Welcome to Open Enrollment

Plan Year: 2023-2024

Pick the best benefits for you and your family.

Osage Nation strives to provide you and your family with a comprehensive and valuable benefits package. We want to make sure you're getting the most out of our benefits—that's why we've put together this Open Enrollment Guide.

Open enrollment is a short period each year when you can make changes to your benefits. This guide will outline all the different benefits offered, so you can identify which offerings are best for you and your family.

Elections you make during open enrollment will become effective on October 1, 2023. If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to HR.

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Questions & Answers

What Changes Are Effective October 1, 2023 ?

- Blue Cross Blue Shield will only offer one medical plan.
- Care ATC will be available to all members.
- Vision frame allowance will increase to $180.
- Open enrollment
- FSA medical contribution increased to $3,050.

PAYCOM Required Enrollment Plans

- Select Medical Plan Options
- New elections must be made in order to continue participating in an FSA.

Are There Educational Opportunities Available?

Yes. To learn more about ’s benefits offerings for the next plan year, please attend an open enrollment meeting.

Open Nation Enrollment Meetings		
Date	Time	Location
08/15/2023	9:00 to 12:00 1:00 to 4:00	Pawhuska Law Office
08/18/2023	9:00 to 12:00	Hominy Education Building
08/24/2023	9:00 to 12:00	Fairfax Language Building
08/25/2023	1:00 to 4:00	Pawhuska Law Office

Welcome to Open Enrollment

Who Is Eligible?

If you're a full-time employee at Osage Nation, you're eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work 30 or more hours per week. In addition, the following family members are eligible for medical, dental and vision coverage:

- Spouse
- Children to age 26

How to Enroll

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes in the Paycom Benefits Enrollment portal.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

When to Enroll

Open enrollment begins on August 1, 2023, and runs through August 31, 2023. The benefits you choose during open enrollment will become effective on October 1, 2023.

How to Make Changes

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Qualifying events include things like:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

Health Insurance

Only one health plan will be offered for the 2023-2024 plan year, which is the Osage Nation Native Blue with a $1,000 Out-of-Network Deductible. Medical coverage enrollment is mandatory to continue the Blue Cross and Blue Shield coverage.

How to receive Native Blue In-Network Level of Benefits
To receive the Native Blue In-Network level of benefits a contracted Native Blue provider must be utilized. To access the doctors and facilities that are in the Native Blue Network please go to the Blue Cross Blue Shield member portal and select the provider search option. **www.bcbsok.com**

The following is a summary of the Osage Nation medical and pharmacy benefits that will take effect on October 1, 2023.

	Blue Cross Blue Shield	
Services	**Native Blue In-Network Approved Services**	**Out-of-Network Approved Services**
Physician Visit Copay	$0	Deductible, then 50%
Deductible (Individual/Family)	$0	$1,000 per person
Hospitalization Inpatient Outpatient Home Health MRI, CT, Complex Scans	$0	Deductible, then 50%
Preventive Care	$0	Deductible, then 50%
Emergency Room Copay	$200 copay	$200 Copay, Deductible, then 50%
Out-of-pocket Maximum (Individual/Family)	$0	Unlimited
Prescription Drugs - Retail/Mail Order - Generic - Preferred - Non-preferred Mail Order – 90 Days 1x Copay	$0 $35 $60	$0 $35 $60

Your Cost in 2023-2024

Good news! Despite rising health care rises and unprecedented changes resulting from health care reform, Osage Nation is pleased to announce there will be no premium increases for the new plan year. Payroll deductions will remain as shown:

Employee Monthly deductions			
Employee Only	Employee & Spouse	Employee & Children	Employee & Family
$80.89	$548.62	$288.61	$808.63

Machine Readable Files Requirements to comply with Health Price Transparency Rule:

Instructions for Self-Funded Accounts to access the Machine-Readable Files, each account has a unique link to a webpage based on the account's Employer Identification Number (EIN). This webpage is publicly available without needing a log in. The process for accessing the Out-of-Network (Allowed Amounts) and In-Network Machine-Readable Files will be the same.

