2016

CITY OF OKLAHOMA CITY

RETIREE BENEFITS GUIDE

Friendly Reminder:

If you are not making any changes you
do not
have to do anything.

However, please review the plan offerings for 2016.

Inside this issue:

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.

If you need to meet with Employee Benefits, please call 297-2144 to set up an appointment. Employee Benefits is temporarily located at 500 N. Walker, Ste. 190, Oklahoma City, OK 73102 (office is located next to the Embark bus station on 4th St. between Hudson and Walker)

Important Dates to Remember…

NEW LOCATION:

Open Enrollment will be held at the Civic Center Music Hall, Hall of Mirrors, 201 N. Walker, Oklahoma City, OK 73102

Staff and vendors will be available from 8 a.m. to 5 p.m. the week of October 26-30 to answer questions and provide assistance. No appointments are necessary.

If you do not make any plan changes, your premiums will automatically adjust to the new rates for the 2016 plan year. Rates are on page 7.

Open Enrollment			
Dates	**Times**	**Location**	**Coverage Period**
October 26, 2015 through October 30, 2015	8 a.m. to 5 p.m. each day	**New Location:** 201 N. Walker Hall of Mirrors 2nd floor	January 1, 2016 through December 31, 2016

Police Retirees:

The Oklahoma Police Pension and Retirement System (OPPRS) requires a Health Election/Change Form (Form 135) before the amount withheld from your pension check will be updated by the OPPRS.

If you are not making any changes to your elections, premium amounts will be automatically updated. If you make any changes to your benefit plans or coverage levels that result in premium changes you will need to complete Form 135 for the Oklahoma Police Pension and Retirement System (OPPRS). **Please contact OPPRS at 405-840-3555 ext. 223 for instructions.** The Form 135 can be downloaded from www.ok.gov/opprs

Things to Know for 2016

New Benefit—Vision Coverage
For 2016, retirees and eligible dependents may purchase vision coverage through VSP. See page 44 for plan details.

OKC Care Employee Medical Center
Your no cost OKC Care Employee Medical Center is opening in Fall 2015. OKC Care is available to employees, **non-Medicare retirees** & spouses, and dependents (ages 2 & up) covered on the City's health plan.

2016 Essential Health Benefits Maximum Out-of-Pocket Limits
Copayments, coinsurance and deductibles for all in-network plan benefits generally apply toward the out-of-pocket limits.

For plan year 2016, the maximum essential health benefits in-network out-of-pocket limits for the City of Oklahoma City's plans are as follows:

Group Indemnity Plan
Medical Benefit (administered by BlueCross BlueShield of Oklahoma):
$4,850 retiree only coverage
$9,700 retiree + 1 or more dependent(s)

Prescription Benefit (administered by Express Scripts, Inc):
$2,000 retiree only coverage
$4,000 retiree + 1 or more dependent(s)

UnitedHealthcare (HMO) Plan
Medical and Prescription Benefit combined: $6,850 retiree only coverage
$13,700 retiree + 1 or more dependent(s)

Remember:
- If you are not making any changes, you do not have to do anything.
- 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 prescription plan. The City sponsored plan includes a prescription drug plan. If you have a non-City sponsored plan with prescription drug coverage, you will need to decide which plan you wish to continue.

Retirees and Dependents **with Medicare** on the Group Indemnity Plan (BlueCross BlueShield)
- Express Scripts, the pharmacy benefit manager, mailed open enrollment materials for any Employer Group Waiver Plan (EGWP) member in September. This is a mandatory informational mailing. **No action is needed from you.**

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.

2016 Premium Rates

Health Maintenance Organization (HMO) and Medicare Advantage Plans Administered by UnitedHealthcare	Retiree Under 65			Retiree Over 64 Medicare Advantage		
	Total	City	Retiree	Total	City	Retiree
Retiree Only	$1,125.88	$630.49	**$495.39**	$453.12	$253.74	$199.38
Retiree + Spouse	$2,533.22	$1,418.60	**$1,114.62**	$906.24	$507.49	**$398.75**
Retiree + Child	$1,970.16	$1,103.28	**$866.88**	**(Medicare Eligible Only)**		
Retiree + Children	$2,420.56	$1,355.51	**$1,065.05**			
Retiree + Family	$3,490.10	$1,954.45	**$1,535.65**			

Group Indemnity Health Plans (PPO) Administered by BlueCross BlueShield	Retiree Under 65			Retiree Over 64		
Alternate Plan Option	Total	City	Retiree	Total	City	Retiree
Retiree Only	$623.71	$349.27	**$274.44**	$359.43	$201.28	**$158.15**
Retiree + Spouse	$1,203.75	$674.10	**$529.65**	$682.09	$381.97	**$300.12**
Retiree + Child	$885.69	$495.98	**$389.71**	$504.64	$282.59	**$222.05**
Retiree + Children	$1,147.64	$642.67	**$504.97**	$649.82	$363.89	**$285.93**
Retiree + Family	$1,640.35	$918.59	**$721.76**	$924.51	$517.72	**$406.79**
	Retiree Under 65			Retiree Over 64		
Standard Plan Option	Total	City	Retiree	Total	City	Retiree
Retiree Only	$985.08	$551.64	**$433.44**	$504.82	$282.69	**$222.13**
Retiree + Spouse	$1,901.21	$1,064.67	**$836.54**	$958.00	$536.48	**$421.52**
Retiree + Child	$1,398.83	$783.34	**$615.49**	$708.77	$396.91	**$311.86**
Retiree + Children	$1,812.56	$1,015.03	**$797.53**	$912.63	$511.07	**$401.56**
Retiree + Family	$2,590.78	$1,450.83	**$1,139.95**	$1,298.46	$727.13	**$571.33**

The City contributes 56% of the Total Premium for medical in 2016. Retiree pays total cost for Dental, Vision and Life coverage.

Dental Plan Administered by BlueCross BlueShield				Vision Plan Administered by VSP	
High Plan Option		Low Plan Option			
Retiree Only	**$31.24**	Retiree Only	**$21.19**	Retiree Only	**$7.00**
Retiree + 1	**$62.47**	Retiree + 1	**$42.40**	Retiree + 1	**$12.98**
Retiree + 2 or more	**$99.95**	Retiree + 2 or more	**$67.81**	Retiree + 2 or more	**$20.88**

Group Term Life Insurance Administered by Dearborn National	
Basic Life ($10,000)	**$13.40**

About Your Coverage

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.

Rules for Medical, Dental, Vision, and Life Insurance

Retirees are not eligible to enroll in medical and/or life insurance plans if you did not elect coverage with your initial application for benefits at 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, vision, or life insurance. However, if you decline medical or life 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.

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.

HIPAA Compliance

The City of Oklahoma City advises members of the Group Indemnity Health Plan that the HIPAA Notice of Privacy Practices is available to you by accessing the internet. Simply type in the following information in the address field - www.okc.gov and navigate to City Departments → Personnel → Personnel Benefits → Privacy Policy to download a copy of the Notice of Privacy Practices. If you do not have access to the internet and you would like a copy of the HIPAA Notice of Privacy Practices, or if you have any questions, please contact a representative of the Employee Benefits Division at (405)297-2144.

How to Enroll in your Benefits:

Three Ways to Enroll

1 Enroll Online

Enroll online from the convenience of your home using eBenefits

1. Type https://okcpeople.okc.gov into the address bar of an internet browser
2. Enter your retiree ID number and your password, then click "Sign In"
3. Click on the links: Human Resources 9.2 → Self-Service → Benefits → Benefits Enrollment.

Your user ID is your retiree ID number—it begins with "B" or "R" and is followed by a 5-digit number. If you are a surviving spouse your ID number may end with "S". Your retiree ID number is located on page one of your 2016 Personal Enrollment Form just to the right of your address. Your password is the last four (4) digits of your Social Security number.

2 Enroll On-Site

Staff members will be available at the Civic Center Music Hall, Hall of Mirrors, 201 N. Walker, Oklahoma City, OK 73102

3 Enroll by Mail

Complete your personalized Enrollment Statement included in your enrollment packet and return by **October 30, 2015**. Additional enrollment instructions are provided on your statement.

