Office of Management and Enterprise Services
Employees Group Insurance Division

Planning for Your Insurance Needs as a Former Employee

Health, Dental, Life and Vision Coverage

3223

This guide is designed to help lead you through the things you must do to continue your insurance when you leave active employment. There are a number of forms included in this guide; however, it will explain which forms you must complete.

Your Member Status

When you leave active employment, you are given a member status based on your vesting right with a state funded retirement system or your years of employment service. There are four member status categories:

- **Vested** – You have worked long enough to keep insurance benefits and you contributed to a retirement system, but you are not ready to draw your retirement benefits.
- **Non-Vested** – You have worked long enough to keep insurance benefits, but you did not contribute to a retirement system that participates with EGID or you withdrew your contributions from your retirement system.
- **Retiree** – You have worked long enough to retire (leave active employment), keep insurance benefits, and draw retirement benefits.
- **Defer** – You have worked long enough to qualify as a vested, non-vested or retiree member, but you elect to transfer your health, dental and/or vision insurance to your spouse's current insurance through the Employees Group Insurance Division (EGID).

If you leave active employment, lose coverage because of a reduction in hours of employment, or your employment is terminated for reasons other than gross misconduct, you are eligible to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Under COBRA, you can continue health, dental, and/or vision coverage for up to 18 months.

Coverage continued under COBRA is temporary. You are encouraged to continue coverage under one of the other status options, if you qualify.

Years of Service You Need to Continue Insurance at Retirement

- **Teachers Retirement System (TRS) –** Ten years of creditable service.
- **Oklahoma Public Employees Retirement System (OPERS) –** Eight years of creditable service.
- **Oklahoma Law Enforcement Retirement System (OLERS) –** Eight years of creditable service.
- **Other or No Retirement System –** Employment years may qualify as creditable service to continue insurance. Please contact EGID Member Services for specific information.

When You Leave Active Employment

Keep all the coverage you think you will need in retirement. You can drop or reduce benefits later, but you cannot add health, dental or life insurance after you leave active employment.

EGID Administrative Rule 260:50-3-13 (rev.

September 2014, states that you must return to work for an EGID participating employer for three years in order to qualify to retain benefits not previously elected upon ceasing current employment.

If your employer offers these benefits through EGID, the following rules apply:

Health and/or Dental Insurance – You can add, keep, drop and/or defer coverage within 30 days of leaving active employment.

Vision Insurance – You can add, keep, drop or defer coverage within 30 days of leaving active employment or during the annual Option Period.

Once you leave active employment, vision insurance is the only benefit that can be added during the annual Option Period.

Life Insurance – You can keep, reduce or drop life coverage you have in place at the time you leave active employment. The election must be made within 30 days of leaving active employment. You cannot add or increase life insurance at retirement. Life insurance cannot be deferred and must be kept in your retirement account.

Life insurance must be kept in $5,000 units. Refer to the premium rate charts included in this guide.

Life insurance continued at retirement does not include Accidental Death and Dismemberment benefits.

Life Insurance Beneficiaries

If you continue life insurance coverage when you leave active employment, it is very important to keep your beneficiary information current. If you are unsure of your beneficiary designations, please complete a new *Beneficiary Designation Form* which is located on page 23 of this guide. Instructions for completing the form are located on page 24.

HealthChoice must pay life benefits to the beneficiaries listed on the most recent beneficiary designation. If there is no signed beneficiary designation, benefits are paid to the estate.

Coverage for Your Dependents

You can add, keep and/or drop health, dental and vision coverage for your spouse and other eligible dependents at retirement; however, dependent life insurance must be in effect before you leave active employment.

You can exclude your spouse from health and dental coverage and cover your other eligible dependents. Your spouse must sign the *Spouse Exclusion Certification* section of your *Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage*.

If you add or keep coverage for your dependent children, including disabled dependents, all your eligible dependents up to age 26 must be covered.

You can exclude dependents from coverage if they have other group coverage or are eligible for Indian or military health benefits. You can also exclude eligible dependents who do not reside with you, are married, or are not

financially dependent on you for support.

After retirement, you cannot add dependents to any coverage except vision, unless one of the following qualifying events occurs:

- Birth of a child;
- Your spouse or eligible dependents lose other group coverage;
- You marry; and/or
- You adopt or gain legal guardianship of a child under age 26.

Your spouse and any eligible dependents must be added within 30 days of the date of the qualifying event.

Dependent Life Insurance

You can keep Dependent Life insurance in effect at retirement, but it cannot be added later. It must be kept in $500 units and each covered dependent pays a separate, individual premium.

- ***For your spouse –*** The amount you keep for your spouse can be different from the amount you keep for your covered dependents.
- ***For your dependents –*** The amount you keep must be the same for each covered dependent.

Plan Premiums

Refer to the premium rate charts in this guide.

Premium Payment Options:

- ***Retirement check deduction –*** Your monthly premium is automatically deducted from your retirement check.
- ***Direct bill –*** You are directly billed for your monthly premium, and your premium is due by the 20th of each month.
- ***Automatic draft –*** Your monthly premium is automatically drafted from your checking account on or around the 20th of each month. To elect this option, select the direct-bill option on your *Application for Retiree/Vested/Non-Vested/ Defer Insurance Coverage* and provide EGID with an *Electronic Fund Transfer Authorization* form and a voided check. This form is available on the EGID website or by contacting Member Services.

Retirement System Contribution to Your Monthly Insurance Premium

Your retirement system may contribute toward your health insurance premium.

- OPERS contributes $105 monthly.
- OLERS contributes $105 monthly.
- TRS contributes $100 to $105 monthly.

The premiums listed in this guide do not reflect any retirement system contribution.

If You Decide to Work Past Age 65

If you decide to work past age 65, you must contact Social Security to delay your enrollment in Medicare Part B. This will prevent any Part B late enrollment penalty when you are ready to leave active employment and begin your Medicare coverage.

The Enrollment Process

When You Turn Age 65 After You Leave Active Employment

If you are close to age 65 and not receiving Social Security benefits, you need to enroll in Medicare Parts A and B.

To enroll, contact Social Security at least three months before you turn age 65. By enrolling early, you avoid any delay in the start of your Medicare coverage.

If You Are Not Yet Eligible for Medicare

To Continue Your Insurance

You must complete only the *Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage* on pages 11 and 12 and return it to EGID.

Retirement is not a qualifying event that allows you to make plan changes; however, if you move out of your health plan's service area, you are allowed to change health plans.

