
# OKC 2020

# City of Oklahoma City

## Employee Benefits Guide

# City of Oklahoma City

Dear City of Oklahoma City Employee,

It's benefit enrollment time again and the City has put together the following guide to help you prepare for the 2020 plan year. We recognize the importance of benefits for you and your family, which is why we take the time to carefully select providers who offer quality benefits.

We encourage you to review the following benefit guide prior to completing self-service enrollment through eBenefits, attending on-site enrollment and/or completing your enrollment forms. Enrollment counselors will be available throughout the open enrollment process to assist you in enrolling in all of your benefits and to answer any questions you may have. To see a complete schedule of this year's on-site enrollment sessions at the Civic Center, please see page 10.

The Employee Benefits Division of the Personnel Department developed the following benefit guide to provide you with information about your benefit options for the new plan year, explain the enrollment and change process, and serve as a valuable resource for information about City benefits.

Thank you in advance for taking the time to review this benefit guide. If you have any questions regarding the benefits outlined in this guide or your current benefits, please contact the Employee Benefits Division at 405-297-2144.

Sincerely,

Chris York
Employee Benefits Manager
Interim Director of Personnel

**Important Note:** At time of publication, the City of Oklahoma City is in negotiations with applicable collective bargaining groups. Benefits and/or rates referenced herein are subject to change. If such change occurs, employees will be notified.

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## About this Guide

This benefit guide is a compilation of City sponsored employee benefits. It is intended for informational purposes only. The actual benefits available and the full descriptions of these benefits are governed in all cases by the relevant plan document, insurance contracts, and Ordinances and Resolutions of The City of Oklahoma City, and where applicable, collective bargaining agreements. If there are discrepancies between the benefit guide and the actual plan documents, insurance contracts, and Ordinances and Resolutions, the documents, contracts, and Ordinances and Resolutions will govern.

## HIPAA Compliance

The Health Insurance Portability and Accountability Act (HIPAA) requires that your health insurance plan limit the release of your health information to the minimum necessary required for your care. If you have questions about your claims, contact your insurance carrier first. If, after contacting the insurance carrier, you need a representative of the Employee Benefits Division to assist you with any claim issues, you may be required to provide written authorization to release information related to your claim. The City of Oklahoma City advises you that the HIPAA Notice of Privacy Practices is available to you by accessing http://www.okc.gov/departments/personnel/benefits. If you do not have access to the internet and you would like a copy of the HIPAA Notice of Privacy Practice, or if you have any questions, please contact a representative of the Employee Benefits Division at 405-297-2144.

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Quik Tips

# Enroll**Online**

All eligible employees can enroll online. Employees without access to a computer can enroll in benefits using the employee application terminals located in various city buildings.

For terminal locations, see page 10.

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# City Benefits Program

*Eligibility & Coverage Information*

## Enrollment

All eligible employees may enroll online between **October 15 - 31, 2019.** Employees can enroll in benefits using the employee application computer terminals located in various City buildings. Please refer to pages 9-10 for instructions and locations of employee application terminals.

On-site enrollment will begin on **Monday, October 21, 2019 and end on Friday, October 25, 2019**. Please refer to page 10 of this guide for a complete enrollment schedule.

## Plan Eligibility

Eligibility is determined by the requirements stated in the appropriate plan document or insurance policy for the year in question. Since the plans are subject to change, eligibility may also change. If you change coverage from one plan to another, you and your dependent(s) must meet the requirements of the new plan selected.

## Benefits Information

Additional information regarding your benefits can be found on InsideOKC. Just click on the Employee tab, then Benefits to find copies of common forms, additional plan information, and contact information. If you need to meet with Employee Benefits, please call 297-2144 to set up an appointment.

## Employee Eligibility

You are eligible to participate in the City's health and welfare plans if you are classified as a regular, full-time active employee, excluding Fire Fighters, or in one of the following categories: 1) An employee on paid disability leave due to an on-the-job injury or illness who was a regular, full-time active employee on the date the disabling injury or illness occurred; 2) An elected official of the City; 3) The City Auditor or a regular, full-time active employee of the City Auditor's office; 4) The Municipal Counselor or a regular, full-time active employee of the Municipal Counselor's office; or 5) A full-time active Oklahoma City Municipal Judge; or 6) An eligible employee of a participating public trust.

You and your dependents will not be covered until you complete the appropriate paperwork with the Employee Benefits Division, provide the necessary documents to be enrolled (i.e. birth certificates, marriage license, copy of the social security card, etc.), and pay the required premium(s).

***For more information, contact Employee Benefits at 405-297-2144.***

# Things to Know for 2020

## Opioid Prescriptions

Due to the national opioid crisis, pharmacy benefit managers are making changes to the way they fill and renew opioid prescriptions. Changes may include maximum dosage limits, quantity limits, and prior authorizations. Both of the City's plan providers have already announced changes to comply with Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) recommendations. Members should expect authorizations to be required if your prescriptions exceed a maximum dosage of 200mg per day Morphine equivalent dosage or lasts longer than a week on some medications. Your doctor can help you work with your plan provider if these situations occur.

## Enrollment Information

By taking no enrollment action, you will remain enrolled in the same benefit plan and premiums will automatically adjust to the new rates, with the exception of the Health Flexible Spending Account or Dependent Day Care Spending Account. **The Health Flexible Spending Account and Dependent Day Care Spending Account require a new election every year.**

## Employee Assistance Plan

Beginning July 1, 2019, the City will have a new to Assistance Plan (EAP) provider, Alliance Work Partners (AWP). Alliance Work Partners provides up 6 counseling sessions for eligible Employees as well as numerous other resources for our members. To learn more about this free benefit see page 47.

## Important Notice Regarding OKCCare Employee Medical Center

For 2020, the onsite operator of the OKCCare Employee Medical Center has not been finalized at the time of publication of this guide. Once the contract with the operator has been finalized, additional information will be provided regarding OKCCare Employee Medical Center operations for 2020. Additional information regarding the services provided by OKCCare Employee Medical Center can be found on page 46 of this guide.

## Beneficiary Information

The City recommends that you provide updated beneficiary information at least every five years. Although your beneficiaries and/or designation of proceeds may not have changed, your beneficiaries address and/or contact information may not be current.

Please take this opportunity to complete the following beneficiary forms: Group Life Beneficiary Designation, Final Wages, and Retirement. In addition, if you have any individual plans, you may wish to contact American Fidelity for additional assistance.

# Rates

## *2020 Health, Dental, Vision, & Group Life*

| Benefit Plan | | Total Premium | Employer | Employee |
|---|---|---|---|---|
| Frequency of Deduction | | Twice each month for a total of 24 times annually (1st & 2nd paycheck of the month)* | | |
| BlueCross BlueShield Group Indemnity Health Plan | Employee Only | $461.70 | $369.36 | $92.34 |
| | Employee + Spouse | $872.61 | $698.09 | $174.52 |
| | Employee + Child | $646.37 | $517.10 | $129.27 |
| | Employee + Children | $831.05 | $664.84 | $166.21 |
| | Employee + Family | $1,177.32 | $941.86 | $235.46 |
| UnitedHealthcare HMO Plan | Employee Only | $422.35 | $359.00 | $63.35 |
| | Employee + Spouse | $950.36 | $807.81 | $142.55 |
| | Employee + Child | $739.17 | $628.30 | $110.87 |
| | Employee + Children | $908.14 | $771.92 | $136.22 |
| | Employee + Family | $1,309.42 | $1,113.01 | $196.41 |
| BlueCross BlueShield Dental Low Plan | Employee Only | $11.22 | $8.00 | $3.22 |
| | Employee + 1 | $22.45 | $8.00 | $14.45 |
| | Employee + 2 or more | $35.90 | $8.00 | $27.90 |
| BlueCross BlueShield Dental High Plan | Employee Only | $16.54 | $8.00 | $8.54 |
| | Employee + 1 | $33.07 | $8.00 | $25.07 |
| | Employee + 2 or more | $52.92 | $8.00 | $44.92 |
| VSP Vision Plan | Employee Only | $3.50 | | $3.50 |
| | Employee + 1 | $6.49 | | $6.49 |
| | Employee + 2 or more | $10.44 | | $10.44 |
| Dearborn National Basic Life | Coverage $15,000 | $0.79 | $0.79 | |
| Dearborn National Basic AD&D | Coverage $5,000 | $0.08 | $0.08 | |
| Dearborn National Supplemental Optional Life | Coverage $5,500 | $0.72 | | $0.72 |
| Dearborn National Voluntary Employee Life (1, 2, or 3 x's annual salary)** | Coverage 1/2, 1x, 2x or 3x | $0.14 | | **See Formula Below or refer to your enrollment statement |
| Dearborn National Voluntary AD&D | Coverage $5,000 | $.08 | | $.08 |
| | Coverage $10,000 | $.16 | | $.16 |
| | Coverage $15,000 | $.24 | | $.24 |
| | Coverage $20,000 | $.32 | | $.32 |
| Dearborn National Voluntary Dependent Life - Spouse | Coverage $10,000 | $1.43 | | $1.43 |
| | Coverage $20,000 | $2.85 | | $2.85 |
| | Coverage $40,000 | $5.70 | | $5.70 |
| | Coverage $60,000 | $8.55 | | $8.55 |
| | Coverage $80,000 | $11.40 | | $11.40 |
| | Coverage $100,000 | $14.25 | | $14.25 |
| Dearborn National Voluntary Dependent Life - Child | Coverage $2,500 | $0.27 | | $0.27 |
| | Coverage $5,000 | $0.53 | | $0.53 |
| | Coverage $7,500 | $0.79 | | $0.79 |
| | Coverage $10,000 | $1.05 | | $1.05 |

* For complete details, see the 2019 payroll calendar on page 61. ** Voluntary Life Calculation: Coverage Amount/$1,000 * rate = Cost

If you are an employee of a participating Trust of the City of Oklahoma City, your premium contribution rates are included on your Benefit Enrollment Form.

# Enrollment for Plan Year 2020

## Important Dates to Remember

Your On-site Enrollment Dates are:

October 21, 2019 - October 25, 2019

Your Period of Coverage Dates are:

January 1, 2020 - December 31, 2020

## Open Enrollment Deadlines

Enrollment Form Changes Due:

October 31, 2019

Online Enrollment Changes Due:

October 31, 2019

Required Open Enrollment Legal Documentation Due:

October 31, 2019

Confirmation Statement Changes Due:

November 15, 2019

## Important Enrollment Information

By taking no enrollment action, you will remain enrolled in the same benefit plan and premiums will automatically adjust to the new rates, with the exception of a Health Flexible Spending Account or Dependent Care Account. **The Health Flexible Spending Account and Dependent Care Spending Account require a new election every year.**

**NOTE: Coverage will only continue for the next plan year, if all required documents supporting eligibility for benefits have been provided to the Employee Benefits Division.**

## 1st Deduction in 2020

The first premium for 2020 will be deducted from earnings on the January 3, 2019 pay date. **Remember to review your paycheck to ensure that the proper premiums are being deducted based on your enrollment elections.**

## Annual Open Enrollment

Each year Open Enrollment provides you an opportunity to change plans and modify dependent coverage. Changes made become effective January 1, 2020, and will remain in effect through the plan year (January 1, 2020 - December 31, 2020).

**NOTE: If dependent eligibility changes during the year you must notify the Employee Benefits Division of the Personnel Department within 31 days of the qualifying event (please see page 60 for additional information regarding Qualifying Events).**

## What You Need to Do During Annual Open Enrollment

1. Review the benefits available and determine which plans best meet your needs.
2. Review the family members you have covered under the Plan. During the annual enrollment period, you are verifying that your dependents meet the City's benefit eligibility requirement. You may be required to provide supporting documentation.
3. Ensure the City has your correct mailing address on file in the Personnel Department.

## Administrative Information

**Clerical Error/Delay**

Clerical error or delay will not invalidate coverage or cause coverage to be in force. Coverage is governed solely by terms and provisions of the Plans, and City policy. Additionally, payment or lack of payment of premiums will not cause coverage under a Plan to commence or terminate. However, upon discovery of clerical error or delay, which results in over or under collection of premiums, an adjustment will be made to reflect the correct amount of premiums. The City has the right to collect premiums owed by the employee and conversely, the employee will be reimbursed if an overpayment occurs. Additionally, if a clerical error results in the processing of claims against the Plan, any payments disbursed to providers will be invalidated and payment of services will be the responsibility of the employee.

## Remember...

We recommend reviewing your current information, including...

- Updating your beneficiaries.
- Removing ineligible dependents
  - If you are divorced, your ex-spouse is no longer eligible for health, dental, and /or vision coverage.
  - If a child no longer qualifies for coverage as a dependent (i.e. stepchildren who are no longer eligible due to divorce, loss of guardianship, etc.)
  - If you have Spousal Life Insurance coverage, and are divorced, your ex-spouse is no longer eligible for this coverage.
  - If you have Child Life Insurance coverage and your children are over the age of 23, your children are no longer eligible for this coverage.

# Three Easy Ways to Enroll

## 1 Enroll Online

Enroll online from the convenience of your home using eBenefits. Note: by enrolling online you can **only** enroll in Medical, Group Term Life, Dental, Vision, and Flexible Spending Accounts. If you wish to enroll in voluntary products (Long-Term Disability, Cancer, Accident Only, Individual Term Life, or Permanent Life plans), you will need to attend the on-site enrollment. **If you are adding dependents to City sponsored benefit plans you will need to enroll on-site or by mail.**

1. Type https://okcpeople.okc.gov into the address bar of an internet browser
2. Enter your City email address and your password, then click "Sign In"
3. Click on the Benefit Icon -->Benefits Enrollment

**NOTE**: You may need to clear your internet cache/cookies.

If you have never logged onto the City's network using a username and password, have forgotten your username or password, or do not know your City email address, please contact an IT representative at 405-297-2727 for assistance. Additional Instructions for online enrollment are available on the Open Enrollment page in the Employee Benefits section of **InsideOKC**.

## 2 Enroll On-Site

On-site enrollment counselors will be available to assist you with the enrollment process. Employees are authorized up to two hours of paid leave to participate in the enrollment process. Refer to the Open Enrollment Schedule provided in this guide for your scheduled attendance dates. Please remember to discuss with your supervisor to determine the best date to attend. **Also, if you add dependent(s), you must provide appropriate documentation (i.e. birth certificate, marriage license, copy of the Social Security card, etc.) to the Employee Benefits division at enrollment, before dependent(s) will be added to the City's plan(s).**

| By enrolling on-site you can enroll in: | | | |
|---|---|---|---|
| • Medical | • Vision | • Accident Only Insurance | • 457(b) Savings Plan |
| • Group Term Life | • Long-Term Disability | • Cancer Insurance | • Fitness Center |
| • Dental | • Individual Term Life | • Flexible Spending Accounts | • Permanent Life |

## 3 Enroll by Mail

Complete your personalized Enrollment Statement included in your enrollment packet and return it by October 31, 2019. Additional enrollment instructions are provided on your statement. **If you are not making any changes, it is not necessary to return your enrollment statement. However, if it is determined that required documentation (i.e. birth certificate, marriage license, copy of the Social Security card, etc.) has not been provided, you will be required to submit the information to the Employee Benefits Division before coverage becomes effective.**

**Remember: You must re-enroll in the Health and/or Dependent Care Flexible Spending Account EACH YEAR!**

| Documents required for Benefit Enrollment or Changes | | |
|---|---|---|
| Birth Certificate | Medicare Card | Social Security Card |
| Dependent Eligibility Form | Common Law Marriage Affidavit and Documentation | Legal Guardianship Documents |
| Marriage License | Divorce Decree | Adoption Papers |

# Enrollment Schedule for Plan Year 2020

**On-Line Enrollment will be held**

**October 15th - 31st**

***https://okcpeople.okc.gov***

All eligible employees can enroll online. Employees without access to a computer can enroll in benefits using the employee application terminals located in various City buildings.

## Public Application Terminals

**Personnel**
420 W Main Street, First Floor

**Will Rogers Garden Exhibition Center**
3400 NW 36 Street

**Schilling Community Center**
539 SE 25 Street

**Northeast Community Center**
1220 NE 33 Street

## Employee Application Terminals

**Airports**
***Field Maintenance***
10321 S Meridian Avenue

**General Services**
***Building Management***
600 SW 12 Street
***Fleet Services***
115 N Shartel Avenue

**Public Works**
***Streets, Traffic, and Drainage***
3738 SW 15 Avenue
***Field Services***
3738 SW 15, Bldg. 4

**Parks**
***Civic Center Music Hall***
201 N Walker
***Grounds Maintenance & Service Shop***
1821 SE 22 Street

**Utilities**
***Line Maintenance/Waste Water Quality/Water Meter & Field Operations***
621 N Pennsylvania Avenue
***Reservoirs and Canals***
1800 Overholser Drive
***Solid Waste Management***
11501 N Portland Avenue
***Water Quality***
420 W Main, Suite 430

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**On-Site Enrollment will be held**

**October 21st - 24th, 2019 from 8:00 a.m. - 5:00 p.m.**

**October 25th, 2019 from 8:00 a.m. - Noon**

Civic Center Music Hall - 2nd Floor Hall of Mirrors

On-site enrollment counselors will be available to assist you with the enrollment process. Employees are authorized up to two hours of paid leave for on-site enrollment. If you are unable to attend On-site Enrollment on the day you are scheduled, you may choose a time most convenient for you, with supervisor approval.

