

UnitedHealthcare
Medical Proposed Rates and Alternate Plan Designs

Customer Name: City of Pryor
Effective Date: January 1, 2017

* The numbers below are on an illustrative basis. Final rates will be determined after Underwriting analysis of the final census.

	Option 9 AG-VU (Premier) Rx Plan- 2V	Option 10 AG-VG (HMO) Rx Plan- 2V	Option 11 AG-VI (HMO) Rx Plan- 2V	Option 12 AG-WY (Flex Point) Rx Plan- 2V
Plan Name	Choice + Insurance *	Navigate HMO *	Navigate HMO *	Choice + Insurance *
Product	OPTION 9	OPTION 10	OPTION 11	OPTION 12
Option	Single Option	Single Option	Single Option	Single Option
Plan Offering	Option(s) N/A	Option(s) N/A	Option(s) N/A	Option(s) N/A
Multiple Option with:	No	No	No	No
HRA or HSA	No	No	No	No
Benefits*	Network Single/Family	Network Single/Family	Network Single/Family	Network Single/Family
Office Copay (PCP/SPC)	PCP \$25, SPC \$25/\$50	PCP \$20, SPC \$60	PCP \$20, SPC \$60	PCP \$25, SPC \$25/\$50
Hospital Copays	OP N/A, IP N/A	OP N/A, IP N/A	OP N/A, IP N/A	OP N/A, IP N/A
UC/ER/Major Diag Copay	UC \$75, ER \$300, Maj Diag N/A	UC \$75, ER \$500, Maj Diag \$500	UC \$75, ER \$500, Maj Diag \$500	UC \$100, ER \$250+20%, Maj Diag N/A
Other	(PCP \$0 if <19); ENRP	\$0 Kid Copay	\$0 Kid Copay	N/A
Deductible	\$500/\$1000 (Emb)	\$500/\$1,500 (Emb)	\$2,000/\$6,000 (Emb)	\$1000/\$2000 (Emb)
Coinsurance	100%	100%	100%	80%
Out-of-Pocket	\$2000/\$4000	\$3,250/\$9,750	\$3,000/\$9,000	\$4000/\$8000
Pharmacy	\$10/35/60; 2.5x for M.O.	\$10/35/60; 2.5x for M.O.	\$10/35/60; 2.5x for M.O.	\$10/35/60; 2.5x for M.O.
	Out of Network Single/Family	Out of Network Single/Family	Out of Network Single/Family	Out of Network Single/Family
Deductible	\$5000/\$10000 (Emb)	N/A	N/A	\$5000/\$10000 (Emb)
Coinsurance	70%	N/A	N/A	50%
Out of Pocket	\$10000/\$20000	N/A	N/A	\$10000/\$20000
Enrollment				
Employee	18	18	18	18
Employee + Spouse	15	15	15	15
Employee + Child(ren)	11	11	11	11
Employee + Family	22	22	22	22
Total	66	66	66	66
	Rates (Billed)	Rates (Billed)	Rates (Billed)	Rates (Billed)
Rates				
Employee	\$581.12	\$468.13*	\$432.04	\$456.14
Employee + Spouse	\$1,278.46	\$1,029.89	\$950.49	\$1,003.51
Employee + Child(ren)	\$1,075.07	\$866.04	\$799.27	\$843.86
Employee + Family	\$1,859.58	\$1,498.02	\$1,382.53	\$1,459.65
Monthly Cost	\$82,374	\$66,358	\$61,242	\$64,658
Annual Cost	\$988,483	\$796,291	\$734,900	\$775,895

*High level benefit summary. Please see your plan summary for more detailed benefit description.

The numbers above are on an illustrative basis. Final rates will be determined after Underwriting analysis of the final census.

For markets moving to service fees, current rates (applicable for renewals only) include commission expenses. Proposed rates, for your convenience, include any applicable producer service fees. Producer service fees are not a contingency of obtaining insurance coverage but are fees agreed to between you (client) and your producer/service provider for service rendered on behalf of client.

For markets continuing to pay commissions, both the current (applicable for renewals only) and proposed rates include commissions.

UnitedHealthcare
Medical Proposed Rates and Alternate Plan Designs
Rates assume 75% or greater participation

Customer Name: City of Pryor
Effective Date: January 1, 2017

The numbers below are on an illustrative basis. Final rates will be determined after Underwriting analysis of the final census.

