CITY OF OKLAHOMA CITY

— COTPA RETIREE —

2022 BENEFITS GUIDE

2022 Premium Rates

NON-MEDICARE MEDICAL

United Healthcare HMO 10-14 Years of Service				United Healthcare HMO 20-24 Years of Service			
Tier	**Total Premium**	**COTPA Subsidy**	**Employee Premium**	**Tier**	**Total Premium**	**COTPA Subsidy**	**Employee Premium**
Retiree Only	$1,524.16	$187.00	$1,337.16	Retiree Only	$1,524.16	$374.00	$1,150.16
Retiree + Spoue	$3,429.35	$187.00	$3,242.35	Retiree + Spouse	$3,429.35	$374.00	$3,055.35
Retiree + Child	$2,667.10	$187.00	$2,480.10	Retiree + Child	$2,667.10	$374.00	$2,293.10
Retiree + Children	$3,276.83	$187.00	$3,089.83	Retiree + Children	$3,276.83	$374.00	$2,902.83
Retiree + Family	$4,724.71	$187.00	$4,537.71	Retiree + Family	$4,724.71	$374.00	$4,350.71
United Healthcare HMO 15-19 Years of Service				**United Healthcare HMO 25+ Years of Service**			
Tier	**Total Premium**	**COTPA Subsidy**	**Employee Premium**	**Tier**	**Total Premium**	**COTPA Subsidy**	**Employee Premium**
Retiree Only	$1,524.16	$275.00	$1,249.16	Retiree Only	$1,524.16	$462.00	$1,062.16
Retiree + Spouse	$3,429.35	$275.00	$3,154.35	Retiree + Spouse	$3,429.35	$462.00	$2,967.35
Retiree + Child	$2,667.10	$275.00	$2,392.10	Retiree + Child	$2,667.10	$462.00	$2,205.10
Retiree + Children	$3,276.83	$275.00	$3,001.83	Retiree + Children	$3,276.83	$462.00	$2,814.83
Retiree + Family	$4,724.71	$275.00	$4,449.71	Retiree + Family	$4,724.71	$462.00	$4,262.71

MEDICARE MEDICAL

Medicare Advantage PPO 10-14 Years of Service				Medicare Advantage PPO 20-24 Years of Service			
Tier	**Total Premium**	**COTPA Subsidy**	**Employee Premium**	**Tier**	**Total Premium**	**COTPA Subsidy**	**Employee Premium**
Retiree Only	$399.78	$140.80	$258.98	Retiree Only	$399.78	$280.50	$119.28
Retiree + Spouse	$799.56	$140.80	$658.76	Retiree + Spouse	$799.56	$280.50	$519.06
Retiree + Child	$799.56	$140.80	$658.76	Retiree + Child	$799.56	$280.50	$519.06
Retiree + 2 Children	$1,199.34	$140.80	$1,058.54	Retiree + 2 Children	$1,199.34	$280.50	$918.84
Retiree + Sp + Child	$1,199.34	$140.80	$1,058.54	Retiree + Sp + Child	$1,199.34	$280.50	$918.84

Medicare Advantage PPO 15-19 Years of Service				Medicare Advantage PPO 25+ Years of Service			
Tier	**Total Premium**	**COTPA Subsidy**	**Employee Premium**	**Tier**	**Total Premium**	**COTPA Subsidy**	**Employee Premium**
Retiree Only	$399.78	$206.80	$192.98	Retiree Only	$399.78	$346.50	$53.28
Retiree + Spouse	$799.56	$206.80	$576.26	Retiree + Spouse	$799.56	$346.50	$453.06
Retiree + Child	$799.56	$206.80	$576.26	Retiree + Child	$799.56	$346.50	$453.06
Retiree + 2 Children	$1,199.34	$206.80	$958.39	Retiree + 2 Children	$1,199.34	$346.50	$852.84
Retiree + Sp + Child	$1,199.34	$206.80	$958.39	Retiree + Sp + Child	$1,199.34	$346.50	$852.84