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

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, and has been amended many times already. 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. The aspect of the legislation that will affect you as an individual is known as the individual mandate. Most Americans are required to purchase health insurance coverage that meets a certain minimum standard. If such coverage is not purchased, individuals will pay an additional tax on his or her personal income tax return.

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 2016. We encourage you to pay careful attention to your health care benefits so you can keep up with the changes.

What coverage must I carry to avoid paying a penalty?

Nearly all Americans are required to carry "minimum essential coverage" or pay a penalty. Most employer-sponsored group health insurance qualifies as minimum essential coverage, as does governmental coverage (like Medicare, Medicaid, CHIP and TRICARE), retiree coverage, COBRA coverage and individual policies. The coverage we offer you qualifies as minimum essential coverage. If you decide not to take our coverage, the penalty amount applies if you go without minimum essential coverage for at least nine months (you cannot have a gap in coverage for more than a continuous three-month period). The penalty assessed when you file your taxes will be the greater of a flat dollar amount or a percentage of income amount, illustrated in the table below.

	Flat Dollar		Percentage of Income
Year	**Adults in household**	**Children in household 18 Years or Younger**	**Calculated when filing taxes for the applicable year***
2015	$325	$162.50	2 %
2016	$695	$347.50	2.5 %

* The penalty amount is determined by subtracting exemptions and standard deductions from the household income. The resulting figure is multiplied by the percentage of income. If this figure is greater than the flat dollar amount, the taxpayer pays the percentage of income penalty.

Health Care Reform Changes

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 9.56 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 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 2016 are on pages 14-31.

2016 HEALTH

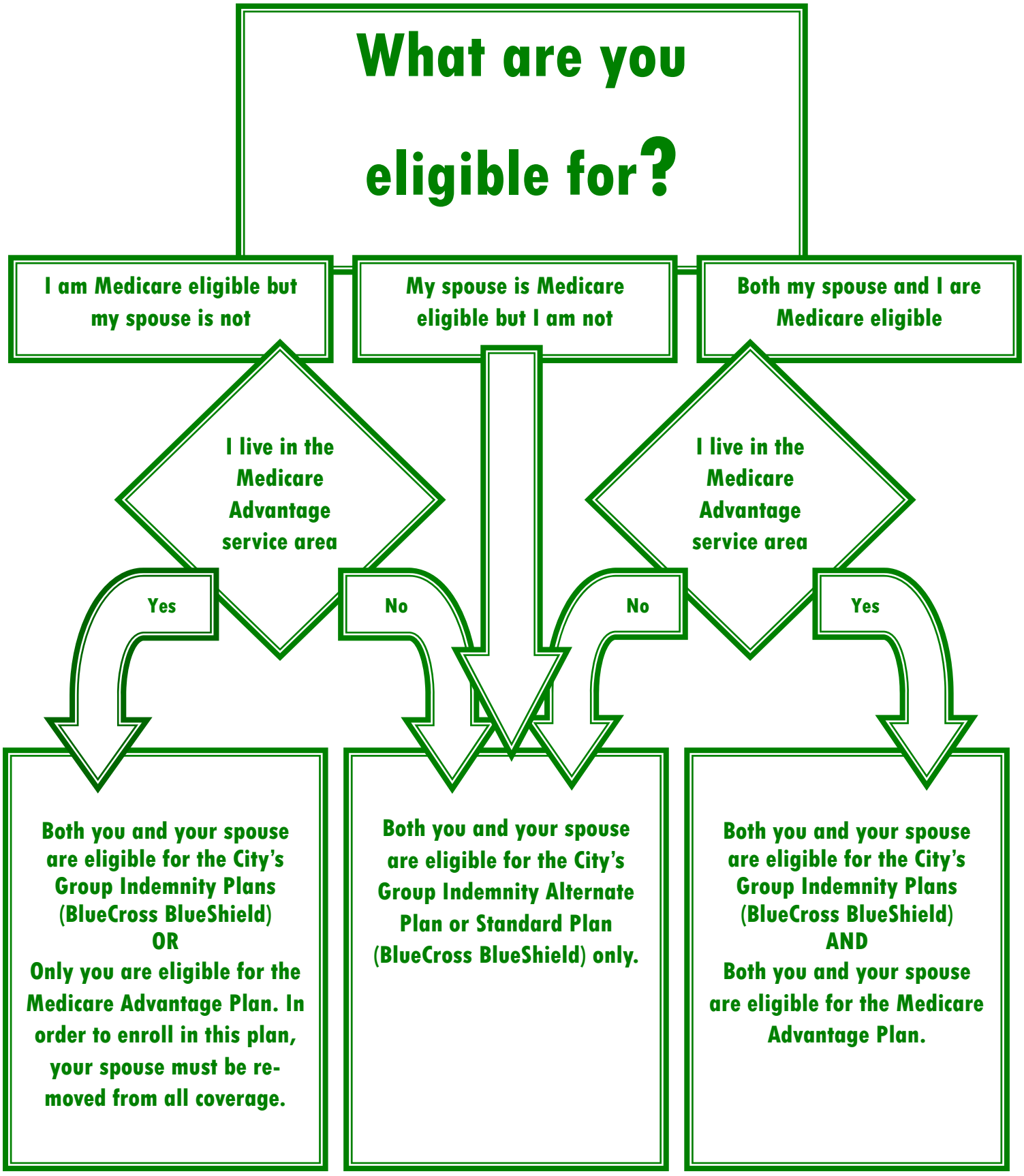
Stay Healthy

The City's Health plans encourage annual preventative care exams, health screens, and immunizations. Contact BlueCross BlueShield or UnitedHealthcare for more information.

PLANS

- About Your Health Plans
- HMO Plan
- Medicare Advantage Plan
- Group Indemnity Health Plans
- Frequently Asked Questions—Medicare
- Medicare Part D Creditable Coverage Disclosure

About Your Health Plans



About Your Health Plans

Which Plan is right for me?

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

Some things to consider when reviewing the health plan options:

- Do you have a specific provider (doctor or hospital) ? Which network(s) includes your provider?
- Are the prescriptions drugs you take generic or brand? Are they included on the formulary?
- What is the deductible, copayment and coinsurance amounts? Have you considered ALL the costs, not just the premium?

Plan Feature	HMO Plan or Medicare Advantage Plan	Group Indemnity Alternate Plan	Group Indemnity Standard Plan
Selection of Doctors and Hospitals	Member selects from the network of providers. No benefits available outside of the network.	Member selects provider of choice. Out of pocket cost is determined by provider network selected.	Member selects provider of choice. Out of pocket cost is determined by provider network selected.
Office Visit Copayment	$15 HMO Plan $ 5 Medicare Advantage Plan	$25	$15
Deductible			
Individual	$0	$750 (network)	$250 (network)
Family	$0	$1,250 (network)	$500 (network)
Coinsurance % of eligible charges	No Coinsurance	20% BluePreferred PPO 30% BlueChoice PPO or BlueCard PPO 40% Non Network	10% BluePreferred PPO 10% BlueChoice PPO or BlueCard PPO 30% Non Network
Prescription Benefit	3-Tier Formulary	3-Tier Formulary	2-Tier Formulary
Premium Contribution (Retiree Only Coverage)			
Under Age 65	$495.39	$274.44	$433.44
Over Age 64	$199.38	$158.15	$222.13

A summary of key differences is below. Additional information about the health plans can be found on pages 16-31.

