Administrative Rules

July 11, 2025

Oklahoma Health Care Authority

Employees Group Insurance Division

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Oklahoma City, OK 73105

TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
EMPLOYEES GROUP INSURANCE DIVISION

JULY 11, 2025

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
EMPLOYEES GROUP INSURANCE DIVISION

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CHAPTER 145. EMPLOYEES GROUP INSURANCE DIVISION – ADMINISTRATIVE AND GENERAL PROVISIONS

SUBCHAPTER 1. PURPOSE, DEFINITIONS, RULES AND REFERENCES

317:145-1-1. Purpose

The purpose of this chapter is to outline the structure of the Oklahoma Health Care Authority (OHCA) Employees Group Insurance Division (EGID), to outline the use and confidentiality of members' personal health information and to identify the availability and procedures to be used to access a grievance hearing.

317:145-1-2. Definitions

The following words and terms as defined by EGID shall have the following meaning unless the content clearly indicates otherwise:

"Adverse determination" means a determination by or on behalf of EGID or its designee utilization review organization that an admission, availability of care, continued stay or other healthcare service is a covered benefit but, after review, based upon the information provided, does not meet EGID's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, or terminated.

"EGID" means the Employees Group Insurance Division of the Oklahoma Health Care Authority.

"Grievance Panel" means EGID's independent constitutionally created administrative court. [Const. Art. 7. § 1.]

"Independent review organization" means properly accredited entity that conducts independent external reviews of adverse determinations on behalf of EGID.

"OEIBB" means the Oklahoma Employees Insurance and Benefits Board.

317:145-1-3. Rules, cumulative

The Employees Group Insurance Division of the Oklahoma Health Care Authority hereinafter "EGID" will, from time to time, adopt handbooks, policies and procedures for the implementation of the rules set forth herein. Nothing in this chapter shall be read, interpreted, understood or applied so as to affect the validity and enforceability of any additional requirements, statutes, rules or regulations of any other governmental entity, public agency or instrumentality which may be otherwise applicable to those transactions, conduct and facilities regulated herein. The rules in this title shall not be deemed cumulative and supplemental but shall replace all previously promulgated rules of this agency.

317:145-1-4. Rules in this title and benefit administration procedures or guidelines as adopted by EGID are controlling in all situations

The rules in this title and the benefit administration procedures or guidelines as adopted by EGID shall be controlling in all situations, without exception, and any and all written information contained in any handbook, summary or other document prepared by or for EGID shall be superseded and limited by the rules in this title and the benefit administration procedures or guidelines as adopted by EGID.

317:145-1-5. Disclaimer of conflicting information

In the event there appears to be a conflict between information contained in the rules in this title and the benefit administration procedures or guidelines as adopted by EGID, and any information contained within any handbook or any other written materials, including any letters, bulletins, notices, or any other written document, or oral communication, regardless of the source, such conflict shall always be resolved by a strict application of the rules in this title or the benefit administration procedures or guidelines as adopted by EGID, and no conflict will be resolved by application of the erroneous information contained within the handbook or other written document when the result would be contrary to the limitations set forth in the rules in this title, and the benefit administration procedures or guidelines as adopted by EGID. All erroneous, incorrect, misleading or obsolete language contained within any handbook or any other written document or oral communication, regardless of the source, shall be void from the inception, and of no effect under any circumstances.

317:145-1-6. Amending of rules

This chapter may be amended or repealed from time to time and new rules adopted by EGID pursuant to the Administrative Procedures Act.

317:145-1-7. Gender reference

All references to "he" or "his" are not intended to be gender related, but shall apply equally to both sexes.

SUBCHAPTER 3. RECORDS AND INFORMATION

317:145-3-1. EGID records; release of information

All official records of EGID shall be public records open to public inspection under reasonable circumstances at any reasonable time during business hours by any person, but such records shall not be taken from the EGID office. Copies of public records may be obtained pursuant to the current fee schedule as adopted by EGID.

317:145-3-2. Confidentiality of medical records

(a) All information, documents, medical reports and copies thereof contained in a member's insurance file held by EGID shall be confidential and shall not be reviewed by unauthorized parties, without permission of the individual or provider, or by court order. The confidentiality of a member's information is maintained when the member's information held by EGID is utilized for health management and communicated among:

(1) employees of EGID;

(2) EGID's contracted third party administrators and consultants;

(3) providers to the member and

(4) the member, according to statutory provisions for privilege and confidentiality or written agreements to protect the confidentiality and non-disclosure of the information.

(b) Authorizations to use or share protected health information will remain valid until termination of the member's or dependent's enrollment in HealthChoice, unless a shorter period of time has been specified, or unless rescinded.

(c) A member's health information is protected by this rule and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations as codified in 45 Code of Federal Regulations Parts 160 and 164.

(1) EGID requires a signed HIPAA compliant authorization from a member or dependent before any confidential information is released to a person, company, or law firm.

(2) When individual circumstances arise in specific cases, EGID has authority to ask the member or dependent to independently confirm that EGID has permission to disclose confidential information before responding to any pending request.

(3) EGID's obligation to respond to record requests is discharged when EGID has responded to the original request, or if permission of the member or dependent is withdrawn. EGID requires a new authorization or subpoena if more records are requested after EGID has responded.

317:145-3-3. Participating entities/business associate protection of confidential health Information

(a) The participating entity/business associate may only use and disclose the member's health information for the purposes of a member's treatment, to facilitate payment for Plan benefits or for participating entity/business associate business operations on behalf of the member. The participating entity/business associate may not use or further disclose a member's health information other than permitted by EGID rules or described in a written contract between EGID and the participating entity/business associate.

(b) Participating entities/business associates shall protect a member's confidential health information according to the following guidelines. Participating entity/business associate shall:

(1) not use or disclose a member's health information other than permitted in these rules; described in a written contract with EGID or required by law,

(2) ensure that subcontractors or agents of the participating entity/business associate maintain confidentiality of any health information provided to its subcontractors or agents,

(3) not use or disclose confidential health information for employment related actions concerning the member, unless required by law,

(4) notify EGID within five [5] working days when the participating entity/business associate becomes aware of any use or disclosure of a member's health information that is inconsistent with this rule and make an accounting of these disclosures available for EGID and each member,

(5) allow a member to access and review health information on file with the participating entity/business associate and submit amending statements for inclusion in their health information file,

(6) establish procedures to protect a member's health information and account for disclosures not authorized by these rules,

(7) identify the participating entity/business associate employees who may access a member's health information and restrict access to those persons,

(8) return to EGID or destroy a member's health information when no longer required by the participating entity/ business associate, and if not feasible, limit the use or disclosure to the required purposes,

(9) ensure that proper security is in place to protect electronically stored health information and

(10) make internal practices, books and records concerning uses and disclosures of protected health information available for inspection by the appropriate authority. A written contract between EGID and participating entity/business associate shall not limit the participating entity/business associate protection of a member's health information to an extent less than described in this rule.