# Benefit Highlights

## New Employee Orientation

The City of Oklahoma City provides specific details about available benefit options during the New Employee Orientation. Sessions for employee benefits are held biweekly for newly hired employees. Any full-time employee who desires more information regarding their current health and welfare plans are also welcome. To attend, the employee must receive authorization from the supervisor. Once approved, contact a representative of the Employee Benefits Division to schedule your attendance.

## Benefit Effective Date (for new employees)

Coverage begins on the first day of the month following the first full month of full-time employment, excluding the month of hire.

## Coverage Ending Dates

In general, your group benefits will end on the last day of the month if:

- The Plan is terminated
- The premium ceases to be paid
- The employee no longer meets the Eligibility Requirements
- The employee voluntarily terminates his/her benefit(s)
- Employment terminates

## Coverage Ending Dates for Dependents

In general, your group benefits for Covered Dependents will end on the last day of the month if:

- The Plan is terminated
- The premium ceases to be paid
- The dependent no longer meets the Eligibility Requirements
- The employee voluntarily terminates his/her benefits for the dependent
- Employment terminates
- The date the plan is amended to end coverage for a benefit program class of participants of which the dependent is a member
- The dependent ceases to be a dependent as defined by the Plan
- The employee fails to provide the required documentation for the dependent
- The employee dies and survivorship benefits are not available
- The legal guardianship or legal custody relationship is terminated for any reason

In the case of a handicapped dependent, the last day of the month in which any of the following events occur:

- The date the child is no longer dependent on the employee for support
- The date the employee fails to provide any required proof of the uninterrupted continuation of the handicap or fails to authorize and comply with any required examinations

## Extension of Medical Benefits

Survivorship Benefit: In the event of the death of an Active or Retired Covered Employee, the previously Covered Dependents shall have the right to continue benefits under the Plan, subject to further provisions hereof:

- If the employee who died was Active and at the time of death was not entitled to any pension benefits, the surviving eligible Covered Dependents shall have the option to elect Continuation of Coverage under the provisions of COBRA.
- If the employee who has died was Active and at the time of death was entitled to any pension benefits but had continued as an active employee instead of choosing these pension benefits prior to the employee's death, the surviving eligible Covered Dependents shall have the option to continue health and dental coverage under which they had previously been covered through the COBRA option, or elect benefits that are provided to qualified survivor dependents.
- If the employee who died was retired at the time of death and was receiving pension benefits prior to their death, the surviving eligible Covered Dependents shall have the option to continue health and/or dental insurance benefits provided for retirees and their Eligible Dependents only if they were covered at the time of death of the retiree.
- Those surviving Eligible Dependents who choose to continue coverage under the retiree benefits shall have the right to continue benefits under that Plan, subject to further provisions hereof, until:
    - The date benefits for all individuals in this class are terminated;
    - If dependent eligible children, the date that they no longer meet the definition of a Covered Dependent.

# Your Benefit Design

*Structuring Your Benefits*

## Recognizing Your Needs

**Structuring your Benefits**

The City of Oklahoma City recognizes that employees have different needs. That's why the City offers a benefit program that allows you to choose among a number of benefit options. You can select from different benefit options to design the benefit plan that's right for you. You are encouraged to carefully consider your personal situation as you evaluate your benefit choices.

**Group Plans**

A group plan is a single policy covering a group of individuals. Group benefits currently provided by The City of Oklahoma City include:

- Major Medical Insurance
- Dental Insurance
- Group Term and AD&D Life Insurance
- Vision Plan
- Long Term Disability Plan
- Health and Dependent Care Flexible Spending Accounts
- Employee Assistance Program

**Individual Plans**

An individual plan is owned by the employee and may be continued if employment with the City ends. Premiums are based on individual assessment and are subject to review and approval by the provider company. Individual benefits currently include:

- Accident Insurance
- Cancer Insurance
- Individual Term Life Insurance
- Permanent Life

If you have questions regarding your City benefits, contact a representative of the Employee Benefits Division or the appropriate Plan provider.

## Contributions for Major Medical Health Insurance:

| Plan Participation | Employee Contribution | The City's Contribution |
|---|---|---|
| Group Indemnity Health Plan | 20% of the premium | 80% of the premium |
| HMO | 15% of the premium | 85% of the premium |

## Example for Family Coverage:

**Group Indemnity Health Plan**

Employee contributes: $470.93 / per month
City contributes: $1,883.71 / per month

**Health Maintenance Organization**

Employee contributes: $392.80 / per month
City contributes: $2,226.01 / per month

**Dental Benefit**

Employee contributes: $55.80 / per month Low Plan Option
$89.83 / per month High Plan Option
City contributes: $16.00 / per month

# Section 125 Plan



## Section 125 Cafeteria Plan

Full-time employees are eligible to participate in the City's Section 125 Cafeteria Plan. The plan allows you to pay your premiums for qualified insurance plans on a pre-tax basis, which can reduce your total taxable income and possibly increase your take-home pay.

## Benefits Eligible for Section 125 Cafeteria Plan

- Group Medical Insurance
- Dental Insurance
- Vision Insurance
- Group Term Life Insurance*
- Accident Only Insurance
- Cancer Insurance

** Up to $50,000 face amount for employee only*

## Oklahoma City Employees Retirement System (OCERS)

For employees participating in the Oklahoma City Employees Retirement System (OCERS) - Benefits taken out of your paycheck on a pre-tax basis will lower your average compensation at retirement. The calculation of average compensation is reduced by any benefits elected under Section 125 according to Oklahoma City Municipal Code 40.51.6. For questions, please contact Oklahoma City Employees Retirement System (OCERS) at 405-297-3413 or 405-297-2408.

## Section 125 Example

| Pre-Tax Example | | After-Tax Example |
|---|---|---|
| $2,500.00 | Monthly Gross Salary | $2,500.00 |
| - $280.00 | Pre-Tax Medical Insurance | $0.00 |
| - $25.00 | Pre-Tax Accident Insurance | $0.00 |
| $2,195.00 | Adjusted Monthly Gross Salary | $2,500.00 |
| - $439.00 | Estimated Federal Tax (20%) | - $500.00 |
| - $167.92 | Estimated FICA (7.65%) | - $191.25 |
| $0.00 | After-Tax Medical Insurance | - $280.00 |
| $0.00 | After-Tax Accident Insurance | - $25.00 |
| **$1,588.08** | **Take-Home Pay** | **$1,503.75** |

** Taxes are a sample average of State, Federal and FICA taxes. Your average tax rate may vary.*

# Health Care Reform Changes

*A Summary of Impacts on Employees*

## The impact of health care reform requires you to take action — enroll yourself in minimum essential coverage or pay a penalty.

The Patient Protection and Affordable Care Act, also known as health care reform or the Affordable Care Act, was enacted on March 23, 2010. In its current form, the law has resulted in a steady stream of regulations and guidance as various governmental entities clarified employers' requirements under the law over the past three years.

As your employer, we continue to implement provisions to comply with the requirements of the health care reform law. This summary focuses on the changes that affect you as an individual, as well as changes in the benefit programs we offer in 2020. We encourage you to pay careful attention to your health care benefits.

**ACA Individual Mandate**

Beginning in 2020, the Tax Cuts and Jobs Act (TCJA) repeals the penalty tax associated with the individual mandate under the Affordable Care Act. However, the penalty tax is still in force for all 2018.

**Essential Health Benefits Maximum Out-of-Pocket Limits**

The Affordable Care Act (ACA) establishes a maximum annual out-of-pocket amount for in-network Essential Health Benefits (EHBs).
The categories of essential health benefits are:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Copayments, coinsurance and deductibles for all in-network plan benefits generally apply toward the out-of-pocket limits.

For plan year 2020, the Essential Health Benefits maximum in-network out-of-pocket limits for the City of Oklahoma City's plans are as follows:

<u>Group Indemnity Plan</u>
Medical Benefit (administered by BlueCross BlueShield of Oklahoma):
$5,050 employee only coverage
$10,100 family coverage

<u>Prescription Benefit (administered by Prime Therapeutics, LLC):</u>
$2,300 employee only coverage
$4,600 family coverage

<u>United Healthcare (HMO) Plan</u>
Medical and Prescription Benefit combined:
$7,350 employee only coverage
$14,700 family coverage

# Health Care Reform Changes

*A Summary of Impacts on Employees*

**Do I have to take the coverage my employer offers me?**
No. But you should be aware that in most cases, the election you make is considered irrevocable and cannot be reversed if you change your mind. If you decide not to take employer-sponsored coverage, you should purchase coverage elsewhere, such as through a health insurance exchange, discussed next.

In some cases you could experience either a HIPAA special enrollment right or qualifying event that would allow you to enroll in our coverage midyear. Examples might include if you get married, have a baby or adopt a child midyear, qualify for premium assistance through CHIP or lose coverage (through Medicaid or another employer-sponsored plan). If the plan we offer is a non-calendar year plan, we may elect to include an optional Section 125 qualifying event to allow you to enroll or drop our coverage midyear. Importantly, not paying premiums for an individual policy or having a change in financial condition will not allow you to join our plan midyear. Ask your Employee Benefits representative for more information about this. In all cases, we are not permitted to retaliate against you for choosing to enroll in coverage somewhere other than our plan.

**Where can I get coverage if I do not want my employer's coverage?**
The federal government and states set up online public health insurance exchanges. You may hear these referred to as marketplaces. There are also many private exchanges and marketplaces. Some states have already created marketplaces.

Importantly, the public exchanges set up and administered by the federal government and the states are the only avenue for qualifying employees to receive assistance with paying premiums and reducing other cost-sharing normally associated with health insurance (including deductibles, co-payments and co-insurance) in the form of advance tax credits and subsidies. These are not available in private exchanges. Income parameters and other eligibility requirements apply to qualify for a tax credit or subsidy. To qualify for subsidies, an employee must have household income of between 100 percent and 400 percent of the federal poverty line. Plus, the cost of health insurance premiums must exceed 9.86 percent of household income.

**What should I consider when deciding whether to enroll in coverage offered through my employer versus an exchange?**
Employer-sponsored coverage is generally subsidized by the employer offering the coverage. This means the cost to you is most likely less than it would be if you purchased it on your own. In many cases, the amount of the employer contribution is more than the federal subsidy or tax credit that you would qualify for through a public exchange. Another reason to consider keeping employer-sponsored coverage is the tax implications of paying for coverage on your own. Coverage purchased through a public exchange cannot be paid on a pre-tax basis. However, paying for coverage offered through your employer can be done on a pre-tax basis. Depending on the amount of premiums paid and your individual effective tax rate, you may see a significant savings in your taxes by paying for employer-sponsored coverage on a pre-tax basis. Finally, allowing us, as your employer, to handle the design choices and narrow down the network of providers, as well as issue the required tax filings, can relieve you of many of the tasks that are inherent when purchasing coverage on your own.

# Health Insurance Marketplace Exchange

## New Health Insurance Marketplace Coverage Options and Your Health Coverage

### PART A: General Information

Key parts of the health care law took effect 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. Open enrollment for health insurance coverage through the Marketplace begins in November 2019 for coverage starting as early as January 1, 2020.

**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 9.56% of your household income for the year, 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.

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 Information?**

For more information about your coverage offered by your employer, please check your summary plan description or contact City of Oklahoma City, Employee Benefits at 405-297-2144

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.

# Health Insurance Marketplace Exchange

## PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name : **City of Oklahoma City**
4. Employer Identification Number (EIN) : **736005359**
5. Employer address: **420 W. Main St. Ste 110**
6. Employer phone number: **405-297-2530**
7. City: **Oklahoma City** 8. State: **Oklahoma** 9. ZIP code: **73102**
10. Who can we contact about employee health coverage at this job? **Employee Benefits**
11. Phone number (if different from above) **405-297-2144**
12. Email address: **employee.benefits@okc.gov**

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

- As your employer, we offer a health plan to: regular, full-time active employee, or in one of the following categories:

  1) An employee on paid disability leave due to an on-the-job injury or illness who was a regular, full-time active employee on the date the disabling injury or illness occurred;

  2) An elected official of the City;

  3) The City Auditor or a regular, full-time active employee of the City Auditor's office;

  4) The Municipal Counselor or a regular, full-time active employee of the Municipal Counselor's office; or

  5) A full-time active Oklahoma City Municipal Judge.

  6) An eligible employee of a participating public trust.

- With respect to dependents: We do offer coverage. Eligible dependents are:
  - Spouse
  - Child(ren)
  - Legally adopted children
  - Child(ren) under Legal Guardianship
  - Step-Child(ren)

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months: **Yes, eligible employees are those currently classified as a regular, full-time active employee as defined previously on this form. Open Enrollment to add or change coverage is October 15, 2018-October 31, 2019 to be effective January 1, 2020.**
14. Does the employer offer a health plan that meets the minimum value standard*? **Yes**
15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee: How much would the employee have to pay in premiums for this plan? **HMO plan: $63.35 per pay period (24 pay periods)**

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Insura

Helpful Tips

## Stay **Healthy**

The City's Health plans offer free annual preventative care exams, health screens, and immunizations. Visit www.bcbsok.com/okc or www.myuhc.com for details.

# ance **Enrollment**

Health Plan Benefits Comparison

Group Indemnity Health Plan

HMO Plan

Dental Plan

Vision Care Plan

Group Term Life Insurance and AD&D

Long-Term Disability Income Insurance

Individual Term Life Insurance

Accident Only Insurance

Cancer Insurance

Permanent Life Insurance

# Health Plan Benefits Comparison

The City of Oklahoma City offers employees a choice in major medical plans: the Group Indemnity Health Plan (PPO Plan administered by BlueCross and BlueShield of Oklahoma) and a Health Maintenance Organization (HMO) Plan (provided by UnitedHealthcare). Only you can decide the type of major medical plan that is right for you and your family.

## Group Indemnity Health Plan

The Group Indemnity Health Plan offers a broad network of doctors, allowing you the ability to select almost any doctor or hospital. By selecting a network doctor, lower coinsurance and deductibles are available. However, non-network care is still partially covered.

A prescription drug plan (administered by Prime Therapeutics) is provided with the Group Indemnity Plan. Prescription drugs must be included on the plan formulary in order to be covered.

**Advantages:** Choice of doctors and hospitals
**Disadvantages:** Greater out-of-pocket expense during the plan year

## HMO Plan

All services are coordinated by a network primary care physician. If your preferred doctor or specialist is not in the HMO network, you must select another doctor or specialist within the HMO network in order to have your medical visits covered by the HMO plan.

Prescription drugs must be included on the plan formulary in order to be covered.

**Advantages:** Less out-of-pocket costs during the plan year
**Disadvantages:** More restricted choice in doctors, hospitals, and prescription medications

All City major medical plans include transition related health care benefits, including gender confirmation surgery, hormone therapy, and mental health counseling among other treatments. Contact your healthcare provider or health insurance provider for more information.

## Comparison

The following pages provide a summary of the Group Indemnity Health Plan and the HMO Plan offered by the City of Oklahoma City.

**This information is only a summary. If there are discrepancies between the chart and the actual plan documents, insurance contracts, or ordinances and resolutions, the plan documents, contracts, or ordinances and resolutions will govern.**

**Want to find out what physicians, hospitals, pharmacies and more are covered under your medical plan?**
This information is right at your fingertips using the City's intranet. Type in **http://InsideOKC/Benefits**.

