2018

CITY OF OKLAHOMA CITY

FIREFIGHTER BENEFITS GUIDE

City of Oklahoma City

Dear City of Oklahoma City Employee,

It's benefit enrollment time again and the City has put together the following guide to help you prepare for the 2018 plan year. We recognize the importance of benefits for you and your family, that's why we take the time to carefully select providers that can best serve our employees. We know you don't make your benefit decisions lightly, which is why we are dedicated to partnering with providers who offer quality benefits.

We encourage you to review the following benefit guide prior to completing self-service enrollment through eBenefits, attending on-site enrollment and/or completing your enrollment forms. Enrollment counselors will be available throughout the open enrollment process to assist you in enrolling in your benefits and to answer any questions you may have. To see a complete schedule of this year's open enrollment sessions at the Civic Center, please see page 6.

The Employee Benefits Division of the Personnel Department developed the following benefit guide to provide you with information about your benefit options for the new plan year, explain the enrollment and change process, and serve as a valuable resource for information about City benefits. Since you are participating, or eligible to participate, in the Fire Fighters Health and Welfare Trust, this guide only pertains to benefits available through the City of Oklahoma City. You will need to consult your Trust administrator for all other questions.

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

Sincerely,

Dianna L. Berry
Director of Personnel

Jeanna Jordan
Interim Employee Benefits Manager

Table of Contents

About this Guide

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

HIPAA Compliance

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

Administrative Information

Clerical Error/Delay

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

Helpful Tips

Enroll Online

All eligible employees can enroll in their Vision Benefits and an FSA plan online.
Visit https://okcpeople.okc.gov.

For instructions on enrolling online, see page 7.

Benefits Enrollment

ENROLLMENT SCHEDULE FOR PLAN YEAR 2018
THREE EASY WAYS TO ENROLL
BENEFIT HIGHLIGHTS
SECTION 125 CAFETERIA PLAN
HEALTH CARE REFORM CHANGES
HEALTH INSURANCE MARKETPLACE EXCHANGE

Enrollment Schedule for Plan Year 2018

Important Dates to Remember

Your On-Site Enrollment Dates are:

October 16, 2017 - October 20, 2017

8:00 a.m. -5:00 p.m.

Civic Center Hall of Mirrors

Your Period of Coverage Dates are:

January 1, 2018 - December 31, 2018

Enrollment Form Changes Due:

October 31, 2017

Online Enrollment Changes Due:

October 31, 2017

Required Open Enrollment Legal Documentation Due:

October 31, 2017

Confirmation Statement Changes Due:

November 18, 2017

City Benefits

You are eligible to participate in the following City benefits:

- Vision Plan
- Long-Term Disability Plan
- Health and Dependent Care Flexible Spending Accounts
- Employee Assistance Program
- Accident Insurance Plan
- Cancer Insurance Plan
- Individual Term Life Insurance Plan

Health, Dental and Life Insurance

Your enrollment form for Health, Dental and Life Insurance will be provided by the Fire Fighter's Health and Welfare Trust. Any changes to your Health, Dental, Life, or any other administered benefit should be provided directly to the Trust.

Annual Open Enrollment

Each year Open Enrollment provides you an opportunity to change plans and modify dependent coverage. Changes made become effective January 1, 2018 and will remain in effect through the plan year (January 1, 2018 - December 31, 2018). The Health Flexible Spending Account and Dependent Care Spending Account require a new election every year.

What You Need to Do During Annual Open Enrollment

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

NOTE: If dependent eligibility changes during the year you must notify the Employee Benefits Division of the Personnel Department within 31 days of the qualifying event. (Personnel Policies Section 717.02 and 717.03)

1st Deduction in 2018

The first premium for 2018 will be deducted from earnings on the January 5, 2018 pay date. **Remember to review your paycheck to ensure that the proper premiums are being deducted based on your enrollment elections.**

Remember: You must re-enroll in the Health and/or Dependent Care Flexible Spending Account EACH YEAR! If you are not making any other changes, it is not necessary to return your enrollment statement.

