, you can:

- Access your digital Member ID Card
- View claims status and history
- See healthcare benefit information
- Find a doctor or pharmacy near you
- Review cost and quality to help you choose a doctor or pharmacy
- Access Pharmacy Tools

MyPrime.com

You have access to great pharmacy benefit information using a single sign-on from Blue Access for Members (BAM). When you click on **MyPrime.com**, you can view:

- In Network and Preferred Pharmacies
- Find drugs/drug list
- View prescription claim history
- Create personal medicine list
- Learn about specific drugs
  - » Rx cost calculator
  - » Health information

Express Scripts Home Delivery Prescriptions

Your pharmacy benefit includes mail order service of your maintenance medications from Express Scripts Pharmacy

- Register online at **express-scripts.com/rx** or by phone at **833.715.0942**.
- Once registered, ask your doctor to submit your prescription electronically or by fax.
- Transfer your existing prescription form a retail pharmacy online or by phone.

DENTAL

Administered by Delta Dental of Oklahoma

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with one of the Emergency Medical Services Authority dental benefit plans. All plans utilize the Delta Dental of Oklahoma PPO network.

Services	Choice Advantage Plan	Base PPO Plan	Buy-Up PPO Plan
Calendar Year Deductible	$50 per person $150 family limit	$50 per person $150 family limit	$50 per person $150 family limit
Calendar Year Benefit Maximum	$1,500	$1,000	$2,500
Preventive Dental Services (cleanings, exams, x-rays)	No Charge	No Charge	No Charge
Basic Dental Services (fillings, root canal therapy, oral surgery)	Amalgam filling: $22 copay Resin composite: $24 copay Extraction: $20 copay	Member pays 20% after deductible	Member pays 20% after deductible
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	Crown: $403 copay Core buildup: $80 copay Post & core: $111 copay	Member pays 50% after deductible	Member pays 50% after deductible
Orthodontia Services (covered for employee, spouse, and dependents children)	Monthly amounts over $50 $1,500 lifetime maximum	Not covered	Member pays 50% to $2,500 lifetime maximum

You can find in network dentists at https://dentistsearch.deltadentalok.org/.

