OKLAHOMA
Employees Group
Insurance Division

PLANNING FOR YOUR INSURANCE NEEDS

AS A FORMER EMPLOYEE

2025

HEALTH
DENTAL
LIFE
VISION

5162

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Monthly Premiums for Former Employees and Surviving Dependents Plan Year Jan. 1-Dec. 31, 2025

OKLAHOMA
Office of Management & Enterprise Services

HEALTH PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Blue Cross Blue Shield of Oklahoma – BlueLincs HMO	$ 642.84	$ 883.80	$ 595.88	$ 1,390.02
CommunityCare HMO	$ 702.72	$ 823.90	$ 386.50	$ 655.88
GlobalHealth HMO	$ 1,035.70	$ 1,528.78	$ 591.44	$ 965.86
HealthChoice High and High Alternative	$ 707.00	$ 828.88	$ 355.62	$ 603.46
HealthChoice Basic and Basic Alternative	$ 564.72	$ 662.72	$ 291.22	$ 492.62
HealthChoice High Deductible Health Plan (HDHP)	$ 492.80	$ 578.68	$ 254.52	$ 429.72

DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
BCBSOK – BlueCare Dental High Plan	$ 37.58	$ 37.58	$ 30.46	$ 77.68
BCBSOK – BlueCare Dental Low Plan	$ 23.84	$ 23.84	$ 20.60	$ 50.40
Cigna Prepaid High K1I09	$ 13.56	$ 10.98	$ 8.40	$ 14.44
Cigna Prepaid Low OKIV9	$ 10.48	$ 6.80	$ 4.62	$ 10.42
Delta Dental PPO	$ 37.72	$ 37.72	$ 32.82	$ 82.94
Delta Dental PPO – Choice	$ 17.88	$ 40.50	$ 40.80	$ 99.02
HealthChoice Dental	$ 48.58	$ 48.58	$ 39.28	$ 100.74
MetLife High Classic MAC	$ 53.22	$ 53.22	$ 45.60	$ 112.94
MetLife Low Classic MAC	$ 30.20	$ 30.20	$ 25.90	$ 63.74
Sun Life Preferred Active PPO	$ 37.08	$ 36.90	$ 27.70	$ 74.36

VISION PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
Primary Vision Care Services (PVCS)	$ 10.40	$ 9.28	$ 9.20	$ 11.50
Superior Vision	$ 7.40	$ 7.34	$ 6.96	$ 14.30
Vision Care Direct	$ 15.48	$ 10.96	$ 10.96	$ 24.48
VSP (Vision Service Plan)	$ 8.62	$ 5.66	$ 5.58	$ 12.22

LIFE PLAN FOR PRE-MEDICARE RETIREES/VESTED MEMBERS			
From $5,000 to $40,000	$3.12 Per $1,000 unit		
AGE-RATED SUPPLEMENTAL LIFE – Cost per $1,000 unit for $41,000 and up			
<30 – $0.06	30-34 – $0.06	35-39 – $0.06	40-44 – $0.08
45-49 – $0.14	50-54 – $0.26	55-59 – $0.40	60-64 – $0.46
65-69 – $0.74	70-74 – $1.28	75+ – $1.96	

DEPENDENT LIFE	$1.56 per $500 unit, per dependent

MONTHLY LIFE INSURANCE PREMIUMS FOR SURVIVING DEPENDENTS			
Surviving Dependents of Current Employees	**Low Option $2.60**	**Standard Option $4.32**	**Premier Option $11.26**
Spouse	$ 6,000 of coverage	$ 10,000 of coverage	$ 20,000 of coverage
Child (live birth to age 26)	$ 3,000 of coverage	$ 5,000 of coverage	$ 10,000 of coverage
Surviving Dependents of Former Employees	**$1.56 per $500 unit, per dependent**		

These rates do not reflect any retirement system contribution.

Monthly Premiums for Medicare Eligible Members Plan Year Jan. 1-Dec. 31, 2025

OKLAHOMA
Office of Management & Enterprise Services

MEDICARE SUPPLEMENT PLANS	
BCBSOK – BlueSecure℠	$ 507.84 per covered person
HealthChoice SilverScript High Option Medicare Supplement	$ 437.00 per covered person
HealthChoice SilverScript Low Option Medicare Supplement	$ 356.06 per covered person

MEDICARE ADVANTAGE PRESCRIPTION DRUG (MAPD) PLANS	
BCBSOK – MAPD	$ 252.72 per covered person
CommunityCare Senior Health Plan	$ 220.00 per covered person
Generations by GlobalHealth	$ 195.00 per covered person
Humana MAPD PPO	$ 250.38 per covered person

DENTAL PLANS	MEMBER	SPOUSE	CHILD	CHILDREN
BCBSOK – BlueCare Dental High Plan	$ 37.58	$ 37.58	$ 30.46	$ 77.68
BCBSOK – BlueCare Dental Low Plan	$ 23.84	$ 23.84	$ 20.60	$ 50.40
Cigna Prepaid High K1I09	$ 13.56	$ 10.98	$ 8.40	$ 14.44
Cigna Prepaid Low OKIV9	$ 10.48	$ 6.80	$ 4.62	$ 10.42
Delta Dental PPO	$ 37.72	$ 37.72	$ 32.82	$ 82.94
Delta Dental PPO – Choice	$ 17.88	$ 40.50	$ 40.80	$ 99.02
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LIFE PLAN			
From $5,000 to $40,000	$3.12 Per $1,000 unit		
AGE-RATED SUPPLEMENTAL LIFE – Cost per $1,000 unit for $41,000 and up			
<30 – $0.06	30-34 – $0.06	35-39 – $0.06	40-44 – $0.08
45-49 – $0.14	50-54 – $0.26	55-59 – $0.40	60-64 – $0.46
65-69 – $0.74	70-74 – $1.28	75+ – $1.96	

DEPENDENT LIFE	$1.56 per $500 unit, per dependent

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

This guide assists with the process of retaining your insurance benefits once you leave active employment. Follow this guide to review the terms, available plans, monthly premiums and the various forms that you may need to complete. You will also find guidance on when and how to apply for Medicare coverage and an easy-to-use checklist of the forms that need to be completed and submitted to the Employees Group Insurance Division (EGID).

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 an approved 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 an approved retirement system that participates with EGID, or you withdrew your contributions from your retirement system.
- **Retiree –** You have worked long enough to leave active employment, keep insurance benefits, and draw your chosen retirement benefit option through an approved retirement system.
- **Defer –** You have worked long enough to qualify as a vested, non-vested or retired member, but you elect to transfer your health, dental or vision insurance to your spouse who is an active employee with a participating EGID employer group. Life insurance benefits cannot be deferred.