1. Link to access: https://bcbsok.com/asomrf?EIN=123456789
a. Copy the above URL, paste it into the browser, and replace the language in red with the account specific details to come to the landing page below

Example of PPO Deductible

Being admitted to the hospital and the total charges are $2000. You pay $1000 to cover your annual deductible, then 20% of the $1000 in charges that is left, for a total of $200. $1000 + $200 = $1200 is your responsibility.

If you go to the hospital again in the same year and have another $1,000 in charges, you would just be responsible for 20% because you have met your annual deductible, so you would be responsible for $200 for this visit.

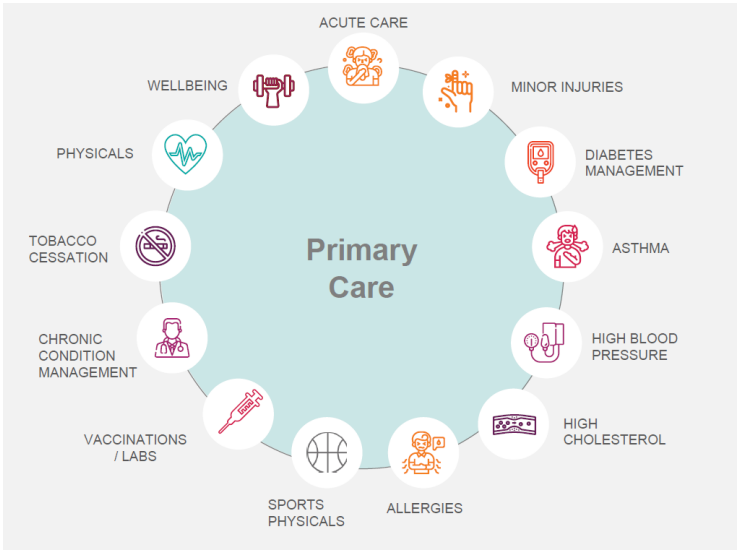
Final Benefit Determination

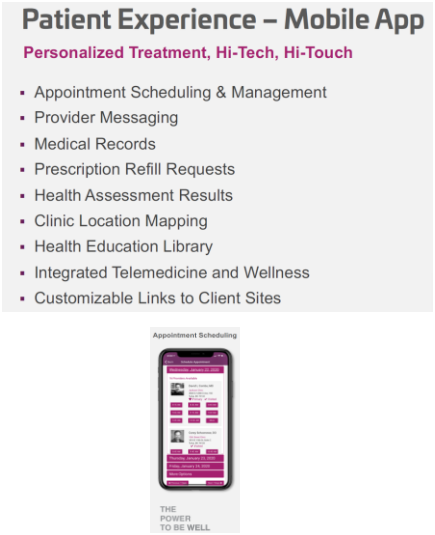
Actual Benefits will be governed by The Summary Plan Description. Please refer to the Summary Plan Description for clarifications, limitations, exclusions, and covered expenses not addressed in this Schedule of Benefits. Summary of Benefits & Coverage located in Paycom Payroll portal.

***For plan comparison in-network benefits are indicated above. Please be aware that the use of out of network providers and facilities could result in costs that are much higher than the out of pocket costs than stated in the grid above.**

Care ATC Primary Care & Wellness

Enhanced Primary Care services with same-day or next-day appointments designed to improve your overall health.





Access to CARE ATC Services is available to all employees covered by Blue Cross for a flat monthly rate and will be selected as an option under medical enrollment in Paycom.

Employee Monthly Cost		
Care ATC	**$67.00**	**Includes all family members covered by the Blue Cross health plan**

Pharmacy Benefit Tools

MyPrime.com – easily manage your medicines.

Save time and money by looking up a medicine, finding a pharmacy in your network or learn about ordering prescriptions for home delivery.