317:145-3-4. HealthChoice authorization for release of medical records

Through the submission of claims, each member for whom coverage is applied authorizes, without further notice or consent, EGID to obtain from any provider of medical services, all records and information pertaining to that service which will aid in the proper payment of said claims. EGID is further authorized to use and release to third party payers any information and records so obtained. In all instances, the Rules of Confidentiality shall be applied without regard to the requirements of 317:145-3-2.

317:145-3-5. Right to receive and release necessary information

For the purpose of determining applicability of and implementing the terms in this Plan or any provision of similar purpose of any other Plan, the Administrator may, without the consent of or notice of any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Administrator such information as may be necessary to implement this section.

317:145-3-6. Call monitoring for quality control

The Administrator may institute procedures for monitoring of telephone calls for purposes of providing quality control.

317:145-3-7. Electronic records and facsimile, electronic or copies of signatures

Use of electronic records, electronic signatures, facsimile signatures and handwritten signatures executed to electronic records.

(1) Electronic records, electronic signatures, handwritten signatures executed to sign electronic records, handwritten signatures used to effectuate an electronic record for network contracting purposes, and facsimile or copies of signatures on EGID forms received from participating entities or members, may be used as an alternative or duplicate of paper records and handwritten signatures executed on paper to comply with any of the record and signature requirements of 12A O.S. §15-101 et seq. these rules or applicable Oklahoma law.

(2) Combinations of paper records and electronic records, electronic records and handwritten signatures executed on paper, or paper records and electronic signatures or handwritten signatures executed to sign electronic records, may be used to comply with any of the record and signature requirements of 12A O.S. §15-101 et seq., these rules or applicable Oklahoma law.

(3) The EGID Administrator or a Deputy Administrator may utilize a facsimile signature stamp to execute EGID contracts of any kind.

SUBCHAPTER 5. GRIEVANCE PANEL PROCEDURES

317:145-5-1. Request for hearing

(a) **Grievances.** EGID has established procedures by which:

(1) Independent Review Organizations shall act as an appeals body for complaints by insured members regarding adverse benefit determinations based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit,

(2) A three [3] member Grievance Panel shall act as an appeals body for complaints by insured members regarding all other issues.

(b) **Court Administrator Appointees.** The Court Administrator shall designate Grievance Panel members as shall be necessary. The members of the Grievance Panel shall consist of two [2] Attorneys licensed to practice law in this state and one [1] state licensed health care professional or health care administrator who has at least three [3] years practical experience, has had or has admitting privileges to a State of Oklahoma hospital, has a working knowledge of prescription medication, or has worked in an administrative capacity at some point in their career.

(c) **Governor Appointees.** The state health care professional shall be appointed by the Governor. At the Governor's discretion, one or more qualified individuals may also be appointed as an alternate to serve on the Grievance Panel in the event the Governor's primary appointee becomes unable to serve.

(d) **Right to a Hearing.** Any covered member who has exhausted EGID's internal review procedures and has timely requested in writing a hearing before the Grievance Panel pursuant to 317:145-5-1(a)(2) shall receive a hearing in person or through licensed counsel before the panel.

(e) **Remedy.** Grievance procedures conducted by the three [3] member Grievance Panel shall be subject to the Oklahoma Administrative Procedures Act, including provisions thereof for review of agency decisions by the district court.

(f) **Failure to timely submit hearing request.** All Grievance Panel requests must be filed within sixty [60] days from the date the member is notified that the member's claim, benefit, coverage, or other matter has been denied and that EGID's internal review procedures have been exhausted. After more than sixty [60] days from the date the member was first notified that the member's claim, benefit, coverage, or other matter has been denied and that EGID's internal review procedures have been exhausted, the matter shall be deemed finally resolved.

(g) **Aggrieved member covered by an HMO.** Any member covered by an HMO is entitled to a hearing before the Panel in the same manner as all other covered members for those matters not covered by an Independent Review Organization. The member must exhaust the HMO's internal grievance procedure, except for an emergency or if the HMO fails to timely respond, before requesting a Grievance Panel hearing. The member must file, along with his request for hearing, a written certification from the HMO that the member has exhausted said procedure, or a detailed explanation of the emergency or of the HMO's failure to respond.

(h) **Submission of Grievance request.** Any Grievance request shall be in writing on a form provided by EGID for such purpose or in writing by the employee if in substantial compliance with the form and shall contain the following information:

(1) Name of employee, Social Security Number and address;

(2) Name of dependent for whom claim was submitted, if not the covered employee;

(3) Name of employee's employing entity, location, and identifying number;

(4) Nature of claim: Health, Dental, Life, Eligibility, Disability, HIPAA or HMO;

(5) Date claim submitted for payment, claim number;

(6) The reason given, if any, by the claims administration contractor for denying the claim in whole or in part; and

(7) A short statement as to the nature of the illness or injury giving rise to the claim.

(i) **Mailing address for submission of Request for Hearing.** The Request for Hearing shall be mailed or delivered to EGID to the attention of Attorney - Grievance Department at PO Box 11137, Oklahoma City, OK 73136-9998.

317:145-5-2. Notice of hearing

Upon receipt of a Grievance request, after a member has exhausted EGID's applicable internal review procedures, a hearing number shall be assigned in grievances involving the three [3] member Grievance Panel and notice shall be forwarded to the claims administration contractor by email, secure workflow, or by regular mail at its closest office. The employee shall be notified of the hearing date by mail with delivery confirmation. A copy of all rules pertinent to the hearing shall be forwarded with the Notice, along with a statement of claimant's rights.

317:145-5-3. Prehearing conference

For grievance hearings conducted by the three [3] member Grievance Panel the Attorney representing EGID, the claimant, or the claimant's attorney may request a pre-hearing conference to determine legal or factual issues. The Attorney representing EGID may conduct such a conference.

317:145-5-4. Grievance hearings conducted by the three [3] member Grievance Panel

(a) **Witness list.** Each party must submit, in writing, at least forty-eight [48] hours prior to the date of a grievance hearing a complete list of witnesses he or she intends to call, along with a brief comment as to the nature of the testimony. Witnesses shall not be called to testify at the hearing unless notice has been given to the opposing parties.