	Option 1 AG-VS (HMO HSA) Rx Plan: 2V-HSA	Option 2 AG-VO (HMO) Rx Plan: 2V	Option 3 AG-VM (HMO) Rx Plan: 2V	Option 4 AE-3P (HSA) Rx Plan: 2V-HSA
Plan Name	Navigate HMO *	Navigate HMO *	Navigate HMO *	Choice + Insurance *
Product	OPTION 1	OPTION 2	OPTION 3	OPTION 4
Plan Offering	Single Option	Single Option	Single Option	Single Option
Multiple Option with:	Option(s) N/A	Option(s) N/A	Option(s) N/A	Option(s) N/A
HRA or HSA	HSA	No	No	HSA
Benefits*	Network Single/Family	Network Single/Family	Network Single/Family	Network Single/Family
Office Copay (PCP/SPC)	PCP N/A, SPC N/A	PCP \$25, SPC \$75	PCP \$25, SPC \$75	PCP N/A, SPC N/A
Hospital Copays	OP N/A, IP N/A	OP N/A, IP N/A	OP N/A, IP N/A	OP N/A, IP N/A
UC/ER/Major Diag Copay	UC N/A, ER N/A, Maj Diag N/A	UC \$100, ER \$500, Maj Diag \$500	UC \$100, ER \$500, Maj Diag \$500	UC N/A, ER N/A, Maj Diag N/A
Other	N/A	\$0 Kid Copay	\$0 Kid Copay	ENRP
Deductible	\$3,750/\$7,500 (Emb)	\$2,500/\$7,500 (Emb)	\$1,000/\$3,000 (Emb)	\$5000/\$10000 (Emb)
Coinsurance	80%	80%	80%	80%
Out-of-Pocket	\$6,350/\$12,700	\$6,600/\$13,200	\$3,000/\$9,000	\$6350/\$12700
Pharmacy	\$10/35/60; 2.5x for M.O.	\$10/35/60; 2.5x for M.O.	\$10/35/60; 2.5x for M.O.	\$10/35/60; 2.5x for M.O.
	Out of Network Single/Family	Out of Network Single/Family	Out of Network Single/Family	Out of Network Single/Family
Deductible	N/A	N/A	N/A	\$5000/\$10000 (Emb)
Coinsurance	N/A	N/A	N/A	50%
Out of Pocket	N/A	N/A	N/A	\$10000/\$20000
Enrollment				
Employee	18	18	18	18
Employee + Spouse	15	15	15	15
Employee + Child(ren)	11	11	11	11
Employee + Family	22	22	22	22
Total	66	66	66	66
	Rates (Billed)	Rates (Billed)	Rates (Billed)	Rates (Billed)
Rates				
Employee	\$285.04	\$355.40	\$411.59	\$333.60
Employee + Spouse	\$627.09	\$781.88	\$905.50	\$733.92
Employee + Child(ren)	\$527.32	\$657.49	\$761.44	\$617.16
Employee + Family	\$912.13	\$1,137.28	\$1,317.09	\$1,067.52
Monthly Cost	\$40,404	\$50,378	\$58,343	\$47,288
Annual Cost	\$484,853	\$604,535	\$700,115	\$567,454

*High level benefit summary. Please see your plan summary for more detailed benefit description.

The numbers above are on an illustrative basis. Final rates will be determined after Underwriting analysis of the final census.

For markets moving to service fees, current rates (applicable for renewals only) include commission expenses. Proposed rates, for your convenience, include any applicable producer service fees. Producer service fees are not a contingency of obtaining insurance coverage but are fees agreed to between you (client) and your producer/service provider for service rendered on behalf of client.

For markets continuing to pay commissions, both the current (applicable for renewals only) and proposed rates include commissions.

August 31, 2016



BROKER COPY

MS. LISA MALONE
CITY OF PRYOR CREEK & MUNICIPAL UTILITY BOARD
6 N ADAIR ST
PRYOR, OK 74361-2433

DEAR MS. LISA MALONE:

Thank you for choosing VSP® Vision Care. We put your employees first and guarantee their satisfaction. As the only national not-for-profit vision company, VSP gives you:

- Lowest employee out-of-pocket costs
- Reduced healthcare costs
- World Class Service

Your VSP plan automatically renews on January 1, 2017. No action is required to continue to receive consumers' #1 choice in vision care.

Group Name/Number: CITY OF PRYOR CREEK & MUNICIPAL UTILITY BOARD / 30038190
Renewal Period: January 1, 2017 - December 31, 2018
Current Plan Frequency: 12 / 12 / 24
Current Copay: \$10 Exam / \$25 Materials
Current Allowance: \$130.00 Retail Frame / \$130.00 Elective Contact Lenses
Current Rates: \$10.84 / 17.34 / 17.70 / 28.54
Renewal Rates: \$10.84 / 17.34 / 17.70 / 28.54

Rates include all applicable taxes and health assessment fees known as of the date of your renewal.

Enhanced Contact Lens Benefit

This benefit design allows members to use their full contact lens allowance toward contact lenses and provides both standard and premium fit contact lens wearers a covered-in-full contact lens exam after a copay that will never exceed \$60.

Please let me know if you have any questions about your VSP plan or would like to see additional options to enhance your benefit or lower your premium. Please contact me at the number below and I can assist you.