Find medicines

Find a pharmacy

See prescription history

Home delivery – 90-Day Supply

Skip the lines at the pharmacy

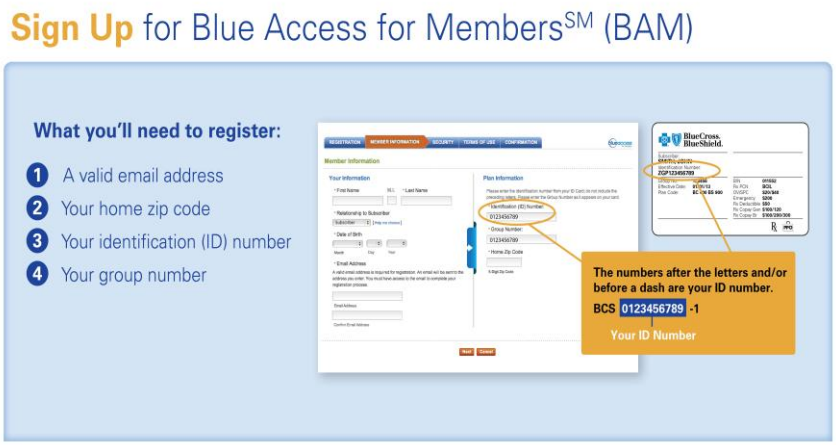
You can get medication sent directly to your door with home delivery provided by AllianceRx Walgreens Prime. It's easy to get started with home delivery, **sign up today.**

allianceRx Walgreens + PRIME

Blue Cross for Members Tool – Your Online Resource

Would you like to know when your medical claims are paid and the payment amounts? Do you need to confirm who in your family is included under your coverage? BAM, the secure member portal from Blue Cross and Blue Shield of Oklahoma (BCBSOK), can help. Get immediate online access to health and wellness information.

www.bcbs.com or download the mobile app



Blue Cross Virtual Medical Visits – MD Live

Care When and Where You Need

MD Live, a leading virtual visits leader, lets you visit independently contracted MD Live board-certified doctors when you may need care for non-emergency and pediatric health issues.

Reason for a Virtual Medical Visit

- Instead of using Emergency Room or Urgent Care
- Your Doctor is booked
- While at home, work or on the go
- Convenience with doctors available 24 hours a day, seven days a week

Most common reasons for visiting MD Live

- Acne
- Constipation
- Fever
- Pink Eye
- Respiratory Problems
- Sports Injuries
- Allergies
- Cough
- Headache
- Rash
- Sinus Infection
- Vomiting
- Bronchitis
- Earaches
- Insect Bites
- Cold & Flu
- Sore Throat
- Many more…

Connect

Computer, smartphone, tablet, or telephone

Interact

Real time Consultation with a board-certified doctor

Diagnose

Prescriptions sent electronically to a pharmacy of your choice. (When appropriate)

Activate MDLIVE now on the Blue App…

Get Connected today!

To register, you will need to provide your first and last name, date of birth and BCBSOK member ID number

Dental Insurance

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings, and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

We're happy to say that there are no cost changes to your dental benefits for. The following chart outlines the dental benefits we offer.

Type of service	Amount Plan Pays	
Preventive Services	100% - Exams, cleanings, X-rays *HOW program enhancements apply*	
Deductible	Applies to basic and major services only— $50 per covered member	
Basic Services	Fillings, root canals, simple extractions— 90%	
Major Services	Oral surgery, bridges, crowns— 60%	
Annual Maximum	$1,500	
Orthodontia	50% - Children to 19 years with $1,000 lifetime maximum per child	
Monthly Payroll Deductions	Employee only Employee & Spouse Employee & Child Family	$0.00 $31.12 $57.28 $86.94

Mobile Features & Services

For quick, on-the-go dental benefits information, there's the Delta Dental Mobile App. The mobile app is perfect for those benefit questions that arise when you are out and about and need a quick answer right at your fingertips. Our mobile website is another convenient way to access contact information and other valuable resources 24/7.

Mobile Website

Contact Information

If you ever have a question about your dental benefits plan, how we paid a claim or simply need clarification, we are just a phone call or email away. Our contact information for Customer Service, Sales and Client Relations, to name a few, is easily located on the www.DeltaDentalOK.org mobile website.

Valuable Resources

With multiple avenues to find a dentist and brush up on your oral wellness tips, our mobile website makes keeping up with your oral wellness routine easy.

Delta Dental – HOW Oral Assessment Program

DELTA DENTAL®

Introducing HOW® HEALTH *through* ORAL WELLNESS®

Delta Dental of Oklahoma is dedicated to advancing the oral wellness of our members. We recognize each member is unique, and some may need additional services in order to achieve optimal oral health.

