

# Planning for Your Insurance Needs at Retirement

## *Continuing Health, Dental, Life, or Vision Coverage*

### Retirement Terms You Should Know

- **Vest** – An employee who has worked long enough to keep benefits at retirement, and who contributed to a retirement system, but who is not ready to retire or draw retirement benefits.
- **Non-Vest** – An employee who has worked long enough to keep benefits at retirement, but who did not contribute to a retirement system.
- **Retiree** – An employee who has worked long enough to retire and draw a retirement check.
- **Defer** – A retired or vested member who chooses to transfer his/her medical, dental, and/or vision insurance to a spouse's current insurance through the Oklahoma State and Education Employees Group Insurance Board (OSEEGIB).
- **COBRA** – An employee who is not eligible to vest or retire, but who may continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Coverage may be continued for up to 18 months.

### Years of Service Needed to Continue Insurance After Termination of Employment

- **Teachers Retirement System (TRS):** 10 years of eligible service to retire or vest.

- **Oklahoma Public Employees Retirement System (OPERS):** 8 years of eligible service to retire or vest.
- **Other or No Retirement System:** Employment years may qualify as eligible service.

**All benefit elections must be made within 30 days of the date you terminate current employment.**

To check your years of eligible service, please contact your retirement system directly.



### Coverage You May Continue After Termination of Employment

- **State Employee** – Any health, dental, life, or vision coverage you have as a current employee.
- **Local Government Employee** – Any health, dental, life, or vision coverage you have as a current employee.
- **Education Employee** – Any coverage your employer offers through OSEEGIB. You may add health or dental coverage at retirement; however,

life insurance cannot be added at retirement. Life insurance coverage must be in effect at least 30 days before you terminate current employment.

Keep all the insurance coverage you think you will need in your retirement years. You can later reduce your benefits, but you can **never** add health, dental, or life insurance after you terminate current employment.

Vision coverage is exempt from this rule. You can add vision coverage during Option Period for the following plan year.

## **Plan Changes are not Allowed at Retirement**

Your retirement is not a qualifying event that allows you to change health, dental, or vision plans, but you may change plans during any Option Period.

## **The Enrollment Process**

Complete the Application for Retiree/Vested/Non-Vest/Defer Insurance Coverage. Be sure to sign your application and mail it 30 days before the date you terminate current employment. Submit your application to:

**OSEEGIB**  
**3545 NW 58th Street, Suite 110**  
**Oklahoma City, OK 73112**

If you are unable to access the application on the HealthChoice website, contact your Benefits/Insurance Coordinator.

## **Enrollment Deadline**

OSEEGIB Rules state that you have 30 days from the date you terminate employment to elect to continue your insurance. If you do not elect coverage within this 30-day time frame, your eligibility in the plans offered through OSEEGIB will be cancelled.

## **Special Note to Medicare Eligible Members:**

It is critical that your application is received the month before you terminate current employment. If your application is received after your employment termination date and you are enrolled in HealthChoice, you will be enrolled in the HealthChoice Medicare Supplement Plan Without Part D until the first of the following month. While the plans provide identical coverage, the premiums for the plans Without Part D are higher. You must pay the higher premium for one month before you can be changed to a plan With Part D. (Also, see Medicare Advantage Prescription Drug Plans on page 5.)

## **Deferring (Transferring) Your Coverage to Your Spouse's Plan**

If your spouse continues to work and he/she is currently enrolled in coverage through OSEEGIB, you may defer (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 retirement insurance application.
- Your spouse **MUST** contact his/her employer to add you to his/her 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 employer group continues to participate with OSEEGIB, you may transfer your coverage back to your own account at any time by completing a new Application for Retiree/Vested/Non-Vest/Defer Insurance Coverage.



## Coverage for Your Dependents

If you elect to continue dependent coverage, all of your eligible dependents must be covered unless they are covered under another group plan or are eligible for Indian or military benefits.

You may elect to exclude coverage for your spouse, but you and your spouse must both sign the Spouse Exclusion Section of your retirement insurance application.

Dependents cannot be added after retirement unless one of the following qualifying events occurs:

- Birth of a child
- Your spouse or dependents under age 25 lose other group coverage
- You marry
- You adopt or gain legal guardianship of a child (up to age 25)

A new spouse and any eligible dependents must be added within 30 days of the date of the qualifying event. Dependents cannot be added at a later date.

## Life Insurance

You may keep all or part of the life insurance you carried while you were a current employee. Life insurance must be kept in \$5,000 increments.

- Premium: \$1.94 per \$1,000 of coverage, up to \$40,000.
- Amounts over \$40,000 are age-rated. For age-rated life premiums, see the premium rate charts on the last two pages of this brochure.

## Dependent Life

You may keep any life insurance in force on eligible dependents at your retirement. Dependent Life must be kept in \$500 increments.

- Premium (per dependent): \$.97 per \$500 of coverage.
- Spouse — You may keep any amount that was in effect prior to your termination date.
- Dependents — The amount you keep must be the same for each covered child.