Three Easy Ways to Enroll

1 Enroll Online

Enroll online from the convenience of your home using eBenefits. Note: by enrolling online you can **only** enroll in the Vision Plan and Flexible Spending Accounts. If you wish to enroll in voluntary products (Long-Term Disability, Cancer, Accident Only, or Individual Term Life plans), you will need to attend the on-site enrollment. **If you add a dependent(s) to vision coverage a copy of the State issued birth certificate or marriage license, and Social Security card is required.**

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

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

If you are adding dependents to vision coverage you will need to enroll on-site or by mail.

2 Enroll On-Site

On-site enrollment for your City Benefits will be held October 16-20, 2017 from 8:00 a.m. - 5:00 p.m at the Civic Center Music Hall - 2nd floor Hall of Mirrors.

By enrolling on-site you can enroll in:	
• Vision	• Cancer Insurance
• Long-Term Disability Income Insurance	• Flexible Spending Accounts
• Individual Term Life	• Fitness Center
• Accident Only Insurance	

3 Enroll by Mail

Complete your personalized Oklahoma City Enrollment Statement included in your enrollment packet and return it by October 31, 2017. Additional enrollment instructions are provided on your statement.

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

Benefit Highlights

When Does My Period of Coverage Begin for My City Benefits?

Current Employees: Your period of coverage is January 1, 2018 through December 31, 2018. See page 27 for additional information about changing your FSA coverage.

New Employees: If you are a new employee, your period of coverage begins on the first day of the month following one month of employment excluding the month of hire. If you do not complete a form during this initial eligibility period, you must wait until the next annual Open Enrollment or until you experience a valid change in status. (See page 27 for FSA coverage only).

Coverage Ending Dates for City Benefits

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

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

Coverage Ending Dates for Dependents

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

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

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

- The date the child is no longer dependent on the employee for support
- The date the employee fails to provide any required proof of the uninterrupted continuation of the disability or fails to submit to any required examinations

Permitted Mid-Year Election Changes for FSA and Voluntary Benefits

The benefits you elect at Open Enrollment will remain in effect for the entire plan year unless you have an eligible change in status or a qualifying event such as:

- Marriage, divorce or legal separation
- Birth, adoption, legal custody or guardianship of a child
- Death of a spouse or dependent
- Dependent gains or loses eligibility
- Change in residence that affect eligibility
- Change in employment status affecting eligibility
- Entitlement to Medicare or Medicaid
- Court orders (including judgements, decrees or qualified medical child support orders)
- Open enrollment of a spouse

When you have an eligible change in status and need to add or drop dependent coverage, you must notify the Employee Benefits Division within 31 calendar days from the event. (Personnel Policy Sections 717.02 and 717.03)

Benefit Highlights

Recognizing Your Needs

Structuring your Benefits

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

Group Plans

A group plan is a single policy covering a group of individuals. Group benefits available to you from The City of Oklahoma City include:

- Vision Plan
- Long Term Disability Plan
- Health and Dependent Care Flexible Spending Accounts
- Employee Assistance Program

Upon termination of active job status, the group plans will terminate.

Individual Plans

An individual plan is owned by the employee and premiums are based on individual assessment and are subject to review and approval by the provider company. Individual benefits include:

- Accident Insurance
- Cancer Insurance
- Individual Term Life Insurance

If your employment with the City ends, you can continue the individual plans through direct billing from the carrier. If you have questions regarding your City benefits, contact a representative of the Employee Benefits Division or the appropriate Plan provider.

Section 125 Plan

Section 125 Plan

Section 125 Cafeteria Plan

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

Benefits Eligible for Section 125 Cafeteria Plan

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

* Benefit provided by the Fire Fighters Health and Welfare Trust

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

Section 125 Example

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

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

Health Care Reform Changes

A Summary of Impacts on Employees

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

The Patient Protection and Affordable Care Act, also known as health care reform or the Affordable Care Act, was enacted on March 23, 2010, 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 over the past three years. 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.

As your employer, we continue to implement provisions to comply with the requirements of the health care reform law. This summary focuses on the changes that affect you as an individual, as well as changes in the benefit programs we offer in 2018. 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 do 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.

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

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

Penalty assessed when you file your taxes if not enrolled in a "Minimum Essential Coverage" Plan. The penalties will be increased by the cost-of-living adjustment. As of the date of the publication, the 2018 information is not available.

