Authority Request No. 379

REQUEST FOR LEGAL SERVICES

This form is used to provide legal opinions and contract approval by the District Attorney's Office. Only that advice that is related to a pending or potential claim against the County or its officers and employees is protected by the attorney-client priviledge. Opinions that are privileged should not be disclosed to anyone or the priviledge may be waived.

All legal opinions and approvals rendered are based only on the documentation and information stated below or attached to this form and, thus, it is important that all relevant facts and information be provided at the time of review. Please advise the District Attorney's Office of new or additional information, as it may cause the opinion to change. In all cases, the opinions of the District Attorney's Office are not binding on the County, its officers or employees and may be followed or disregarded in the discretion of the elected official.

Date of Request: 6-2-25 Department: Benefits & Retirement

State the nature of the legal request: Please review the attached Blue Cross Group Medicare Advantage Benefit Program Application as to form and legality.

RECEIVED
JUN 02 2025
CIVIL DIVISION
DISTRICT ATTORNEY

Jon Wilkerson
Signature

Reply of District Attorney's Office: Reviewed OK

Date of Reply: 6/2/25

Assistant District Attorney

Blue Cross Group Medicare Advantage℠

Blue Cross Group MedicareRx℠

BENEFIT PROGRAM APPLICATION ("BPA") For GROUP MAPD/PDP PLANS

ACCOUNT INFORMATION (TO BE COMPLETED BY THE PLAN)	
Account Status: New ☐ Renewal ☑ Off-Cycle Change: Yes ☐ No ☑	Current Non-Medicare Group Customer: Yes ☐ No ☐
Account Number (6-digits):	Group Number(s): POK000006
Sub-Group Number(s) (if applicable):	
Policy Effective Date: 07/01/2025	Policy Anniversary Date: 07/01/2026
Legal Account Name: County of Oklahoma	
CMS Contract Number: H0107	Region:
Plan Benefit Package (PBP) Code Number: 813	
Plan/Product Description: Standard ☐ Custom ☑	
Group Administration Document (GAD) MA/MAPD Provided: Yes ☑ No ☐	

GROUP INFORMATION	
Legal Name of Applicant/Employer and d/b/a if any: County of Oklahoma	
Check One: Employer ☑ Union ☐ Trustee of a Fund ☐ Other ☐ **(Specify the employer, labor organization, or trust applying for coverage. An employee benefit plan may not be named.)**	
Employer Identification Number (EIN): 73-6006400 SIC:	Public Entity: Yes ☑ No ☐
Blue Cross Group MedicareRx (PDP) is a prescription drug plan provided by HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association. A Medicare-approved Part D sponsor. Enrollment in HISC's plan depends on contract renewal. Blue Cross Group Medicare Advantage HMO and PPO employer/union group plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HCSC is a Medicare Advantage organization with a Medicare contract. Enrollment in these plans depends on contract renewal.	
Employer Organization Type (check one):	
☐ State Government ☑ Local Government ☐ Publicly Traded Organization ☐ Privately Held Organization	☐ Non-Profit ☐ Church Group ☐ Other:
Nature of Business: County Government	

GROUP INFORMATION (continued)

Primary (Mailing) Address (location where Employer is domiciled): 320 RObert S, Kerr. Room 220

City:	State:	ZIP Code:
Oklahoma City	OK	7 3 1 0 2

Administrative Contact:	Title:
Jon Wilkerson	Director of Benefits & Retirment
Phone Number: (4 0 5) 7 1 3 - 1 5 3 5	FAX Number: (___) ___ - ____

Email Address: jon.wilkerson@oklahomacounty.org

Physical Address (if different from Primary - required):

City:	State:	ZIP Code:

Contact:

Subsidiary Companies:

Subsidiary Address:

City:	State:	ZIP Code:

Billing Contact:

Email:

Phone Number:	FAX Number:
(___) ___ - ____	(___) ___ - ____
Affiliated Companies:	Location(s):
ERISA Plan:	If yes, specify ERISA plan year: (mm/dd/yyyy)

ERISA Plan Administrator:

Plan Administrator Address:

City:	State:	ZIP Code:

EMPLOYER GROUP BROKER FEE

If checked below, Employer instructs that as part of the services provided by HCSC, HCSC is authorized to administer payment of Employer's fee, in the amount set forth by Employer below ("Employer's Broker Fee"), to a Broker entity for services performed on behalf of Employer (not on HCSC's behalf).

