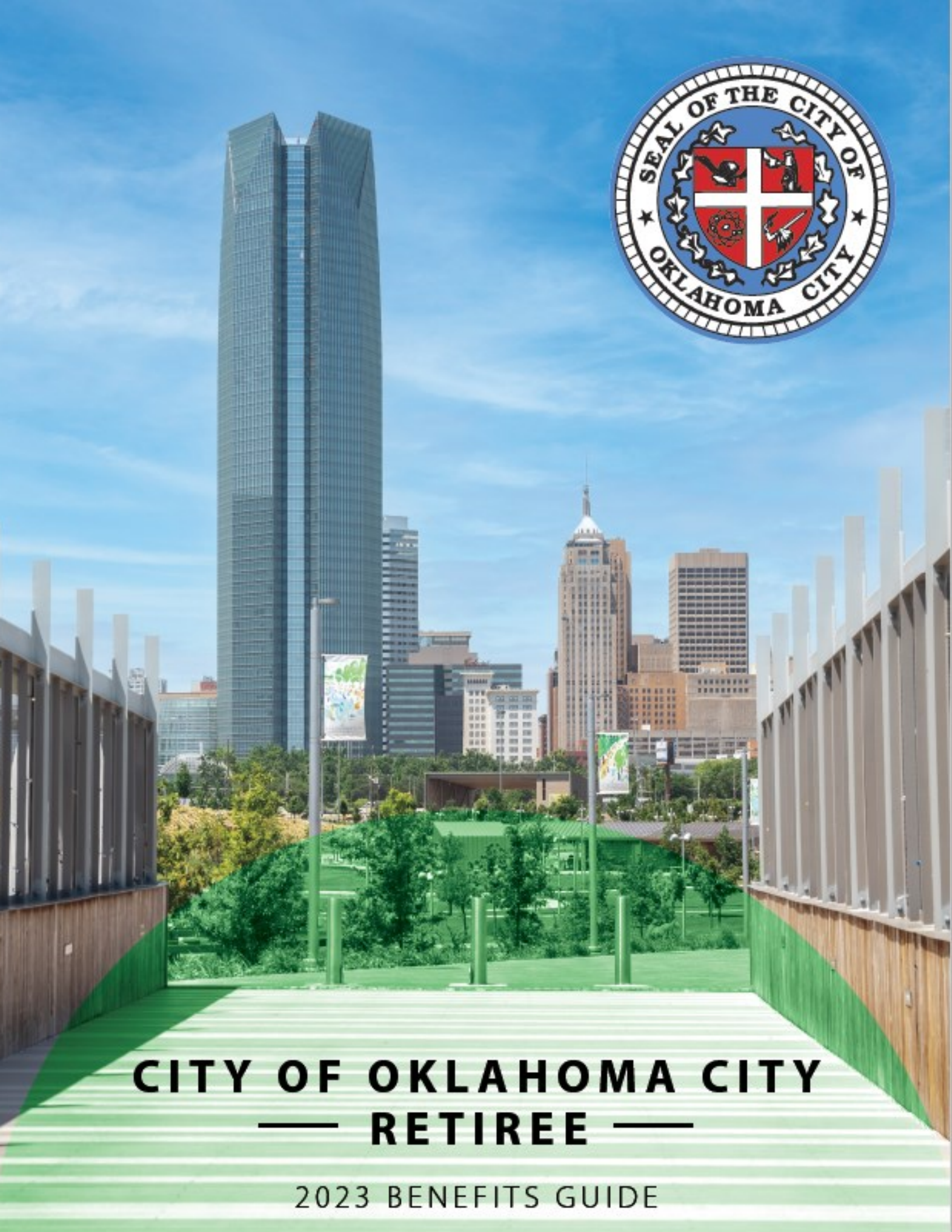


CITY OF OKLAHOMA CITY
RETIREE

2023 BENEFITS GUIDE

2023 Premium Rates

Health Maintenance Organization (HMO) and Medicare Advantage Plans Administered by UnitedHealthcare	UnitedHealthcare HMO (Non-Medicare)			Medicare Advantage Plan (Medicare)		
	Total	City	Retiree	Total	City	Retiree
Retiree Only	$1,524.16	$762.08	$762.08	$399.78	$199.89	$199.89
Retiree + Spouse	$3,429.35	$1,714.67	$1,714.68	$799.56	$399.78	$399.78
Retiree + Child	$2,667.10	$1,333.55	$1,333.55	$799.56	$399.78	$399.78
Retiree + Children*	$3,276.83	$1,638.41	$1,638.42	$1,199.34	$599.67	$599.67
Retiree + Family*	$4,724.71	$2,362.35	$2,362.36	$1,199.34	$599.67	$599.67