	Flat Dollar		Percentage of Income
Year	Adults in Household	Children In household 18 Years or Younger	Calculated when filing taxes for the applicable year*
2017	$695	$347.50	2.5%

* *The penalty amount is determined by subtracting exemptions and standard deductions from 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

A Summary of Impacts on Employees

Where can I get coverage if I do not want my employer's coverage?
The federal government and states are in the process of setting 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 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, an employee must have household income of between 100 percent and 400 percent of the federal poverty line. Plus, the cost of health insurance premiums must exceed 9.56 percent of household income.

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

Health Insurance Marketplace Exchange

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment ¬based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 2017 for coverage starting as early as January 1, 2018.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.56% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after- tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the **Oklahoma City Fire Fighters Health and Welfare Trust 405-232-9543.**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Health Insurance Marketplace Exchange

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name : **City of Oklahoma City**
4. Employer Identification Number (EIN) : **736005359**
5. Employer address: **420 W. Main St. Ste 110**
6. Employer phone number: **405-297-2530**
7. City: **Oklahoma City** 8. State: **Oklahoma** 9. ZIP code: **73102**
10. Who can we contact about employee health coverage at this job? **Oklahoma City Fire Fighters Health and Welfare Trust 405-232-9543**
11. Phone number (if different from above) **405-232-9543**
12. Email address: **pbolin@local157.org**

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

- As your employer, we offer a health plan to some employees: Eligible employees are classified as a regular, full-time active fire fighter.
- With respect to dependents: We do offer coverage. Eligible dependents are:
  - Spouse;
  - Child(ren) up to the age of 26;
  - Legally adopted children
  - Child(ren) who are physically or mentally incapable of self support on the date coverage would otherwise end.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months: **Yes, eligible employees are those currently classified as a regular, full-time active fire fighter. Open Enrollment to add or change coverage is October 23-26, 2017 to be effective January 1, 2018. New full-time active fire fighters are eligible for benefits 1st of the month following 30 days of employment.**
14. Does the employer offer a health plan that meets the minimum value standard*? **Yes**
15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee: How much would the employee have to pay in premiums for this plan? $29.32 per pay period (24 pay periods).

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

Helpful Tips

Make Changes

Open enrollment is your opportunity to make changes to your coverage each year. Employees must notify Employee Benefits within 31 days of the event to update coverage. Common qualifying events are marriage, divorce or birth of a child.

Insurance Plans

VISION CARE PLAN
LONG-TERM DISABILITY INCOME INSURANCE
INDIVIDUAL TERM LIFE INSURANCE
ACCIDENT ONLY INSURANCE
CANCER INSURANCE

Vision Care Plan

VSP

Your VSP Vision Benefits Summary

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

You'll Like What You See with VSP

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

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

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

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

Using your VSP benefit is easy.

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

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

Choice in Eyewear

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

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

vsp.com
800-877-7195

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

Vision Care Plan

VSP

VSP Vision Plan	Rates
Member Only	$3.50
Member + 1	$6.49
Member + 2 or more	$10.44

VSP Doctor Network: VSP Choice

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

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

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

Long-Term Disability Income Insurance

American Fidelity Assurance Company

How do you pay for your mortgage, bills, food and other monthly expenses? If your paycheck stopped today, could you maintain your current lifestyle?

American Fidelity's Long-Term Disability Income Insurance is designed to help protect you if you become disabled and cannot work due to a covered Accidental Injury or Sickness.

How the Plan Works

If you become disabled due to a covered accident or sickness, long-term disability income insurance will pay up to 60% of your monthly income once you have satisfied the elimination period. Disability benefits will be payable up to the benefit period stated in your policy.

Benefits Begin

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

Eligibility

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

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

Limitations, exclusions, and waiting periods apply. Refer to your policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage.**

Individual Term Life Insurance

American Fidelity Assurance Company

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

American Fidelity offers an Individual Term Life Insurance policy to help with your financial needs for your short-term and long-term goals.

