

HealthChoice

Dental Plan Handbook



This dental handbook replaces and supersedes any dental handbook the Office of Management and Enterprise Services (OMES) Employees Group Insurance Department (EGID) previously issued. This dental handbook will, in turn, be superseded by any subsequent dental handbook OMES issues.

Any updates made to this handbook after printing can be found on the HealthChoice website at www.healthchoiceok.com.

HealthChoice Dental Plan

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Information

Available On Our Website at www.healthchoiceok.com

HealthConnect

This online benefit application is designed to give you quick and easy access to your benefit information. “HealthConnect” provides you with member and dependent coverage information, access to “ClaimLink”, a secure messaging center and a link to the “Frequently Asked Questions” (FAQ) section of the website. Your covered dependents ages 18 and over must register independently for “HealthConnect.”

ClaimLink

You can access your current Plan information through the HealthChoice website. Using the “ClaimLink” option on the home page, you can view your eligibility, benefits, deductible and claim status, as well as download your “Explanation of Benefits.” Registration is quick and easy. You will need to enter your name, date of birth, HealthChoice ID number, ZIP code and the last four digits of your Social Security number. Your covered dependents ages 18 and over must register independently for “ClaimLink.” If you have any questions, please contact the dental claims administrator. For contact information, refer to “Plan Identification Information and Notice.”

Network Provider Directory

You can easily access the “HealthChoice Network Provider Directory” through the HealthChoice website. Select “Find a Provider” in the top menu bar of the home page and then select “Medical and Dental Providers” under “HealthChoice Provider Listings.”

Frequently Asked Questions

The “FAQ” section of our website is an interactive application that allows easy access to general Plan information by simply entering a keyword, phrase or question in the search line.

A fully accessible version of this handbook is available on the HealthChoice website at www.healthchoiceok.com.

Plan Identification Information and Notice Revised March 2015

- Plan Name:** HealthChoice Dental Plan
- Plan Administrator:** Office of Management and Enterprise Services (OMES) Employees Group Insurance Department (EGID)
3545 N.W. 58th St., Ste. 110
Oklahoma City, OK 73112
1-405-717-8701 or
Toll-free 1-800-543-6044
TDD 1-405-949-2281 or
Toll-free 1-866-447-0436
- Member Services:** HealthChoice Member Services and Provider Directory
1-405-717-8780 or
Toll-free 1-800-752-9475
TDD 1-405-949-2281 or
Toll-free 1-866-447-0436
Fax 1-405-717-8942
www.healthchoiceok.com
- Dental Claims Administrator:** HP Administrative Services, LLC
P.O. Box 24870
Oklahoma City, OK 73124-0870
1-405-416-1800 or
Toll-free 1-800-782-5218
TDD 1-405-416-1525 or
Toll-free 1-800-941-2160

NOTICE: The Office of Management and Enterprise Services Employees Group Insurance Department (EGID) provides dental benefits to eligible state, education and local government employees, former employees, survivors, and their dependents in accordance with the provisions of O.S. 74 2012, §§ 1301, et seq. **The information provided in this handbook is a summary of the benefits, conditions, limitations and exclusions of the HealthChoice Dental Plan.** It should not be considered an all-inclusive listing.

All references to “you” and “your” relate to the Plan member. Please use this handbook to become familiar with the Plan’s benefits and rules. Throughout this handbook, the HealthChoice Dental Plan is often referred to as the “Plan.”

Plan benefits are subject to conditions, limitations and exclusions, which are described and located in Oklahoma statutes, handbooks, and *Administrative Rules* adopted by the plan administrator. You can obtain a copy of the official *Administrative Rules* from the office of the Oklahoma Secretary of State. An unofficial copy of the rules is available on the HealthChoice website at www.healthchoiceok.com. Under the heading “About EGID,” select “Administrative Rules.”

PLEASE READ THIS HANDBOOK CAREFULLY

A dispute concerning information contained within any Plan handbook or any other written materials, including any letters, bulletins, notices, other written document or oral communication, regardless of the source, shall be resolved by a strict application of *Administrative Rules* or benefit administration procedures and guidelines as adopted by the Plan. Erroneous, incorrect, misleading or obsolete language contained within any handbook, other written document or oral communication, regardless of the source, is of no effect under any circumstance.

How the HealthChoice Dental Plan Works

This handbook provides a quick guide to the plan benefits. Please read this handbook carefully for explanations of the eligibility rules and what the Plan pays, limits and excludes.

The benefits of the HealthChoice Dental Plan are based on cost-sharing features that include a deductible and coinsurance. Plan benefits and your out-of-pocket costs will differ depending on the provider you choose.

HealthChoice Provider Network

As a HealthChoice member, you have the option to be treated by any dental provider and the option to change dental providers at any time. You are encouraged to use Network Providers whenever possible because you receive a higher level of benefits.

Network Providers are contracted with HealthChoice and have agreed to accept HealthChoice Allowable Fees for the services and equipment they provide. Network Providers have agreed not to bill you for charges that are greater than Allowable Fees. You are still responsible for your Plan's deductibles and coinsurance and charges for non-covered services.

Non-Network providers are not contracted with HealthChoice and have not agreed to accept Allowable Fees. This means you are responsible for paying the difference between the amount the provider bills and Allowable Fees. This process, known as balance billing, can be a large amount of money out of your own pocket. Even after you reach your Plan's out-of-pocket maximum, you are still responsible for all amounts above Allowable Fees when you use non-Network providers.

Finding a HealthChoice Network Provider

You can find a HealthChoice Network Provider by selecting “Find a Provider” in the top menu bar of the HealthChoice website at www.healthchoiceok.com. You can search for providers by name, specialty or location.

You can also contact HealthChoice Member Services to find a Network Provider. A member services specialist can give you the names of Network Providers in your area. For contact information, refer to “Plan Identification Information and Notice.”

If you are unable to locate a HealthChoice Network Provider in your area, you can nominate a provider for participation by completing the online provider nomination form or contacting HealthChoice Member Services.