To Defer (Transfer) Your Coverage to Your Spouse's Plan

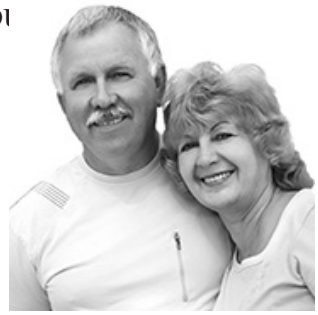
If your spouse works and is currently enrolled in coverage through EGID, you can defer, or transfer, your health, dental and/or vision coverage to your spouse's coverage as a dependent.

Life insurance cannot be deferred and must be kept in your retirement account.

To transfer your coverage to your spouse's plan:

- Mark *Defer* on your *Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage* on pages 11 and 12 and return it to EGID.
- Your spouse must contact their employer to add you to their coverage as a dependent.
- Any retirement system contribution paid toward your health insurance premium will not be paid during the deferral period.

As long as your former employer group continues to participate with EGID, you can transfer your coverage back to your own EGID account during the annual Option Period, or at any time, by completing a new *Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage*.



If You Are Eligible for Medicare

About Medicare

Medicare is the health insurance program for people age 65 or older, people under age 65 with certain disabilities, and those with end-stage renal disease.

- **Medicare Part A** pays for hospitalization services.
- **Medicare Part B** pays for doctor and outpatient medical services. Call Social Security for information on your Part B

premiums. Refer to the *Contact Information* section included in this guide.

- **Medicare Part D** pays for prescription drug coverage. All the plans offered through EGID provide Part D coverage. This means the plans all meet the benefit guidelines set by Medicare for creditable prescription drug coverage.

Your enrollment in Medicare is handled in one of two ways.

1. You are automatically enrolled.
2. You must apply. You should apply three months prior to your 65th birthday to avoid a possible delay in the start of your coverage.

Contact the Social Security Administration for more information.

To Continue Your Insurance and Enroll in a Medicare Supplement or MA-PD Plan

There are two forms you must complete to continue your health coverage.

1. Complete the *Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage* on pages 11 and 12.

2. Depending on your current health plan, you must also complete either the *Application for Medicare Supplement With Part D* or the *Application for Medicare Advantage Prescription Drug (MA-PD) Plan.*

To Enroll in a Medicare Supplement Plan With Part D

The HealthChoice Medicare supplement plans provide supplemental benefits for Medicare Part A and Part B covered services, as well as Part D prescription drug benefits. The Plans pay benefits as if you are enrolled in both Medicare Part A and Medicare Part B.

The plans are:

- HealthChoice High Option Medicare Supplement Plans With and Without Part D
- HealthChoice Low Option Medicare Supplement Plans With and Without Part D

To enroll in a HealthChoice Medicare supplement plan with Part D, you must complete and return the *Application for Medicare Supplement With Part D* on pages 15 through 18 of this guide. Be sure to fill in your Medicare ID number (HICN). Your Medicare ID number must be provided to coordinate your benefits with Medicare.

To Enroll in a Medicare Advantage Prescription Drug (MA-PD) Plan

Medicare Advantage Prescription Drug (MA-PD) plans provide benefits for Medicare Part A and Part B covered services, as well as Part D prescription drug benefits.

You must be enrolled in Medicare Part A and Part B to be eligible for enrollment. When you enroll in an MA-PD plan, the plan replaces Medicare as your primary insurer.

You must also live in the MA-PD plan's approved ZIP code service area to be eligible to enroll.

The plans are:

- CommunityCare Senior Health Plan
- Generations Healthcare

To enroll in an MA-PD plan, you must complete and return the *Application for Medicare Advantage Prescription Drug (MA-PD) Plan* on pages 19 through 22 of this guide. Be sure to fill in your Medicare ID number (HICN).

Enrollment Deadline

If You Are Not Eligible for Medicare

EGID *Administrative Rules* state you have 30 days from the date you leave active employment to elect to begin or continue your insurance.

If you fail to add, keep or defer your coverage within 30 days of leaving active employment, your eligibility in the plans offered through EGID is cancelled.

If You Are Eligible for Medicare

It is important that your application is received at least 30 days prior to the date you leave active employment. This will allow EGID enough time to process your application and resolve any problems before your coverage is effective.

If your application is not received prior to your employment termination, you may be enrolled in the HealthChoice High Option Medicare Supplement Plan Without Part D until the first of the following month. This is so you do not experience a break in prescription drug coverage and become subject to a late enrollment penalty.

While the plans with and without Part D provide creditable coverage, the premiums for the plans without Part D are higher.

Plan ID Cards

HealthChoice Plans

Members have two ID cards, one card for medical and/or dental benefits and one for pharmacy benefits.

- Pre-Medicare retirees should keep their current ID cards. New cards are not issued.
- Members eligible for Medicare should keep their current medical ID card, but new pharmacy ID cards are issued.

HMO and MA-PD Plans

HMOs and MA-PD plans generally issue new ID cards.

Do not destroy your current cards until you receive your new ones.

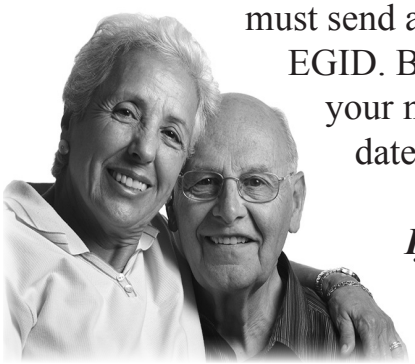
If You Move Outside Your Plan's Service Area

If You Are Not Eligible for Medicare

If you are enrolled in an HMO plan and move outside your plan's ZIP code service area, you must notify EGID in writing of your new address. Your health coverage will be changed to the HealthChoice High Plan. The HealthChoice USA Plan is an option if you move and establish residency outside of Oklahoma and Arkansas for a minimum of 90 days.

You must enroll within 30 days of your move or wait until the next annual Option Period.

To enroll in the HealthChoice USA Plan, you must send a written request to EGID. Be sure you include your new address and the date you moved.



If You Are Eligible for Medicare

If you are enrolled in an MA-PD plan and move outside your plan's ZIP code service area, you must contact EGID to disenroll. Your coverage will be changed to the HealthChoice High Option Medicare Supplement Plan Without Part D.

To change your coverage to a plan that includes Part D prescription drug benefits, you must also complete an *Application for Medicare Supplement With Part D* or an *Application for Medicare Advantage Prescription Drug (MA-PD) Plan*.

Address Information

It is important to keep your address information current. You risk delaying claims processing or missing important communications when information in our files is incorrect.

Medicare requires that you report any change in your home address to your insurance plan.

Contact EGID Member Services for an *Address Change Form* or submit a written request to:

Office of Management and Enterprise Services
Employees Group Insurance Division
3545 N.W. 58th St., Ste. 110
Oklahoma City, OK 73112

Requests for changes can also be faxed to 1-405-717-8939. Verbal requests for address changes are not accepted.