Other Benefit Plans		***Retiree Rate***
BlueCross BlueShield Dental Low Plan	Retiree Only	$23.10
	Retiree + 1	$46.24
	Retiree + 2 or more	$73.95
BlueCross BlueShield Dental High Plan	Retiree Only	$34.07
	Retiree + 1	$68.12
	Retiree + 2 or more	$109.00
VSP Vision Plan	Retiree Only	$7.00
	Retiree + 1	$12.98
	Retiree + 2 or more	$20.88

Friendly Reminder:

If you are not making any changes you DO NOT have to notify Employee Benefits or submit the enclosed enrollment form.

However, please review the plan offerings for 2022.

Additional plan information is located at:

www.okc.gov/retirees

Contents:

Things to Know for 2022

****Retiree Website****
For most current up to date retiree information, please visit **www.okc.gov/retirees**. You will find important plan information and links that will assist you in keeping up to date regarding your benefit elections. ***As a COTPA retiree, some benefit programs listed on the retiree website above are not available to COTPA retirees.***

****2022 Essential Health Benefits Maximum Out-of-Pocket Limits****
(Retirees and Dependents without Medicare)
The Affordable Care Act (ACA) establishes a maximum annual out-of-pocket amount for in-network Essential Health Benefits (EHBs). This provision does not apply to the Medicare secondary plan or the Medicare Advantage plan as outlined in the Affordable Care Act. Copays, coinsurance and deductibles for all in-network plan benefits generally apply toward the out-of-pocket limits. For plan year 2022, the maximum essential health benefits in-network out-of-pocket limits for the City of Oklahoma City's plans are as follows:

UnitedHealthcare (HMO) Plan
Medical and Prescription Benefit combined: $8,700 retiree only coverage
$17,400 retiree + 1 or more dependent(s)

****No Surprises Act****
NEW FOR 2022. The No Surprises Act protects individuals from surprise medical bills for emergency services, air ambulance services provided by out-of-network providers, and non-emergency services provided by out-of-network providers at in-network facilities in certain circumstances. Additional information can be found on page 9 of this guide.

****Dependent Verification****
Employee Benefits may periodically request verification to ensure current documentation for dependents enrolled in the City's medical and dental plans are on file. You may receive a letter requesting documentation for verification of eligibility. You 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 your file is selected for verification, you will receive a letter.

Documents can be sent to benefit.doc@okc.gov or fax to 405-297-2565.

****Medicare Advantage PPO****
This plan has no deductible, low copays for office visits and prescriptions and the member can see any provider that accepts Medicare nationwide. **Copays for prescriptions in the catastrophic phase will not be subject to the 5% copay.** To see specific copays for this plan, refer to pages 11 of this guide. The Medicare Advantage PPO plan offers Medicare eligible retirees and covered Medicare eligible dependents additional premium savings versus the Group Indemnity plan.

****OKCCare Employee Medical Center****
Premise Health is the onsite operator of the OKCCare Employee Medical Center. Additional information regarding the services provided by OKCCare Employee Medical Center can be found on pages 14-15 of this guide.

Important Dates to Remember...

Open Enrollment will be held at:

Will Rogers Gardens
3400 NW 36th St.
Oklahoma City, OK 73112

Staff will be available from 8 a.m. to 4 p.m. the week of October 25-28 to answer questions and provide assistance. No appointments are necessary.

As a result of the COVID-19 pandemic, there may be limited vendors present this year at the onsite enrollment. This change was necessary to maximize space for social distancing. If you need to reach a vendor, please refer to the back page of this guide.

If you do not make any plan changes, your premiums will automatically adjust to the new rates for the 2022 plan year. Rates are on page 2 of this guide.