Cordially,

Ross San (800) 852-7600

cc: KURTIS SCHULTZ
COURTSIDE BENEFITS GROUP
PO BOX 52679
TULSA, OK 74152

Central Team



Protect
your vision
with VSP.

**Get the best in eye care and eyewear
with CITY OF PRYOR CREEK &
MUNICIPAL UTILITY BOARD and VSP®
Vision Care.**



Why enroll in VSP? We invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we're the only national not-for-profit vision care company, you can trust that we'll always put your wellness first.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP provider, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, your satisfaction is guaranteed.
- **Choice of Providers.** The decision is yours to make—choose a VSP provider or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Register at vsp.com** Once your plan is effective, review your benefit information.
- **Find an eye care provider who's right for you.** To find a VSP provider, visit vsp.com or call 800.877.7195.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on vsp.com.

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

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 more¹. Visit vsp.com to find a Premier Program location who carries these brands.

Enroll in VSP today.
You'll be glad you did.
Contact us. 800.877.7195
vsp.com



courtside

BENEFITS GROUP, LLC

CITY OF PRYOR / MUB CURRENT DENTAL	CITY OF PRYOR / MUB RENEWAL DENTAL	CITY OF PRYOR / MUB DENTAL	CITY OF PRYOR / MUB DENTAL
DELTA DENTAL (VOLUNTARY)	DELTA DENTAL (VOLUNTARY)	HUMANA	HUMANA
Deductible \$50	Deductible \$50	Deductible \$50	Deductible \$50
Preventative/Diagnostic 100%	Preventative/Diagnostic 100%	Preventative/Diagnostic 100%	Preventative/Diagnostic 100%
Basic Restorative 80%	Basic Restorative 80%	Basic Restorative 80%	Basic Restorative 80%
Major Restorative 50%	Major Restorative 50%	Major Restorative 50%	Major Restorative 50%
Orthodontic Services 50% Child Only			
Annual Maximum \$1500 Per Person Orthodontic Maximum \$1000 Per Child	Annual Maximum \$1500 Per Person Orthodontic Maximum \$1000 Per Child	Annual Maximum \$1500 Per Person Orthodontic Maximum \$1000 Per Child	Annual Maximum \$2000 Per Person Orthodontic Maximum \$2000 Per Child
\$27.82	\$29.78	\$21.71	\$22.89
\$55.60	\$59.50	\$43.41	\$45.78
\$63.96	\$68.44	\$61.60	\$72.12
\$85.98	\$92.00	\$84.56	\$98.26

Delta Dental Program Highlights

For Employees of **CITY OF PRYOR CREEK (CITY) • 3215**
Delta Dental PPO – Plus Premier • January 2017

Your Program Highlights provides a brief description of the most important features of your group's dental benefits program. If you have more specific questions regarding your benefits, please contact Delta Dental of Oklahoma's Customer Service Department at **405-607-2100 (OKC Metro)** or **800-522-0188 (Toll Free)**.

Dental benefits for participants and covered dependents are payable for eligible dental treatment not otherwise limited or excluded, and shall be paid in accordance with the benefit provisions of your plan, as follows:

Percent Payable for Covered and Allowable Dental Services	
Class I: Diagnostic and Preventive Services	100%
Class II: Basic Services such as amalgam and composite fillings	80%
Class III: Major Services such as crowns, dentures and implants	50%
Class IV: Orthodontic Services are available to dependent children under age 26	50%

Deductible and Maximum Amounts	
Annual Maximum Benefit and Deductible Accumulation Period	January 1 - December 31
Annual Deductible Per Person – applies to Classes II and III	\$25*
Annual Maximum Benefit Per Person – applies to Classes I, II and III combined	\$1,500**
Lifetime Maximum Benefit Payment Per Child – applies to Class IV only	\$1,000

*Family Deductible not to exceed 3 times the Annual Deductible Per Person.

**Benefits paid by the plan for covered oral evaluations and routine prophylaxis (cleanings) will not reduce your Annual Maximum Benefit Per Person for Classes I, II and III combined services.

Endodontics, Periodontics and Oral Surgery are covered benefits under Class II Services.

Eligible dependent children can be covered to age twenty-six (26).

The information contained herein is not intended as a Summary Plan Description nor is it designed to serve as Evidence of Coverage for this program. Some benefits are subject to limitations such as age of patient, frequency of procedure, exclusions, etc.



October 5, 2016

Eva Smith
City of Pryor Creek (City)
PO Box 1167
Pryor, OK 74362

Re: City of Pryor Creek (City)
Group No.: 3215
Anniversary Date: January 1, 2017

Dear Ms. Smith:

Thank you for selecting Delta Dental of Oklahoma as your dental benefits provider. We appreciate your business, and we hope you have been pleased with the quality service, savings, and access you and your employees have come to expect from us.