# Health Plan Benefits Comparison

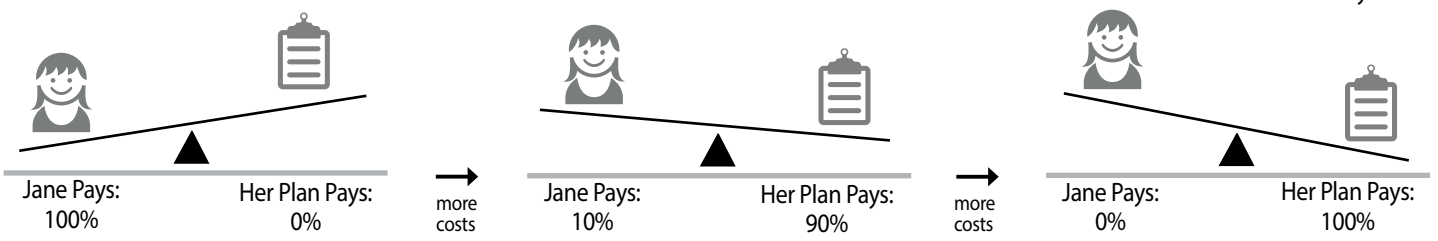
| Plan Features | Group Indemnity Health Plan Network | Group Indemnity Health Plan Non-Network | HMO Plan |
|---|---|---|---|
| Selection of Doctors | Member selects from Blue Preferred PPO network of providers | Member selects the provider of choice | Member selects from the UnitedHealthcare Signature Value network of providers |
| Network Provider Exceptions | N/A | Penalty Applies (higher deductibles, coinsurance, & out-of-pocket maximums) | No benefits outside of network |
| Deductible<br>- Person<br><br>- Family | $250*<br><br>$500 | $300*<br><br>$900 | $0<br><br>$0 |
| | * Accumulators for network and non-network deductibles are separate. For example, an individual could have a total deductible of $550 ($250 network + $300 non-network). | | |
| Coinsurance Maximum<br>- Individual | $1,000 | $3,000 | N/A |
| Out-of-Pocket Maximums<br>- Individual<br><br>- Family | Deductible + Coinsurance<br><br>Individual maximums apply for each family member | Deductible + Coinsurance<br><br>Individual maximums apply for each family member | $1,500<br><br>$3,000 |
| Lifetime Benefit Maximum | No lifetime maximum | No lifetime maximum | No lifetime maximum |
| Contact Information for Additional Questions | BlueCross BlueShield of Oklahoma<br>877-219-4301<br>www.bcbsok.com/okc | | UnitedHealthcare<br>800-825-9355<br>www.myuhc.com |

## How You and Your Insurer Share Costs - Group Indemnity Health Plan Network Example

**Jane's Plan Deductible: $250** **Co-insurance: 10%** **Out-of-Pocket Limit: $1,250**

January 1st - Beginning of Policy Period

December 31st - End of Policy Period




Jane hasn't reached her $250 deductible yet.
*Her plan does not pay part of the costs.*
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $250 deductible, co-insurance begins.
*Jane has seen a doctor several times and paid $250 in total. Her plan pays some of the costs for her next visit.**
Office visit costs: $100
Jane pays: 10% of $100 = $10
Her plan pays: 90% of $100 = $90

Jane reaches her $1,250 out-of-pocket limit.
*Jane has seen a doctor often and paid $1,250 in total. Her plan pays the full cost of her covered health care services for the rest of the year.*
Office visit costs: $125
Jane pays: $0 *
Her plan pays: $125

* Copayments may apply.

# Health Plan Benefits Comparison

| Common Medical Event | Services You May Need | Group Indemnity Health Plan Network | Group Indemnity Health Plan Non-Network | HMO Plan |
|---|---|---|---|---|
| If you visit a health care provider's office or clinic... | Primary care visit to treat an injury or illness | $15 copayment + deductible + 10% of eligible charges | $15 copayment + deductible + 30% of eligible charges | $30 copayment per visit |
| | Specialist visit | $15 copayment + deductible + 10% of eligible charges | $15 copayment + deductible + 30% of eligible charges | $30 copayment per visit |
| | Preventative Care/ Screening/Immunization | Plan pays 100% | Plan pays 100% | Plan pays 100% |
| | Chiropractic Care | $15 copayment + deductible + 10% of eligible charges | $15 copayment + deductible + 30% of eligible charges | $30 copayment |
| | Virtual Visit | N/A | N/A | $25 copayment |
| If you have a test... | Diagnostic Test (x-ray, blood work) | $15 copayment + Deductible + 10% of eligible charges | $15 copayment + Deductible + 30% of eligible charges | $0 |
| | Imaging (CT/PET Scans, MRIs) | $50 copayment + Deductible + 10% of eligible charges | $50 copayment + Deductible + 30% of eligible charges | $0 |
| If you need drugs to treat your illness or condition... | Generic Drugs | $15 | No Benefit | $15 |
| | Preferred Brand | $30 | No Benefit | $30 |
| | Non-Preferred Brand | N/A | No Benefit | $65 |
| | 90-day Mail Order | 2 copayments for up to a 90-day supply | No Benefit | 2 copayments for up to a 90-day supply |
| | Website for more information | www.myPrime.com | | www.myuhc.com |
| If you become pregnant... | Prenatal and postnatal care | $15 copayment + deductible + 10% of eligible charges | $15 copayment + deductible + 30% of eligible charges | $30 copayment first visit |
| | Delivery and all inpatient services | $50 copayment + deductible + 10% of eligible charges Plan pays 100% for birthing centers and related physician expenses | $50 copayment + deductible + 30% of eligible charges Plan pays 100% for birthing centers and related physician expenses | $100 copayment per admission |
| If you need immediate medical attention... | Emergency medical transportation | EMSA paid at 100%, deductible waived.<br><br>Non-EMSA providers: Deductible + 10% of eligible charges | EMSA paid at 100%, deductible waived.<br><br>Non-EMSA providers: Deductible + 30% of eligible charges | $0 copayment (prior authorization required except for emergencies) |
| | Emergency Room | $50 copayment + deductible + 10% of eligible charges | $50 copayment + deductible + 30% of eligible charges | $50 copayment, waived if admitted |
| | Urgent Care | $15 copayment + deductible + 10% of eligible charges | $15 copayment + deductible + 30% of eligible charges | $30 copayment |

# Health Plan Benefits Comparison

| Common Medical Event | Services You May Need | Group Indemnity Health Plan Network | Group Indemnity Health Plan Non-Network | HMO Plan |
|---|---|---|---|---|
| If you have outpatient surgery... | Facility fee (e.g. ambulatory surgery center) | $50 copayment + deductible + 10% of eligible charges | $50 copayment + deductible + 30% of eligible charges | $50 copayment |
| | Physician/Surgeon fee | Deductible + 10% of eligible charges | Deductible + 30% of eligible charges | $0 copayment per visit |
| If you have a hospital stay... | Facility Fee (e.g. hospital room) | $50 copayment + deductible + 10% of eligible charges | $50 copayment + deductible + 30% of eligible charges | $100 copayment per admission |
| | Physician/Surgeon Fee | Deductible + 10% of eligible charges | Deductible + 30% of eligible charges | $0 |
| If you have mental health, behavioral health, or substance abuse needs... | Mental/Behavioral Health Outpatient Services | $15 copayment + deductible + 10% of eligible charges | $15 copayment + deductible + 30% of eligible charges | $30 copayment per visit |
| | Mental/Behavioral Health Inpatient Services | $50 copayment + deductible + 10% of eligible charges | $50 copayment + deductible + 30% of eligible charges | $100 copayment per admission |
| | Substance Use Disorder Outpatient Services | $15 copayment + deductible + 10% of eligible charges | $15 copayment + deductible + 30% of eligible charges | $30 copayment per visit |
| | Substance Use Disorder Inpatient Services | $50 copayment + deductible + 10% of eligible charges | $50 copayment + deductible + 30% of eligible charges | $100 copayment per admission |
| If you have recovery or other special health needs... | Home Health Care | Deductible + 10% of eligible charges (Maximum of 120 days) | Deductible + 30% of eligible charges (Maximum of 120 days) | $0 |
| | Rehabilitation Services | Deductible + 10% of eligible charges | Deductible + 30% of eligible charges | $100 copayment per admission |
| | Skilled Nursing Care | Deductible + 10% of eligible charges (Limited to 120 days) | Deductible + 30% of eligible charges (Limited to 120 days) | $0 (Limited to 100 consecutive Inpatient days per disability) |
| | Durable Medical Equipment | Deductible + 10% of eligible charges | Deductible + 30% of eligible charges | $0 ($5,000 maximum benefit per Calendar Year) |
| | Hearing Services (Adult) | $500 Benefit for Hearing Aid every 24 months | $500 Benefit for Hearing Aid every 24 months | $0 copayment (Limited to one hearing aid every 3 years) |
| If your child needs dental, eye care, or hearing services... | Eye Exam | No benefit | No benefit | $30 copayment (One visit per year) www.myspectera.com |
| | Glasses | No benefit | No benefit | Preferred pricing from network provider |
| | Dental Check-up | No benefit | No benefit | No benefit |
| | Hearing Services | Deductible + 10% of eligible charges on hearing aids for children age 17 and under | Deductible + 30% of eligible charges on hearing aids for children age 17 and under | No copayment on hearing aids for children age 17 and under |

The Summary of Benefits and Coverage for each plan is available at the following locations:

BlueCross and BlueShield: ***www.bcbsok.com/okc/coverage/medical.html***

UnitedHealthcare: ***InsideOKC > Employee > Benefits > Major Medical HMO***

# Group Indemnity Health Plan

***BlueCross BlueShield of Oklahoma***
***Prime Therapeutics***

BlueCross BlueShield of Oklahoma administers the City's Group Indemnity Health Plan. Under this health plan you may go to any physician. However, it is to your advantage to go to a network provider to maximize your health plan's benefits and lower out-of-pocket expenses. For questions regarding the plan or a list of BlueCross BlueShield of Oklahoma PPO providers, visit the account representative on-site during the enrollment period, contact a representative of the Employee Benefits Division or visit the City's BlueCross BlueShield of Oklahoma web site at www.bcbsok.com/okc.

## Prescription Plan

Prime Therapeutics is the pharmacy manager for this Plan. For questions, contact at Prime Therapeutics 877-357-7463 or via their website at www.myPrime.com or for mail order www.alliancerxwp.com.

| **Retail Copay (up to a 34-day supply)** | **Mail Order Copay (up to a 90-day supply)** |
|---|---|
| Generic: $15 | Generic: $30 |
| Name Brand: $30 | Name Brand: $60 |

## Plan Provisions

Coverage is provided only for a service or supply, "necessary for diagnosis, care or treatment of a physical or mental condition involved." Only that part of a charge that is "reasonable" is covered.

## Coinsurance

Patient's responsibility of 10 percent or 30 percent applies to coinsurance annual maximum of $1,000 network and $3,000 non-network per individual.

## The BlueCard Program

The BlueCard Program allows you to use a BlueCross BlueShield of Oklahoma PPO Physician or Hospital outside the state of Oklahoma and to receive the advantages of PPO benefits and savings.

- **Finding a PPO Physician or Hospital**
  When you're outside of Oklahoma and you need to find information about a BlueCross BlueShield of Oklahoma PPO Physician or Hospital, just call the BlueCard Doctor and Hospital Information Line at 800-810-BLUE (2583), or you may refer to the Blue National Doctor and Hospital Finder at http://www.bcbs.com/healthtravel/finder.html. They will help you locate the nearest PPO Physician or Hospital.
- **Remember to Always Carry the BlueCard**
  Make sure you always carry your Identification Card. Its "PPO in a suitcase" logo shows you are eligible to receive PPO Benefits and savings through the BlueCard Program. And be sure to use BlueCross BlueShield of Oklahoma Physicians and Hospitals whenever you're outside the state of Oklahoma and need health care.

## Inpatient Predetermination

Predetermination of benefits is recommended.

## Claims Filing Deadline

Claims must be filed with the Claims Administrator within twelve (12) months of the date of service. Claims will be denied if received after twelve (12) months.

## Denial of Claim

The Claims Administrator will have the discretionary authority to construe and interpret the Plan and determine whether a particular claim is covered.

## Right of Subrogation

In the event you are injured in an accident caused by the negligence of a third party (i.e. automobile accident, supermarket slip and fall, etc), your health plan will pay eligible claims. However, the Plan reserves the right to recover from the negligent third party or from you if you recover damages. You are required to notify the Plan Administrator of all such injuries.

Failure to notify the Personnel Department or Employee Benefits Division of an accident in which you were injured by the negligence of a third party, may result in disciplinary action, up to and including termination and further legal action against the employee.

## Claim Appeal

BlueCross BlueShield of Oklahoma has established a process to review your dissatisfactions, complaints and/or appeals. If you have a question or complaint, an initial attempt should be made to resolve the problem by directly communicating with a BlueCross BlueShield of Oklahoma Service Representative. In most cases, a Customer Service Representative will be able to provide you with a satisfactory solution to your problem. However if a resolution cannot be reached in an informal exchange, you may request an administrative review of the problem through the appeal process described in the Oklahoma City Group Indemnity Healthcare Plan Document.

## Plan Modification and Amendment

The Mayor and City Council may modify or amend the Plan from time to time at its sole discretion and such amendments or modifications may affect Covered Persons, which could include elimination of any Plan provision(s).

## Health Plan Identifier: 7871596020

# HMO Plan

*UnitedHealthcare*

All services are coordinated by a UnitedHealthcare primary care physician. The following summaries do not contain a complete listing of the exclusions, limitations, and conditions, which may apply to benefits shown. For more information, call UnitedHealthcare at **800-825-9355.** *Group Number 010931*

## Primary Care Physician (PCP)

Each family member may choose a PCP from one of the doctors listed in UnitedHealthcare's Provider Directory. The doctors are listed according to the city where they are located. Members may change their PCP every month by contacting a UnitedHealthcare customer service representative. PCP changes will take effect the first of the following month. For example, if a member calls September 30th the PCP change will take effect on October 1st. Also, members do not have to stay within a certain network of physicians. For instance, if your PCP is with Mercy and you want to see a St. Anthony specialist, you can. Additionally, if you are with a Mercy PCP and want to move to a St. Anthony PCP the next month, you can.

Step 1: Choose the type of physician (family practice, internal medicine, pediatrics)
Step 2: Consider location
Step 3: Consider reputation, ask friends, or contact Customer Services
Step 4: Indicate the ID number and Name for your selected PCP to the enroller or on the enrollment form (paper or electronic)

## Specialty Care

Members do not have to have a referral to see a specialist as long as the specialist is in the UnitedHealthcare network.

## Authorized Inpatient and Outpatient Care

The PCP and/or the specialist determines required inpatient and outpatient care, and he/she will work together to arrange these covered services. All inpatient and out-of-area outpatient services, except emergency and urgent care services, must be pre-authorized by the Primary Care Physician (PCP) at an in-plan facility (contracting hospital, clinic, etc.).

## Mail Order Prescription Drug Program

UnitedHealthcare partners with Optum RX for your mail order prescriptions. Interested in receiving your maintenance medications through the mail instead of going to the pharmacy? UnitedHealthcare offers a convenient way to order your maintenance medications and have them delivered to you. Receive for up to a 90-day supply for two prescription copays. Call Customer Services for a mail order form, or go to www.uhcwest.com to link to the mail order prescription drug program form.

## Your ID Card

You and each of your covered family members will receive a member identification (ID) card from the Plan. When you go to a doctor or hospital, provide the card before you receive treatment.

## UnitedHealthcare Website

Visit the UnitedHealthcare website at www.myuhc.com. The website features searchable provider and pharmacy directories, a searchable formulary and product line information. **Questions? Call the Customer Service Department at 800-825-9355 or 800-557-7595 (TDHI).**

# Dental Plan

*BlueCross BlueShield of Oklahoma*

## Dental Benefit Highlights

| Type of Service | Low Option | | High Option | |
|---|---|---|---|---|
| | Network Benefits | Non-Network Benefits | Network Benefits | Non-Network Benefits |
| **General Provisions** | | | | |
| Calendar Year Deductible | $50 Individual/ $150 Family | $50 Individual/ $150 Family | $50 Individual/ $150 Family | $50 Individual/ $150 Family |
| Three-month Deductible carryover applies | Yes | Yes | Yes | Yes |
| Deductible credit from prior carrier | Yes | Yes | Yes | Yes |
| Calendar Year Maximum per Participant | $1,000 | $1,000 | $1,500 | $1,500 |
| **Diagnostic and Preventive Care Benefits**<br>Deductible Waived<br>Oral Examinations (2 exams per benefit period)<br>Prophylaxis (2 cleanings per benefit period)<br>Fluoride Treatment (to age 19)<br>Dental X-rays | 100% | 100% | 100% | 100% |
| **Miscellaneous Services**<br>Sealants<br>Space Maintainers<br>Labs and Tests<br>Palliative Care | 100% | 100% | 100% | 100% |
| **Restorative Services**<br>Routine Fillings (amalgams and resins) | 80% | 60% | 80% | 80% |
| **General Services**<br>Intravenous sedation<br>Injection of antibiotic drugs<br>Stainless Steel Crowns | 80% | 60% | 80% | 80% |
| **Endodontic Services**<br>Root Canals<br>Direct pulp caps | 50% | 30% | 80% | 80% |
| **Periodontal Services**<br>Scaling and root planning<br>Osseous surgery | 50% | 30% | 80% | 80% |
| **Oral Surgery Services**<br>Simple/Surgical tooth extractions | 50% | 30% | 80% | 80% |
| **Crowns, Inlays/Onlays Services**<br>Inlays, Onlays and Crowns (other than temporary crowns) | 50% | 30% | 50% | 50% |
| **Prosthodontic Services**<br>Bridges<br>Full and partial dentures<br>Implants | 50% | 30% | 50% | 50% |
| **Orthodontic Benefits (no deductible)**<br>Orthodontic Diagnostic Procedures and Treatment (Adult and Child)<br>Lifetime Maximum per Participant | 50%<br>$1,000 | 50%<br>$1,000 | 50%<br>$1,200 | 50%<br>$1,200 |

# Dental Plan

*BlueCross BlueShield of Oklahoma*

## Employee Information

This is a general summary of your benefit design. Please refer to your dental benefit booklet for other details and for limitations and exclusions.

## Eligibility

The following eligibility provisions apply:

- Dependent children are covered to age 26. Disabled dependent children can be covered beyond age 26.
- Retirees are eligible for coverage.