HMO Plan or
Medicare Advantage Plan

- No deductible or coinsurance
- Lower premiums
- Services must be provided by a network provider. No benefits available outside of the network
- Prescriptions must be included on the formulary

Group Indemnity
Alternate Plan

- Higher deductible and coinsurance than the Group Indemnity Standard Plan
- Lower premiums than the Group Indemnity Standard Plan
- More flexibility than with an HMO plan
- 3-Tier Formulary

Group Indemnity
Standard Plan

- Lower deductible and coinsurance than the Group Indemnity Alternate Plan
- More flexibility than with an HMO plan
- 2-Tier Formulary

HMO Plan

Plan Features	HMO Plan
Eligibility	Retirees and dependents not Medicare eligible and living within the coverage area
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

HMO Plan

Common Medical Event	Services You May Need	HMO Plan
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copayment per visit
	Specialist visit	$15 copayment per visit
	Screening / Immunization	Plan pays 100%
	Chiropractic Care	$15 copayment
If you have a test	Diagnostic test (x-ray, blood work)	$0
	Imaging (CT/PET scans, MRIs)	$0
If you need drugs to treat your illness or condition	Generic Drugs	$10
	Preferred Brand	$25
	Non-Preferred Brand	$40
	90-day Mail Order	2 copayments for up to a 90 day supply
	Website for more information	www.myuhc.com
If you have a hospital stay	Facility fee (e.g. hospital room)	$100 copayment per admission
	Physician / Surgeon fee	$0
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	$50 copayment
	Physician/surgeon fee	$0
If you need immediate medical attention	Emergency medical transportation	$0 copayment (prior authorization required except for emergencies)
	Emergency Room	$50 copayment, waived if admitted
	Urgent care	$15 copayment
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copayment per visit
	Mental/Behavioral health inpatient services	$100 copayment per admission
	Substance use disorder outpatient services	$15 copayment per visit
	Substance use disorder inpatient services	$100 copayment per admission
If you have recovery or other special health needs	Home health care	$0
	Rehabilitation services	$100 copayment per admission
	Skilled nursing care	$0 (Limited to 100 consecutive Inpatient days per disability)
	Durable medical equipment	$0 ($5,000 maximum benefit per Calendar Year)
	Hearing Services	$0 copayment (Limited to one hearing aid every 3 years)
	Vision Benefit	$15 copayment (one visit per year) www.myspectera.com Preferred pricing from network provider

HMO Plan

Plan Administrator

UnitedHealthcare HMO
1-800-825-9355
www.myuhc.com

HMO Health Plans

A Health Maintenance Organization (HMO) is an exclusive group of physicians and hospitals. All services are coordinated by an in-network primary care physician. If your preferred doctor is not in the HMO network, you must select another doctor in order to have your medical visits covered by the HMO plan.

Advantages: No deductible, less out-of-pocket costs during the plan year

Disadvantages: Choice in doctors and hospitals is limited to those within the HMO network, formulary based prescription drug benefit.

Common Definitions

Copayments: are fixed dollar amounts (for example, $15 for office visits) you pay for covered health care, usually when you receive the service.

Formulary: is a listing of prescription medications approved for use and/or covered by the plan.

What is the difference between emergency care and urgent care?

Emergency Care is a serious medical condition that arises suddenly and requires immediate care and/or treatment. The primary care physician must be contacted WITHIN 48 hours.

Urgent Care is a less serious than an emergency, but still requires medical attention. The primary care physician MUST be contacted immediately, before receiving care. The PCP will then provide further instructions.

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 example, 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)

HMO Plan

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

Age Requirements
Retirees and spouses under the age of 65 and not Medicare participants are eligible for UnitedHealthcare HMO. Dependent children are eligible if they are under the age of 26.

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 PCP at an in-network facility (contracting hospital, clinic, etc.).

Mail Order Prescription Drug Program
UnitedHealthcare partners with Optum Rx, for your mail order prescriptions.
UnitedHealthcare offers a convenient way to order your maintenance medications and have them delivered to you. Receive a 90-day supply for two prescription copays. Call Customer Services 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.

Coverage Area
If you live in the coverage area, you are eligible to enroll in UnitedHealthcare HMO. At the time of this publication, all counties in Oklahoma are covered.

Please contact UnitedHealthcare at 1-800-825-9355 to determine limitations.

Medicare Advantage Plan

Plan Features	Medicare Advantage Plan
Eligibility	Retiree or Retiree + Spouse with Medicare Parts A and B and living within the coverage area
Selection of Doctors and Hospitals	Member selects from UnitedHealthcare Medicare Advantage network
Network Provider Exceptions	$25 copayment for non-network, out of area urgent care
Deductible -Individual -Family	 $0 $0
Out-of-Pocket Maximums (Does not include premiums) -Individual -Family	 $6,850 Individual maximums apply for each family member
Lifetime Benefit Maximum	No lifetime benefit maximum
Contact Information for Additional Questions	UnitedHealthcare Medicare Advantage 1-800-950-9355 www.uhcretiree.com

Medicare Advantage Plan

Common Medical Event	Services You May Need	Medicare Advantage Plan
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copayment per visit
	Specialist visit	$5 copayment per visit
	Screening / Immunization	$0 copayment
	Chiropractic Care	$5 copayment per visit (Up to 12 visits per plan year)
If you have a test	Diagnostic test (x-ray, blood work)	$0
	Imaging (CT/PET scans, MRIs)	$0
If you need drugs to treat your illness or condition	Generic Drugs	$10 copayment
	Preferred Brand	$20 copayment
	Non-Preferred Brand	$40 copayment
	90-day Mail Order	2 copayments for up to a 90 day supply
	Website for more information	www.uhcretiree.com
If you have a hospital stay	Facility fee (e.g. hospital room)	$0
	Physician / Surgeon fee	$0
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	$0
	Physician/surgeon fee	$0
If you need immediate medical attention	Emergency medical transportation	No copayment (but must be medically necessary)
	Emergency Room	$50 copayment, waived if admitted
	Urgent care	$5 copayment per visit
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$5 copayment per visit
	Mental/Behavioral health inpatient services	$0 copayment per admission, 190 day lifetime maximum
	Substance use disorder outpatient services	$5 copayment per visit
	Substance use disorder inpatient services	$0
If you have recovery or other special health needs	Home health care	$0
	Rehabilitation services	$5 copayment per visit
	Skilled nursing care	Covered up to 100 days per benefit period
	Durable medical equipment	0% coinsurance for each Medicare-covered item
	Hearing Services	$5 copayment (one exam per year) $500 hearing aid allowance every 24 months
	Vision Benefit	$5 copayment (one exam per year) Up to $130 eyewear allowance every 2 year or up to $175 contact lens allowance (in lieu of eyewear) every 2 years

Medicare Advantage Plan

A Group Retiree Medicare Advantage (MA) Plan is offered by UnitedHealthcare® that contracts with the federal government. Anyone with Medicare Parts A and B may apply. Members must continue to pay the Medicare Part B premium and use contracting pharmacies and providers for routine care. Limitations, co-payments and coinsurance will apply. Group Retiree prospects of the Medicare Advantage plan must meet the eligibility requirements to enroll for group coverage. Health plan premiums and benefits may vary by employer group. Pharmacy benefits are limited to a formulary (list of approved medications for use by the plan) that is subject to change without notice during the contract year. Contact UnitedHealthcare for details.

What is a Medicare Advantage Plan?

This is a health plan, offered by a private company and approved by Medicare. It is an alternative to the original Medicare Plan.

When you join the Medicare Advantage Plan, you must continue to participate in Medicare Parts A and B. However, instead of paying Medicare deductibles and coinsurance charges you pay health plan premiums, co-payments and co-insurance. Medicare Advantage Plan covers all services and supplies offered by Medicare plus additional services and supplies not covered by Medicare.

This health plan is very attractive to retirees. Monthly premiums can be much less than other plans and co-payments/co-insurance are more affordable.

Eligibility

Retirees who elect individual coverage or Retiree + Spouse coverage are eligible as long as both participants have Medicare Parts A and B. Dependent children are not eligible for coverage.

Primary Care Physician (PCP)

Each family member may choose a primary care physician from the doctors listed in UnitedHealthcare's Provider Directory. Doctors are listed according to the city in which 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 St. Anthony specialist you may. Additionally, if you are with a Mercy PCP and want to move to a St. Anthony PCP the next month, you may.

Step 1 Choose the type of physician (family practice, internal medicine or general medicine)
Step 2 Consider location
Step 3 Consider reputation, ask friends, or contact customer service.
Step 4 Indicate primary care physician 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 contracted with UnitedHealthcare Medicare Advantage.

Medicare Advantage Plan

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.

Mail Order Prescription Drug Program

UnitedHealthcare offers a convenient way to order your maintenance medications and have them mailed to your home. Receive up to a 90-day supply for two prescription co-payments. Call Member Services for a mail order form, or go online to **www.uhcretiree.com** and select the link for the mail order prescription drug program. Prescriptions must be filled as written, so before ordering be sure mail-orders are written as a 90-day supply instead of a 30-day supply with two refills.