## Life Insurance Beneficiaries

If you wish to keep life insurance at retirement, it's a good idea to complete a new Beneficiary Designation Form when you complete your retirement insurance application. Please keep your beneficiary information current. You may request a beneficiary change at any time by completing a new Beneficiary Designation Form and returning it to OSEEGIB. If you are unable to access the beneficiary form on the HealthChoice website, contact your Benefits/Insurance Coordinator.

Please complete a new Beneficiary Designation Form\* if any of the following events occur:

- A beneficiary changes his/her name
- A beneficiary has a change of address
- Your beneficiary pre-deceases you

\*Please Note: This form is for Life Insurance through OSEEGIB only. If you are retired, it does not affect the Death Benefit that may be available through your retirement system.

## In the Event of Your Death

Your surviving spouse and eligible dependents have 60 days to notify OSEEGIB they wish to continue health, dental, life, and/or vision insurance coverage.

- Your surviving spouse or dependents may continue insurance coverage as long as premiums are paid. A surviving spouse will pay the primary member rate, and any retirement system contribution will not apply.

Your surviving dependent children may continue coverage until they:

- Reach age 25
- Get married

Surviving dependent children who elect self-coverage will be set up as a primary member, but will continue to pay the child premium rate.

## Medicare Eligible Members

You should be notified by the Social Security Administration when you are eligible for Medicare Part A and Part B.

- **Medicare Part A** pays for hospital services, and there is generally no charge for this coverage.
- **Medicare Part B** pays for doctor and outpatient medical services. The standard Part B monthly premium for 2009 is \$96.40 which is deducted from your Social Security check.
- **Medicare Part D** pays for prescription drug coverage. All the plans offered through OSEEGIB provide Part D prescription drug coverage or creditable prescription drug coverage. This means the plans all meet the benefit guidelines that are set by Medicare.

All the Medicare supplement plans offered through OSEEGIB pay benefits as if you are enrolled in both Medicare Part A and Part B.

## Enrollment in Medicare

Enrollment in Medicare is handled in two ways: either you are automatically enrolled or you must apply. If you have been a disabled beneficiary under Social Security or Railroad

Retirement prior to turning age 65, you are automatically enrolled and your Medicare ID card will be mailed to you about three months before your Medicare eligibility date.

If you are not already receiving disability benefits, you must apply for Medicare by contacting the Social Security Administration, or if appropriate, the Railroad Retirement Board. You should apply three months before your 65th birthday to avoid a possible delay in the start of your coverage.

Always notify OSEEGIB in the event you become Medicare eligible due to a disability.

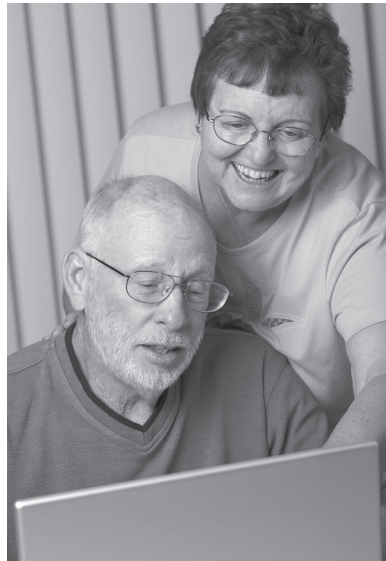
## **Delaying Medicare Part B and Medicare Part D Coverage**

### **Medicare Part B**

If you choose to work past the age of 65 and delay your enrollment in Medicare Part B, you must notify Social Security of your decision and make arrangements to delay your Medicare coverage.

### **Medicare Part D**

If you choose to work past the age of 65 and delay your enrollment in Medicare Part D, you will not have to pay a Medicare late enrollment penalty if you are currently enrolled in a health plan through OSEEGIB.



## **Medicare Supplement Plans Offered Through OSEEGIB**

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

The HealthChoice Plans provide supplemental benefits for Medicare Parts A and B covered services, as well as Medicare Part D prescription drug benefits.

### ***PacifiCare High and Low Option Senior Supplement Plans***

The PacifiCare Plans provide supplemental benefits to Medicare Parts A and B covered services, as well as Medicare Part D prescription drug benefits.

### **Medicare Advantage Prescription Drug Plans (MA-PD Plans)**

You must be enrolled in Medicare Parts A and B to be eligible for enrollment. When you enroll in a Medicare Advantage Prescription Drug plan (MA-PD), the plan replaces Medicare as your primary insurer. The plans provide benefits for Medicare Part A and B covered services, as well as Medicare Part D prescription drug benefits.

You must live in the plan's approved ZIP Code service area to be eligible to enroll in a MA-PD plan. Available plans include:

- CommunityCare Senior Health Plan
- Generations HealthCare by GlobalHealth

If you wish to enroll in a MA-PD plan, you must contact the MA-PD plan directly and also notify OSEEGIB.

## Your Medicare ID Number

When you complete the Application for Retiree/Vested/Non-Vest/Defer Insurance Coverage, be sure to fill in your Medicare ID number (HICN). HealthChoice must have your Medicare ID number in order to coordinate your benefits with Medicare.