With regard to your Delta Dental plan, we reviewed dental utilization along with dental costs and inflation trends, and calculated the necessary premiums for your upcoming dental plan renewal effective January 1, 2017. In addition, your plan's renewal rates, listed below, include the health care reform required annual issuer's fee. These rates are guaranteed for 24 months.

<u>Current Rates</u>	<u>Renewal Rates</u>
Employee Only.....\$27.82	Employee Only \$29.78
Employee + Spouse\$55.60	Employee + Spouse \$59.50
Employee + Child(ren)\$63.96	Employee + Child(ren)..... \$68.44
Employee + Family.....\$85.98	Employee + Family \$92.00

Effective January 1, 2016, your group benefit plan may be required to offer coverage for certain pediatric dental services that are considered essential health benefits under the Affordable Care Act. Please review the enclosed information regarding federally compliant options that are available in addition to your current dental plan(s).

Thank you again for choosing Delta Dental of Oklahoma. Should you have any questions, or require any further information, please contact your broker or our Sales Department at (405) 607-4709 or toll-free at (866) 685-2112.

Sincerely,

Lan Miller
Vice President of Sales

LPM/bb

cc: Kurt Schultz, Courtside Benefits Group LLC

SUMMARY OF DENTAL PLAN BENEFITS

SUPPLEMENTAL PLAN DESCRIPTION – Revised February 11, 2016

NAME OF PLAN	CITY OF PRYOR CREEK (CITY) Group Dental Plan Group No. 3215-0001
PLAN SPONSOR/ EMPLOYER	CITY OF PRYOR CREEK (CITY) P O BOX 1167 PRYOR, OK 74362
TYPE OF PLAN	Employee Welfare Benefit Plan
PLAN BENEFIT YEAR	January 1 - December 31
PLAN BENEFITS PROVIDED BY	Delta Dental Plan of Oklahoma P.O. Box 54709 Oklahoma City, Oklahoma 73154 (405) 607-2100 or (800) 522-0188
AGENT FOR LEGAL SERVICE	CITY OF PRYOR CREEK (CITY) 12 N ROWE ST PRYOR, OK 74362

GENERAL PROVISIONS

Eligible Persons

Persons eligible for coverage under this Plan include all full-time employees and their eligible dependents.

Dependent Children

Covered to age twenty-six (26). *Note: Refer to the "About Your Plan" section of the Summary Plan Description for information on extended coverage for handicapped children. Note: Orthodontic benefits are available only to eligible dependent children, and only until such eligible dependent child reaches age 26.*

Probationary Period (New-hire Employees)

New-hire employees will be eligible for coverage under this Plan on the first of the month following thirty (30) days of continuous, full-time employment.

SELECTED BENEFITS

The dental services included in the Plan Sponsor's group dental plan are listed in this Summary, under "Description of Covered Services", and described by classes of service. After an eligible person satisfies the plan benefit year deductible, if any, the Plan will pay a percentage of the lesser of the dentist's submitted fee or the maximum allowable amount. The Plan's percentage payment will be based on the class of dental service provided, as indicated next to each class of service. *Note: Some benefits are subject to limitations, e.g. age of patient, frequency of procedure, etc., or excluded in some instances. Please review "LIMITATIONS" and "EXCLUSIONS" in this Summary.*

MAXIMUM CONTRACT BENEFIT

The maximum benefit payable for combined Classes I, II, and III covered dental services rendered to an eligible person during the benefit year shall be One Thousand Five Hundred Dollars (\$1,500). The maximum lifetime benefit payable for covered Class IV services rendered to an eligible dependent child shall be One Thousand Dollars (\$1,000). *Note: Benefits paid by the Plan for covered oral evaluations (procedure codes D0120-D0180) and routine prophylaxis (procedure codes D1110 and D1120) rendered to an eligible person during the benefit year will not reduce such person's maximum benefit for combined Class I, Class II, and Class III covered dental services.*

DEDUCTIBLE

Twenty-Five Dollars (\$25) per person per benefit year. *Note: The maximum family deductible is three (3) individual deductibles per benefit year. Note: Deductible is not applicable to Classes I and IV Services.*

BENEFIT PAYMENT PROCEDURE, PARTICIPATING DENTISTS

Under the Delta Dental Plans participating agreements with participating dentists, benefit claims are reimbursed based on the lesser of the dentist's submitted fee for his or her service or the maximum allowable amount he or she has agreed to accept as payment for covered services in accordance with the Participating Agreement applicable to the plan. Participating dentists accept the maximum allowable amount as payment in full.

If a Delta Dental PPO Participating Dentist provides treatment, you are not responsible for paying the dentist any amount that exceeds the maximum allowable amount the Delta Dental PPO Participating Dentist has agreed to accept as payment for covered services. You are responsible for paying the dentist any non-covered charges, deductible and co-payment amounts, and any charges over your plan maximum.

