DENTAL PLAN HANDBOOK

Plan Year 2024

HealthChoice

5039

TABLE OF CONTENTS

This dental handbook replaces and supersedes any dental handbook the Office of Management and Enterprise Services Employees Group Insurance Division previously issued. This dental handbook will, in turn, be superseded by any subsequent dental handbook OMES issues. The most current version of this dental handbook can be found at **HealthChoiceOK.com**.

NOTICES

PLEASE READ THIS HANDBOOK CAREFULLY

The Office of Management and Enterprise Services Employees Group Insurance Division provides dental benefits to eligible state, education and local government employees, former employees and their dependents in accordance with the provisions of 74 O.S. § 1301, et seq.

The information provided in this handbook is a summary of the benefits, conditions, limitations and exclusions of the HealthChoice Dental Plan (referenced herein as plan or plans). It should not be considered an all-inclusive listing. All references to "you" and "your" relate to the plan member.

- 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 EGID website at **Oklahoma.gov/omes.** In the menu bar under Divisions, select Employees Group Insurance Division. Select Oklahoma Employees Insurance and Benefits Board, then select Policies & Resources. Finally, select Administrative Rules under Resources.
- 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.

INFORMATION AVAILABLE ONLINE

HealthChoice website

The HealthChoice website at **HealthChoiceOK.com** is for existing and prospective HealthChoice members to find detailed information around the clock. This includes an overview of each of the HealthChoice plans for active and Medicare members. The HealthChoice Health, Dental, Life, Disability and Medicare Supplement Plan handbooks are available online where members can also search for HealthChoice network providers.

HealthChoice member portal

You can log into the HealthChoice member portal from the HealthChoice website. This online tool is designed to give you quick and easy access to your member and dependent benefit information, temporary member ID cards, claims, account balances and more. You can also use the member portal to find a network provider or chat with a HealthChoice Customer Service representative via secure message. If you haven't already registered for the HealthChoice member portal, you need to create a unique username and password to access your information. Your covered dependents 18 and older must register independently for their own access.

HEALTHCHOICE PLAN CONTACT INFORMATION

HealthChoice Customer Service
Dental benefit coverage, claims, certification inquiries and dental records
800-323-4314
TTY 711
HealthChoiceOK.com.

Claims and correspondence
P.O. Box 30511
Salt Lake City, UT 84130-0511

Appeals and provider inquiries
P.O. Box 30546
Salt Lake City, UT 84130-0546

Subrogation administrator
McAfee & Taft
405-235-9621 or 800-235-9621
Two Leadership Square, 10th Floor
211 N. Robinson Ave.
Oklahoma City, OK 73102

Eligibility and enrollment
EGID Member Services
405-717-8780 or 800-752-9475
TTY 711

HEALTHCHOICE PLAN IDENTIFICATION

Plan name
HealthChoice Dental Plan

Plan administrator
Office of Management and Enterprise Services
Employees Group Insurance Division
405-717-8780 or 800-752-9475.
P.O. Box 11137
Oklahoma City, OK 73136-9998

HEALTHCHOICE PROVIDER NETWORK

You can seek care from a network or non-network provider; however, the amount you are responsible for paying is substantially higher when you use a non-network provider. With a statewide and multistate network of more than 1,800 dentists, oral and maxillofacial surgeons, orthodontists and periodontists, the HealthChoice Provider Network is one of the largest in Oklahoma.

Finding a HealthChoice network provider

You can find a HealthChoice network provider through **HealthChoiceOK.com** using the HealthChoice member portal or the HealthChoice app .

You can also contact HealthChoice Customer Service and a member advocate can give you the names of network providers in your area.

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 EGID Member Services.

Refer to HealthChoice Plan Contact Information.

Importance of selecting a HealthChoice network provider

Network providers

Network providers are contracted with HealthChoice and have agreed to accept HealthChoice allowable amounts for the services and equipment they provide. Network providers have agreed not to bill you for charges that are greater than allowable amounts until you exceed your calendar year maximum benefit. You are still responsible for your plan’s copays, deductibles, coinsurance and charges for non-covered services.