Enrollment Procedures

To enroll in Medicare Advantage, either at the time of retirement, during Open Enrollment, or with a qualifying event, the Employee Benefits Division must receive an enrollment form with proof of Medicare Parts A & B. Enrollment forms must be received by the 15th of the month for coverage to begin on the first day of the next month. Effective dates are always the first day of the month and there are no retroactive coverage begin dates. For example, if the change is to be effective December 1st, the Employee Benefits Office must have the completed enrollment form and Medicare proof by November 15th. This provides enough time to forward the retiree's application to UnitedHealthcare and meet enrollment requirements.

Disenrollment Procedures

When a Medicare Advantage participant decides to enroll in another health plan, return to original Medicare coverage, or terminate participation in one of the City's health plans all together, the participant must complete and sign a disenrollment form. The form is available from the Employee Benefits Division and must be returned by the 15th day of the month for the change to become effective on the first day of the next month. Coverage under Medicare Advantage will end on the last day of the month and coverage under the original Medicare plan(s) will automatically be reinstated. Retroactive disenrollments or terminations are not accepted.

Coverage Area

If you live in the coverage area, you are eligible to enroll in Medicare Advantage. At the time of this publication, the following Oklahoma counties are in the Medicare Advantage service area:

Canadian	Oklahoma
Cleveland	Osage*
Creek	Pottawatomie*
Logan	Rogers
Mayes	Tulsa
Muskogee*	Wagoner

* An asterisk (*) identifies counties where partial county coverage exists. Please contact UnitedHealthcare-Medicare Advantage at 1-800-950-9355 to determine limitations.

Group Indemnity - Alternate

Plan Features	Group Indemnity Plan Network	Group Indemnity Plan Non-Network
Eligibility	Retirees and dependents	Retirees and dependents
Selection of Doctors and Hospitals	Member selects from the **BluePreferred PPO**, **BlueChoice PPO** or **BlueCard PPO** network of providers	Member selects the provider of choice
Deductible*		
-Individual	$750	$1,500
-Family	$1,250	$2,500
	*Accumulators for in-network and out-of-network deductibles are separate. For example, an individual could have a total deductible of $2,250 ($750 in-network + $1,500 out-of-network)	
Coinsurance	BluePreferred PPO: 20% of eligible charges BlueChoicePPO or BlueCard PPO: 30% of eligible charges	40% of eligible charges
Coinsurance Maximum		
-Individual	$4,000	$ 8,000
Annual Out-of-Pocket Maximums (does not include premiums)		
-Individual	Deductible + Coinsurance	Deductible + Coinsurance
-Family	Individual maximums apply for each family member.	Individual maximums apply for each family member.
Lifetime Benefit Maximum	No lifetime benefit maximum	No lifetime benefit maximum
Contact Information for Additional Questions	BlueCross BlueShield of Oklahoma 1-877-219-4301 www.bcbsok.com/okc	
Prescription Plan		
Generic Drugs	$15	No benefit
Preferred Brands	$40	No benefit
Non-Preferred Brands	$55	No benefit
90-day Mail Order	2 copayments for up to a 90-day supply	Not applicable
Contact Information for Additional Questions	www.express-scripts.com	

Group Indemnity - Alternate

Common Medical Event	Services You May Need	Group Indemnity Alternate Plan
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment + deductible + coinsurance
	Specialist visit	$25 copayment + deductible + coinsurance
	Screening / Immunization	Plan pays 100%
	Chiropractic Care	$25 copayment + deductible + coinsurance
If you have a test	Diagnostic test (x-ray, blood work)	$25 copayment + deductible + coinsurance
	Imaging (CT/PET scans, MRIs)	$50 copayment + deductible + coinsurance
If you have a hospital stay	Facility fee (e.g. hospital room)	$100 copayment + deductible + coinsurance
	Physician / Surgeon fee	Deductible + coinsurance
If you have outpatient facility services	Facility fee (e.g. ambulatory surgery center)	$50 copayment + deductible + coinsurance
	Physician/surgeon fee	Deductible + coinsurance
If you need immediate medical attention	Emergency medical transportation	EMSA paid at 100%, deductible waived. Other providers: deductible + coinsurance
	Emergency Room	$50 copayment + deductible + coinsurance
	Urgent care	$25 copayment + deductible + coinsurance
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services (office visit)	$25 copayment + deductible + coinsurance
	Mental/Behavioral health inpatient services	$100 copayment + deductible + coinsurance
	Substance use disorder outpatient services (office visit)	$25 copayment + deductible + coinsurance
	Substance use disorder inpatient services	$100 copayment + deductible + coinsurance
If you have recovery or other special health needs	Home health care	Deductible + coinsurance Maximum of 120 days
	Rehabilitation services	Deductible + coinsurance
	Skilled nursing care	Deductible + coinsurance (Limited to 120 days)
	Durable medical equipment	Deductible + coinsurance
	Vision Benefit	No benefit

Group Indemnity - Standard

Plan Features	Group Indemnity Plan Network	Group Indemnity Plan Non-Network
Eligibility	Retirees and dependents	Retirees and dependents
Selection of Doctors and Hospitals	Member selects from the **Blue-Choice PPO** or **BlueCard PPO** network of providers	Member selects the provider of choice
Network Provider Exceptions		Higher deductibles, coinsurance & out of pocket maximums
Deductible*		
-Individual	$250	$300
-Family	$500	$900
	*Accumulators for in-network and out-of-network deductibles are separate. For example, an individual could have a total deductible of $550 ($250 in-network + $300 out-of-network)	
Coinsurance Maximum		
-Individual	$1,000	$3,000
Out-of-Pocket Maximums (Does not include premiums)		
-Individual	Deductible + Coinsurance	Deductible + Coinsurance
-Family	Individual maximums apply for each family member.	Individual maximums apply for each family member
Lifetime Benefit Maximum	No lifetime benefit maximum	No lifetime benefit maximum
Contact Information for Additional Questions	BlueCross BlueShield of Oklahoma 1-877-219-4301 www.bcbsok.com/okc	
Prescription Plan		
Generic Drugs	$15	No benefit
Preferred Brands	$30	No benefit
90-day Mail Order	2 copayments for up to a 90-day supply	Not applicable
Contact Information for Additional Questions	www.express-scripts.com	

Group Indemnity - Standard

Common Medical Event	Services You May Need	Group Indemnity Network	Group Indemnity Non-Network
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
	Specialist visit	$15 copayment + deductible + 10% of eligible charges	$15 copayment + deductible + 30% of eligible charges
	Screening / Immunization	Plan pays 100%	Plan pays 100%
	Chiropractic Care	$15 copayment + deductible + 10% of eligible charges	$15 copayment + deductible + 30% of eligible charges
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
	Imaging (CT/PET scans, MRIs)	$50 copayment + deductible + 10% of eligible charges	$15 copayment + deductible + 30% of eligible charges
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
	Physician / Surgeon fee	Deductible +10% of eligible charges	Deductible + 30% of eligible charges
If you have outpatient facility services	Facility fee (e.g. ambulatory surgery center)	$50 copayment + deductible + 10% of eligible charges	$50 copayment + deductible + 30% of eligible charges
	Physician/surgeon fee	Deductible + 10% of eligible charges	Deductible + 30% of eligible charges
If you need immediate medical attention	Emergency medical transportation	EMSA paid at 100%, deductible waived. Other providers: Deductible + 10% of eligible charges	EMSA paid at 100%, deductible waived. Other providers: Deductible + 30% of eligible charges
	Emergency Room	$50 copayment + deductible + 10% of eligible charges	$50 copayment + deductible + 30% of eligible charges
	Urgent care	$15 copayment + deductible + 10% of eligible charges	$15 copayment + deductible + 30% of eligible charges
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services (office visit)	$15 copayment + deductible + 10% of eligible charges	$15 copayment + deductible + 30% of eligible charges
	Mental/Behavioral health inpatient services	$50 copayment + deductible + 10% of eligible charges	$50 copayment + deductible + 30% of eligible charges
	Substance use disorder outpatient services (office visit)	$15 copayment + deductible + 10% of eligible charges	$15 copayment + deductible + 30% of eligible charges
	Substance use disorder inpatient services	$50 copayment + deductible + 10% of eligible charges	$50 copayment + deductible + 30% of eligible charges
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
	Rehabilitation services	Deductible + 10% of eligible charges	Deductible + 30% of eligible charges
	Skilled nursing care	Deductible + 10% of eligible charges (Limited to 120 days)	Deductible + 30% of eligible charges (Limited to 120 days)
	Durable medical equipment	Deductible + 10% of eligible charges	Deductible + 30% of eligible charges
	Hearing Services	$500 benefit for hearing aid every 24 months	$500 benefit for hearing aid every 24 months
	Vision Benefit	No benefit	No benefit

Group Indemnity Health Plans

The Group Indemnity Health Plans offer a broad network of doctors, allowing 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 is offered with the Group Indemnity Plan.