Summary of Dental Plan Benefits

Network Providers

When using a Network Provider, the Plan provides the following benefits:

- Preventive services covered at 100% of Allowable Fees;
- Basic restorative services covered at 85% of Allowable Fees;
- Major restorative services covered at 60% of Allowable Fees;
- A \$25 individual or a combined \$75 family calendar year deductible for Basic and Major restorative services; and
- Orthodontic services for members under age 19, or members ages 19 and older with temporomandibular joint dysfunction (TMD), are covered at 50% of Allowable Fees. There is no calendar year deductible or lifetime maximum benefit; however, a 12-month waiting period applies to all orthodontic benefits. Refer to “Limitations” in the “Exclusions and Limitations” section.

Network Providers file your claims for you.

The calendar year maximum benefit per person for Network and non-Network Preventive, Basic and Major services combined is \$2,500. The calendar year maximum benefit does not apply to orthodontic services.

You are responsible for all non-covered services and amounts above the calendar year maximum benefit.

Once you exhaust your \$2,500 calendar year maximum benefit, your provider is not limited to the HealthChoice Allowable Fees.

Non-Network Providers

When using a non-Network provider, the Plan provides the following benefits:

- Preventive services covered at 100% of Allowable Fees;
- Basic restorative services covered at 70% of Allowable Fees;
- Major restorative services covered at 50% of Allowable Fees;
- A \$25 individual or a combined \$75 family calendar year deductible for Preventive, Basic and Major services; and
- Orthodontic services for members under age 19, or members ages 19 and older with temporomandibular joint dysfunction (TMD), are covered at 50% of Allowable Fees. There is no calendar year deductible or lifetime maximum benefit; however, a 12-month waiting period applies to all orthodontic benefits. Refer to “Limitations” in the “Exclusions and Limitations” section.

If you use a non-Network provider, you may have to file your claims yourself. You must file your non-Network claims with the dental claims administrator, unless the provider chooses to file for you as a courtesy. Refer to the “Claim Procedures” section.

The calendar year maximum benefit per person for Network and non-Network Preventive, Basic and Major services combined is \$2,500. The calendar year maximum benefit does not apply to orthodontic services.

You are responsible for all non-covered services, amounts above the calendar year maximum benefit and amounts above Allowable Fees.

Schedule of Covered Benefits

Covered Services	Network		Non-Network	
	Calendar Year Deductible	Plan Pays (of Allowable Fees)	Calendar Year Deductible	Plan Pays (of Allowable Fees)
Preventive	None	100%	\$25**	100%
Basic Restorative	\$25*	85%	\$25**	70%
Major Restorative	\$25*	60%	\$25**	50%
Orthodontic	None	50%	None	50%

***Network Services:** There is a \$25 individual or a combined \$75 family calendar year deductible for Basic and Major services combined.

****Non-Network Services:** There is a \$25 individual or a combined \$75 family calendar year deductible for Preventive, Basic and Major services combined.

Note: Network and non-Network deductibles accumulate separately.

There is no calendar year deductible or lifetime maximum benefit for Network and non-Network orthodontic services; however, a 12-month waiting period applies to all orthodontic benefits. Refer to “Limitations” in the “Exclusions and Limitations” section.

You are responsible for all non-covered services and amounts above the calendar year maximum benefit. You are also responsible for amounts above Allowable Fees when using non-Network providers.

Maximum Benefits

The calendar year maximum benefit per person for Network and non-Network Preventive, Basic and Major services combined is \$2,500.

You are responsible for all charges above the \$2,500 calendar year maximum benefit. Once you exhaust your \$2,500 calendar year maximum benefit, your provider is not limited to the HealthChoice Allowable Fees.

There is no calendar year or lifetime maximum benefit for orthodontic services.

Preventive Services

Covered services include:

- Cleaning, bitewing X-rays, routine oral examinations, two covered per calendar year;
- Topical fluoride treatments, two covered per calendar year;
- Full mouth X-rays, one covered per 36 months;
- Supplemental bitewing X-rays, two covered per calendar year;
- Space maintainers to replace prematurely lost teeth for covered dependent children under age 19;
- Emergency palliative treatment;
- Sealants, only on molars, through age 16; reapplication once every 36 months; and
- Preventive resin restorations in moderate-to-high-risk caries patients, only on molars, through age 16; reapplication every 60 months.

Basic Restorative Services

Covered services include:

- Extractions, including wisdom teeth;
- Oral surgeries, including general anesthesia;
- Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or fractured teeth;
- Certain treatments for periodontal disease;
- Endodontic treatments, root canal therapies and injections of antibiotic medications;
- Repairs or recementing of bridges, crowns, inlays, onlays or dentures; and
- Relining or rebasing of dentures once every three years, except during the first six months after the initial installation or replacement of the denture.

Major Restorative Services

Covered services include:

- Initial placement of full or partial removable dentures, fixed bridgework, replacement of existing partials, or an addition of teeth to partial removable dentures or bridgework as covered by the Plan. The existing dentures or bridgework must have been installed at least five years prior to its replacement and cannot be repairable, or the existing dentures must be immediate temporary dentures that cannot be made permanent. Replacement with permanent dentures must take place within 12 months of the initial installation of the temporary dentures.

- Dental implant systems approved by the Food and Drug Administration.
- Inlays, onlays, gold fillings or crown restorations to restore diseased or fractured teeth, but only when the teeth, as a result of extensive cavities or fractures, cannot be restored to proper function with amalgam, silicate, acrylic, synthetic porcelain or composite restorations.

Orthodontic Services

Covered services include:

- Orthodontic services for members under age 19;
- Orthodontic services for treatment of TMD for members ages 19 and older*; and
- Molar uprighting.

There is no calendar year deductible or lifetime maximum benefit for Network and non-Network orthodontic services.

A 12-month orthodontic waiting period applies to all orthodontic benefits. Refer to “Limitations” in the “Exclusions and Limitations” section.

Overpayments are assessed for orthodontic banding if the member terminates HealthChoice dental coverage prior to the standard 24 months (or specific treatment time) of orthodontic treatment. These overpayments may be your responsibility.

*Certification is required for specific orthodontic services. Providers must submit certification requests to the dental claims administrator for certification review.