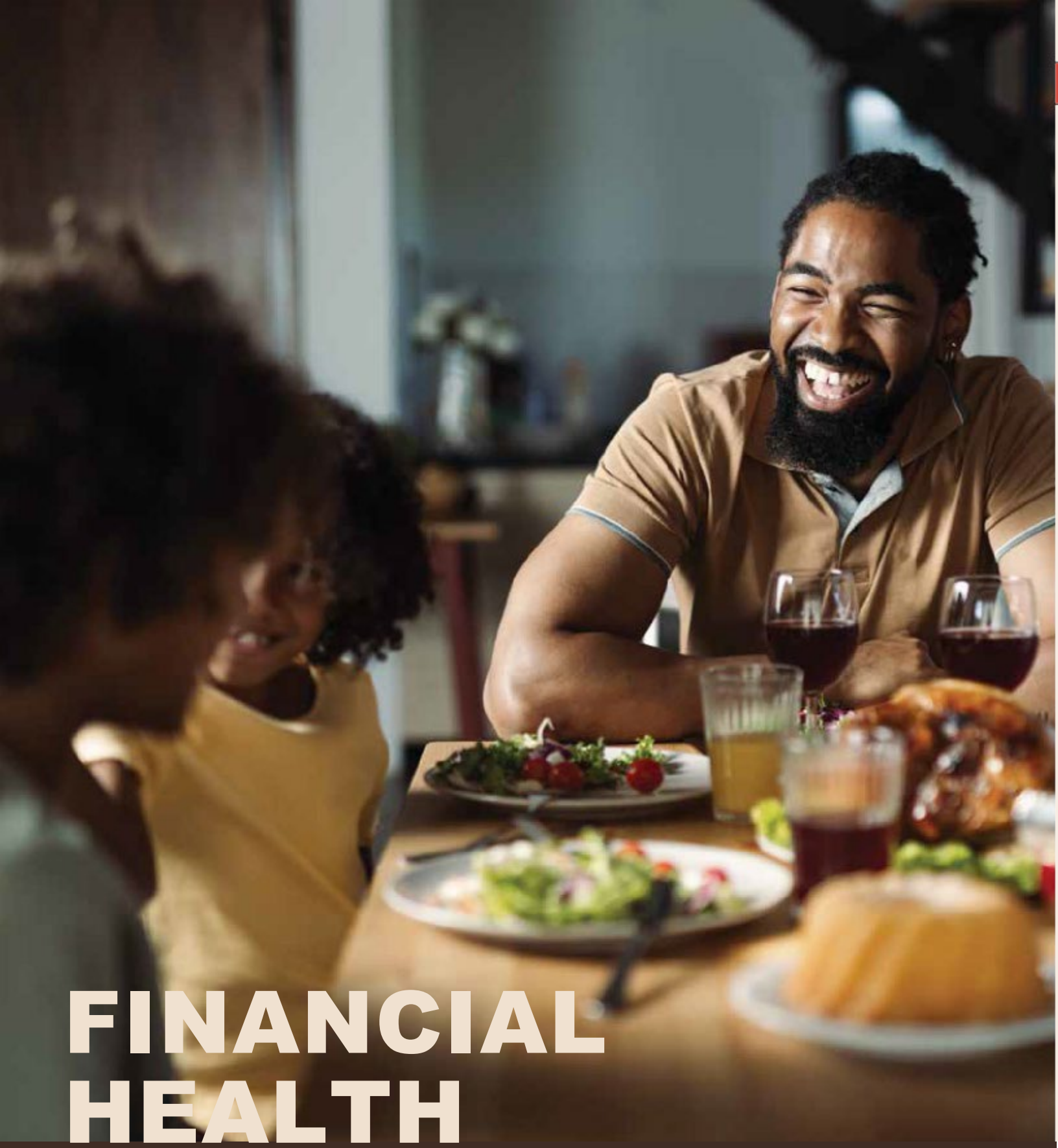
VISION

Administered by Ameritas

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

Your coverage from a VSP doctor

Service	Base Plan In-Network VSP Choice Network + Affiliates	Buy-Up Plan In-Network VSP Choice Network + Affiliates
Eye Exam	$10 copay	$10 copay
Materials	$25 copay	$25 copay
LENSES		
Single Vision Lenses Lined Bifocal Lenses Lined Trifocal Lenses Lenticular Lenses	Included in materials copay	Included in materials copay
FRAMES		
Frames	$130 allowance	$200 allowance
CONTACT LENSES		
Contact Lenses (if you elect contacts instead of lenses/ frames)	$130 allowance	$200 allowance
Contact Lenses Fit & Follow Up Exam	Up to $60 copay	Up to $60 copay
FREQUENCIES		
Exam	once every 12 months	once every 12 months
Lens or Contact Lenses	once every 12 months	once every 12 months
Frames	once every 24 months	once every 12 months



FINANCIAL HEALTH

HEALTH SAVINGS ACCOUNT (HSA)

Administered by HSA Bank

At EMSA, your financial well-being is important to us. Therefore, we offer benefit plans designed to protect our employees. If you enroll in the 2026 Blue Advantage HDHP HSA $4,000 medical plan and are not covered by any other non– HSA compatible health plan, you are eligible to contribute to an HSA.

A Health Savings Account, or HSA, is a tax-advantaged account you can use to pay for IRS–qualified healthcare expenses. Visit **hsabank.com/QME** for a full list of eligible medical expenses. Along with saving you money on taxes, HSAs can help you grow your nest egg for retirement.

How an HSA works

- You can contribute to your HSA via payroll deduction with pre-tax dollars, online banking transfer, or personal check.
- You can pay for qualified medical expenses with your Health Benefits Debit Card directly to your medical provider or pay out-of-pocket. You can choose to reimburse yourself or keep the funds in your HSA to grow your savings. When you use your HSA funds for IRS–qualified medical expenses, distributions are free from tax.
- Unused funds will roll over year to year. It's your money for life.
- Invest your HSA funds and potentially grow your savings.

Am I eligible for an HSA?

You're most likely eligible to open an HSA if:

- You have a qualified high-deductible health plan (HDHP).
- You're not covered by any other non-HSA-compatible health plan, like Medicare Parts A and B.
- You're not covered by TriCare.
- No one (other than your spouse) claims you as a dependent on their tax return.

2026 Blue Advantage HSA Annual Contribution Limits		
	Single	Family Plan
IRS Maximum Contribution Limit	$4,400	$8,750
HSA Catch-up Contributions (age 55 or older)	$1,000	$1,000

FLEXIBLE SPENDING ACCOUNT

Administered by Optum Financial

You can save money on your healthcare and/or dependent day care expenses with an FSA. You set aside funds each pay period on a pretax basis and use them tax-free for qualified expenses. You pay no federal income or Social Security taxes on your contributions to an FSA. (That's where the savings comes in.) Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income.