Open Enrollment			
Dates	**Times**	**Location**	**Coverage Period**
October 25,2021 through October 28, 2021	8 a.m. to 4 p.m. Monday-Thursday	Will Rogers Gardens 3400 NW 36th St. Oklahoma City, OK 73112	January 1, 2022 through December 31, 2022

How to Enroll in your Benefits:

1

Enroll On-Site

Staff members will be available at the Will Rogers Gardens 3400 NW 36th St. Oklahoma City OK 73112. See page 6 for dates and times for on-site enrollment.

2

Enroll by Mail

Complete your personalized Enrollment Statement included in your enrollment packet and return by **October 31, 2021**. Additional enrollment instructions are provided on your statement.

If you are not making any changes, it is not necessary to contact us or return your enrollment statement.

About Your Coverage

Which medical plan is right for me?

The City offers COTPA retirees two health plan options—the HMO plan and Medicare Advantage Plan. Each plan offers a large network of providers, prescription drug benefits, and basic medical and preventive care such as office visits and immunizations.

Which medical plan am I eligible to enroll myself and/or dependents?

- ***Myself and ALL covered dependent(s) are not Medicare eligible***

  UHC HMO Plan

- ***Myself and ALL covered dependent(s) are Medicare eligible***

  UHC Medicare Advantage Plan (MAPD)

Rules for Medical, Dental, and Vision

Retirees are not eligible to enroll in medical if you did not elect coverage with your initial application for benefits at the time of retirement.

You may add or drop dental coverage each year. If you are adding dental coverage, only limited services are provided for the first twelve (12) months of coverage.

You may add or drop vision coverage each plan year.

Declining Insurance Coverage

You may decline medical, dental, and vision. However, if you decline medical insurance, you will **NOT** be eligible to enroll at a later time. To exercise this option, submit your written, signed request to the Employee Benefits Division. Coverage will end on the first day of the month following receipt of the request or the last day of the month for which payment was received.

If you decline health coverage under any of the City's health plans, the Health Insurance Marketplace Exchange has other health insurance options available to you. Visit healthcare.gov to find out more.

No Surprises Act

The No Surprises Act protects individuals from surprise medical bills for emergency services, air ambulance services provided by out-of-network providers, and non-emergency services provided by out-of-network providers at in-network facilities in certain circumstances. Provisions include:

- Bans surprise billing for emergency services. Emergency services, regardless of where they are provided, must be treated on an in-network basis without requirements for prior authorization.

- Bans high out-of-network cost-sharing for emergency and non-emergency services. Patient cost-sharing, such as co-insurance or a deductible, cannot be higher than if such services were provided by an in-network doctor, and any coinsurance or deductible must be based on in-network provider rates.

- Bans out-of-network charges for ancillary care (like an anesthesiologist or assistant surgeon) at an in-network facility in all circumstances.

- Bans other out-of-network charges without advance notice. Health care providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.

These provisions will provide patients with financial peace of mind while seeking emergency care as well as safeguard them from unknowingly accepting out-of-network care and subsequently incurring surprise billing expenses. Contact the medical plan provider with any additional questions regarding how the No Surprises Act affects your individual services provided.

HMO Plan

Plan Features	HMO Plan
Eligibility	All retirees and covered dependents must NOT be Medicare eligible and live within the coverage area (State of Oklahoma).
Selection of Doctors and Hospitals	Member selects from the UnitedHealthcare Signature Value network of providers
Network Provider Exceptions	No benefits outside of network
Deductible	
-Individual	$0
-Family	$0
Out-of-Pocket Maximums (Does not include premiums)	
-Individual	$1,500
-Family	$3,000
Lifetime Benefit Maximum	No lifetime benefit maximum
Contact Information for Additional Questions	UnitedHealthcare 1-800-825-9355 www.myuhc.com

Medicare Advantage Plan (MAPD)