## Moving Outside Your Plan's Service Area

### Pre-Medicare

If you enrolled in an HMO plan and move outside the plan's ZIP Code service area, you must inform OSEEGIB in writing of your new address. Your coverage will be changed to the HealthChoice High Option Plan.

The HealthChoice USA Plan is an option if you move outside of Oklahoma and Arkansas. You must enroll within 30 days of your relocation, or you must wait until the following Option Period.

To enroll in the HealthChoice USA plan, send a written request to OSEEGIB including your new address.



## Medicare

If you enrolled in a MA-PD plan and move outside the service area and want to disenroll, contact both OSEEGIB and the HMO. Your coverage will be changed to the HealthChoice Medicare Supplement Plan Without Part D.

If you wish to enroll in a plan with Part D prescription drug benefits, you must complete an Application for HealthChoice Medicare Supplement With Part D. Your coverage will be effective the first of the month

following receipt of your form. If you are unable to access the application on the HealthChoice website, contact HealthChoice Member Services.

## Plan Premiums

Please refer to the premium chart available on the last two pages of this brochure.

## Three Premium Payment Options

- **Retirement check** —Your monthly premium is automatically deducted from your retirement check.
- **Direct bill** —You will be billed directly for your monthly premium and your premium will be due on the 20<sup>th</sup> of each month.
- **Automatic draft** — Your monthly premium is automatically drafted from your personal checking account. If you elect this option, provide OSEEGIB with an Electronic Fund Transfer Authorization Form and a voided check. Your checking account will be debited on or around the 20<sup>th</sup> of each month. If

you are unable to access the Electronic Fund Transfer Authorization Form on the HealthChoice website, contact OSEEGIB Member Services.

- Medicare requires that any change in your home address be reported to your plan.

## **Retirement System Contribution to Your Monthly Insurance Premium**

- Oklahoma Public Employees Retirement System – \$105 monthly
- Teachers’ Retirement System – \$100 to \$105 monthly

## **ID Cards**

### *HealthChoice*

- Members will have two ID cards, one card for health and/or dental benefits, and the other for pharmacy benefits.
- Pre-Medicare retirees should keep their current ID cards. New cards will not be issued by HealthChoice.
- Medicare eligible members should keep their current health ID card, but new pharmacy ID cards will be issued.

### *HMO Plans*

- HMOs generally issue new ID cards. Do not destroy your current cards until you receive new ones.

## **Address Information**

- It’s important for you to keep your address information up-to-date. You run the risk of delaying claims processing or missing important communications when there is incorrect information in our files.

## **Option Period**

After you terminate current employment, you will receive your Option Period materials through the mail. If you wish to make plan changes, mail your form directly to OSEEGIB.

## **Contact Information**

### *Health Plans*

OSEEGIB / HealthChoice Member Services  
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](http://www.healthchoiceok.com) or [www.sib.ok.gov](http://www.sib.ok.gov)

PacifiCare Senior Supplement

Toll-free 1-800-851-3802

Toll-free TDD 1-800-627-6038

[www.securehorizons.com](http://www.securehorizons.com)

CommunityCare Senior Health Plan

1-918-594-5323

Toll-free 1-800-642-8065

Relay Service for the Hearing Impaired:

Toll-free 1-800-722-0353

[www.ccok.com](http://www.ccok.com)

Generations Healthcare by GlobalHealth

1-405-280-2990

Toll-free 1-877-280-2990

TTY/TDD/Voice toll-free 1-800-522-8506

[www.generationshealthcare.cc](http://www.generationshealthcare.cc)

## ***Dental Plans***

HealthChoice Dental Plan  
See OSEEBIG / HealthChoice contact  
information under Health Plans

Assurant Dental Plans  
Prepaid plan toll-free 1-800-443-2995  
Indemnity plan toll-free 1-800-442-7742  
[www.assurantemployeebenefits.com](http://www.assurantemployeebenefits.com)

CIGNA Dental Care Plan (Prepaid)  
Toll-free 1-800-367-1037  
Hearing Impaired Relay 1-405-948-3303  
[www.cigna.com](http://www.cigna.com)

Delta Dental Plans  
1-405-607-2100  
Toll-free 1-800-522-0188  
[www.deltadentalok.org/state\\_employees/](http://www.deltadentalok.org/state_employees/)

## ***Vision Plans***

Humana/CompBenefits VisionCare Plan  
Toll-free 1-800-865-3676  
Toll-free TDD 1-877-553-4327  
[www.compbenefits.com/custom/  
stateofoklahoma/](http://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](http://www.pvcs-usa.com)

Superior Vision Services  
Toll-free 1-800-507-3800  
Toll-free TDD 1-916-852-2382  
[www.superiorvision.com](http://www.superiorvision.com)

UnitedHealthcare Vision  
Toll-free 1-800-638-3120  
Toll-free TDD 1-800-524-3157  
[www.myuhcvision.com](http://www.myuhcvision.com)

Vision Service Plan (VSP)  
Toll-free 1-800-877-7195  
Toll-free TDD 1-800-428-4833  
[www.vsp.com](http://www.vsp.com)