Health *through* Oral Wellness® (HOW®) enhanced benefits are designed to boost members' existing Delta Dental plan with additional preventive benefits if they are at high risk for developing caries (tooth decay) and/or periodontal (gum) disease.*

*Based on the results of the HOW® approved assessment performed in a dentist office.

How HOW® works

DDOK member receives the HOW® approved assessment from a dentist

RISK SCORES

Member assessment results will have two (2) risk scores, on a scale of 1-5, associated with HOW® benefits:

- **Tooth Decay Risk Score**
- **Gum Disease Risk Score**

Boosted Benefits

If member receives risk score(s) of 4 or 5, he/she will qualify to receive additional preventive benefits

Members eligible for HOW® who receive a qualifying score(s) on the assessment will receive additional preventive benefits to enhance their Delta Dental plan. HOW® enhanced benefits include greater frequency of cleanings, caries susceptibility testing, sealants and more.

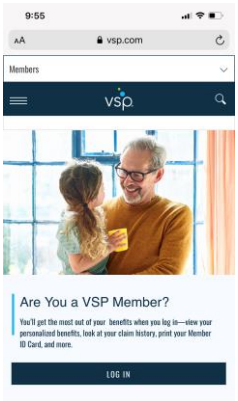
For more information, including a Summary of HOW® Enhanced Benefits, visit
DeltaDentalOK.org/HOW

Vision Insurance

Osage Nation vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

Benefit	Description	In-Network Copay	Out of Network Allowance	Frequency
Well Vision Exam	Focuses on your eyes and overall wellness	$10	Up to $45	Every Plan Year
Prescription Glasses		$25		
Frame	$180 Allowance of Frames $180 Allowance of Featured Brands 20% savings over the allowance $70 Costco Frame Allowance	Included with Prescription Copay	Up to $70	Every Plan Year
Lenses	Single Vision Lined Bifocal Lined Trifocal Polycarbonate lenses for dependent children	Included with Prescription Copay	Up to $30 Up to $50 Up to $65	Every Plan Year
Lens Enhancements	Standard, Premium and Custom Progressive lenses Anti-Reflective coating Average savings of 20-25% on other lenses	$0 $0	Up to $50	Every Plan Year
Contacts (Instead of glasses)	$130 allowance; copay does not apply Contact lens exam	Up to $60	Up to $150	Every Plan Year
Diabetic Eyecare Plus Program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration. Ask your VSP doctor for details	$20		As Needed
Monthly Payroll Deductions	Employee only Employee & Spouse Employee & child Family	$12.39 $24.38 $22.46 $34.47		

VSP Mobile: www.vsp.com for discounts and provider information. Visit the Paycom Portal for information on discount programs or the VSP mobile app



Disability Income Benefits

Osage Nation provides full-time employees with short-term and long-term disability income benefits. Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness.

At Osage Nation, we want to do everything we can to protect you and your family. That's why Osage Nation pays for the full cost of short-term disability. Long-term disability insurance is on a voluntary basis with the employee paying the full cost.

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. Please note, though, that you are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

	Short-term Disability	Long-term Disability
Benefits Begin	1st day of accident 8th day of illness PTO must be exhausted	After 26 Weeks
Benefits Payable	26 weeks	5 years
Percentage of Income Replaced	60%	60%
Maximum Benefit	$1,385	$5,000

Basic Life Insurance

Life insurance can help provide for your loved ones if something were to happen to you. Osage Nation pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums.

	Life Insurance	Accidental Death & Dismemberment
Benefit	1.5 x Annual Salary - Minimum Benefit is $50,000	1.5 x Annual Salary - Minimum Benefit is $50,000
Age Reduction Schedule:	35% at age 65 50% at age 70	
Beneficiary Information:	Update Beneficiary in Paycom or contact the Benefits Departments for assistance	
Employee Monthly Costs	**100% Paid by Osage**	**100% Paid by Osage**

Voluntary Life Insurance

While Osage Nation offers basic life insurance, some employees may want to purchase additional coverage. Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage.