Plan Features	Medicare Advantage Plan
Eligibility	All retirees and covered dependents are REQUIRED to be enrolled in Medicare Parts A and B
Selection of Doctors and Hospitals	Member may use most providers that accepts Medicare
Network Provider Exceptions	This plan provides national coverage and includes most providers that accepts Medicare and the plan
Deductible	
-Individual	$0
-Family	$0
Out-of-Pocket Maximums (Does not include premiums)	
-Individual	$6,700
-Family	Individual maximums apply for each family member
Lifetime Benefit Maximum	No lifetime benefit maximum
Contact Information for Additional Questions	UnitedHealthcare Medicare Advantage 1-800-457-8506 (Current MAPD members) 1-877-714-0178 (Prospective MAPD members) www.uhcretiree.com

Common Medical Event	Services You May Need	HMO Plan	Medicare Advantage Plan
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit	$5 copay per visit
	Specialist visit	$30 copay per visit	$5 copay per visit
	Screening / Immunization	Plan pays 100%	$0 copay
	Chiropractic Care	$30 copay	$5 copay per visit (Up to 12 visits per plan year)
If you have a test	Diagnostic test (x-ray, blood work)	$0	$0
	Imaging (CT/PET scans, MRIs)	$0	$0
If you need drugs to treat your illness or condition	Generic Drugs	$15	$10 copay
	Preferred Brand	$30	$20 copay
	Non-Preferred Brand	$65	$40 copay
	90-day Mail Order	2 copays for up to a 90 day supply	2 copays for up to a 90 day supply
	Website for more information	www.myuhc.com	www.uhcretiree.com
If you have a hospital stay	Facility fee (e.g. hospital room)	$100 copay per admission	$0
	Physician / Surgeon fee	$0	$0
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	$50 copay	No copay (but must be medically necessary)
	Physician/surgeon fee	$0	$50 copay, waived if admitted
If you need immediate medical attention	Emergency medical transportation	$0 copay (prior authorization required except for emergencies)	$5 copay per visit
	Emergency Room	$50 copay, waived if admitted	$5 copay per visit
	Urgent care	$30 copay	$0 copay per admission, 190 day lifetime maximum
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay per visit	$5 copay per visit
	Mental/Behavioral health inpatient services	$100 copay per admission	$0
	Substance use disorder outpatient services	$30 copay per visit	$0
	Substance use disorder inpatient services	$100 copay per admission	$5 copay per visit
If you have recovery or special health needs	Home health care	$0	Covered up to 100 days per benefit period
	Rehabilitation services	$100 copay per admission	0% coinsurance for each Medicare-covered item
	Skilled nursing care	$0 (Limited to 100 consecutive Inpatient days per disability)	$0 copay Plan pays up to $500 (every 2 years)
	Durable medical equipment	$0 ($5,000 maximum benefit per Calendar Year)	$5 copay
	Hearing Services	$0 copay (Limited to one hearing aid every 3 years)	Plan pays up to $500 (every 2 years)
	Vision Benefit	$30 copay (one visit per year) Preferred pricing from network provider ww.myspectera.com	$5 copay (one exam per year) Up to $130 eyewear allowance or up to $175 contact lens allowance (in lieu of eyewear) every 2 years

HMO Plan

NOTE: All covered individuals enrolled in the HMO plan MUST NOT be Medicare eligible. If you and/or covered dependent(s) become Medicare eligible , CONTACT Employee Benefits immediately.

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 1 800-825-9355. Group Number 10933

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.

Specialty Care

Members do not have to have a referral to see a specialist as long as the specialist is in the UnitedHealthcare Signature Value 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 Service for a mail order form, or go to www.myuhc.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 1 800-825-9355 or 1 800-557-7595 (TDHI).

Medicare Advantage Plan

UnitedHealthcare® Group Medicare Advantage (PPO) is a Medicare Advantage plan that delivers all the benefits of Original Medicare (Parts A and B), includes prescription drug coverage (Part D) and offers additional benefits and features. It is not a supplement plan and does not pay secondary to Medicare. All claims are submitted directly to UnitedHealthcare for payment, not Medicare.