## ***HealthChoice Life Insurance Plan***

See OSEEGIB / HealthChoice contact  
information under Health Plans

## ***Other Important Numbers***

Social Security Administration  
Toll-free 1-800-772-1213  
Toll-free TTY 1-800-325-0778  
[www.ssa.gov](http://www.ssa.gov)

Medicare  
Toll-free 1-800-633-4227  
Toll-free TTY 1-877-486-2048  
[www.medicare.gov](http://www.medicare.gov)

Oklahoma Public  
Employees Retirement System  
1-405-858-6737  
Toll-free 1-800-733-9008  
[www.opers.state.ok.us](http://www.opers.state.ok.us)

Oklahoma Teachers' Retirement System  
1-405-521-2387  
Toll-free 1-877-738-6365  
[www.ok.gov/trs](http://www.ok.gov/trs)



**Oklahoma State & Education Employees Group Insurance Board  
APPLICATION FOR RETIREE/VESTED/NON-VEST/DEFER INSURANCE COVERAGE**

<b>RETIREMENT SYSTEM</b>	<input type="checkbox"/> <b>OPERS</b>	<input type="checkbox"/> <b>TRS</b>	<input type="checkbox"/> <b>OLERS</b>	<input type="checkbox"/> <b>OTHER</b>
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My Member Status Will Be:  Retiree     Vested     Non-Vest    \* Defer

\***IMPORTANT** See Defer Instructions DEFER - Spouse's SSN or Member ID# \_\_\_\_\_

Cancel My Deferment and Reinstate My Retiree/Vest - Spouse's SSN or Member ID# \_\_\_\_\_

SSN or Member ID # _____	Member's Birth Date: _____
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**Member's Name** \_\_\_\_\_  
First
M.I.
Last

**Permanent Residence**  
**Street Address** \_\_\_\_\_  
Street
City
State
Zip Code

**Home Telephone #** (     ) \_\_\_\_\_

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	

<b>MEMBER HEALTH PLAN</b> <input type="checkbox"/> <b>Keep</b> <input type="checkbox"/> <b>Drop</b> <input type="checkbox"/> <b>Defer</b>
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Health Plan Name: \_\_\_\_\_  Pre-Medicare  
 Medicare ID# (Required if Medicare eligible): \_\_\_\_\_  Medicare

<b>MEMBER DENTAL PLAN</b> <input type="checkbox"/> <b>Keep</b> <input type="checkbox"/> <b>Drop</b> <input type="checkbox"/> <b>Defer</b>
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Dental Plan Name: \_\_\_\_\_

<b>MEMBER VISION PLAN</b> <input type="checkbox"/> <b>Keep</b> <input type="checkbox"/> <b>Drop</b> <input type="checkbox"/> <b>Defer</b>
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Vision Plan Name: \_\_\_\_\_

<b>MEMBER LIFE INSURANCE</b>
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You may 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 already have as a current employee. You must retain life insurance on yourself to be able to retain life insurance on your dependents. It is important to consider future life insurance needs because increases cannot be made after this election.

\* **Defer** – You must keep your Life Insurance as a primary Retiree/Vested member. You can only defer your Health, Dental, or Vision.

- I elect to keep \$ \_\_\_\_\_ (\$5,000 to \$40,000 in \$5,000 increments) of member life insurance at a flat rate per \$1,000 (\$1.94 per thousand)
- I elect to keep \$ \_\_\_\_\_ (amount above \$40,000 in \$5,000 increments) of additional life insurance at an age-rated premium

<b>If you or your dependents are Medicare eligible, please answer the following questions to help Medicare coordinate your benefits:</b>
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1. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

Will 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 this coverage:

Name of other coverage: \_\_\_\_\_ ID # for this coverage: \_\_\_\_\_

<b>For OSEEGIB Use Only</b>

2. Are you a resident in a long-term care facility, such as a nursing home?     Yes     No

**DEPENDENT INFORMATION**

**Keep Drop**  
SPOUSE   Health Medicare ID# (Required if Medicare eligible): \_\_\_\_\_  
  Dental Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
  Vision Date of Birth: \_\_\_\_\_  
  Dep Life I elect to keep \$ \_\_\_\_\_ (in \$500 increments) of Dependent Life Insurance

Does your Spouse currently have health, dental, or vision coverage through OSEEGIB?  Yes  No (If yes, list Name and SSN above)

**Keep Drop**  
CHILD   Health Medicare ID# (Required if Medicare eligible): \_\_\_\_\_  
  Dental Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
  Vision Date of Birth: \_\_\_\_\_  Male  Female  
  Dep Life I elect to keep \$ \_\_\_\_\_ (in \$500 increments) of Dependent Life Insurance

**Keep Drop**  
CHILD   Health Medicare ID# (Required if Medicare eligible): \_\_\_\_\_  
  Dental Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
  Vision Date of Birth: \_\_\_\_\_  Male  Female  
  Dep Life I elect to keep \$ \_\_\_\_\_ (in \$500 increments) of Dependent Life Insurance