How the Plan Works

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

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

Optional Riders

Enhance your base plan with the following riders:

- **Spouse Term Rider**
- **Children's Term Rider**

Coverage Feature	What It Means To You
Three Plan Options: 10, 20 and 30-Year Level Term Coverage	Choose the coverage period to meet your financial needs.
Guaranteed Premium	Your premiums are guaranteed for each applicable period.
Guaranteed Death Benefit	Your death benefit is guaranteed for the life of the policy provided premiums are paid.
Accelerated Death Benefit	Receive a portion of the chosen death benefit if you are diagnosed with a terminal condition. Limitations and exclusions may apply.
Conversion Benefit	Turn your policy into a permanent plan any time up to age 75. The rate for your new plan will be based on your attained age.
Guaranteed Renewable	Renew your policy up to age 90 regardless of your health.
Interim Coverage	You will be covered from the date of your application if you are insurable for the requested coverage on the date the policy takes effect. This Interim Coverage will remain in force until the policy has been issued or declined.
Enhance Your Coverage	Add an optional Spouse Term or Children's Term Rider to expand your policy.
Easy Application	No medical exams and minimal health questions.[1]
Portable	You own the policy. Take the coverage with you if you choose to leave your current job.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

[1] *Issuance of the policy may depend on the answer to these question.*

Limitations, exclusions, and waiting periods apply. Refer to your policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage.** The company has the right to change premiums by class. The premium and amount of benefits provided vary dependent upon the plan selected. **Individuals life plans do not qualify under Section 125.**

Accident Only Insurance

Limited Benefit Accident Only Insurance

American Fidelity Assurance Company

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

American Fidelity's Accident Only Insurance policy provides you a solution for those unforeseen accidents that life sometimes delivers. Our Limited Benefit Accident Only Insurance is designed to help pay for the unexpected medical expenses an individual may incur for the treatment of covered injuries received in an accident.

How the Plan Works

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

All benefits are only paid as a result of Injuries received in an accident that occurs while coverage is in force. All treatment, procedures, and medical equipment must be diagnosed, recommended and treated by a physician. All benefits are paid once per covered person per covered accident unless otherwise specified in the limitations and exclusions section.[1]

[1]*Premium and amount of benefits may vary dependent upon plan selected.*

Optional Accident Disability Income Rider

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

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

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

Cancer Insurance

Limited Benefit Cancer Indemnity Insurance Policy

American Fidelity Assurance Company

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

American Fidelity's Cancer Insurance can help offer financial protection so you can focus your attention on fighting cancer. We offer plans that can help assist with out-of-pocket costs often associated with a cancer diagnosis.

How the Plan Works

Our plan is designed to help cover expenses if you are diagnosed with a covered Cancer. With over 20 benefits available to you, this plan provides benefits for the treatment of cancer, transportation, hospitalization and more. We provide the money directly to you, to be used however you see fit.

Optional Riders

Enhance your base plan with the following riders:

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

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

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

FLEXIBLE

Helpful Tips

Elect FSA

You must re-enroll in the Health and/or Dependent Care Flexible Spending Account (FSA) each year. If you currently participate in the Health Flexible Spending Account, verify the expiration date on your current debit card. New debit cards are sent every three years.

E SPENDING ACCOUNT

HEALTH FSA
DEPENDENT DAY CARE FSA
HEALTH FSA DEBIT CARD
CHANGING YOUR COVERAGE

Flexible Spending Accounts

American Fidelity Assurance Company

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

Flexible Spending Account Savings Example

With FSA		Without FSA
$30,000	Annual Gross Income	$30,000
- $2,500	Health FSA Deposit	$0
- $5,000	Dependent Care Account Deposit	$0
$22,500	Taxable Gross Income	$30,000
- $4,500	Estimated Federal Tax (20%)	- 6,000
- $1,721.25	Estimated FICA (7.65%)	- 2,295
$16,278.75	Annual Net Income	$21,705
$0	Cost of Medical Expenses	- $2,500
$0	Cost of Dependent Care Expenses	- $5,000
$16,278.75	**Spendable Income**	**$14,205**
With an FSA you have a potential annual savings of: $2,073.75		

By using an FSA to pay for eligible recurring expenses, you can cut down on your taxable income which will result in additional spendable income.

