Tulsa FOP 93 Health Benefits Plan
Eligibility, Enrollment and Termination Summary
(February 2024)

Overview

Tulsa FOP 93 Health and Welfare Trust (the "Trust") sponsors the following health and welfare benefit plans (individually and collectively, the "Plan") for active and retired police officers of the City of Tulsa (the "Employer") who are or were members of the collective bargaining unit represented by the Lodge 93, Fraternal Order of Police (the "Union") and their eligible dependents:

- Health Benefits Plan;
- Dental Benefits Plan;
- Vision Benefits Plan;
- Group Term Life Plan;
- Voluntary Life Plan; and
- Long Term Disability Plan.

Voluntary Products. ***In addition, Trust offers various voluntary products (individually and collectively, the "Voluntary Product") for employees and retirees. Eligibility requirements for participation in any Voluntary Product are subject to the applicable carrier's eligibility rules and requirements. Employees and retirees pay 100% of their premiums.***

All funds contributed by the Employer, employees, retirees, and any other Plan participants are paid to and maintained by the Trust.

This is a summary of the eligibility requirements for participation in the Plan. Many of the terms used in this Summary are capitalized. These terms are important in understanding your eligibility, and are defined the applicable Plan document or policy.

Eligibility

Eligibility for participation in the Plan for an " Employee" or " Retiree" is based on information received by the Plan Administrator from your Employer.

Employee Benefits

Employee
Health, Dental, Vision, Group Term Life, Voluntary Life, and Long Term Disability Coverage

You are eligible for coverage described in the Plan if you are in an eligible class. You are in an eligible class, if (1) you were hired as a permanent, full-time sworn Employee of the Tulsa Police Department; (2) you are the Chief of Police; or 3) you are an Employee entering the police academy.*
**Eligibility under the Long Term Disability Plan is limited to Employees with less than 20 years of service. NOTE: Eligibility may be continued under the Plan while you are on an employer-approved leave of absence, subject to the applicable Plan's eligibility rules and requirements.*

You become eligible on your "Eligibility Date", which is the first of the month coincident with or next following the date you complete 30 days of continuous service for your Employer. Employees entering the police academy who are *eligible* for the City of Tulsa's employee benefit plan(s) will not need to meet the Trust Plan's eligibility waiting period, and the "Eligibility Date" will be the first day of the month coincident with or next following the date the Employee enters the police academy program.

Your coverage becomes effective on your Eligibility Date.*
**Group Term Life, Voluntary Life, and Long Term Disability Plans have additional eligibility requirements that may*

delay your coverage if you are not "actively-at-work" on your Eligibility Date.

Reinstatement of Coverage. If your coverage ends due to termination of employment, leave of absence, or reduction of hours, and you qualify for eligibility under the Plan again (you are reinstated with the Employer) within one (1) year of your date of separation, your coverage will be reinstated effective on your "Reinstatement Date" if you enroll for coverage within 30 days after satisfaction of the eligibility requirements.

Employee and Dependents
Health, Dental, Vision and Voluntary Life Coverage

Your eligible "Dependents"* (described below) may be covered under the Health, Dental, Vision, and Voluntary Life Plans:

- Your "Spouse" means any person who is lawfully married to you under any State law, including marriages recognized in States other than where the covered person resides. *The Plan Administrator may require documentation proving a legal marital relationship.*
- Your "Child(ren)" to age 26. Children includes (1) your own biological children; (2) stepchildren, if you live with the child(ren) and his/her/their custodial parent; and (3) other child(ren) who live with you in a parent child relationship and who depend on you for financial support and maintenance. Other child(ren) includes, but is not limited to: foster child(ren), adopted child(ren), or child(ren) "placed with you for adoption", and grandchild(ren) of whom you have been awarded custody or guardianship by a court or agency of competent jurisdiction. Stepchildren and other child(ren) who do not live with you are eligible if a court or agency of competent jurisdiction has placed responsibility with you for relevant expenses. *A copy of a court order or a birth record may be required to demonstrate eligibility.* Child(ren) "placed with you for adoption" means a Child that you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such adoption or placement. The term "placed" means assumption and retention by you of a legal obligation for total or partial support of the Child in anticipation for adoption of the Child. The Child must be available for adoption and the legal process must have commenced.
- A Dependent also includes your unmarried fully handicapped Child beyond age 26 subject to the following:
    - The Child must have been covered under the Plan immediately prior to reaching age 26 and have been unable to earn his or her own living prior to reaching age 26 because he or she is mentally or physically handicapped and depends on you for financial support. The employee must provide over one-half of the Child's support for the calendar year.
    - The Employee must provide written proof of incapacity and dependency to the Plan Administrator within the 31-day period beginning on the date the Child reaches age 26. *The Plan Administrator may require subsequent proof at reasonable intervals thereafter.*
    - If an individual who is covered as a Dependent under this provision terminates Dependent coverage, he or she will not be eligible to again become covered as a Dependent unless he or she furnishes written proof, for the period of non-coverage of: (i) continuous coverage under other medical insurance coverage; (ii) incapacity; and (iii) dependency on the Employee.