If treatment is provided by a Delta Dental Premier Participating Dentist, you are not responsible for paying the dentist any amount that exceeds the maximum allowable amount the Delta Dental Premier Participating Dentist has agreed to accept as payment for covered services. You are responsible for paying the dentist for any non-covered charges, deductible and co-payment amounts, and any charges over your plan maximum.

The DDPOK Participating Dentists Network lists are furnished upon request, without charge, as separate documents. You may also obtain lists of participating dentists in the Delta Dental PPO and Delta Dental Premier networks by accessing the DDPOK website at www.DeltaDentalOK.org.

BENEFIT PAYMENT PROCEDURE, NONPARTICIPATING DENTISTS, OUT-OF-NETWORK SERVICES

If you obtain treatment from a dentist who has not signed a participating agreement with Delta Dental, any benefit payment will be paid directly to you, or to other participant or beneficiary if required by law, and will be based on the lesser of the dentist's submitted fee for his or her service or the prevailing fee. Prevailing fee is an amount established by the Delta Dental Plan in the state in which the dental services are rendered. You are responsible for paying the dentist and for filing your own claim.

DESCRIPTION OF COVERED SERVICES

CLASS I SERVICES - 100%

Diagnostic Services: Procedures performed by properly licensed dentists in evaluating existing conditions to determine the required dental treatment. By way of description, such covered services include: Oral evaluations (examinations), emergency palliative treatment, and x-rays.

Preventive Services: Procedures performed by properly licensed dentists to prevent the occurrence of disease. By way of description, such covered services include: Routine prophylaxis (cleaning) and periodontal maintenance (D4910); and topical application of fluoride, limited sealants, and space maintainers for eligible dependent children.

CLASS II SERVICES - 80%

Basic Restorative Services: Procedures performed by properly licensed dentists in the treatment of carious lesions (decay/cavity). By way of description, such covered services include: Amalgam and composite restorations (fillings); and stainless steel restorations (crowns) for eligible dependent children.

Oral Surgery Services: Procedures performed by properly licensed dentists for extractions and other oral surgical procedures.

Endodontic Services: Procedures performed by properly licensed dentists for the treatment of non-vital teeth. By way of description, such covered services include: Pulpal therapy and root canal treatment.

Periodontic Services: Procedures performed by properly licensed dentists for the treatment of diseases of the gums and supporting structures of the teeth, excluding periodontal maintenance (D4910) which is payable as a Class I dental service.

CLASS III SERVICES - 50%

Major Restorative Services: Provides porcelain or cast restorations (other than stainless steel) for the treatment of carious lesions (decay/cavity) when teeth cannot be restored with another filling material. **Note: A crown or cast restoration is optional treatment unless the tooth is damaged by decay or fracture to the point it cannot be restored by an amalgam or composite restoration.**

Prosthetic Services: Procedures for construction of fixed partial dentures (bridges), removable partial dentures, and complete dentures, including adjustment or repair of an existing prosthetic device provided under this Plan.

Implant Services: Procedures for implant placement, implant-supported prosthetics, and maintenance and repair of implants and implant-supported prosthetics provided under this Plan.

CLASS IV SERVICES - 50%

(Available to eligible Dependent Children under age 26)

Orthodontic Services: The necessary treatment and procedures required for the correction of malposed teeth.

LIMITATIONS

The benefits to be provided to Subscribers and eligible Dependents under this Plan shall be limited as follows:

- For purposes of this Plan, any procedure frequency limitation is measured in a period of continuous calendar-year months (a consecutive-month period), which begins on the date of service for which the procedure was last paid.
- Prophylaxis is a benefit twice in a 12 consecutive month period. **Note: Cleanings/prophylaxis of any type, including periodontal maintenance, are limited to any combination of two in a 12 consecutive month period.**
- Oral evaluation is a benefit twice in a 12 consecutive month period.
- Limited (emergency) oral evaluation is a benefit twice in a 12 consecutive month period. **Note: Benefits for limited (emergency) oral evaluation may be disallowed if other services are provided on the same day.**
- Bitewing x-rays are a benefit once in a 12 consecutive month period. **Note: Benefits may be limited if multiple same-day x-rays are provided on the same day by the same dentist/dental office.**
- Full-mouth x-rays, a panoramic film, or multiple same-day x-rays is a benefit once in a 60 consecutive month period unless necessary for the diagnosis and treatment of a specific disease or injury.
- Topical application of fluoride solutions is a benefit for patients through age 18, and once in a 12 consecutive month period.
- A space maintainer is a benefit for missing primary posterior teeth for persons through age 15, and not for orthodontic purposes.
- Sealants are a benefit for persons through age 15, limited to permanent first and second molar teeth free of caries and restorations on the occlusal surfaces. Sealants are a benefit once per tooth in a 60 consecutive month period.
- Stainless steel crowns are a benefit only for persons through age 11, and once per tooth in an 84 consecutive month period.