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

Healthcare Flexible Spending Account

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

Minimum Annual Deposit: $150
Maximum Annual Deposit: $2,600

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

FSA Fund Availability

Healthcare FSA

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

Dependent Care Account (DCA)

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

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

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

Dependent Care Account (DCA)

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

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

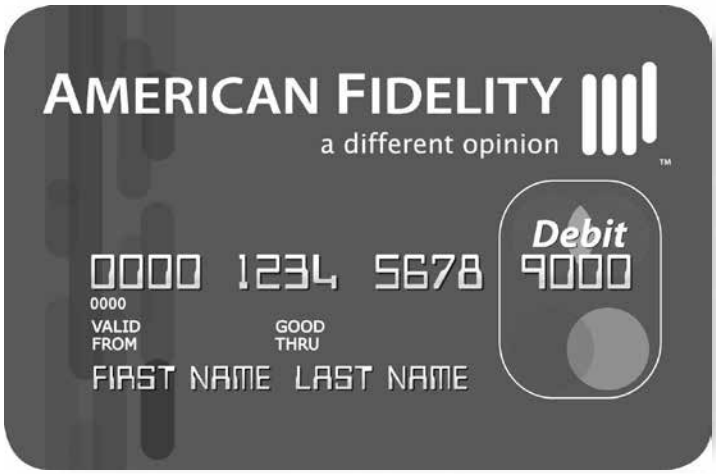
SB-23290-0817

Flexible Spending Accounts

Benefits Debit Card

Benefits Debit Card

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



Using Your Benefits Debit Card

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

Cards for Healthcare FSAs can be used at:

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

Snap. Submit. And Go!

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

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

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

SB-23290-0817

Flexible Spending Accounts

American Fidelity Assurance Company

Important FSA Notes

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

Direct Deposit

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

Three ways to sign up for direct deposit:

1. Through AFreimburse.
2. Online through your account at americanfidelity.com.
3. By paper by downloading a direct deposit request form.

Manage Your Reimbursement Account With AFreimburse™

American Fidelity is excited to introduce our new mobile app, AFreimburse™! AFreimburse allows FSA and HRA participants to submit reimbursement account claims while on the go. Our mobile app allows customers to:

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

Download AFreimburse. To register, you will need:

- Your employee ID - for most participants this is your Social Security Number.
- A registration ID - which is your Benefits Debit Card number, or your employer ID AFA165.

Using Our Online Portal

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

Getting started

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

Flexible Spending Accounts

Changing Your Coverage

Changing your FSA during the Plan Year

Within 31 days of a qualifying event, you must submit supporting documentation to your employer. Upon the approval of your election change request, your existing FSA(s) elections will be stopped or modified (as appropriate).

Changes in Status	
Marital Status	A change in marital status includes marriage, death of a spouse, divorce or annulment (legal separation is not recognized in all states).
Change in Number of Tax Dependents	A change in number of dependents includes the following: birth, death, adoption and placement for adoption. You can add existing dependents not previously enrolled whenever a dependent gains eligibility as a result of a valid Change in Status event.
Change in Status of Employment Affecting Coverage Eligibility	Change in employment status of the employee, or a spouse or dependent of the employee, that affects the individual's eligibility under an employer's plan includes commencement or termination of employment.
Gain or Loss of Dependents' Eligibility Status	An event that causes an employee's dependent to satisfy or cease to satisfy coverage requirements under an employer's plan may include change in age, marital, employment or tax dependent status.
Change in Residence*	A change in the place of residence of the employee, spouse or dependent that affects eligibility to be covered under an employer's plan includes moving out of a HMO service area.
Some Other Permitted Changes	
Coverage and Cost Changes*	Your employer's plans may permit election changes due to cost or coverage changes. You may make a corresponding election change to your Dependent Day Care FSA benefit whenever you actually switch dependent care providers. However, if a relative (who is related by blood or marriage) provides custodial care for your eligible dependent, you cannot change your salary reduction amount solely on a desire to increase or decrease the amount being paid to that relative.
Open Enrollment Under Other Employer's Plan*	You may make an election change when your spouse or dependent makes an Open Enrollment Change in coverage under their employer's plan if they participate in their employer's plan and: • the other employer's plan has a different period of coverage (usually a plan year) or • the other employer's plan permits mid-plan year election changes under this event.
Judgement/Decree/Order**	If a judgment, decree or order from a divorce, legal separation (if recognized by state law), annulment or change in legal custody requires that you provide accident or health coverage for your dependent child (including a foster child who is your dependent), you may change your election to provide coverage for the dependent child. If the order requires that another individual (including your spouse and former spouse) covers the dependent child and provides coverage under that individual's plan, you may change your election to revoke coverage only for that dependent child and only if the other individual actually provides the coverage.
Medicare/Medicaid**	Gain or loss of Medicare/Medicaid coverage may trigger a permitted election change.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	If your employer's group health plan(s) are subject to HIPAA's special enrollment provision, the IRS regulations regarding HIPAA's special enrollment rights provide that an IRC § 125 cafeteria plan may permit you to change a salary reduction election to pay for the extra cost for group health coverage, on a pre-tax basis, effective retroactive to the date of the CIS event, if you enroll your new dependent within 30 days of one of the following CIS events: birth, adoption or placement for adoption. Note that a Medical Expense FSA is not subject to HIPAA's special enrollment provisions if it is funded solely by employee contributions.
Family and Medical Leave Act (FMLA) Leave of Absence	Election changes may be made under the special rules relating to changes in elections by employees taking FMLA leave. Contact your employer for additional information.