**Eligibility for your Dependents under the Voluntary Life Plan is subject to the applicable carrier's eligibility rules and requirements.*

Court Ordered Coverage for a Child

Federal law requires the Plan, under certain circumstances, to provide coverage for your Child(ren). The details of these requirements are summarized below.

The Plan Administrator shall enroll for immediate coverage under the Plan any Child, who is the subject

of a "qualified medical child support order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Plan Administrator receives a QMCSO, the Plan Administrator shall also enroll you for immediate coverage under the Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Administrator determines that the order is a QMCSO. Any required contribution for coverage pursuant to this provision will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your child and includes certain information concerning such coverage. The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no child is eligible for Plan coverage, even if you are required to provide coverage for that child under the terms of a separation agreement or court order, unless the child is an eligible child under the Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Plan Administrator.

When You and Your Spouse Are Both Covered Employees
When both you and your Spouse are covered Employees, each of you must choose health, dental and/or vision coverage as either an Employee or Dependent. You may not be covered under the Plan as both an Employee and a Dependent.

Employee Contributions
Health Coverage
Cost of coverage is funded in part by Employer contributions and in part by Employee contributions.
Dental Coverage
Cost of coverage is funded in part by Trust contributions and in part by Employee contributions; however, if Employee is not enrolled in the Health Plan, Employee pays 100% of the cost of coverage.
Vision Coverage
Employee pays 100% of their premiums.
Group Term Life Coverage
Employer pays 100% of the premiums.
Voluntary Life Coverage
Employee pays 100% of their premiums.
Long Term Disability Coverage
Trust pays a portion of the premiums and Employees pay a portion of their premiums.

Enrollment Procedures for Employee and Dependents Coverage

Health, Dental and Vision Coverage
Once you are eligible to participate in the Plans, you must enroll for coverage by completing all election and enrollment forms and submitting them to the Plan Administrator within 30 days after satisfaction of the eligibility requirements. If you are required to contribute towards the cost of coverage you must complete and submit a payroll deduction authorization for the Plan Administrator to notify your Employer to deduct the required contribution from your pay. *In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your enrolled Dependents. The Plan Administrator may request this information at any time for continued eligibility under the Plans. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plans.*

If you fail to complete and submit the appropriate election and enrollment forms within the 30- day period described above, you will not be eligible to enroll in the Plan until the next Open Enrollment Period or unless you experience a Special Enrollment Event or a Status Change Event (described in the Plans).

Newborn Children

- If you have a newborn Child while covered under the Plans, then the following applies:
  - If you are enrolled under individual coverage, you may add coverage for a newborn effective on the Child's date of birth provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) to the Plan Administrator within 30 days of the Child's date of birth
  - If you are enrolled under family coverage, no additional contribution is required to add coverage for a newborn and coverage for the newborn will be effective on the Child's date of birth. However, you must notify the Plan in writing of the Child's birth (please submit the election and enrollment forms to the Plan Administrator within 30 days of the Child's date of birth) to avoid any claim delays. If you chose to decline enrollment for the newborn, you should provide a statement to the Plan Administrator indicating the reason you are declining enrollment. If you declined enrollment for the newborn due to other health coverage, if the Child loses such other health coverage, it may constitute a Special Enrollment Event (described in the Plans) that gives you a right to enroll the Child in the Plan mid-year due to such loss of coverage.
- A contribution will be charged from the first day of coverage for the newborn if an additional contribution is required.