* For Medicare Advantage Plan maximum covered is 3 individuals; Retiree + 2 Dependents

BlueCross BlueShield PPO Plans	Non-Medicare			Medicare		
Alternate Plan Option	Total	City	Retiree	Total	City	Retiree
Retiree Only	$963.80	$481.90	$481.90	$419.52	$209.76	$209.76
Retiree + Spouse	$1,860.13	$930.06	$930.07	$796.15	$398.07	$398.08
Retiree + Child	$1,368.60	$684.30	$684.30	$589.00	$294.50	$294.50
Retiree + Children	$1,773.39	$886.69	$886.70	$758.47	$379.23	$379.24
Retiree + Family	$2,534.79	$1,267.39	$1,267.40	$1,079.06	$539.53	$539.53
Standard Plan Option	Non-Medicare Total	City	Retiree	Medicare Total	City	Retiree
Retiree Only	$1,642.56	$821.28	$821.28	$643.04	$321.52	$321.52
Retiree + Spouse	$3,170.14	$1,585.07	$1,585.07	$1,220.32	$610.16	$610.16
Retiree + Child	$2,332.44	$1,166.22	$1,166.22	$902.81	$451.40	$451.41
Retiree + Children	$3,022.31	$1,511.15	$1,511.16	$1,162.58	$581.29	$581.29
Retiree + Family	$4,319.93	$2,159.96	$2,159.97	$1,653.98	$826.99	$826.99

The City contributes 50% of the Total Premium for medical in 2023. 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	$32.37	Retiree Only	$21.95	Retiree Only	$7.00
Retiree + 1	$64.71	Retiree + 1	$43.93	Retiree + 1	$12.98
Retiree + 2 or more	$103.55	Retiree + 2 or more	$70.25	Retiree + 2 or more	$20.88

Group Term Life Insurance Administered by BCBS Life (formerly Dearborn National)	
Basic Life ($10,000)	$18.25

IMPORTANT NOTICE FOR PLAN YEAR 2023

****Changes to Dental and Vision Election Eligibility****

The 2023 Open Enrollment period will be the last opportunity for any retiree who previously waived dental and/or vision to elect dental and/or vision. Effective January 1, 2023, the City will not allow retirees to elect vision and dental after initial eligibility for coverage. In addition, once a retiree chooses to waive dental and/or vision coverage, the retiree will no longer be eligible to re-elect coverage. ***(See page 8 for additional info)***

This change will mirror the current election rules for medical and retiree life.

Friendly Reminder:

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

****However, please review the plan offerings for 2023****

Additional plan information is located at:

www.okc.gov/retirees

Contents:

For most current up to date retiree information, please visit **www.okc.gov/retirees (QR Code Below)**.

You will find important plan information and links that will assist you in keeping up to date regarding your benefit elections.

Things to Know for 2023

****Retiree Self-Service Enrollment****

Due to recent IT security updates, Self-Service will be unavailable for Open Enrollment for 2023. Changes may be submitted by completing the enclosed enrollment form or by attending on-site enrollment. Additional forms, including Address Change and Group Life Beneficiary, are located at www.okc.gov/retirees.

****2023 Essential Health Benefits Maximum Out-of-Pocket Limits****
(Retirees and Dependents without Medicare)

The Affordable Care Act (ACA) establishes a maximum annual out-of-pocket amount for in-network Essential Health Benefits (EHBs). This provision does not apply to the Medicare secondary plan or the Medicare Advantage plan as outlined in the Affordable Care Act. Copays, coinsurance and deductibles for all in-network plan benefits generally apply toward the out-of-pocket limits. For plan year 2023, the maximum essential health benefits in-network out-of-pocket limits for the City of Oklahoma City's plans are as follows:

BlueCross BlueShield PPO Plans:	
Medical and Prescription Benefit combined:	$9,100 retiree only coverage
	$18,200 retiree + 1 or more dependent(s)
UnitedHealthcare (HMO) Plan	
Medical and Prescription Benefit combined:	$9,100 retiree only coverage
	$18,200 retiree + 1 or more dependent(s)

**** UnitedHealthcare and OU Health Renew Relationship ****
UnitedHealthcare and OU Health have reached a multi-year agreement that restores network access to OU Health's hospitals and facilities for people enrolled in UnitedHealthcare employer-sponsored and Medicare Advantage plans.

****Medicare Advantage PPO****
This plan has no deductible, low copays for office visits and prescriptions and the member can see any provider that accepts Medicare nationwide. **Copays for prescriptions in the catastrophic phase will not be subject to the 5% copay.** To see specific copays for this plan, refer to pages 13 of this guide. The Medicare Advantage PPO plan offers Medicare eligible retirees and covered Medicare eligible dependents additional premium savings versus the Group Indemnity plan.