Exclusions and Limitations

Exclusions

There is no coverage for the items listed below:

1. Dental care and supplies that are furnished in a facility operated under the direction of, or at the expense of, the U.S. Government, or its agency, or by a provider employed by such a facility;
2. Dental care and supplies for which there is no charge made, or no payment would be required, if the insured individual did not have coverage;
3. Dental care and supplies provided by a dentist;
4. Dental care and supplies that result from taking part in committing, or attempting to commit, an assault or felony;
5. Dental care and supplies due to sickness or injury covered by workers' compensation, occupational disease law or similar laws;
6. Dental care and supplies to the extent that they are payable under other provisions of the policy;
7. Dental care and supplies as a result of an act of war, declared or undeclared, insurrection or release of nuclear energy;
8. Charges incurred after the covered individual's benefit ends;
9. Supplies and prescription drugs for dental care or treatment, other than those used in a dentist's office, or instructions in dental hygiene. Prescription drugs prescribed by your dentist may be covered by your health plan;
10. Expenses relating to an intentionally self-inflicted injury;
11. Hospital confinement and ancillary services, including anesthesia for dental surgery, when the confinement is necessary due to illness or other health conditions. These charges should be filed with your health plan;
12. Replacement of lost dentures;

13. Separately billed infection control fees;
14. Charges for missed or canceled appointments;
15. Gel-Kam[®] and other take home fluorides;
16. Oral care and supplies which are used to change vertical dimension or closure, except as provided under orthodontic benefits;
17. Adult orthodontics without a diagnosis of TMD;
18. Cosmetic procedures;
19. Charges made by a duly qualified dentist or oral surgeon for treatment of fractures and dislocations of the jaw, or for cutting procedures and treatment. These charges may be covered by your medical plan;
20. Medical expenses for the treatment of TMD;
21. Medical services treating an oral condition;
22. Services supplied by a provider who is a relative of the patient, by blood or by marriage, or one who normally lives within the patient's home; and
23. Separately billed local or block anesthesia used in conjunction with restorative and/or surgical procedures.

This list is not all-inclusive.

Limitations

Orthodontic Waiting Period

No orthodontic benefits are available to members and/or dependents during the first 12 consecutive months of coverage. This includes orthodontic services for TMD.

Benefits for orthodontic services received during the waiting period are prorated once 12 consecutive months of coverage are completed.

Dental Accidents

Dental accidents are covered under the HealthChoice health plans which pay for medically necessary treatment for the repair of injury to sound natural teeth or gums. You must be a member of a HealthChoice health plan and treatment must be performed within 12 months following the accident. If you are enrolled in a different health plan, contact that plan for information on how dental accidents are covered.

Claim Procedures

Claim Filing and Payment

Dental claims must be submitted on the most current ADA claim form. Items such as cash register receipts, pull-apart forms and billing statements are not accepted.

Network

HealthChoice Network Providers are required by contract to submit your claims for you using the appropriate form. Payment is automatically made to your provider.

Non-Network

Non-Network providers are not required to submit claims on your behalf and may not use the appropriate form. If this is the case, ask if they can submit the claim on your behalf using the appropriate form or if they can provide you a completed form so you can file the claim yourself.

Claims should be filed as soon as services are received or completed. Send your claim to the dental claims administrator. For contact information, refer to “Plan Identification Information and Notice.”

Non-Network claims are usually paid to you; however, you can choose to assign benefits directly to your provider.

When a valid assignment of benefits to your provider is submitted with your claim, payment is made to your provider. When there is no valid assignment of benefits, payment is made to you and you are responsible for paying your provider.

Claims Requiring Additional Information

If your dental claim requires additional information for processing, your “Explanation of Benefits” identifies the specific information needed. In some instances, a letter is also sent further explaining what information is required to complete claim processing. Your claim is closed until this information is received.

Please be sure to include your member ID number and claim number when returning the requested information. Once the information is provided to the dental claims administrator, your claim is automatically processed. You do not need to resubmit your claim.

Claims Filing Deadline

Claims must be received no later than the last day of the calendar year following the year the claim was incurred. For example, if the date of service is July 1, 2015, the claim will be accepted through Dec. 31, 2016.

Claims for Services Outside the United States

If you receive dental care outside the United States, follow these claim procedures:

- Make arrangements to pay for the services or supplies;
- Submit an itemized statement for reimbursement;
- Have claims translated into English with U.S. dollar amounts before you file your claim;
- Convert charges to U.S. dollars using the exchange rates applicable for the date of service; and
- File the original claim along with the translation; the Plan does not pay any costs for translating claims or dental records.

Itemized bills should be sent to:

HealthChoice
P.O. Box 24870
Oklahoma City, OK 73124-0870

Allowable Fees are paid at the non-Network rate of coinsurance. You are responsible for amounts above the Allowable Fees.

Coordination of Benefits

If you or your covered dependents have dental coverage with another group dental plan, HealthChoice benefits are coordinated so that the total benefits received are not greater than the charges billed, benefits allowed or your responsibility.

If you terminate your other group dental coverage, please send written notice and supporting documentation to the dental claims administrator. For contact information, refer to “Plan Identification Information and Notice.”

Verification of Other Insurance Coverage

If you have other group dental insurance, the “Verification of Other Insurance Coverage” (VOIC) form provides HealthChoice with information about your other group dental insurance. This information is used to coordinate your HealthChoice benefits with your other insurance plan. When a VOIC is needed to process your claim, the dental claims administrator sends one to you to complete and return. **Failure to complete and return a VOIC when requested causes your claim to be denied for non-compliance.**

Pre-Estimate

If your dental treatment is expected to cost more than \$200 for Preventive, Basic or Major services, a pre-estimate of dental benefits is recommended. A pre-estimate is filed like a claim and provides you with an overview of the costs of your treatment and the amounts the Plan will pay. A pre-estimate should be submitted before treatment begins and include required supporting documentation.

Your dentist or specialist must bill for the exact services pre-estimated, unless you make a request for additional services.

Disputed Claims Procedure

If your claim is denied in whole or in part for any reason, you have the right to have your claim reviewed. Requests for review of your denied claim must be submitted in writing, along with any additional information you wish to provide, to the dental claims administrator. For more information, call the dental claims administrator. For contact information, refer to “Plan Identification Information and Notice.”