(b) **Assignment of Panel and Chairman.** All hearings shall be held before a three-member Grievance Panel, as assigned by the Office of the Administrative Director of the Courts. All hearings shall be conducted in accordance with and be governed by the provisions of the Oklahoma Administrative Procedures Act, 75 O.S. §301-326. At each convening of the Panel, one member shall be designated to act as the Chairman.

(c) **Admissibility of evidence.** Rulings on admissibility of evidence shall be made by the Panel Chairman; provided, however, that the remaining members of the Panel may, by affirmative vote, overrule the Chairman's decision, on their own motion or upon motion of any party to the hearing.

(d) **Oaths and subpoena.** The Chairman of the Panel shall have the authority to administer oaths for obtaining testimony for the hearing; and any member of the Panel or the Attorney representing EGID shall have the authority to issue subpoenas for witnesses or subpoenas duces tecum to compel the production of books, records, papers and other objects for the hearing. Said subpoenas may be served by any duly qualified officer of the law, or any employee of EGID in any manner prescribed for the service of a subpoena in a civil action.

(e) **Court reporter.** The Attorney representing EGID shall cause a recording of the proceedings to be made by a certified court reporter at EGID's expense. If transcribed, such written transcript shall become a part of the official record of the hearing, and a copy shall be furnished to any other party having a direct interest therein at the request and expense of such party. The cost of preparing the written transcript of the hearing and providing a copy of the transcript to the other party shall be paid by the party on whose behalf the written transcript is requested.

(f) **Procedure.** In all hearings, opportunity shall be afforded the party or parties requesting same to respond and present evidence and argument on all issues involved. The hearing shall

be conducted in an orderly manner. The party or parties requesting the hearing shall appear in person or through licensed counsel and be heard first; those, if any, who oppose the relief sought by the requesting party shall next be heard. Each party shall have the opportunity to present closing arguments.

(g) **Standard of review.** When considering complaints by insured members, the three [3] 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.

317:145-5-5. Continuance; disposition; Attorney representation

Any request for continuance of a hearing conducted by the three [3] member Grievance Panel may be granted by the Attorney representing EGID or the Panel if requested for any of the following reasons: illness or unavailability of the party requesting the hearing, unavailability or illness of a material witness, unavoidable conflict of schedule, unavailability of relevant documents, or other good cause. All parties to the hearing shall be notified of the continuance as soon as possible.

(1) Unless precluded by law, informal disposition may be made of any individual proceedings by stipulation, agreed settlement, consent order, or default.

(2) Any party shall at all times have the right to be represented by counsel at their own expense, provided such counsel is licensed to practice law by the Supreme Court of Oklahoma.

317:145-5-6. Certificate of mailing

All filings, including Orders, Notices and Briefs, considered or issued by a three [3] member Grievance Panel shall include a Certificate of Mailing showing the names and mailing addresses of adverse parties or their attorneys of record.

317:145-5-7. Final order; appeals

(a) **Final Order.** The Grievance Panel shall enter a Final Order within no more than forty-five [45] days after the date of the hearing in all cases in which evidence and testimony has been offered and admitted. The Final Order shall separately state all Findings of Fact, Conclusions of Law and an Order approving or denying the claim.

(b) **District Court appeals.** The Grievance Panel's Final Order shall be considered a final decision of EGID for purposes of appeal. Any party to the hearing has the right to appeal to District Court from Final Orders entered by the Panel. This appeal shall be governed by the Administrative Procedures Act, 75 O.S. §301, et seq., and by other pertinent statutes such as 74 O.S. §1301, et seq.

317:145-5-8. Scheduling of hearings

All requests for hearings assigned to the three [3] member Grievance Panel shall be placed on the Grievance Panel docket to be heard in open court following the receipt of a properly submitted Request For Grievance Panel Hearing form.

CHAPTER 150. EMPLOYEES GROUP INSURANCE DIVISION - HEALTH, DENTAL, VISION AND LIFE PLANS

SUBCHAPTER 1. PURPOSE AND DEFINITIONS

317:150-1-1. Purpose

The purpose of this chapter is to outline definitions, plan administration, coverage, and exclusions pertaining to health, dental, vision and life benefits.

317:150-1-2. Definitions

The following words and terms as defined by EGID, when used in this chapter, shall have the following meaning, unless the content clearly indicates otherwise:

"Administrative error" occurs when the coverage elections the member makes are not the same as those entered into payroll for deduction from the member's paycheck. This does not include untimely member coverage elections or member misrepresentation. When such an administrative error results in underpaid premiums, full payment to EGID shall be required before coverage elected by the member can be made effective. If overpayment occurs, EGID shall refund overpaid funds to the appropriate party.

"Administrator" means the Administrator of the Employees Group Insurance Division or a designee.

"Allowable fee" means the maximum allowed amount based on the HealthChoice Network Provider Contracts payable to a provider by EGID and the member for covered services.

"Attorney representing EGID" means any attorney designated by the Administrator to appear on behalf of EGID.

"The Board" means the seven [7] Oklahoma Employees Insurance and Benefits Board members designated by statute [74 O.S. §1303(1)].

"Business Associate" shall have the meaning given to "Business Associate" under the Health Insurance Portability and Accountability Act of 1996, Privacy Rule, including, but not limited to, 45 CFR §160.103.

"Carrier" means the State of Oklahoma.

"Comprehensive benefits" means benefits which reimburse the expense of facility room and board, other hospital services, certain out-patient expenses, maternity benefits, surgical expense, including obstetrical care, in-hospital medical care expense, diagnostic radiological and laboratory benefits, providers' services provided by house and office calls, treatments administered in providers' office, prescription drugs, psychiatric services, Christian Science practitioners' services, Christian Science nurses' services, optometric medical services for injury or illness of the eye, home health care, home nursing service, hospice care and such other benefits as may be determined by EGID. Such benefits shall be provided on a copayment or coinsurance basis, the insured to pay a proportion of the cost of such benefits, and may be subject to a deductible that applies to all or part of the benefits as determined by EGID. [74 O.S. §1303 (14)]

"Cosmetic procedure" means a procedure that primarily serves to improve appearance.