☐ If this blank is completed and the terms for payment are fully set out below, Employer directs HCSC to pay a fee to Employer's Broker on behalf of Employer and HCSC hereby agrees to pay such fee in accordance with the terms set forth herein. Employer acknowledges that Employer's Broker Fee is reflected in the rates set forth in this BPA. HCSC will administer the payments to Employer's Broker pursuant to Employer's directions and the schedule and in the amounts described herein and will not administer a payment in response to invoices which may be received from Employer's Broker. The parties further acknowledge and agree that HCSC shall not be obligated to administer the payment of any of Employer's Broker Fees until HCSC has received payment in full under the Contract. Any dispute regarding the amount of Employer's Broker Fee or the terms under which it should be paid is between Employer and Employer's Broker. If Broker Fee is paid per the terms below but Employer determines it is incorrect, Employer agrees to reimburse HCSC for such Broker Fee payments and Employer may recover directly from the Broker, if applicable under Employer's agreement with Broker. Employer acknowledges and agrees that HCSC will discontinue administering payments to Employer's Broker at the earliest of the following: (a) the termination of the Contract, (b) as mutually agreed by HCSC and Employer, (c) upon ninety (90) days' notice from Employer, or (d) upon five (5) days' notice from HCSC to Employer.

Note: The Employer Group Broker Fee described below is not HCSC Medicare sales or marketing Compensation, as those terms are defined in CMS Medicare regulations and guidance. HCSC continues to require licensure, Medicare Certification, and appointment for any producer who sells or markets Medicare Plans on HCSC's behalf, as set out in the Producer of Record section of this BPA, above.

Amount of Employer's Broker Fee to be paid: $40

Timing of Employer's Broker Fee payment:

☑ monthly ☐ quarterly ☐ annually ☐ other (specify_____)

Additional instructions to HCSC on Broker Fee payment:

Contact information to whom Employer's Broker Fee is to be paid:

Name: Donald Trudeau/TPG Group, Inc.

Street Address: 25 Seir Hill Rd.

City:	State:	ZIP Code:
Norwalk	CT	0 6 8 5 0

Phone Number:	Date:
(8 0 0) 2 3 6 - 4 7 8 2	

PRODUCER OF RECORD INFORMATION

Please provide the information requested below on all Producers/Agencies to whom commissions are to be paid. Producers/Agencies must be appointed to do business with HCSC and Medicare Certified for sale of MAPD Plans.The Producer's or Agency's name(s) must exactly match the name(s) on record with HCSC.

Only one (1) Producer/Agency can receive commission from Medicare Plan for this Medicare group plan. If a Producer is affiliated with a General Agent, the General Agent for the Producer listed below may receive override compensation from Medicare Plan.

Producer/Agency name to whom commissions are to be paid (if Medicare Certified and Eligible for Payment):
TPG Group Inc.

Producer Number of Producer or ☐ Agency ☑ :

Street Address:
25 Seir Hill Rd.

City:	State:	ZIP Code:
Norwalk	CT	0 6 8 5 0

Phone Number:	FAX Number:
(2 0 3) 9 6 9 - 6 0 0 0	(___) ___ - ____

Email Address:
dtrudeau@benistar.com

Is Producer/Agency Medicare Certified with HCSC? Yes ☑ No ☐

General Agent's Signature:	Date:
Producer Agency Representative:	Signature of Employer/Authorized Purchaser:
Signature of Producer Agency Representative:	Title:

Producer Agency Name:	Date:	Witness:
Producer Steet Address: 25 Seir Hill Rd.	Phone Number: (2 0 3) 9 6 9 - 6 0 0 0	

City:	State:	ZIP Code:
Norwalk	CT	0 6 8 5 0

Contracted Producer Tax ID Number:	Amount Submitted (for initial enrollment only):
06-1432630	$
HCSC Sales Representative:	District/Cluster:

Other Information:

ACTUARIAL AUTHORIZATION - INTERNAL USE ONLY	
Date BPA approved by Actuary:	Actuary:
Benefit program and premium notification letter included: Yes ☐ No ☐	Date of Letter:

SCHEDULE OF ELIGIBILITY	
1	**Standard Eligibility Provisions:**
	Retirees. Employer has determined that Eligible Person means a retiree who was enrolled in the Employer's health plan while an active employee, and meets CMS eligibility criteria to enroll in the Medicare Plan (e.g., entitled to Part A and enrolled in Part B).
	NOTE: Medicare Plan reserves the right to deny coverage for any group in which less than 51% of the Eligible Persons live in the geographical service area of Medicare Plan's provider network.
2	**Employer has determined the following are also eligible (check all that apply):**
	☑ **Dependents of Retirees.** Eligible retirees' spouses, children, and Civil Union Partners (as defined in Employer's Policy) who are Medicare Eligible, meet CMS eligibility criteria to enroll in the Medicare Plan (e.g., entitled to Part A and enrolled in Part B), and for those of retired employees, were formerly covered by the group health plan. ☐ **Domestic Partners.** Domestic Partners, as defined in the Policy, who are Medicare Eligible, meet CMS eligibility criteria to enroll in the Medicare Plan (e.g., entitled to Part A and enrolled in Part B), and for those of retired employees, were formerly covered by the group health plan. The Employer is responsible for providing notice of possible tax implications to those retirees with Domestic Partner Coverage. ☐ **Other:**
	Are any classes of employees or retirees to be excluded from coverage? Yes ☐ No ☑
	If yes, please identify the classes and describe the exclusion:
	NOTE: The Medicare Plan reserves the right to disapprove class exclusion if prohibited under applicable law.
3	**The Limiting Age for covered children (if applicable):** Covered child means a natural child, a stepchild, an eligible foster child, an adopted child (including a child involved in a suit for adoption,) a child for whom the Insured is the legal guardian, under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status (if applicable under the Policy), marital status, or any combination of those factors. If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet. To cover children age twenty-six (26) or over, Employer may select option (a) or (b) below: (a) ☐ Limiting Age for covered children age twenty-six (26) or over, who are ☐ married ☐ unmarried ☐ regardless of marital status, is ____ years [twenty-seven (27) - thirty (30) are the available options]. If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet. (b) ☐ Limiting Age for covered children who are full-time students and age twenty-six (26) or over, who are ☐ married ☐ unmarried ☐ regardless of marital status, is ____ years [twenty-seven (27) - thirty (30) are the available options]. If the covered child is eligible military personnel, the Limiting Age is thirty (30) years as described in the Certificate Booklet.

SCHEDULE OF ELIGIBILITY (continued)	
4	Coverage will terminate at the end of the period for which premium has been accepted. However, coverage shall be extended due to a leave of absence in accordance with any applicable federal or state law.

CURRENT ELIGIBLE POPULATION INFORMATION		
1	Total Number of Employees (not including Dependents) on payroll:	563
2	Total Number declining coverage (not covered elsewhere):	
3	Total Number of Retirees (not including Dependents):	563
4	Total Number of Employees Eligible for Medicare (not including Dependents):	
5	Total Number of Retirees Eligible for Medicare (not including Dependents):	563
6	Total Number (or estimate) of Dependents Eligible for Medicare (if applicable):	
7	Total Number of expected enrollees in the Medicare Plan:	563
Employer's Open Enrollment Period:		
If non-calendar year plan, provide renewal date: 07/01/2025 to 06/30/2026 (PBP=813)		

BENEFIT PLAN OPTIONS

Late Enrollment Penalty (LEP) attestation for enrollees*: Global ☐ Partial ☐

*Employer please note whether you certify (either globally as to all enrollees or partially as to a subset of enrollees) that Eligible Persons had prior creditable Part D prescription drug coverage, and therefore should not be subject to any CMS Late Enrollment Penalty.

Person/entity responsible for paying LEP: Employer ☐ Group Member ☐

Medicare Benefit Plan Options (check all that apply):

- ☐ Medicare Prescription Drug Plan (PDP)
- ☐ Medicare Advantage Prescription Drug (MAPD) Plan (HMO)
- ☐ Medicare Advantage Prescription Drug (MAPD) Plan (PPO)
- ☑ Medicare Advantage ONLY*

* If you select Medicare Advantage ONLY, enrollees will not have coverage for Part D prescription drugs at the pharmacy (retail or mail order), but Part B drugs will be covered under the medical benefit (in the doctor's office, hospital, clinic, etc., but not in a pharmacy).