If your claim remains denied after a claim review, you can appeal that decision to the Grievance Panel by writing to:

HealthChoice Legal Grievance
3545 N.W. 58th St., Ste. 110
Oklahoma City, OK 73112

or calling 1-405-717-8701 or toll-free 1-800-543-6044. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

The Grievance Panel is an independent review group established by statute 74 O.S. 2012, § 1306.6.

All requests for hearings must be filed within one year from the date you are notified of the denial of a claim, benefit or coverage.

You can submit a request for a Grievance Panel hearing and represent yourself in these proceedings. If you are unable to submit a request for a Grievance Panel hearing yourself, only attorneys licensed to practice in Oklahoma are permitted to submit your hearing request for you, or to represent you through the hearing process (75 O.S. 1999, § 310.5).

All claim reviews and final decisions of the Grievance Panel are made as quickly as possible. After completing the claim review and grievance procedures, an appeal can be pursued in an Oklahoma District Court.

Subrogation

Subrogation is the process through which HealthChoice has the right to recover any benefit payments made to you or your dependents by a third party's insurer because of an injury or illness caused by the third party. Third party means another person or organization.

Subrogation applies when you are sick or injured as a result of the negligent act or omission of another person or party. If you or your covered dependents receive HealthChoice benefits and have a right to recover damages, this plan has the right to recover any benefits paid on your behalf. All payments from a third party, whether by lawsuit, settlement or otherwise, must be used to repay HealthChoice.

If you are asked to provide information about the injury or accident to the HealthChoice subrogation office, any related claims are pended until you have supplied the necessary information.

The HealthChoice subrogation office can be reached at 1-405-717-8987 or toll-free 1-800-543-6044, ext., 8898. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

General Provisions

Provider-Patient Relationship

You can choose any provider or practitioner who is licensed or certified under the laws of the state in which they practice, and who is **recognized by the Plan**. Each provider offering dental care services is an independent contractor. Providers retain the provider-patient relationship with you and are solely responsible to you for any dental advice and treatment or subsequent liability resulting from that advice or treatment.

Although a provider recommends or prescribes a service or supply, this does not necessarily mean it is covered by the Plan.

For information on the types of providers recognized by the Plan, contact HealthChoice Network Management at 1-405-717-8790 or toll-free 1-800-543-6044. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436. This information can also be found by selecting “Specialty Search” in the top menu bar of the “HealthChoice Network Provider Directory” on the HealthChoice

website at www.healthchoiceok.com. Select “Find a Provider” in the top menu bar to access the provider directory.

Inaccurate or Erroneous Information

Coverage obtained by means of inaccurate or erroneous information is canceled retroactive to the effective date, and premiums you paid for coverage are refunded. Refunded premiums are reduced by any claims paid by HealthChoice.

Confirmation Statements

Anytime you make a change to your coverage, you are mailed a “Confirmation Statement” (CS). The CS lists your coverage, the effective date of your coverage, and the premium amount for your coverage. A CS is provided so you can review changes, and any errors can be identified and corrected as soon as possible.

Corrections to Benefit Elections

If you find errors to your benefit elections on your CS, you should submit corrections within 60 days. Current employees must submit corrections to their Insurance/Benefits Coordinator and former employees must submit corrections directly to EGID. Corrections reported after 60 days are effective the first of the month following notification.

Member Audit Program

Despite your provider’s best efforts, the complexity of arranging for your care and treatment may result in inaccurate billing. That is why it is important to check your bill carefully. If you discover certain mistakes in your bill, you can share in the savings through the Member Audit Program. You can receive up to 50% of any savings resulting from a billing error you find, up to a maximum reimbursement of \$200.

Eligible errors include charges for services not provided or charges that are billed incorrectly. Billing mistakes such as transposed numbers, addition mistakes, and misplaced decimals are not eligible for the program. Only charges for services covered by the Plan are eligible.

If you find an error on a dental bill and you wish to participate in the Member Audit Program, you can call the EGID toll-free hotline at 1-866-381-3815, email a message to antifraud@omes.ok.gov, or send a report in writing to:

EGID Compliance Officer
3545 N.W. 58th St., Ste. 110
Oklahoma City, OK 73112

Right of Recovery

HealthChoice retains the right to recover any payments made by the Plan in excess of the maximum Allowable Fees. HealthChoice has the right to recover such payments, to the extent of excess, from one or more of the following:

- Any persons to, or for, or with respect to whom such payments were made;
- Any other insurers; and/or
- Service plans or any other organizations.

Eligibility and Effective Dates

You are eligible to participate in the HealthChoice Dental Plan if you are:

- A current **education** employee eligible to participate in the Oklahoma Teachers Retirement System and working a minimum of four hours per day or 20 hours per week; or

- A current **State of Oklahoma, local government, or certain non-profit** employee regularly scheduled to work at least 1,000 hours a year and not classified as a temporary or seasonal employee.

New Employee

As a new employee, your coverage is effective the first day of the month following your employment date or the date you become eligible with your employer. If you want to make changes to the coverage you initially elected, you have a 30-day window following your eligibility date to make benefit changes. These changes are effective the first day of the month following the date the changes are made.

Note: No orthodontic benefits are available to members and/or dependents during the first 12 consecutive months of coverage. This includes orthodontic services for TMD. Refer to “Limitations” in the “Exclusions and Limitations” section.

Dependent Coverage

You must be enrolled in a group health plan in order to enroll yourself and your dependents in the HealthChoice Dental Plan. If dependent coverage is elected, all of your eligible dependents must be covered. Refer to “Excluding Dependents from Coverage” in this section for exceptions to this rule.

If you are enrolled and have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll your dependent provided you request enrollment within 30 days following the marriage, birth, adoption or placement for adoption. All other enrollments must be made during the annual Option Period and some limitations may apply. Refer to the “Exclusions and Limitations” section.

Note: Former employees can make changes **only** within 30 days of a qualifying event. Dependents or new benefit plans, other than vision, cannot be added during the annual Option Period.

If your spouse is also a primary member of the HealthChoice Dental Plan through their employer, dependent children can be covered under either parent’s dental plan, provided the parent is also enrolled. Dependent children cannot be covered under both parents’ dental plans.