"Current employee" means an employee in the service of a participating entity who receives compensation for services actually rendered and is listed on the payrolls and personnel records of said employer, as a current and present employee, including employees who are otherwise eligible who are on approved leave without pay, not to exceed twenty-four [24] months. A person elected by popular vote will be considered an eligible employee during his tenure of office. Eligible employees are defined by statute. [74 O.S. §1303 and §1315]

"Custodial care" means treatment or services regardless of who recommends them or where they are provided, that could be given safely and reasonably by a person not medically skilled. These services are designed mainly to help the patient with daily living activities. These activities include but are not limited to: personal care as in walking, getting in and out of bed, bathing, eating by spoon, tube or gastrostomy, exercising, dressing, using toilet, preparing meals or special diets, moving the patient, acting as companion or sitter, and supervising medication which can usually be self-administered.

"Dependent" means the primary member's spouse (if not legally separated by court order), including common-law. Dependents also include a member's daughter, son, stepdaughter, stepson, eligible foster child, adopted child, child for whom the member has been granted legal guardianship or child legally placed with the primary member for adoption up to the child's twenty-sixth [26th] birthday. In addition other unmarried children up to age twenty-six [26] may be considered dependents if the child lives with the member and the member is primarily responsible for the child's support. A child that meets the definition of a disabled dependent in this section and also all requirements in 317:150-3-18, may also be covered regardless of age if the child is incapable of self-support because of mental or physical incapacity that existed prior to reaching age twenty-six [26]. Coverage is not automatic and must be approved with a review of medical information. A disabled dependent deemed disabled by Social Security does not automatically mean that this disabled dependent will meet the Plan requirements. [74 O.S. §1303(14)]. See additional eligibility criteria for disabled dependents over the age of twenty-six [26] at 317:150-3-18. Participating employer groups may have a more restrictive definition of Dependent.

"Durable medical equipment" means medically necessary equipment, prescribed by a provider, which serves a therapeutic purpose in the treatment of an illness or an injury. Durable medical equipment is for the exclusive use of the afflicted member and is designed for prolonged use. Specific criteria and limitations apply.

"Eligible Provider" means a practitioner who or a facility that is recognized by EGID as eligible for reimbursement. EGID reserves the right to determine provider eligibility for network and non-Network reimbursement.

"Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd (e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

"Enrollment period" means the time period in which an individual may make an election of coverage or changes to coverage in effect.

"Excepted Benefits" means the four categories of benefits as established in section 2791 of the PHS Act, section 733 of ERISA and section 9832 of the Internal Revenue Code, as summarized in IRS Bulletin 2015-14 and subsequent regulatory guidance. These Excepted Benefits include but are not limited to vision coverage, dental coverage, long-term care insurance, Medicare supplement coverage, automobile liability insurance, workers compensation, accidental death and dismemberment insurance and specific disease coverage (such as cancer).

"Facility" means any organization as defined by EGID which is duly licensed under the laws of the state of operation and meets credentialing criteria established by EGID.

"Fee schedule" means a listing of one or more allowable fees.

"Former participating employees and dependents" means eligible former employees who have elected benefits within thirty [30] days of termination of service and includes those who have retired, or vested through an eligible State of Oklahoma retirement system, or who have completed the statutory required years of service, or who have other coverage rights through Consolidated Omnibus Budget Reconciliation Act (COBRA) or the Oklahoma Personnel Act. An eligible dependent is covered through the participating former employee or the dependent is eligible as a survivor or has coverage rights through COBRA.

"Health information" means any information, whether oral or recorded in any form or medium: (1) that relates to the past, present or future physical or mental condition of a member; the provision of health care to a member; or the past, present or future payment for the provision of health care to a member; and (2) that identifies the member or with respect to which there is a reasonable basis to believe the information can be used to identify the member.

"Home health care" means a plan of continued care of an insured person who is under the care of a provider who certifies that without the Home health care, confinement in a hospital or skilled nursing facility would be required. Specific criteria and limitations apply.

"Hospice care" means a concept of supportive care for terminally ill patients. Treatment focuses on the relief of pain and suffering associated with a terminal illness. Specific criteria and limitations apply.

"Inaccurate or erroneous information" means materially erroneous, false, inaccurate, or misleading information that was intentionally submitted in order to obtain a specific coverage.

"Initial enrollment period" means the first thirty [30] days following the employee's entry-on-duty date. A group initial enrollment period is defined as the thirty [30] days following the enrollment date of the participating entity.

"Insurance Coordinator" means Insurance/Benefits Coordinator for Education, Local Government, and State Employees.

"Insured(s)" means both the Primary insured and covered Dependents.

"Maintenance care" means there is no measurable progress of goals achieved, no skilled care required, no measurable improvement in daily function or self-care, or no change in basic treatment or outcome.

"Medically necessary" means services or supplies which are provided for the diagnosis and treatment of the medical and/or mental health/substance abuse condition and complies with criteria adopted by EGID. Direct care and treatment are within standards of good medical practice within the community, and are appropriate and necessary for the symptoms, diagnosis or treatment of the condition. The services or supplies must be the most appropriate supply or level of service, which can safely be provided. For hospital stays, this means that inpatient acute care is necessary due to the intensity of services the member is receiving or the severity of the member's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The services or supplies cannot be primarily for the convenience of the member, caregiver, or provider. The fact that services or supplies are medically necessary does not, in itself, assure that the services or supplies are covered by the Plan.

"Members" means all persons covered by one or more of the group insurance plans offered by EGID including eligible current and qualified former employees of participating entities and their eligible covered dependents.

"Mental health and substance abuse" means conditions including a mental or emotional disorder of any kind, organic or inorganic, and/or alcoholism and drug dependency.

"Network provider" means a practitioner who or facility that is duly licensed or operates under the laws of the state, satisfies credentialing criteria as established by EGID, and has entered into a contract with EGID to accept scheduled reimbursement for covered health care services and supplies provided to members.

"Non-Network out-of-pocket" means the member's expenses include the total of the member's deductibles and co-insurance costs plus all amounts that continue to be charged by the non-Network provider after the HealthChoice allowable fees have been paid.

"OEIBB" means Oklahoma Employees Insurance and Benefits Board.

"Open enrollment period" means a limited period of time as approved by either EGID or the Legislature in which a specified group of individuals are permitted to enroll.

"Option period" means the time set aside at least annually by EGID in which enrolled plan members may make changes to their enrollments. Eligible but not enrolled employees may also make application for enrollment during this time. Enrollment is subject to approval by EGID.

"Orthodontic limitation" means an individual who enrolls in the Dental Plan will not be eligible for any orthodontic benefits for services occurring within the first twelve [12] months after the effective date of coverage. Continuing orthodontic services for newly hired employees who had previous group dental coverage will be paid by prorating or according to plan benefits.