****HMO Prescription Formulary****
For 2023, United Healthcare is implementing a new formulary for the HMO plan. The Access Prescription Drug List will replace the formulary under the legacy SignatureValue plan. Some medications may change tiers under the new formulary, with the vast majority of 2023 changes resulting in a positive impact on the member. Plan design and pharmacy network remains the same with added member positive programs including access to a 90 day supply of approved maintenance medications at Walgreens and CVS.

Most members will see no impact to their prescription benefit. United Healthcare will notify impacted members, which may include lower-cost alternative options for review.

****Beneficiary Update/Changes for Retiree Group Life****
The City recommends that you provide updated beneficiary information at least every five years. Although your beneficiaries and/or designation of proceeds may not have changed, your beneficiaries address and/or contact information may not be current. Please take this opportunity to complete the Group Life Beneficiary Designation form located on the retiree website : **www.okc.gov/retirees**

****Dependent Verification****
Employee Benefits may periodically request verification to ensure current documentation for dependents enrolled in the City's medical and dental plans are on file. You may receive a letter requesting documentation for verification of eligibility. You must comply with the request. Failure to do so may result in loss of coverage for your dependent(s). You do not need to contact Employee Benefits to inquire about your file. If your file is selected for verification, you will receive a letter.

Important Dates to Remember...

Open Enrollment will be held at:

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

Staff will be available the week of October 24-28 (See Times Below) to answer questions and provide assistance. No appointments are necessary.

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

If you do not make any plan changes, your premiums will automatically adjust to the new rates for the 2023 plan year. Rates are on page 2 of this guide.

Open Enrollment			
Dates	**Times**	**Location**	**Coverage Period**
October 24, 2022 through October 28, 2022	8 a.m. to 4 p.m. Monday-Thursday 8 a.m. to noon Friday	Will Rogers Gardens 3400 NW 36th St. Oklahoma City, OK 73112	January 1, 2023 through December 31, 2023

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 for instructions.** The Form 135 can be downloaded from www.ok.gov/opprs

How to Enroll in your Benefits:

Two Ways to Enroll

1 Enroll On-Site

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

2 Enroll by Mail

Complete your personalized Enrollment Statement included in your enrollment packet and return by **October 31, 2022**. Additional enrollment instructions are provided on your statement.

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

About Your Coverage

Who is eligible for coverage?

Spouse and eligible child(ren) up to age 26 (disabled children over age 26 incapable of self-support) are eligible for medical, dental, and vision coverage at the time of initial enrollment or eligibility (birth and/or marriage). Elections must be made within 31 days of qualifying event. Retirees are responsible to provide any required supporting documents that establishes eligibility. Retirees and eligible dependents must maintain continuous coverage. Once coverage is waived, coverage cannot be re-elected at a later date.

Surviving spouse may elect coverage at initial enrollment for any child(ren) that were covered at the time of retiree's death. New spouses and any new dependents are not eligible to be added to a survivor's elected coverages.

About Your Coverage

Which medical 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.

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

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

  UHC HMO Plan
  BCBS Group Indemnity Plan (Standard or Alternate option), non-Medicare rate

- ***Myself or at least one covered dependent(s) are Medicare eligible but not ALL covered individuals***

  BCBS Group Indemnity Plan (Standard or Alternate option), Medicare rate

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

  UHC Medicare Advantage Plan (MAPD)
  BCBS Group Indemnity Plan (Standard or Alternate option), Medicare rate

***Updated for 2023** Rules for Medical, Dental, Vision, and Life Insurance*

Retirees are not eligible to enroll in medical, **(New for 2023) dental, vision**, and/or life insurance plans if you did not elect coverage with your initial application for benefits at the time of retirement.

***Updated for 2023** Declining Insurance Coverage*

You may decline medical, dental, vision, or life insurance. However, if you decline medical, **(New for 2023) dental, vision,** and/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.

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 Careers → Benefits 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.

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

Blue Cross Blue Shield (formerly Dearborn National) administers this plan.

HMO Plan

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

Medicare Advantage Plan (MAPD)

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

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

HMO Plan

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

All services are coordinated by a UnitedHealthcare primary care physician. The following summaries do not contain a complete listing of the exclusions, limitations, and conditions, which may apply to benefits shown.

For more information, call UnitedHealthcare at 1 800-825-9355. Group Number 10933

Primary Care Physician (PCP)

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

Specialty Care

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

Authorized Inpatient and Outpatient Care

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

Mail Order Prescription Drug Program

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

Your ID Card

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

UnitedHealthcare Website

Visit the UnitedHealthcare website at www.myuhc.com. The website features searchable provider and pharmacy directories, a searchable formulary and product line information. Questions? Call the Customer Service Department at 1 800-825-9355 or 1 800-557-7595 (TDHI).