Option Period

After you leave active employment, your Option Period materials are mailed directly to you.

To make plan changes, complete your Option Period form and return it directly to EGID.

PRE-MEDICARE

Monthly Premiums for Former Employees and Surviving Dependents

Plan Year Jan. 1, 2015 - Dec. 31, 2015

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
HealthChoice High	$499.42	$ 676.28	$253.56	$391.20
HealthChoice High Alternative	$499.42	$ 676.28	$253.56	$391.20
HealthChoice Basic	$391.52	$ 501.74	$215.94	$342.74
HealthChoice Basic Alternative	$391.52	$ 501.74	$215.94	$342.74
HealthChoice High Deductible Health Plan (HDHP)	$338.02	$ 430.60	$186.80	$295.24
HealthChoice USA	$764.44	$ 764.44	$251.06	$387.16
CommunityCare HMO	$711.34	$1,036.16	$362.30	$579.68
GlobalHealth HMO	$469.02	$ 769.22	$247.18	$394.04

DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
HealthChoice Dental	$32.00	$32.00	$27.40	$ 68.20
Assurant Freedom Preferred	$28.82	$28.66	$21.50	$ 57.80
Assurant Heritage Plus with SBA (Prepaid)	$11.74	$ 8.86	$ 7.60	$ 15.20
Assurant Heritage Secure (Prepaid)	$ 7.20	$ 5.98	$ 5.20	$ 10.38
Cigna Dental Care Plan (Prepaid)	$ 9.26	$ 6.06	$ 7.08	$ 15.32
Delta Dental PPO	$33.64	$33.62	$29.26	$ 74.04
Delta Dental PPO Plus Premier	$47.98	$47.98	$41.76	$105.66
Delta Dental PPO — Choice	$15.06	$34.18	$34.44	$ 83.60

VISION PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Humana/CompBenefits VisionCare Plan	$ 7.14	$12.46	$10.90	$11.84
Primary Vision Care Services (PVCS)	$ 9.00	$ 8.00	$ 8.00	$11.00
Superior Vision	$ 7.40	$ 7.36	$ 6.96	$14.30
UnitedHealthcare Vision	$ 8.18	$ 5.78	$ 4.58	$ 6.98
Vision Care Direct	$14.16	$ 8.50	$ 8.50	$12.00
Vision Service Plan (VSP)	$ 9.50	$ 6.36	$ 6.12	$13.72

HEALTHCHOICE LIFE INSURANCE PLAN		
From $5,000 to $40,000	$1.88 Per $1,000	
Age Rated Supplemental Life — Cost Per $1,000 for $41,000 and Up		
< 30 ------- $0.04	30 - 34 ---- $0.04	35 - 39 ---- $0.04
40 - 44 ---- $0.06	45 - 49 ---- $0.10	50 - 54 ---- $0.20
55 - 59 ---- $0.30	60 - 64 ---- $0.34	65 - 69 ---- $0.56
70 - 74 ---- $0.96	75 + ---- $1.48	
DEPENDENT LIFE	$0.94 Per $500 Unit, Per Dependent	

These rates do not reflect any contribution from your retirement system.

MEDICARE

Monthly Premiums for Medicare Eligible Members

Plan Year Jan. 1, 2015 - Dec. 31, 2015

MEDICARE SUPPLEMENT PLANS	
HealthChoice Employer PDP High Option With Part D	$307.28 per enrolled person
HealthChoice Employer PDP Low Option With Part D	$239.90 per enrolled person
HealthChoice High Option Without Part D	$404.56 per enrolled person
HealthChoice Low Option Without Part D	$314.54 per enrolled person

MEDICARE ADVANTAGE PRESCRIPTION DRUG (MA-PD) PLANS	
CommunityCare Senior Health Plan	$242.00 per enrolled person
Generations Healthcare	$190.40 per enrolled person

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HealthChoice Dental	$32.00	$32.00	$27.40	$ 68.20
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< 30 ---------- $0.04	30 - 34 ------- $0.04	35 - 39 ------- $0.04
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55 - 59 ------- $0.30	60 - 64 ------- $0.34	65 - 69 ------- $0.56
70 - 74 ------- $0.96	75+ ---------- $1.48	
DEPENDENT LIFE	$0.94 per $500 unit, per dependent	

These rates do not reflect any contribution from your retirement system.

Office of Management and Enterprise Services

Employees Group Insurance Division

APPLICATION FOR RETIREE/VESTED/NON-VESTED/DEFER INSURANCE COVERAGE

RETIREMENT SYSTEM ☐ **OPERS** ☐ **TRS** ☐ **OLERS** ☐ **OTHER**

My Member Status Will Be: ☐ Retiree ☐ Vested ☐ Non-Vested ☐ Defer*

* Refer to *Defer* instructions on page 3 - Spouse's SSN or Member ID# _____

☐ Cancel My Deferment and Reinstate My Retiree/Vest/Non-Vest Insurance Coverage

MEMBER INFORMATION

SSN or Member ID # _____ Member's Birth Date _____ Gender ☐ Male ☐ Female

Member's Name _____ Employer _____
First M.I. Last

Mailing Address _____
Street City State ZIP Code

Phone # (____) _____ Alt Phone # (____) _____ Email Address _____

Last Date of Employee Insurance Coverage	Mo.		Day		Yr.	

Vested / Non-Vested Insurance Effective Date	Mo.		Day		Yr.	
			0	1		

Retirement Insurance Effective Date	Mo.		Day		Yr.	
			0	1		

MEMBER HEALTH PLAN ☐ Add/Keep ☐ Drop ☐ Defer

Health Plan Name: _____ ☐ Check if Medicare Eligible (See Note)

Employee Primary Physician (HMO Only): _____
☐ Current Patient ☐ New Patient

NOTE: If you and/or your dependents are eligible for Medicare, an additional application must be completed. Please contact EGID Member Services to request an application.

MEMBER DENTAL PLAN ☐ Add/Keep ☐ Drop ☐ Defer

Dental Plan Name: _____

Employee Primary Dentist (Prepaid Only): _____
☐ Current Patient ☐ New Patient

For EGID Use Only

MEMBER VISION PLAN ☐ Add/Keep ☐ Drop ☐ Defer

Vision Plan Name: _____

MEMBER LIFE INSURANCE

You can keep a minimum of $5,000 up to the total amount of your current life insurance. You cannot enroll in more life insurance than you currently have. You must keep life insurance on yourself to be able to keep life insurance on your dependents. It is important to consider future life insurance needs because increases cannot be made after this election.