"Other hospital services and supplies" means services and supplies rendered by the hospital that are required for treatment, but not including room and board nor the professional services of any provider, nor any private duty, special or intensive nursing services, by whatever name called, regardless of whatever such services are rendered under the direction of the hospital or otherwise.

"Participating entity" means any employer or organization whose employees or members are eligible to be participants in any plan authorized by or through the Oklahoma Employees Insurance and Benefits' Act.

"The Plan or Plans" means the self-insured Plans by the State of Oklahoma for the purpose of providing health benefits to eligible members and may include such other benefits as may be determined by EGID. Such benefits shall be provided on a coinsurance basis and the insured pays a proportion of the cost of such benefits.

"Primary insured" means the member who first became eligible for the insurance coverage creating eligibility rights for dependents.

"Prosthetic appliance" means an artificial appliance that replaces body parts that may be missing or defective as a result of surgical intervention, trauma, disease, or developmental anomaly. Said appliance must be medically necessary.

"Provider" means a practitioner who or facility that is duly licensed or operates under the laws of the state in which the Provider practices and is recognized by this Plan, to render health and dental care services and/or supplies.

"Qualifying Event" means an event that changes a member's family or health 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 or other federally required mandates. A complete summary of qualifying events are set out in Title 26, Treasury Regulations, Section 125.

"Schedule of benefits" means the EGID plan description of one or more covered services.

"Skilled care" means treatment or services provided by licensed medical personnel as prescribed by a provider. Treatment or services that could not be given safely or reasonably by a person who is not medically skilled and would need continuous supervision of the effectiveness of the treatment and progress of the condition. Specific criteria and limitations are applied.

SUBCHAPTER 3. ADMINISTRATION OF PLANS

317:150-3-1. Open enrollment period

The Board or the Legislature may, at its discretion, declare an open enrollment period during which time eligible individuals may enroll in optional coverage on behalf of themselves or eligible dependents.

317:150-3-2. Approval of exceptional claims and eligibility matters

The Administrator shall have the authority to approve individual exceptional claims or eligibility matters when circumstances require.

317:150-3-3. Insurance/Benefits Coordinator for Education, Local Government, and State Employees

The appointing authority or governing body of each participating entity shall designate an Insurance/Benefits Coordinator and at least one [1] Alternate to properly enroll members of the entity. Any information given by an Insurance/Benefits Coordinator shall not supersede or modify the statutes, rules in this title or any Insurance/Benefits Coordinator Guide governing the Group Insurance Plan. Insurance/Benefits Coordinator representing retirees may be provided by the retirement system from which the retiree is receiving benefits. It is the employee's duty to notify his Insurance/Benefits Coordinator of a change in eligibility for himself, his spouse or his dependents. It is the Coordinator's duty to notify EGID within ten [10] working days of the employee's notice of change. EGID is not obligated to accept untimely notifications of change and may elect to refuse to permit said changes.

317:150-3-4. Right of recovery

(a) **Error in payment.** Any benefits paid erroneously by EGID are fully recoverable from the recipient. No such erroneous payment shall constitute waiver or estoppel or result in any equitable obligation by EGID to pay any benefits which are not specifically payable according to the rules in this title and the benefit administration procedures or guidelines as adopted by the Board. [74 O.S. §1321]

(b) **Excessive amounts.** Whenever payments have been made by EGID with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at the time to satisfy the intent of this part, the Administrator shall have the right to recover such excess, from any person, organization or company with respect to whom such payments were made.

(c) **Right to Audit.** EGID reserves the right to audit any enrollment or insurance change form and to require that supporting documentation showing the participant's eligibility, including (but not limited to) proof of a qualifying event, be provided. EGID may retroactively terminate coverage on any individual who was not eligible to be enrolled in the Plan and recover any claims paid on the individual's behalf.

317:150-3-5. Responsibility for premium payment

(a) **Participating entity premiums.** Employer and employee premiums for participating entities are due to EGID no later than the tenth [10th] day of each month following the month of coverage. The first payroll deductions for insurance premiums of individuals paid bi-weekly will be withheld from the first pay period that extends into the month during which insurance coverage begins. It is ultimately the employing agency's responsibility to check and verify that premiums paid to EGID are a true and accurate accounting of the member's approved coverage selections. If premium for coverage selected by the employee differs from the amount deducted from the member's check, then the participating entity is responsible for payment to EGID for any deficiencies in premium for the member's coverage. Any shortage of premiums due and payable will result in suspension of benefits for Plan participants.

(1) An employee may continue coverage while on approved leave without pay status for up to twenty-four [24] months as long as the entity continues to remit premiums with the entity's monthly payment. The twenty-four [24] month limitation shall be extended to eight [8] years for education employees who are absent from employment because of

election or appointment as a local, state, or national education association officer. Except as protected by federal statute, employees on leave whose premiums are not remitted in a timely manner shall have their coverage terminated at the end of the month for which last payment was received. If coverage is terminated for non-payment all coverage is terminated. Upon return to work, the employee may re-enroll. All Plan limitations apply and evidence of insurability is required to re-enroll in any life coverage.

(2) Provided that if a State employee is on leave without pay due to an injury or illness arising out of the course of his employment, the employee may continue the insurance during the maximum period of the time allowed by law, and the employing agency shall pay the benefit allowance allowed by law.

(3) An employee may continue coverage while on suspension without pay for up to ninety [90] days following the date of suspension or the duration of the administrative appeals process, whichever is greater, as long as premiums are remitted by the entity for the coverage.

(4) Collecting any employee share from an employee on leave without pay or suspension without pay is the responsibility of the entity.

(b) **Premiums remitted by retirement systems.** Any State of Oklahoma retirement system establishing a withholding system for its retired employees shall forward the retirement contribution and employees' withholding to EGID by the tenth [10th] of the month following the month for which payment is due. This same time frame also applies to members receiving disability benefits.

(c) **Premiums remitted by former employees, COBRA participants or survivors.** Premiums are due by the twentieth [20th] day of the month of coverage. All premiums due, in excess of the retirement system contributions, shall be paid by the member. The member may elect to have the premiums withheld from their retirement benefit if the retirement benefit is sufficient to cover the entire premium. If the total monthly premium is the same as or greater than the retirement benefit, the member shall remit the entire amount due directly to EGID.

317:150-3-6. Cancellation of coverage

After notice and opportunity for a hearing according to the Oklahoma Administrative Procedures Act and these rules, coverage may be cancelled.