With voluntary life insurance, you are responsible for paying the full cost of coverage through biweekly payroll deductions. You can purchase coverage for yourself or for your spouse in $10,000 increments. The minimum coverage level is $20,000 and the maximum is $300,000. The chart below outlines the monthly costs of purchasing additional coverage.

	Employee	Spouse to age 70	Child(ren)
Life Benefit	Up to 5x annual Salary in $10,000 increments	Up to 50% of Employee Election	$10,000
Voluntary Accident Benefit	Up to 5x annual Salary in $10,000 increments	Up to 50% of Employee Election	$10,000
Guarantee Issue Amounts subject to New York Life guidelines	$150,000	$30,000	$10,000
Portability:	Coverage may be continued if you leave employment with Osage Nation. Please request information from New York Life regarding options and pricing		
Evidence of Insurability	Evidence is required for any amounts over the Guarantee Issue for initial enrollees and for any increase in coverage to all existing employees and dependents		
Voluntary Life Rates*	**Age Rated**	**Age Rated**	**Flat Rates**

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

All State Voluntary Benefits

All State 24-Hour Accident Plan

Cash benefits are paid directly to employees to help with out-of-pocket expenses associated with medical treatment. Help protect savings and retirement plans 401(k)s from being depleted. Can help pay the mortgage, continue rental payments, or perform needed home repairs for aftercare. See the plan brochure for a complete list of coverage.

Base Policy Benefit	Coverage	
Initial Hospital Confinement	$1,000	
Daily Hospital Confinement	$200	
Intensive Care	$400	
Urgent Care Accident Treatment	$50	
Ambulance	$100	
X-Ray	$100	
Dislocation/Fracture	$2,000	
Monthly Payroll Deductions	Employee only Employee & Spouse Employee & Child Family	$7.32 $12.66 $15.58 $20.96

All State Critical Illness

The benefit is paid upon diagnosis of one of the following conditions and can be purchased in limits of $10,000 or **$20,000.** Spouse and Child benefit is 50% of the Employee benefits limit chosen. Benefits pay directly to employees to help offset out-of-pocket costs associated with medical insurance.

BENEFIT EXAMPLES	
✓ Heart Attack or Stroke (100%)	✓ Invasive Cancer (100%)
✓ End Stage Renal Disease (100%)	✓ Carcinoma in Situ (25%)
✓ Coronary Artery Bypass Surgery (25%)	✓ Advanced Parkinson's Disease (100%)
Recurrence benefits vary on payout limits. See plan documents for details.	
Critical Illness Rates	**Rates are based on age, gender, and smoker status. The enrollment portal will calculate payroll deductions based on benefits elected**

All State Hospital Indemnity

Cash benefits are paid directly to employees to help with out-of-pocket expenses associated with hospital services. Help protect savings and retirement plans 401(k)s from being depleted. Can help pay the mortgage, continue rental payments, or perform needed home repairs for aftercare. See the plan brochure for a complete list of coverage

Base Policy Benefit	Coverage	
Initial Hospital Confinement	$500	
Daily Hospital Confinement	$100 – 10 days max	
Intensive Care	$100 – 10 days max	
Pregnancy Waiting Period	10 Months	
Monthly Payroll Deductions	Employee only Employee & Spouse Employee & Child Family	$11.84 $30.80 $20.54 $33.54

All State Voluntary Benefits

All State Burial Expense

The Burial Expense benefit is paid directly to the beneficiary and can be assigned to directly pay the funeral home within a 48-hour period. A copy of the expected charges from the funeral home is required instead of a death certificate. See the plan brochure for complete details of the plan.

Base Policy Benefit	Coverage
Guarantee Issue Employee & Spouse	$5,000
Benefits Levels	$5,000 or $10,000
Eligible Members	All Osage Employees and Spouses Age 18-70
Evidence of Insurability	Required for amounts over $5,000
Portable	Yes – rates and coverage are guaranteed after employment ends as long as premiums are paid
Termination	Coverage ends at age 85
FINAL BURIAL EXPENSE RATES	**Rates are based on age, gender, and smoker status. The enrollment portal will calculate payroll deductions based on benefits elected**

All State Identity Theft

With Allstate Identity Protection **Select**, members are able to*

- Check their identity health score
- Get comprehensive identity and financial monitoring
- View and manage alerts in real time
- Receive high-risk financial transaction alerts
- Depend on in-house customer care specialists 24/7
- Rely on $1 million identity theft expense coverage**
- Protect themselves and their family (everyone that's "under the member's roof and wallet")***
- And much more!