Advantages: Choice of doctors, hospitals, and prescription medications

Disadvantages: Greater out-of-pocket expenses during the plan year

Common definitions

Annual Out of Pocket Maximum: the maximum amount of coinsurance and deductible you pay for covered medical expenses in any single calendar year. Monthly premiums do not count toward out of pocket maximums.

Coinsurance: is a percentage the patient is required to pay on all eligible medical expenses, in excess of the deductible.

Copayments: are fixed dollar amounts (for example, $15 office visit) you pay for covered health care, usually when you receive the service.

Deductible: is the amount of eligible medical expenses the participant must pay before the plan will make any benefit payments.

Formulary: is a listing of prescription medications approved for use and/or covered by the plan.

Preferred provider network: is a group of physicians and hospitals that furnish services or supplies for a negotiated charge. Providers exchange discounted services for increased volume. A participant's out-of pocket expenses are usually lower when using a preferred provider network. Participants using an out-of network provider may encounter financial penalties in the form of a separate out-of network deductible, higher co-insurance, and balance billing.

What is the difference between emergency care and urgent care?
Emergency Care is a serious medical condition that arises suddenly and requires immediate care and/ or treatment.

Urgent Care is less serious than an emergency, but still requires medical attention.

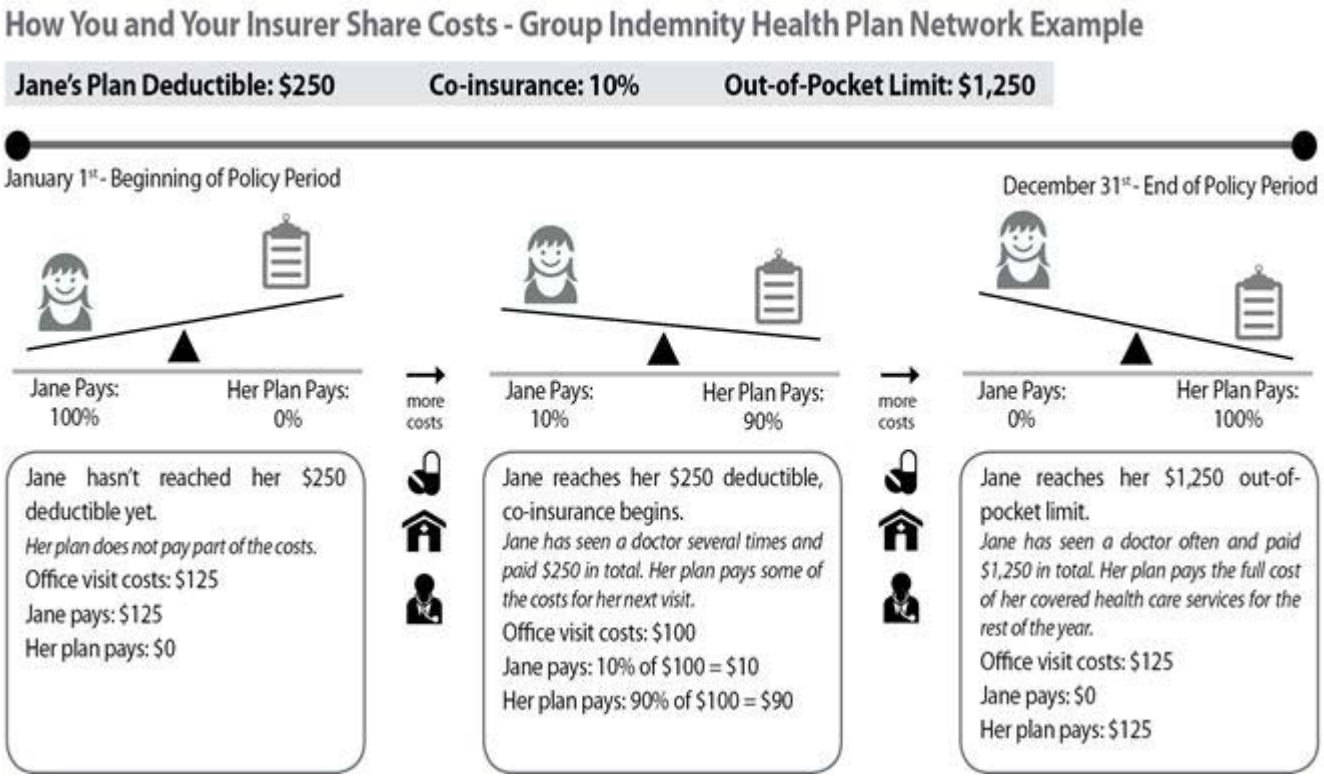
Two Plan Options

There are two Group Indemnity Plan Options available: **Alternate Plan** and **Standard Plan**.
Summary charts are available on the following pages to identify the differences.

Health Plan Identifier: 7871596020

Group Indemnity Health Plans

Example of Co-insurance and Deductible:



Copayments may apply.

Group Indemnity Health Plans

Health Plan Provisions
Coverage is provided only for a service or supply, which is *"necessary for diagnosis, care or treatment of a physical or mental condition involved."* Only that part of a charge that is "*reasonable and customary*" is payable.

Inpatient Pre-Certification
Pre-Certification is required for inpatient hospital services, skilled nursing facility services, services received in a Coordinated Home Care Program, and private duty nursing services, at least one day prior to the scheduling of the admission.

Hospitalization
Private room limit is the Institution's semi-private rate. If the institution does not offer a semi-private rate, a semi-search rate will be utilized for coverage.

Coordination of Benefits
Medical or dental benefits paid by *"other plans"* will be taken into account when determining benefits under this Plan. Medicare benefits will be calculated before the medical benefits of this Plan are determined.

The City's Group Indemnity Health Plans (both self-insured plans) are administered by BlueCross BlueShield of Oklahoma. Under these health plans, you may go to any physician. However, by using in -network providers your out-of-pocket expenses will typically be lower. For a list of preferred providers, visit the BlueCross BlueShield of Oklahoma representative at Open Enrollment on October 26-30, 2015, call our office at 297-2144, or visit the BlueCross BlueShield web site **www.bcbsok.com/okc**

Age Requirements
The Group Indemnity Health Plan is available for all eligible retirees regardless of Medicare eligibility. Dependent children are eligible if they are under the age of 26.

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

Denial of Claim
The Claims Administrator will have discretionary authority to construe and interpret the Plans 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.), the Plans will pay eligible claims. However, the Plans reserves the right to recover expenses paid on your or your dependent's behalf, from the negligent third party or from you if you receive a monetary settlement. You are required to notify the Plan Administrator of all such injuries.

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

Group Indemnity Health Plans

Claim Appeal

BlueCross and BlueShield 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.

Prescription Plan—Express Scripts

Express-Scripts is the pharmacy manager for the Group Indemnity plans. For questions contact Express-Scripts at 800-737-4484 or via their website at www.express-scripts.com.

Employer Group Waiver Plan (EGWP) for all Retirees and Dependents with Medicare

What is an Employer Group Waiver Plan?

An Employer Group Waiver Plan (EGWP) - is a Medicare approved prescription drug plan. EGWP is only available to Medicare-eligible members. Non-Medicare eligible members will remain on the current plan.

What about the Medicare Part D Coverage Gap or Donut Hole?

Members of the EGWP plan with the City of Oklahoma City will not experience a Medicare Part D plan Coverage Gap or Donut Hole.

How do I enroll in EGWP?

All Medicare eligible members are automatically enrolled when the enroll in the BlueCross BlueShield Medical plan and are on Medicare. You can opt-out BUT you will lose City sponsored coverage for medical and prescription coverage.

Will I be getting a new ID card?