*** Defer** – Life Insurance cannot be deferred and must be carried as a primary retiree/vested member. You can only defer your health, dental and/or vision.

☐ I elect to keep $ _____ ($5,000 to $40,000 in $5,000 units) of member life insurance at a flat rate per $1,000 of coverage

☐ I elect to keep $ _____ (amount above $40,000 in $5,000 units) of additional life insurance

DEPENDENT INFORMATION

NOTE: If you and/or your dependents are eligible for Medicare, an additional application must be completed. Please contact EGID Member Services to request an application.You cannot add dependent life if you do not already have it. The dependent life amount must be the same for each child. The amount for your spouse can be different from that of your child(ren).

Add/Keep **Drop**

SPOUSE ☐ ☐ Health Name: _____ ☐ Check if Medicare eligible
☐ ☐ Dental SSN: _____ Date of Birth: _____ ☐ Male ☐ Female
☐ ☐ Vision Primary Physician: _____ ☐ Current Patient ☐ New Patient
(HMO Only)
☐ ☐ Dep Life* Primary Dentist: _____ ☐ Current Patient ☐ New Patient
(Prepaid Only)
*I elect to keep $_____ (in $500 units) of Dependent Life Insurance

Does your spouse have health, dental, and/or vision coverage through EGID? ☐ Yes ☐ No (If yes, list Name and SSN above)

Add/Keep **Drop**

CHILD ☐ ☐ Health Name: _____ ☐ Check if Medicare eligible
☐ ☐ Dental SSN: _____ Date of Birth: _____ ☐ Male ☐ Female
☐ ☐ Vision Primary Physician: _____ ☐ Current Patient ☐ New Patient
(HMO Only)
☐ ☐ Dep Life* Primary Dentist: _____ ☐ Current Patient ☐ New Patient
(Prepaid Only)
*I elect to keep $_____ (in $500 units) of Dependent Life Insurance

CERTIFICATION SIGNATURES

☐ I authorize EGID to deduct the amount of my premiums from my retirement check according to Rule 360:10-3-3-5. (You must verify with your retirement system that your retirement check will cover your premiums.)

☐ I request EGID direct bill me for my monthly premiums at the mailing address on this form.

Spouse must sign 1.) if being excluded from health/dental and/or 2.) if a common-law spouse.

☐ **Spouse Exclusion Certification:** I certify that I am aware **I am being excluded from health and/or dental coverage as indicated on this form.** I am also aware that I cannot be added to coverage at a later date except within 30 days of loss of other group coverage. (Required only if children are covered and spouse is not.)

☐ **Common-Law Spouse Certification:** I certify that the person listed as my spouse and I have an actual and mutual agreement between ourselves to be married; that this is a permanent relationship; and that our relationship is exclusive, as proven by our cohabitation as spouses; and do hereby hold ourselves out publicly as married. **I am aware that this relationship can be dissolved only by legal divorce.**

Spouse Signature: _____ **Date:** _____

I understand that no coverage, except vision, can be added at a later date.

Member Signature: _____ **Date:** _____

Revised 10/09/2014

Retirement information can be found at www.healthchoiceok.com

You can carry health, dental, vision, and life insurance on yourself and your dependents.

The health, dental, and life coverage that you take into retiree/vested status is the only coverage you can have through your retirement years. If you do not keep coverage now, you cannot add it later. Plan changes can be made during the annual Option Period.

If you are insuring one dependent, you must insure all eligible dependents (for any given coverage) unless they are covered by other group insurance, or Indian or military benefits. Children who have Indian or military benefits or other group insurance may be required to show proof of coverage.

Following your retirement, dependents can be added only within 30 days of one of the following events: birth, adoption or guardianship, marriage or loss of other group insurance.

*** DEFER** If your spouse has separate coverage through EGID at the time you terminate employment, you can transfer your individual health, dental, and/or vision coverage to dependent coverage under your spouse's coverage. Your spouse must contact their employer to add you as a dependent. You must elect to transfer coverage within 30 days of your termination of employment. Any 30-day break in coverage voids your eligibility to keep coverage in the future. Life insurance cannot be deferred and must be carried as a primary retiree/vested member. When you are ready to return to retiree/vested status, you must again complete this form and mark the box on page 1 of your form to cancel your deferment.

THINGS TO CONSIDER AS A RETIREE WHEN YOU BECOME MEDICARE ELIGIBLE

IMPORTANT: If you are under age 65 and eligible for Medicare, you must notify EGID and provide your Medicare ID# as it appears on your Medicare card. Medicare supplement coverage is effective the date you become eligible for Medicare, or the 1st day of the month following notification of your Medicare eligibility, whichever is later.

When you turn age 65, if you are enrolled in HealthChoice pre-Medicare health coverage, you will be automatically enrolled in the HealthChoice Employer PDP High Option Medicare Supplement Plan With Part D. If you are on an HMO, you can enroll in their Medicare Advantage Prescription Drug (MA-PD) plan, if you live in their service area.

All Medicare supplement plans (except HealthChoice) and all MA-PD plans offered through EGID require you to have both Medicare Part A and Medicare Part B.

If you are eligible and do not enroll in Medicare Part B, there are four plans available to you: HealthChoice Employer PDP High and Low Option Medicare Supplement Plans With Part D and HealthChoice High and Low Option Medicare Supplement Plans Without Part D. All medical benefits under these Plans are paid as if you are enrolled in both Medicare Parts A and Part B. If you are not enrolled in Medicare Part B, the Plan will estimate Medicare's benefits and provide supplemental coverage as if Medicare is the primary carrier. This means HealthChoice pays secondary, and you are responsible for the primary share of the claim.

If you didn't enroll in Part B when you first became eligible, your monthly premium amount for Part B may be higher due to a late enrollment penalty. The Part B premium is separate from your HealthChoice premium, and it is taken out of your Social Security check.

For information concerning HMO, MA-PD, dental, or vision plans, contact their customer service numbers.
For information regarding HealthChoice plans, contact:
Employees Group Insurance Division
3545 N.W. 58th St., Ste. 110, Oklahoma City, OK 73112
1-405-717-8780 or toll-free 1-800-752-9475 or TDD 1-405-949-2281 or toll-free 1-866-447-0436.

Notes

Office of Management and Enterprise Services
Employees Group Insurance Division
APPLICATION FOR MEDICARE SUPPLEMENT WITH PART D

Member ID #_____ Phone (_____) _____

E-mail Address _____ Alternate Phone # (_____) _____

Member's Name _____
First M.I. Last

Dependent's Name _____
(if enrolling in Medicare) First M.I. Last

Permanent Residence _____
(P.O. Box is not allowed) Street City State Zip Code

Mailing Address _____
(if different than above) Street City State Zip Code

If your dependent is the person enrolling in Medicare, all the information and questions relate to them.