Plan Year	Healthcare FSA	Dependent Care FSA	Limited-Purpose FSA
	January 1, 2026 – December 31, 2026		
Eligible Expenses Include	• Insurance deductibles, copayments, coinsurance, prescriptions, dental care, vision care, OTC medications, and hearing expenses. • Any IRS deductible expense not covered by a health plan. • Healthcare expenses must be incurred during the plan year by you, your spouse, or your child through age 26.	• Eligible day care expenses for a dependent who lives with you, who is under age 13, or is disabled and any age. You must claim this person as a dependent on your income tax return. • You may be reimbursed only for care that enables you to work or look for work on a full-time basis. • Dependent care expenses must be incurred for services rendered after the date of your election and during the plan year.	• Dental expenses • Vision expenses
Annual Contribution Amount	$3,400	$7,500 ($3,750 married/filing separately)	$3,400
Claim Filing Deadline	Claims incurred during the 2026 plan year must be filed by March 31, 2027		Claims incurred during the 2026 plan year must be filed by March 31, 2027
Carry Over	Up to $680 of unused funds will carry over to the next plan year.	No carryover provision	Up to $680 of Unused funds will carry over to the next plan year
Eligibility	Not available if you have a HDHP and an HSA	All benefit eligible employees	Available if you have a HDHP and an HSA

INCOME PROTECTION

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Administered by Mutual of Omaha

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Emergency Medical Services Authority. The company provides basic life insurance equal to 2x your basic annual earnings up to $375,000 at no cost to you. You do need to designate a beneficiary for the coverage by UKG.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Emergency Medical Services Authority provides AD&D coverage equal to 2x your basic annual earnings up to $375,000 at no cost to you. This coverage is in addition to your company-paid life insurance described above. You do need to designate a beneficiary for the coverage.

VOLUNTARY LIFE AND AD&D INSURANCE

Administered by Mutual of Omaha

You may purchase Life and AD&D insurance in addition to the company-provided coverage. You may also purchase Life and AD&D insurance for your dependents, if you purchase additional coverage for yourself.

Employee – Can elect up to five times your annual earnings in increments of $10,000 up to a maximum of $500,000

Spouse – Up to $100,000 in increments of $5,000; May elect 100% of employee's benefit

Children – Up to $10,000 in increments of $1,000

You are guaranteed coverage up to $100,000 and up to $35,000 for your spouse without answering medical questions, if you enroll when you are first eligible. If you request a coverage amount above the guaranteed issue, you will be required to submit "evidence of insurability" and the carrier will determine the amount of coverage, if any, upon review. You will not be responsible for paying for any coverage above the guaranteed amount until it is approved and becomes effective.

DISABILITY INSURANCE

Emergency Medical Services Authority also provides disability insurance through Mutual of Omaha. This benefit replaces a portion of your income if you become disabled and are unable to work.

	How it Works	Who Pays for the Benefit
Base Short-Term Disability	You receive 50% of your income up to $300 per week. Benefits begin after 7 calendar days for accident or illness of absence from work and continue for up to 12 weeks.	Company
Buy Up Short-Term Disability	You receive 60% of your income up to $1,500 per week. Benefits begin after 7 calendar days for accident or illness of absence from work and continue for up to 12 weeks.	Employee
Long-Term Disability	You receive 60% of your income up to $10,000 per month. Benefits begin after 90 calendar days of absence from work and continue until you reach the Social Security Normal Retirement Age.	Company

EMSA RETIREMENT OVERVIEW

Bank of Oklahoma – 457(b) Matching Plan

You become eligible to participate on the 1st day of the month following the 30th day of employment; You will be automatically enrolled at the rate of 3% of your compensation, when you become eligible.

- If you want to opt out of the automatic enrollment or change your contribution percentage, you will create a member login at the member site:

Contribution elections can be pre-tax, post-tax (ROTH), or a combination of both. Employer matching is discretionary. The employer intends to match $1.00 for $1.00 up to 6% of your permitted compensation for eligible employees who have worked at least 500 hours during the plan year and are employed on the last day of the plan year.

- To receive EMSA's matching contribution, you must be employed at the end of the plan year (12/31) and employee and employer contributions are 100% fully vested.

Loans are permitted under the restrictions of the Plan's Loan Policy.

MENTAL HEALTH & PERSONAL WELLBEING

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Administered by Mutual of Omaha

At some point, we all need help coping or making difficult decisions. The Employee Assistance Program makes it easy to access support, guidance, and resources. The EAP is there for you and your family. It's completely confidential. Information will be released only with your permission or as required by law. Health Advocate professionals can help with referrals to support groups, in network counselors, community resources or your health plan.