(1) **Cancellation of coverage due to non-payment of premium**. If payment is not received by the end of the month in which the payment is due, coverage shall be canceled effective the end of the month for which the last premium was received. EGID may reinstate coverage within sixty [60] days after the date EGID canceled coverage, if it is shown that the failure to pay premiums was not due to the member's negligence, subject to payment of any required premiums. The employee shall be notified in writing by EGID of cancellation of coverage and provided an opportunity for a hearing.

(2) **Cancellation of coverage due to insufficient funds.** In the event the member's payment is returned or refused due to insufficient funds or closed account, coverage may be cancelled unless the check is returned due to no fault of the member.

(3) **All coverage canceled.** If coverage is canceled for either of the reasons listed above all coverage will be terminated. When the employee is eligible to re-enroll, all Plan limitations apply and evidence of insurability is required to enroll in any life coverage.

(4) **Cancellation of coverage for Medicare members.** If payment is not received by the twentieth [20th] of the month, Medicare members will be notified of the delinquency and given thirty [30] days to make the payment. If payment is not made within the thirty [30] day grace period, coverage will be terminated effective the first [1st] day of the following month.

317:150-3-7. Underpaid premiums

When premiums are underpaid for coverage which has been selected and provided, future payments will first be applied to the shortage and the shortage will be rolled forward. Employees may not choose to retroactively cancel coverage that was selected. The full amount of the underpaid premium shall be submitted within sixty [60] days after the date EGID notifies the insured or the insured's employer of the error. When the underpayment occurs because an employee has entered into a salary reduction agreement pursuant to the Internal Revenue Code, and the insured's employer has erroneously failed to withhold and submit the proper premiums to EGID, the insured's employer shall be solely responsible for the payment of outstanding underpaid premiums to EGID. Failure to submit premiums could result in loss of coverage in accordance with 317:150-3-5(a)(3).

317:150-3-8. Refunds

(a) **Refunds of premium overpayments.** Any refund of payment for any premium overpayment shall be made only when EGID is notified in writing of the overpayment.

(b) **Administrative Error.** Refunds for overpayment due to administrative error, as limited and defined in the rules in this title, of the Insurance/Benefits Coordinator or the payroll clerk for EGID, shall be made at one hundred percent [100%].

(c) **Refunds on behalf of employees.** Refunds on behalf of employees shall be paid to the appropriate party. For an entity to receive a refund, the entity must have a credit balance.

(d) **Inaccurate or erroneous information**. If EGID finds that materially erroneous, false, inaccurate, or misleading information was intentionally submitted in order to obtain a specific coverage, then:

(1) For optional or supplemental life insurance coverage in excess of any guaranteed amounts of coverage, EGID shall extinguish its liability by tendering a refund of premiums paid to the insured or the beneficiary;

(2) Health or dental coverage would be canceled retroactive to the effective date of the coverage obtained by the misrepresentation. Refunded premiums would be reduced by any claims paid by HealthChoice.

(e) **Medicare eligibility**. There shall be no refund of premiums for prior months during which the member was eligible for Medicare, and written notice was not provided to EGID. An exception shall be made for individuals who are retroactively awarded Medicare coverage by the Social

Security Administration, when written notice of the retroactive award is provided to EGID within thirty [30] days after the member's notification of the Social Security Administration award. A member's sixty-fifth [65th] birthday is considered automatic notification of Medicare eligibility.

(f) **Deceased member**. All refunds for overpayment resulting from the death of an employee or former employee will be capped at the overpayment amount received by EGID within twenty four [24] months of notification.

(g) **Dependent life insurance premium reimbursement**. If, after a receipt of a life insurance application, EGID finds that the deceased dependent does not meet eligibility requirements for dependent life coverage, EGID may reimburse the member for qualifying premiums paid to EGID. Any premium reimbursement shall not exceed the amount of the dependent life policy.

317:150-3-13. Rights of eligible former employees to continue in the Group Health, Dental, and Vision Insurance Plan

(a) Health, dental and vision coverage may be elected as determined by State Statute or retained at the time of termination of employment from an employer who participates in that health, dental or vision coverage, if such election to continue in force or begin is made within thirty [30] days from the date of termination of service, and if the following conditions are met:

(1) The former employee either retires or has a vesting right with a State funded retirement plan, or has the requisite years of service with an employer participating in the Plan.

(2) The election must be received by EGID no later than thirty [30] days after the date of termination of service.

(b) If an eligible former employee does not elect coverage at the time of termination of employment, or subsequently drops the coverage that was elected, the coverage may not be reinstated at a later date, except as permitted for former State employees exercising insurance retention rights available through a reduction in force (RIF) severance agreement.

(c) A participating eligible former employee cannot add dependents to coverage after termination of employment, except as follows:

(1) During an open enrollment period; or

(2) Eligible dependent(s) not covered at the time of the former employee's termination from active employment, as long as the dependent election is made within thirty [30] days of the termination date.

(3) If the dependent is newly acquired. New dependent[s] or additional dependent coverage must be added within thirty [30] days after acquiring the new dependent[s].

(4) If the dependent has lost other health or group dental insurance coverage and notice has been given to EGID within thirty [30] days after the loss of the other coverage. Excepted Benefits do not qualify as other health coverage for purposes of this rule, and replacement is limited to the corresponding type of coverage lost.

(d) During an option period, covered former employees may make changes to their existing benefits but not add additional benefits with the exception of vision coverage. Vision coverage cannot be dropped mid-year except as allowed at 317:150-3-22(c).

(e) If an eligible former employee has a spouse who is participating in the Plan as an employee of a participating entity, the former employee may defer or transfer his or her health, dental and vision coverage to be dependent coverage under the spouse at any time, so long as the following conditions are met:

(1) Coverage must remain continuous; and

(2) All eligible dependents must be insured unless they have other verifiable coverage.

(3) The eligible former employee, at a later date, may cancel deferment and defer or transfer his or her insurance coverage from dependent status back to former employee status if coverage with the Plan has remained continuous, and the former employer of the eligible former employee continues to participate in the Plan.

(f) An individual who has retained health, dental or vision coverage who is returning to current employment for a participating entity and meets the eligibility criteria for a current employee is entitled to transfer his present coverage to that employer as long as the employer is a participant in the benefit transferred. The employee may retain his present life coverage and may add life coverage so long as the total amount of life coverage does not exceed the guaranteed issue amount. Evidence of insurability must be submitted and approved for any amount exceeding guaranteed issue or the amount previously held in retirement, whichever is greater.

(g) An eligible former employee who has retained any coverage and is returning to work for a participating entity but does not meet the eligibility criteria for a current employee is not entitled to coverage through that employer.