- General anesthesia/IV sedation is a benefit only when administered by a properly licensed dentist in a dental office in conjunction with oral surgical procedures (D7000-D7999) when covered, or when necessary due to concurrent medical conditions. The fee for general anesthesia/IV sedation is denied when billed by anyone other than a licensed dentist.
- Payment is made for a single tooth surface repair once in a 24 consecutive month period, regardless of the number of combinations of restorations placed therein.
- Root canal therapy is a benefit once per tooth in a 36 consecutive month period.
- Prosthodontics: (1) An upper or lower denture is a payable benefit once per arch in a 60 consecutive month period; (2) a removable partial denture or fixed partial denture (bridge) may not be provided more often than once per arch in any 60 consecutive month period, except where the loss of additional teeth requires the construction of a new appliance; (3) relines and rebase is a benefit once in any 36 consecutive month period for any one appliance.
- Crowns/onlays/veneers on the same tooth are a benefit once in an 84 consecutive month period.
- Orthodontic Benefits: (1) benefits are limited to periodic payments; and (2) benefits cease the last day of the month in which: (a) such person becomes ineligible for orthodontic coverage under this Plan, (b) treatment is terminated for any reason before completion of the treatment plan, (c) treatment is completed, or (d) the maximum orthodontic benefit has been paid, whichever occurs first.
- Implant Benefits: The implant and the associated crown over the implant are a benefit for persons 16 years of age and over, limited to once in an 84 consecutive month period. *Note: Some implant procedures or procedures associated with implants are not covered services under the plan and no benefits will accrue or be payable for those excluded procedures (please contact DDPOK Customer Service with any questions).*
- Single crowns/onlays/veneers are benefits for persons age 12 and over.
- Fixed partial dentures (bridges) and removable partial dentures are benefits for persons age 16 and over.
- Alternate Benefits/Optional Treatment: DDPOK may consider alternate dental services that are suitable for care of a specific condition if those alternate services will produce a professionally acceptable result, as determined by DDPOK. If patient and dentist elect other treatment, patient will be responsible for any charges in excess of DDPOK's payment. For example: if a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment based on such procedure will be made toward a more elaborate or precision appliance the dentist and patient may choose to use, and patient is responsible for the balance of the cost; a fixed partial denture (bridge) will be allowed only when a removable partial denture will not suffice; if a crown or cast restoration is not allowed, an alternate benefit allowance for an amalgam or composite restoration may be made and any fee charged in excess of the allowance is chargeable to the patient; etc.
- DDPOK's obligation to provide benefits for covered dental services terminates on the last day of the month in which the patient becomes ineligible for benefits under this Plan.
- Care terminated due to death will be paid in full, to the limit of DDPOK's liability, for services completed or in progress.
- When services in progress are interrupted and completed later by another dentist, DDPOK will review the claim to determine the payment to each dentist.
- Processing policies, if applied, may limit benefits and can be found on each Explanation of Benefits.
- Charges for any covered dental service or supplies which are included as covered medical expenses under the plan of Major Medical or Comprehensive Medical Expense Benefits Plan must first be submitted for payment to the medical carrier. DDPOK may benefit as the secondary carrier.

EXCLUSIONS

The following shall be excluded from the benefits to be provided to Subscribers and eligible Dependents.

- Benefits or services for injuries or conditions compensable under Workers' Compensation or Employers' Liability laws.
- Benefits or services available from any federal or state government agency, or from any municipality, county, or other political subdivision or community agency, or from any foundation or similar entity.
- Charges for services or supplies for which no charge is made that the patient is legally obligated to pay or for which no charge would be made in the absence of dental coverage.
- Benefits for services or appliances started prior to the date the patient became eligible under this Plan may be excluded.
- Benefits for services when a claim is received for payment more than 12 months after services are rendered.
- Charges for treatment by other than a properly licensed dentist, except that cleaning and scaling of teeth and topical application of fluoride may be performed by a properly licensed hygienist if treatment is rendered under the supervision and guidance of the dentist, in accordance with generally accepted dental standards.
- Charges for completion of forms or submission of documentation required by DDPOK for a benefit determination.
- Charges for broken appointments, hospitalization or additional fees charged for hospital treatment, and bleaching of teeth.
- Prescription drugs, pre-medications, and relative analgesia.
- Experimental procedures.
- Benefits or services to correct congenital or developmental malformations.
- Services for the purpose of improving appearance when form and function are satisfactory and there is insufficient pathological condition evident to warrant the treatment (cosmetic dentistry).
- Restorations for altering occlusion (bite), involving vertical dimensions, replacing tooth structure lost by attrition (grinding of teeth), erosion, abrasion (wear), or for periodontal, orthodontic, or other splinting.
- Charges for replacement of lost, missing, or stolen crowns or appliances, or for repair of an orthodontic appliance.
- Services with respect to diagnosis and treatment of disturbances of the temporomandibular joint (TMJ).
- Services and benefits excluded by the rules and regulations of Delta Dental, including the processing policies.
- All other benefits and services not specified in the Plan Agreement, including but not limited to the following excluded services.