## Pre-Existing Condition

A pre-existing condition exclusion will apply to expenses involving the replacement of teeth that were missing prior to the effective date of the dental contract. This exclusion will not apply to:

- Any participant who becomes eligible on the dental contract date who was covered under a previous group dental care contract by the Employer.
- Any participant who has been continuously covered for 24 months under a group dental care contract with BlueCross BlueShield of Oklahoma, which included prosthetic benefits.

## Limitations

When the course of treatment will be in excess of $300, a predetermination request should be submitted to BlueCross BlueShield of Oklahoma in advance of treatment. It is the covered persons responsibility to ensure the request is submitted.

**Freedom of Choice**

The dental plan allows you the freedom to choose any dentist you wish. Below highlights the differences between choosing a Contracting Network Dentist and a Non-Contracting Dentist, who is not part of BlueCross BlueShield of Oklahoma's Dental network

**Contracting Network Dentist**

Regardless of which plan you are enrolled in (Low Plan Option or High Plan Option), when you receive services from a Contracting Network Dentist, you receive the following advantages:

- Reduced out-of-pocket costs due to the provider accepting a negotiated (discounted) allowed amount;
- No balance billing for amounts over the allowed amount. However, you are still responsible for your co-insurance amount;
- No referral needed for specialty dentists;
- Contracting network dentists will submit claims for you.

When you receive services from a Non-Contracting Dentist, your out–of-pocket cost will be greater, as Non-Contracting Dentists do not accept any negotiated (discounted) fees. Therefore, the dentist will be reimbursed based on the Allowed Amount, as determined by the plan, and you are balanced billed for costs exceeding the BlueCross BlueShield of Oklahoma Maximum Allowable Amount.

Please note, there is a difference on how Non-Contracting Dentists are reimbursed, based on the plan you may be enrolled in:

- **Low Plan Option:**
  Claims will be reimbursed at the Maximum Allowable Charge (MAC). This is where the plan will pay a set dollar amount for each procedure, regardless of the actual billed charge. You will be balance billed for the difference between BlueCross BlueShield of Oklahoma MAC and the total billed charge. You are required to file claim forms.

- **High Plan Option:**
  Claims will be reimbursed at a Usual and Customary (U&C) Allowed Amount, which is based on the geographic location of the rending dentist. The U&C Allowed Amount may be higher or lower than what your dentist charged, so you may be balanced billed for the costs exceeding the BlueCross BlueShield of Oklahoma U&C Allowable Amount.

Please note that our dental plan is a "freestanding" product and can be purchased separately from the health product (i.e., an employee can elect employee only coverage for health, but elect dental for the family).

**Find out what Dentists are on your dental plan.**
This information may be found using the City's intranet. Type in **http://InsideOKC/Benefits**, then click the Dental Plan link.

# Vision Care Plan

*VSP*

## Your VSP Vision Benefits Summary

Why enroll in VSP? Your eyes deserve the best care to keep them healthy year after year. Plus with VSP, you'll get a great value on your eyecare and eyewear.

## You'll Like What You See with VSP

**Value and Savings.**
You'll get great benefits on your exam and eyewear at an affordable price.

**Personalized Care**
You'll get quality care that focuses on your eyes and overall wellness through a WellVision Exam® from a VSP doctor. When you see a VSP doctor, you'll get the most out of your benefit and have lower out-of-pocket costs. Plus, with a VSP doctor your satisfaction is guaranteed—if you're not 100% happy, we'll make it right.

**Great Eyewear**
Choose the eyewear that's right for you and your budget.

**Choice of Providers**
With open access to see any eyecare provider, you can see the one who's right for you. Choose a VSP doctor or any other provider.

## Using your VSP benefit is easy.

- **Find an eyecare provider who's right for you.** To find a VSP doctor, visit vsp.com or call 800.877.7195.
- **Review your benefit information.** Visit vsp.com to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.** There's no ID card necessary.

**That's it! We'll handle the rest**—there are no claim forms to complete when you see a VSP doctor.

## Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more. Visit **vsp.com** to find a Premier Program location who carries these brands.

## Enroll in VSP today.
## You'll be glad you did.

**vsp.com**
**800-877-7195**

*VSP guarantees coverage from VSP doctors only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.*

# Vision Care Plan

*VSP*

**VSP Doctor Network:** VSP Choice

| Benefit | Description | Copay | Frequency |
|---|---|---|---|
| **Your Coverage with a VSP Doctor** | | | |
| **WellVision Exam** | • Focuses on your eye health and overall wellness | $10 | Every Calendar Year |
| **Prescription Glasses** | | **$25** | **See Frame and Lenses** |
| Frame | • $170 allowance for a wide selection of frames<br>• 20% off the amount over your allowance | Included in Prescription Glasses | Every Calendar Year |
| Lenses | • Single vision, lined bifocal, and lined trifocal lenses<br>• Polycarbonate lenses for dependent children | Included in Prescription Glasses | Every Calendar Year |
| Lenses Options | • Standard progressive lenses $55 copay<br>• Premium progressive lenses $95-$105 copay<br>• Custom progressive lenses $150-$175 copay<br>• Average 20-25% off other lens options | $55<br>$95 - $105<br>$150 - $175 | Every Calendar Year |
| **Contact (Instead of glasses)** | • $150 allowance for contacts<br>• 15% off contact lens exam (fitting and evaluation) | $0<br>up to $60 | Every Calendar Year |
| **Diabetic EyecarePlus Program** | • Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. | $20 | As needed |
| **Extra Discounts and Savings** | **Glasses and Sunglasses**<br>• 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam<br>**Retinal Screening**<br>• No more than a $39 copay on routine retinal screening as an enhancement to a wellVision Exam. | | |
| | **Laser Vision Correction**<br>• Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities. | | |

| Your Coverage with Other Providers | | | |
|---|---|---|---|
| Visit vsp.com for details, if you plan to see a provider other than a VSP doctor. | | | |
| Exam ..... Up to $45 | Single vision lenses ..... Up to $30 | Lined trifocal lenses ..... Up to $65 | Contacts ..... Up to $105 |
| Frame ..... Up to $70 | Lined bifocal lenses ..... Up to $50 | Progressive Lenses ..... Up to $65 | |
| VSP guarantees coverage from VSP doctors only. Coverage information is subject to change. In the event if a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. | | | |

VSP does not provide identification cards. Visit vsp.com for a list of providers and plan benefits.

# Group Term Life Insurance and AD&D

*Dearborn National*

The City of Oklahoma City provides life insurance coverage to help protect the employee's family in the event of a death. The employee is also eligible to purchase additional life insurance for himself/herself, and dependent life insurance for a spouse and/or dependent children.

Dearborn National is the City's administrator for Group Term Life and Accidental Death & Dismemberment (AD&D) insurance plan benefits. Dearborn National was founded in Illinois in 1969, when it began providing group life and disability insurance to the people of Illinois. Since then, Dearborn National has expanded its product portfolio to offer products intended to enhance the quality of employee benefit programs while minimizing costs for the employer.

Group Term Life and AD&D Insurance coverage is available while you are a full-time employee. Term insurance is payable to a beneficiary only when an insured dies. There are no permanent policy benefits such as cash or loan value.

## Enrollment/Evidence of Insurability

If you or your eligible dependents enroll within 31 days of your eligibility date, you may apply for the $5,500 supplemental coverage and additional coverage of ½, 1, 2, or 3 times your annual salary, up to $500,000 for yourself (base and additional combined) and coverage for your dependents without evidence of insurability. If you choose coverage of 3 times your annual salary for Voluntary life, or spousal coverage above $20,000, you will be required to furnish evidence of insurability and be approved to qualify for coverage.

During open enrollment, evidence of insurability will be required if you apply for new coverage or request to increase coverage for yourself and/or your spouse.

## Basic Life

The City provides $15,000 in basic life insurance and an additional $5,000 in Accidental Death and Dismemberment insurance at no additional cost.

## Optional Supplemental Life

You may purchase an additional $5,500 of supplemental term life insurance. You no longer have to purchase Optional Supplemental Life as prerequisite for purchasing Voluntary Life.

## Voluntary Supplemental Life

You may also purchase voluntary life coverage at ½x, 1x, 2x or 3x annual base salary. Life insurance will be rounded to the next highest $1,000, if not already a multiple thereof.

**Note:** Maximum coverage for basic, supplemental, and voluntary life insurance combined is $500,000.

Coverage amounts will reduce according to the following schedule:

| Age: | Insurance Amount Reduces to: |
|---|---|
| 65 | 65% of original amount |
| 70 | 40% of original amount |
| 75 | 25% of original amount |

Coverage may not be increased after a reduction.

## Dependent Life Coverage*

You may purchase Voluntary Dependent Life insurance for a qualified dependent spouse and/or child(ren) as follows:

**Spouse:** Spouse coverage may be elected for one of the following amounts: $10,000, $20,000, $40,000, $60,000, $80,000, or $100,000

**Child(ren):** Age live birth to 6 months - $100

6 months to 23 years - Child coverage may be elected for one of the following amounts: $2,500, $5,000, $7,500, or $10,000

Coverage is available for eligible dependents of active, full-time employees; required documentation must be on file with the Employee Benefits Division of the Personnel Department.

At initial enrollment opportunity, satisfactory evidence of insurability is only required on spouse dependent life insurance amounts in excess of $20,000. Dearborn National will guarantee issue all other dependent life insurance for both spouse and dependent child(ren). After initial enrollment, satisfactory evidence of insurability is required on all amounts of spouse life insurance.

**** Dependent coverage is not available for a spouse who also works for the City.***

## Accidental Death and Dismemberment Coverage (AD&D)

The City of Oklahoma City provides $5,000 of AD&D insurance for each full-time employee. Employees may purchase an additional AD&D coverage in the following amounts: $5000, $10,000, $15,000, and $20,000. AD&D coverage provides benefits for an accidental death, and for an accidental dismemberment, as defined in the schedule of benefits.

## Accelerated Benefit

If you become terminally ill and are not expected to live more than twelve months, you may request 50 percent of your life insurance amount up to $150,000 without fees or present value adjustments. A doctor must certify your condition in order to qualify for this benefit. Upon your death, the remaining benefit will be paid to your designated beneficiary(ies).

# Group Term Life Insurance and AD&D

*Dearborn National*

## Waiver of Premium

If you become disabled (as defined by your plan) and are no longer able to work, your premium payments will be waived until you are no longer totally disabled or you reach age 65, whichever occurs first.

## Portability

An Employee may elect to continue Voluntary Group Life Insurance under the terms of the Policy by paying the premium directly to Dearborn National. The maximum amount of Voluntary Term Life Insurance which may be continued under Portability is the amount of Voluntary Term Life Insurance in force at the time the Portability Benefit is elected plus any life insurance to which an Insured is entitled under the Additional Purchase Option.

## Suicide Exclusion

Insurance benefits, including Waiver of Premium, will not be available for a loss which is caused by suicide or attempted suicide, while sane or insane, within one (1) year from the effective date of your Voluntary Term Life Insurance. This exclusion will not apply if you: 1) were covered for voluntary life insurance under a prior carrier's policy; and 2) were insured under this Policy on its effective date; and 3) there was no lapse in coverage. The death benefit, if payable under this provision, will be the lesser of your benefit under this Policy or your benefit under the prior carrier's policy.

## AD&D Limitations

We will not pay any benefit for any Loss that , directly or indirectly, results in any way from or is contributed to by: 1) any disease or infirmity of mind or body, and any medical or surgical treatment thereof; or 2) any infection, except a pus-forming infection of an accidental cut or would; or 3) suicide or attempted suicide while sane or insane; or 4) any intentionally self-inflicted Accident; or 5) war, declared or undeclared, whether or not the Insured is a member of any armed forces; or 6) travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft; or 7) commission of , participation,in, or an attempt to commit an assault or felony; or 8) being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, or any other controlled substance as defined in Title II of the comprehensive Drug Abuse Prevention and Control Act of 1970, as no or hereafter amended, unless as prescribed by the Insured's licensed physician and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence; or 9) intoxication as defined by the laws of the jurisdiction in which accident occurred. Conviction is not necessary for a determination of being intoxicated; or 10) active participation in a riot. "Riot" means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

## Termination of Coverage

Your coverage and your dependents' coverage under the Summary of Benefits ends on the earliest of: the date the policy or plan is cancelled; the date you no longer are in an eligible group; the date your eligible group is no longer covered; the last day of the period for which you made any required contributions; the last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in the certificate of coverage; or for dependent's coverage, the date of your death. In addition, coverage for any one dependent will end on the earliest of: the date your coverage under a plan ends; the date your dependent ceases to be an eligible dependent; or for a spouse, the date of divorce or annulment

## Deferred Effective Date of Coverage

You must be Actively at Work on the date your initial coverage or any increases in coverage are scheduled to begin. If: 1) you are absent from Active Work on the date such coverage would otherwise become effective; and 2) your absence is caused by an injury, illness or layoff, the effective date of any initial coverage or increased coverage will be deferred until the first day he returns to Active Work. You will be considered Actively at Work if you were actually at work on the day immediately preceding: (1) a weekend (except for one or both of these days if they are scheduled work days; (2) a holiday(except when such a holiday is a scheduled work day); (3) a paid vacation (4) any nonscheduled work day. If a Spouse or a Dependent Child is hospital confined on the date his coverage would otherwise become effective, insurance will not become effective until the date the Spouse or Dependent Child is no longer confined.

## Changes to Coverage

At each annual enrollment period or within 31 days of a change in status, you will be given the opportunity to change your coverage. You will be required to provide evidence of insurability and be approved to increase your coverage amounts.

## Questions

If you have any questions about your coverage or how to enroll, please contact Dearborn National at 800-778-2281.

*This plan highlight is a summary provided to help you understand your insurance coverage from Dearborn National. Some provisions may vary or not be available in all states. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.*

*Disclaimer*

*This information is only a product highlight. The policy has exclusions, limitations, and reduction of benefits and/or terms under which the policy may be continued or discontinued. The policy may be cancelled only during the annual open enrollment period or a qualifying event. The insurer reserves the right to change premium rates, but not more than once in a 12-month period.* **GROUP POLICY NUMBER: GAE0255-0001**

# Long-Term Disability Income Insurance

*American Fidelity Assurance Company*

How do you pay for your mortgage, bills, food and other monthly expenses? If your paycheck stopped today, could you maintain your current lifestyle?
American Fidelity Assurance Company's AF™ **Long-Term Disability Income Insurance** is designed to help protect you if you become disabled and cannot work due to a covered Accidental Injury or Sickness.

## How the Plan Works

If you become disabled due to a covered accident or sickness, Long-Term Disability Income Insurance will pay the disability benefit once you have satisfied the elimination period. Your benefit amount is dependent on your salary and the amount you select at the time of application. Disability benefits will be payable up to the benefit period stated in your policy.

## Benefits Begin

Accidental Injury and Sickness benefits will be payable beginning on the 181st day of disability.

## Eligibility

All full-time employees and employees of members on active service working 25 hours or more per week. Applicant's eligibility for this program may be subject to insurability. It is your responsibility to see the American Fidelity representative once you have satisfied your employer's waiting period.

| Coverage Feature | What It Means To You |
|---|---|
| Maximum Benefit of 60% of Your Monthly Gross Income | Protect up to 60% of your paycheck. |
| Accidental Injury and Sickness Coverage | You are covered in the case of a covered accident that occurs away from work or a covered sickness that causes you to be disabled. |
| Benefit Paid Directly to You, Regardless of Other Coverage | Use the money however best fits your financial needs, regardless of other insurance. |
| Waiver of Premium | Premiums are not required while you are disabled based on the length of your disability. |
| Age at Entry | Your premiums will be based on the date your policy becomes effective. |
| Return to Work Part Time | If you return to work part time, you will receive a portion of your disability benefit in addition to your take home pay. |
| Accidental Death Benefit | Receive a benefit if you die as the direct result of an Accidental Injury and death occurs within 90 days after the date of the Accidental Injury. |
| Competitive Premiums | Your monthly premiums could be paid with only one hour of a week's paycheck. |
| Payroll Deducted | Enjoy the convenience of having your premiums deducted straight from your paycheck. |

Limitations, exclusions, and waiting periods apply. Refer to your policy for complete details.

# Individual Term Life Insurance

*American Fidelity Assurance Company*

Life insurance is an important factor to any family. It serves as a foundation to help in the case of a loved one's premature death. Plan today to make the right move for your loved ones.

American Fidelity Assurance Company offers an AF™ **Term Life Insurance** policy to help with your financial needs for your short-term and long-term goals.

## How the Plan Works

Individual Term Life Insurance has a death benefit with no cash accumulation feature. The policy is initially written for a 10, 20 or 30-year term period, but may be renewed at the insured's option for the same level renewal period depending upon the term chosen.