EAP services can help with

- Stress, anxiety, depression, and emotional well-being
- Grief, loss, and life adjustments
- Relationship conflicts
- Substance abuse
- Life improvement and goal setting
- Financial and legal concerns
- Identity theft resolution
- Online will preparation and other legal documents

EAP Services (at no cost to you)

- Assistance for you or a household family member
- Services are available at no cost to you or your family member
- Up to six (6) in-person sessions with a counselor, per year, per issue
- Unlimited toll-free phone access 24/7
- Online resources 24/7
- Work/life services for assistance with childcare, elder care, financial issues, plus much more

Visit the EAP website mutualofomaha.com/eap or call us at 800.316.2796

FIRST RESPONDER ASSISTANCE PROGRAM (FRAP)

Administered by MYGroup

EMSA provides employees with FRAP coverage through MYGroup

Counseling on Personal or Work-Related Issues, such as:

- Stress, anxiety, depression
- Grief, loss, and life adjustments
- Relationship conflicts
- Substance abuse
- Preventive

FRAP Services (at no cost to you)

- Assistance for you and your family members
- These services are provided at no cost to you or your family members.
- EMSA employees are eligible for up to ten (10) in-person, virtual, or telephonic sessions with a counselor, per year, per issue for unlimited separate issues.
- Family members of EMSA employees receive six (6) sessions of counseling per issue per year for unlimited separate issues.
- Chat, messaging, and interactive support group sessions via BetterHelp partnership
- Unlimited toll-free phone access 24/7
- Online resources 24/7
- Work/life services for assistance with childcare, elder care, financial issues, plus much more
- Legal and Financial Consultations

To Access FRAP

1. Call 800.633.3353 or
2. Visit: **mygroup.com** > click on my portal login > work-life
   Username: emsa
   Password: guest
3. Or scan the QRcode

Username: emsa

Password: guest

YMCA MEMBERSHIP

YMCA offers a corporate membership rate to EMSA team members

- Access to all area Y locations
- Robust schedule of group exercise classes (yoga, cycling, aerobics, boot camp, weight-training, Zumba, and more)
- Indoor pools, basketball courts, racquetball, and gym with state-of-the art exercise equipment
- Outdoor pools in summer
- Discounts on Y programs including youth sports, camp, childcare, swim lessons and more
- Discounted Member Rates for you and your household
- The current YMCA discounted rates for EMSA Team Members can be found in the News & Information section of UKG employee self-service.
- Membership fees are Payroll Deducted Bi-weekly
- To obtain an enrollment form, please email **hr@emsa.net**
- For more info on all the programs, please visit the YMCA websites:
  - » OKC – **ymcaokc.org**
  - » Tulsa – **ymcatulsa.org**

SUPPLEMENTAL INSURANCE COVERAGES

While you can't predict life's unexpected events, you can plan for them by choosing benefits that help protect what's important to you.

Accident Insurance

Administered by Mutual of Omaha

The Accident plan provides cash payments directly to you to help cover out-of-pocket costs, such as deductibles or coinsurance. The full schedule of benefits payable for accidental injuries include initial/follow-up treatment, ambulance trips, medical imaging, surgeries, concussion, dislocations and fractures, hospital stays, and AD&D. The plan includes coverage for accidents that occur on and off the job. Some benefits are payable once per covered accident, while others are once per plan year. See Benefit Summary and/or Certificate for detailed information and schedule of benefits and exclusions.

Critical Illness Insurance

Administered by Mutual of Omaha

Critical illness insurance provides a lump-sum payment for an insured person diagnosed with any of the following critical illnesses while insurance is in effect for the insured person, after any applicable waiting period: Cancer, Heart Attack, Stroke, Major Organ Failure, End Stage Renal (Kidney) Failure, and more. The plan includes a health maintenance screening benefit. See Benefit Summary or Certificate for detailed information and schedule of benefits and exclusions.

HOSPITAL INDEMNITY INSURANCE

Administered by Mutual of Omaha

Hospital indemnity coverage eases the financial impact of an employee's hospitalization by providing a lump sum payment to help cover the costs associated with a hospital stay. Hospital indemnity coverage can be used to supplement medical insurance to help handle additional out-of-pocket costs that add up after a hospital stay. This can include copayments, coinsurance, deductibles, and incidental hospital expenses or other expenses such as transportation and lodging needs. See Benefit Summary or Certificate for detailed information and schedule of benefits and exclusions.

IDENTITY FRAUD PROTECTION

Administered by Norton LifeLock Benefit Solutions

Identity theft protection and more – for the whole family.

You and your family share all kinds of personal, private, and sensitive information online everyday. Your information is valuable to you, and it's also valuable to cyber criminals.

Consider your own digital habits:

- How do you protect personal information on your mobile devices?
- Do you ever connect to public, unsecured Wi-Fi?
- Are you using the same password on multiple accounts?
- How does your family engage online?
- Have you been a victim of identity theft before?
- How do you identify phishing texts or emails and compromised websites? Identity theft can happen easily. Norton LifeLock Benefit Solutions make protection easy too.

You have the right to feel safe online.

Millions of people trust Norton LifeLock to keep them safe online, and so can you. Norton LifeLock Benefit Plans can help safeguard multiple devices, keep your online activity private, and help protect your identity. It's never been easier.

Protect your digital health and peace of mind.