Eligible Dependents

Eligible dependents include:

- Your legal spouse (refer to common-law marriages in this section).
- Your daughter, son, stepdaughter, stepson, eligible foster child, adopted child or child legally placed with you for adoption up to age 26, whether married or unmarried.
- Your dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26. A “Disabled Dependent Assessment” form must be submitted at least 30 days prior to the dependent’s 26th birthday. The “Disabled Dependent Assessment” form must be approved by EGID before coverage begins or is extended beyond age 26.
- Other unmarried dependent children up to age 26, upon completion of an “Application for Coverage for Other Dependent Children.” Guardianship papers or a tax return showing dependency can be provided in lieu of the application.

Common-law marriages are recognized by the Plan. A new employee can add a common-law spouse at the time of enrollment. A current employee can request coverage on a common-law spouse during the annual Option Period or in the event the common-law spouse loses other group coverage. To enroll a common-

law spouse, the employee and spouse must sign and submit an enrollment or change form.

Note: A former employee can add a common-law spouse only if the common-law spouse loses other group dental coverage.

Coverage for Other Eligible Dependents

You can cover certain other dependents if they are legally adopted, you have legal guardianship, or they meet other specific requirements. To cover these dependents, you must:

- Meet all eligibility requirements;
- Provide the necessary documentation;
- Cover all eligible dependents;
- Request coverage within the set time frame; and
- Pay all premiums.

Legal Adoption

An adopted dependent is eligible for coverage the first day of the month you obtain physical custody of your child. You must submit an enrollment or change form, including a copy of your adoption papers. Current employees must submit the paperwork to their Insurance/Benefits Coordinator and former employees must submit their paperwork directly to EGID. In the absence of adoption papers or other court records, someone involved in the adoption process, such as your attorney or a representative of the adoption agency, must provide proof of the date you actually received custody of your child pending the final adoption hearing.

You must request coverage within 30 days of the date of the initial placement for adoption, otherwise:

- Current employees cannot add dependents to coverage until the next annual Option Period; and

- Former employees cannot add dependents to coverage at any future date.

Legal Guardianship

Guardianship follows the same guidelines as an adoption. Refer to “Legal Adoption” in this section.

Other Forms of Custody

In the absence of a court order indicating adoption, guardianship or divorce, you can request coverage for other eligible dependents by submitting an enrollment or change form and a copy of the portion of your most recent income tax return listing the children as dependents for income tax deduction purposes. Current employees must submit the form and tax return to their Insurance/Benefits Coordinator, and former employees must submit these documents to EGID.

In the absence of a federal income tax return listing the children as dependents, you must provide and have approved an “Application for Coverage for Other Dependent Children” as specified by the Plan.

Coverage for other eligible dependents begins on the first day of the month following the date you obtain physical custody or the date the “Application for Coverage for Other Dependent Children” is approved and never applies retroactively.

You must request coverage within 30 days of the date of initial placement, otherwise:

- Current employees cannot add dependents to coverage until the next annual Option Period; and
- Former employees cannot add dependents to coverage at any future date.

Note: The Plan has the right to verify the dependent status of children, request copies of the portion of your most recent income tax return listing the children as dependents, and discontinue coverage for dependents who are ineligible for coverage.

Excluding Dependents from Coverage

Any of your eligible dependents can be excluded from coverage if they have other group coverage or are eligible for Indian or military benefits. You can exclude your eligible dependent children who do not reside with you, are married, or are not financially dependent on you for support.

You can also exclude your spouse from dental coverage. If you exclude your spouse and cover other eligible dependents, your spouse must sign the “Spouse Exclusion Certification” section of your enrollment or change form.

Changes to Coverage After Initial Enrollment

If you declined enrollment in the HealthChoice Dental Plan because you had other group dental insurance coverage, or Indian or military dental benefits, you can enroll:

- Within 30 days of the date you lose other group coverage; or
- During the annual Option Period.

Certain qualifying events allow a midyear benefit change; however, an enrollment or change form must be completed within 30 days of the qualifying event. Examples of midyear qualifying events include:

- A change in your legal marital status, such as marriage, divorce or death of your spouse;

- A change in the number of your dependents, such as the birth of a child;
- A change in employment status that affects your eligibility or that of your spouse or dependent;
- An event that causes your dependent to meet, or fail to meet, eligibility requirements;
- Commencement or termination of adoption proceedings;
- Judgments, decrees or orders (your employer may allow changes only to health and dental);
- Medicare eligibility for you or a dependent;
- Medicaid eligibility for you or a dependent; only two changes are allowed per plan year, once out and once back in or vice versa;
- Changes in the coverage of your spouse or dependent under another employer's plan;
- Eligibility for leave under the *Family Medical Leave Act* (FMLA); and
- USERRA.

Current Employees

You can make changes to coverage only within 30 days of a qualifying event or during the annual Option Period.

All changes to coverage must be in compliance with the rules of your employer's Section 125 Plan, or if no 125 Plan is offered, in compliance with allowed midyear coverage changes as defined by Title 26, Section 125, of the Internal Revenue Codes (as amended) and pertinent regulations. Current employees must contact their Insurance/Benefits Coordinator and complete an enrollment or change form.

Former Employees and Surviving Dependents

You can make changes to coverage **only** within 30 days of a qualifying event. Dependents or new benefit plans, other than vision, cannot be added during the annual Option Period.

Former employees and surviving dependents must submit a written request for changes in coverage to:

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

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

Note: Oklahoma law prohibits dropping your spouse/dependents if you are in the process of a divorce or legal separation at any time. If you are in the process of separation or divorce, it is important that you contact your legal counsel for advice before making any changes to your coverage.

Options for Current Employees Called to Active Military Service

Under the *Uniform Services Employment and Re-employment Rights Act of 1994* (USERRA), coverage can be continued for up to 24 months. USERRA provides certain rights and protections for all employees called to serve our nation. All branches of the military including the Army, Navy, Marines, Air Force, Coast Guard, all military reserve units and all National Guard units come under USERRA.

In addition to dental care provided by the military, you have the following four choices regarding your current coverage:

- Retain all coverage. Your current employer is responsible for collecting and forwarding all premiums to EGID.
- Discontinue member coverage but retain dependent coverage. This is the COBRA option and dependents are billed directly at 102% of premiums, the COBRA rate, for health, dental and/or vision coverage. Under COBRA rules, life insurance cannot be retained.
- Discontinue all coverage except life insurance. You are billed directly.
- Discontinue all member and dependent coverage.