Non-network providers

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

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 amounts.
- A calendar year deductible of $25 per individual or $75 maximum per family of three or more for basic and major restorative services. This is separate from the non-network calendar year deductible and amounts accumulated do not cross-apply.
- Basic restorative services covered at 85% of allowable amounts after the deductible has been met.
- Major restorative services covered at 60% of allowable amounts after the deductible has been met.
- Orthodontic services for members under 19, or members 19 and older with temporomandibular joint dysfunction, are covered at 50% of allowable amounts. There is no calendar year deductible or lifetime maximum benefit; however, a 12-month waiting period applies to all orthodontic benefits except for those members being treated for TMJ/TMD. Refer to Limitations in the Exclusions and Limitations section.
- Network providers file your claims for you.

Non-network providers

When using a non-network provider, the plan provides the following benefits:

- Preventive services covered at 100% of allowable amounts after the deductible has been met.
- A calendar year deductible of $25 per individual or $75 maximum per family of three or more for preventive, basic and major services. This is separate from the network calendar year deductible and amounts accumulated do not cross-apply.
- Basic restorative services covered at 70% of allowable amounts after the deductible has been met.
- Major restorative services covered at 50% of allowable amounts after the deductible has been met.
- Orthodontic services for members under 19 or members 19 and older with TMJ/TMD are covered at 50% of allowable amounts. There is no calendar year deductible or lifetime maximum benefit; however, a 12-month waiting period applies to all orthodontic benefits except for those members who are being treated for TMJ/TMD. Refer to Limitations in the Exclusions and Limitations section.

Note: If you use a non-network provider, you must file your claims yourself unless the provider is willing to file for you as a courtesy. Refer to Claim Procedures.

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 amounts when using non-network providers.

Schedule of covered benefits

	Network		Non-network	
Covered services	**Calendar year deductible**	**Plan pays (of allowable amounts)**	**Calendar year deductible**	**Plan pays (of allowable amounts)**
Preventive	**None**	**100%**	**$25/$75****	**100%**
Basic restorative	**$25/$75***	**85%**		**70%**
Major restorative		**60%**		**50%**
Orthodontic	**None**	**50%**	**None**	**50%**

***Network services:** There is a calendar year deductible of $25 per individual or $75 maximum per family of three or more for basic and major services combined.

****Non-network services:** There is a calendar year deductible of $25 per individual or $75 maximum per family of three or more for preventive, basic and major services combined.

Note: Network and non-network deductibles accumulate separately.

Maximum benefits

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.

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

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 19.

- Emergency palliative treatment.
- Sealants, only on molars; reapplication once every 36 months.
- Preventive resin restorations in moderate-to-high-risk caries patients, only on molars, no age restriction; 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.
- Repair or recementing of bridges, crowns, inlays, onlays or dentures.
- 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.

Note: HealthChoice does not have a missing tooth clause.

Orthodontic services

Covered services include:

- Orthodontic services for members under 19.
- Orthodontic services for treatment of TMJ/TMD for members at any age.*
- Molar uprighting.

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

A 12-month orthodontic waiting period applies to all orthodontic benefits except for those members who are being treated for TMJ/TMD. 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 the member's responsibility.

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

*Certification is required for specific orthodontic services. Providers must submit certification requests to HealthChoice Customer Service for certification review.

EXCLUSIONS AND LIMITATIONS

Exclusions

There is no coverage for the items listed below:

1. Dental care and supplies 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 is required if the insured individual does not have coverage.
3. Dental care and supplies provided by a denturist.
4. Dental care and supplies that result from 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. Direct-to-consumer orthodontic treatment.
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. Intentionally self-inflicted injury or illness, except when the injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a documented medical condition that is covered under the HealthChoice Dental Plan.
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 amounts.

14. Charges for missed or canceled appointments.
15. Gel-Kam and other take-home fluorides.
16. Oral care and supplies used to change vertical dimension or closure, except as provided under orthodontic benefits.
17. Adult orthodontics without a diagnosis of TMJ/TMD.
18. Medical expenses for the treatment of TMJ/TMD.
19. Cosmetic procedures.
20. 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 health plan.
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 in the patient's home.
23. Separately billed local or block anesthesia used in conjunction with restorative or surgical procedures.
24. Charges for injuries resulting from war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.