When considering deferment of your benefits to your spouse's current insurance, refer to their employer for information regarding benefit allowances to see if any would be applied. Your spouse will need to complete the necessary forms with their employer to add you to their insurance benefits within 30 days of you leaving active employment.

Leaving active employment

Keep all the coverage you think you will need once you leave active employment. You can drop or reduce benefits later, but you cannot add health, dental or life insurance as a former employee.

Leaving employment is not a qualifying event that allows you to make plan changes unless you are Medicare eligible. If you or your dependent are eligible for Medicare, and you retain health coverage, you will need to enroll in one of the Medicare plans offered through EGID. All covered dependents must enroll with the same plan. For example, if you are enrolled in a Medicare Advantage Prescription Drug (MAPD) Plan, your pre-Medicare dependents must enroll in the pre-Medicare HMO option of that same plan. If you move out of your health plan's service area, you are allowed to change health plans within 30 days of your move.

The only way to add benefits after you leave employment is if you return to work for an employer group that participates with EGID. EGID Administrative Rule 260:50-3-13 (h) states that you must return to work for an EGID participating employer for three years to qualify to retain benefits not elected upon ceasing current employment.

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

Health and Dental insurance – You can add, keep, drop or defer coverage 30 days before or after leaving active employment.

Vision insurance – You can add, keep, drop or defer coverage 30 days before or after leaving active employment. Vision is the only benefit that you can add or drop during the annual Option Period. Vision coverage cannot be termed midyear unless all other coverage is terminated as well.

Life insurance – You can keep, reduce or drop life coverage you have in place at the time you leave active employment. You must make the election 30 days before or after leaving active employment. You cannot add or increase life insurance at retirement. Life insurance cannot be deferred and must be kept in your former employee retirement account.

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

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

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 the Beneficiary Designation Form (Page E1). Instructions are on the font page of the form.

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.

Years of service needed to continue insurance benefits

- **Teachers' Retirement System (TRS):** Ten years minimum of creditable service.
- **Oklahoma Public Employees Retirement System (OPERS):** Eight years minimum of creditable service.
- **Oklahoma Law Enforcement Retirement System (OLERS):** Eight years minimum of creditable service.
- **Oklahoma Pathfinders Plan:** Five years minimum of creditable service.
- **Other or no retirement system:** Employment years may qualify as creditable service to continue insurance. Contact EGID Member Services for specific information.

Retirement system contributions

Your retirement system may contribute toward your EGID health insurance premium.

- **TRS contributes between $100 to $105 monthly.**
- **OPERS contributes $105 monthly.**
- **OLERS contributes $105 monthly.**
- **Pathfinders does not contribute.**

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

Premium payment options

- **Retirement check deduction:** Your monthly premium is automatically withheld from your retirement check. When selecting this option, the premium withheld is for the previous month's coverage.
- **Direct bill:** You are billed directly for your monthly premium. Payments are due by the 20th of each month and pays for the current month of coverage.
- **Automatic draft:** Your monthly premium is automatically drafted from your checking account on or around the 20th of each month. This payment is for the current month of coverage. To elect this

option, select the direct bill option on the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A2) and provide EGID an Electronic Fund Transfer Authorization form and a voided check. This form (Page D1-D2) is available on the EGID website or by contacting member services.

Gaining Medicare

What is Medicare?

Medicare is a federal health insurance program for people who are 65 years of age and older or for people under 65 with certain disabilities, end stage renal disease or ALS (Lou Gehrig's disease). The Medicare program, also referred to as original Medicare, offers basic coverage to help pay for things like doctor visits, hospital stays, surgeries and medical supplies.

Original Medicare offers basic health coverage, but there are many services that are not included such as prescription drug coverage, eye exams, glasses, hearing aids and most dental care. By electing to enroll in one of the health, dental, and/or vision plans offered by Employees Group Insurance Division (EGID), it may help lower some of your out-of-pocket costs throughout the year.

What are the four parts of Medicare?

- **Medicare Part A – Hospital coverage:** Covers items such as inpatient hospital stays, home health care, and some skilled nursing facility care.
- **Medicare Part B – Medical coverage:** Covers outpatient services such as doctor visits, outpatient surgery, X-rays, lab tests and preventative screenings.
- **Medicare Part C – Medicare Advantage Plans:** Private health insurance companies that contract with Medicare to offer the same benefits of original Medicare. Prescription drugs and additional benefits such as vision, hearing and dental may be included. Requires enrollment in Medicare Part A and Part B.
- **Medicare Part D – Prescription Drug coverage:** Helps cover the cost of prescription drugs. Part D coverage is included in both the EGID Medicare Supplement and Medicare Advantage Prescription Drug (MAPD) plans.

How do I enroll in Medicare?

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

- Automatic enrollment (depending on your individual circumstances). If you currently receive Social Security benefits, you should automatically be enrolled in Medicare Parts A and B when you become eligible.
- Application for enrollment. You should apply three months prior to turning 65 to avoid a possible delay in the start of your coverage. Contact the Social Security Administration or visit ssa.gov for more information.

What are the premiums associated with Medicare Part A or B enrollment?

For most people, Medicare Part A coverage has no monthly premium, but there is a premium associated with your Medicare Part B coverage. These premiums are generally deducted from your Social Security benefits. If you are not receiving benefits from Social Security, you will get a premium bill from Medicare. Refer to the Social Security Administration or ssa.gov for details.

Your monthly Medicare premium is in addition to the plan premium you elect through EGID.

The Enrollment Process

Continue your insurance benefits

You must complete the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A1) and return it to EGID. This form tells EGID what coverage you want to continue.

Defer (transfer) your coverage to your spouse's plan

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

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

To transfer your coverage to your spouse's plan:

- Mark Defer as your member status on the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A1-A2) and return it to EGID. Be sure to indicate on the form which benefits you want to defer.
- Your spouse must contact their employer and complete the necessary steps 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 deferment period.

As long as your former employer group continues to participate with EGID, you can transfer your coverage back to your own EGID account at any time by completing the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage. Once your health insurance is moved back to your own account, you will begin receiving the retirement system contribution, if applicable.

If you are Medicare eligible

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

- The Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A1).
- One of the following applications:
  - The Application for Medicare Supplement with Prescription Drug Plan.
  - The Application for Medicare Advantage Prescription Drug (MAPD) Plan.

This application must be received before your active employer coverage through EGID ends.