Yes, you and any dependents who are Medicare-eligible will each receive new individual member ID cards when they are enrolled in EGWP. You will need to use this card at the pharmacy for prescriptions. Your BlueCross BlueShield card and your Medicare card should be used for doctor visits.

What if I have another medical plan in addition to my City coverage?

If the non-City sponsored plan includes a prescription drug plan offered under Medicare Part D, you will need to decide which plan you wish to continue. Medicare does not allow participants to be enrolled in more than one drug prescription plan.

Whom should I contact if I have questions about EGWP?

If you have any questions about the new plan, you may contact Express Scripts Medicare Customer Service at 1-877-895-9706. Customer Service is available 24 hours a day, 7 days a week. TTY users should call 1-800-716-3231.

Frequently Asked Questions
Medical Benefits

What should I consider if I am thinking about switching from one health plan to another including the Marketplace Exchange?
We recommend you compare the different provisions of each plan. You may also want to ensure that any maintenance medications you take are covered by the plan you are considering. If considering an HMO you will want to make sure your doctors and preferred facilities are in their network or be willing to select a new primary care physician. Coverage through the Marketplace Exchange and the City's health plans covers the minimum essential coverage requirement. However, coverage under any of the City's health plans are subsidized by the City. This means the cost to you may be less than it would be if you purchased it on your own. Coverage under the Marketplace Exchange may qualify you for a tax credit that may be unavailable to you under one of the City's plans.

How can I find out which physicians, hospitals, and pharmacies are on my medical plan?
This information is easily found from the convenience of your home; all you need is access to the internet. Simply enter the provider's web address into your internet browser. UnitedHealthcare is at www.myuhc.com and BlueCross BlueShield is at www.bcbsok.com/okc. If you do not have access to the internet, provider directories may be available on-site during this enrollment period. Additionally, you may contact a representative of UnitedHealthcare, BlueCross BlueShield, or the Employee Benefits Division. Please refer to the back cover for specific telephone numbers. Visit www.healthcare.gov to find more about the Marketplace Exchange network.

How can I find out which prescription drugs are covered under the medical plan?
The City's Group Indemnity Alternate Plan and the HMO plan offer a three tier formulary plan; the Standard Plan offers a two tier formulary. All Plans allow most prescribed medications. Prescriptions available with the City Plans are located on each provider's website. Websites 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 I did not elect health insurance at the time of my retirement, can I add it now?
No. If you did not elect coverage under one of the City's plans at the time of your retirement you may not enroll now. Note: nearly all Americans are required to carry minimum essential coverage or pay a penalty. There may be health insurance coverage available to you through the Health Insurance Marketplace Exchange. Visit www.healthcare.gov to find out more.

Can I drop my health insurance and later return?
No. If you elect to drop your health insurance this will result in the permanent loss of your retiree health benefit.

What is 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 under the City's health plan, and your spouse also receives health coverage through his/her employer, the City's plan will always be secondary. Likewise, if you're currently working and you elect coverage for yourself as an employee, your current employer's health plan will be primary and your coverage with the City's health plan becomes secondary with respect to your benefits.

Frequently Asked Questions
About Medicare

What parts of Medicare should I enroll in?
To participate in the City sponsored health plans, you must enroll in Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance).

I am under age 65 but recently became Medicare eligible. What do I need to do?
Provide a copy of your Medicare card or Medicare Award Letter to the Employee Benefits Division at 420 W. Main, Suite 110, Oklahoma City, OK 73102. Some plans offer reduced premiums once you become Medicare eligible.

My spouse will soon be 65 and eligible for Medicare. What do I need to do? Will my premiums be reduced again?
Premiums are only reduced once, when the first member becomes eligible for Medicare. Provide a copy of your Medicare card or Medicare Award Letter to the Employee Benefits Division.

Will the City notify me about what I need to do when I am close to Medicare eligibility?
As a courtesy, the City attempts to notify retirees when either they or their spouse is approaching age 65. The notice requests a copy of the Medicare card, provides new premium rates (if applicable), and gives instructions on changing plans, if necessary.

I will soon be 65 and Medicare eligible. What do I need to do and how does Medicare effect my benefits?
- Provide a copy of your Medicare card or Medicare Award Letter to the Employee Benefits Division at 420 W. Main, Suite 110, Oklahoma City, OK 73102. Some plans offer reduced premiums once you become Medicare eligible.
- If you are a Group Indemnity Plan participant your premium will be reduced because Medicare becomes the primary insurer with the City's plan becoming secondary. A secondary insurer is not "Gap" or "Supplemental" coverage.
- You may be required to select a different plan. UnitedHealthcare HMO only accepts participants under the age of 65. UnitedHealthcare Medicare Advantage requires that all participants are covered under Medicare Parts A and B, including spouses.
- For Group Indemnity participants, enrollment in Medicare Parts A and B is assumed when processing claims for at least one of the participants (retiree or spouse) regardless of whether or not the individual is actually receiving Medicare benefits. This means that if the individual does not have Medicare parts A or B, because they refused, neglected, discontinued, or did not qualify, claims are processed as though they do have Medicare. An individual without Medicare could pay higher out of pocket expenses on individual claims.

When my spouse or I become Medicare eligible will our health premiums be reduced?
Yes, but only once. Premiums will be reduced when the first one of you becomes Medicare eligible (usually at age 65.) There will not be a change in premium when the second person becomes Medicare eligible.

If Medicare is the primary payer why does the City's Group Indemnity Health Plan insurance not pay what is left?
The City's Group Indemnity Health Plans is secondary insurance that coordinates benefits with Medicare and is *not* a supplemental or *"gap"* plan. The Group Indemnity Health Plans will pay no more than the allowable charges. If Medicare pays the allowable charges or more, then the Plans will not pay more towards the bill.

Frequently Asked Questions About Medicare Part D

What is Medicare Part D?

Medicare Part D is prescription drug insurance. Medicare has contracted with private companies to offer the insurance. Participants choose the plan and pay a monthly premium; then Medicare helps pay the cost of prescriptions after a deductible is met. For complete details, visit **www.Medicare.gov** or call 1-800-MEDICARE.

Should I enroll in Medicare Part D?

As a Medicare-eligible retiree, or as a Medicare eligible spouse of a retiree, who is currently receiving benefits you will automatically be enrolled in the plan. For retirees with Medicare the Express Scripts Medicare Plan is a Part D plan.

What can I do if I do not want this plan?

You may "opt out" of this coverage, but please be aware that this may be the only prescription coverage available to you through the City's Group Indemnity health plans and opting out will result in a loss of medical benefits.

How does Medicare Part D affect my health insurance?

Depending on which of the City sponsored health plans you are enrolled in, participation in a non-City Medicare Part D Plan could disenroll you from your current health insurance. For a complete disclosure on how Medicare Part D affects participants in the City sponsored health plans, review the *Creditable Coverage Disclosure* on pages 35-37. Additional information is available from Medicare at www.Medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227.)

What if I am enrolled in a different Part D plan, not through the City's Health plans?

The Centers for Medicare & Medicaid Services (CMS) does not permit Medicare beneficiaries to be enrolled in two Medicare Part D plans at a time. Therefore, you will need to choose if you want your prescription drug coverage through Express Scripts Medicare Part D Plan offered with the City's plan or through another Part D plan. Note: if you disenroll in the Medicare Part D plan offered through the City, your medical insurance plan is also discontinued.

Medicare Part D - Creditable Coverage Disclosure

An 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 HMO 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.

Medicare Part D - Creditable Coverage Disclosure

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 HMO 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 or the Group Indemnity Health Plans, changes. You also may request a copy of this notice at any time.

Medicare Part D - Creditable Coverage Disclosure

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, 2015
Name of Entity/Sender:	City of Oklahoma City
Contact--Position/Office:	Personnel 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).

CMS Form 10182.CC **Updated April 1, 2011**

2016 ADDITION

Beneficiaries

You may change beneficiaries at ANY time.