Identity Theft Monthly Rates	
Employee Only: $5.95	**Family: $11.95**

Flexible Spending Accounts

Paying for health care, dental, hearing, and vision out-of-pocket costs can be stressful. That's why Osage Nation offers an employer-sponsored flexible spending account (FSA). A health care FSA lets you use pre-tax dollars for certain IRS-approved medical care expenses not covered by your insurance plan. For example, cash that you now spend on deductibles, copayments, or other out-of-pocket medical expenses can instead be placed in the health care FSA on a pre-tax basis.

What Are the Benefits of a Health Care FSA?

There are a variety of different benefits of using a health care FSA, including the following:

- It saves you money. Allows you to put aside money tax-free that can be used for qualified medical expenses.
- It's a tax-saver. Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- It is flexible. You can use your FSA funds at any time, even if it's the beginning of the year.

What Is a Dependent Care FSA?

Similar to health FSAs, dependent care FSAs allow you to contribute pre-tax dollars to qualified dependent care. The maximum amount you may contribute each year is $5,000 (or $2,500 if married and filing separately).

For the 2023-2024 plan year, you may not roll over unused funds for dependent care.

Enrollment Required

Complete the FSA Enrollment in Paycom during open enrollment. Even if you signed up last year, you must re-enroll for 2023.

	Health Care Reimbursement Account	Dependent Care Reimbursement Account
Annual Contribution Maximum	$3,050	$5,000 Joint with Spouse $2,500 if married and filing separately
Annual Roll Over Limit	$610 – excess balance will be forfeited	None – balance will be forfeited
Tax Status	Pre-tax subject to validation	Pre-tax subject to validation
Covered Expenses *IRS defined approved expenses as outlined under the Section 125 Code*	Examples include: • Out-of-pocket expenses for Medical, Dental, Vision and Hearing • Eye Surgery or Vision Correction Surgery • Long Term Care • Stop Smoking programs • Weight Loss programs if it is to treat a specific disease	Examples include: • Child or Adult dependent care • The cost for an individual to provide care either in or out of your house. • Nursery schools and preschools (excluding kindergarten) • Note: Any amount elected must be used by – September 30, 2020

Employee Assistance Plan

Benefits You Receive:

The Employee Assistance Program is offered to all employees and immediate family members of Osage Nation. It is a completely confidential counseling program that covers issues such as marital and family concerns, depression, substance abuse, grief and loss, financial entanglement, and other personal stressors.

To use the EAP, simply contact the Employee Assistance Program toll-free to arrange for a free initial assessment interview. You may be provided brief solution-based counseling, or you may be referred to outside resources for ongoing therapy.

Employee Assistance Program Services 1-800-827-2377 or 918-877-9685	
✓ Free Confidential Assessment/Referral/Follow-Up Services	✓ 24/7 Access for Emergency Situations
✓ Face to Face Assessment Interview	✓ Master-Level Licensed Counselors
✓ Community Based Referrals	✓ Many more…

Employee Monthly Costs	**Free of Charge to employees and their immediate dependents**

COMPLETELY CONFIDENTIAL

Retirement Saving 401(k)

Osage Nation offers a 401(k) plan to all full-time employees on the first of the month following 60 days of employment. Each eligible employee is invited to participate and receive a company match. Please enter the BOK online access tool to update your plan.

401k Employer Match	
Employee Contributions	**Osage Nation Match**
1-5%	Matches up to 5%
5% to IRS Defined Limits	No Employer Match

Online Access Tools for Retirement Planning and Trading

BOK FINANCIAL ADVISORS
LONG LIVE YOUR MONEY.

Start Right. Retire Right.

Access retirement account information, incorporate it into your accounting software, plan what-if scenarios for your future, and learn how best to fill your retirement gap, all via desktop, tablet or mobile.