Enroll in a Medicare Supplement plan

A Medicare Supplement plan helps pay for some of the remaining out-of-pocket costs that original Medicare does not cover, such as copayments, coinsurance and deductibles. A Medicare Supplement plan is in addition to and works with original Medicare. To participate in a Medicare Supplement plan, you must be entitled to benefits under Medicare Part A and live within the United States. EGID offers three Medicare Supplement plans:

- BCBSOK-BlueSecure – Requires enrollment in both Medicare Part A and Part B.
- HealthChoice SilverScript High and Low Option Medicare Supplement plans – Must be enrolled in Medicare Part A. You are not required to be enrolled in Medicare Part B, but HealthChoice will pay benefits as if you are.

To enroll in one of the Medicare supplement plans, complete and return the Application for Medicare Supplement With Prescription Drug Plan (Page B1). You must provide your Medicare

ID number to coordinate your benefits with Medicare.

Enroll in a Medicare Advantage Prescription Drug plan

Medicare Advantage Prescription Drug (MAPD) plans contract with Medicare to 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. This plan will take the place of Medicare and you will use the ID card issued to you instead of your Medicare card.

EGID offers four Medicare Advantage Prescription Drug (MAPD) plans. There are two MAPD HMO options and two MAPD PPO options.

MAPD HMO plans:

- CommunityCare Senior Health Plan.
- Generations by GlobalHealth.

MAPD PPO plans:

- BCBSOK – MAPD.
- Humana MAPD HMO.

To be eligible to enroll in an MAPD HMO plan, you must live in the plan's approved service area. You will need to select a primary care physician and can receive services only within the plan's network.

To be eligible to enroll in an MAPD PPO plan, you may live anywhere in the United States. You can receive services anywhere in the U.S. as long as the provider is a Medicare eligible provider, will submit claims for you and accepts the plan's payment terms and conditions.

To enroll in one of the MAPD plans, you must complete and return the Application for Medicare Advantage Prescription Drug (MAPD) Plan (Page C1). Be sure to provide your Medicare ID number on your application.

Coverage for your dependents

You can add, keep or drop health, dental and vision coverage for your spouse and other eligible dependents at the time you leave active employment; however, dependent life insurance must be in effect at the time you leave employment in order to continue the coverage. Dependent coverage must be with the same carrier as the member.

If you elect to continue health coverage for a Medicare eligible dependent, they must also complete the applicable Medicare application to be enrolled in their selected plan.

You can exclude your spouse from health, dental and vision coverage and cover your other eligible dependents. Your spouse must sign the Spouse Exclusion Certification section of the Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A2).

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

You can exclude dependents from coverage if they have other group coverage or are eligible for Indian Health Services 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.

After retirement, you cannot add dependents to any coverage except vision, unless a qualifying event occurs. Examples of a qualifying event are:

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

You must add your spouse and any eligible dependents within 30 days of the qualifying event. This cannot be done during the annual Option Period.

Dependent life insurance

You can keep dependent life insurance in effect at the time you leave employment but cannot add or increase it 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 dependent children.
- For your dependents – The amount you keep must be the same for each covered dependent child.

Surviving dependents

In the event of your death, your surviving dependents may continue their insurance coverage. A surviving spouse can continue their insurance benefits, including dependent life, as long as the premiums are paid. The spouse will be moved to their own account and pay the primary member rate.

Surviving dependent children can continue coverage, including dependent life, until age 26. A letter will be sent by EGID to your surviving dependents advising them of their options. Dependents have 60 days to notify EGID that they wish to continue insurance coverage.

Enrollment deadlines

If you are not eligible for Medicare

EGID Administrative Rules allows 30 days from the day your active insurance ends to elect, begin or continue your insurance. There cannot be a break in coverage, which means your former employee benefits will begin the day after your active employment coverage ends.

Failure to add, keep or defer coverage within 30 days of your active coverage ending cancels eligibility in the plans offered through EGID.

If you are eligible for Medicare

It is important that your applications are received at least 30 days **prior** to the day you leave active employment. This gives EGID enough time to process the applications and resolve problems before coverage is effective. It also prevents delays in enrolling in a Part D prescription drug plan.

If your application is not received prior to your employment termination, you **may be** enrolled in a HealthChoice Medicare supplement plan that includes creditable prescription drug benefits. This is to prevent you from having a break in coverage. Be aware, this plan has a higher premium.

If you decide to work past age 65

If you decide to work past the age of 65, you may contact Social Security to delay your enrollment in Medicare Part B. Your employer insurance will be the primary payer while working. Since all insurance offered through EGID is creditable coverage, you will not be assessed a penalty once employer insurance ends. Have your employer complete a CMS-564 form once you decide to leave employment. This form can be found on the Medicare.gov website and will provide proof that you had continuous group coverage from the time you became Medicare eligible until the time you active your Part B plan.

When you turn age 65 after you leave active employment

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

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

You will also receive a packet from EGID two months prior to your 65th birthday advising you of the Medicare plans available, along with the two Medicare applications. Select the Medicare plan you want to enroll in and submit the appropriate application back to EGID prior to your birth month.

COBRA

To comply with federal guidelines, a COBRA packet is mailed to you when you leave employment. Do NOT complete this packet if you are electing to continue your insurance coverage as a Former Employee. Coverage continued under COBRA is temporary. You are encouraged to retain your insurance benefits in a vested, non-vested, retiree or defer status if you meet the qualifications.

Moving 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 service area, you must notify EGID in writing of your new address. To continue your health coverage, you will need to select a new plan that is available in your service area.

If you are eligible for Medicare

If you are enrolled in an MAPD HMO plan and move outside your plan's service area, you must contact EGID to disenroll. To change your coverage to a plan including Part D prescription drug benefits, you must complete an Application for Medicare Supplement With Prescription Drug Plan or an Application for Medicare Advantage Prescription Drug (MAPD) Plan.

Option Period

After you leave active employment, EGID mails your Option Period materials directly to you. To make plan changes, complete your Option Period form and return it directly to EGID. Keep a copy of your form for your records. EGID will mail you a confirmation statement if changes are made.

If you have no plan changes, do not return your form. You will not receive a confirmation statement.

Plan ID cards

If you enroll in a Medicare plan through EGID, a new ID card will be issued. Do not destroy your current cards until you receive your new ones.

Confirmation Statement

When you enroll as a former employee or make changes to your coverage, EGID mails you a Confirmation Statement, which lists the coverage you are enrolled in, the effective date of your coverage and the premium amounts. The amount shown on this statement does not reflect the contribution amount received from your retirement system.