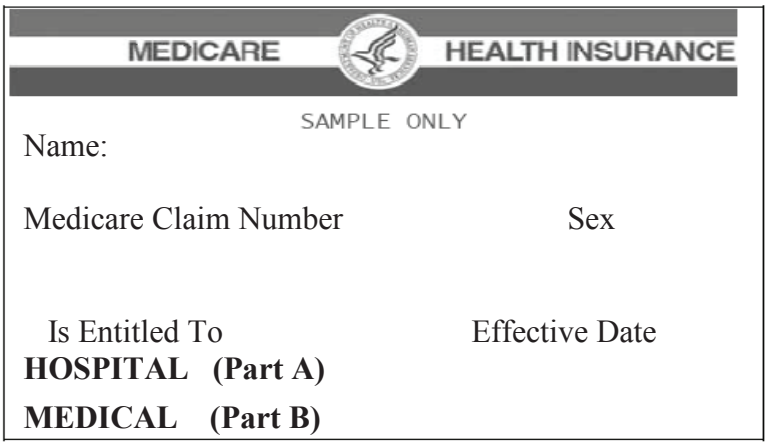
Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in the blanks to the right so they match your red, white, and blue Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or Railroad Retirement Board.


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name:

Medicare Claim Number Sex

Is Entitled To Effective Date

HOSPITAL (Part A)

MEDICAL (Part B)

HealthChoice Medicare Supplement Plan coverage becomes effective as of the date you become eligible for Medicare, or the 1st of the month following the Plan's notification of your Medicare eligibility, whichever is later. All medical benefits under this Plan are paid as if you are enrolled in both Medicare Parts A and B. If you are not enrolled in Medicare Part B, the Plan will estimate Medicare's benefits and provide supplemental coverage as if Medicare is the primary carrier. This means that HealthChoice pays secondary, and you are responsible for the primary share of the claim.

Please Answer the Following Questions

1. In which Medicare Supplement With Part D plan do you want to enroll?

HealthChoice Employer PDP Medicare Supplement with Part D ☐ High ☐ Low

2. Some individuals may have other drug coverage through private insurance, TRICARE, federal employee health benefits coverage, VA benefits, or state pharmaceutical assistance programs. Do you have other **prescription** drug coverage in addition to HealthChoice? ☐ Yes ☐ No

If yes, please list your other coverage and your identification (ID) number(s) for your coverage:
Name of other coverage: _____ ID #: _____ Group #: _____

Revised 09/12/2013

3. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
If yes, please provide the name, address, and phone number of the facility:
Name _____ Address and Phone _____

Typically, you can enroll in a Medicare Prescription Drug Plan only during the Annual Enrollment Period. There are a few exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the Annual Enrollment Period.

☐ I am enrolling during an Annual Enrollment Period (Option Period).

There are exceptions that may allow you to enroll in a PDP plan outside of this period.

4. Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I recently moved outside of the service area of my current plan. I moved on (insert date) _____.

☐ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.

☐ I get Extra Help paying for Medicare prescription drug coverage.

☐ I no longer qualify for Extra Help paying for my Medicare prescription drug coverage. I stopped receiving extra help on (insert date) _____.

☐ I live in or recently moved out of a long-term care facility (for example, a nursing home or long term care facility). I moved/will move into/out of the facility on (insert date) _____.

☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date) _____.

☐ I am leaving employer or union coverage on (insert date) _____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I recently returned to the United States after living permanently outside of the U.S.

☐ None of these statements apply to me. (Please contact HealthChoice at 1-405-717-8780 or toll-free 1-800-752-9475 Monday through Friday, 7:30 am to 4:30 pm, Central Time to see if you're eligible to enroll. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.)

Please Read This Important Information

If you or your dependent(s) are currently a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By enrolling in a Medicare Supplement With Part D plan offered by the Office of Management and Enterprise Services (OMES) - Employees Group Insurance Division (EGID), your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage, as well as your prescription drug benefits. Read the information your Medicare Advantage Plan sends you, and if you have questions, contact your Medicare Advantage Plan.

Revised 09/12/2013

If you or your dependent(s) currently have health coverage from an employer or union, enrolling in a Medicare Supplement With Part D plan offered by EGID could affect your employer or union health benefits. You could lose your employer or union health coverage if you enroll in a Medicare Supplement With Part D plan offered by EGID. Read the communications your employer or union sends you. If you have questions, visit their website- or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

If you are assessed a Part D-Income Related Monthly Adjustment Amount (IRMAA), you will be notified by the Social Security Administration. You will be responsible for paying this extra amount in addition to your plan premium. You will either have the amount withheld from your Social Security or Railroad Retirement Board benefit check or be billed directly by Medicare. **Do NOT pay the Part D-IRMAA extra amount to EGID**.

People with limited incomes may qualify for Extra Help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a Coverage Gap or a late enrollment penalty. Many people are eligible for these savings and don't even know. For more information about this Extra Help, contact your local Social Security office, or call Social Security toll-free at 1-800-772-1213. TTY users should call toll-free 1-800-325-0778. You can also apply for Extra Help online at **www.socialsecurity.gov/prescriptionhelp.**

If you qualify for Extra Help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

Please Read and Sign Next Page

By completing this enrollment application, I agree to the following:

The Medicare Supplement With Part D plans offered by EGID are Medicare supplement and prescription drug plans and have a contract with the federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A and Part B coverage. It is my responsibility to inform EGID of any prescription drug coverage that I have or may get in the future. I can be enrolled in only one Medicare prescription drug plan at a time. If I am currently in a Medicare Prescription Drug Plan, my enrollment in a Medicare Supplement With Part D plan offered by EGID will end that enrollment. Enrollment in one of these plans is generally for the entire year. Once I enroll, I can only leave that plan or make changes if an enrollment period is available, generally during the Annual Enrollment Period, unless I qualify for enrollment under certain special circumstances.

The Medicare Supplement With Part D plans offered by EGID serve the entire United States. If I move out of the United States, I need to notify EGID so I can disenroll and find a new plan in my new area. I understand that I must use Network Pharmacies except in an emergency when I cannot reasonably use a Network Pharmacy. Once I am a member of one of the Medicare Supplement With Part D plans offered by EGID, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document provided by my selected plan when I get it to know the rules I must follow to get coverage.

I understand that if I leave this Plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage if I re-enroll in the future.

Release of Information:

By joining this Medicare supplement prescription drug plan, I acknowledge that the Medicare Supplement With Part D plans offered by EGID will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that they will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under state law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by EGID or Medicare.