** Does not apply to a Health FSA.*

*** Does not apply to a Dependent Day Care FSA.*

Helpful Tips

Enroll Online

The City has several different beneficiary forms:

1) Final Payout - HRIS
2) Retirement Savings - Retirement
    a) Oklahoma Fire Pension & Retirement System
    b) ICMA-RC
    c) Nationwide

You may change beneficiaries at ANY time.

OTHER CITY BENEFITS

Employee Assistance Program

Fitness Center

IRC 457 Deferred Compensation

Employee Assistance Program

Alliance Work Partners

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

Your EAP Benefits

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

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

WorkLife
Resources and referrals for everyday needs. Available by telephone.

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

1 to 6 Counseling Sessions
Per issue, per year. Short-term counseling sessions which include assessment, referral, and crisis services.

All benefits can be accessed by calling:

800-343-3822

We are available to take your call 24 hours a day, 7 days a week.

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

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

Initial Login:
registration code: awp-okc-2151
You will be prompted to create your own unique username and password.

Employee Assistance Program

Alliance Work Partners

Criteria for Benefits Eligibility

Full Benefits:

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

Assessment & Referral:

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

Information & Referral

- Anyone contacting Alliance Work Partners regardless of contract status

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

Fitness Center

10GYM, LLC and Gold's Gym

10GYM

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

Membership Includes:

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

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

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

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

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

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

Gold's Gym

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

Additional Amenities (vary by location):

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

Membership:
Individual Membership $19.95 per month ($9.97 plus tax per pay period)
Individual + 1 Membership $ 39.90 ($19.95 plus tax per pay period)

Additional Family Member:
Family Membership (covers up to 4 members) $65.95 per month ($32.97 plus tax per pay period)

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

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

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

IRC 457 Deferred Compensation

ICMA Retirement Corporation
Nationwide Retirement Solutions, Inc.

IRC 457 Deferred Compensation

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

Advantages

- Reduce current income taxes while boosting retirement savings
- Earnings accumulate tax-deferred
- Portability. Beginning in 2002, an employee can move savings to another governmental 457 plan, IRA, or qualified plan

Withdrawals

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

- Retirement or separation of service
- Qualified unforeseeable emergency

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

How Much Can I Contribute?

Contribution Limits for Eligible 457(b) Deferred Compensation Plans* This information is not intended as tax advice. It is provided for your education only.	
Annual Contribution Limit	Annual cost of living adjustments may occur. This limit includes both employee and vested employer contributions.
	2017 Annual Maximum: $18,000
	2018 Annual Maximum: Annual cost of living may occur.
457(b) Special Catch-up Provision	The 457(b) Special Catch-up provision permits increased annual contributions on behalf of a participant. It allows you to make up, or "catch up," for prior years in which you may not have contributed the maximum amount to your employer's 457(b) plan.
	2017 Annual Maximum: $36,000
	2018 Annual Maximum: Annual cost of living may occur.
Age 50+ Catch-up Provision	If you are at least age 50, and currently participate in a governmental 457(b) plan, you are eligible to contribute an additional amount over the annual contribution limit. However, you cannot use both the 457(b) Special Catch-up provision and the Age 50+ Catch-up provision in the same year. You must use whichever is greater.
	2017 Annual Maximum: additional $6,000
	2018 Annual Maximum: Annual cost of living may occur.