Check it carefully. If incorrect, immediately contact EGID Member Services. Corrections must be submitted to EGID within 60 days of the election. Corrections reported after 60 days are effective the first of the month following notification. Refer to Contact Information at the back of this guide.

Address information

It is important to keep your mailing and email addresses current, or you risk delaying claims processing or missing important communications. Medicare requires that you report any change in your home address to your insurance plan.

Contact EGID Member Services for a Change of Address form or submit a written request to:

EGID
P.O. Box 11137
Oklahoma City, OK 73136-9998

You can email your signed form to EGIDMail@omes.ok.gov.
Verbal requests for address changes are not accepted.


FORMS

FORMS CHECKLIST

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 (MAPD) PLAN
Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage (Page A1)	**Yes**	**Yes**	**Yes**
Application for Medicare Supplement With Prescription Drug Plan (Page B1)	**No**	**Yes** Each enrollee must complete an application	**No**
Application for Medicare Advantage Prescription Drug (MAPD) Plan (Page C1)	**No**	**No**	**Yes** Each enrollee must complete an application
Beneficiary Designation Form (If continuing life insurance coverage) (Page E1)	**Yes**	**Yes**	**Yes**

OKLAHOMA
Employees Group
Insurance Division

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

Retirement information

Retirement system: ☐ OPERS ☐ TRS ☐ OLERS ☐ PATHFINDER ☐ OTHER

My member status will be: ☐ Retiree ☐ Vested ☐ Non-vested ☐ Defer (see instructions on Page 3)

Defer only – Spouse's Social Security number or member ID number:

☐ Cancel my deferment and reinstate my retiree/vested/non-vested insurance coverage.

Member information

Member name (First MI Last)	Member ID or SSN	
Employer	Date of birth	☐ Male ☐ Female

Mailing address (☐ New) City State ZIP code

Phone	Alt phone	Email

Last date of employee insurance coverage			Vested/Non-vested insurance effective date			Retirement insurance effective date		
Month	Day	Year	Month	Day	Year	Month	Day	Year
				01			01	

Health plan

☐ **Add/keep** ☐ **Drop** ☐ **Defer**

Health plan name:

☐ Current patient ☐ New patient

Name of member's primary physician (HMO only):

☐ Medicare eligible. (If you and/or your dependents are Medicare eligible, a Medicare Part D application is required with this form. Please contact EGID Member Services.)

Dental plan

☐ **Add/keep** ☐ **Drop** ☐ **Defer**

Dental plan name:

☐ Current patient ☐ New patient

Name of member's primary dentist (Prepaid only):

Vision plan

☐ **Add/keep** ☐ **Drop** ☐ **Defer**

Vision plan name:

Member Life plan election

☐ **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.**

You can keep a minimum of $5,000 up to the total amount of your current life insurance. You cannot add life insurance. You must keep life insurance on yourself to keep dependent life insurance. Life insurance cannot be deferred and must be carried as a primary retiree/vested member.

For EGID use only

Dependent information

Notes: 1) If your dependents are Medicare eligible, a Medicare Part D application is required with this form. Please contact EGID Member Services. 2) You cannot add dependent life if you do not currently have it. The dependent life amount must be the same for each child; the amount for your spouse can be different. You can keep all or decrease dependent life coverage in $500 units.

Spouse name ☐ Medicare eligible	SSN	Date of birth	☐ Male ☐ Female

Do you currently have coverage through EGID? (If yes, list name and SSN above.)
☐ Yes ☐ No

Health ☐ **Add/keep** ☐ **Drop**	Primary physician (HMO only) ☐ Current patient ☐ New patient	
Dental ☐ **Add/keep** ☐ **Drop**	Primary dentist (Prepaid only) ☐ Current patient ☐ New patient	
Vision ☐ **Add/keep** ☐ **Drop**		
Dep. Life ☐ **Add/keep** ☐ **Drop**	☐ I elect to keep **$** _____ (in $500 units) of Dependent Life.	

Child name ☐ Medicare eligible	SSN	Date of birth	☐ Male ☐ Female

Health ☐ **Add/keep** ☐ **Drop**	Primary physician (HMO only) ☐ Current patient ☐ New patient	
Dental ☐ **Add/keep** ☐ **Drop**	Primary dentist (prepaid only) ☐ Current patient ☐ New patient	
Vision ☐ **Add/keep** ☐ **Drop**		
Dep. Life ☐ **Add/keep** ☐ **Drop**	☐ I elect to keep **$** _____ (in $500 units) of Dependent Life.	

Child name ☐ Medicare eligible	SSN	Date of birth	☐ Male ☐ Female

Health ☐ **Add/keep** ☐ **Drop**	Primary physician (HMO only) ☐ Current patient ☐ New patient	
Dental ☐ **Add/keep** ☐ **Drop**	Primary dentist (prepaid only) ☐ Current patient ☐ New patient	
Vision ☐ **Add/keep** ☐ **Drop**		
Dep. Life ☐ **Add/keep** ☐ **Drop**	☐ I elect to keep **$** _____ (in $500 units) of Dependent Life.	

To list additional dependents, please obtain the Dependent Attachment Form from EGID.

Signatures

Member signature	Date

I understand that no coverage except vision can be added during the annual Option Period.

☐ I authorize EGID to deduct the amount of my premiums from my retirement check according to Administrative Rule 260:50-3-5. (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 if common-law or excluded from health, dental and/or vision coverage.

☐ **Common-law spouse certification:** I certify that this person listed above as my spouse and I have an actual and mutual agreement between ourselves to be married; this is a permanent relationship, and 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 exclusion certification (only required if children are covered and spouse is not):** I certify that I am aware I am being excluded from health, dental and/or vision coverage as indicated on this form.

Spouse signature	Date

Retirement information can be found at oklahoma.gov/omes.

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

The health, dental and life coverage you take into retiree/vested/non-vested status is the only coverage you can have with EGID 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 INSTRUCTIONS

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/non-vested member. When you are ready to return to retiree/vested/non-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 65 and eligible for Medicare, you must notify EGID and provide your Medicare number as it appears on your Medicare card. Medicare supplement coverage is effective the date you become eligible for Medicare or the first day of the month following notification of your Medicare eligibility, whichever is later.

When you turn 65, you have the option to enroll in either a Medicare supplement with prescription drug plan or a Medicare Advantage prescription drug plan.