While you're relaxing, Norton LifeLock is scanning. Norton LifeLock Benefit Plans provide an all-in-one solution to help protect you and your information from falling victim to identity theft. Get alerts to possible identity threats, the ability to proactively lock accounts, and if your identity is stolen, Norton LifeLock will work to fix it.

Easily view your protection from any device.

Access the Norton LifeLock dashboard to manage your account and alerts. Download their easy-to-use app so you can manage alerts and notifications.

Many additional features are included form more details on the plan offering, visit www.Norton.com/BenefitPlans.

LEGAL PLAN

Administered by MetLife

MetLife Legal Plans provides you, your spouse/domestic partner, and dependents with access to experienced attorneys and reduces the worry, stress, and financial burden on your end. It's protection at every step.

Experience and convenience you can count on.

You'll have all the help you're looking for from the MetLife dedicated service team, network of attorneys and a variety of online resources.

Award-winning service

- Regularly recognized for excellence in customer service
- Experienced service team available from 7am to 7pm CST

Top-quality attorney network

- Average of 25 years of experience and vetted regularly
- Nationwide network with a range of specialties

24/7 access at your fingertips

- Create an account on the MetLaw website to access coverage information and our attorney locator
- Access to over 1,700 self-help documents
- Access to digital estate planning to create wills, livin g wills, and powers of attorney all online

1. Easy to find an attorney
   Go to **members.legalplans.com** or call 800.821.6400 to speak to an experienced service team that can match you with the right attorney.
2. Easy to Make an appointment
   Call the attorney you select and schedule a time to talk or meet.
3. Easy from start to finish
   That's it! There are no copays, deductibles, or claim forms when you use a network attorney for a covered matter.

Ease of use

- All billing is handled between MetLife and the attorney
- No claim forms, hidden fees, or deductibles

Legal Representation

- Estate Planning
- Money Matters
- Real Estate Matters
- Elder Law Matters
- Family Law
- Traffic Offenses
- Document Preparation
- Immigration Assistance
- Juvenile Matters
- Consumer Protection
- Defense of Civil Lawsuits
- Personal Property Protection

Additional Plan Features

- E-Services
- Family Matters

PET INSURANCE

Administered by Pet Partners

New and improved pet insurance for your furry family members. If you haven't had pet insurance in the past, here's why you should consider it you're a pet parent, your fur babies are an important part of your family, bringing comfort, joy, and unconditional love. In return, you do the best you can to take care of them. But pet care is expensive and veterinary costs continue to rise. That's why pet insurance is offered to EMSA employees. The plan is underwritten by Independence American Insurance Company.

What's Covered

- Pre-Existing Conditions*
- Broken bones
- Diagnostics
- Surgery
- Prescription Medications
- Alternative Treatments
- Toxin Ingestion
- Digestive Issues
- Behavioral Issues
- Cancer
- Hospitalization

Take the Stress Out of Unexpected Vet Bills

Pet insurance reimburses you for the cost of accidents and illnesses throughout your pet's life.

Here's how it works:

1. Visit your vet (or any licensed vet or clinic)
2. Pay your vet then submit a claim
3. Get reimbursed for eligible expenses

Please request a full plan brochure including the rates from:
https://portal.independenceamerican. com/login
Group # GP-PI-00267 .

Accident Only – per covered pet
Bi-Weekly
$5.03

Accident Only – per covered pet Bi-Weekly		
	Age 0-10	Adult Weight in Pounds 0-90+
Dog	$16.82	
Cat	0-10	$8.65

Accident & Illness – per covered pet Bi-Weekly		
Bi-Weekly		
Dog	Age 0-10	Adult Weight 0-90+ lbs
	Rate $16.82 per pay period	
Cat	Age 0-10	Rate $8.65 per pay period