**** As of the date of this publication, the 2018 information is not available. For the most up-to-date information about 457(b) contribution limits, visit www.irs.gov*** **For more information, contact OCERS at 405-297-2408.**

Helpful Tips

Know Your Benefits

There is a wealth of information about your benefits and other important news available right at your fingertips. Visit the City's intranet site at http://InsideOKC/Benefits.

OTHER INFORMATION

Dependent Eligibility Requirements

Payroll Calendar

Frequently Asked Questions

Glossary

Eligibility Requirements

Plan Eligibility

Eligibility is determined by the requirements stated in the appropriate plan document or insurance policy for the year in question. Since the plans are subject to change, eligibility may also change. If you change coverage from one plan to another, you and your dependents(s) must meet the requirements of the new plan selected. For specific details, please refer to each plan's eligibility requirements listed in this Guide.

Employee Eligibility

You are eligible to participate in the City's Vision, Long-Term Disability, and FSA plans if you are classified as a regular full-time active employee.

Participation Requirement

You and your dependents are not covered until you complete the appropriate paperwork with the Employee Benefits Division of the Personnel Department; provide the necessary documents to be enrolled and pay the required premium(s).

A dependent child cannot be covered both as an employee and as a dependent.

Eligible Dependents Include

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

Disabled Child

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

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

Dependent Verification

Employees must provide official documentation establishing a legal relationship with dependents in order for the dependents to be eligible for coverage. Acceptable documentation must be received in the Employee Benefits Division of the Personnel Department within 31 days of becoming eligible. (Personnel Policies Section 717.02 and 717.03)

Dependent Child Age Limitations

Benefit Plan	
Vision Plan	Under age 26

Dependent Documentation

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

- Dependent's address, if different than yours; and
- Dependent's telephone number, if different than yours.

Non-Eligible Dependents

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

Eligibility Requirements

Change in Dependent Status

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

NOTE: The Personnel Department reserves the right to require proof of continued eligibility for dependents. Failure to provide the required documentation may result in termination of coverage.

Common-Law Marriage Guidelines

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

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

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

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

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

Disciplinary Action for Failure to Notify the Employee Benefit Division

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

Dependent Audit

Employee Benefits may audit employee benefit files to ensure proper documentation for dependents enrolled in the City's medical, dental, and vision plans have been provided. You will receive a letter requesting missing documentation and must comply with the request. Failure to do so may result 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.

2018 Payroll Calendar

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

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

Frequently Asked Questions

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

My spouse and I recently divorced/legally separated. What do I do to drop my ex-spouse and/or stepchildren from my City insurance?
It is essential that you notify a representative of the Employee Benefits Division of the Personnel Department within 31 days of the divorce/legal separation. Failure to notify in a timely matter may result in financial and disciplinary consequences. Coverage for ex-spouse and/or stepchildren will end on the last day of the month in which the divorce/legal separation was final.

How Does Termination or Leave Affect my FSA?
If you terminate employment or go on unpaid leave, your eligibility for either or both FSAs may change. While your Dependent Care FSA cannot be continued following termination or the start of unpaid leave, you may be able to change or continue your Health FSA election upon completion of the appropriate forms and requirements. To make this change or to continue coverage, contact American Fidelity within 30 days of the event by calling, 800-437-1011.

Specific guidelines about the City's termination and leave policies can be obtained from the City. In addition, the Family and Medical Leave Act (FMLA) may affect your rights to continue coverage while on leave. Please contact the Employee Benefits Division for further information.

Glossary

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.

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

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.

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

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.

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

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.

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

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

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.

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

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

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.

Benefits Directory

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

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

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

Fire Fighters Health and Welfare Trust (VEBA)
232-9543

American Fidelity Assurance Company
Mon - Fri, 7 a.m. - 7 p.m. CST
800-437-1011
www.americanfidelity.com

Alliance Work Partners
Employee Assistance Program
24 hours a day
800-343-3822
800-448-1823 (TDD)
www.awpnow.com

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

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

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

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

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

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

Date Updated: October 5, 2017