(h) In the event an otherwise eligible former employee returns to current employment who did not retain health coverage upon termination of employment, the eligibility requirements of a new employee must be met in order to obtain that coverage through the employer. Such individuals must work for three [3] years in order to qualify for retaining any benefits not previously elected upon ceasing current employment when they re-retire. This includes members who terminated from employers not participating in the Group Plans authorized by the Oklahoma State Employees Benefits Act [74 O. S. §1301] when they originally ended employment.

(i) Enrollment in a Medicare Plan:

(1) **Medicare Supplement coverage enrollment required regardless of age.** All covered individuals who are eligible for Medicare, except current employees and their dependents as addressed in 317:150-5-41, must be enrolled in a Medicare Plan, offered through EGID, regardless of age.

(2) **Effective date of Medicare Supplement coverage.** Medicare Supplement coverage shall become effective on the first [1st] day of the month following the date EGID receives actual notice of the member's eligibility for Medicare. There shall be no refund of premiums for prior months during which the member was eligible for Medicare, and written notice was not provided to EGID. An exception shall be made for individuals who are retroactively awarded Medicare coverage by the Social Security Administration,

when written notice of the retroactive award is provided to EGID within thirty [30] days after the member's notification of the Social Security Administration award. A member's sixty-fifth [65th] birthday is considered automatic notification of Medicare eligibility.

(3) **Non-Medicare eligible individuals.** Nothing in the rules in this chapter prohibits individuals who are not eligible for Medicare from being enrolled in EGID's regular health plan; however, individuals eligible to purchase Medicare coverage are excluded and are presumed to be enrolled in both Parts A and B of Medicare.

317:150-3-14. Coverage for eligible non-vested employee

A non-vested employee must apply for continuation of coverage thirty [30] days after the date of termination of employment. Coverage must be continuous and eligibility to continue must be based upon the length of service required by statute. [74 O.S. §1316.2; 74 O.S. §1316.3]

317:150-3-15. Effective dates of coverage for current employees

An employee other than an education employee is eligible to participate if not classified as seasonal or temporary and whose actual performance of duties normally requires one thousand [1,000] hours per year or more. An education employee who is a member of or eligible to participate in the Oklahoma Teacher's Retirement System and working a minimum of four [4] hours per day or twenty [20] hours per week may participate in the Plan. Part-time education employees are those who meet the requirements of a half-time employee as defined by the Oklahoma Teachers Retirement System. Eligible employees shall be covered on the first [1st] day of the month following the month in which the employee is in an eligible status.

(1) If an employee is absent due to accident or illness on the date the employee coverage would normally become effective, benefits shall not be payable until the employee returns to the job. If the employee is absent from work because of a holiday, vacation or nonscheduled working day and the employee was on the job on a scheduled working day immediately preceding the effective date, this effective date will not be changed. An employee coming to work during the latter part of a payroll period who is not able to complete an insurance change form should be placed on the appropriate plans on the first [1st] day of the following month with employee only coverage, so that the employee life, dental and health will be in effect. Members may add optional coverages within the member's initial thirty [30] day enrollment period to be effective the first [1st] day of the month following the date the member enrolled for optional coverages.

(2) Participating entities shall forward members' enrollment information and any changes to enrollment information during the initial enrollment period to the Administrator within ten [10] days after the last day a member may enroll.

(3) If an employee leaves a participating entity and is hired by another participating entity within the following thirty [30] day period, premiums must be forwarded to EGID to avoid a break in coverage.

(4) An enrolled member who terminates employment or is in leave without pay status and whose spouse is also an enrolled employee may transfer coverage to their spouse to be insured as a dependent. The health, dental, vision and basic life may be transferred. The employee's basic life amount will transfer to a dependent spouse

amount. If there are dependent children, they must also be insured unless they have other group or qualified individual health insurance.

(5) An employee that terminates from a participating employer and is hired by another participating employer shall be entitled to be treated as a new employee with new health, dental, vision and life benefit options available. A rehired employee returning to a former employer has new health, dental and vision benefit options only after a thirty [30] day break in coverage and may be subject to orthodontic limitations.

(6) Except as provided by statute, an individual employee may choose not to be enrolled in the health or dental plans or may disenroll from these plans because of other health or group dental coverage or by reason of eligibility for military or Indian health services within thirty [30] days after the date the employee becomes eligible for the other health or group dental coverage. Such employees who subsequently lose the other coverage or eligibility for military or Indian health services may enroll in the corresponding health or dental plans offered through EGID if the election is made no later than thirty [30] days after the date of loss of the other coverage. At the insured's option, in order to avoid a break in coverage and the application of the dental limitation, coverage under this Plan shall become effective on the first [1st] day of the month during which the insured actually lost the previous coverage, provided the insured pays the full premium for that month. Otherwise, coverage shall become effective under this Plan on the first [1st] day of the month following the election of health and/or dental coverage, and any break in coverage shall result in the application of the HealthChoice dental limitations. Excepted Benefits do not qualify as other health coverage for purposes of this rule.

317:150-3-16. Participating entities

(a) **Participation in plans offered by EGID.** Entities electing to participate in the dental, life, vision, or disability plans offered by EGID must participate in one of the authorized health plans, unless the Administrator grants a waiver. Coverage offered by EGID to eligible education employees will also be offered to all elected members of the school board for that entity.

(b) **Enrollment in group term life benefits.** An entity may elect to participate in the group term life coverage offered by EGID. This includes basic and optional supplemental life coverage for the employee and dependent life coverage. Entities electing to participate in the life plan offered by EGID must participate in the health plan, unless the Administrator grants a waiver.

(c) **Non-participating entities in other group plans.** The group plans offered by EGID shall not be offered to any entity which is participating in any other group insurance program, regardless of the percentage or number of employees eligible to enroll, unless the Administrator grants a waiver.

(d) **Right of Board to approve or deny applications for coverage.** EGID shall retain the right to approve or deny any employer group applications for coverage. Upon approval, coverage will become effective at 12:01 a.m. on the first [1st] day of the month following the month in which approval is granted unless a subsequent month is requested and approved in advance.

(e) **Coverage without preexisting conditions.** When an entity enrolls all employees of the new entity are covered without penalty for preexisting conditions.

(f) **Enrollment of all individuals presently insured.** Upon the group initial enrollment of an institution of higher education, all individuals presently insured by the institution's previous group health plan may become enrolled. If any such individual does not meet the eligibility requirements of this plan, they are eligible for coverage only for the remaining period of the institution's contractual liability. The institution must provide written proof of its contractual liability at the time of said individual's enrollment.