Employee Contributions for Benefits

MEDICAL COVERAGE				
BP PPO $1,000	**Monthly Total Cost**	**Monthly Employer Portion**	**Monthly Employee Portion**	**Per Pay Period Employee**
Employee	$778.93	$584.20	$194.73	$89.88
Employee + One	$1,713.66	$1,285.24	$428.42	$197.73
Employee + Child(ren)	$1,402.10	$1,051.58	$350.52	$161.78
Family	$2,336.69	$1,752.52	$584.17	$269.62
BP PPO $2,500	**Monthly Total Cost**	**Monthly Employer Portion**	**Monthly Employee Portion**	**Per Pay Period Employee**
Employee	$642.03	$544.16	$97.87	$45.17
Employee + One	$1,412.47	$1,197.15	$215.32	$99.38
Employee + Child(ren)	$1,155.68	$979.51	$176.17	$81.31
Family	$1,926.11	$1,632.50	$293.61	$135.51
BP HSA $4,000	**Monthly Total Cost**	**Monthly Employer Portion**	**Monthly Employee Portion**	**Per Pay Period Employee**
Employee	$522.02	$468.97	$53.05	$24.49
Employee + One	$1,148.44	$1,031.73	$116.71	$53.87
Employee + Child(ren)	$939.63	$844.14	$95.49	$44.07
Family	$1,566.06	$1,406.91	$159.15	$73.46
DENTAL COVERAGE				
Choice Advantage	**Monthly Total Cost**	**Monthly Employer Portion**	**Monthly Employee Portion**	**Per Pay Period Employee**
Employee	$25.10	$12.56	$12.55	$5.79
Employee + One	$50.20	$25.11	$25.09	$11.58
Employee + Child(ren)	$69.16	$34.58	$34.58	$15.96
Family	$94.26	$47.14	$47.13	$21.75
Base PPO	**Monthly Total Cost**	**Monthly Employer Portion**	**Monthly Employee Portion**	**Per Pay Period Employee**
Employee	$30.54	$15.27	$15.28	$7.05
Employee + One	$60.70	$30.35	$30.36	$14.01
Employee + Child(ren)	$68.64	$34.32	$34.32	$15.84
Family	$98.98	$49.49	$49.49	$22.84
Buy-Up PPO	**Monthly Total Cost**	**Monthly Employer Portion**	**Monthly Employee Portion**	**Per Pay Period Employee**
Employee	$40.36	$20.19	$20.17	$9.31
Employee + One	$80.70	$40.36	$40.34	$18.62
Employee + Child(ren)	$124.18	$62.08	$62.10	$28.66
Family	$164.52	$82.25	$82.27	$37.97
VISION COVERAGE				
Base Plan	**Monthly Total Cost**	**Monthly Employer Portion**	**Monthly Employee Portion**	**Per Pay Period Employee**
Employee	$6.08	$3.04	$3.04	$1.40
Family	$14.32	$7.16	$7.16	$3.30
Buy-Up Plan	**Monthly Total Cost**	**Monthly Employer Portion**	**Monthly Employee Portion**	**Per Pay Period Employee**
Employee	$8.80	$4.40	$4.40	$2.03
Family	$20.20	$10.10	$10.10	$4.66

Voluntary Life Monthly Rate per $1,000 of Total Coverage*			
Age (as of January 1)	Monthly Rate	Age	Rate
EMPLOYEE			
Under Age 25	$0.07	55 – 59	$0.45
25 – 29	$0.08	60 – 64	$0.68
30 – 34	$0.10	65 – 69	$1.29
35 – 39	$0.11	70 – 74	$2.08
40 – 44	$0.12	75 – 79	$2.52
45 – 49	$0.17	80+	$5.58
50 – 54	$0.25		
SPOUSE			
Under Age 25	$0.07	55 – 59	$0.45
25 – 29	$0.08	60 – 64	$0.68
30 – 34	$0.10	65 – 69	$1.29
35 – 39	$0.11	70 – 74	$2.08
40 – 44	$0.12	75 – 79	$2.52
45 – 49	$0.17	80+	$5.58
50 – 54	$0.25		
Child(ren) Voluntary Life Monthly Rate Per $1,000			
$0.10			

**Rates include a monthly AD&D rate of $.02 per $1,000 of AD&D benefit*
+Use employee's age to for spouse 's rate.

Figure Your Monthly Premium				
$_____	divided by $1,000 x $_____	= $_____	>	$ _____
Benefit Amount	Age Rate (from above table)	Monthly Premium		Bi-Weekly premium multiply monthly premium by 12 & divide by 26
Example: Employee Age 35 – $100,000 divided by $1,000 x $0.11 = $11.00 per month – > $5.08 per pay period				

Identity Fraud Protection		
Bi-Weekly Rates	Benefit Essential	Benefit Premier
Employee	$4.15	$6.92
Family	$8.30	$13.84

Buy Up Short-Term Disability		
EMPLOYEE CONTRIBUTION		
Age (as of January 1)	Per Pay Period	Monthly Rate
Under Age 25	$0.13	$0.28
25 – 29	$0.13	$0.28
30 – 34	$0.14	$0.31
35 – 39	$0.13	$0.28
40 – 44	$0.13	$0.28
45 – 49	$0.16	$0.34
50 – 54	$0.19	$0.42
55-59	$0.24	$0.52
60-64	$0.29	$0.64
65+	$0.32	$0.69
Rates shown are per $10 of the weekly benefit amount		

Accident Insurance	
Coverage Tier Bi-Weekly Rates	
Employee	$2.44
Employee + One	$3.80
Employee + Child(ren)	$4.72
Family	$7.36