This list is not all-inclusive.

Limitations

Orthodontic waiting period

No orthodontic benefits are available to members or dependents during the first 12 consecutive months of coverage. This 12-month waiting period does not apply to the treatment of TMJ/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 American Dental Association claim form. Items such as cash register receipts, pull-apart forms and billing statements are not accepted.

Network

Network providers file your claims for you and 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 HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

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 filing deadline

Claims must be submitted within 180 days from the date of service.

Claims for services outside the United States

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

- Arrange to pay for the services or supplies.
- 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(s) of service.
- Log into the member portal at **HealthChoiceOK.com** and select Submit a claim.
- File the original claim along with the translation; the plan does not pay costs for translating claims or medical records.
- Contact HealthChoice Customer Service for assistance. Refer to HealthChoice Plan Contact Information.

Allowable amounts are paid in accordance with your plan's non-network benefits. You are responsible for amounts above the allowable amounts.

Coordination of benefits

You are required to annually verify if you or any of your covered dependents have other group dental insurance coverage. You should also notify us anytime you or your covered dependent(s) adds or drops other dental insurance. You may complete your verification online by registering at **HealthChoiceOK.com** or by calling HealthChoice Customer Service at 800-323-4314. **Failure to verify other insurance coverage will result in denial of claims until verification is completed.**

This process establishes which insurance plan is primary when two plans must work together to pay claims for the same person. Coordinating benefits ensures that the two plans do not pay more than the total amount of the claim, thereby helping to reduce the cost of insurance premiums.

Failure to verify other insurance coverage may result in denial of claims until verification is completed.

Explanation of benefits

Each time a claim is processed, HealthChoice Customer Service creates an explanation of benefits that explains how your benefits are applied. Your EOB includes:

- Amount allowed.
- Amount not covered.
- Coinsurance.
- Copay.
- Date of service.
- Deductible.
- Explanation code.
- Provider write-off.
- Provider.
- Total benefits.
- Total billed amount.

Your EOBs are available through the HealthChoice member portal at **HealthChoiceOK.com or by using the HealthChoice app**. If you have difficulty accessing your EOB online, contact HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

Claims requiring additional information

If your dental claim requires additional information for processing, your EOB identifies the specific information needed. In some instances, a letter is also sent that explains 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 HealthChoice Customer Service, your claim is automatically processed. You do not need to resubmit your claim.

Pre-estimate

If your dental treatment is expected to cost more than $500 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, either you or your authorized representative can request the claim be reviewed. Log into the member portal at **HealthChoiceOK.com** and complete the online appeal submission form, or submit a written request within 180 days of your receipt of a denial to:

HealthChoice Appeals Unit
P.O. Box 30546
Salt Lake City, UT 84130-0546

Please follow the steps below when submitting a written request to make sure that your appeal at any level is processed in a timely manner:

- If applicable, send a copy of any letter regarding a decision of your appeal.
- Send a copy of the EOB and any relevant additional information (e.g., benefit documents, medical records) that could help to determine if your claim is covered under the plan.
- Provide a letter summarizing the request for reconsideration that includes your name, the claim or transaction numbers, HealthChoice member ID number, the name of the patient and their relationship to the primary member.
- Include **Attention: Appeals Unit** on all supporting documents. Be certain the member ID appears on each document.
- If you choose to designate an authorized representative, you must provide this designation to us in writing.
- If your situation is medically urgent, you may request an expedited appeal, which is generally conducted within 72 hours. If you believe your situation is urgent, follow the instructions above for filing an internal appeal and call HealthChoice Customer Service to request a simultaneous external review.

Your HealthChoice plan's internal appeals process includes two internal review levels. If you are not satisfied with the final internal review determination due to denial of payment, coverage

or service requested, you may ask for an independent, external review of our decision by either an independent review organization or a grievance panel. The entity that performs the external review depends on the nature of your appeal.