**IF YOU OR YOUR DEPENDENTS ARE ON HEALTHCHOICE EMPLOYER PDP HIGH/LOW OPTION MEDICARE SUPPLEMENT WITH PART D, PLEASE READ THE FOLLOWING.**

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

HealthChoice Employer PDP is a Medicare Supplement With Part D (prescription drug) Plan and is in addition to my coverage under Medicare Parts A and/or B; therefore, I will need to keep my Parts A and/or B. It is my responsibility to inform HealthChoice of any prescription drug coverage that I have or may get in the future. I can only be enrolled in one Medicare Part D Plan at a time – if I am currently in a Medicare prescription drug plan, my enrollment in HealthChoice will end that enrollment. Enrollment in this Plan is generally for the entire year. I may leave this plan only at certain times of the year, or under certain special circumstances, by sending a request to HealthChoice or by calling toll-free 1-800-Medicare (24 hours a day/7 days a week). TDD users should call toll-free 1-877-486-2048.

HealthChoice serves the entire United States. If I move out of the United States, I need to notify HealthChoice so I can be disenrolled from the Plan. Once I am a member of HealthChoice, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HealthChoice when I receive it to know which rules I must follow in order to receive coverage with this Medicare Supplement With Part D Plan.

I understand that if I leave this Plan and do not have or obtain other Medicare prescription drug coverage or creditable 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 in the future.

**Release of Information:**

By joining the HealthChoice Employer PDP High/Low Option Medicare Supplement With Part D Plan, I acknowledge that HealthChoice will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that HealthChoice will release my information, including my prescription drug event date, to Medicare, who may release it for research and other purposes which follow all applicable federal statutes and regulations. The information I provided 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 on this application means that I have read and understand the contents of this application. 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.

**CERTIFICATION SIGNATURES**

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

I request that the Board direct bill me for my monthly premiums at the mailing address above.

**Spouse must sign 1.) if he/she is enrolling in Medicare coverage and/or 2.) if he/she is being excluded from health/dental and/or 3.) if he/she is 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 for within 30 days of loss of other group coverage. (Needed 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 husband and wife; that this is a permanent relationship; and that our relationship is exclusive, as proven by our cohabitation as man and wife; and do hereby hold ourselves out publicly as husband and wife. I am aware that this relationship can only be dissolved by legal divorce.

Spouse’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I understand that any coverage (except vision) not kept cannot be added at a later date.

Member Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IMPORTANT-STATUTES ALLOW ELECTION OF INSURANCE  
WITHIN 30 DAYS OF THE RETIREMENT, VESTING, OR NON-VESTING DATE**

*Retirement information can be found at [www.healthchoicework.com](http://www.healthchoicework.com)*

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

The health, dental, and life coverage that you take into retirement/vest is the only coverage you may have through your retirement years. If you do not retain coverage **now**, you may not add it later. **Cancellation** of any basic insurance coverage after your termination of employment prevents you from adding that coverage at a later date. **Plan changes** can be made at Option Period.

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

Dependents may only be added after retirement within 30 days of one of the following occurs:

1. Birth, adoption or guardianship.
2. Marriage.
3. Loss of other group insurance.

**\* DEFER** If you have a spouse who has separate coverage through OSEEGIB at the time of your termination of employment, you may transfer your individual health, dental, or vision coverage as a retiree/vest to dependent coverage through your spouse. The employed spouse must contact their employer to add dependent coverage. You must make the election to transfer coverage within 30 days of your termination of employment. Any 30-day break in coverage will void your eligibility to retain coverage in the future. Life insurance must be carried as a primary retiree/vested member. You can only defer your health, dental, or vision benefits. When you are ready to return to a member status, you must complete this form and mark "yes" to cancel your previous deferment.

**THINGS TO CONSIDER AS A RETIREE WHEN BECOMING MEDICARE ELIGIBLE**

**IMPORTANT:** *If you are under age 65 and eligible for Medicare, you must notify OSEEGIB and provide your Medicare ID# as it appears on your Medicare card. Medicare Supplement coverage will become effective as of the date you become eligible for Medicare, or the 1<sup>st</sup> of the month following notification of your Medicare eligibility, whichever is later.*

At Medicare eligibility, you will be enrolled in the Medicare Supplement of your plan at that time. If you are on HealthChoice Employer PDP Medicare Supplement, you will be enrolled in the Medicare Supplement High Option with Part D Plan. **If you are on an HMO, you may enroll in their Medicare Supplement or Medicare Advantage Prescription Drug (MAPD) plan. You must contact your HMO for more information on enrollment into an MA-PD.**

**Medicare eligible members must have Medicare Part A and Medicare Part B. All Medicare Supplement plans and MA-PD plans offered through OSEEGIB require you to have both.**

If you or one of your dependents will soon become Medicare eligible, please pay close attention to the deadlines for enrollment into a Medicare supplement or Medicare Advantage plan with Part D benefits. Enrollments that are not received within the timeframe established by CMS will delay your enrollment into a Medicare Part D plan.