Group Term Life, Voluntary Life and Long Term Disability Coverage

Once you are eligible to participate in the Plans, you must enroll for coverage by completing all election and enrollment forms and submitting them to the Plan Administrator within 30 days after satisfaction of the eligibility requirements. If you are required to contribute towards the cost of coverage you must complete and submit a payroll deduction authorization for the Plan Administrator to notify your Employer to deduct the required contribution from your pay. *In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your enrolled Dependents, if applicable. The Plan Administrator may request this information at any time for continued eligibility under the Plans. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plans.*

If you fail to complete and submit the appropriate election and enrollment forms within the 30- day period described above, you will not be eligible to enroll in the Plan until the next Open Enrollment Period; however, you may add Life coverage for a newly-acquired Dependent if you experience a Special Enrollment Event (as described in the Plan).

Retiree Benefits

Retiree

Health, Dental and Vision Coverage

Individuals who meet at least one of the following requirements will be eligible to continue current benefit elections for Retiree coverage under the Health, Dental and Vision Plans:

- You must be a member of the Trust at the time your employment ends; *and*
- Must have at least 10 years with the City of Tulsa Police Department; *and*
- Must have at least 20 years with the Oklahoma Police Pension and Retirement System (OPPRS); *or*

- You must be a member of the Trust at the time you become medically retired through OPPRS due to an injury in the line of duty with the City of Tulsa Police Department

Optional Medicare Advantage Plans. ***In addition, the Trust offers various Medicare Advantage Plan options for Medicare eligible Retirees. If a Retiree leaves the Health Plan and enrolls in a Medicare Advantage Plan option, then the Retiree shall not be eligible to re-enroll in the Health Plan at a later date. However, if a Retiree enrolls in a Medicare Advantage Plan option and leaves the Medicare Advantage Plan, then the Retiree shall be eligible to enroll in a Medicare Advantage Plan option offered by the Trust at a later date according to Medicare eligibility rules. In addition, the Clinic Access/CCOK Senior Health Plan options are subject to the underlying Health Plan eligibility rules.***

Health Coverage

You are eligible to continue your coverage under the Health Plan until you become Medicare eligible. When Medicare (Medicare Part A and/or Part B) benefits are not available, you may remain on the regular plan rate tiers until you do qualify for Medicare. If you do not maintain *continuous* health coverage after your retirement date or deferred retirement termination date you will lose eligibility. Retirees who become Medicare eligible and have Medicare Parts A and B may continue their health coverage under the Plan as their secondary coverage. Members may remain on this health plan with single or family coverage if they activate Parts A and B of Medicare. The Trust then becomes secondary for the member that has Medicare. The Trust Plan will be secondary to Medicare for any Medicare eligible participants.

Retirees who do not maintain *continuous* coverage under the Health Plan shall not be eligible for Plan re-entry at a later date.

A special eligibility rule for specifically identified Tulsa Police Department Retirees who were employed with the Employer as of December 1, 2007, and who had not yet accumulated five years of service with the Employer. If these named Employees retired from the Employer with less than five years of service, they would be allowed to elect Retiree benefits from the Plans. Once these named Employees had accumulated five years of service with the Employer, they would no longer be eligible for Retiree benefits from the Plans per this rule.

Retiree and Dependents
Health, Dental and Vision Coverage

Spouses and Child(ren) to age 26 may be covered under the Health, Dental and Vision Plans, including your unmarried handicapped Child as described above under ***Employee and Dependents.***

Optional Medicare Advantage Plans. ***In addition, the Trust offers various Medicare Advantage Plan options for Medicare eligible Spouses. If a Spouse enrolls in a Medicare Advantage Plan option and leaves the Medicare Advantage Plan, then the Spouse shall be eligible to enroll in a Medicare Advantage Plan option offered by the Trust at a later date according to Medicare eligibility rules. In addition, the Clinic Access/CCOK Senior Health Plan options are subject to the underlying Health Plan eligibility rules.***

Health Coverage

Your Spouse may continue coverage under the Health Plan until your Spouse becomes Medicare eligible except when Medicare (Medicare Part A and/or Part B) benefits are not available, in which case your Spouse may remain on the plan until they qualify for Medicare. Retiree Spouses who become Medicare eligible and have Medicare Parts A and B may continue their health coverage under the Plan as their secondary coverage. Continuing Dependent(s) who are not Medicare eligible will be covered under regular plan rate

tiers.