- **Life Insurance (contact Employee Benefits)**
- **Retirement or Pension**
  - **OCERS**
  - **Fire Pension**
  - **Police Pension**
- **Retirement Savings**
  - **ICMA-RC**
  - **Nationwide**

NAL BENEFITS

- Dental Plans
- Vision
- Group Term Life
- OKC Care Medical Center
- Fitness

BlueCross BlueShield Dental

DENTAL BENEFIT HIGHLIGHTS **Low** Plan Option (MAC)

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

BlueCross BlueShield Dental

DENTAL BENEFIT HIGHLIGHTS **High** Plan Option (UCR)

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

Dental Plan Benefits Highlights

Retiree 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 may be covered up to age 26. Disabled dependent children can be covered beyond age 26 if they meet the disability requirements rule.
- 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 effective 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.

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 the BlueCross BlueShield of Oklahoma's Dental network.

Contracting Network Dentist

Regardless of what 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.

Non-Contracting Network Dentist

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.

Dental Plan Benefits Highlights

There is a difference on how Non-Contracting Dentists are reimbursed, based on the plan you in which you are enrolled.:

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 rendering 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 dental is a “freestanding” product and can be purchased separately from the health product.

Find out which Dentists are on your dental plan.
This information may be found on the BlueCross BlueShield website at:
www.bcbsok.com/okc

Vision Care Plan

Your VSP 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 are not 100% happy, VSP 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! VSP will 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 for you and your family.

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 conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

Vision Care Plan

VSP Vision Plan	Rates
Retiree Only	$7.00
Retiree + 1	$12.98
Retiree + 2 or more	$20.88

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	• $150 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 bifocals, and lined trifocals • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every calendar year
Lenses Option	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 20-25% off other lens enhancements	$55 $95-$105 $150-$175	Every calendar year
Contact (instead of glasses	• $150 allowance for contacts and the contact lens exam (fitting and evaluation) • 15% off contract lens exam (fitting and evaluation)	$0	Every calendar year
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 **Laser Vision Correction** • Average 15% off the regular prices 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

Basic Coverage

Retirees may purchase a $10,000 group term life insurance policy (a surviving spouse is not eligible to purchase this benefit) at the time of retirement. Group term life insurance is payable only when the insured retiree dies. There are no permanent policy benefits such as cash or loan value.

Can I purchase more life insurance through the City?

No. The City of Oklahoma City offers a $10,000 life insurance policy to retirees at the time of retirement. If the retiree elects not to participate in this life insurance policy at the time of retirement, he/she is not eligible to elect coverage at a later date. There are no additional life insurance policies available to retirees through the City of Oklahoma City Employee Benefits Division.

Other Life Insurance Coverage

Your Enrollment Form will only reflect your participation in the City of Oklahoma City's basic retiree coverage. As an active employee you may have had additional life insurance coverage purchased through a union or employee association. For information on those policies contact the union, employee association, or insurance carrier directly.

Choosing a Beneficiary

It is important to select a beneficiary(ies). In the event of your death, life insurance benefits are distributed as indicated on your Life Insurance Enrollment Form or as designated online, unless prohibited by law. You should review your beneficiary information periodically to make sure that you have listed the persons or organizations whom you want to receive benefits in the event of your death.

You may name more than one beneficiary and indicate the percentage of your death benefit each should receive. If minors are named, a guardian or trustee must be appointed on their behalf. You should discuss this with an attorney to make sure the minor(s) will be paid according to your wishes.

You may change your beneficiary at any time by completing a new form and returning it to the Employee Benefits office or by logging onto PeopleSoft and changing it online.

Plan Provider

Dearborn National underwrites this plan.

OKC Care Medical Center Highlights

Your no cost OKC Care Employee Medical Center is opening in Fall 2015. OKC Care is available to employees, **non-Medicare retirees** & spouses, and dependents (ages 2 & up) covered on the City's medical plan.

Located in the Arts District parking garage, 424 W. Colcord St., Suite F
Monday—Friday
7:30 am—Noon & 1 pm—4:30 pm
To schedule an appointment:
Login at www.careatc.com or call 800.993.8244

OKC Care Employee Medical Center offers:

- Completely confidential services
- No co-pay
- No deductible
- Full service primary care
- On-site lab draws
- On-site generic prescriptions
- Personal Health Assessment (PHA)
    - ◊ PHA blood draw to identify risk factors
    - ◊ CONFIDENTIAL PHA booklet mailed to your home which displays results as well as tips for improvement
    - ◊ Friendly follow-up by phone for urgent and abnormal results
    - ◊ Physician follow-up in clinic

What can be treated?

- Allergies
- Cold and flu
- Diabetes management
- High blood pressure
- Lab work / tests
- Asthma
- Physicals
- Congestion
- Headaches
- High cholesteral
- Personal Health Assessments (PHA)
- Tobacco cessation

Fitness

10Gym

Amenities include fitness club services, personal training, tanning, group fitness classes, locker room facilities with showers, dry saunas and supervised childcare. 10GYM offers membership in locations throughout the Oklahoma City metropolitan area, including our all-new ultra clubs in Edmond & Norman. Retiree's membership will include all 10GYM locations. Membership agreements are between the retiree and 10GYM, retirees are personally and financially responsible for the payment of the membership fees to 10GYM.

Membership includes:

- Access to all 10GYM locations.
- Free Unlimited Guest Privileges
- Unlimited Group Fitness – including Zumba®, Yoga, Boot Camp, Pilates, and Cardio Kickboxing.
- Free Unlimited Tanning
- Supervised Childcare (Kid's Fun Zone): $10 + tax one child; $15.00 + tax for two or more children

Membership:
$19.00 + tax per month for retiree only.

Additional Family Member:$5.00 + tax per month

Fitness

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)

- Personal Training
- Free Child Care
- Exclusive Cardio Cinema (Movie Theatre)
- Lap Pools
- Sauna, Hot Tub, Steam Room
- Basketball Courts
- Smoothie Bar

Membership:
Individual Membership $19.95 + tax per month
Individual + 1 Membership $39.90 + tax per month
Family Membership (covers up to 4 members) $65.95 + tax per month

No Initial Card Fee. Membership contracts are between the retiree and Gold's Gym. Retirees are personally and financially responsible for the payment of their membership fees to Gold's Gym.

* Personal Training sessions are not payroll deductible and must be paid by the member.

2016 OTHER IN

Enroll Online

All eligible retirees can enroll online.
For instructions, see page 9.

Remember, if you are not making any changes, you do not have to do anything.

NFORMATION

- Things to Know
- COBRA
- Health Insurance Marketplace
- Frequently Asked Questions
- Glossary of Terms

Things to Know...

Verification of Dependents

If you experience a qualifying event and wish to enroll dependents in any of the City's benefit programs, you must submit appropriate documentation to the Employee Benefits Division. Appropriate documentation includes, but is not limited to, documents supporting your relationship to the dependent such as a copy of your marriage license, dependent's birth certificate or legal guardianship, and Social Security cards.

If the above documents are not already on file at the time of your initial application for retiree benefits, you are required to submit them to the Employee Benefits Division. Note: The City of Oklahoma City Personnel Department reserves the right to require dependent documentation to verify coverage eligibility.

Dependent Audit

Employee Benefits may audit employee and retiree benefit files to ensure proper documentation for dependents enrolled in the City's medical and dental plans have been provided. You may receive a letter requesting missing documentation. 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 documents are needed, you will receive a letter.

Disabled Dependent Documentation

Written documentation from an attending physician supporting an ongoing total disability for a disabled dependent child is required. Documentation must describe the dependent's medical condition, a diagnosis, and the prospect of recovery. Evidence of disability status is required, at minimum, every two years or upon request.

Address/Telephone Change

You may change your address and/or telephone number by:

- Requesting a *Change Form* from the Employee Benefits Division; or
- Mailing a signed letter with your new contact information to the Employee Benefits Division; or
- Changing your address online via PeopleSoft (see Page 9 for instructions under *Enroll Online*.)

***Important note**:* If you are currently enrolled in an HMO plan (UnitedHealthcare HMO or UnitedHealthcare Medicare Advantage) and move outside of the plan's service area, you will not be eligible to continue participation in their plan. Please contact the Employee Benefits Division at (405) 297-2144 for options and additional information.

Things to Know...

Common-Law Marriage Guidelines

A common-law marriage relationship in the state of Oklahoma is defined as two adults who 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 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 shared residence, parties must provide evidence such as (1) a lease, deed, or mortgage showing both partners as parties to the transaction, (2) drivers' license for both partners showing the same address, (3) utility bills showing the same address, and/or (4) passports for both parties showing the same address.