CMS does not allow members to be retroactively enrolled into any Part D participating plan. Because of this regulation, when enrollment forms are received after the requested effective date, OSEEGIB must place members into the HealthChoice Employer PDP Medicare Supplement Plan Without Part D until the 1<sup>st</sup> of the month following the receipt of your enrollment form. Be aware that this alternate plan without Part D has a higher premium than the plan with Part D benefits, but does have Creditable Coverage.

**IMPORTANT INFORMATION FOR MEDICARE MEMBERS**

If you or your dependent(s) are currently a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining HealthChoice Employer PDP High/Low Option Medicare Supplement With Part D, 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 that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

If you or your dependent(s) currently have health coverage from an employer or union, joining the HealthChoice Employer PDP High/Low Option Medicare Supplement With Part D Plan could affect your employer or union health benefits. Joining HealthChoice Employer PDP High Option Medicare Supplement With Part D may change how the benefits of your current coverage are administered. Read the information your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no contact information available, contact your benefits administrator or the office that answers questions about your coverage.

(Continued on next page.)

For information concerning HMOs, MA-PDs, Dental, or Vision plans, contact their customer service numbers.

For information on HealthChoice or the HealthChoice Medicare Supplement Plans, contact:

**Oklahoma State and Education Employees Group Insurance Board**  
3545 NW 58<sup>th</sup>, Suite 110, Oklahoma City, OK 73112  
1-405-717-8780 or 1-800-752-9475 or TDD 1-405-949-2281 or 1-866-447-0436

**THIS FORM SHOULD BE RETURNED TO YOUR INSURANCE/BENEFITS COORDINATOR FOR THEIR REVIEW AND FORWARDING TO OSEEGIB 30 DAYS PRIOR TO YOUR LAST DAY OF EMPLOYMENT TO ENSURE CONTINUOUS COVERAGE.**

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Oklahoma State and Education Employees Group  
Insurance Board (OSEEGIB)

**Privacy Notice**

**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.**

OSEEGIB is a State of Oklahoma governmental agency that is created and governed by Oklahoma law for the purpose of administering health, life, disability, and dental benefits to state, local government, and education employees, and other groups designated by statute, including each of the preceding group's respective retirees. Oklahoma privacy laws and the federal Health Insurance Portability and Accountability Act (HIPAA) govern privacy matters between OSEEGIB and its participants concerning the privacy of identifiable health information. Information contained in an OSEEGIB member's file is confidential by law and we at OSEEGIB are committed to protecting this information.

This notice describes and gives you examples of the permitted ways your health information may be used and disclosed.

OSEEGIB uses and discloses your protected health information for your treatment, payment for services, and OSEEGIB business operations in the administration of health plans. The health claims you submit, or health claims submitted by providers for your treatment, contain protected health information and are processed for payment and data collection by claims administrators according to Oklahoma law and contractual terms of confidentiality with OSEEGIB. Your health information is used and disclosed by OSEEGIB employees and other entities under contract with OSEEGIB, according to the "minimum necessary" standard. OSEEGIB or its claims administrators may use and disclose health information to determine medical necessity for certification of hospital and medical benefits, case management, approval for supplemental life insurance, grievance matters, premium rate setting, required disease management programs, law enforcement, public health threats, workers' compensation / disability, national security and as required by law. OSEEGIB will ask for your written permission before it uses or discloses your health information for purposes that are not described in this Notice.

You have the right to: a) inspect and copy your health information, (generally EOBs) with the exception of psychotherapy notes and/or information that requires a court order; b) amend and restrict the health information that OSEEGIB discloses about you; however, OSEEGIB is not required to agree to a requested restriction; c) request your communications remain confidential with OSEEGIB; d) receive a copy of this Notice; e) file a complaint if you believe OSEEGIB has improperly used or disclosed your information; f) request a listing of disclosures except for treatment, payment, business operations, and per your Authorization after April 14, 2003; and, g) receive a paper copy of this Notice upon request if you have received this Notice electronically.

OSEEGIB reserves the right to change the terms of this Privacy Notice and will provide all interested persons a revised notice either by U.S. Postal Service delivered to the individual's mailing address on file with OSEEGIB or electronic communication by posting the revised Privacy Notice on the OSEEGIB website at [www.sib.ok.gov](http://www.sib.ok.gov) and [www.healthchoiceok.com](http://www.healthchoiceok.com)

If you believe your privacy rights have been violated, call or send a written complaint to the OSEEGIB HIPAA Information Officer at 3545 NW 58th, Suite 110, Oklahoma City, Oklahoma, 73112, 1-405-717-8701, toll-free 1-800-543-6044, TDD 1-405-949-2281, toll-free TDD 1-866-447-0436; the Secretary of the U. S. Department of Health and Human Services (HHS) at the Office of Civil Rights, 1301 Young Street, Suite 1169, Dallas, TX 75202, 1-214-767-4056, or submit an electronic complaint according to directions located on the HHS Office of Civil Rights website. Complaints to HHS must be filed within 180 days after the date on which you became aware, or should have been aware, of the violation. No retaliation is allowed against the individual filing a complaint.