Additionally, if a Retiree remain on this health plan with single or family coverage as their secondary coverage, spouse and dependents may remain on the family regular plan rate tier with the retiree. The Trust plan will be secondary to Medicare for any Medicare eligible participants.

Enrollment Procedures for Retiree Coverage

Health Coverage

Election to continue Retiree coverage under the Health Plan must be made within 30 days of your retirement date. If you do not elect to continue Retiree coverage under the Plan during this 30-day period, you are not eligible to enroll in Retiree coverage at a later date. The Open Enrollment Period and Special Enrollment Events (described in the Plan) do not entitle a Retiree to enroll in the Plan; however, they do allow a Retiree to add Dependents, as applicable, to his or her Retiree health coverage.

Dental and Vision Coverage

Election to continue Retiree coverage under the Dental and Vision Plans must be made within 30 days of your retirement date. If you do not elect to continue Retiree coverage under the Plans during this 30-day period, you will not be eligible to enroll in the Plans until the next Open Enrollment Period or unless you experience a Special Enrollment Event or Status Change Event (described in the Plans).

At the time of retirement, you may elect to enroll in COBRA Continuation Coverage in lieu of Retiree coverage. If you elect COBRA Continuation Coverage in lieu of Retiree coverage for yourself and any eligible Dependents or if you fail to make any election under the Plan, you and/or your Dependents will not be eligible to enroll in the Retiree coverage under the Plan at a later date, except as described above during the Open Enrollment Period or unless you experience a Special Enrollment Event or a Status Change Event (described in the Plan). If, however, you elect Retiree coverage in lieu of COBRA Continuation Coverage, the Retiree coverage under the Plan will be treated as alternative coverage and you will not be eligible to continue under COBRA once Retiree coverage under the Plan has ended. Provided however, if any of your eligible Dependents would lose Retiree coverage as a result of a COBRA qualifying event (such as divorce or Child ceases to be a Dependent Child) that Dependent would be eligible to continue under COBRA once Retiree coverage under the Plan has ended. (*See COBRA Continuation Coverage in this Section.)* Provided however, if any of your eligible Dependents would lose Retiree coverage as a result of a COBRA qualifying event (such as divorce or Child ceases to be a Dependent Child) that Dependent would be eligible to continue under COBRA once Retiree coverage under the Plan has ended. (*See COBRA Continuation Coverage in this Section.)*

If you decide to enroll yourself and your eligible Dependents in Retiree coverage, you must enroll by completing all required election and enrollment forms and submitting them to the Plan Administrator within 30 days after your retirement date. Participation in the Plan will begin for you and your eligible Dependents as of your date of retirement provided all required election and enrollment forms are properly submitted to the Plan Administrator. You are required to pay the entire cost of Retiree coverage for yourself and any eligible Dependents in accordance with the policies and procedures established by the Plan Sponsor. The amount of any required contribution will be communicated to you prior to the date of your retirement.

If you decide to terminate your Retiree coverage when you become Medicare eligible, your covered Dependents may continue their Retiree coverage. Your Dependent(s) who retains the coverage will be subject to the same rules, rates, and administrative procedures as those Participants covered by COBRA, except for COBRA insurance retention time limit.

Retiree Contributions

Health Coverage

Cost of coverage is funded in part by Trust subsidies and in part by Retiree contributions.

Dental Coverage

Cost of coverage is funded in part by Trust subsidies and in part by Retiree contributions.

Vision Coverage

Retirees pay 100% of their premiums.

Optional Medicare Advantage Coverage

CCOK Senior Health Plan options-Retirees pay 100% of their premiums.