Hospital Indemnity Insurance	
Coverage Tier Bi-Weekly Rates	
Employee	$9.47
Employee + One	$16.12
Employee + Child(ren)	$13.42
Family	$23.87

Critical Illness Insurance	
Bi-Weekly Rates per $1,000 for $10,000, $20,000 or $30,000 of coverage	
Employee Age	Employee & Spouse Rates
18-29	$0.15
30-39	$0.23
40-49	$0.49
50-59	$1.02
60-69	$1.89
70+	$3.34

Legal Plan	
Coverage Tier Bi-Weekly Rate	
Employee + Family	$9.00

Monthly Benefits Premium Responsibility

If a Team Member has active benefits coverage for any dates that are also represented in a pay-period date range of which the Team Member is employed, then the employee will be responsible for the full premium for that month's coverage. Depending on the payroll calendar, some months have only two bi-weekly premium deductions, while other months require three.

When a Team Member separates from employment, deductions from their final paycheck and/or PTO payout check may be adjusted to ensure the correct premium amount is collected for the particular month's benefits coverage.

CONTACT INFORMATION

If you have specific questions about any of the benefit plans, please contact the administrator listed below, or your local human resources department.

Benefit	Administrator	Phone	Website/Email
Medical	BlueCross BlueShield of Oklahoma	800.942.5837	www.bcbsok.com
Dental	Delta Dental	866.851.5505	www.deltadentalok.org
Vision	Ameritas	800.522.0188	www.vsp.com
Health Savings Account	HSA Bank	800.357.6246	www.hsabank.com
Flexible Spending Account	Optum Financial	888.339.3685	www.optumfinancial.com
Basic and Voluntary Life and AD&D	Mutual of Omaha	800.775.8805	www.mutualofomaha.com
Short Term and Long Term Disability	Mutual of Omaha	800.775.8805	www.mutualofomaha.com
Accident, Critical Illness, and Hospital	Mutual of Omaha	800.877.5176	www.mutualofomaha.com
Conversion: Basic & Voluntary Life	Mutual of Omaha	800.826.8054	www.mutualofomaha.com
Portability: Basic & Voluntary Life/AD&D, Accident, Critical Illness, & Hospital	Mutual of Omaha	877.466.8367	www.mutualofomaha.com
Health Club Membership	YMCA	Call any local branch	www.ymcaokc.org www.ymcatulsa.org
Retirement 457(b) Matching Plan	Bank of Oklahoma	800.876.9557	Startright.bokf.com
First Responders Assistance Program	MyGroup	800.633.3353	www.mygroup.com (username:emsa | password:guest)
Employee Assistance Program	Mutual of Omaha	800.316.2796	www.mutualofomaha.com/eap
Legal Plan	MetLife Legal	800.821.6400	www.members.legalplans.com
Identity Theft Protection	Norton LifeLock	800.607.9174	www.Norton.com/BenefitPlans
Pet Insurance	Pet Partners	800.956.2495	https://portal.independenceamerican.com/login? Group # GP-PI-00267
COBRA Administrator	Optum Financial	855.687.2021	www.optumfinancial.com
Gallagher Account Manager	Christie Kennedy	918.779.5005	christie_kennedy@ajg.com

LEGAL NOTICES

ANNUAL ENROLLMENT NOTICES & DISCLOSURES

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Blue Preferred PPO $1,000 Plan (Individual: 20% coinsurance and $1,000 deductible; Family: 20% coinsurance and $3,000 deductible)

Plan 2: Blue Advantage PPO $2,500 Plan (Individual: 20% coinsurance and $2,500 deductible; Family: 20% coinsurance and $7,500 deductible)

Plan 3: Blue Advantage PPO $4,000 HDHP HSA Plan (Individual: 20% coinsurance and $4,000 deductible; Family: 20% coinsurance and $8,000 deductible)

If you would like more information on WHCRA benefits, please contact your Plan Administrator at **hr@emsa.net**.

Newborns' and Mothers' Health Protection Act

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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 **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 **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, 2025. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com
855.692.5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
http://myakhipp.com/ | 866.251.4861
CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
http://myarhipp.com
855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov

COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program)
https://www.healthfirstcolorado.com
Member Contact Center: 800.221.3943 | State Relay 711
Child Health Plan Plus (CHP+)
https://hcpf.colorado.gov/child-health-plan-plus
Customer Service: 800.359.1991 | State Relay 711
Health Insurance Buy-In Program (HIBI)
https://www.mycohibi.com/
HIBI Customer Service: 855.692.6442

FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
877.357.3268

GEORGIA – Medicaid
GA HIPP: https://medicaid.georgia.gov/
health-insurance-premium-payment-program-hipp
678.564.1162, Press 1
GA CHIPRA: https://medicaid.georgia.gov/programs/third-party-liability/
childrens-health-insurance-program-reauthorization-act-2009-chipra
678.564.1162, Press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
https://www.in.gov/medicaid/ | 800.457.4584
Family and Social Services Administration
http://www.in.gov/fssa/dfr/ | 800.403.0864

IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
800.338.8366
Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
800.257.8563
HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
888.346.9562

KANSAS – Medicaid
https://www.kancare.ks.gov/
800.792.4884 | HIPP Phone: 800.967.4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP):
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
855.459.6328 | KIHIPP.PROGRAM@ky.gov
KCHIP: https://kynect.ky.gov | 877.524.4718
Medicaid: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp
888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)

MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US
800.442.6003 | TTY: Maine relay 711
Private Health Insurance Premium:
https://www.maine.gov/dhhs/ofi/applications-forms
800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa
800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
https://mn.gov/dhs/health-care-coverage/
800.657.3672

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
573.751.2005

MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
800.694.3084 | Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178

NEVADA – Medicaid
http://dhcfp.nv.gov
800.992.0900

NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 15218 | Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid
800.356.1561
CHIP: http://www.njfamilycare.org/index.html
800.701.0710 (TTY: 711) | Premium Assistance: 609.631.2392

NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/
800.541.2831

NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov
919.855.4100

NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare
844.854.4825

OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org
888.365.3742

OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx
800.699.9075

PENNSYLVANIA – Medicaid and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
800.692.7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800.986.KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov
855.697.4347 or 401.462.0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov
888.549.0820

SOUTH DAKOTA – Medicaid
http://dss.sd.gov
888.828.0059

TEXAS – Medicaid
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
800.440.0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
https://medicaid.utah.gov/upp/ | Email: upp@utah.gov | 888.222.2542
Adult Expansion: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/
CHIP: https://chip.utah.gov/

VERMONT – Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program
800.250.8427

VIRGINIA – Medicaid and CHIP
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 and Chip: 800.432.5924

WASHINGTON – Medicaid
https://www.hca.wa.gov/
800.562.3022

WEST VIRGINIA – Medicaid and CHIP
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/
Medicaid: 304.558.1700
CHIP Toll-free: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
800.362.3002

WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
800.251.1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

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

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.

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Emergency Medical Services Authority is committed to the privacy of your health information. The administrators of the Emergency Medical Services Authority Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources at **Hr@emsa.net**.

HIPAA Special Enrollment Rights

Emergency Medical Services Authority Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Emergency Medical Services Authority Health Plan (to actually participate, you must complete an enrollment form and may be required to pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan – your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Human Resources at **Hr@emsa.net**.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Notice of Creditable Coverage

Important Notice from Emergency Medical Services Authority 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 Emergency Medical Services Authority 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. Emergency Medical Services Authority has determined that the prescription drug coverage offered by the medical plan 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 15 to December 7.

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

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

If you decide to join a Medicare drug plan, your current Emergency Medical Services Authority coverage will not be affected. You can keep this coverage can keep this coverage if you elect part D. This plan will not coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Emergency Medical Services Authority coverage, be aware that you and your dependents will be able to get this coverage back during the annual open enrollment or if you elect coverage timely after a qualifying 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 Emergency Medical Services Authority 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 Emergency Medical Services Authority 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 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 800.772.1213 (TTY 800.325.0778).

Date:	October 1, 2025
Name of Entity/Sender:	Emergency Medical Services Authority
Contact:	Human Resources
Address:	1417 N Lansing Ave Tulsa, Oklahoma 74106-5905 United States
Phone Number:	918.596.3100

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).

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Natalie Johnson

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you**.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Emergency Medical Services Authority
Human Resources
1417 N Lansing Ave
Tulsa, Oklahoma 74106-5905
United States
hr@emsa.net

1 https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

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 Employer 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.[1] [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 of these factors in determining whether to purchase a health plan through the Marketplace.

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.

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, 2025. Since the onset 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, 2025, 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, 2025, 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 800.318.2596. TTY users can call 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 Human Resources at hr@emsa.net.

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 Emergency Medical Services Authority		4. Employer Identification Number (EIN) 73-1038915
5. Employer address 1417 N Lansing Ave		6. Employer phone number 918.596.3100
7. City Tulsa	8. State Oklahoma	9. ZIP code 74106-5905
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	12. Email address **hr@emsa.net**	

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

- As your employer, we offer a health plan to:

  □ All employees. Eligible employees are:

  X Some employees. Eligible employees are:
  Full time employees

- With respect to dependents:

  X We do offer coverage. Eligible dependents are:
  Legal spouse, domestic partner, and dependent child(ren) under the age of 26. A dependent child who is medically certified as disabled and dependent upon the member, spouse, or domestic partner would be eligible for coverage over the age of 26, provide the disability began before the age of 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.

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This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

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