Member Signature: _____ Date: _____

(You must return the first four pages of this form to EGID at the address listed below.)

Dependent Signature: _____ Date: _____

(Required only if dependent is enrolling in Medicare.)

For information about the Medicare Supplement With Part D plans offered by EGID, contact:

Office of Management and Enterprise Services
Employees Group Insurance Division
3545 NW 58th Street, Suite 110 Oklahoma City, OK 73112
1-405-717-8780 or toll free 1-800-752-9475 or TDD 1-405-949-2281 or toll free 1-866-447-0436

Office of Management and Enterprise Services
Employees Group Insurance Division
APPLICATION FOR MEDICARE ADVANTAGE PRESCRIPTION DRUG (MA-PD) PLAN
A separate application must be submitted for each Medicare beneficiary enrolling.

Member ID #_____ Phone # (_____) _____

Email Address_____ Alternate Phone # (_____) _____

Member Name _____
First M.I. Last

Member SSN _____ Member Date of Birth _____ Sex ☐ M ☐ F

Dependent Name _____
(if enrolling in Medicare) First M.I. Last

Dependent SSN _____ Dependent Date of Birth _____ Sex ☐ M ☐ F

Permanent Residence_____
(P.O. Box is not allowed) Street City State ZIP Code County

Mailing Address_____
(if different than above) Street City State ZIP Code County

If your dependent is the person enrolling in Medicare, all information and questions relate to them.

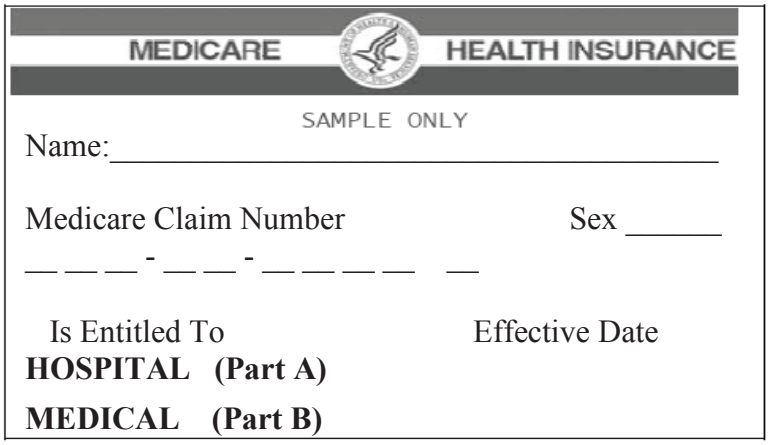
Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Fill in the blanks to the right so they match your red, white and blue Medicare card.

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or Railroad Retirement Board.


MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name:_____

Medicare Claim Number Sex _____

__ __ __ - __ __ - __ __ __ __ __

Is Entitled To Effective Date

HOSPITAL (Part A)

MEDICAL (Part B)

You must have Medicare Part A and Part B to join an MA-PD plan.

Please Answer the Following Questions

1. In which MA-PD plan do you want to enroll?

CommunityCare Senior MA-PD ☐

Generations Healthcare MA-PD ☐

2. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
If you have had a successful kidney transplant and/or you don't need regular dialysis any more, ***please attach a note or records*** *from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise, the MA-PD plan may need to contact you to obtain additional information.*

3. Some individuals may have other prescription drug coverage through private insurance, TRICARE, federal employee health benefits coverage, VA benefits, worker's compensation, or state pharmaceutical assistance programs. Do you have other **prescription** drug coverage? ☐ Yes ☐ No

If yes, please list your other coverage and your identification (ID) number(s) for your coverage:
Name of other coverage: _____ ID #:_____ Group #:_____

Typically, you can enroll in an MA-PD plan *only* during the Annual Enrollment Period *from* October 15 *through* December 7 of each year. Please check the box below if you are enrolling during an Annual Enrollment Period.

☐ I am enrolling during an Annual Enrollment Period (Option Period).

There are exceptions that may allow you to enroll in an MA-PD plan outside of this period.

4. Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an enrollment period. If we later determine that this information is incorrect, you may be disenrolled.

☐ I am new to Medicare.

☐ I recently moved outside of the service area of my current plan, or I recently moved and this plan is a new option for me. I moved on (insert date) _____.

☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.

☐ I have both Medicare and Medicaid, or my state helps pay for my Medicare premiums.

☐ I get Extra Help paying for Medicare prescription drug coverage.

☐ I no longer qualify for Extra Help paying for my Medicare prescription drug coverage. I stopped receiving Extra Help on (insert date) _____.

☐ I am moving into, live in, or recently moved out of a long-term care facility (for example, a nursing home). I moved/will move into/out of the facility on (insert date) _____.

☐ I recently left a PACE program on (insert date) _____.

☐ I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's). I lost my drug coverage on (insert date) _____.

☐ I am leaving employer or union coverage on (insert date) _____.

☐ I belong to a pharmacy assistance program provided by my state.

☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.

☐ None of these statements apply to me. (Please contact the Office of Management and Enterprise Services (OMES) - Employees Group Insurance Division (EGID) at 1-405-717-8780 or toll-free 1-800-752-9475 Monday through Friday, 7:30 a.m. to 4:30 p.m., CST to see if you're eligible to enroll. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

Would you prefer that the MA-PD plan send you information in a language other than English or in another format?

☐ Yes ☐ No If you mark yes, please contact the MA-PD plan directly. See contact information below.

PRIMARY CARE SELECTION

As an MA-PD plan member, you must choose a primary care physician (PCP) who will coordinate your health care. Once you choose an MA-PD plan, you can obtain a list of the plan's network physicians by contacting your plan or going to one of the websites listed below.

CommunityCare Senior Health Plan
Member Services / Monday through Sunday / 8:00 a.m. to 8:00 p.m., CST
P.O. Box 3327, Tulsa, OK 74101
Toll-free 1-800-642-8065
Relay Service for the Hearing Impaired toll-free 1-800-722-0353
Website: www.ccok.com

Generations HealthCare Plan
Customer Care / Monday through Sunday / 8:00 a.m. to 8:00 p.m., CST
P.O. Box 1747, Oklahoma City, OK 73101-1747
1-405-280-5555 or toll-free 1-844-280-5555 TTY/TDD/Voice 711
Website: www.generationshealthcare.cc

Physician's First Name: _____
Physician's Last Name: _____

Are you currently a patient of the physician: ☐ Yes ☐ No

Please Read This Important Information

By completing this enrollment application, I agree to the following:
The MA-PD plans offered through EGID are Medicare Advantage Prescription Drug plans and they have a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one MA-PD plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform EGID of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: annual enrollment period from October 15 – December 7), or under certain special circumstances.