Medicare Advantage Plan

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

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

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

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

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

Highlights include:

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

BlueCross Blue Shield PPO Plans

Plan Features	BlueCross BlueShield Standard	BlueCross BlueShield Alternate
Eligibility	Retirees and dependents	Retirees and dependents
Selection of Doctors and Hospitals	Member selects from the Blue Preferred PPO for in-network of providers. For out-of-network benefits, member selects the provider of choice.	Member selects from the Blue Preferred PPO for in-network of providers. For out-of-network benefits, member selects the provider of choice.
Deductible*		
-Individual	$250 (in-network), $300 (out-of-network)	$750 (in-network), $750 (out-of-network)
-Family	$500 (in-network), $900 (out-of-network)	$2,250 (in-network), $2,250 (out-of-network)
	*Accumulators for in-network and out-of-network deductibles are separate. For example, an individual could have a total deductible of $1,500 ($750 in-network + $750 out-of-network)	
Coinsurance	10% of eligible charges (in-network) 30% of eligible charges (out-of-network)	20% of eligible charges (in-network) 40% of eligible charges (out-of-network)
Coinsurance Maximum		
-Individual	$1,000(in-network), $3,300 (out-of-network)	$1,750 (in-network), $3,250 (out-of-network)
-Family	$3,000(in-network), Individual maximum applies to each family member out-of-network	$1,750 (in-network), $3,250 (out-of-network)
Annual Out-of-Pocket Maximums (does not include premiums)		
-Individual	Deductible + Coinsurance	Deductible + Coinsurance
-Family	Individual maximums apply for each family member up to family maximum (in-network).	Individual maximums apply for each family member up to family maximum.
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 (in-network only)*	$15 (in-network only)*
Preferred Brands	$30 (in-network only)*	$30 (in-network only)*
Non-Preferred Brands	$30 (in-network only)*	$60 (in-network only)*
90-day Mail Order	2 copays for up to a 90-day supply	2 copays for up to a 90-day supply
Contact Information for Additional Questions	www.myPrime.com	

***No benefit for out-of-network providers.**

Common Medical Event	Services You May Need	BlueCross BlueShield Standard	BlueCross BlueShield Alternate
If you visit a health care provider's office or clinic	**Primary care visit to treat an injury or illness**	$15 copay + deductible + coinsurance	$25 copay + deductible + coinsurance
	Specialist visit	$15 copay + deductible + coinsurance	$25 copay + deductible + coinsurance
	Screening / Immunization	Plan pays 100%	Plan pays 100%
	Chiropractic Care	$15 copay + deductible + coinsurance	$25 copay + deductible + coinsurance
If you have a test	**Diagnostic test (x-ray, blood work)**	$15 copay + deductible + coinsurance	$25 copay + deductible + coinsurance
	Imaging (CT/PET scans, MRIs)	$50 copay + deductible + coinsurance	$50 copay + deductible + coinsurance
If you have a hospital stay	**Facility fee (e.g. hospital room)**	$50 copay + deductible + coinsurance	$100 copay + deductible + coinsurance
	Physician / Surgeon fee	Deductible + coinsurance	Deductible + coinsurance
If you have outpatient facility services	**Facility fee (e.g. ambulatory surgery center)**	$50 copay + deductible + coinsurance	$50 copay + deductible + coinsurance
	Physician/surgeon fee	Deductible + coinsurance	Deductible + coinsurance
If you need immediate medical attention	**Emergency medical transportation**	EMSA paid at 100%, deductible waived. Other providers: deductible + coinsurance	EMSA paid at 100%, deductible waived. Other providers: deductible + coinsurance
	Emergency Room	$50 copay + deductible + coinsurance	$50 copay + deductible + coinsurance
	Urgent care	$15 copay + deductible + coinsurance	$25 copay + deductible + coinsurance
If you have mental health, behavioral health, or substance abuse needs	**Mental/Behavioral health outpatient services (office visit)**	$15 copay + deductible + coinsurance	$25 copay + deductible + coinsurance
	Mental/Behavioral health inpatient services	$50 copay + deductible + coinsurance	$100 copay + deductible + coinsurance
	Substance use disorder outpatient services (office visit)	$15 copay + deductible + coinsurance	$25 copay + deductible + coinsurance
	Substance use disorder inpatient services	$50 copay + deductible + coinsurance	$100 copay + deductible + coinsurance
If you have recovery or other special health needs	**Home health care**	Deductible + coinsurance (Maximum of 120 days)	Deductible + coinsurance (Maximum of 120 days)
	Rehabilitation services	Deductible + coinsurance	Deductible + coinsurance
	Skilled nursing care	Deductible + coinsurance (Limit 120 days)	Deductible + coinsurance (Limit 120 days)
	Durable medical equipment	Deductible + coinsurance	Deductible + coinsurance
	Vision Benefit	No benefit	No benefit

BlueCross Blue Shield PPO Health Plans

Group ID #019574

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

Two Plan Options

There are two plan options available: Alternate Plan and Standard Plan.
Summary charts are available on the previous pages to identify the differences.