When you join a Medicare Advantage plan, it is considered Part C. Part C is the combined coverage of Medicare Parts A and B with additional benefits administered by the plan. Instead of paying for Medicare deductibles and coinsurance, you pay health plan premiums, co-insurance and co-payments.

This health plan is attractive to retirees. Monthly premiums and/or out of pocket expenses can be much less than other plans. This plan is the complete Medicare solution offered by the City. All participants must be eligible for Medicare and maintain enrollment in Part A and B.

To enroll in the Medicare Advantage Plan, you must notify Employee Benefits a minimum of 31 days prior to the effective date of Medicare and/or start of coverage. Additional information can be found at www.uhcretiree.com.

IMPORTANT NOTE: If you enroll in another Medicare Advantage Plan and/or Part D prescription drug plan, you will automatically be disenrolled from the City's MAPD plan. This is a Medicare rule.

Highlights include:

No Deductible - Low Copays for Office Visits and Prescriptions
Nationwide access - You have access to our nationwide coverage. You can see any provider (in-network or out-of-network) at the same cost share, as long as they accept the plan and have not opted out of or been excluded or precluded from the Medicare Program.
Prescription drugs - Your Medicare Part D prescription drug coverage includes thousands of brand name and generic prescription drugs. Check your plan's drug list to see if your drugs are covered. ***Prescription copays will remain at the same low copay through all phases of Medicare Part D prescription coverage program.***
Telephonic Nurse Support- Speak to a registered nurse 24/7 about your medical concerns at no additional cost to you.
Renew Rewards - Renew by UnitedHealthcare is our health and wellness experience that helps empower you to take charge of your well-being every day. It provides a wide variety of useful resources and activities, including brain games, healthy recipes, learning courses, fitness activities and more. Plus, you may be eligible to earn rewards by completing certain health care activities such as your annual physical or wellness visit.
Renew Active® – Renew Active® is the gold standard in Medicare fitness programs for body and mind, available at no additional cost. You'll receive a free gym membership with access to the largest Medicare fitness network of gyms and fitness locations. This includes access to many premium gyms, on-demand digital workout videos and live streaming classes, social activities and access to an online Fitbit® Community for Renew Active and access to an online brain health program from AARP® Staying Sharp® (no Fitbit device is needed.)
Virtual Visits - See a doctor or a behavioral health specialist using your computer, tablet or smartphone. With Virtual Visits, you're able to live video chat — anytime, day or night. You will first need to register and then schedule an appointment.
HouseCalls -With UnitedHealthcare® HouseCalls, you get a yearly in-home visit from one of our health care practitioners at no extra cost. A HouseCalls visit is designed to support, but not take the place of, your regular doctor's care. Every visit includes tailored recommendations based on health care screenings.

OKCCare Medical Center

OKCCare Medical Center Highlights

OKCCare is currently available at no cost to retirees, spouses, and dependents (ages 2 & up) that are covered on a City sponsored medical plan.

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

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

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

Can my family use the 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 medical 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,

BlueCross BlueShield Dental

Group ID#
K19574

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.

BlueCross BlueShield Dental

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				
Deductible Waived Oral Examinations (2 exams per benefit period) Prophylaxis (2 cleanings per benefit period) Fluoride Treatment (to age 19) Dental X-rays	100%	100%	100%	100%
Miscellaneous Services				
Sealants Space Maintainers Labs and Tests Palliative Care	100%	100%	100%	100%
Restorative Services				
Routine Fillings (amalgams and resins)	80%	60%	80%	80%
General Services				
Intravenous sedation Injection of antibiotic drugs Stainless Steel Crowns	80%	60%	80%	80%
Endodontic Services				
Root Canals Direct pulp caps	50%	30%	80%	80%
Periodontal Services				
Scaling and root planning Osseous surgery	50%	30%	80%	80%
Oral Surgery Services				
Simple/Surgical tooth extractions	50%	30%	80%	80%
Crowns, Inlays/Onlays Services				
Inlays, Onlays and Crowns (other than temporary crowns)	50%	30%	50%	50%
Prosthodontic Services				
Bridges Full and partial dentures Implants	50%	30%	50%	50%
Orthodontic Benefits (no deductible)				
Orthodontic Diagnostic Procedures and Treatment (Adult and Child)	50%	50%	50%	50%
Lifetime Maximum per Participant	$1,000	$1,000	$1,200	$1,200