When considering complaints by insured members, the three-member grievance panel shall determine by a preponderance of the evidence whether EGID has followed its statutes, rules, plan documents, policies and internal procedures. The grievance panel shall not expand upon or override any EGID statutes, rules, plan documents, policies and internal procedures.

To request access to and copies of all documents, records and other information about your claim, free of charge, contact HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

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 or an 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, as HealthChoice holds first priority with regard to any recovery. The Make Whole and Common Fund Doctrines do not apply.

If you are asked to provide information about the injury or accident to the HealthChoice subrogation administrator at the law firm of McAfee & Taft, any related claims are pended until you have supplied the necessary information. Failure to provide the required information in a timely manner may result in your claim being denied.

Refer to HealthChoice Plan Contact Information.

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 Customer Service. You can also search the HealthChoice Network Provider Directory **HealthChoiceOK.com**.

Intentional misrepresentation

Coverage obtained by means of intentional misrepresentation of material fact 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 and corrections to benefit elections

When a change is made to your coverage, you are mailed a confirmation statement, which lists your coverage and the effective date and premium amount for your coverage. It is provided so you can review changes and identify errors as soon as possible.

If you find errors to your benefit elections, you should submit corrections within 60 days. Current employees must submit corrections to their insurance coordinator or benefit partner, 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, so 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, limited to a maximum reimbursement of $200 per incident/$500 per year, per member or family. **Note:** the error must have impacted the actual benefit amount paid by at least $50 per claim. Additionally, prior to paying any money pursuant to this program, HealthChoice must have recovered an amount from the provider(s) that is equal to or greater than the shared savings incentive compensation.

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, complete the Member Audit Program Form found at **HealthChoiceOK.com** and return to the address below. **You must report the billing error prior to detection and correction by the claims administrator to qualify.** If you have any questions regarding the Member Audit Program, call the EGID HealthChoice Fraud, Waste and Abuse toll-free hotline at 866-381-3815, email **egid.antifraud@omes.ok.gov**, or fax 405-717-8922.

EGID HealthChoice Program Integrity Unit
P.O. Box 11137
Oklahoma City, OK 73136-9998

Right of recovery

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

- Any persons to, for or with respect to whom such payments were made.
- Any other insurers.
- 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 or new 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.
- A **current or new State of Oklahoma, local government or certain nonprofit employee** regularly scheduled to work at least 1,000 hours a year and not classified as a temporary or seasonal employee.
- A **person elected by popular vote** (e.g., board members for education and elected officials of state and local government, rural water district board members and county election board secretaries).

As a new employee, your coverage is effective on 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 on the first day of the month following the date the changes are made.

Note: No orthodontic benefits are available to members and dependents during the first 12 consecutive months of coverage. This does not include orthodontic services for TMJ/TMD if the member is 19 or older. Refer to Limitations in the Exclusions and Limitations section.

Dependent coverage

You must be enrolled in a group health plan or other qualified health insurance to enroll yourself and your dependents in the HealthChoice Dental Plan. If dependent coverage is selected, all 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.

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 the paragraph on 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. **Note:** Plan coverage that terminates upon the dependent's 26th birthday will terminate at the end of the month in which the birthday occurs.
- Your dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26; subject to medical review and approval of the Disabled Dependent Assessment form, which must be submitted at least 30 days prior to the dependent's 26th birthday.
- Other unmarried children up to age 26 who live with you and for whom you are primarily responsible. This requires completion of an acceptable Application for Coverage for Other Dependent Children. 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.

Adding a newborn to coverage:

- Newborns must be added on the first day of the month of the child's birth. You have 30 days from the date of birth to enroll a newborn in coverage. An Insurance Change Form must be completed and submitted to your insurance coordinator, benefit partner or EGID.
- Premiums must be paid for the full month of the child's birth.
- When one or more eligible dependents are currently covered, a newborn must be added to the same coverage, unless there is proof of other dental coverage.
- When a newborn is added to coverage, all other eligible dependents must be enrolled in coverage if they are not already enrolled; however, you can elect to exclude your spouse from dental coverage.
- You can request coverage for a newborn grandchild by completing an Application for Coverage for Other Dependent Children. Coverage for a newborn grandchild is retroactive to the first day of the month of birth following the receipt and approval of an application and payment of premiums. After 30 days, a retired member cannot add a newborn to coverage without a qualifying event.
- A Social Security number for the newborn is not required at the time of initial enrollment but must be provided when it is received from the Social Security Administration.
- Current employees must provide the number to their insurance coordinator or benefit partner.
- Former employees must provide it to EGID.

