

4. Typically, you may enroll in a Medicare Prescription Drug Plan only during the annual Option Period. There are a few exceptions that may allow you to enroll in a Medicare Prescription Drug Plan outside of the annual enrollment period.

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

- I am new to Medicare.
- I recently moved outside of the service area for my current plan.
- I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- I get extra help paying for Medicare prescription drug coverage.
- I no longer qualify for extra help paying for my Medicare prescription drug coverage.
- I live in or recently moved out of a Long-Term Care Facility (for example, a nursing home).
- I recently left a PACE program.
- I recently involuntarily lost my creditable prescription drug coverage (as good as Medicare's).
- I am leaving employer or union coverage.
- I belong to a pharmacy assistance program provided by my state.
- I recently returned to the United States after living permanently outside of the U.S.
- None of these statements apply to me. (Please contact HealthChoice at 1-405-717-8780 or toll-free 1-800-752-9475 to see if you are eligible to enroll. We are open Monday through Friday, 7:30 am to 4:30 pm. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.)

Also, after contacting HealthChoice to determine if you're eligible, please briefly explain your situation:

Please Read This Important Information

If you or your dependent(s) are currently a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have prescription drug coverage from your Medicare Advantage Plan that will meet your needs. By joining HealthChoice Employer PDP High/Low Option Medicare Supplement With Part D, your membership in your Medicare Advantage Plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage Plan sends you and if you have questions, contact your Medicare Advantage Plan.

If you or your dependent(s) currently have health coverage from an employer or union, joining the HealthChoice Employer PDP High/Low Option Medicare Supplement With Part D Plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join HealthChoice Employer PDP. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there isn't information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

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

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

HealthChoice serves the entire United States. If I move out of the United States, I need to notify HealthChoice so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use HealthChoice Network Pharmacies. Once I am a member of HealthChoice, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from HealthChoice when I get it to know the rules I must follow to get coverage.

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

Release of Information:

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

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

Member Signature: _____ Date: _____

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

Dependent Signature: _____ Date: _____

(Only required if dependent is enrolling in Medicare.)

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

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

Privacy Notice

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

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

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

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

You have the right to: a) inspect and copy your health information, (generally EOBs) with the exception of psychotherapy notes and/or information that requires a court order; b) amend and restrict the health information that OSEEGIB discloses about you; however, OSEEGIB is not required to agree to a requested restriction; c) request your communications remain confidential with OSEEGIB; d) receive a copy of this Notice; e) file a complaint if you believe OSEEGIB has improperly used or disclosed your information; f) request a listing of disclosures except for treatment, payment, business operations, and per your Authorization after April 14, 2003; and, g) receive a paper copy of this Notice upon request if you have received this Notice electronically. OSEEGIB reserves the right to change the terms of this Privacy Notice and will provide all interested persons a revised notice either by U.S. Postal Service delivered to the individual's mailing address on file with OSEEGIB or electronic communication by posting the revised Privacy Notice on the OSEEGIB website at **www.sib.ok.gov and www.healthchoiceok.com**

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

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