GROUP VOLUNTARY LONG-TERM DISABILITY CERTIFICATE SUMMARY



This summary describes some of the terms and conditions of the Policy. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate, available from the Policyholder. A person is not necessarily entitled to insurance because he or she received this summary. A person is only entitled to insurance if he or she is eligible in accordance with the terms of the Policy. This summary was published on January 16, 2015.

POLICY INFORMATION

Policyholder:	City of Pryor Creek and Municipal Utility Board
Policy Effective Date:	January 1, 2015
Policy Anniversary:	January 1
Policy Number:	GUPR-AVQY
Group Number:	G000AVQY
Classification:	All Eligible Employees of City of Pryor Creek
Minimum Work Hours Required:	30 hours per week
Eligibility Present Waiting Period:	60 days
Eligibility Future Waiting Period:	60 days
Elimination Period:	The later of: <ul style="list-style-type: none"> a) 180 calendar days; or b) the date Your short-term Disability ends.

BENEFITS

Monthly Benefit Percentage:	60%	
Maximum Monthly Benefit:	\$5,000	
Minimum Monthly Benefit:	\$50	
Maximum Benefit Period:	Age at Disability	Maximum Benefit Period
	61 or less.....	to age 65, Your SSNRA, or 3 years and 6 months, whichever is longest;
	62.....	Your SSNRA, or 3 years and 6 months, whichever is longer;
	63.....	Your SSNRA, or 3 years, whichever is longer;
	64.....	Your SSNRA, or 2 years and 6 months, whichever is longer;
	65.....	2 years;
	66.....	1 year and 9 months;
	67.....	1 year and 6 months;
	68.....	1 year and 3 months;
	69 or older.....	1 year.
Own Occupation Definition:	2 years	
Survivor Benefit:	3 months	
Vocational Rehabilitation Benefit:	5%	

GROUP VOLUNTARY TERM LIFE CERTIFICATE SUMMARY



This summary describes the terms and conditions of the Policy. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate, available from the Policyholder. The capitalization of a term not normally capitalized according to standard punctuation rules indicates a word or phrase that is a defined term in the Certificate. A person is not necessarily entitled to insurance because he or she received this summary. A person is only entitled to insurance if he or she is eligible in accordance with the terms of the Policy. This summary was published on January 16, 2015.

POLICY INFORMATION

Policyholder: City of Pryor Creek and Municipal Utility Board
Policy Effective Date: January 1, 2015
Policy Number: GVTL-AVQY
Class(es): All Eligible Employees
Policy Anniversary: January 1
Group Number: G000AVQY

ELIGIBILITY

You (the Employee) must be performing the normal duties of Your regular job for the Policyholder on a regular and continuous basis 30 or more hours each week to be eligible for insurance.

Your eligible Dependents must be able to perform normal activities and not be confined (at home, in a hospital, or in any other care facility) to be eligible for insurance.

An Employee who is not eligible for insurance under the Policy on the Policy Effective Date, or an Employee who is hired after the Policy Effective Date, becomes eligible for insurance under the Policy on the day following completion of an Eligibility Waiting Period of 60 days.

BENEFIT AMOUNT(S)

Insurance for You (The Employee)

You may elect to be insured for an amount of life insurance from \$10,000 to \$500,000, in increments of \$10,000. In no event shall Your amount of life insurance exceed 5 times Your Annual Earnings, rounded to the next higher multiple of \$10,000.

Provided You have elected some amount of life insurance, Your amount of accidental death and dismemberment (AD&D) insurance is equal to Your amount of life insurance.

Your Guarantee Issue Amount is 5 times Your Annual Earnings or \$100,000, whichever is less. If You have questions regarding the amount of Your insurance, You may contact the Policyholder.

Insurance for Your Dependent(s)

You may elect to have Your Spouse insured for an amount of life insurance from \$5,000 to \$200,000, in increments of \$5,000, provided the amount elected does not exceed 50% of Your amount of life insurance.

Provided You have elected some amount of life insurance for Your Spouse, Your Spouse's amount of accidental death and dismemberment (AD&D) insurance is equal to Your Spouse's amount of life insurance.

You may elect to have Your eligible Dependent child(ren) insured for an amount of life insurance equal to \$10,000, provided the amount elected does not exceed 50% of Your amount of life insurance. Each eligible Dependent child must have the same amount of insurance.

Provided You have elected some amount of life insurance for Your Dependent child(ren), the amount of accidental death and dismemberment (AD&D) insurance for Your Dependent child(ren) is equal to the amount of life insurance for Your Dependent child(ren).