Coverage for other eligible dependents

When you have not been granted custody, adoption or guardianship by a court and the dependent is not your natural child or stepchild, you can request coverage for other unmarried dependents up to age 26 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 coordinator or benefit partner, 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 an approved 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 date the Application for Coverage for Other Dependent Children is approved and never applies retroactively, except in the case of a newborn. Coverage for a newborn is effective on the first day of the month of birth.

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

- Current employees and COBRA members cannot add dependents to coverage until the next annual Option Period.
- Former employees cannot add dependents to coverage without a qualifying event.

Note: You must meet all eligibility requirements, cover all eligible dependents and pay all premiums.

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 deemed ineligible for coverage.

Legal adoption

An adopted dependent is eligible for coverage on 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 coordinator or benefit partner 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 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 and COBRA members cannot add dependents to coverage until the next annual Option Period.
- Former employees cannot add dependents to coverage without a qualifying event.

Legal guardianship

Legal guardianship follows the same guidelines as an adoption. Refer to Legal adoption in this section.

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 Health Services 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/HIPAA special enrollment rights

If you are a current employee and declined enrollment in the HealthChoice Dental Plan because you had other group dental insurance coverage or Indian Health Services or military dental benefits, you can enroll:

- Within 30 days of the date you lose other group dental coverage.
- 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.
- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

To request special enrollment or obtain more information, current employees contact your insurance coordinator or benefit partner. Former employees contact EGID Member Services. Refer to HealthChoice Plan Contact Information.

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 comply 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 coordinator or benefit partner and complete an enrollment or change.

Note: Due to Section 125 considerations, all state agencies are part of the same employer.

Former employees and surviving dependents

The only time you can make changes to your existing dental coverage is within 30 days of a qualifying event. For example, dependents can be added to your existing dental coverage if a qualifying event occurs, but they cannot be added at the annual Option Period. In addition, no new benefit plans, other than vision, can be added at the annual Option Period after retirement.

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

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

Requests for changes can also be faxed to 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

Coverage can be continued for up to 24 months under USERRA, which provides certain rights and protections for all employees called to serve our nation. All branches of the military, all military reserve units and all National Guard units come under USERRA.

In addition to health 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 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 your insurance coordinator or benefit partner 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 coordinator or benefit partner 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 coordinator or benefit partner.

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, 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.
- Survivor rights for your covered dependents in the event of your death.
- Consolidated Omnibus Budget Reconciliation Act, also known as COBRA.

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 eligible to participate in the Oklahoma Pathfinder Plan and have five or more years of service.
- 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 10 or more years of service with a participating employer.
- 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 10 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), 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 Termination or Reinstatement of Coverage.

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 you discontinue or allow to lapse unless you return to work as an employee of a participating employer. Refer to Termination or Reinstatement of Coverage.

Some reinstatement exceptions may apply if you are a state employee who terminated employment because of a reduction in force. 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 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 Plan

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 Termination or Reinstatement of Coverage section.

Survivor rights

Your surviving spouse and dependents have 60 days following your death to notify EGID that they wish to continue coverage. Coverage is effective on 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

If your or your dependent's coverage is terminated for any of the reasons listed below, each member has the right to elect temporary continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act.

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

- A reduction in your hours of employment.
- 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 Survivor 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.*

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

- Your death (refer to Survivor 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.*
- Your dependent no longer meets the eligibility 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.
- 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.
- You and/or your dependents become covered under another group dental plan.

If you have questions regarding COBRA, contact your insurance coordinator or benefit partner 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 when one or more of the following events occur:

- You terminate employment with a participating employer and do not continue coverage through vesting, non-vesting, retirement, disability or COBRA.
- You do not pay premiums.
- The plan is terminated.
- 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 until the next annual Option Period, or the loss of other group dental coverage or other qualifying event.