To document financial inter-dependence, 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 *"married filing jointly"* or *"married filing separately"*, and/or (4) joint wills.

Oklahoma recognizes common law through case law as opposed to statute. The retiree applicant and partner must also sign and have notarized an official Statement of Common-Law Marriage. The form is available from the Personnel Department/Employee Benefits Division. The Employee Benefits Manager will review all applications and determine eligibility based upon the documentation provided. Documents must accompany the application. Supplemental documents will not be accepted at a later date. Recognition of common-law marriage by another entity, such as a pension system, does not negate the need to complete a common-law application with the Employee Benefits Division. Refer to the Frequently Asked Questions on page 57 for additional information and exclusions.

Certificate of Creditable Coverage

A certificate of creditable coverage will be provided upon request, loss of coverage, or a COBRA qualifying event. Certificates provide evidence of health coverage and may be needed if you become eligible under a group health plan that excludes coverage for certain pre-existing medical conditions. If you enroll in Medicare Part D you may need a certificate of coverage to avoid higher Medicare Part D premiums.

Beneficiary Change

It is very important to keep your life insurance beneficiary information current. To change your beneficiary you may contact our office at (405) 297-2144 and request a beneficiary change form or submit a written notice to:

The City of Oklahoma City
Employee Benefits Division
420 W. Main, Suite 110
Oklahoma City, OK. 73102

You may also change your beneficiary online using PeopleSoft self-service (instructions for self-service are on page 9 under *"Enroll Online"*).

COBRA

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."

COBRA

Is COBRA continuation coverage available to a retiree's spouse and/or dependent?

A former spouse and/or dependent of a retiree may be eligible for COBRA coverage following as defined on the previous page:

- the death of the retiree;
- the retiree becomes entitled to Medicare benefits (under Part A, Part B, or both);
- a divorce; or
- a child is no longer eligible for coverage under the Plan as a "dependent child."

Is COBRA continuation coverage available to a retiree as a result of an employer bankruptcy?

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 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).

COBRA

General Notice

A General Notice of COBRA Continuation of Coverage Rights is provided 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. It also contains information about the Health Insurance Marketplace Exchange.

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 entitlement for Medicare
5) Military leave, after the 12-month benefit extension expiration
6) Death of an employee

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 Web site 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.

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

Frequently Asked Questions
General

This booklet is merely a compilation of City sponsored retiree benefits. Actual benefits available and full descriptions of these benefits are governed in all cases by the relevant plan document, insurance contracts, ordinances or resolutions of The City of Oklahoma City. The Mayor and Council may modify or amend plan documents or insurance contracts from time to time at its sole discretion. Such amendments or modifications may affect covered persons, which could include elimination of any plan provisions. If there are discrepancies between this benefit guide and actual plan documents, insurance contracts, ordinances or resolutions; the documents, contracts, ordinances or resolutions will govern.

When does my retiree coverage begin?

New Retirees: As a new retiree, health and dental coverage begins on the first of the month following the month you retire from the City. For example, if your retirement date is January 15th active employee coverage continues through January 31st and retiree coverage begins February 1st. Retiree life insurance begins on the first day of your retirement.

You must elect health and/or life insurance coverage within 31 days of the date you retire from the City or you will not be eligible for those benefits.

Who are eligible dependents?

Generally, eligible dependents include:

- Spouse, except for the spouse of a survivor.
- Children, as defined by Oklahoma law (or those who qualify as a dependent under Internal Revenue Code)
- Children who are physically or mentally incapable of self-support on the date coverage would have otherwise ended.
- Adult children under age 26.

Each provider has specific age limits for determining dependents

Benefit Plan	Dependent Age
BlueCross BlueShield Dental	Age 26
Group Indemnity Plan	Age 26
UnitedHealthcare HMO	Age 26

Frequently Asked Questions
General

If a spouse is not enrolled at the time of my retirement, can I add them later?

A spouse who was not enrolled when initial elections were made at the time of retirement may not be later added to a health or dental plan, except in the case of marriage. You must add the new spouse within 31 days of the qualifying event or you will not be able to add him/her at a later date.

Can I drop my spouse this year and then add them back at a later open enrollment?

No. If a spouse's coverage is dropped, the change is permanent.

Can I add my dependent child at open enrollment?

Yes. Dependent children up to age 26 can be added to a health or dental plan at open enrollment. Appropriate dependent documentation (birth certificate and social security number) must be provided to Employee Benefits before a dependent child will be added.

I am a surviving spouse. If I remarry, may I add my new spouse and his/her dependents to the insurance?

No. As a surviving spouse you are not allowed to add a new spouse or that spouse's dependents to health or dental plans.

I recently married and want to add my new spouse (and dependents) 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. If dependents are to be added, copies of official birth certificates and Social Security cards are required. Coverage under the health plan becomes effective the date of your marriage.

There are other qualifying events which might permit you to add dependents. Contact the Employee Benefits Division for additional details. In all cases you must notify and provide required documentation to the Employee Benefits Division within 31 days of the qualifying event or you will not be allowed to add new dependents.

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 Benefits Division of the Personnel Department within 31 days of the divorce/legal separation. Failure to notify timely may result in a financial consequence. 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 affected dependent will be eligible to continue health and/or dental coverage through COBRA.

Glossary of Terms

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 and deductible 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 copayments, which are still required). Prescription copayments and monthly premiums 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.

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.

Glossary of Terms

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 a retiree 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.

Copayment: 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 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.

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.

Glossary of Terms

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 Plan: An individual or group plan that provides or pays some or all of your eligible 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: A hospital stay (usually 24 hours or more) for which a room and board charge is made by the hospital.

Managed 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.

Glossary of Terms

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: 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.

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.

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.

Glossary of Terms

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/retiree 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.

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.

Summary Plan Descriptions (SPD): A document that provides explains fundamental features about your benefits, including eligibility requirements.

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.

Directory

Provider	Group Number	Hours	Phone #	Web Address
Health Maintenance Organizations (HMOs)				
UnitedHealthcare HMO	010933	M—F 7 a.m. to 9 p.m. CST	1-800-825-9355	www.myuhc.com
Medicare Advantage	010934	M—F 8 a.m. to 8 p.m. CST	1-800-950-9355	www.uhcretiree.com
Group Indemnity Health Plan				
BlueCross BlueShield of Oklahoma, Health Plan Administrator	019574	M—F 8 a.m. to 8 p.m. CST	1-877-219-4301	www.bcbsok.com/okc
Express-Scripts Inc. Pharmacy Plan Administrator	Q7MA (non-Medicare)	M—F 8 a.m.—5 p.m. CST	1-800-737-4484	www.express-scripts.com
	KXPA (Medicare only)	24 hours a day, 7 days a week	1-877-895-9706	
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
Life Insurance				
Dearborn National	GAE00255	M—F 7 a.m. to 7 p.m. CST	1-800-778-2281	www.dearbornnational.com
Pension Systems				
Fire—Oklahoma Fire Fighters Pension & Retirement System	N/A	M—F 8 a.m. to 4:30 p.m. CST	(405) 522-4600 1-800-525-7461	www.ok.gov/fprs
Police—Oklahoma Police Pension and Retirement System	N/A	M—F 8 a.m. to 4:30 p.m. CST	(405) 840-3555 1-800-347-6552	www.ok.gov/opprs
OCERS—Oklahoma City Employee Retirement System	N/A	M—F 8 a.m. to 5 p.m. CST	(405) 297-3413 (405) 297-2408	www.okc.gov
Savings Plans				
Municipal Employees Credit Union (MECU)	N/A	M&F 8:30 a.m. to 5:30 p.m. T—Th 8 a.m. to 5 p.m. CST	(405) 297-2995	www.mecuokc.org
ICMA Retirement Corp.	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	www.okc.gov
10GYM, LLC	N/A	M—F 9 a.m. to 6 p.m. CST (administration)	(405) 301-0170	www.10gym.com
Gold's Gym	N/A	M—F 9 a.m. to 6 p.m. CST (administration)	(405) 601-8998	www.goldsgym.com
Medicare	N/A		1-800-633-4227	www.medicare.gov
Healthcare Exchange	N/A			www.healthcare.gov

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