**Revised Notice 8/5/05**

OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP INSURANCE BOARD  
3545 NW 58<sup>th</sup> Street, Suite 110  
Oklahoma City, Oklahoma 73112  
1-405-717-8701 or 1-800-543-6044

## BENEFICIARY DESIGNATION FORM INSTRUCTIONS

**Please Note:** This form is for Life Insurance through the Oklahoma State and Education Employees Group Insurance Board only. If you are retired, it does not affect the Death Benefit that may be available through your retirement system.

**Beneficiary proceeds are paid in accordance with the last beneficiary(ies) designation on file.**

**Basic** and **Supplemental** benefit designation amounts are combined and paid according to the payment method you have designated. If minors are designated, a guardian must be appointed by the courts before payment is made, unless otherwise permitted by law.

**Primary Beneficiary:** Receives priority distribution upon the member's death

**Contingent Beneficiary:** Receives distribution only if primary beneficiary(ies) are deceased at time of the insured's death.

### **Factors That Affect Distribution of Proceeds:**

1. If more than one party is named as Primary or Contingent Beneficiary, the insured may indicate how the proceeds are to be divided by percentage.
2. If percentage proportions have not been specified by the insured, proceeds will be paid in **equal shares** to the living beneficiaries. Percentages **if elected** must total 100%
3. To make a detailed specific distribution request, the insured may provide a written statement, signed and dated, regarding the method of distribution of Life Insurance proceeds. The statement must include members name and Social Security number.

### **Please keep all addresses and beneficiary designees current.**

**When listing more than 4 beneficiaries please use two forms or a separate sheet of paper with listed beneficiaries and member signature.**

**Retain a copy of the completed form for your records and mail the original to OSEEGIB at the address listed at the top of this form.**



## BENEFICIARY DESIGNATION FORM

Insured Member's SSN or Member ID: \_\_\_\_\_

Insured Member's Name: \_\_\_\_\_

Insured Member's Address: \_\_\_\_\_

### I HEREBY DESIGNATE MY BENEFICIARY(IES) AS FOLLOWS:

<b>Primary Beneficiary:</b>	% (Optional) _____
Full Name: _____	DOB (m/d/y): _____
Social Security #: _____	Relationship: _____
Address: _____	
Street	City State Zip Code

<b>Beneficiary:</b> Primary _____ OR Contingent _____	% (Optional) _____
Full Name: _____	DOB (m/d/y): _____
Social Security #: _____	Relationship: _____
Address: _____	
Street	City State Zip Code

<b>Beneficiary:</b> Primary _____ OR Contingent _____	% (Optional) _____
Full Name: _____	DOB (m/d/y): _____
Social Security #: _____	Relationship: _____
Address: _____	
Street	City State Zip Code

<b>Beneficiary:</b> Primary _____ OR Contingent _____	% (Optional) _____
Full Name: _____	DOB (m/d/y): _____
Social Security #: _____	Relationship: _____
Address: _____	
Street	City State Zip Code

\_\_\_\_\_  
**Member's Signature – Original Signature Required**

\_\_\_\_\_  
**Date**

Mail this page to OSEEGIB at 3545 NW 58<sup>th</sup> Street, Suite 110, Oklahoma City, OK 73112

**Oklahoma State and Education Employees Group Insurance Board**  
**Monthly Premiums for Former Employees and Dependents**  
**Plan Year January 1, 2009, through December 31, 2009**

<b>HEALTH PLANS</b>	<b>MEMBER</b>	<b>SPOUSE</b>	<b>CHILD</b>	<b>CHILDREN</b>
HealthChoice High	\$409.12	\$587.92	\$199.98	\$343.10
HealthChoice Basic	\$347.96	\$503.74	\$171.56	\$293.44
HealthChoice S-Account	\$322.68	\$468.90	\$162.24	\$276.72
HealthChoice USA Account	\$626.96	\$626.96	\$198.24	\$339.96
Aetna Standard HMO	\$668.30	\$888.76	\$654.90	\$654.90
Aetna Alternative HMO	\$431.16	\$573.40	\$422.52	\$422.52
CommunityCare Standard HMO	\$715.76	\$1,023.52	\$357.88	\$572.60
CommunityCare Alternative HMO	\$484.72	\$693.14	\$242.36	\$387.78
GlobalHealth Standard HMO	\$333.78	\$495.26	\$178.98	\$285.40
GlobalHealth Alternative HMO	\$303.44	\$450.28	\$162.74	\$259.46
PacifiCare Standard HMO	\$600.46	\$858.64	\$300.22	\$480.36
PacifiCare Alternative HMO	\$388.70	\$555.68	\$194.20	\$310.81
<b>DENTAL PLANS</b>	<b>MEMBER</b>	<b>SPOUSE</b>	<b>CHILD</b>	<b>CHILDREN</b>
HealthChoice Dental	\$28.58	\$28.58	\$23.82	\$61.84
Assurant Freedom Preferred	\$24.84	\$24.70	\$18.52	\$49.80
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 (POS)	\$29.88	\$29.90	\$26.28	\$66.88
Delta's Choice (PPO)	\$12.88	\$29.48	\$29.26	\$71.56
<b>VISION PLANS - Voluntary</b>	<b>MEMBER</b>	<b>SPOUSE</b>	<b>CHILD</b>	<b>CHILDREN</b>
Humana/CompBenefits VisionCare Plan	\$6.76	\$5.06	\$3.57	\$ 4.46
Primary Vision Care Services	\$9.25	\$8.00	\$8.50	\$10.75
Superior Vision Services	\$6.98	\$6.90	\$6.60	\$ 6.60
UnitedHealthcare Vision	\$8.18	\$5.79	\$4.59	\$ 6.98
Vision Service Plan (VSP)	\$8.96	\$6.00	\$5.74	\$12.92
<b>LIFE PLAN</b>	<b>PRE-MEDICARE RETIREES/VESTS</b>			
From \$5,000 to \$40,000	\$1.94 Per \$1,000			
<b>Age-Rated Life Cost Per \$1,000 for \$41,000 and Up</b>				
< 30 ----- \$0.05	45 - 49 ----- \$0.19	65 - 69 ----- \$0.99		
30 - 34 ----- \$0.05	50 - 54 ----- \$0.32	70 - 74 ----- \$1.67		
35 - 39 ----- \$0.08	55 - 59 ----- \$0.52	75+ ----- \$2.60		
40 - 44 ----- \$0.12	60 - 64 ----- \$0.60			
<b>DEPENDENT LIFE</b>	<b>\$0.97 Per \$500 Unit, Per Dependent</b>			