Each month, you must pay the full premium for the coverage you selected. Failure to pay premiums timely can result in the termination of coverage at the end of the month for which the last full premium was received. There is no penalty for renewing coverage upon discharge from active duty if coverage is elected within 30 days of your return to the same employment.

Regardless of whether you receive written or verbal military orders, EGID staff and/or your Insurance/Benefits Coordinator will assist you in making any benefit arrangements. If you are a member of a military reserve unit or the National Guard and anticipate being called to active service, notify your Insurance/Benefits Coordinator at work.

Leave Without Pay — Current Employees

If you are on approved leave without pay through your employer, you can continue coverage for up to 24 months from the day you begin leave without pay status. You must make timely premium payments in full each month to your Insurance/Benefits Coordinator.

If your coverage terminates for failure to pay premiums on time, you can re-enroll upon returning to work.

If you take leave under the *Family Medical Leave Act* (FMLA), please make premium payment arrangements with your employer before you take leave.

Continuing Coverage After Leaving Employment

If you leave employment, you and/or your eligible dependents may be able to begin or continue coverage through one of the following options:

- Vesting or retirement rights through a state funded retirement system established by the State of Oklahoma;
- Years of service with state, education or local government employers; refer to “Years of Service” in this section;
- Receiving benefits through the HealthChoice Disability Plan administered by EGID;
- Survivors’ Rights for your covered dependents in the event of your death; or
- COBRA (Consolidated Omnibus Budget Reconciliation Act).

Each month, premiums must be paid in full. Failure to pay premiums on time can result in the termination of coverage at the end of the month for which the last premium was received.

Years of Service

You can begin or continue coverage after leaving employment if you make an election within 30 days following your employment termination date, and you meet one of the following conditions:

- You are eligible to participate in the Oklahoma Public Employees Retirement System and have eight or more years of service with a participating employer;
- You are an employee of a local government employer that participates in the Plan but does not participate in the Oklahoma Public Employees Retirement System, and have eight or more years of creditable service;
- You are eligible to participate in the Oklahoma Teachers Retirement System and have ten or more years of service with a participating employer; or
- You are an employee of an education employer that participates in the Plan but does not participate in the Oklahoma Teachers Retirement System, and have ten or more years of creditable service.

Education Employees

If you were a career tech employee or a common school employee who terminated active employment on or after May 1, 1993, you can continue coverage through the Plan as long as the school system from which you retired or vested continues to participate in the Plan. If your former school system terminates coverage under the Plan, you must follow your former employer to its new insurance carrier.

If you were an employee of an education entity other than a common school, e.g., higher education, charter school, etc., you can continue coverage through the Plan as long as the education entity from which you retired or vested continues to participate in the Plan. If your former employer terminates coverage with the Plan, you must follow your former employer to its new insurance carrier.

Note: You cannot reinstate coverage that you discontinue or allow to lapse unless you return to work as an employee of a participating employer. Refer to “Reinstatement” in the “Termination or Reinstatement of Coverage” section.

Local Government Employees

If you were a local government employee who terminated active employment on or after Jan. 1, 2002, you can continue coverage through the Plan as long as the employer from which you retired or vested continues to participate in the Plan. If your former employer terminates coverage with the Plan, you must follow your former employer to its new insurance carrier.

Note: You cannot reinstate coverage that you discontinue or allow to lapse unless you return to work as an employee of a participating employer. Refer to “Reinstatement” in the “Termination or Reinstatement of Coverage” section.

Some reinstatement exceptions may apply if you are a state employee who terminated employment as a result of a reduction in force (RIF). Refer to “State Government Reduction In Force and Severance Benefits Act” in the “Termination or Reinstatement of Coverage” section.

New Employer Retirees

All retirees with former employers that joined the Plan after the specified grandfathered dates must follow their former employer to its new insurance carrier.

Following Your Employer to a New Carrier

When you terminate employment, your benefits are tied to your most recent employer. If your employer discontinues participation with EGID, some or all of the employer’s retirees and their dependents (depending on the type of employer) must follow the employer to its new insurance carrier. This is true regardless of the amount of time you were employed with any participating employer.

If you retire and then return to work for another employer and enroll in benefits through your new employer, your benefits are tied to your new employer.

Continuation through the Disability Program

You can keep dental coverage in effect if you are receiving benefits through the HealthChoice Disability Plan. You can continue coverage as long as you are covered under the HealthChoice Disability Plan and pay premiums on time. You must maintain continuous coverage. If you discontinue coverage or allow coverage to lapse, it cannot be reinstated unless you return to work as an employee of a participating employer. Refer to “Reinstatement” in the “Termination or Reinstatement of Coverage” section.

Survivors’ Rights

Your surviving spouse and dependents have 60 days following your death to notify EGID they wish to continue coverage. Coverage is effective the first day of the month following your death.

- Your surviving spouse is eligible to continue insurance coverage indefinitely as long as premiums are paid.
- Surviving dependent children are eligible to continue coverage until age 26 as long as premiums are paid.
- Disabled dependent children are eligible to continue coverage as long as they continue to meet the HealthChoice definition of a disabled dependent and premiums are paid.

Note: COBRA continuation of coverage is available for dependent children who lose eligibility.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

If your or your dependents' coverage is terminated for any of the reasons listed below, each covered member has the right to elect temporary continuation of coverage under the *Consolidated Omnibus Budget Reconciliation Act* (COBRA).

You are eligible to continue coverage for up to 18 months if you lose coverage due to:

- A reduction in your hours of employment; or
- Termination of your employment for reasons other than gross misconduct.

Your covered **spouse** is eligible to continue coverage if coverage is lost due to:

- Your death (refer to “Survivors’ Rights” in this section);
- Termination of your employment for reasons other than gross misconduct;
- A reduction in your hours of employment resulting in loss of coverage; or
- A divorce or legal separation*.