The Guarantee Issue Amount for Your Spouse is 100% of Your elected amount of life insurance or \$50,000, whichever is less. The Guarantee Issue Amount for Your Dependent child(ren) is 100% of Your elected amount of life insurance or \$10,000, whichever is less. If You have questions regarding the amount of insurance for Your Dependent(s), You may contact the Policyholder.


courtside
 BENEFITS GROUP, LLC

CITY OF PRYOR/MUB
EFFECTIVE DATE: 1/1/2017

O/C B/S

United H/C

H choice

CITY OF PRYOR MEDICAL	CITY OF PRYOR MEDICAL <i>HMO</i>	CITY OF PRYOR MEDICAL <i>United H/C</i>	CITY OF PRYOR MEDICAL	CITY OF PRYOR MEDICAL
option 2	option 3	option 4	option 5	option 6
Deductible \$1000 individual	Deductible \$0	Deductible \$1000 individual / \$3000 family	Deductible \$750 individual / \$2250 family	Deductible \$500 individual / \$1500 family
\$3,000/\$4,000/\$5,000/\$6,000	Out of Pocket \$1750 individual / \$5250 family	Out of Pocket \$3000 individual / \$9000 family	Out of Pocket \$2500 individual / \$7500 family	Out of Pocket \$3300 individual / \$8400 family
PCP \$30	Primary Care Visit \$10 Specialist Visit \$30	Primary Care Visit \$25 Specialist Visit \$75	Primary Care Visit \$20 Specialist Visit \$50	Primary Care Visit \$30 Specialist Visit \$50
\$15/\$35/\$60/\$150	RX: \$10/\$35/\$60; 2.5X for M.O.	RX: \$10/\$35/\$60; 2.5X for M.O.	RX: \$0/\$10/\$45/\$60/\$100	RX: \$0/\$10/\$45/\$75/\$100
Emergency Room \$500 Urgent Care \$50	Emergency Room \$500 Urgent Care \$50	Emergency Room \$500 Urgent Care \$100	Emergency Room Subject to Plan Year Deductible & Co-Insurance after \$50 per Visit Urgent Care \$20 per Visit Co-Pay	Emergency Room \$200/20% Coins Urgent Care 20% Coins
80%/70%/60%/50%	Coinsurance 100%	Coinsurance 80%	Coinsurance 80%	Coinsurance 80%
\$600.75	\$513.53	\$411.59	\$511.86	\$571.04
\$1,330.88	\$1,129.77	\$905.50	\$1,070.00	\$1,245.34
\$1,053.90	\$950.03	\$761.44	\$761.28	\$1,059.70
\$1,784.01	\$1,643.30	\$1,317.09	\$1,301.38	\$1,734.00
19.00%	2.00%	18.00%	1.00%	13.00%

KURT SCHULTZ
 918-991-8020

INSURANCE PLAN COST COMPARISON

	Enrollment	Current Plan	Current Totals	Option 3	Option 3 Totals	Option 4	Option 4 Totals	Option 10	Option 10 Totals
Emp	18	\$ 501.86	\$ 9,033.48	\$ 513.53	\$ 9,243.54	\$ 411.59	\$ 7,408.62	\$ 468.13	\$ 8,426.34
Emp + Sp	15	\$ 1,111.80	\$ 16,677.00	\$ 1,129.77	\$ 16,946.55	\$ 905.50	\$ 13,582.50	\$ 1,029.89	\$ 15,448.35
Emp + Ch	11	\$ 880.42	\$ 9,684.62	\$ 950.03	\$ 10,450.33	\$ 761.44	\$ 8,375.84	\$ 866.04	\$ 9,526.44
Emp + Fam	22	\$ 1,490.35	\$ 32,787.70	\$ 1,643.30	\$ 36,152.60	\$ 1,317.09	\$ 28,975.98	\$ 1,498.02	\$ 32,956.44
Total	66	\$ 3,984.43	\$ 68,182.80	\$ 4,236.63	\$ 72,793.02	\$ 3,395.62	\$ 58,342.94	\$ 3,862.08	\$ 66,357.57

Department	Current Budget	Option 10	2017 Budget Savings
Cemetery	\$ 47,500.00	\$ 46,874.00	\$ 626.00
Clerk	\$ 50,681.00	\$ 43,803.00	\$ 6,879.00
Court	\$ 21,000.00	\$ 17,186.76	\$ 3,813.00
Library	\$ 38,550.00	\$ 31,820.00	\$ 6,730.00
Managerial	\$ 33,632.00	\$ 30,359.00	\$ 3,274.00
Park	\$ 34,161.00	\$ 30,557.00	\$ 3,604.00
Animal Control	\$ 15,741.00	\$ 12,515.00	\$ 3,226.00
Police	\$ 407,366.00	\$ 342,234.00	\$ 65,132.00
Com. Dev.	\$ 18,000.00	\$ 17,948.00	\$ 51.00
		Total Budget Savings	\$129,974