The last level renewal period is no later than age 70 for the 10-year term policy and age 60 for the 20-year term policy. Thereafter, premiums are renewable annually up to age 90. The 30-year term policy is renewable annually after the initial 30-year term period up to age 90. Renewal rates will be based on the insured's age at the time of renewal.[1]

## Optional Riders

Enhance your base plan with the following riders:

- **Spouse Term**
- **Children's Term**
- **Waiver of Premium**
- **Accidental Death & Dismemberment**
- **Accelerated Benefit for Long Term Illness (30 Year Term Only)**

| Coverage Feature | What It Means To You |
|---|---|
| Three Plan Options: 10, 20 and 30-Year Level Term Coverage | Choose the coverage period to meet your financial needs. |
| Guaranteed Death Benefit | Your death benefit is guaranteed during the initial term period you choose. |
| Accelerated Death Benefit for Terminal Condition | Receive a portion of the chosen death benefit if you are diagnosed with a covered Terminal Condition. Limitations and exclusions may apply. |
| Conversion Benefit | Turn your policy into a permanent plan any time up to age 70. The rate for your new plan will be based on your attained age. |
| Guaranteed Renewable | Renew your policy up to age 90 regardless of your health.[1] |
| Interim Coverage for Death | Death benefit coverage starts when the life insurance application has been signed and underwriting guidelines have been met. |
| Express Issue Application | Only 3 express issue health questions are required to issue coverage.[2] |
| Portable | You own the policy. Take the coverage with you if you choose to leave your current job. |
| Payroll Deducted | Enjoy the convenience of having your premiums deducted straight from your paycheck. |

*[1]Premiums are subject to increase upon renewal. [2]Issuance of the policy may depend on the answer to these questions.*

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details, Policy Form Series ICC14 RCTL14. Not generally qualified benefits under Section 125 Plans.

# Accident Only Insurance

*Limited Benefit Accident Only Insurance*

***American Fidelity Assurance Company***

Whether a weekend warrior with an active lifestyle or the stay at-home type, accidents can happen anytime, anywhere, without warning. Being prepared for the unexpected can make all the difference.

Being prepared for the unexpected can make all the difference. American Fidelity Assurance Company's AF™ **Limited Benefit Accident Only Insurance** policy can provide you with a solution for those unforeseen accidents that life sometimes delivers. Our Limited Benefit Accident Only Insurance is designed to help pay for the unexpected medical expenses an individual

## How the Plan Works

Our Accident Only Insurance policy pays according to a wide-ranging schedule of benefits. In addition, the policy provides 24-hour coverage for accidents that occur both on and off the job.

All benefits are only paid as a result of Injuries received in an Accident that occurs while coverage is in force. All treatment, procedures, and medical equipment must be diagnosed, recommended and treated by a Physician. All benefits are paid once per Covered Person per Covered Accident unless otherwise specified in the Limitations and Exclusions section.

## Optional Accident Disability Income Rider

This rider covers you 24-hours a day and pays a monthly benefit amount when a covered person becomes totally disabled due to Injuries received in a covered accident after the elimination period. The monthly benefit will be paid directly to you to use as you see fit.

| Coverage Feature | What It Means For You |
|---|---|
| Plan Options: Basic, Enhanced and Enhanced Plus | Choose the plan to meet your financial needs. |
| Four Choices of Coverage: Individual, Individual and Spouse, Individual and Child, or Family | Choose the coverage that fits your lifestyle. |
| Wide-Ranging Schedule of Benefits | Covers all types of covered injuries. |
| Wellness Benefit | After the policy has been in force for 30 days, you receive a benefit for an annual routine exam, including immunizations and preventive testing once per policy per calendar year. |
| Accident Emergency Treatment Benefit | Receive a benefit when emergency treatment in a Physician's office or emergency room occurs within 72 hours of a covered accident. |
| Benefit Paid Directly to You, to use as you see fit | Use the benefit however best fits your financial needs. |
| Guaranteed Renewable | Keep your coverage as long as premiums are paid as required. |
| 24-Hour Coverage | You are covered on or off the job. |
| Portable | You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same. |
| Additional Coverage Options | Enhance the base plan by adding an optional rider. |
| Payroll Deducted | Enjoy the convenience of having your premiums deducted straight from your paycheck. |

Limitations, exclusions and waiting periods apply. Refer to your policy for complete details, AO-03 series with AMDI258 rider. **This product is inappropriate for people who are eligible for Medicaid coverage**. The premium and amount of benefits provided vary dependent upon the plan selected. The company has the right to change premiums by class. Availability of riders my vary by state.

# Cancer Insurance

*Limited Benefit Cancer Indemnity Insurance Policy*

***American Fidelity Assurance Company***

A cancer diagnosis may be overwhelming. Even with a good major medical plan, the out-of-pocket costs of cancer treatment, such as travel, childcare, and loss of income, are considerable and may not be covered.

American Fidelity Assurance Company's AF™ **Limited Benefit Individual Cancer Insurance** offers a solution to help you focus your attention on fighting cancer. We offer plans that can help assist

## How the Plan Works

Our plans are designed to help cover expenses if you are diagnosed with a covered Cancer. With over 20 benefits available to you, these plans can provide benefits for the treatment of cancer, transportation, hospitalization and more.

## Optional Riders

Enhance your base plan with the following riders:

- **Critical Illness Rider**
  Includes a cancer benefit and a heart attack/stroke benefit
- **Hospital Intensive Care Unit Rider**

| Coverage Feature | What It Means For You |
|---|---|
| Plan Options: Enhanced and Enhanced Plus | Choose the plan to meet your financial needs. |
| Three Choices of Coverage: Individual, Single Parent Family, or Family | Choose the coverage that fits your lifestyle. |
| Wide-Ranging Schedule of Benefits | Covers a wide range of treatments. |
| Benefit Paid Directly to You | Use the money however best fits your financial needs. |
| Guaranteed Renewable | Policy is guaranteed renewable as long as premiums are paid as required. |
| Diagnostic and Prevention Benefit | Receive a benefit for visiting your doctor for a cancer screening test, which helps with early detection. |
| Transportation and Lodging | Receive benefits if you travel more than 50 miles from your home using the most direct route for covered treatment. |
| Portable | You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same. |
| Additional Coverage Options | Enhance the base plan by choosing from a selection of optional riders. |
| Payroll Deducted | Enjoy the convenience of having your premiums deducted straight from your paycheck. |

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage.** The company has the right to change premiums by class. The premium and amount of benefits provided vary dependent upon the plan selected. Availability of riders may vary by state.

# Universal Life Insurance

*Texas Life Insurance Company*

It is impossible for life insurance to emotionally compensate for a loss, but it may help ease the financial obligations placed on your loved ones. Individual life insurance products can help.

## Universal Life Insurance

**(PureLife-Plus)**

A voluntary permanent[7] life insurance product that guarantees life insurance to age 121. *(Underwritten by Texas Life Insurance Company)*

## Did You Know?

More Americans were relying on employer-sponsored life insurance coverage than individual coverage.[1]

Ask your employer or your AFES representative can provide you with the opportunity for Group Life Insurance — but, do you have individual life insurance you can take with you after your employment ends? Life insurance at retirement can be very costly.

## Consider a PureLife-Plus Policy!

Ask Employer or American Fidelity Representative how you can secure your permanent[7] life insurance with a product that provides:

- Guaranteed death benefit to age 121.[7]
- Minimal cash value – premiums dedicated primarily to the purchase of life insurance.
- Long premium guarantees.[2]
- Limited right to partial refund of premium if future premium required to continue coverage increases.[2] (Conditions apply)
- Take it with you when you leave employment.
- Coverage available for employee, spouse, children and grandchildren.[3]

| Coverage Feature | What It Means To You |
|---|---|
| Several Product Options | Choose the coverage to meet your financial needs. |
| Guaranteed Premium[2] | Your premiums are guaranteed for each applicable period. |
| Guaranteed Death Benefit[4] | Your death benefit is guaranteed for the life of the policy provided premiums are paid when due. |
| Interim Coverage[5] | Coverage normally begins when you complete the application and the authorization for your employer to deduct premiums from your paycheck. Two year suicide and contestability provisions apply. (one year in ND). |
| Enhance Your Coverage | Additional riders may be available on certain products to expand your policy. |
| Easy Application | No medical exams and minimal health questions.[6] |
| Portable | You own the policy. Take the coverage with you if you choose to leave your current job. |
| Payroll Deducted | Enjoy the convenience of having your premiums deducted straight from your paycheck. |

This product may not be available in all states and may contain limitations. Not generally qualified benefits under Section 125 Plans. Underwritten by Texas Life Insurance Company. Not affiliated with American Fidelity Assurance Company.

*[1]LIMRA: Life Ownership Focus, 2016.*
*[2]After the guaranteed period, premiums may go down, stay the same or go up.*
*[3]Coverage not available in WA on children or on grandchildren in WA or MD. In MD, child must reside with the applicant to be eligible for coverage.*
*[4]Some limitations apply. See brochure for details.*
*[5]Conditions apply. In Kansas, Temporary Insurance applies. Form 16M050.*
*[6]Issuance of this policy may depend on the answer to these questions.*
*[7]Provided required premiums are timely paid.*

Flexible Premium Adjustable Life Insurance to age 121. PureLife-plus is underwritten and issued by Texas Life Insurance Company, 900 Washington Avenue, Waco, Texas 76701. Texas Life is licensed to do business in the District of Columbia and every state but NY. See the PureLife-plus brochure for details. Policy Form ICC18-PRFNG-NI-18 or Form Series PRFNG-NI-18.
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# Notes

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Flexible

## Helpful Tips

# Elect **FSA**

You must re-enroll in the Healthcare and/or Dependent Care Flexible Spending Account (FSA) each year.

# e Spending Accounts

Healthcare FSA

Dependent Care

FSA Benefits Debit Card

# Flexible Spending Accounts

*American Fidelity Assurance Company*

Flexible Spending Accounts (FSA) are great cost savings tools to help with common medical and/or dependent care expenses not covered by your insurance. You can elect a portion of your pay to be deducted, on a pre-tax basis, from each paycheck to use for reimbursement of qualified out-of-pocket expenses throughout the plan year.

## Flexible Spending Account Savings Example

| With FSA | | Without FSA |
|---|---|---|
| $30,000 | Annual Gross Income | $30,000 |
| - $2,700 | Health FSA Election | $0 |
| - $5,000 | Dependent Care Account Election | $0 |
| $22,300 | Taxable Gross Income | $30,000 |
| - $4,460 | Estimated Federal Tax (20%) | - 6,000 |
| - $1,705.95 | Estimated FICA (7.65%) | - 2,295 |
| $16,278.75 | Annual Net Income | $21,705 |
| $0 | Cost of Medical Expenses | - $2,700 |
| $0 | Cost of Dependent Care Expenses | - $5,000 |
| **$16,134.05** | **Spendable Income** | **$14,005** |
| **With an FSA you have a potential annual savings of: $2,129.05** | | |
| By using an FSA to pay for eligible recurring expenses, you can cut down on your taxable income which will result in additional spendable income. | | |

**Remember: You must re-enroll in the Healthcare Flexible Spending Account and/or Dependent Care Account EACH YEAR!**

## Healthcare Flexible Spending Account (Healthcare FSA)

A Healthcare FSA allows you to allocate money on a pre-tax basis to reimburse yourself for qualified medical expenses for you and your family. Qualified expenses include anything from copayments, medical deductibles, prescriptions and much more.

Minimum Annual Deposit: $150
Maximum Annual Deposit: $2,700

Carryover Provision - Typically, any Healthcare FSA amounts not used by the end of the plan year are forfeited. The Internal Revenue Service (IRS) guidance gives employers the ability to allow Healthcare FSA participants to carry over up to $500 of unused contributions from one plan year to the next. This carryover amount may then be used to reimburse eligible medical expenses incurred anytime during the next plan year.

## FSA Fund Availability

**Healthcare FSA**

Your full annual election is available to you on the first day of the plan year.

## Dependent Care Account (DCA)

A (DCA) allows you to allocate money on a pre-tax basis to reimburse yourself for the cost of dependent care services such as after school care and dependent day care centers.

Minimum Annual Deposit: $240
Maximum Annual Deposit*: $5,000

If you participate in a DCA, you must provide the IRS with the name, address and taxpayer identification number (TIN) or Social Security number of your dependent care provider(s) by completing either Schedule 2 of Form 1040A or Form 2441 and attaching it to your annual income tax return. Be sure that you follow the current instructions given by the IRS for preparing your annual income tax return. Failure to provide this information to the IRS could result in loss of the pre-tax exemption for your dependent care expenses.

**Dependent Care Account (DCA)**

Unlike the Healthcare FSA, the entire elected amount is not available on the first day of the plan year, but rather as contributions are received.

* Highly Compensated Employees as defined by IRS Tax Code § 414(q) may be required to reduce their elected amount based on nondiscrimination testing.

**For a complete list of eligible expenses, please visit www.americanfidelity.com**

# Flexible Spending Accounts



## Benefits Debit Card

American Fidelity will provide a Benefits Debit Card to all employees who elect to participate in a Healthcare FSA (where offered by your employer.) The debit card gives immediate, convenient access to Healthcare FSA funds at the point of sale for prescriptions, copays, and other common qualified medical expenses. The card can only be used for the Healthcare FSA and is not available for the DCA.


## Using Your Benefits Debit Card

Simply swipe your card like you would with any other credit card. Whether at the doctor's office or the dentist, the amount of your eligible expenses will be automatically deducted from your Healthcare FSA. Save ALL receipts!

Cards for Healthcare FSAs can be used at:

- Health care related facilities which include: hospitals, physician offices, dental offices, vision offices; and,
- Merchants participating in the Inventory Information Approval System (IIAS).
- The card is for medical expenses only; dependent day care expenses are not eligible.
- The card cannot be used for over-the-counter drugs filled with a prescription. You will need to file a manual claim for these types of expenses.

## Snap. Submit. And Go!

When using your Benefits Debit Card to pay for an eligible expense, you may need to retain documentation to verify the expense. The AFmobile® app makes this easy.

- **Snap** a photo of the itemized receipt* with your phone.
- **Submit** the photo of the itemized receipts within the app when you receive notification that a receipt is needed to verify your expense.
- **Go**! After submitting your verification and its review, you will be able to view the status of your reimbursement within the app.

*The Internal Revenue Code (IRC) requires proof of the eligible expenses using itemized receipts or other documentation showing the date of service, person for whom service was provided and description of the expense. Depending on the type of expense, documentation may come in the form of third party itemized statements or Explanation of Benefits.

## Activating Your Card

You will receive your card at your home address and may begin using your card on the first day of your plan year. Your card will be automatically activated when you use it for the first time for an eligible expense.

# Flexible Spending Accounts

*American Fidelity Assurance Company*

## Important FSA Notes

- Participants are allowed a 90-day run-off period after the plan year ends to submit claims that occurred during the plan year but were not yet submitted.
- If you are a new employee entering the FSA during a plan year, expenses must be incurred after you are eligible to participate in the FSA.
- If you are enrolled in the Healthcare FSA and take a leave of absence during the plan year, you may:
  1. Prepay the contributions pre-tax;
  2. Continue the contributions on an after-tax basis (pre-tax contributions may continue when you return to work); or
  3. Prorate the unpaid contributions over the remaining pay periods when you return to work.
- Failure to make all elected contributions will result in termination of your account as of the date contributions ceased.
- Healthcare FSAs must comply with COBRA and offer COBRA continuation rights to qualified beneficiaries who lose their Health care FSA coverage as a result of termination of employment. Generally, COBRA may only be offered upon termination of employment if you have a balance remaining in your Healthcare FSA. The balance is calculated by subtracting the reimbursements made from the contributions received. You may choose to continue your contributions by either sending your contributions to your employer on an after-tax basis each pay period, or, you can choose to make a pre-tax contribution for your remaining election for the plan year from your severance pay. Expenses incurred while contributions are being made are eligible for reimbursement. The coverage generally may not continue beyond the current plan year. If you do not elect to continue the contributions on an after-tax basis, only expenses incurred during the period of employment will be reimbursed. Coverage under the Healthcare FSA ceases when the contributions cease.

# Flexible Spending Accounts

*American Fidelity Assurance Company*

## File a Claim

Three Easy Ways

1. **On your mobile device using AFmobile®**

Use AFmobile to manage your reimbursement accounts and insurance benefits.

2. **Online at americanfidelity.com**

3. **By mail or fax**

Insurance Claim
American Fidelity Assurance Company, Attn: Benefits Department
P.O. Box 268898, Oklahoma City, OK 73125
Fax: 800-818-3453

FSA Claim
American Fidelity Assurance Company
Attn: Flex Account Administration
P.O. Box 161968, Altamonte Springs, FL 32716
Fax # 844-319-3668

*Obtain a claim form for your insurance claim at www.americanfidelity.com/fileaclaim.

## Manage Your Reimbursement Account With AFmobile®

AFmobile® allows FSA participants to submit reimbursement account claims while on the go.

- Access accounts - check balances, view transaction history, and more.
- Manage claims - submit new claims, upload receipts, and check claims status.
- Receive account alerts - choose to receive account updates by text and push notifications.
- Submit documentation - tie receipts and other documentation to a pending card swipe to expedite adjudication.

## Getting Started:

Download AFmobile. To register, you will need:

- Your email address - this should be the same email address provided at time of enrollment.
- Your Social Security Number.

## Using Our Online Portal

Our online portal provides all the same great features as mobile, plus powerful self-service account access and education resources to help put you in the driver's seat.