Vision Care Plan

Group ID#
30021658

VSP Doctor Network:
VSP Choice

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.

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 • 20% off the amount over your allowance	Included in Prescription Glasses	Every Calendar Year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every Calendar Year
Lenses Options	• Standard progressive lenses $55 copay • Premium progressive lenses $95-$105 copay • Custom progressive lenses $150-$175 copay • Average 20-25% off other lens options	$55 $95 - $105 $150 - $175	Every Calendar Year
Contact (Instead of glasses)	• $150 allowance for contacts • 15% off contact lens exam (fitting and evaluation)	$0 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** • 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a wellVision Exam.		
	Laser Vision Correction • 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.

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.

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

Notes

About this Guide

This benefit guide was developed to provide information about available benefit options, explain the enrollment and change process, and serve as a valuable resource for information about benefits available through the City of Oklahoma City. We recommend reading this guide before attending the annual Open Enrollment and/or completing enrollment forms. If you are married, please share the information in this guide with your spouse or beneficiary.

The guide is merely a compilation of City-sponsored retiree benefits. It is intended for informational purposes only. Actual benefits available and full descriptions of these benefits are governed in all cases by the relevant plan document, insurance company contracts, ordinances, and/or resolutions of The City of Oklahoma City. If there are discrepancies between this benefit guide and actual plan documents, insurance company contracts, ordinances and/or resolutions; the documents, contracts, ordinances and/or resolutions will govern.

Clerical Error/Delay

Clerical errors will not invalidate coverage or cause coverage to be in force. Upon discovery of any such error or delay, an adjustment will be made. The City has the right to collect contributions owed by a retiree. Conversely, the retiree will be reimbursed if an overpayment occurs.

Eligibility

Eligibility is determined by requirements stated in the appropriate plan document, insurance policy, plan contract, and/or certificate of coverage for the year in question. Since plans are subject to change at any time, eligibility requirements may also change. If you change coverage from one plan to another, you and your dependent must meet the requirements of the plan you have selected. An eligible retiree cannot be a member and a dependent on the same health and/or dental plan.

If any relevant fact has been misstated, whether intentionally or unintentionally, by or on behalf of any person that results in improper coverage under the Plan, the individual is subject to termination from the Plan and other appropriate action. Upon discovery of such misstatement, equitable adjustment of any contributions or benefits paid will be made.

Monthly Premiums

Medical, dental, vision ,and/or life insurance premiums are automatically deducted from a retiree's pension check each month (12 times per year.) As an example, for the month of May the health, dental and/or life insurance premium is deducted from the pension check issued on the last day of May. When a pension check is less than the premiums due, deductions from the pension check will cease. Retiree will be responsible for payment of monthly premium.

If you need to meet with Employee Benefits, please call 297-2144 to set up an appointment.

Remember:

- If you are not making any changes, you do not have to contact us or submit the enclosed election form.
- If you are under age 65 and are Medicare eligible, remember to provide a copy of your Medicare card to Employee Benefits.
- If you are Medicare eligible, you must enroll in Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance).
- Medicare does not allow participants to be enrolled in more than one Medicare Part D prescription plan. The City sponsored plans include either a Medicare Part D prescription drug plan or credible prescription drug coverage in lieu of Medicare Part D. If you have a non-City sponsored plan with Medicare Part D prescription drug coverage, you will need to decide which plan you wish to continue.