The MA-PD plans offered through EGID serve a specific service area. If I move out of that service area, I need to notify EGID and the plan so I can disenroll and find a new plan in my new area. Once I am a member of an MA-PD plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the member handbook or Evidence of Coverage document from the MA-PD plan when I get it so I know which rules I must follow to get coverage through my MA-PD plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date my MA-PD plan coverage begins, I must get all of my health care from that plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by the MA-PD plan and other services contained in my MA-PD Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MY MA-PD PLAN WILL PAY FOR THE SERVICES.**

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that this MA-PD plan will release my information, including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Member Signature: _____ Date: _____

Dependent Signature: _____ Date: _____
(Required only if dependent is enrolling in an MA-PD plan.)

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (___) _____

Relationship to Enrollee: _____

You must return this form to EGID at the address or fax number listed below.

For more information regarding this application, contact EGID:

Office of Management and Enterprise Services
Employees Group Insurance Division
3545 N.W. 58th Street, Ste. 110, Oklahoma City, OK 73112
1-405-717-8780 or toll free 1-800-752-9475 or TDD 1-405-949-2281 or toll free TDD 1-866-447-0436
Fax 1-405-717-8939

Office of Management and Enterprise Services
Employees Group Insurance Division
Beneficiary Designation Form

Please read the instructions carefully and complete this form in ink.

SSN or Member ID: ________________ Member Name: ______________________________
First MI Last

Address: ____
☐ New Address Street City State ZIP

Beneficiary: Primary ☐ % (Optional): _______ Contingent ☐ % (Optional): _______
Full Legal Name of Person, Trust, or Institution: ______________________________
SSN: ________________ Date of Birth: ____________ Relationship: ______________
Address: ____
Street City State ZIP
Phone: (___) ______________________ Alt Phone: (___) ______________________

Beneficiary: Primary ☐ % (Optional): _______ Contingent ☐ % (Optional): _______
Full Legal Name of Person, Trust, or Institution: ______________________________
SSN: ________________ Date of Birth: ____________ Relationship: ______________
Address: ____
Street City State ZIP
Phone: (___) ______________________ Alt Phone: (___) ______________________

Beneficiary: Primary ☐ % (Optional): _______ Contingent ☐ % (Optional): _______
Full Legal Name of Person, Trust, or Institution: ______________________________
SSN: ________________ Date of Birth: ____________ Relationship: ______________
Address: ____
Street City State ZIP
Phone: (___) ______________________ Alt Phone: (___) ______________________

Beneficiary: Primary ☐ % (Optional): _______ Contingent ☐ % (Optional): _______
Full Legal Name of Person, Trust, or Institution: ______________________________
SSN: ________________ Date of Birth: ____________ Relationship: ______________
Address: ____
Street City State ZIP
Phone: (___) ______________________ Alt Phone: (___) ______________________

Signature – I have named the above beneficiary or beneficiaries to receive my life insurance benefits from HealthChoice. I understand this form replaces and cancels all prior beneficiary designations and will becomes effective only when it is received by EGID.

______________________________________ ______________________
Member Signature - original signature required Date

Mail this form to EGID at 3545 NW 58th Street, Suite 110, Oklahoma City, OK 73112

Revised 10/12/2012

Instructions for Completing the Beneficiary Designation Form

This beneficiary form applies to the HealthChoice Life Insurance plan offered through the Office of Management and Enterprise Services (OMES) Employees Group Insurance Division (EGID). If you are retired, it does not affect the beneficiaries for any death benefit that may be available through your retirement system.

The beneficiary designations you make on this form replace and cancel all prior life insurance beneficiary designations with EGID. Your designations do not become effective until this form is **signed** and **received** by EGID. Do not alter this form or attach additional pages.

It is very important that you provide the **full legal name, address, relationship, date of birth, and Social Security Number (SSN) of each beneficiary you designate**. This information is essential in ensuring that your named beneficiaries can be located and receive your intended benefit amount. The *Beneficiary Designation Form* has three parts: Member Information, Primary and Contingent Beneficiary Designation, and Signature. **Please print clearly in ink.**

Member Information – Provide your name, SSN or Member ID, and address.

Primary Beneficiary Designation – You can designate one or more primary beneficiaries. All primary beneficiaries share equally, unless you note otherwise.

Contingent Beneficiary Information – You can designate one or more contingent beneficiaries. Contingent beneficiaries receive benefits only in the event all primary beneficiaries die before or simultaneously with the member. All contingent beneficiaries share equally, unless you note otherwise on your form.

Signature – You must sign and date your form.

Special Beneficiary Designations

Sometimes members wish to make a special designation for trusts, minors, or institutions. If you wish to make a special designation, please read the following information carefully.

Designating a trust as beneficiary – To designate a trust as beneficiary, provide the actual name of the trust and the date the trust was created in the space provided.

Designating a minor as beneficiary – A minor can be named your beneficiary; however, it is often difficult and costly for a minor to receive payment, especially if the amount exceeds $10,000. Before you designate a minor as your beneficiary, you should consult an attorney or professional financial advisor.

Designating an institution as beneficiary – To designate an institution (church, charity, funeral home, etc.) as your beneficiary, provide the full name of the institution and list the address in the space provided.

After you complete and sign the *Beneficiary Designation Form*, mail it to:

Employees Group Insurance Division
Office of Management and Enterprise Services
3545 NW 58th Street, Suite 110
Oklahoma City, OK 73112

Remember to keep a copy of your completed form for your records.

Revised 10/12/2012

STATE OF OKLAHOMA
Office of Management and Enterprise Services (OMES)
Privacy Notice
Revised: June 1, 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

For questions or complaints regarding privacy concerns with OMES, please contact:

OMES HIPAA Privacy Officer, 3545 NW 58th St., Ste. 110, Oklahoma City, OK 73112
Telephone: 1-405-717-8701 or toll-free 1-800-543-6044
TTY/TDD 1-405-949-2281 or toll-free TTY/TDD 1-866-447-0436
http://ok.gov/OSF/

Why is the Notice of Privacy Practices Important?

This Notice provides important information about the practices of OMES pertaining to the way OMES gathers, uses, discloses, and manages your protected health information (PHI) and it also describes how you can access this information. PHI is health information that can be linked to a particular person by certain identifiers including, but not limited to names, social security numbers, addresses and birth dates.