Getting started:

- Register at americanfidelity.com
- Register using your email address and Social Security Number
- Once completed, access your reimbursement accounts and insurance benefits.

## Direct Deposit

By enrolling in direct deposit, you can ensure a timely reimbursement! You will no longer need to worry about having to wait on checks or make any more trips to the bank.

**Three ways to sign up for direct deposit:**

1. Through your mobile app.
2. Online through your account at americanfidelity.com
3. By downloading a direct deposit request form

Helpful Tips

# Maintain **Beneficiaries**

1. Life Insurance - Employee Benefits
2. Final Payout of wages and leave balances - HRIS
3. Retirement Savings - Retirement
   - OCERS
   - FIRE PENSION
   - POLICE PENSION
   - ICMA-RC
   - Nationwide

You may change beneficiaries at ANY time.

# er City Benefits

Employee Medical Center

Employee Assistance Program

Fitness Center

Temporary Disability Income Protection IRC 457

Compensation

# Employee Medical Center



## Located in the Arts District parking garage, 424 W. Colcord St., Suite A

**OKCCare Employee Medical Center offers:**

- Completely confidential services
- No co-pay
- No deductible
- Full service primary care
- On-site lab draws
- On-site generic prescriptions
- Annual Personal Health Assessment (PHA) with lab work and consultation

**What types of treatment may be offered at the OKCCare Employee Medical Center?**

- Chronic Disease Management
- Annual Physical Examinations
- Medication Prescriptions
- Sports Physicals
- Allergies
- Personal Health Assessment
- Acute/Sick Visits as Needed
- Lab Orders and Follow Up
- Specialty Referrals as Needed
- Women's Health
- Asthma
- Tobacco Cessation

**Can my family use the OKCCare Employee Medical Center?**

Yes. Spouses and dependents over the age of 2 who are enrolled in the City's health insurance program also have access to the medical center. Please note, you will need to maintain a relationship with your pediatrician for well-child visits and immunizations; however, OKCCare will see young children ages 2 and up for acute care needs.

**Is parking available at OKCCare?**

Free parking is available at the Arts District Parking Garage located at 431 West Main Street. Take your parking ticket to your appointment and clinic staff will provide a validation ticket to use upon exit of the Arts District Parking Garage .

**Is there a co-pay or other cost to use OKCCare?**

There is not currently a charge or co-pay to use the OKCCare wellness center. In addition, OKCCare stocks a large variety of generic medications for many chronic and acute medical conditions and will dispense necessary prescriptions during your visit. Medications dispensed at the clinic are currently free of charge to you.

**What do I need for my visit?**

Appointments are strongly recommended. Please arrive 15 minutes prior to your scheduled time with a valid I.D., such as a driver's license, as well as your medical insurance card. Please be prepared to have your photo taken. You are encouraged to complete your new patient paperwork prior to your new patient visit,. Additional information regarding appointments will be provided once the operator is finalized.

# Employee Assistance Program

*Alliance Work Partners*

AWP is proud to serve as your EAP, offering you and your household valuable, confidential services at no cost to you. Your benefits are designed to help you manage daily responsibilities, major events, work stresses, or any issue affecting your quality of life.

## Your EAP Benefits

**Law Access**

Legal and Financial services provided by a lawyer or financial professional specializing in your area of concern. Available online or by telephone.

**HelpNet**

Customized EAP website featuring resources, skill building tools, online assessments and referrals.

**Worklife**

Resources and referrals for everyday needs. Available by telephone.

**SafeRide**

Reimbursement for emergency cab fare for eligible employees and dependents that opt to use a cab service instead of driving while impaired.

**1 to 6 Counseling Sessions**

Per issue, per year. Short-term counseling sessions which include assessment referral and crisis services.

**All benefits can be accessed by calling:**
**800-343-3822**
We are available to take your call 24 hours a day, 7 days a week.

Visit your EAP website at:
**awpnow.com**
and create a customized account.

Go to: http: //www.awpnow.com.
Click"login" at the top right

Initial Login:
registration code: AWP-OKC-2151
You will be prompted to create your own unique username and password

## Criteria for Benefits

**Eligibility Full Benefits:**

- Employee, married/divorced spouse, partner, significant other
- Any household member, regardless of age or relationship, residing in employee's home, including significant other and their children
- All covered employees may bring anyone with them to their authorized/covered sessions regardless of relationship to employee.
- Children and grandchildren, age 26 or under, residing in U.S. or Puerto Rico. This includes children and grandchildren of significant other or partner.
- Any person meeting benefit eligibility prior to lay-off or termination of an employee will continue to be eligible for benefits up to 6 months from the date of employee's lay-off or termination. Benefits are extended for 6 months from date of employee's call within this timeframe.

**Assessment & Referral:**

- Children and grandchildren age 27 and over of employee, married/ divorced spouse, partner, or significant other living outside employee's home
- Employee instructed by law to receive court ordered counseling
- All crisis cases (suicidal/homicidal domestic violence, chemical dependence, substance abuse, child/elderly abuse) not otherwise covered
- Any person meeting benefit eligibility prior to layoff or termination of an employee will continue to be eligible for assessment and referral after 6 months and up to 1 year from the date of employee's lay-off or termination. Benefits are extended 1 year from date of employee's call within this timeframe.

**Information & Referral**

- Anyone contacting Alliance Work Partners regardless of contract status

Children under the age of 18 must have a written, signed release by their guardian who has custody (whether living in the home or not) to attend counseling on their own. This release is given to their affiliate provider. Divorced parents who bring their children in for counseling must bring a copy of their divorce decree or have signed permission from the other parent before bringing a child into counseling. Grandparents who bring their grandchildren into counseling must have proof of guardianship or written permission from the child's parents.

# Fitness Center

*10GYM and Gold's Gym*

## 10GYM

Services include fitness club services, personal training, tanning and childcare. 10GYM offers membership in seven locations throughout the Oklahoma City metropolitan area. Employee's membership will include all 10GYM, locations. The City will facilitate employee membership payments by permitting payroll deduction for the membership fees. Deductions will be taken out of 24 pay periods annually. Membership contracts are between the employee and 10GYM should payroll deductions cease for any reason, members are personally and financially responsible for the payment of their membership fees to 10GYM. There will be a one-time card activation fee assessed when signing up for the membership. The card fee will be deducted with the first membership deduction. For enrollment information, call 405-601-8998.

**Membership Includes:**

- Access to All Locations: 10GYM
- Free Unlimited Guest Privileges
- Unlimited Group Fitness
- Free Unlimited Tanning
- Personal Training: Responsibility of the member/employee no payroll deduction allowed for these expenses.
- Childcare (Kid Fun Zone): $5 + tax per pay period of one child; $7.50 + tax per pay period for two or more children.

**Membership:**
$9.50 + tax per pay period for employee only.

**Additional Family Member:**
$2.50 + tax per pay period.

**Initial Card Fee:**
$10.00 per membership, through payroll deduction. (Cards for additional family members will be provided at no additional costs.)

**Replacement Cards:**
$5.00 each. Responsibility of the member/employee, no payroll deduction allowed for this expense.

10GYM
Find All Locations http://10gym.com/

# Fitness Center

*10GYM and Gold's Gym*

## Gold's Gym

Services include Latest Cardio and Weight Equipment, Free Group Exercise and Cycle classes, Certified Personal Trainers*, Complimentary Fitness Assessment. Access to seven (7) locations in the Oklahoma City Metropolitan are and all Gold's Gyms worldwide.

**Additional Amenities (vary by location):**

- Free Child Care/Kid's Club
- Exclusive Cardio Cinema (Movie Theatre)
- Lap Pools
- Sauna, Hot Tub, Steam Room
- Basketball Courts
- Smoothie Bar

**Membership:**
Individual Membership $19.95 per month ($9.97 plus tax per pay period) + $19.95 for each additional family member.

No Initial Card Fee. Deductions will be taken out of 24 pay periods annually. Membership contracts are between the employee and Gold's Gym. Should payroll deductions cease for any reason, members are personally and financially responsible for the payment of their membership fees to Gold's Gym.

*Personal Training: Responsibility of the member/employee, no payroll deduction allowed for these expenses.

Gold's Gym
Enroll On-line: http://okc.goldsgym.com/

# Temporary Disability Income Protection

*City of Oklahoma City*

## Temporary Disability Income Protection Plan *(For Management Employees Only)*

This plan is provided by the City of Oklahoma City and is designed for management employees who are temporarily disabled and are expected to return to work. This program is not intended as a long-term disability, or salary continuance plan.

**Definition of Management Employees**

- All full-time management and executive pay plan employees
- All full-time City Council appointees
- All full-time employees in the City Auditor's pay plan
- All full-time employees in the Municipal Counselor's pay plan

**Effective Date**

All qualified employees are covered by the Plan on their first day on the job. It is not necessary to complete enrollment paperwork for this program.

**Benefits**

A benefit in the amount equal to 60% of the employee's basic earnings is payable monthly to an eligible employee. The maximum amount of benefits payable to any employee is $3,000 per month and the maximum benefit period is 36 months.

For additional details, refer to the Temporary Disability Income Protection Plan booklet or contact an Employee Benefits representative.

# IRC 457 Deferred Compensation

*ICMA Retirement Corporation*
*Nationwide Retirement Solutions, Inc.*

## IRC 457 Deferred Compensation

Employees are offered a choice of two voluntary deferred compensation programs administered by ICMA Retirement Corporation and Nationwide Retirement Solutions, Inc. These programs allow employees to save today for retirement. Beginning in 2002, under Section 457 of the Internal Revenue Code, employees may generally defer the lesser of 100% of their total compensation or the limit for the year. Participation is handled through payroll deduction so taxes are reduced each pay period. An employee may join either 457 plan anytime during the year.

**Advantages**

- Reduce current income taxes while boosting retirement savings
- Earnings accumulate tax-deferred
- Portability. An employee can move savings to another governmental 457 plan, IRA, or qualified plan

**Withdrawals**

An employee may withdraw assets under certain conditions. Additionally, it's necessary to complete the appropriate paperwork, which is available at the Employee Retirement System Office, or which may be obtained by contacting ICMA or Nationwide at the telephone numbers listed in the back of this guide.

- Retirement or separation of service
- Qualified unforeseeable emergency

The City offers quarterly Retirement Education and Planning seminars. For more information and seminar schedules please contact the Oklahoma City Employees Retirement System at 405-297-2408 or Employee Benefits at 405-297-2144.

## How Much Can I Contribute?

| Contribution Limits for Eligible 457(b) Deferred Compensation Plans*<br>This information is not intended as tax advice. It is provided for your education only. | |
|---|---|
| Annual Contribution Limit | Annual cost of living adjustments may occur. This limit includes both employee and vested employer contributions. |
| | 2019 Annual Maximum: $19,000 |
| | 2020 Annual Maximum: Annual cost of living may occur. |
| 457(b) Special Catch-up Provision | The 457(b) Special Catch-up provision permits increased annual contributions on behalf of a participant. It allows you to make up, or "catch up," for prior years in which you may not have contributed the maximum amount to your employer's 457(b) plan. |
| | 2019 Annual Maximum: $38,000 |
| | 2020 Annual Maximum: Annual cost of living may occur. |
| Age 50+ Catch-up Provision | If you are at least age 50, and currently participate in a governmental 457(b) plan, you are eligible to contribute an additional amount over the annual contribution limit. However, you cannot use both the 457(b) Special Catch-up provision and the Age 50+ Catch-up provision in the same year. You must use whichever is greater. |
| | 2019 Annual Maximum: additional $6000 |
| | 2020 Annual Maximum: Annual cost of living may occur. |

**** As of the date of this publication, the 2020 information is not available. For the most up-to-date information about 457(b) contribution limits, visit www.irs.gov.***

**For more information, contact OCERS at 405-297-2408.**

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## Helpful Tips

## Make**Changes**

Open enrollment is your opportunity to make changes to your coverage each year. Changes during the plan year can only be made due to a qualifying even listed on page 62. Employees must notify Employee Benefits within 31 days of the event to update coverage. Common qualifying events are marriage, divorce or birth of a child.

# er Information

Dependent Eligibility Requirements Important Benefit Plan Information Continuation of Coverage (COBRA) Guide to Qualifying Changes in Status Payroll Calendar Frequently Asked Questions Medicare Disclosure Chip Notification Glossary Benefit Resource Directory

# Dependent Eligibility Requirements

## Eligible Dependents Include

- Spouse.
- Child(ren), under age 26, (or those who qualify as a dependent under the Internal Revenue Code).
- Child(ren) who are physically or mentally incapable of self support on the date coverage would otherwise end.

## Disabled Child

A permanently and totally disabled child must meet all of the following tests:

- The child cannot engage in any substantial gainful activity because of a physical or mental condition;
- A doctor determines the condition has lasted or can be expected to last continuously for at least one year or can lead to death;
- The child is incapable of self-sustaining employment by reason of mental or physical disability, and is primarily dependent upon the employee for support and maintenance; and
- The employee provides proof of the continuance of such dependency upon request by the City. Evidence of the disability status will be required, at minimum, every two years.

## Dependent Verification

Employees must provide official documentation establishing a legal relationship with dependents in order for the dependents to be eligible for coverage. Acceptable documentation must be received in the Employee Benefits Division of the Personnel Department within 31 days of becoming eligible.

Dependent Child Age Limitations

| Benefit Plan | |
|---|---|
| Group Indemnity Plan | Under age 26 |
| HMO Plan | Under age 26 |
| Dental Plan | Under age 26 |
| Vision Plan | Under age 26 |
| Group Term Life | Under age 23 |

## Dependent Audit

Employee Benefits may audit employee benefit files to ensure proper documentation for dependents enrolled in the City's medical, dental, and vision plans have been provided. You will receive a letter requesting missing documentation and must comply with the request. Failure to do so may result in loss of coverage for your dependent(s). You do not need to contact Employee Benefits to inquire about your file. If documents are needed, you will receive a letter.

## Dependent Documentation

Acceptable documents include but are not limited to copies of marriage certificate, state issued birth certificates, social security card, or court order establishing legal guardianship, legal custody or adoption. Supporting documentation must be provided in English. Additional information you need to have to add your dependent:

- Dependent's address, if different than yours;
- Dependent's telephone number, if different than yours; and
- Dependent's Primary Care Physician (if electing HMO).

## Non-Eligible Dependents

- Ex-spouse, except as allowed under COBRA
- Domestic Partner
- Parents, grandparents, aunts, uncles, grandchild(ren), foster child, brother, sister, nephew, niece, unless such child(ren) are under your legal guardianship, legal custody or adopted as evidenced by court documents
- Step-child(ren), if the employee is divorced from the natural parent of the stepchild(ren), such child is no longer qualified as the employee's stepchild(ren), and is no longer eligible for coverage
- Dependents who do not meet the eligibility requirements outlined in this section
- Dependents cannot be covered by the same plan by more than one employee

## Change in Dependent Status

**If you divorce, or if your marriage is annulled, your ex-spouse is no longer an eligible dependent under the Plan. Divorce or annulment is a qualified event. You must remove an ex-spouse from your coverage, and remove other individuals including step-children that are no longer eligible dependents. It is your responsibility to provide notification to the Personnel Department/Employee Benefits Division, of any change in your dependents eligibility within 31 days of the qualifying event.**

**NOTE: The Personnel Department reserves the right to require proof of continued eligibility for dependents. Failure to provide the required documentation may result in termination of coverage (Personnel Policies Sections 717.02 and 717.03).**

# Dependent Eligibility Requirements

## Common-Law Marriage Guidelines

A common-law marriage relationship is defined as two adults who present themselves as a married couple, have chosen to share their lives in an intimate and committed relationship, reside together and share mutual obligations of support for the basic necessities of life. To be recognized as a qualified common-law relationship, the two individuals must attest to the fact that they are (1) living together; (2) mutually responsible for the costs of basic living expenses (financially interdependent); (3) not related by blood to a degree that would prohibit marriage; and (4) are age 18 or older.

To document that the partners reside together, the parties must provide evidence such as: (1) a lease, deed, or mortgage showing both partners as parties to the transaction; (2) driver's licenses for both partners showing the same address; (3) utility bills showing the same address; and/or (4) passports for both partners showing the same address.

To document that the partners are financially interdependent, the partners must provide evidence such as: (1) joint checking account; (2) credit cards with the same account number in both names; (3) copy of the most recent tax year federal tax return filed as "married filing jointly" or "married filing separately" and/or (4) joint wills.

Oklahoma recognizes common law through case law as opposed to statute. The employee applicant and the partner must also sign and have notarized an official Statement for Common-Law Marriage available from the Personnel Department/Employee Benefits Division.

Employees may add common-law spouses only during the annual open enrollment period, or upon initial employment with the City of Oklahoma City. The Employee Benefits Manager will review all applications and approve or deny based on the documentation the employee has provided.