Medicare

The plan offers retirees and covered dependents to be split participants under one plan. Split participant coverage is when one or more individual(s) is Medicare eligible and the other covered individual(s) are not Medicare eligible. Premiums reduce to the Medicare rate upon the first individual reaching Medicare eligibility. No further reductions in rate occurs for subsequent covered individual(s) becoming Medicare eligible.

Once a participant becomes Medicare Eligible, Medicare becomes the primary payer. BCBS will process claims and payments based on enrollment in Part A and B. Failure to maintain enrollment in Part A and/or Part B will result in you being responsible for payment of services that would have been covered under Medicare.

Prescription Plan

Prime Therapeutics is the pharmacy manager for this Plan. For questions, contact at Prime Therapeutics 877-357-7463 or via their website at www.myPrime.com or for mail order www.alliancerxwp.com. The plan utilizes a formulary for medications approved for use and/or covered by the plan.

The network does not include CVS pharmacies. If you have prescriptions with CVS or Express Scripts, you must transfer your prescriptions to a Prime Therapeutics network pharmacy in order to receive benefits.

- **Mail Order**
  AllianceRx Walgreens Prime offers the convenience and savings of a mail order program to get your prescriptions filled as a 90 day supply, while paying the equivalent of 2 monthly copays. For questions contact Prime Therapeutics at 877-357-7463 or via their website at www.alliancerxwp.com.

- **Prior Authorization**
  A prior authorization is a requirement that the physician obtain approval prior to prescribing a specific medication. Your physician will be responsible for submitting the required documentation.

- **Step Therapy**
  Some medications require that alternatives be prescribed and determined to be ineffective or not appropriate treatment options. Your physician will be responsible for submitting the required documentation.

BlueCross Blue Shield PPO Health Plans

The BlueCard Program

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

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.

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.

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.

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.

Claims

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.

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

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

Right of Subrogation

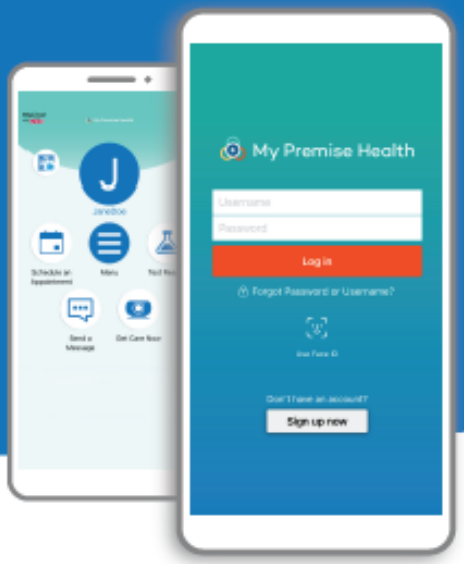
In the event you are injured in an accident caused by the negligence of a third party, (i.e. automobile accident, supermarket slip and fall, etc.), the Plans will pay eligible claims. However, the Plans reserve the right to recover expenses paid on your or your dependent's behalf, from the negligent 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

OKCCare Medical Center

Get, stay and be connected.



My Premise Health

My Premise Health is your secure patient portal that you can access online at **mypremisehealth.com** or through the **My Premise Health app**. It provides you with convenient access to your providers, health records, vital history, test results and more.

Convenience

- Schedule appointments
- Conduct virtual visits
- Get appointment confirmations and reminders
- Complete forms before your visit

Health management

- View lab results
- Manage medications
- Pay your bill
- View your visit history

Activate your account.

My Premise Health app | mypremisehealth.com

OKC Care Employee Medical Center
424 Colcord Drive, Ste A, Oklahoma City, OK
73102 Monday – Friday, 7:30 a.m. – 4:30 p.m.
(405) 276-2030

Premise Health. | OKCCare EMPLOYEE MEDICAL CENTER

OKCCare Medical Center

My Premise Health

Helpful resources

- Find directions, hours and contact information
- Access to health and wellness education

Secure communication

- Exchange private, secure messages with your providers
- Ask a question, get advice, confirm a result or get an update on your condition

Virtual health

- Online and mobile visits allow you to engage your providers remotely
- eVisits offer treatment for common conditions via secure messaging – without the need for a face-to-face encounter

How to activate your account:

1. Download the My Premise Health app or visit mypremisehealth.com.
2. Select "Sign up now." For assistance, call your wellness center or email mypremisehealthsupport@premisehealth.com. You can also visit mypremisehealth.com and click "Contact Support."