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

Former retired employees who did not continue coverage upon leaving active employment or who later discontinued coverage must return to work with a participating employer for three years to be eligible to add or 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 continues to provide benefits for two months following termination of coverage. The plan pays the allowable amounts 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 must 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

You can reinstate dental insurance coverage at any time within two years following the date of the reduction in force from the state 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 any time after July 1, 1997.
- Was offered severance benefits pursuant to the State Government Reduction-in-Force and Severance Benefits Act.

For further information, contact EGID Member Services. Refer to HealthChoice Plan Contact Information.

State of Oklahoma
Office of Management and Enterprise Services
Privacy Notice
Revised October 2023

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
P.O. Box 11137, Oklahoma City, OK 73136
405-717-8780 or toll-free 800-752-9475
TTY 711
oklahoma.gov/omes

Why is the notice of privacy practices important?

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

Oklahoma privacy laws and the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protect the privacy of an individual's health information. Please note, in general the laws and regulations of HIPAA do not apply to the Health Choice Disability Plan and HealthChoice Life Insurance Plan. 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 OMES divisions and positions that may share or access your PHI as needed for treatment, payment and health care operations:

- Employees Group Insurance Division (EGID).
- General Counsel Legal.
- Information Services as it applies to maintenance and storage of PHI.
- The Director of Public Affairs and Grants Management and the Legislative Liaison.

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

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

Ask us to correct health and claims records.

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this using the contact information at the beginning of this notice.
- We may decline your request but will explain the reasons in writing within 60 days

Request confidential communications.

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

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment or our operations.
    - We are not required to approve your request and may decline if it would affect your care.

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

- You can ask for an accounting of the times we'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 free accounting per year but will charge a reasonable fee if you request an additional accounting within 12 months.

Get a copy of this privacy notice.

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

Choose someone to act for you.

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

File a complaint if you feel your rights are violated.

- You can file a complaint if you feel we have violated your rights by contacting us using the information at the beginning of this notice.
- You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave., S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your choices

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

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

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

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

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

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

Our uses and disclosures

How do we typically use or share your health information?

Your PHI is used and disclosed by OMES employees and other entities under contract with OMES according to HIPAA Privacy Rules and the “minimum necessary” standard, which releases only the minimum necessary health information to achieve the intended purpose or to carry out a desired function within 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 member health and reduce costs, assist in the coordination and continuity of health care, and to set premium rates.

Pay for your health services.

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

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

Administer your plan.

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

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

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must comply with the law to share your information for these purposes. For more information, refer to **hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues

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

- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.

- Reporting suspected abuse, neglect or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.

Do research.

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

Comply with the law.

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

Respond to organ and tissue donation requests.

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

Work with a medical examiner or funeral director.

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions.

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

Our responsibilities

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

- We are required by law to maintain the privacy and security of your Protected Health Information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your PHI other than as described here unless you notify us in writing that we can. You may change your mind at any time but must let us know in writing if you do.

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

Changes to the terms of this notice.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will deliver a copy to you. You may also subscribe online to receive notice of changes to this page via email or text message.

FRAUD, WASTE AND ABUSE

The Office of Management and Enterprise Services Employees Group Insurance Division 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 government bodies. Most importantly, it applies to employees, subcontractors and representatives of 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 EGID has been defrauded or is being defrauded or that resources have been wasted or abused, report the matter to the EGID HealthChoice Program Integrity Unit immediately. You can report suspicious acts or claims by:

- Sending a report in writing to the EGID HealthChoice Program Integrity Unit at P.O. Box 11137, Oklahoma City, OK 73136-9998.
- Emailing a message to **egid.antifraud@omes.ok.gov**.
- Calling the EGID HealthChoice Fraud, Waste and Abuse toll-free hotline at 866-381-3815.
- Individuals are encouraged to provide adequate information to assist with further investigation of fraud. All investigations will be handled confidentially. Every attempt will be 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 have believed to be fraudulent or abusive. Any employee who violates the non-retaliation policy will be subject to disciplinary action up to and including termination.