## Disciplinary Action for Failure to Notify the Employee Benefits Division

**It is a fraudulent act to knowingly add or maintain ineligible dependents on the City's benefit plans. If the information provided to the Employee Benefits Office of the Personnel Department is determined to be false or misleading, you may be subject to disciplinary action up to and including termination from employment. Failure to notify the Personnel Department, Employee Benefits Division, in writing of any change in marital status and/or change in dependent status that results in the improper extension of health and welfare benefits, may result in disciplinary action, up to and including termination and/or further legal action against the employee. You must notify the Employee Benefits Division within 31 days of a qualifying event (Personnel Policies Sections 717.02 and 717.03).**

# Important Benefit Plan Information

## Court Ordered Benefits

When the Employee Benefits Division receives a qualified medical support order or other court order, as defined by ERISA and/or applicable federal law, to enroll your child under the Plan, the Employer will enroll your child at any time without regard to open enrollment limits and shall provide the benefits of the plan in accordance with the applicable requirements of such order. The qualified medical support order or other court order may require the Employee Benefits Division to add additional coverage that may have been previously waived or change medical plans in order to comply with the requirements of such order.

Once the child has been enrolled in benefits, as a result of the medical support order or other court order, the employee will receive confirmation of the child's enrollment and a copy of the order received. A child's coverage under this provision will not extend beyond any Dependent Age Limit of the Plan. Any claims payable under the Plan will be paid, at the Plan's discretion, to the child or the child's custodial parent or legal guardian. The Administrator, on behalf of the Employer, will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to the Employer and Administrator directly. Any questions in regard to the qualified medical support order or other court order should be directed to the issuing agency of the order.

**Can a court order be modified once the coverage is started as a result of the qualified child support order?**

The court order obligates the City to provide benefits of the plan in accordance with the applicable requirements of such order regardless if the child is covered under another plan. Employee Benefits can only make changes if the issuing agency sends a modification of the qualified medical support order or other court order. Any questions in regard to the qualified medical support order or other court order should be directed to the issuing agency of the order.

**Please Note:** You may be able to remove the child from another plan within 31 days of the date you gain coverage. Please contact the plan administrator of your other insurance for more information.

**Why did the City change my medical plan?**

If you are enrolled in an HMO and the custodial parent lives outside the HMO service area, Employee Benefits is obligated to change your medical coverage to a plan that will provide coverage for the child in order to satisfy the applicable requirements of the qualified medical support order or other court order.

**Why did the City enroll me in coverage I had previously waived or never elected?**

In order to comply with the applicable requirements of the qualified medical support order or other court order, Employee Benefits may have to elect additional coverage for yourself and child. For example, if the order states to enroll the child in "any available coverage", then Employee Benefits is required to enroll you and your child in any coverage offered, which would include medical, dental, and vision.

**Can I add other dependents to coverage?**

No. The qualified medical support order or other court order is not considered a qualifying event to add additional dependents. You may add additional dependents at Open Enrollment or if a qualifying event occurs, such as loss of other coverage.

**I believe the qualified child support order Employee Benefits received is inaccurate, what should I do?**

Any questions in regards to the qualified medical support order or other court order should be directed to the issuing agency of the order. Employee Benefits can only make changes if the issuing agency sends a modification of the qualified medical support order or other court order.

**How long is the qualified child support order or court order valid?**

The qualified medical support order or other court order remains valid until the date specified in the order, the child reaches the age of majority (age 18). or a modification of the original order is received by Employee Benefits. An employee may elect to continue coverage for the dependent up to age 26. Employees must provide supporting documentation, a state issued birth certificate and Social Security card, for the dependent to be eligible for coverage after the court order expires.

# Important Benefit Plan Information

## Family Medical Leave Act (FMLA)

Any employee will continue to be eligible for group rate benefits while they are on an approved FMLA leave. The employee must continue to pay his/her share of the premiums during the leave period. Failure to pay the required premium will result in cancellation of the employee's coverage. Termination of benefits, if necessary, are date sensitive and will vary on an individual basis. For additional information regarding FMLA, please refer to Personnel Service Bulletin 05-02.

**What happens to my group benefits while I'm on paid Family Medical Leave?**

While on a paid FMLA status, City and employee contributions for health and welfare benefits will continue to be paid to the same extent as they would be if the employee were in an active employment status.

**What happens to my group benefits while I'm on unpaid Family Medical Leave?**

When an employee enters an unpaid status, they will be afforded the opportunity to pay premiums due through the end of the month that their FMLA entitlement ends. If the employee does not pay premiums, benefits will be terminated retroactively to the first day of the month following the last full month of paid premiums.

**What happens to my voluntary benefits while I'm on Family Medical Leave?**

Deductions for voluntary services/products, which may include flexible spending accounts, deferred compensation, union dues, etc., will not cease, unless the employee requests cancellation, and may continue to accrue in your absence. Once you have returned to an active employment status, the accrued premiums will be deducted through the payroll system.

**What happens when I return to work?**

When an employee returns to work after an FMLA status, the employee must meet with an Employee Benefits staff member within 31 days to restore his or her benefits. Any terminated benefits must be restored to the plan and tiers in effect prior to the FMLA leave. The only exceptions to this rule are when an open enrollment has passed or if there was a qualifying event during the unpaid leave which makes the employee eligible to change benefits plans or tiers. Should money be owed to any plan for missed deductions while on leave, collection will be made through the payroll system upon employees return to work.

**How does non-payment of premium affect my COBRA rights?**

If benefits are terminated due to non-payment of premiums, the termination is considered voluntary and all qualified beneficiaries will become ineligible for COBRA continuation of coverage.

## Leave Without Pay

If you are on leave without pay for any reason, excluding an approved FMLA leave or military leave, for one or more pay periods, you are eligible to continue your group coverage for a specific period of time subject to premium payment. The employee must continue to pay his/her share of the premiums during the leave period. Failure to pay the required premium will result in cancellation of the employee's coverage. Termination of benefits, if necessary, are date sensitive and will vary on an individual basis. Contact a representative of the Employee Benefits Division for detailed information.

**What happens to my group benefits while I'm in an unpaid status?**

When an employee enters an unpaid status, they will be afforded the opportunity to pay premiums due for group benefits through the end of the month of the second unpaid pay period. If the employee pays the premiums due, the employee will be offered COBRA continuation coverage the first of the following month. If the employee does not pay premiums, benefits will be terminated retroactively to the first day of the month following the last full month of paid premiums.

**What happens to my voluntary benefits while I'm in an unpaid status?**

Deductions for voluntary services/products, which may include flexible spending accounts, deferred compensation, union dues, etc., will not cease, unless the employee request cancellation and may continue to accrue in your absence. Once you have returned to an active employment status, the accrued premiums will be deducted through the payroll system.

**What happens when I return to work?**

When an employee returns to work after an unpaid status, the employee must meet with an Employee Benefits staff member within 31 days to restore his or her benefits. Any terminated benefits must be restored to the plan and tiers in effect prior to the unpaid status. The only exceptions to this rule are when an open enrollment has passed or if there was a qualifying event during the unpaid leave which makes the employee eligible to change benefits plans or tiers. Should money be owed to any plan for missed deductions while on leave, collection will be made through the payroll system upon employees return to work.

**How does non-payment of premium affect my COBRA rights?**

If benefits are terminated due to non-payment of premiums, the termination is considered voluntary and all qualified beneficiaries will become ineligible for COBRA continuation of coverage.

# Important Benefit Plan Information

## Military Leave

While an employee is in a military leave status, they will continue to be eligible for group rate benefits for up to 12 months after they enter an unpaid status. The employee will continue to pay his/her share of the premiums during the leave period. Failure to pay the required premium will result in cancellation of the employee's coverage. Termination of benefits, if necessary, are date sensitive, and will vary on an individual basis. For additional information regarding military leave, please refer to Personnel Service Bulletin 05-05 and City Council Resolution.

**What happens to my group benefits while I'm on paid military leave?**
Unless instructed by the employee, their attorney in fact or agent to terminate benefits, City and employee contributions for health and welfare benefits will continue to be paid to the same extent as they would be if the employee were in an active employment status.

**What happens to my group benefits while I'm in an unpaid military status?**
When an employee enters an unpaid military status, they will be afforded the opportunity to pay premiums due for group benefits for an additional 12 months. If the employee pays the premium due, the employee will be offered COBRA continuation coverage the first of the month following the 12th month of unpaid status. If the employee does not manually pay premiums, benefits will be terminated retroactively to the first day of the month following the last full month of paid premiums.

**What happens to my voluntary benefits while I'm in an unpaid military status?**
Deductions for voluntary services/products, which may include flexible spending accounts, deferred compensation, individual term life, cancer plan, union dues, credit union, etc., will not cease and may continue to accrue in your absence. When an employee enters an unpaid military status, the Employee Benefits Division will mail information to the employee regarding continuation and/or reinstatement of voluntary benefits when the employee returns to a paid status.

**What happens when I return to work?**
When an employee returns to work after an unpaid military status, it will be their responsibility to meet with a representative of the Employee Benefit Division within 31 days to re-establish any terminated benefits. In the event an open enrollment has passed or if there was a qualifying event during the unpaid leave which makes the employee eligible to change benefit plans or tiers, they will have that option. Should money be owed to any plan for missed deductions while on leave, collection will be made through the payroll system upon employees return to work.

**How does non-payment of premium affect my COBRA rights?**
If benefits are terminated due to non-payment of premiums, the termination is considered voluntary and all qualified beneficiaries will become ineligible for COBRA continuation of coverage.

## Special Enrollment Rights

**Loss of Coverage**
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in one of the plans offered, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
29 CFR 2590.701-6(c)

**Loss of Medicaid or SCHIP**
Employee or dependents will be allowed to enroll mid-year if they lose Medicaid or the State Children's Health Insurance Program (SCHIP) coverage, as a result of losing eligibility, or becoming eligible for Medicaid or SCHIP assistance with the group health plan premiums. An employee will be given 60 days after the event to request enrollment in one of the City's health plans. To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date the employee or dependent become eligible for premium assistance under Medicaid or SCHIP or the date you or your dependent's Medicaid or state-sponsored SCHIP coverage ends.

# Important Benefit Plan Information

## Federal Regulations Acts

**Newborns' and Mothers' Health Protection Act of 1996**

Group health plans and health insurance issuers generally may not, under Federal or State 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 and State law generally do 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 or State 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).

In addition, under State law group health plans and health insurance issuers shall provide for one home visit within 48 hours of childbirth by a licensed health care provider whose scope of practice includes providing postpartum care, following a vaginal delivery when childbirth occurs at home or in a licensed birthing center.
§711(d); 29 CFR 2520.102-3(u) and §36-6060.3 of Oklahoma Statutes.

**Women's Health and Cancer Rights Act of 1998**

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 states 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. Refer to your plan documents for applicable deductibles and coinsurance amounts. § 713(a)

# Continuation of Coverage (COBRA)

## COBRA Continuation of Coverage

Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise would be terminated.

COBRA contains provisions giving certain employees, former employees, retirees, spouses and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available in specific instances. Coverage for COBRA participants is usually more expensive than coverage for active employees, since usually the employer formerly paid a part of the premium.

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary generally is any individual covered by a group health plan on the day before a qualifying event. A qualified beneficiary may be an employee, the employee's spouse and dependent children, and in certain cases, a retired employee, the retired employee's spouse and dependent children.

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

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

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.

Your dependent children 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."

**Is COBRA continuation coverage available to a retiree?**

Sometimes, filing a proceeding in bankruptcy of the employer under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the City of Oklahoma City, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

**How long will continuation coverage last?**

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of loss of coverage due to an employee's death, divorce or legal separation, the employee's enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months. 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. This notice lists the maximum period of continuation coverage available to qualified beneficiaries.

# Continuation of Coverage (COBRA)

Continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid on time;
- A qualified beneficiary becomes covered under another group health plan that does not impose a pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
- A qualified beneficiary enrolls in Medicare after electing continuation coverage; or
- The employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

## General Notice

You will receive a General Notice of your COBRA Continuation of Coverage Rights when you initially become covered under a group health or dental group plan. The notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage. Additionally, the 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.

## Election Notice

You will receive an Election Notice when you or one of your qualified beneficiaries lose coverage under a qualified plan. The Election Notice contains the election form that must be returned in order to participate in COBRA, along with the COBRA rate sheet and other information about your rights under COBRA. You or your qualified beneficiaries will receive an Election Notice for any of the following reasons:

1) Termination (for reasons other than gross misconduct) or a reduction in work hours
2) A child's loss of dependent status
3) A divorce or legal separation
4) Employee eligibility for Medicare
5) Military leave, after the 12-month benefit extension expiration
6) Death of an employee

**This information is based on federal regulations. For more information, please contact Employee Benefits at 405-297-2144.**

## For More Information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the COBRA Administrator. You can get a copy of your summary plan description from:

The City of Oklahoma City
Personnel Department / Employee Benefits Division
Attn: COBRA Administrator
420 W. Main, Suite 110
Oklahoma City, OK 73102
Phone: 405-297-2144

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

## Keep Your Address Updated

In order to protect your family's rights, you should keep the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer.

# Guide to Qualifying Changes in Status

| Qualifying Event | Documentation Requirements to Complete Changes | Changes Permitted | | | |
|---|---|---|---|---|---|
| It is the employee's responsibility to notify Employee Benefits within 31 days of any of the qualifying events listed below: | All required documents must be submitted and elections made within 31 days of the qualifying event date. Note: With the exception of Initial Enrollment and Open Enrollment, all changes must be consistent with the type of event. Employee Benefits reserves the right to determine eligibility of the qualifying event and which changes will be permitted. Supporting documentation provided must be in English. | Add Coverage | Terminate Coverage | Change Carrier | Waive Coverage |
| Initial Enrollment/Open Enrollment | Official State Issued Birth Certificate (Dependent Child), OR Marriage Certificate (Spouse), AND copy of Social Security Number, copy of official document | Y | Y | Y | Y |
| Marriage | Marriage Certificate AND Social Security Number<br>Note: Refer to requirements for New Dependent if adding stepchildren | Y | | Y | |
| New Dependent | Official State Issued Birth Certificate (required) AND Social Security Number<br>Note: Hospital Birth Record acceptable for temporary enrollment of newborns. | Y | | Y | |
| Adoption, Placement for Adoption, Legal Guardianship, or Legal Custody | Valid Adoption Decree/Order, OR Petition for Adoption, placement agreement, or other legal document that establishes guardianship or legal custody AND Requirements for New Dependent | Y | | Y | |
| Divorce, Annulment (Spouse, Stepchildren) | First and last page of order with Judge's signature and court stamp that contains the date that the divorce or annulment is finalized.<br>(Coverage can only be terminated for spouse/stepchildren) | | Y | Y | |
| Death | Notify Employee Benefit Representative<br>Note: Employee Benefits may require an original Death Certificate | | Y | | |
| Employee / Dependent becomes eligible for insurance through another plan | Employer letter, Certificate of Creditable Coverage, or other acceptable documentation indicating the date coverage began, type of plan(s) enrolled, and individuals covered | | Y | | |
| Employee / Dependent loses eligibility for insurance through another plan | Employer letter, Certificate of Credible Coverage, or other acceptable documentation indicating the date coverage ended, type of plan(s) enrolled, and individuals covered | Y | | | |
| Dependent reaches maximum age to qualify for coverage | No document requirements | | Y | | |
| Dependent elects coverage through his/her employer | Letter, or other acceptable documentation indicating the date coverage began, type of plan(s) enrolled, and individuals covered | | Y | | |
| Disabled Dependent | Letter from Physician describing the dependent's medical condition, prospect of recovery and a diagnosis.<br>(Documentation must be supplied upon request or every two years) | Y | | | |
| Significant change in premium cost or coverage attributable to spouse's employment | Acceptable documentation that illustrates the differences in cost or coverage | Y | | | |
| New residence outside of HMO service area | Completed Change of Address Form | | | Y | Y |

**Note: The effective date of the change is the date of the qualifying event. Any change in premium will be based on the effective date of coverage. The City of Oklahoma City does not does not prorate premiums for changes.**

**It is your responsibility as the employee to notify the Employee Benefits division of the City's Personnel Department within 31 days of the event. You will be held liable for any employer premiums paid on behalf of the ineligible dependent(s) that are not recoverable.**

# 2020 Payroll Calendar

Employees are paid 26 times per year. Two of those paychecks, in the month where there are three pay periods, will not include premium deductions. This does not include other deductions you may have that include union dues, credit union deductions, federal and state taxes, and/or retirement contributions.

| Pay Period Begins | Pay Period Ends | Pay Date | Month of Benefit Coverage | Coverage Period Premium Pays |
|---|---|---|---|---|
| 12/13/19 | 12/26/19 | 01/03/20 | January** | January/1st half |
| 12/27/19 | 01/09/20 | 01/17/20 | | January/2nd half |
| 01/10/20 | 01/23/20 | 01/31/20 | NO DEDUCTION | |
| 01/24/20 | 02/06/20 | 02/14/20 | February | February/1st half |
| 02/07/20 | 02/20/20 | 02/28/20 | | February/2nd half |
| 02/21/20 | 03/05/20 | 03/13/20 | March | March/1st half |
| 03/06/20 | 03/19/20 | 03/27/20 | | March/2nd half |
| 03/20/20 | 04/02/20 | 04/10/20 | April | April/1st half |
| 04/03/20 | 04/16/20 | 04/24/20 | | April/2nd half |
| 04/17/20 | 04/30/20 | 05/08/20 | May** | May/1st half |
| 05/01/20 | 05/14/20 | 05/22/20 | | May/2nd half |
| 05/15/20 | 05/28/20 | 06/05/20 | June** | June/1st half |
| 05/29/20 | 06/11/20 | 06/19/20 | | June/2nd half |
| 06/12/20 | 06/25/20 | 07/02/20 | July** | July/1st half |
| 06/26/20 | 07/09/20 | 07/17/20 | | July/2nd half |
| 07/10/20 | 07/23/20 | 07/31/20 | NO DEDUCTION | |
| 07/24/20 | 08/06/20 | 08/14/20 | August | August/1st half |
| 08/07/20 | 08/20/20 | 08/28/20 | | August/2nd half |
| 08/21/20 | 09/03/20 | 09/11/20 | September | September/1st half |
| 09/04/20 | 09/17/20 | 09/25/20 | | September/2nd half |
| 09/18/20 | 10/01/20 | 10/09/20 | October | October/1st half |
| 10/02/20 | 10/15/20 | 10/23/20 | | October/2nd half |
| 10/16/20 | 10/29/20 | 11/06/20 | November** | November/1st half |
| 10/30/20 | 11/12/20 | 11/20/20 | | November/2nd half |
| 11/13/20 | 11/26/20 | 12/04/20 | December** | December/1st half |
| 11/27/20 | 12/10/20 | 12/18/20 | | December/2nd half |
| 12/11/20 | 12/24/20 | 12/31/20 | NO DEDUCTION | |

** = One-Time deduction(s) will be necessary for deductions starting the 1st day of this month.

# Frequently Asked Questions

**Can I continue benefit coverage after my employment ends?**
If premiums have been paid for the month, benefit coverage will end on the last day of the month in which employment terminated. You and any dependents covered on the day before employment ended are eligible to continue coverage under COBRA. COBRA contains provisions giving former employees, spouses and dependent children the right to temporarily continue coverage. Coverage for COBRA participants is more expensive than coverage as an employee, since the City is no longer contributing towards the premium. Please refer to the COBRA section in this guide for additional details.