Who can use these services?

Eligible to all employees, retirees and dependents on the health plan.

Premise Health. | OKCCare EMPLOYEE MEDICAL CENTER

Managing your healthcare just got easier.

- Schedule appointments
- Conduct virtual visits
- View lab results
- Message your providers
- Manage medications
- Complete forms
- Pay your bill
- And more

BlueCross BlueShield Dental

Group ID#
K19574

Employee Information

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

Eligibility

The following eligibility provisions apply:

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

Pre-Existing Condition

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

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

Limitations

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

Freedom of Choice

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

Contracting Network Dentist

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

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

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

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

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

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

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

BlueCross BlueShield Dental

Dental Benefit Highlights

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

A Look at Your VSP Vision Coverage

With VSP and CITY OF OKLAHOMA CITY, your health comes first.

Enroll in VSP® Vision Care to get access to savings and personalized vision care from a VSP network doctor for you and your family.

Value and savings you love.
Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras which provide offers from VSP and leading industry brands totaling over $3,000 in savings.

Provider choices you want.
vsp PREMIER PROGRAM
Maximize your benefits at a Premier Program location, which is part of our incredible network of doctors.

Shop online and connect your benefits.
eyeconic
Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

Quality vision care you need.
You'll get great care from a VSP network doctor, including a WellVision Exam®. An annual eye exam not only helps you see well, but helps a doctor detect signs of eye conditions and health conditions, like diabetes and high blood pressure.

Using your benefit is easy!
Create an account on **vsp.com** to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

vsp vision care

More Ways to Save

Extra
$20
to spend on Featured Brands†

bebe · CALVIN KLEIN · COLE HAAN · DRAGON · FLEXON · LACOSTE · and more

See all brands and offers at **vsp.com/offers**.

+

Up to
40%
Savings on lens enhancements‡

Enroll through your employer today.
Contact us: **800.877.7195** or **vsp.com**

Your VSP Vision Benefits Summary

CITY OF OKLAHOMA CITY and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Choice
EFFECTIVE DATE:
01/01/2023

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10	Every calendar year
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES		**$25**	
FRAME†	• $190 featured frame brands allowance • $170 frame allowance • 20% savings on the amount over your allowance • $95 Walmart®/Sam's Club®/Costco® frame allowance	Included in Prescription Glasses	Every calendar year
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses	Every calendar year
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175	Every calendar year
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington.

About this Guide

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

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

Clerical Error/Delay

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

Eligibility

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

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

Monthly Premiums

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

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

Remember:

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

Health Care Reform Changes

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

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

As your former employer, we continue to implement provisions to comply with the requirements of the health care reform law. This summary focuses on the changes that affect you as an individual, as well as changes in the benefit programs we offer in 2023. We encourage you to pay careful attention to your health care benefits so you can keep up with the changes.

ACA Individual Mandate

Beginning in 2018, the Tax Cuts and Jobs Act (TCJA) repeals the penalty tax associated with the individual mandate under the Affordable Care Act.

Do I have to take the coverage my former employer offers me?

No. But you should be aware that in most cases, the election you make is considered irrevocable and cannot be reversed if you change your mind. If you did not elect to take employer-sponsored coverage at retirement, you should purchase coverage elsewhere, such as through a health insurance exchange. Additional information on health plans offered through the health insurance exchange can be found at www.healthcare.gov.

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

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

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

What should I consider when deciding whether to enroll in coverage offered through my former employer versus an exchange?

Employer-sponsored coverage is generally subsidized by the employer offering the coverage. This means the cost to you is most likely less than it would be if you purchased it on your own. In many cases, the amount of the employer contribution is more than the federal subsidy or tax credit that you would qualify for through a public exchange. Allowing us, as your former employer, to handle the design choices and narrow down the network of providers, as well as issue the required tax filings, can relieve you of many of the tasks that are inherent when purchasing coverage on your own.

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

The City of Oklahoma City currently offers medical and prescription benefits to retirees. Medical coverage must be elected within 31 days of retirement to be eligible to participate. The medical plan offerings for 2023 are on pages 10-17.

REQUIRED NOTICES

Important Notice from City of Oklahoma City About Your Prescription Drug Coverage and Medicare under the United Healthcare of Oklahoma and BlueCross BlueShield of Oklahoma Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Oklahoma City and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. City of Oklahoma City has determined that the prescription drug coverage offered by the United Healthcare of Oklahoma and BlueCross BlueShield of Oklahoma plan(s) is, 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 to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Oklahoma City coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may be able to get this coverage back.