Additional coverage options (check all that apply):

- ☐ Vision
- ☑ Hearing
- ☑ Fitness Program
- ☐ Dental Coverage
- ☐ Over-the-Counter benefits (OTC Medicine and supplies)
- ☑ Wellness Incentives & Rewards

Comments:

RATES

For the current year's premium and rate information, and benefit package selected, refer to the accepted finalized new group rates letter ("Letter") or the renewal exhibit ("Exhibit") for complete details. The Letter, or Exhibit, shall be incorporated by reference and made part of the BPA and Group Administration Document.

1	**FUNDING ARRANGEMENT:**
	☑ Premium – Prospective
	☐ Other (if approved in advance): Please specify:
2	**PAYMENT METHOD:** Employer chooses one of the following three methods of paying premiums as described in the Rate Letter:
	☑ Employer Pays full amount directly to Medicare Plan (Employer may in its discretion collect some or a portion from Participants, according to its policies, but need not indicate that amount herein).
	☐ Eligible Person/Participant Pays full amount directly to Medicare Plan.
	☐ Split: Employer has determined the flat amount or percentage of contribution as outlined in the table below. Employer pays its portion directly to Medicare Plan; Eligible Person/Participant pays its portion directly to Medicare Plan.

PRODUCT DESCRIPTION	TOTAL MONTHLY PREMIUM	MONTHLY EMPLOYER CONTRIBUTION IF SPLIT METHOD IS CHECKED ABOVE
MA/PD		
Plan 1	$	% or $
Plan 2	$	% or $
Plan 3	$	% or $
PDP		
Plan 1	$	% or $
Plan 2	$	% or $
Plan 3	$	% or $
MA ONLY		
Plan 1 H0107 - 813	$ 114.21	% or $
Plan 2	$	% or $
Plan 3	$	% or $

3	Premium must be paid in accordance with the timeframes set out in Section III of the Group Administration Document for Medicare Group Plans. If not paid within the stated time, Medicare Plan can cancel coverage for non-payment in accordance with Sections III and IV of the Group Administration Document.
4	Medicare Plan will give sixty (60) days prior written notification to Employer for change of premium rates, in accordance with the terms of Section III (F) of the Group Administration Document.
5	HCSC reserves the right to change premium rates when a substantial change occurs in the number or composition of subscribers covered. A substantial change will be deemed to have occurred when the number of subscribers covered changes by ten percent (10%) or more over a thirty (30) day period or twenty five percent (25%) or more over a ninety (90) day period.

BILLING SPECIFICATIONS

Retirees Listed: alphabetically ☑ by location ☐

If by location, list locations including location numbers if applicable:

Billing Method for Employer Payments (check one): Paper Bill ☐ Electronic pdf ☑ Excel version ☐
(Billing Method for Participant Payments will be selected by each Participant upon enrollment.)

Billing Contact: Jen Dougherty

Billing Street Address:
10 Tower Lane

City:	State:	ZIP Code:
Avon	CT	06001

Billing Phone Number:	Billing Email Address:
(800)236-4782	jdougherty@benistar.com

ID CARD DELIVERY

Medicare Plan will mail ID Cards to each Participant's address on file with Medicare Plan.

OTHER PROVISIONS

1	This BPA is incorporated into and made a part of the Contract entered into and agreed upon by the Medicare Plan and the Employer. Contract means the Group Administration Document, the Benefit Program Application, and any other applications, Evidence of Coverage, riders, enclosures, attachments, appendices, addenda, exhibits, and amendments thereto.
2	Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.
3	Employer represents and warrants that this BPA includes retiree-only plans and excepted benefits that are not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). In no event shall the Medicare Plan be responsible for any legal, tax or other ramifications related to Employer's representation of exempt plan status. Employer shall indemnify and hold harmless the Medicare Plan and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought or asserted against the Medicare Plan in connection with exempt plan status or any provision of inaccurate information. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.
4	All terms of any existing BPA as amended from time to time shall remain in force and effect. For the purposes of this Contract, the term "existing BPA" includes any other BPA for commercial group coverage, Schedule of Specifications and/or Group Agreement signed by the Employer, and any subsequent Schedules of Specifications and/or Group Agreements and amendments thereto.