BCBSOK-BlueSecure and all MAPD 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 two Medicare supplement plans available to you: HealthChoice SilverScript High Option Medicare Supplement Plan and HealthChoice SilverScript Low Option Medicare Supplement Plan. All medical benefits under these plans are paid as if you are enrolled in both Medicare Part A and Part B. If you are not enrolled in Medicare Part B, your 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.

For information concerning the HMO, MAPD, Medicare supplement, dental or vision plans, contact their customer service numbers.

For information regarding enrollment or to obtain an application for Medicare supplement plan or MAPD plan, call 405-717-8780 or toll-free 800-752-9475. TTY users call 711.

EGID
P.O. Box 11137
Oklahoma City, OK 73136-9998

Who can use this form? People with Medicare who want to join a Medicare prescription drug plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area.

Important:
To join a HealthChoice SilverScript Medicare supplement with prescription drug plan, you must have either, or both:

- Medicare Part A (hospital insurance).
- Medicare Part B (medical insurance).

To join the BCBSOK Medicare supplement with prescription drug plan, you must have both:

- Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).

When do I use this form?
You can join a plan:

- Between Oct. 15-Dec. 7 each year (for coverage starting Jan. 1).
- Within three months of first getting Medicare.
- In certain situations where you're allowed to join or switch plans. Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white and blue Medicare card).
- Your permanent address and phone number.

Reminder:

- If you want to join a plan during fall open enrollment (Oct. 15-Dec. 7), the plan must have your completed form by Dec. 7.

What happens next?
Send your completed and signed form to:
OHCA EGID
P.O. Box 11137
Oklahoma City, OK 73136-9998

Once they process your request to join, they'll contact you.

How do I get help with this form?
Call EGID Member Services at 405-717-8780 or toll-free 800-752-9475 Monday-Friday, 8 a.m. to 4:30 p.m. Central time to see if you are eligible to enroll. TTY users call 711. Or, call Medicare at 800-MEDICARE (800-633-4227). TTY users call 877-486-2048. **En español:** Llame a EGID al 800-752-9475/TTY 711 o a Medicare gratis al 800-633-4227 y oprima el 2 para asistencia en español y un representante estara disponible para asistirle.

Individuals experiencing homelessness
If you want to join a plan but have no permanent residence, a post office box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

OKLAHOMA
Employees Group Insurance Division

APPLICATION FOR MEDICARE SUPPLEMENT WITH PRESCRIPTION DRUG PLAN

Member information

Member name (First	MI	Last)	Member ID

Date of birth	☐ Male ☐ Female	Member SSN

Permanent address (P.O. Box not allowed)	City	State	ZIP code

Mailing address (if different from above)	City	State	ZIP code

Phone	Alternate phone	Email

Dependent information (only if enrolling in Medicare)

Dependent name (First	MI	Last)

Date of birth	☐ Male ☐ Female	Dependent SSN

Your Medicare information (required to process your application)

Name on Medicare card:

Medicare number: __ __ __ __ - __ __ __ - __ __ __ __

Part A effective date:

Part B effective date:

To participate in the BCBSOK Medicare supplement plan, you must be enrolled in both Medicare Part A (hospital) and Part B (medical) and continue to pay your monthly Part B premium. To participate in the HealthChoice Medicare supplement plans, you must be entitled to benefits under Medicare Part A. You are not required to be in enrolled in Part B, but the plan pays benefits as if you are. To maximize your benefits, you need to be enrolled in Medicare Part B.

Answer these important questions

1. In which Medicare supplement with Medicare Part D prescription drug plan do you want to enroll?

HealthChoice SilverScript Medicare Supplement Plan
☐ High ☐ Low

☐ BCBSOK – BlueSecure

2. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

3. Some individuals may have other drug coverage through private insurance, TRICARE, federal employee health benefits, VA benefits or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to your coverage through the Oklahoma Health Care Authority Employees Group Insurance Division?

☐ Yes ☐ No	Name of other coverage	ID#	Group#

4. Typically, you can enroll in a Medicare prescription drug plan only during the annual enrollment period from Oct. 15 through Dec. 7. Additionally, there are exceptions that may allow you to enroll in a Medicare prescription drug plan outside of the Annual Enrollment Period. (Refer to statements below)

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

Read the following statements 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 recently was released from incarceration. I was released on (insert date):

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

☐ I recently obtained lawful presence status in the U.S. I got this status on (insert date):

☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance or lost Medicaid) on (insert date):

☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in level of Extra Help or lost Extra Help) on (insert date):

☐ I have both Medicare and Medicaid or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.

☐ I live in or recently moved out of a long-term care facility (for example, a nursing home or other 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.

☐ I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on (insert date):

☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a federal, state or local government entity). One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.

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

☐ None of these statements apply to me. Call EGID at 405-717-8780 or toll-free 800-752-9475 Monday-Friday, 8 a.m. to 4:30 p.m. Central time to see if you are eligible to enroll. TTY users call 711.

Answering these questions is your choice. You cannot be denied coverage if you don't answer.

5. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

☐ No, not of Hispanic, Latino/a, or Spanish origin
☐ Yes, Mexican, Mexican American, Chicano/a
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, another Hispanic, Latino/a, or Spanish origin
☐ **I choose not to answer.**

6. What's your race?

☐ American Indian or Alaska Native
☐ Asian Indian
☐ Black or African American
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Japanese
☐ Korean
☐ Native Hawaiian
☐ Other Asian
☐ Other Pacific Islander
☐ Samoan
☐ Vietnamese
☐ White
☐ **I choose not to answer.**

Signatures – Important: Read and sign below

- I must keep Part A or Part B to stay in the plans offered by EGID.
- By joining this Medicare supplement with prescription drug plan, I acknowledge that the Medicare supplement with prescription drug plans offered by EGID will release my information to Medicare, who may use it to track beneficiary enrollment, for payment and other purposes applicable to federal statutes that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment.
- I understand that I can be enrolled in only one Part D plan at a time – and that enrollment in this plan will automatically end my enrollment in another Part D plan.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
    1) This person is authorized under state law to complete this enrollment.
    2) Documentation of this authority is available upon request by Medicare.

Member signature	Date
Dependent signature (only if dependent is enrolling in Medicare)	Date

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

Name	Phone
Address	
Relationship to enrollee	

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e., agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name	Relationship to enrollee
Signature	National Producer Number (Agents/Brokers only)

Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Mail or fax the form to Attn: Member Accounts

Mail: OHCA EGID
P.O. Box 11137
Oklahoma City, OK 73136-9998

Fax: 405-717-8939

2025 monthly premium information – does not reflect any retirement system contribution

MEDICARE SUPPLEMENT WITH PRESCRIPTION DRUG PLANS	
BCBSOK – BlueSecure	$507.84 per covered person
HealthChoice SilverScript High Option Medicare Supplement	$437.00 per covered person
HealthChoice SilverScript Low Option Medicare Supplement	$356.06 per covered person

If you have questions, call EGID Member Services at 405-717-8780 or toll-free 800-752-9475. TTY users call 711.