Your covered **dependent children** are eligible to continue coverage if coverage is lost due to:

- Your death (refer to “Survivors’ Rights” in this section);
- Termination of your employment for reasons other than gross misconduct;
- A reduction in your hours of employment resulting in loss of coverage;
- A divorce or legal separation of the parents*; or
- Your dependent no longer meets the requirements for dependent status.

*Oklahoma law prohibits dropping your spouse/dependents if you are in the process of a divorce or legal separation at any time. It is important you contact your legal counsel for advice before attempting to make changes to your coverage.

If you are a **current employee**, it is your responsibility to notify your employer within 30 days of a divorce, legal separation or your child's loss of dependent status under this Plan.

If you are a **former employee**, you must notify EGID in writing within 30 days of a divorce, legal separation or your child's loss of dependent status under this Plan.

You and/or your eligible dependents must elect continuation of coverage within 60 days after the later of the following events occur:

- The date the qualifying event would cause you and/or your dependents to lose coverage; or
- The date your employer notifies you and/or your dependents of continuation of coverage rights.

If the qualifying event is related to termination of employment or reduced hours, coverage can be continued for a maximum of 18 months. If the qualifying event is for any other eligible reason, coverage for dependents can be continued for a maximum of 36 months. Continuation of coverage terminates immediately for you and/or all covered dependents under the following circumstances:

- The Plan ceases to provide coverage;
- Premiums are not paid on time; and/or
- You and/or your dependents become covered under another group dental plan.

If you have questions regarding COBRA, contact your Insurance/Benefits Coordinator or EGID.

If you continue coverage under COBRA, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify EGID of a disability or second qualifying event in order to extend the coverage continuation period. Failure to provide timely notice of a disability or second qualifying event can affect your right to extend the coverage continuation period.

Termination or Reinstatement of Coverage

Termination

Your coverage, as well as any dependent coverage, ends on the last day of the month one or more of the following events occur:

- You terminate employment with a participating employer and do not continue coverage through vesting, non-vest, retirement, disability or COBRA;
- You do not pay premiums;
- The Plan is terminated; and/or
- Your death occurs.

In addition, a dependent's coverage ends on the last day of the month they cease to be an eligible dependent. Upon review by EGID, if you or your dependent is found to be ineligible, coverage is terminated effective on the first day of the month of discovery. EGID reserves the right to recover any benefits paid on behalf of an ineligible member.

Reinstatement

If you are currently employed by a participating employer and discontinue coverage on yourself or your dependents, you cannot

apply for reinstatement of coverage for at least 12 months. To reinstate discontinued coverage, you must enroll within 30 days of:

- The expiration of the 12-month waiting period; if coverage is not reinstated within 30 days of the end of the waiting period, you cannot enroll in coverage until the next annual Option Period, or
- The loss of other group dental coverage or other qualifying event.

To reinstate coverage, proof of the loss of other group coverage or other qualifying event must be submitted.

Former employees who did not continue coverage upon leaving active employment, or who later discontinued coverage, must return to work with a participating employer and carry coverage for three years to be eligible to continue that coverage when they re-retire.

Loss of Coverage While Under Treatment

If you or your covered dependents lose dental coverage while undergoing treatment, the Plan still continues to provide benefits for two months following termination of coverage. The Plan pays the Allowable Fees in the following situations according to Plan benefits:

- For dentures, denture impressions must be taken before coverage ends.
- For bridgework, crowns and gold restoration, the tooth must be prepared before coverage ends, and the bridgework, crown or gold restoration must be installed within the extended benefit period.
- For endodontics, including root canal, the tooth has to be opened before coverage ends, and all covered services must be provided and charges must be incurred within the extended benefit period.

State Government Reduction In Force and Severance Benefits Act

If you are a former state employee who:

- Had a vested or retirement benefit based on the provisions of any of the state public retirement systems,
- Was separated from state service as a result of a reduction in force anytime after July 1, 1997, and
- Was offered severance benefits pursuant to the *State Government Reduction in Force and Severance Benefits Act*,

you can reinstate dental insurance coverage at any time within two years following the date of the reduction in force from the state.

For further information, contact HealthChoice Member Services. For contact information, refer to “Plan Identification Information and Notice.”

**State of Oklahoma
Office of Management and Enterprise
Services (OMES)
Privacy Notice
Revised: March 2015**

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

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

OMES HIPAA Privacy Officer
3545 N.W. 58th, Suite 1000, Oklahoma City, OK 73112
Telephone: 1-405-717-8701, Toll-free 1-800-543-6044
TDD 1-405-949-2281, Toll-free TDD 1-866-447-0436
OMES.OK.gov

Why is the Notice of Privacy Practices Important?

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

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

- The State Wellness Program, Employees Group Insurance Department (EGID), and Section 125 plan within Human Capital Management;
- The Performance and Efficiency Division as it applies to operations of the Employees Group Insurance Department;
- The Legal Division; and
- The Information Services Division (ISD) as it applies to maintenance and storage of PHI.

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

Your Information. Your Rights. Our Responsibilities.

Your Rights

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

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this using the contact information 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 fee.

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

Get a list of those with whom we’ve shared information

- You can ask for an accounting of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make.) We will provide one accounting a year free of charge but will charge a reasonable fee if you ask for another accounting within 12 months.

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the 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 Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. Complaints to HHS must be filed within 180 days of when you knew that the violation occurred.
- We will not retaliate against you for filing a complaint.

Your Choices

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

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent health or safety threat.

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

Our Uses and Disclosures

How do we typically use or share your health information (PHI)?

Your PHI is used and disclosed by OMES employees and other entities under contract with OMES according to HIPAA Privacy Rules using the “minimum necessary” standard which releases only the minimum necessary health information to achieve the intended purpose or to carry out a desired function within OMES.

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

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

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

Pay for your health services

We can use and disclose your health information as we pay for your eligible health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose summarized health information to your health plan sponsor for plan administration.

Example: Your employer contracts with us to provide a health plan, and we provide the employer with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

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

Help with public health and safety issues

We can share health information about you for certain situations such as:

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

Do research

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

Comply with the law

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

Work with a medical examiner or funeral director

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information (PHI).
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI.

- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your PHI other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

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

Fraud, Waste and Abuse Compliance

OMES EGID is committed to conducting its business activities with integrity and in full compliance with the federal, state and local laws governing its business. This commitment applies to relationships with members, providers, auditors and all public and governmental bodies. Most importantly, it applies to employees, subcontractors and representatives of OMES EGID. This commitment includes the policy that all such individuals have an obligation to report problems or concerns involving ethical or compliance violations related to its business.

If you suspect that OMES EGID and/or Medicare have been defrauded, are being defrauded, or that resources have been wasted or abused, report the matter to the OMES EGID Compliance Officer immediately. To report suspicious acts or claims:

- Visit the compliance officer in person;
- Send a report in writing to: OMES EGID Compliance

Officer, 3545 N.W. 58th St., Ste. 110, Oklahoma City, OK 73112;

- Email a message to AntiFraud@omes.ok.gov;
- Leave a report in the secure drop box outside the OMES EGID 5th Floor Board Room; and/or
- Call the OMES EGID toll-free hotline at 1-866-381-3815.

You are encouraged to provide adequate information in order to assist with further investigation of fraud. All investigations are handled confidentially. Every attempt is made to ensure the confidentiality of any report, but please remember that confidentiality may not be guaranteed if law enforcement becomes involved. There will be no retaliation against anyone who reports conduct that a reasonable person acting in good faith would believe to be fraudulent or abusive. Any employee who violates the non-retaliation policy is subject to disciplinary action up to and including termination.

You can also submit such reports anonymously. If you choose to submit information anonymously and want to receive updates on the status of the investigation, you are required to supply the compliance officer with an alias and a password as a means of obtaining secure updates. It is the reporting individual's responsibility to remember both the alias and password he or she provides, since the compliance officer is not able to divulge or reconfirm these if they are forgotten.

Plan Definitions

Allowable Fees: The set dollar amount allowed under the Plan for a covered service or supply.

Coinsurance: The percentage of Allowable Fees paid by you and by HealthChoice once your deductible is satisfied.

Cosmetic Procedure: A procedure that primarily serves to improve appearance.

Deductible: The initial amount of out-of-pocket expenses you pay on Allowable Fees before a benefit is paid by the Plan.

EGID: The Office of Management and Enterprise Services (OMES) Employees Group Insurance Department.

Eligible Dependent:

- Your legal spouse (including common-law spouse).
- Your daughter, son, stepdaughter, stepson, eligible foster child, adopted child or child legally placed with you for adoption up to age 26, whether married or unmarried.
- Your dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26. A “Disabled Dependent Assessment” form must be submitted at least 30 days prior to the dependent’s 26th birthday. The “Disabled Dependent Assessment” form must be approved by EGID before coverage begins.
- Other unmarried dependent children up to age 26, upon completion of an “Application for Coverage for Other Dependent Children.” Guardianship papers or a tax return showing dependency may be provided in lieu of the application.

Eligible Employee: An employee of a participating employer who receives compensation for services rendered and is listed on that employer's payroll. This includes persons elected by popular vote, i.e., board members for education and elected officials of state and local government, state employees, rural water district board members, county election board secretaries, and any employee otherwise eligible who is on approved leave without pay, not to exceed 24 months.

- Education employees must be eligible to participate in the Oklahoma Teachers Retirement System and work a minimum of four hours per day or 20 hours per week.
- Local government employees, including rural water districts, must be employed in a position requiring a minimum of 1,000 hours work per year.

Eligible Former Employee: An employee who participates in any of the Plans authorized by or through the *Oklahoma Employees Insurance and Benefits Act* who retired or vested their rights with a state funded retirement system, or has the required years of service with a participating employer.

Network Provider: A provider who has entered into a contract with EGID to accept the Plan's Allowable Fees for services and/or supplies provided to Plan participants.

Non-covered Service: Any service, procedure or supply excluded from coverage and not paid for by the Plan.

Option Period: The annual time period established by EGID when changes can be made to coverage.

Orthodontic Limitation: A 12-month waiting period for orthodontic benefits. No orthodontic benefits are available to members and/or dependents during the first 12 consecutive months of coverage. This includes orthodontic services for TMD.

Participating Employer: Any municipality, county, or education employer or other state agency whose employees or members are eligible to participate in any plan authorized by or through the *Oklahoma Employees Insurance and Benefits Act*.

Plan: The HealthChoice Dental Plan offered through EGID and described in this handbook.

NOTICE

Section 1557 of the Patient Protection and Affordable Care Act

HealthChoice complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. HealthChoice does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HealthChoice provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). HealthChoice provides free language services to people whose primary language is not English, such as qualified interpreters. If you need these services, contact HealthChoice Member Services at 800-752-9457 (TDD: 866-447-0436).

If you believe that HealthChoice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with the civil rights coordinator, 3545 NW 58th Suite 110, OKC, OK 73112, 866-381-3815, 866-447-0436 (TDD), 405-717-8609 (fax), DiscriminationComplaints@omes.ok.gov. You can file in person or by mail, fax or email. If you need help filing a grievance, the civil rights coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 800-868-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800-752-9457 (TDD: 866-447-0436).

(Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-752-9457 (TDD: 866-447-0436).

(Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-752-9457 (TDD: 866-447-0436).

(Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-752-9457 (TDD: 866-447-0436)。

(Korean) 주의: 한국어를 사용하지는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-752-9457 (TDD: 866-447-0436) 번으로 전화해 주십시오.

(German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-752-9457 (TDD: 866-447-0436).

(Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-752-9457 (رقم هاتف الصم والبكم: 866-447-0436).

(Burmese) သတိပြုရန် - အကယ်၍ သင့်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 800-752-9457 (TDD: 866-447-0436) သို့ ခေါ်ဆိုပါ။

(Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-752-9457 (TDD: 866-447-0436).

(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-752-9457 (TDD: 866-447-0436).

(French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-752-9457 (TDD: 866-447-0436).

(Laotian) ໄປັດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-752-9457 (TDD: 866-447-0436).

(Thai) หมายเหตุ: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-752-9457 (TDD: 866-447-0436).

(Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ (TDD: 866-447-0436) 800-752-9457 کال کریں۔

(Cherokee) Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 800-752-9457 (TDD: 866-447-0436)

(Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-752-9457 (TDD: 866-447-0436) تماس بگیرید.