PLAN DEFINITIONS

Allowable amount: HealthChoice pays benefits based on set amounts known as allowable amounts. This is the maximum amount HealthChoice will consider for payment for a covered service or supply, regardless of the amounts billed by a provider. A network provider will have agreed to accept the allowable amount as payment in full for the services rendered. A network provider cannot bill you for amounts above the allowable amounts. If you use a non-network provider that charges more than the plan's allowed amount, you may have to pay the difference. This is referred to as balance billing.

Example: A provider may charge $150 for a service. HealthChoice's allowed amount is $90. A network provider will accept the $90 in full as payment for the service. HealthChoice will pay up to the $90, depending on any copayment or deductible you may owe. A network provider will write off the remaining $60 and you cannot be billed for that amount. If you use a non-network provider, then you are responsible for everything that HealthChoice does not pay, up to the full charge of $150(if you are billed by the provider).

Billed Charges: all properly billed **charges** for dental services (including professional service fees, facility fees, and equipment),and supplies that the member has received from the provider, whether they are a covered service or not.

Coinsurance: Coinsurance is a percentage of a medical charge that you pay, with the rest paid by your health insurance plan, after your deductible has been met.

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

Deductible: The initial amount of out-of-pocket expenses you pay on allowable amounts before a benefit is paid by the plan.

EGID: The Office of Management and Enterprise Services Employees Group Insurance Division.

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. **Note:** Plan coverage which terminates upon the dependent's 26th birthday will terminate at the end of the month in which the birthday occurs.
- 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 children up to age 26 who live with you and for whom you are primarily responsible. This requires completion of an acceptable Application for Coverage for Other Dependent Children. A tax return showing dependency can 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 (e.g., board members for education, elected officials of state and local government, rural water district board employees and county election board secretaries), state, education and local government employees 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 worked 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. Surviving dependents and COBRA participants are considered as former employees.

Network provider: A provider who has entered a contract with EGID to accept the plan's allowable amounts for services and 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. The 12-month waiting period does not exist if the treatment is 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.

Qualifying event: An event that changes a member's family or dental insurance situation and qualifies the member and/or dependent for a special enrollment period. The most common qualifying life events are the loss of health care coverage, a change in household (such as marriage or birth of a child) or a change of residence. A complete summary of qualifying events is set out in Title 26, Treasury Regulations, Section 125.

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 Customer Service at 800-323-4314 (TTY: 711).

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, 2401 N. Lincoln Blvd, Ste. 300, Oklahoma City, OK 73105, 866-381-3815 (TTY: 711), 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, 800-368-1019, 800-537-7697 (TTY). Complaint forms are available at **https://www.hhs.gov/ocr/complaints/index.html**.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800-323-4314 (TTY: 711).

(Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-323-4314 (TTY: 711).

(Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-323-4314 (TTY: 711).

(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 800-323-4314 (TTY: 711).

(Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-323-4314 (TTY: 711) 번으로 전화해 주십시오.

(German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-323-4314 (TTY: 711).

(Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم800-323-4314 (رقم هاتف الصم والبكم:711).

(Burmese) သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 800-323-4314 (TTY: 711) သို့ ခေါ်ဆိုပါ။

(Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-323-4314 (TTY: 711).

(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-323-4314 (TTY: 711).

(French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-323-4314 (TTY: 711).

(Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-323-4314 (TTY: 711).

(Thai) เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-323-4314 (TTY: 711).

(Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 800-323-4314 (TTY: 711).

(Cherokee) Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 800-323-4314 (TTY: 711)

(Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-323-4314 (TTY: 711) تماس بگیرید.

This publication was printed by the Office of Management and Enterprise Services as authorized by Title 62, Section 34. 75 copies have been printed at a cost of $695.
A copy has been submitted to Documents.OK.gov in accordance with the Oklahoma State Government Open Documents Initiative (62 O.S. 2012, § 34.11.3).

NOTES

OKLAHOMA

HealthChoice is administered by EGID, a division of the
Oklahoma Office of Management and Enterprise Services.