OKLAHOMA
Employees Group
Insurance Division

Who can use this form? People with Medicare who want to join a Medicare Advantage prescription drug plan.

To join a plan, you must:

- Be a United States citizen or be lawfully present in the U.S.
- Live in the plan's service area.

Important:
To join a Medicare prescription drug plan, you must also have both:

- Medicare Part A (hospital insurance).
- Medicare Part B (medical insurance).

When do I use this form?
You can join a plan:

- Between Oct. 15-Dec. 7 each year (for coverage starting Jan. 1).
- Within three months of first getting Medicare.
- In certain situations where you're allowed to join or switch plans. Visit Medicare.gov to learn more about when you can sign up for a plan.

What do I need to complete this form?

- Your Medicare Number (the number on your red, white and blue Medicare card).
- Your permanent address and phone number.

Reminder:

- If you want to join a plan during fall open enrollment (Oct. 15-Dec. 7), the plan must have your completed form by Dec. 7.

What happens next?
Send your completed and signed form to:
OHCA EGID
P.O. Box 11137
Oklahoma City, OK 73136-9998

Once they process your request to join, they'll contact you.

How do I get help with this form?
Call EGID Member Services at 405-717-8780 or toll-free 800-752-9475 Monday-Friday, 8 a.m. to 4:30 p.m. Central time to see if you are eligible to enroll. TTY users call 711. Or, call Medicare at 800-MEDICARE (800-633-4227). TTY users can call 877-486-2048. **En español:** Llame a EGID al 800-752-9475/TTY 711 o a Medicare gratis al 800-633-4227 y oprima el 2 para asistencia en español y un representante estara disponible para asistirle.

Individuals experiencing homelessness
If you want to join a plan but have no permanent residence, a post office box, an address of a shelter or clinic, or the address where you receive mail (e.g., Social Security checks) may be considered your permanent residence address.

OKLAHOMA
Employees Group
Insurance Division

APPLICATION FOR MEDICARE ADVANTAGE PRESCRIPTION DRUG (MAPD) PLAN

Member information

Member name (First	MI	Last)	Member ID

Date of birth	☐ Male ☐ Female	Member SSN

Permanent address (P.O. Box not allowed)	City	State	ZIP code	County

Mailing address (if different from above)	City	State	ZIP code	County

Phone	Alternate phone	Email

Dependent information (only if enrolling in Medicare)

Dependent name (First	MI	Last)

Date of birth	☐ Male ☐ Female	Dependent SSN

Your Medicare information (required to process your application)

Name on Medicare card:

Medicare number: __ __ __ __ - __ __ __ - __ __ __ __

Part A effective date:

Part B effective date:

You must have Medicare Part A and Part B to join an MAPD plan.

Answer these important questions

1. In which MAPD plan do you want to enroll?

- ☐ BCBSOK – MAPD
- ☐ CommunityCare Senior Health Plan
- ☐ Generations by GlobalHealth
- ☐ Humana MAPD PPO

2. Some individuals may have other drug coverage through private insurance, TRICARE, federal employee health benefits, VA benefits or state pharmaceutical assistance programs. Will you have other prescription drug coverage in addition to your coverage through the Oklahoma Health Care Authority Employees Group Insurance Division?

☐ Yes ☐ No	Name of other coverage	ID#	Group#

3. Typically, you can enroll in a Medicare prescription drug plan only during the annual enrollment period from Oct. 15 through Dec. 7 each year. Additionally, there are exceptions that may allow you to enroll in a Medicare prescription drug plan outside of the Annual Enrollment Period. (Refer to statements on Page 2.)

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

Read the following statements 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 recently was released from incarceration. I was released on (insert date):
- ☐ I recently returned to the U.S. after living permanently outside of the U.S. I returned to the U.S. on (insert date):
- ☐ I recently obtained lawful presence status in the U.S. I got this status on (insert date):
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance or lost Medicaid) on (insert date):
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in level of Extra Help or lost Extra Help) on (insert date):
- ☐ I have both Medicare and Medicaid or I get Extra Help paying for my Medicare prescription drug coverage, but I haven't had a change.
- ☐ I live in or recently moved out of a long-term care facility (for example, a nursing home or other 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.
- ☐ I was enrolled in a plan by Medicare (or my state), and I want to choose a different plan. My enrollment in that plan started on (insert date):
- ☐ I was affected by an emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA) or by a federal, state or local government entity). One of the other statements here applied to me, but I was unable to make my enrollment request because of the disaster.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ None of these statements apply to me. Call EGID at 405-717-8780 or toll-free 800-752-9475 Monday-Friday, 8 a.m. to 4:30 p.m. Central time to see if you are eligible to enroll. TTY users call 711.

Answering these questions is your choice. You cannot be denied coverage if you don't answer.

4. Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ☐ No, not of Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Puerto Rican
- ☐ Yes, another Hispanic, Latino/a, or Spanish origin
- ☐ Yes, Mexican, Mexican American, Chicano/a
- ☐ Yes, Cuban
- ☐ **I choose not to answer.**

5. What's your race?

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ **I choose not to answer.**

Primary care physician selection

As an MAPD plan member with CommunityCare Senior Health Plan or Generations by GlobalHealth, you must choose a PCP who will coordinate your health care. You can obtain a list of the plan's network physicians by contacting the plan or visiting their website.

Physician name (First Last)	Are you a current patient of this physician? ☐ Yes ☐ No

Signatures – Important: Read and sign below

- I must keep both Part A and Part B to stay in the plans offered by EGID.
- By joining this Medicare Advantage plan, I acknowledge the Medicare Advantage prescription drug plans offered by EGID will release my information to Medicare, who may use it to track beneficiary enrollment, for payment and other purposes applicable to federal statutes that authorize the collection of this information (see Privacy Act Statement below). Your response to this form is voluntary. However, failure to respond may affect enrollment.
- I understand that I can be enrolled in only one Medicare Advantage plan at a time – and that enrollment in this plan will automatically end my enrollmetn in another Medicare Advantage plan.
- 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 people with Medicare are generally not covered under Medicare while out of the country, except for limited coverage near the U.S. border.
- I understand that when my MAPD coverage through EGID begins, I must get all of my medical and prescription drug benefits from that plan. Benefits and services provided by my plan and contained in my evidence of coverage document (also known as a member contract or subscriber agreement) will be covered. Neither Medicare nor my plan will pay for benefit or services that are not covered.
- I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
    1) This person is authorized under state law to complete this enrollment.
    2) Documentation of this authority is available upon request by Medicare.