I UNDERSTAND AND AGREE THAT:	
1	A minimum participation of two (2) Participants must be maintained under the MA-PD Plan(s) elected. With regard to MA-PD Plan(s), a substantial change in enrollment will be deemed to have occurred when the number of covered Participants changes by 10% or more over a 30-day period or 25% or more over a 90-day period.
2	Producer Statement (if applicable): I certify that I have reviewed all enrollment materials. I have also advised the employer that I have no authority to bind these coverages, to alter the terms of the Contract(s), this BPA or enrollment material in any manner or to adjust any claims for benefits under the Contract(s).
3	The Medicare Plan will report the value of all remuneration by the Medicare Plan to ERISA plans with 100 or more participants for use in preparation of ERISA Form 5500 schedules. Reporting will also be provided upon request to non-ERISA plans or plans with fewer than 100 participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which your agent/ consultant is eligible for the sale or renewal of self-funded and/or insured products.
4	The undersigned person represents that he/she is authorized and responsible for purchasing coverage on behalf of the employer and by signing this BPA, Employer agrees to the terms of the Contract. It is understood that the actual terms and conditions of coverage are those contained in the Contract into which this BPA shall be incorporated at the time of acceptance by the Medicare Plan.
5	The Employer's Benefit Program Application must pre-date the pre-requested Policy Effective Date and be received by the Medicare Plan at its home office, 300 E Randolph Street, Chicago, IL, 60601, no less than ninety (90) days prior to the requested Effective Policy Date.

Authorized Medicare Plan Representative	Signature of Authorized Purchaser
Title	Title
Address	Address
Date	Date
Agent Representative (if applicable)	

PROXY

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

Group Number:	**By:**
	Print Signer's Name Here
	Signature and Title

Group Name:

Group Street Address:

City:	State:	ZIP Code:

Dated this _____ day of _____

Blue Cross Group MedicareRx (PDP) is a prescription drug plan provided by HCSC Insurance Services Company (HISC), an Independent Licensee of the Blue Cross and Blue Shield Association. A Medicare-approved Part D sponsor. Enrollment in HISC's plan depends on contract renewal. Blue Cross Group Medicare Advantage HMO and PPO employer/union group plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HCSC is a Medicare Advantage organization with a Medicare contract.aut Enrollment in these plans depends on contract renewal.

Approved on June 18, 2025.

By Oklahoma County Budget Board

Chairman

Forrest "Butch" Freeman

Vice-Chair

ATTEST:

Maressa Treat

Maressa Treat, Oklahoma County Clerk

Approved on ____, day of _____, 2025

By Board of County Commissioners

_____
Chairman

_____
Vice-Chairman

_____
Member

ATTEST:

_____
Maressa Treat, County Clerk,
Oklahoma County

Bill To
OKLAHOMA COUNTY COMMISSIONERS
320 ROBERT S KERR
ROOM 101
OKLAHOMA CITY, OK
73102

Requisition 12600082-00 FY 2026

Acct No:
UNDEFINED ACCOUNT.
Review:
Buyer: 6065cmjescla
Status: Created

Vendor
BESTCO BENEFIT PLANS LLC
10 TOWER LANE SUITE 100

AVON, CT 06001

Tel#800-236-4782

Ship To
OKLAHOMA COUNTY COMMISSIONERS
320 ROBERT S KERR
ROOM 101
OKLAHOMA CITY, OK 73102

Deliver To
OKLAHOMA COUNTY COMMISSIONERS
320 ROBERT S KERR
ROOM 101
OKLAHOMA CITY, OK 73102

Date Ordered	Vendor Number	Date Required	Ship Via	Terms	Department
05/27/25	004571				General Government

LN	Description / Account	Qty	Unit Price	Net Price
001	Medicare Advantage services July 2025	1.00 EACH	152062.80000	152062.80

Ship To
OKLAHOMA COUNTY COMMISSIONERS
320 ROBERT S KERR
ROOM 101
OKLAHOMA CITY, OK 73102

Deliver To
OKLAHOMA COUNTY COMMISSIONERS
320 ROBERT S KERR
ROOM 101
OKLAHOMA CITY, OK 73102

Requisition Link

Requisition Total 152062.80

***** General Ledger Summary Section *****

Account	Amount	Remaining Budget