**What benefits are currently available once I retire?**
Health, dental, and life insurance coverage is currently available to retired elected officials, officers, employees of the City, contract employee to whom the City has by contract extended benefits and to employees of participating trusts of which the City is beneficiary, who have served in an official or employment capacity the required period of time and made the required contributions to a retirement system. You must elect to participate within 31 days from your termination date. Eligibility to participate as a retired employee or a qualified survivor in City sponsored group health care, dental insurance and life insurance plans is dependent upon the payment of premiums. Benefits become effective the first day of the month following your retirement.

**My spouse and/or children have other insurance coverage, are they eligible to participate in the City's benefit plans?**
Yes, however you must notify both insurance carriers of the other coverage. Consequently, in many, but not all situations, covering someone under two plans at the same time is of limited value. If you choose to cover your spouse or other dependents, you should be aware of an important provision called "Coordination of Benefits".

**I've recently married and want to add my new spouse to the City's benefit plans. What do I need to do?**
Marriage is a qualifying event that allows you to add new dependents to your coverage, however you must provide legal documentation of your marriage to a representative of the Employee Benefits Division of the Personnel Department within 31 days of the date of marriage. Coverage under the health plan becomes effective the date of your marriage.

**Where may I get information about the Health Insurance Marketplace Exchange?**
See pages 16 and 17 of this guide.

# Frequently Asked Questions

**My spouse and I recently divorced/legally separated. What do I do to drop my ex-spouse and/or stepchildren from my City insurance?**
It is essential that you notify a representative of the Employee Benefit Division of the Personnel Department within 31 days of the divorce/legal separation. Failure to notify in a timely matter may result in financial and disciplinary consequences. Coverage for ex-spouse and/or stepchildren will end on the last day of the month in which the divorce/legal separation was final. Once coverage has been cancelled the ex-dependent will be eligible to continue health and/or dental coverage through COBRA. (Personnel Policies Section 717.02 and 717.03).

**How do I find out what physicians, hospitals, and pharmacies are on your medical plan?**
This information is right at your fingertips using the City's intranet. Type in **http://InsideOKC/Benefits**.

Additionally, you can access this information from the convenience of your home. All you need is access to the Internet. For example, visit BlueCross BlueShield of Oklahoma at **www.bcbsok.com/okc** or UnitedHealthcare at **www.myuhc.com** (refer to the Back Cover of this guide for additional web sites). If you do not have access to the City's intranet or the Internet, provider directories may be available on-site during the enrollment period.

**How do I find out which prescription drugs are covered under your medical plan?**
The City's Group Indemnity Health Plan offers an open-formulary plan, which allows most prescribed medications. Prescriptions available with the City's Health Maintenance Organization, UnitedHealthcare, will be located on the provider's website. You may access this information using the City's intranet. Go to **http://InsideOKC/Benefits**.

Additionally, you can access prescription information from the convenience of your home with internet access. Simply visit the provider's website (UnitedHealthcare is at **www.myuhc.com)**. The website may provide whether there is a generic drug for your brand name prescription or an alternative name brand if your prescription is not listed. In all cases, please consult with your physician. If you do not have access to the City's intranet or the Internet, during the Open Enrollment period, representatives will be on-site to assist you with your questions.

# Medicare Disclosure

## Important Notice from the City of Oklahoma City 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 one of the City's sponsored health plans, that include UnitedHealthcare or the City's self-insured Group Indemnity Health Plan, and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Oklahoma City has determined that the prescription drug coverage offered by all of our health plans, that includes the HMO Plan and the Group Indemnity Health Plan are, 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 15th through December 7th. 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 enroll in Medicare prescription drug plan (Medicare Part D), **you and your dependents will automatically be disenrolled from your current health and prescription coverage.** Once you are disenrolled (or dropped) from one of the City's sponsored health plans (UnitedHealthcare or the City of Oklahoma City's Group Indemnity Health Plan) and enroll in a Medicare prescription drug plan, **you will not be able to get this coverage back later.**

Before enrolling in Medicare Part D, make an informed decision about what is best for you. Compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

## 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 one of the City of Oklahoma City's sponsored health plans 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 I% 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.

### Your Medicare Secondary Payer Responsibility

In order to comply with Medicare Secondary Payer (MSP) laws, it is very important that you promptly and accurately complete any requests for information from the City or the Claims Administrator (UnitedHealthcare or BlueCross BlueShield of Oklahoma) regarding the Medicare eligibility of you, your spouse and covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed. Please contact the City or your group administrator promptly to ensure that your claims are processed in accordance with applicable MSP laws.

# Medicare Disclosure

## 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 one of the City's sponsored health plans which include UnitedHealthcare HMO or the Group Indemnity Health Plan, changes. You may also request a copy of this notice at any time.

Contact an Employee Benefits Representative at (405) 297-2144.

## For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **800-MEDICARE (800-633-4227)**.
- TTY users should call **877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 800-772-1213 (TTY 800-325-0778).

| | |
|---|---|
| Date: | July 1, 2019 |
| Name of Entity/Sender: | City of Oklahoma City |
| Contact--Position/Office: | Personnel Department<br>Employee Benefits Division |
| Address: | 420 West Main, Suite 110<br>Oklahoma City, OK 73102 |
| Phone Number: | 405-297-2144 |

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained Creditable Coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

# CHIP Notification

## Medicaid and the Children's Health Insurance Program (CHIP)

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can 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, you can contact your State Medicaid or CHIP office or dial 877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

**OKLAHOMA – Medicaid**
Web site: https://okhca.org/individuals.aspx
Phone: 888-365-3742

# Glossary

**Allowed Amount:** Maximum amount on which payment is based for covered health care services. This may be called "eligible expenses, payment allowance, or negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference.

**Annual Open Enrollment:** The annual period during which you may choose to change your medical and/or dental coverage level or switch plans for the next plan year.

**Annual Out–of–Pocket Maximum:** The maximum amount of coinsurance you pay for covered medical expenses in any single calendar year. Once you have paid the out-of-pocket maximum, the Plan pays 100% of expenses (except for plan copays, which are still required). Prescription copays do not count toward your out-of-pocket maximum.

**Appeal:** A request for your health insurer or plan to review a decision or a grievance again.

**Auto-adjudication:** This process allows the Flexible Benefits Plan Administrator to immediately recognize that an expense is eligible for reimbursement under your employer's plan and IRS regulations. These transactions eliminate the need for you to send documentation to the Administrator for your expense.

**Balance Billing:** When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

**Beneficiary:** Person(s) named by the employee or retiree in an insurance policy to receive any benefits provided by the plan if the participant dies.

**Brand-name drugs:** Prescription drugs that carry a trademark or brand name. Brand-name drugs may be significantly higher in cost than generic drugs, even though, by law, both must have the equivalent active ingredients.

**Coinsurance:** The percent (for example, 10%) you pay of the allowed amount for covered health care services to providers. Network coinsurance usually costs less than non-network coinsurance. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 10% would be $10. The health insurance or plan pays the rest of the allowed amount.

**Contingent Beneficiary:** Person(s) named to receive policy benefits if the primary beneficiary is deceased.

**Coordination of Benefits:** Typically, coordination of benefits is the insurance industry standard practice used to share the cost of care between two or more carriers when a member is covered by more than one benefit plan. When someone is covered under two plans at the same time, the benefits received under those plans will be coordinated so that the participant will receive a benefit that is not greater than either one of the plans would pay under its own terms. In order to accomplish this, one plan is designated as "primary" and the other is designated as "secondary".

If you are covering your spouse as a dependent, and he or she also receives coverage elsewhere, for your spouse the City's benefit plan will always be secondary and the other plan will always be primary. Likewise, if you cover yourself as an employee on our plan, and your spouse covers you under his or her plan, our plan is primary and his or her plan would be secondary with respect to your benefits.

**Copay:** A fixed amount (for example, $15) you pay for a covered health care services to providers, usually when you receive the service. Network copayments are usually less than non-network copayments.

**Deductible:** The amount you owe for health care services that your health insurance or plan covers before your health insurance begins to pay. For example, if your deductible is $1,250, your plan won't pay anything until you've met your $1,250 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

**Durable Medical Equipment (DME):** Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

**Emergency Medical Condition:** An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

**Emergency Medical Transportation:** Ambulance services for an emergency medical condition.

**Emergency Room Care:** Emergency services received in an emergency room.

**Emergency Services:** Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

**Excluded Services:** Health care services that your health insurance or plan doesn't pay for or cover.

# Glossary

**Explanation of Benefits (EOB):** A detailed statement from your health plan that explains which procedures and services were given, how much they cost, how much your plan pays, and how much you pay.

**Formulary Drugs:** Listing of prescription medications which are approved for use and/or coverage by the plan and which will be dispensed through participating pharmacies to covered enrollees. Formularies are subject to change without notice.

**Grievance:** A compliant that you communicate to your health insurer or plan.

**Generic Drugs:** Prescription drugs that meet the standards for safety, purity, strength, and quality as their brand-name counterparts. These drugs, however, bear only a chemical or general-classification name — not a brand name.

**Habilitation Services:** Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient services.

**Health Insurance:** A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

**Health Maintenance Organization (HMO):** A pre-paid medical plan that provides a comprehensive predetermined medical care benefit package.

**Home Health Care:** Health care services a person receives at home.

**Hospice Services:** Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

**Hospitalization:** Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

**Inpatient Hospitalization:** A hospital stay (usually 24 hours or more) for which a room and board charge is made by the hospital.

**Managed (Closed) Formulary:** A listing of drugs on a plan approved list intended to include a large enough range of medications and sufficient information about them to enable health practitioners to prescribe treatment that is medically appropriate.

**Medically Necessary:** Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

**Medicare:** The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD). Part A, Hospital Insurance, pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care. Part B, Supplementary Medical Insurance, helps pay for doctors' services, outpatient hospital care, and other medical services that are not covered by Part A. Enrollment in Part B is voluntary and available for a small premium. (You are required to be enrolled in Part B if you are enrolled in any of the City's health plans.)

**Network Provider:** The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

**Non-Formulary Drugs:** Prescription medications not on a plan-approved list.

**Non-Network Provider:** A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

**Open Formulary:** A relatively unrestricted listing of drug medications and sufficient information about them to enable health practitioners to prescribe treatment that is medically appropriate.

**Outpatient (Hospital) Care:** Care in a hospital, clinic, or health facility that usually doesn't require an overnight stay.

**Physician Services:** Health care services a licensed medical physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) provides or coordinates.

**Plan:** A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

**Preauthorization:** A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

# Glossary

**Pre-existing Condition:** A physical and/or mental condition of an insured person that existed prior to the issuance of his or her policy.

**Preferred Providers or Network Providers:** A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a tier.

**Preventive Care:** Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examinations, immunization and well person care.

**Primary Care Provider:** A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

**Provider:** A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

**Qualifying Event:** An event entitling an employee to add and/or drop an eligible dependent or drop coverage in the middle of a plan year. A qualifying event may include, but is not limited to, marriage, divorce or legal separation, birth, adoption, court order, legal guardianship, or a dependent child's loss of dependent status.

**Reconstructive Surgery:** Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

**Regular, Full-time Employee:** An employee in a position which is budgeted for a full work week (typically 40 hours) and is scheduled to work more than 1,664 hours in a fiscal year and is eligible for health and welfare benefits.

**Rehabilitation Services:** Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

**Skilled Nursing Care:** Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

**Specialist:** A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

**Subrogation:** The right of the employer or insurance company to recoup benefits paid to participants through legal suit, if the action causing the injuries and subsequent medical expenses was the fault of another individual.

**UCR (Usual, Customary and Reasonable):** The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

**Urgent Care:** Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

# Benefits Resource Directory

## Core Benefits

**UnitedHealthcare of Oklahoma**
***HMO Plan***
(Group Number 010931)
Mon - Fri, 7 a.m. - 9 p.m. CST
800-825-9355
www.myuhc.com

**BlueCross BlueShield of Oklahoma**
***Group Indemnity Health Plan***
(Group Number 019574)
Mon - Fri, 8 a.m. - 8 p.m. CST
877-219-4301
www.bcbsok.com/okc

**Prime Therapeutics**
***Pharmacy Benefit Manager for the Group Indemnity Health Plan***
(Group Number 019574)
Mon - Fri, 8 a.m. - 6 p.m. CST
877-357-7463
www.myPrime.com
www.alliancerxwp.com (mail order)

**BlueCross BlueShield of Oklahoma**
***Dental Plan***
(Group Number K19574)
Mon - Fri, 8 a.m. - 8 p.m. CST
888-381-9727
www.bcbsok.com/okc

**VSP**
***Vision Plan***
(Group Number 30021658)
Mon - Fri, 7 a.m. - 9 p.m. CST
800-877-7195
www.vsp.com

**Dearborn National**
***Group Life Insurance***
(Group Number GAE00255)
Mon - Fri, 7 a.m. - 7 p.m. CST
800-778-2281
www.dearbornnational.com

## Voluntary Benefits and Flexible Spending Accounts

**American Fidelity Assurance Company**
***Long-Term Disability Income, Individual Term Life, Accident Only, Cancer, and Permanent Life Insurance***
Mon - Fri, 7 a.m. - 7 p.m. CST
800-437-1011
www.americanfidelity.com

**Alliance Work Partners**
***Employee Assistance Program***
24 hours a day
800-343-3822
awpnow.com

**10GYM, LLC**
Mon - Fri, 9 a.m. - 6 p.m. (Administration)
405-301-0170
800-725-6756
www.10GYM.com

**Gold's Gym**
Monday - Friday: 5am to 11 pm
Saturday & Sunday: 7am to 7 pm
405-601-8998
http://okc.goldsgym.com

## Pension Systems

**Oklahoma Fire Fighters Pension & Retirement System (Fire)**
Mon - Fri, 8 a.m. - 4:30 p.m. CST
405-522-4600
800-525-7461
www.okfirepen.state.ok.us

**Oklahoma Police Pension & Retirement System (Police)**
Mon - Fri, 8 a.m. - 4:30 p.m. CST
405-840-3555
800-347-6552
www.opprs.state.ok.us

**Oklahoma City Employee Retirement System (OCERS)**
Mon - Fri, 8 a.m. - 5 p.m. CST
405-297-3413
405-297-2408

## Savings Plans

**Municipal Employees Credit Union (MECU)**
Mon & Fri, 8:30 a.m. - 5:30 p.m. CST
Tues - Thurs, 8 a.m. - 5 p.m. CST
405-297-2995
www.mecuokc.org

**ICMA - Retirement Corporation**
Mon - Fri, 8:30 a.m. - 9 p.m. EST
800-669-7400
www.icmarc.com

**Nationwide Retirement Solutions**
Mon - Fri, 8 a.m. - 9 p.m. EST
877-677-3678
www.nationwide.com

## Other Contact Information

**City of Oklahoma City**
***Employee Benefits Division***
Mon - Fri, 8 a.m. - 5 p.m. CST
405-297-2144
www.okc.gov

**City of Oklahoma City**
***Accounting Services Division - Payroll***
Mon - Fri, 8 a.m. - 5 p.m. CST
405-297-2196

**Medicare**
800-633-4227
www.medicare.gov

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