Member signature	Date
Dependent signature (only if dependent is enrolling in Medicare)	Date

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

Name	Phone
Address	
Relationship to enrollee	

For individuals helping enrollee with completing this form only

Complete this section if you're an individual (i.e., agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form.

Name	Relationship to enrollee
Signature	National Producer Number (Agents/Brokers only)

Privacy Act Statement

The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) Plans, improve care, and for the payment of Medicare benefits. Sections 1860D-1 of the Social Security Act and 42 CFR §§ 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

Mail or fax the form to Attn: Member Accounts

Mail: OHCA EGID
P.O. Box 11137
Oklahoma City, OK 73136-9998

Fax: 405-717-8939

2025 monthly premium information – does not reflect any retirement system contribution

MEDICARE ADVANTAGE PRESCRIPTION DRUG (MAPD) PLANS	
BCBSOK – MAPD	$252.72 per covered person
CommunityCare Senior Health Plan	$220.00 per covered person
Generations by GlobalHealth	$195.00 per covered person
Humana MAPD PPO	$250.38 per covered person

If you have questions, call EGID Member Services at 405-717-8780 or toll-free 800-752-9475. TTY users call 711.

OKLAHOMA
Office of Management
& Enterprise Services

Re: Automatic Bank Withdrawal for Insurance Premium

The Office of Management and Enterprise Services Employees Group Insurance Division is pleased to offer you a convenient way to pay your monthly insurance premiums. Through a program established by the Office of the State Treasurer, upon your authorization, EGID will automatically draft your bank account for your monthly insurance premiums.

If you wish to participate, your bank account will be debited on the 20th of each month, and you will not need to mail a check for your insurance premium. There is no charge for this service.

Once you are enrolled in this process, you will no longer receive a monthly bill from us. EGID will notify you of any change in the monthly debit amount. This process will continue as long as you have insurance through EGID, until you notify us in writing that you no longer wish to participate, or until a debit does not clear your bank.

We encourage you to take advantage of direct debiting by completing the enclosed authorization form. A confirmation will be sent to you showing the amount that will be debited every month along with the month in which this process will begin.

The authorization form must be received in our office by the 10th of the month to be effective for the current month's premium. Forms received after the 10th will be effective the following month. Premiums are required to be paid in full prior to enrolling in direct debiting.

If you have any questions, call EGID Member Services at 405-717-8780 or 800-752-9475. TTY users call 711.

OKLAHOMA
Office of Management
& Enterprise Services

Employees Group Insurance Division

ELECTRONIC FUND TRANSFER AUTHORIZATION

Member name_____

SSN or member ID_____

Member's financial institution_____

I hereby authorize the Office of the State Treasurer to initiate debit entries for the checking account at the financial institution indicated above for amounts due to the Office of Management and Enterprise Services Employees Group Insurance Division. This authority is to remain in full force and effect until one of the following occurs:

- EGID has received notification from the insured of his or her desire to stop participating in automatic bank withdrawals. The notice must be made at least one week before the debit date.

- The Office of the State Treasurer is unable to debit the account for any month because of a closed account, insufficient funds or any other reason.

_____ _____

Signature Date

Attach a voided check here. Deposit slips **will not be accepted**.

ATTACH CHECK HERE

This authorization form must be received in our office by the 10th of the month to be effective for the current month's premium. Forms received after the 10th will be effective the following month. Premiums are required to be paid in full prior to enrolling in direct debiting.

Please mail this completed form to:

EGID MEMBER ACCOUNTS
P.O. BOX 11137
OKLAHOMA CITY, OK 73136-9998

Instructions for completing the Beneficiary Designation Form

This beneficiary form applies to the HealthChoice Life Insurance Plan offered through the Employees Group Insurance Division. If you are retired, it does not affect the beneficiaries for any death benefit you may have 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 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 four parts: Member Information, Primary Beneficiary(ies), Contingent Beneficiary(ies) and the Member signature. **If you complete the form by hand, please print clearly in ink.**

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

Primary Beneficiary(ies) – You can designate one or more primary beneficiaries. All primary beneficiaries share equally unless you note otherwise. If multiple primary beneficiaries are named and a primary beneficiary dies before or simultaneously with you, the remaining primary beneficiary(ies) will be entitled to equal share of the deceased beneficiary's designated benefit amount.

Contingent Beneficiary(ies) – You can designate one or more contingent beneficiaries. Contingent beneficiaries receive benefits only in the event all primary beneficiaries die before or simultaneously with you. All contingent beneficiaries share equally unless you note otherwise on your form. If multiple contingent beneficiaries are named and a contingent beneficiary dies before or simultaneously with you, the remaining contingent beneficiary(ies) will be entitled to equal share of the deceased beneficiary's designated benefit amount.

Member signature – You must sign and date your form. **Your signature must be original in ink.**

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
P.O. Box 11137, Oklahoma City, OK 73136-9998

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

OKLAHOMA
Employees Group Insurance Division

Employees Group Insurance Division
Beneficiary Designation Form

Member Information

SSN or Member ID: _____ Member name: _____
First MI Last

Address: _____
☐ New address Street City State ZIP

Phone: (____) _____ Alt Phone: (____) _____

Important: Please ensure the Share percentage in both Primary Beneficiary(ies) and Contingent Beneficiary(ies) add up to 100%. Payment will be made in equal shares to all surviving beneficiaries unless otherwise indicated.

Primary Beneficiary(ies)

Primary beneficiary's name and address	SSN	Phone	Relationship	Date of birth	Share percentage
					100%

Contingent Beneficiary(ies)

Proceeds are paid to the contingent beneficiary(ies) identified below only if there is no surviving primary beneficiary(ies).

Contingent beneficiary's name and address	SSN	Phone	Relationship	Date of birth	Share percentage
					100%

I have named the above beneficiary(ies) to receive my life insurance benefits from HealthChoice. I understand this form replaces and cancels all prior beneficiary designations and will become effective only when it is received by EGID.