401(k) enrollment and changes are allowed throughout the year. Please contact BOK Financial Advisors directly to enroll or make updates.

401(k) Enrollment Portal
Link: www.startright.bokf.com
Questions: 1-800-876-9557

Employee General Notices

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

INTRODUCTION

You are receiving 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 generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**
Read this notice carefully to help understand your COBRA rights. Keep in mind that 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice does not fully describe COBRA continuation coverage or other rights under the Plan. For additional and more complete 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 does not 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 known as 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 may be required to pay for COBRA continuation coverage.

Employee: If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either of the following qualifying events happens:

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

Spouse: If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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. In the event your spouse, who is the employee, reduces or terminates your coverage under the Plan in anticipation of a divorce or legal separation that later occurs, the divorce or legal separation may be considered a qualifying event even though the coverage was reduced or terminated before the divorce or separation.

Dependent Children: Your dependent children (including any child born to or placed for adoption with you during the period of COBRA coverage who is properly enrolled in the Plan and any child of yours who is receiving benefits under the Plan pursuant to a qualified medical child support order) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- 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 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;
- 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 the Plan Benefit Manager. The Plan procedures for this notice, including a description of any required information or documentation, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, you will lose your right to elect COBRA continuation coverage.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives timely 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. If COBRA continuation coverage is not elected within the 60-day election period, a qualified beneficiary will lose the right to elect COBRA continuation coverage.

COBRA continuation coverage is a temporary continuation of coverage.

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of **36 months**.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of **18 months**. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Also, when the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Disability Extension
If you or anyone in your family covered under the Plan is determined by the Social Security Administration 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 total 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 continuation coverage.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, there will be no disability extension of COBRA continuation coverage. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

Second Qualifying Event Extension
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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both) or 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.
The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, there will be no extension of COBRA continuation coverage due to a second qualifying event.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid 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.

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 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.
Erin Casoose
Benefits Administrator
Osage Nation
239 W. 12th St, Pawhuska, OK 74056
Phone: 918-287-5235
Email: erin.casoose@osagenation-nsn.gov

HIPAA SPECIAL ENROLLMENT NOTICE

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

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

Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

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

Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired by us, your children received health coverage under CHIP and you did not enroll them in our health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance: To request special enrollment or obtain more information, please contact:

Erin Casoose
Benefits Administrator
Osage Nation
239 W. 12th St, Pawhuska, OK 74056
Phone: 918-287-5235
Email: erin.casoose@osagenation-nsn.gov

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator.

NEWBORNS' AND MOTHER'S 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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

DEPENDENT TO AGE 26

Due to a change in the laws governing your employer's Group Health Plan, your children generally can be covered until the plan until age 26, regardless of their student or marital status and regardless of whether your home is their principal place of abode or whether you support them. The dependents are eligible for coverage regardless of eligibility on another employer group health plan.

MENTAL HEALTH PARITY

According to the Mental Health Parity Act of 1996, the group health plan is prohibited from offering benefits that contain annual and/or lifetime dollar maximums for mental health or substance abuse benefits that are more restrictive than limitations imposed on benefits for medical or surgical benefits. However, mental health benefits may be limited to a maximum number of treatment days per year or series per lifetime.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act applies to your Group Health Plan. This law establishes a basic uniform national standard to protect the public from discrimination based on genetic information.

HEALTH INSURANCE MARKEPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

Beginning in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. The 2017 open enrollment period for health insurance coverage through the Marketplace ran from Nov. 1, 2016, through Jan. 31, 2017. After Jan. 31, 2017, you can get coverage through the Marketplace for 2017 only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year (adjusted to 9.69% for 2017), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Plan Information? For more information about your coverage offered by your employer, please check your summary plan description or contact you benefits administrator. 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.

MEDICARE PART D NOTICE

Important Notice Osage Nation 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 Osage Nation 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:

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.

Osage Nation has determined that the prescription drug coverage offered by the Osage Nation Health 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 coverage will be affected. You can keep this coverage if they elect part D but this plan will not coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back only during open enrollment or a special enrollment period.

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 Osage Nation 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 Osage Nation changes. You also may request a copy of this notice at any time.