*Clinic Access/CCOK Senior Health Plan options-Effective July 1, 2022, c*ost of Clinic Access is funded in part by Trust subsidies and in part by Retiree contributions, however Retirees pay 100% of their CCOK Senior Health Plan premiums.

Survivor Benefits

Survivor Benefits for Employees

Health, Dental and Vision Coverage

In the event of death of a covered Employee, the eligible Dependent(s) will be allowed to retain continuous coverage under the Health, Dental and Vision Plans until the earlier of the following:

- The date the Dependent fails to satisfy the eligibility requirements for coverage under the Plan;
- The date your surviving Spouse becomes Medicare eligible, except when Medicare (Medicare Part A and/or Part B) benefits are not available, in which case they may remain on the Health Plan until they qualify for Medicare*; or
- The date the monthly premium is not paid.

**Survivor Spouses who become Medicare eligible and have Medicare Parts A and B may continue their coverage under the Health Plan as secondary coverage. Continuing Dependent(s) who are not Medicare eligible may be covered under regular plan rate tiers.* Additionally, surviving spouses may remain on this health plan with single or family coverage if they activate Parts A and B of Medicare and the Trust then becomes secondary for the Surviving Spouse that has Medicare. The Trust plan will be secondary to Medicare for any Medicare eligible participants.

Survivor Benefits for Retirees

Health, Dental and Vision Coverage

If you (the Retiree) die while enrolled in Retiree coverage under the Health, Dental and Vision Plans, your covered surviving Dependent(s) may elect to continue Retiree coverage until the earlier of the following:

- The date your Dependent fails to satisfy the eligibility requirements for coverage under the Plan;
- The date your surviving Spouse becomes eligible for Medicare, except when Medicare (Medicare Part A and/or Part B) benefits are not available, in which case they may remain on the Health Plan until they qualify for Medicare*; or
- The date the monthly premium is not paid.

**Survivor Spouses who become eligible for Medicare and have Medicare Parts A and B may continue their coverage under the Health Plan as secondary coverage. . Continuing Dependent(s) who are not Medicare eligible will be covered under the regular plan rate tiers.* Additionally, surviving spouses may remain on this health plan with

single or family coverage in the Spouse Continuee rate tiers if they activate Parts A and B of Medicare . The Trust then becomes secondary for the Surviving Spouse that has Medicare.

Enrollment Procedures for Survivor Coverage

If your surviving Spouse and/or any eligible surviving Dependents decide to continue their enrollment in coverage (including Retiree coverage) under the Plan, they must enroll by completing all required election and enrollment forms and submitting them to the Plan Administrator within 30 days after the date of your death. Survivor coverage will begin for your Spouse and any eligible surviving Dependents as of the date of your death provided all required election and enrollment forms are properly submitted to the Plan Administrator. The cost of Plan coverage (including Retiree coverage) under this survivor benefit will be communicated to your surviving Dependents by the Plan Administrator. Surviving Dependents (including surviving Dependents of Retirees) who retain their coverage will be subject to the same rules, rates and administrative procedures as those who are covered by COBRA Continuation Coverage, except for the COBRA Continuation Coverage insurance retention time limit. The surviving Spouse becomes the Retiree upon the death of the Retiree and is subject to the same limitations as the Retiree concerning termination of coverage. ***If the surviving Spouse and/or any surviving Dependents leaves the Plan, he or she is not allowed to re-enroll at a later date.***

At the time of your death, your surviving Dependents may elect COBRA Continuation Coverage in lieu of Plan coverage (including Retiree coverage). If any of your surviving Dependents elect COBRA Continuation Coverage in lieu of Plan coverage (including Retiree coverage) available under this survivor benefit, they will not be eligible to enroll in the Plan at a later date. If, however, they elect to continue Plan coverage (including Retiree coverage) under this survivor benefit in lieu of COBRA Continuation Coverage, the coverage (including Retiree coverage) available under this survivor benefit will be treated as alternative coverage and they will not be eligible to continue coverage under COBRA once Plan coverage available under this survivor benefit has ended. Provided however, if your surviving Dependent Child would lose survivor benefits as a result of a COBRA qualifying event (such as Child ceases to a Dependent Child) the Dependent Child would be eligible to continue coverage under COBRA once Plan coverage available under this survivor benefit has ended. (*See COBRA Continuation Coverage in this Section.)*

Survivor Contributions

Health, Dental and Vision Coverage

Surviving participants pay 100% of their premiums.