_____ _____
Member signature (original signature required) Date

Mail this form to EGID at P.O. Box 11137, Oklahoma City, OK 73136-9998

State of Oklahoma
Employees Group Insurance Division
Privacy Notice
Revised November 2024

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 Employees Group Insurance Division (EGID), a division of the Oklahoma Health Care Authority (OHCA), please contact:

EGID HIPAA Privacy Officer
P.O. Box 11137, Oklahoma City, OK 73136
405-717-8780 or toll-free 800-752-9475
TTY 711
EGIDComplianceTeam@omes.ok.gov
oklahoma.gov/omes

Why is the notice of privacy practices important?

This notice provides important information about the practices of EGID pertaining to the way it gathers, uses, discloses and manages your Protected Health Information and 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. Please note, in general the laws and regulations of HIPAA do not apply to the Health Choice Disability Plan and HealthChoice Life Insurance Plan. EGID is designated as a HIPAA entity. This notice applies to the privacy practices of the following divisions and positions that may share or access your PHI as needed for treatment, payment and health care operations:

- OHCA EGID.
- OHCA General Counsel Legal.
- Office of Management and Enterprise Services (OMES) Information Services as it applies to maintenance and storage of PHI.

EGID 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 an electronic or paper copy of your health and claims records.

- You can ask to see or get an electronic copy of your medical record and other health information we have about you. Ask us how to do this using the contact information at the beginning of this notice.
- 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, cost-based 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 using the contact information at the beginning of this notice.
- We may decline your request but will explain the reasons in writing within 60 days.

Request confidential communications.

- You can ask us to contact you in a specific manner, e.g., home or office phone, or to send mail to an alternate address.
- We will consider all reasonable requests.
    - If declining would put you in danger, tell us and we will automatically approve your request.

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 approve your request and may decline if it would affect your care.

Get a list of those with whom we've shared information.

- You can ask for an accounting of the times we have 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 free accounting per year but will charge a reasonable fee if you request an additional 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 promptly provide you with a paper copy.
Choose someone to act for you.

- If you have named a medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make decisions about your health information.
- We will verify the person has this authority and can act for you before any action is taken.

File a complaint if you feel your rights are violated.

- You can file a complaint if you feel we have violated your rights by contacting us using the information at the beginning of this notice.
- 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 Ave., S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **hhs.gov/ocr/privacy/hipaa/complaints.**
- 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.
- Contact you for fundraising efforts.

If you are not able to tell us your preference (e.g., if you are unconscious), we may 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.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes.
- Sale of your information.
- Most sharing of psychotherapy notes.

Our uses and disclosures

How do we typically use or share your health information?

Your PHI is used and disclosed by EGID employees and other entities under contract with EGID according to HIPAA Privacy Rules and 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 EGID.

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 member 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 must comply with the law to share your information for these purposes. For more information, refer to **hhs.gov/ocr/privacy/hipaa/understanding/consumers/index**.

Help with public health and safety issues.

We can share your health information for certain situations such as:

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

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 ensure we are complying with federal privacy laws.

Respond to organ and tissue donation requests.

We can share health information about you with organ procurement organizations.

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.
- 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

When it comes to your health information, we have specific obligations such as:

- We are required by law to maintain the privacy and security of your Protected Health Information.
- 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 notify us in writing that we can. You may change your mind at any time but must let us know in writing if you do.

For more information, refer to **hhs.gov/hipaa/for-individuals/notice-privacy-practices/index**.

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. You may also subscribe online to receive notice of changes to this page via email or text message.

Contact Information

Health Plans – Pre-Medicare

BCBS – BlueLincs
855-609-5684
bcbsok.com/state

CommunityCare
918-594-5242 or 800-777-4890
TDD/TTY 800-722-0353
state.ccok.com

GlobalHealth Inc.
405-280-5600 or 877-280-5600
TTY 711
GlobalHealth.com/Oklahoma/mystateplan

HealthChoice
Customer Care 800-323-4314
TTY 711
HealthChoiceOK.com

Pharmacy 877-720-9375
TTY 711
Caremark.com

Health Plans – Medicare Supplement Plans

BCBSOK Member Services
833-418-0443
TTY 711
bcbsok.com/retiree-medicare-state

HealthChoice
Customer Care 800-323-4314
TTY 711
HealthChoiceOK.com

Pharmacy 866-275-5253
TTY 711
Caremark.com

Health Plans – MAPD Plans

BCBSOK Member Services
833-418-0443
TTY 711
bcbsok.com/retiree-medicare-state

CommunityCare Senior Health Plan
918-594-5323 or 800-642-8065
TDD/TTY 800-722-0353
stateshp.ccok.com

Generations by GlobalHealth
Prospective Members:
844-322-8322
Current Members:
405-280-5555 or 844-280-5555
TTY 711
GlobalHealth.com/Oklahoma/osr

Humana Group Medicare Customer Care
Identify yourself as a retiree with the State of Oklahoma/EGID when calling as a prospective member.
866-396-8810
TTY 711
7 a.m. to 8 p.m. CT
your.humana.com/ok-medicare

Dental Plans

BCBS – BlueCare
855-609-5684
Bcbsok.com/state/dental

Cigna Prepaid Dental
800-244-6224
Hearing-impaired relay 800-654-5988
view.ceros.com/cigna/ok-ins-benefits

Delta Dental
405-607-2100 or 800-522-0188
DeltaDentalOK.org/clients/OK

Contact Information

HealthChoice
Customer Care 800-323-4314
TTY 711
HealthChoiceOK.com

MetLife
855-676-9443
metlife.com/info/Oklahoma

Sun Life
800-442-7742
onboard.sunlifeconnect.com

Life Plan

HealthChoice
Customer Care 800-323-4314
TTY 711
HealthChoiceOK.com

Vision Plans

Primary Vision Care Services (PVCS)
888-357-6912
TDD 800-722-0353
pvcs-usa.com/okstate

Superior Vision
844-549-2603
TDD 916-852-2382
superiorvision.com/stateofoklahoma/benefits

Vision Care Direct
877-488-8900
TTY 711
okstate.vision

VSP
800-877-7195
TTY 711
stateofok.vspforme.com

Other important numbers

Employees Group Insurance Division
405-717-8780 or 800-752-9475
TTY 711
Oklahoma.gov/omes

Social Security Administration
800-772-1213
TTY 800-325-0778
SSA.gov

Medicare
800-633-4227
TTY 877-486-2048
Medicare.gov

Oklahoma Public Employees Retirement System
405-858-6737 or 800-733-9008
opers.ok.gov

Oklahoma Teachers' Retirement System
405-521-2387 or 877-738-6365
ok.gov/trs

Oklahoma Law Enforcement Retirement System
405-522-4931 or 877-213-0856
olers.state.ok.us

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