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 City of Oklahoma City 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 October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed at the end of these notices 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 City of Oklahoma City changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

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

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Medicare Part D 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).

Date:	January 1, 2023
Name of Entity/Sender:	City of Oklahoma City
Contact—Position/Office:	Human Resources Employee Benefits Division
Address:	420 West Main, Suite 110 Oklahoma City, OK 73102
Phone Number:	405-297-2144

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

» All stages of reconstruction of the breast on which the mastectomy was performed;
» Surgery and reconstruction of the other breast to produce a symmetrical appearance;
» Prostheses; and
» Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources Employee Benefits Division at 405-297-2144.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources Employee Benefits Division at 405-297-2144.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:
» Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
» Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
» Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
» Failing to return from an FMLA leave of absence; and
» Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent(s) other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources Employee Benefits Division at 405-297-2144.

Medicare Secondary Payer Laws

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

INELIGIBLE DEPENDENTS

You must notify the Employee Benefits Division within 31 days of a qualifying event (Human Resources Policies Sections 717.02 and 717.03).

It is a fraudulent act to knowingly add or maintain ineligible dependents on the City's benefit plans. If the information provided to the Employee Benefits Office of the Human Resources is determined to be false or misleading, you may be subject to legal action up to and including reimbursement to the City of premiums paid on behalf of ineligible dependent and/or termination of retiree coverage(s).

In addition, failure to notify the Human Resources, Employee Benefits Division, in writing of any change in marital status and/or change in dependent status that results in the improper extension of health and welfare benefits, you may be subject to legal action up to and including reimbursement to the City of premiums paid on behalf of ineligible dependent and/or termination of retiree coverage(s).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid

WEBSITE	http://myalhipp.com/
PHONE	1-855-692-5447

ALASKA – Medicaid

	The AK Health Insurance Premium Payment Program
WEBSITE	http://myakhipp.com/
PHONE	1-866-251-4861
EMAIL	CustomerService@MyAKHIPP.com
MEDICAID ELIGIBILITY	https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

WEBSITE	http://myarhipp.com/
PHONE	1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

	Health Insurance Premium Payment (HIPP) Program
WEBSITE	http://dhcs.ca.gov/hipp
PHONE	916-445-8322 / (fax) 916-440-5676
EMAIL:	hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

WEBSITE	Health First Colorado Website: https://www.healthfirstcolorado.com/
PHONE	Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711
CHP+ WEBSITE	https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ PHONE	Customer Service: 1-800-359-1991 / State Relay 711
WEBSITE	Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
PHONE	HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

WEBSITE	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
PHONE	1-877-357-3268

GEORGIA – Medicaid

A HIPP WEBSITE	https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
PHONE	678-564-1162, Press 1
GA CHIPRA WEBSITE	https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
PHONE	678-564-1162, Press 2

INDIANA – Medicaid

	Healthy Indiana Plan for low-income adults 19-64
WEBSITE	http://www.in.gov/fssa/hip/
PHONE	1-877-438-4479
	All other Medicaid
WEBSITE	https://www.in.gov/medicaid/
PHONE	1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

MEDICAID WEBSITE	https://dhs.iowa.gov/ime/members
MEDICAID PHONE	1-800-338-8366
HAWKI WEBSITE	http://dhs.iowa.gov/Hawki
HAWKI PHONE	1-800-257-8563
HIPP WEBSITE	https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP PHONE	1-888-346-9562

KANSAS – Medicaid

WEBSITE	https://www.kancare.ks.gov/
PHONE	1-800-792-4884

KENTUCKY – Medicaid

	Kentucky Integrated Health Insurance Premium Payment (KI-HIPP) Program
WEBSITE	https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
PHONE	1-855-459-6328
EMAIL	KIHIPP.PROGRAM@ky.gov
KCHIP WEBSITE	https://kidshealth.ky.gov/Pages/index.aspx
KCHIP PHONE	1-877-524-4718
KENTUCKY MEDICAID WEBSITE	https://chfs.ky.gov

LOUISIANA – Medicaid

WEBSITE	www.medicaid.la.gov or www.ldh.la.gov/lahipp
PHONE	1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

ENROLLMENT WEBSITE	https://www.maine.gov/dhhs/ofi/applications-forms
PHONE	1-800-442-6003 TTY: Maine relay 711
WEBSITE	Private Health Insurance Premium https://www.maine.gov/dhhs/ofi/applications-forms
PHONE	1-800-977-6740 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

WEBSITE	https://www.mass.gov/masshealth/pa
PHONE	1-800-862-4840 TTY: 617-886-8102

MINNESOTA – Medicaid

WEBSITE https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
PHONE 1-800-657-3739

MISSOURI – Medicaid

WEBSITE http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
PHONE 573-751-2005