Oklahoma privacy laws and the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protect the privacy of an individual's health information. For HIPAA purposes, OMES has designated itself as a hybrid entity. This means that HIPAA only applies to areas of OMES operations involving health care, and not to all lines of service offered by OMES. This notice applies to the privacy practices of the following components included within OMES that may share or access your Protected Health Information as needed for treatment, payment and health care operations:

- The Employee Benefits Division (EBD) and the Employees Group Insurance Division (EGID) within Human Capital Management;
- The Performance and Efficiency Division as it applies to operations of the Employees Group Insurance Division;
- The Section 125 plan within the Division of Central Accounting and Reporting (DCAR);
- The Legal Division; and
- The Information Services Division (ISD) as it applies to maintenance and storage of PHI.

OMES is committed to protecting the privacy and security of your PHI as used within the components listed above.

Your Information. Your Rights. Our Responsibilities.

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records.
- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this using the contact information above.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable fee.

Ask us to correct health and claims records.
- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications.
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests.

Ask us to limit what we use or share.
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information.
- You can ask for an accounting of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year free of charge but will charge a reasonable fee if you ask for another accounting within 12 months.

Get a copy of this privacy notice.
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will verify the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

- You can complain if you feel we have violated your rights by contacting us using the information at the back of this packet.
- You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW, Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. Complaints to HHS must be filed within 180 days of when you knew that the violation occurred.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent health or safety threat.

OMES does not share your information for purposes of marketing or by sale of your information.

Our Uses and Disclosures

How do we typically use or share your health information (PHI)?
Your PHI is used and disclosed by OMES employees and other entities under contract with OMES according to HIPAA Privacy Rules using the "minimum necessary" standard which releases only the minimum necessary health information to achieve the intended purpose or to carry out a desired function within OMES. We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
- Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

- Examples: We use health information about you to develop better services for you, provide customer service, resolve member grievances, member advocacy, conduct activities to improve members' health and reduce costs, assist in the coordination and continuity of health care, and to set premium rates.

Pay for your health services
- We can use and disclose your health information as we pay for your eligible health services.
- Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
- We may disclose summarized health information to your health plan sponsor for plan administration.
- Example: Your employer contracts with us to provide a health plan, and we provide the employer with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information refer to **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues.
We can share health information about you for certain situations such as:

- Preventing disease;
- Helping with product recalls;
- Reporting adverse reactions to medications;
- Reporting births and deaths;
- Reporting suspected abuse, neglect, or domestic violence;
- Preventing or reducing a serious threat to anyone's health or safety; or
- Public health investigations.

Do research
- We can use or share your information for health research, as permitted by law.

Comply with the law.
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy laws.

Work with a medical examiner or funeral director.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests.

- We can use or share health information about you:
- For workers' compensation claims;
- For law enforcement purposes or with a law enforcement official;
- With health oversight agencies for activities authorized by law; or
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions.

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our responsibilities

- We are required by law to maintain the privacy and security of your protected health information (PHI).
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your PHI other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, refer to **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will deliver a copy to you.

Contact Information

Office of Management and Enterprise Services

Employees Group Insurance Division

1-405-717-8701
Toll-free 1-800-543-6044
TDD 1-405-949-2281
Toll-free TDD 1-866-447-0436

Health Plans

HealthChoice

1-405-717-8780
Toll-free 1-800-752-9475
TDD 1-405-949-2281
Toll-free TDD 1-866-447-0436
www.healthchoiceok.com

CommunityCare Senior Health Plan

Toll-free 1-800-642-8065
Toll-free relay service 1-800-722-0353
www.ccok.com

Generations Healthcare

Toll-free 1-844-280-5555
Toll-free TTY/TDD/Voice 711
www.generationshealthcare.cc

Dental Plans

HealthChoice Dental

1-405-717-8780
Toll-free 1-800-752-9475
TDD 1-405-949-2281
Toll-free TDD 1-866-447-0436
www.healthchoiceok.com

Assurant Dental Plans

Prepaid Heritage Plus
Toll-free 1-800-443-2995
PPO Freedom Preferred
Toll-free 1-800-442-7742
www.assurantemployeebenefits.com

CIGNA Dental Care (Prepaid)

Toll-free 1-800-244-6224
Hearing Impaired Relay 1-800-654-5988
www.cigna.com

Delta Dental Plans

1-405-607-2100
Toll-free 1-800-522-0188
www.deltadentalok.org

Life Plan

HealthChoice

1-405-717-8780
Toll-free 1-800-752-9475
TDD 1-405-949-2281
Toll-free TDD 1-866-447-0436
www.healthchoiceok.com

Contact Information

Vision Plans

Humana/CompBenefits VisionCare Plan

Toll-free 1-800-865-3676
Toll-free TDD 1-877-553-4327
www.compbenefits.com/custom/stateofoklahoma/

Primary Vision Care Services (PVCS)

Toll-free 1-888-357-6912
Toll-free TDD 1-800-722-0353
www.pvcs-usa.com

Superior Vision Services

Toll-free 1-800-507-3800
Toll-free TDD 1-916-852-2382
www.superiorvision.com

UnitedHealthcare Vision

Toll-free 1-800-638-3120
Toll-free TDD 1-800-524-3157
www.myuhcvision.com

Vision Care Direct

Toll-free 1-877-488-8900
Toll-free TDD 1-877-488-8900
visioncaredirect.com

Vision Service Plan (VSP)

Toll-free 1-800-877-7195
Toll-free TDD 1-800-428-4833
www.vsp.com

Other Important Numbers

Social Security Administration

Toll-free 1-800-772-1213
Toll-free TTY 1-800-325-0778
www.ssa.gov

Medicare

Toll-free 1-800-633-4227
Toll-free TTY 1-877-486-2048
www.medicare.gov

Oklahoma Public Employees Retirement System

1-405-858-6737
Toll-free 1-800-733-9008
www.opers.ok.gov

Oklahoma Teachers Retirement System

1-405-521-2387
Toll-free 1-877-738-6365
www.ok.gov/trs

Oklahoma Law Enforcement Retirement System

1-405-522-4931
Toll-free 1-877-213-0856
www.olers.state.ok.us

Forms You Must Complete to Continue Insurance When You Leave Active Employment

Insurance Forms	If You Are a Pre-Medicare Member	If You Are a Member Enrolling in a Medicare Supplement Plan	If You Are a Member Enrolling in a Medicare Advantage Prescription Drug (MA-PD) Plan
Application for Retiree/Vested/ Non-Vested/ Defer Insurance Coverage	**Yes**	**Yes**	**Yes**
Application for Medicare Supplement with Part D	**No**	**Yes** Each Enrollee Must Complete an Application	**No**
Application for Medicare Advantage Prescription Drug (MA-PD) Plan	**No**	**No**	**Yes** Each Enrollee Must Complete an Application
Beneficiary Designation Form (If Continuing Life Insurance Coverage)	**Yes**	**Yes**	**Yes**

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