Leaves of Absence

Employee

Health, Dental, Vision, Life and Long Term Disability Coverage

In the event of an Employee leave of absence (described in the Plan), the Plan will follow your Employer's determination of your employed/active and approved leave of absence status.

Termination of Coverage

Termination of Employee Coverage

Health, Dental, Vision, Life and Long Term Disability Coverage

Coverage under the Plan will terminate on the earliest of the following dates:

- The date the Plan terminates, in whole or in part;
- If you fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;
- The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA);

- The end of the month in which you cease to be eligible for coverage under the Plan;*
- The end of the month in which you terminate employment or cease to be included in an eligible class of Employees;*
- The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; and
- The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

** An insured's basic and supplemental life insurance coverage may be continued if you no longer meet the eligibility requirements, provided you make a written request and make the first premium payment within 31 days after your life insurance coverage would otherwise terminate, subject to certain exceptions and minimum/maximum amount restrictions that may apply. If you elect to continue your own life insurance coverage, you may also elect to continue contributory dependent life insurance for any other individual insured under your coverage. Coverage under the Long Term Disability Plan will terminate on the earliest of the date you cease to be a "Member" or the date your employment terminates.*

Termination of Employee's Dependent Coverage
Health, Dental and Vision Coverage

Coverage under the Plan will terminate on the earliest of the following dates:

- The date the Plan terminates, in whole or in part;
- The date the Plan discontinues coverage for Dependents;
- The date your Dependent Spouse becomes covered as an Employee under the Plan;
- The date coverage terminates for the Employee;
- If you and/or your Dependents fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;
- The date your Dependent Spouse reports to active military service;
- The end of the month in which your Dependent ceases to be a Dependent as defined by the Plan;
- The date your Dependent (or any person seeking coverage on behalf of your Dependent) performs an act, practice or omission that constitutes fraud; and
- The date your Dependent (or any person seeking coverage on behalf of your Dependent) makes an intentional misrepresentation of a material fact.

Termination of Retiree Coverage
Health, Dental and Vision Coverage

Coverage under the Plan will terminate for you and any Dependents on the earliest of the following dates:

- The date in which a required contribution has not been paid;
- The date the Plan terminates or no longer provides Retiree coverage;
- The date in which a Dependent no longer satisfies the eligibility requirements as a Dependent under the terms of the Plan;
- The plan terminates as primary coverage and becomes secondary to Medicare on the date you or your eligible spouse becomes Medicare eligible.
- The date you or your Dependent (or any person seeking coverage on behalf of you or your Dependent) performs an act, practice or omission that constitutes fraud;
- The date you or your Dependent (or any person seeking coverage on behalf of you or your Dependent) makes an intentional misrepresentation of a material fact.

Retroactive Termination of Coverage
Health, Dental and Vision Coverage

Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your

covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required Employee contributions have not been paid by the applicable deadline.

COBRA Continuation Coverage
Health, Dental and Vision Coverage

COBRA continuation coverage can become available to an Employee and his or her covered Spouse and Dependent children when group health plan coverage would otherwise be lost due to certain "qualifying events" described in the Plan. You may also 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, or 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 the plan generally does not accept late enrollees.

Administrative Ruling: Effective 11.17.2022

Tricare and Soonercare members may be added retroactively to the Tulsa FOP 93 Health and Welfare Trust Plan upon submission of documentation that they were terminated from coverage but did not receive proper documentation within the normal qualifying event election time frame.

When documentation is presented that the member received Proof of Loss of Coverage late, and through no fault of their own, Trust administrators may add eligible members and their eligible family members back to the date they were originally eligible, provided member agrees to pay their back premiums, and City of Tulsa agrees to fund their portion per the CBA.

Additionally, administrators will seek approval from the stop loss carrier unless current stop loss carrier has pre-approved this Administrative Ruling document.