Erin Casoose
Benefits Administrator
Osage Nation
239 W. 12th St, Pawhuska, OK 74056
Phone: 918-287-5235
Email: erin.casoose@osagenation-nsn.gov

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

IOWA – Medicaid and CHIP (Hawki)	MONTANA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**

Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

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

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

No Surprise Billing Notice

Your Rights and Protections Against Surprise Medical Bills
When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

*"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.*

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
*If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.*

As of February 2021, the following 18 states had enacted comprehensive Balance Billing Protections: California, Colorado, Connecticut, Florida, Georgia, Illinois, Maine, Maryland, Michigan, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon Texas, Virginia, Washington.

As of February 2021, the following 15 states had enacted limited Balance-Billing Protections: Arizona, Delaware, Indiana, Iowa, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Nevada, North Carolina, Pennsylvania, Rhode Island, Vermont, West Virginia.

Generally, those state passed protections apply to fully insured medical plans governed by the specific state and not self-funded medical plans. Check the state insurance commissioner website for details on specific state laws.

If your state is not listed, check your state commissioner's website as states may adopt a surprising billing mandate at any time.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers ***can't*** *balance bill you and may* ***not*** *ask you to give up your protections not to be balance billed.*
If you get other services at these in-network facilities, out-of-network providers ***can't*** *balance bill you, unless you give written consent and give up your protections.*

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- *You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.*
- *Your health plan generally must:*
- *Cover emergency services without requiring you to get approval for services in advance (prior authorization).*
- *Cover emergency services by out-of-network providers.*
- *Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.*
- *Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.*

If you believe you've been wrongly billed*, you may contact the US Department of Health & Human Services at 1-877-696-6775 or your State Insurance Commissioner.*

DISCLAIMERS

This booklet gives you an overview of the primary features of your benefit plans. The plans are administered according to the legal plan documentsand insurance contracts. Although we have tried to summarize the provisions of these legal documents clearly and accurately, if any information contained herein conflicts with the legal documents, the legal documents will govern. All benefits are subject to change from time to time and youremployer reserves the right to amend or cancel any benefits described in this booklet, with or without notice.

The intent of this booklet is to provide you with general information regarding the status of and/or potential concerns related to, your current employee benefits environment. It should not be construed as, nor is it intended to provide, legal advice. Laws may be complex and subject tochange. This information is based on current interpretation of the law and is not guaranteed. Questions regarding specific issues should be addressed by legal counsel who specializes in this practice area.

Contact Information

Osage Nation offers you and your eligible family members a comprehensive and valuable benefits program. See below for information on our benefit carriers. You can find all plan documents on the PAYCOM Payroll System. If you have any questions please contact your Benefits Department.

Medical and Prescription Drugs:
Blue Cross Blue Shield of Oklahoma
Customer Service: 800-672-2567
Pharmacy Assistance: 877-546-2779
Web Address: www.bcbsok.com

Delta Dental of Oklahoma
Client Services: 800-522-0188
Web Address: www.DeltaDentalOK.org

Life & Disability Insurance
Life: Policy# FLX967181
LTD: Policy# LK964929
ADD Policy# OK968689
STD: Policy# SHD962885

MD Live – Virtual Visit
Call MD Live: 888-676-4204
Web Address: www.MDLIVE.com/BCBSOK

Primary Care & Wellness
Web Address: www.info@careatc.com
Phone: 800-993-8244

Flexible Spending (FSA)
Benefit Resources, Inc.
Client Services: 800-339-7493
Web Address: www.britulsa.com

Vision Service Plan
Customer service 800-877-7195
Web Address: www.vsp.com

Accident -Hospital Indemnity – Critical Illness
Burial Expense and Identity Theft
Web Address: www.allstatebenefits.com
Phone: 1-800-521-3535

Employee Assistance Program
Customer Service 800-827-2377 or 918-877-9685

Osage Nation – Benefits Department
Erin Casoose
Benefits Administrator
Osage Nation
239 W. 12th St, Pawhuska, OK 74056
Phone: 918-287-5235
Email: erin.casoose@osagenation-nsn.gov

Broker Contact Information:
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