MONTANA – Medicaid

WEBSITE http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
PHONE 1-800-694-3084
EMAIL HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

WEBSITE http://www.ACCESSNebraska.ne.gov
PHONE 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

MEDICAID WEBSITE http://dhcfp.nv.gov
MEDICAID PHONE 1-800-992-0900

NEW HAMPSHIRE – Medicaid

WEBSITE https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
PHONE 603-271-5218
TOLL FREE FOR HIPP PROGRAM 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

MEDICAID WEBSITE http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
MEDICAID PHONE 609-631-2392
CHIP WEBSITE http://www.njfamilycare.org/index.html
CHIP PHONE 1-800-701-0710

NEW YORK – Medicaid

WEBSITE https://www.health.ny.gov/health_care/medicaid/
PHONE 1-800-541-2831

NORTH CAROLINA – Medicaid

WEBSITE https://medicaid.ncdhhs.gov/
PHONE 919-855-4100

NORTH DAKOTA – Medicaid

WEBSITE http://www.nd.gov/dhs/services/medicalserv/medicaid/
PHONE 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

WEBSITE http://www.insureoklahoma.org
PHONE 1-888-365-3742

OREGON – Medicaid

WEBSITE http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
PHONE 1-800-699-9075

PENNSYLVANIA – Medicaid

WEBSITE https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
PHONE 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

WEBSITE http://www.eohhs.ri.gov/
PHONE 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid

WEBSITE https://www.scdhhs.gov
PHONE 1-888-549-0820

SOUTH DAKOTA - Medicaid

WEBSITE http://dss.sd.gov
PHONE 1-888-828-0059

TEXAS – Medicaid

WEBSITE http://gethipptexas.com/
PHONE 1-800-440-0493

UTAH – Medicaid and CHIP

MEDICAID WEBSITE https://medicaid.utah.gov/
CHIP WEBSITE http://health.utah.gov/chip
PHONE 1-877-543-7669

VERMONT– Medicaid

WEBSITE http://www.greenmountaincare.org/
PHONE 1-800-250-8427

VIRGINIA – Medicaid and CHIP

WEBSITE https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
MEDICAID AND CHIP PHONE 1-800-432-5924

WASHINGTON – Medicaid

WEBSITE https://www.hca.wa.gov/
PHONE 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

WEBSITE http://dhhr.wv.gov/bms
http://mywvhipp.com
MEDICAID PHONE 304-558-1700
CHIP TOLL-FREE 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

WEBSITE https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
PHONE 1-800-362-3002

WYOMING – Medicaid

WEBSITE https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
PHONE 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits
Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare
& Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

NOTES:

NOTES:

Vendor Directory

Provider	Group Number	Hours	Phone #	Web Address
Health Maintenance Organizations (HMO)				
UnitedHealthcare HMO	10933	M—F 7 a.m. to 9 p.m. CST	1-800-825-9355	www.myuhc.com
Medicare Advantage	12299-01	M—F 8 a.m. to 8 p.m. CST	1-800-457-8506 (current members) 1-877-714-0178 (prospective members)	retiree.uhc.com
BlueCross BlueShield PPO Health Plans				
BlueCross BlueShield of Oklahoma, Health Plan Administrator	19574	M—F 8 a.m. to 8 p.m. CST	1-877-219-4301	www.bcbsok.com/okc
Prime Therapeutics, LLC Pharmacy Plan Administrator	19574	M—F 8 a.m.—6 p.m. CST	1-877-357-7463	www.myPrime.com www.alliancerxwp.com (mail order)
Dental Plan				
BlueCross BlueShield of Oklahoma, Dental	K19574	M—Th 7:30 a.m. to 5 p.m. F 8 a.m. to 5 p.m. CST	1-888-381-9727	www.bcbsok.com/okc
Vision				
VSP	30021658	M—F 7 a.m. to 9 p.m. CST	1-800-877-7195	www.vsp.com
Life Insurance				
Blue Cross Blue Shield	GAE00255	M—F 7 a.m. to 7 p.m. CST	1-888-778-2281	
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.opprs.ok.gov
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				
Mission Square Retirement (formerly ICMA-RC)	N/A	M—F 8:30 a.m. to 9 p.m. EST	1-800-669-7400	www.icmarc.com
Nationwide Retirement Solutions	N/A	M—F 8 a.m. to 9 p.m. EST	1-877-677-3678	www.nationwide.com
Other				
The City of Oklahoma City Employee Benefits Division	N/A	M—F 8 a.m. to 5 p.m. CST	(405) 297-2144 employee.benefits@okc.gov	www.okc.gov/retirees
Medicare	N/A		1-800-633-4227	www.medicare.gov
Healthcare Exchange	N/A			www.healthcare.gov