Rates do not reflect any retirement system contribution

**Oklahoma State and Education Employees Group Insurance Board**  
**Monthly Premiums for Medicare Eligible Members**  
**Plan Year January 1, 2009, through December 31, 2009**

<b>MEDICARE SUPPLEMENT PLANS</b>					
	<b>MEMBER</b>	<b>SPOUSE</b>	<b>CHILD</b>	<b>CHILDREN</b>	
HealthChoice High Option With Part D	\$279.28	\$279.28	\$279.28	\$279.28	
HealthChoice Low Option With Part D	\$222.92	\$222.92	\$222.92	\$222.92	
HealthChoice High Option Without Part D	\$333.24	\$333.24	\$333.24	\$333.24	
HealthChoice Low Option Without Part D	\$276.88	\$276.88	\$276.88	\$276.88	
PacifiCare Senior High Option	\$326.44	\$326.44	\$326.44	\$326.44	
PacifiCare Senior Low Option	\$293.60	\$293.60	\$293.60	\$293.60	
<b>MEDICARE ADVANTAGE PRESCRIPTION DRUG PLANS (MA-PD)</b>					
CommunityCare Senior Health Plan		\$148.00 per enrolled member			
Generations HealthCare by GlobalHealth		\$158.00 per enrolled member			
<i>You must be a permanent resident of the MA-PD plan's service area to be eligible</i>					
<b>DENTAL PLANS</b>					
	<b>MEMBER</b>	<b>SPOUSE</b>	<b>CHILD</b>	<b>CHILDREN</b>	
HealthChoice Dental	\$28.58	\$28.58	\$23.82	\$61.84	
Assurant Freedom Preferred	\$24.84	\$24.70	\$18.52	\$49.80	
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 (POS)	\$29.88	\$29.90	\$26.28	\$66.88	
Delta's Choice (PPO)	\$12.88	\$29.48	\$29.26	\$71.56	
<b>VISION PLANS</b>					
	<b>MEMBER</b>	<b>SPOUSE</b>	<b>CHILD</b>	<b>CHILDREN</b>	
Humana/CompBenefits VisionCare Plan	\$6.76	\$5.06	\$3.57	\$ 4.46	
Primary Vision Care Services	\$9.25	\$8.00	\$8.50	\$10.75	
Superior Vision Services	\$6.98	\$6.90	\$6.60	\$ 6.60	
UnitedHealthcare Vision (Spectera)	\$8.18	\$5.79	\$4.59	\$ 6.98	
Vision Service Plan (VSP)	\$8.96	\$6.00	\$5.74	\$12.92	
<b>LIFE PLAN</b>					
		<b>From \$5,000 to \$40,000</b>		<b>\$1.94 Per \$1,000 Unit</b>	
<b>Age Rated Life – Cost Per \$1,000 from \$41,000 and Up</b>					
<b>&lt; 30</b>	<b>----- \$0.05</b>	<b>45 - 49</b>	<b>----- \$0.19</b>	<b>65 - 69</b>	<b>----- \$0.99</b>
<b>30 - 34</b>	<b>----- \$0.05</b>	<b>50 - 54</b>	<b>----- \$0.32</b>	<b>70 - 74</b>	<b>----- \$1.67</b>
<b>35 - 39</b>	<b>----- \$0.08</b>	<b>55 - 59</b>	<b>----- \$0.52</b>	<b>75+</b>	<b>----- \$2.60</b>
<b>40 - 44</b>	<b>----- \$0.12</b>	<b>60 - 64</b>	<b>----- \$0.60</b>		
<b>DEPENDENT LIFE</b>					
<b>\$0.97 Per \$500 Unit, Per Dependent</b>					

Rates do not reflect any retirement system contribution