Health Care Reform Changes

The impact of health care reform on employees/former employees 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.

As your former 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 2022. We encourage you to pay careful attention to your health care benefits so you can keep up with the changes.

ACA Individual Mandate

Beginning in 2021, the Tax Cuts and Jobs Act (TCJA) repeals the penalty tax associated with the individual mandate under the Affordable Care Act.

Do I have to take the coverage my former 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 did not elect to take employer-sponsored coverage at retirement, you should purchase coverage elsewhere, such as through a health insurance exchange. Additional information on health plans offered through the health insurance exchange can be found at www.healthcare.gov.

Where can I get coverage if I do not want my former employer's coverage?

The federal government and states have set up online public health insurance exchanges. You may hear these referred to as marketplaces. There are also many private exchanges and marketplaces being formed. Some states have already created marketplaces.

Importantly, the public exchanges set up and administered by the federal government and the states will be the only avenue for qualifying employees/former 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 will not be available in private exchanges. Income parameters and other eligibility requirements apply to qualify for a tax credit or subsidy. To qualify for subsidies, the household income must be 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 former 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. Allowing us, as your former 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.

Will my former employer continue to provide coverage as it always has or is it getting out of the medical and prescription benefits business?

The City of Oklahoma City currently offers medical and prescription benefits to retirees. Medical coverage must be elected within 31 days of retirement to be eligible to participate. The medical plan offerings for 2022 are on pages 10-13.

An Important Notice from The City of Oklahoma City About Your Prescription Drug Coverage and Medicare (Credible Coverage Disclosure)

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 HMO, UnitedHealthcare Medicare Advantage PPO, or the City's self-insured Group Indemnity Health Plans, 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. 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:

I. 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, which include UnitedHealthcare HMO and the Group Indemnity Health plans, 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 Non-City of Oklahoma City Medicare Drug Plan?
If you decide to enroll in a non-City of Oklahoma City 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 Plans) 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 1 % of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...
Contact the person listed on the next page 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, UnitedHealthcare Medicare Advantage PPO or the Group Indemnity Health Plans, changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
- Visit www.Medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 1-800-772-1213 (TTY 1-800-325-0778).

Date:	July 1, 2021
Name of Entity/Sender:	City of Oklahoma City
Contact--Position/Office:	Human Resources Department Employee Benefits Division
Address:	420 West Main, Suite 110 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).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid 0MB control number. The valid 0MB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Vendor Directory

Provider	Group Number	Hours	Phone #	Web Address
Health Maintenance Organizations (HMO)				
UnitedHealthcare HMO	10933	M—F 7 a.m. to 9 p.m. CST	1-800-825-9355	www.myuhc.com
Medicare Advantage	12299-01	M—F 8 a.m. to 8 p.m. CST	1-800-457-8506 (current members) 1-877-714-0178 (prospective members)	www.uhcretiree.com
Dental Plan				
BlueCross BlueShield of Oklahoma, Dental	K19574	M—Th 7:30 a.m. to 5 p.m. F 8 a.m. to 5 p.m. CST	1-888-381-9727	www.bcbsok.com/okc
Vision				
VSP	30021658	M—F 7 a.m. to 9 p.m. CST	1-800-877-7195	www.vsp.com
Savings Plans				
Mission Square (formerly ICMA-RC)	N/A	M—F 8:30 a.m. to 9 p.m. EST	1-800-669-7400	www.icmarc.com
Nationwide Retirement Solutions	N/A	M—F 8 a.m. to 9 p.m. EST	1-877-677-3678	www.nationwide.com
Other				
The City of Oklahoma City Employee Benefits Division	N/A	M—F 8 a.m. to 5 p.m. CST	(405) 297-2144 employee.benefits@okc.gov	www.okc.gov/retirees
Medicare	N/A		1-800-633-4227	www.medicare.gov
Healthcare Exchange	N/A			www.healthcare.gov