(g) **Attestation of continuous coverage for retirees.** Upon beginning or reinstating participation in health coverage offered by EGID, the entity must provide EGID with an attestation that retirees over age sixty-five [65] that will gain coverage through EGID have had continuous creditable coverage for prescription drugs (coverage that is at least as good as Medicare's) since the retirees became eligible for Medicare. The entity must provide an accurate list of any retiree over age sixty-five [65] that does not meet this requirement in order for EGID to properly report uncovered months to Medicare.

317:150-3-17. Dependents

Eligible dependents may be enrolled by new employees with their coverage effective concurrently with the employee's coverage if the member has signed the insurance change form requesting such coverage within the member's initial thirty [30] day enrollment period. Dependent coverage not elected at that time shall not become available until the next enrollment period. Dependents are not eligible for any coverage in which the member is not enrolled. Exceptions may apply for dependents electing COBRA or Survivor coverage. When one eligible dependent is covered, all eligible dependents must be covered for all elected coverage. The spouse or dependent may elect not to be covered when the spouse or dependent is covered by other corresponding and verifiable health, group dental or vision coverage. The member can elect not to cover dependents who do not reside with the member, are married, are not financially dependent on the member for support, have other coverage or are eligible for Indian or military health benefits. The spouse may elect not to be covered provided a statement signed by the employee and the spouse is submitted to the Insurance/Benefits Coordinator. Dependent's benefits shall only be covered under one primary insured except in the case of dependent life. Excepted Benefits do not qualify as other coverage for purposes of this rule.

(1) Newborns may be added to coverage with the completion of an insurance change form and remittance of any appropriate premium for the month of birth to the Insurance/Benefit Coordinator within thirty [30] days after the date of birth of the newborn.

(2) When one or more eligible dependents are currently covered, the newborn must be added to the same coverage.

(3) Where a newborn is added to coverage, all other eligible dependents must be enrolled in coverage if they are not currently enrolled. A member can waive health, dental, or vision coverage for their spouse.

(4) Eligible dependents who lose other health, group dental or vision insurance coverage may be added to the equivalent health, dental or vision coverage offered through EGID within thirty [30] days after the loss of the other insurance coverage if those dependents have been continuously covered by the other health, dental or vision insurance, or have been eligible for treatment at military or Indian health facilities. Notice and proof of the loss of other coverage and termination date of other coverage must be submitted within thirty [30] days after the loss of the other coverage. At the insured's

option, in order to avoid a break in coverage this Plan shall become effective on the first [1st] day of the month during which the insured actually lost previous coverage, provided the insured pays the full premium for that month. Otherwise, coverage shall become effective under this Plan on the first [1st] day of the month following notice of the loss of other coverage. Excepted Benefits do not qualify as other health coverage for purposes of this rule.

(5) Newly acquired dependents may be added if the election is made within thirty [30] days after the qualifying event, or other federally required mandate, or during the annual enrollment period as established by EGID. Documentation proving the qualifying event may be required. The effective date of coverage will be the first [1st] day of the month following notification to EGID of the qualified event except for newborn or adopted dependent children.

(6) Provided all other eligibility requirements are satisfied, adopted eligible dependent children, eligible children for which guardianship has been newly granted to the insured or the insured's spouse, or eligible children of which the insured has been newly granted physical custody pending adoption, guardianship, or other legal custody, may be covered from the first [1st] day they are placed in the insured's physical custody, only upon payment of the full monthly premium for that individual, not prorated, and only after written notice has been given to EGID within thirty [30] days after obtaining physical custody. Copies of all documents relating to the matter are also required.

(7) At the insured's option, coverage for eligible dependent children newly placed in the insured's physical custody may become effective on the first [1st] day of the second month following placement, if written notice is provided within thirty [30] days after the date of placement, or at the next option period as established by EGID.

(8) In the absence of a court order indicating adoption, guardianship, legal separation or divorce, an insured may apply for coverage on other unmarried children living with the insured provided: (1) the insured submits a copy of his most recent federal income tax return showing the child was listed as the insured's dependent for income tax deduction purposes; and (2) if the last federal income tax form requested above does not list the child, the insured shall be required to provide an Application for Coverage for Other Dependent Children form prescribed by the Plan; and (3) coverage, if approved, shall begin on the first [1st] day of the month following approval, and will never apply retroactively except in the case of a newborn which shall be added the first [1st] of the month of birth; and (4) all other applicable eligibility requirements must be satisfied; and (5) all necessary premiums have been paid. EGID shall have the right to verify the dependent's status, to request copies of the insured's federal income tax returns from time to time, and to discontinue coverage for such dependents if they are found to be ineligible for any reason.

317:150-3-18. Eligibility criteria for disabled dependent over the age of twenty- six [26]

Eligibility criteria for covering a disabled dependent beyond the age of twenty-six [26] pursuant to 74 O. S. §1303(14) are as follows, provided all other eligibility requirements are also satisfied:

(1) It is intended that the following dependents beyond the age of twenty-six [26] are eligible for coverage under this provision:

(A) An individual who has been medically determined to be incapable of self-support because of mental or physical incapacity that currently exists and has continuously existed since before reaching the age of twenty-six [26] years; and

(B) The individual resides in the primary member's home at least six [6] months of the year, and is the primary member's natural child, foster child, adopted child, or a child of the primary member's spouse when the spouse has been ordered by a Court to provide health insurance for the child; and

(C) If the requirements of subsection (A) and (B) are met, eligibility through court appointed guardianship will be accepted for disabled children, foster children and grandchildren, but only when guardianship existed prior to the dependent reaching age nineteen [19]. The assessment/application for coverage must be submitted within thirty [30] days of obtaining legal guardianship. Power of attorney, including durable power of attorney, does not qualify as guardianship. Coverage ceases at the end of the month in which the primary member's appointment as guardian is terminated.

(D) An approved disabled dependent who has been medically determined to be incapable of self-support because of mental or physical incapacity that currently exists and has continuously existed since before reaching the age of twenty-six [26] years can only be added to coverage within thirty [30] days of a qualifying event. While changes to coverage (benefits or plan options) may be made during the annual Option Period, enrollment of a disabled dependent will not be considered without a qualifying event.

(2) Other criteria required for disabled dependent status are:

(A) For a primary member who is a new hire or a re-hire, assessment/application for disabled dependent status must be completed and submitted to EGID within thirty [30] days of primary member's initial enrollment. As stated above, the disabled dependent must have been medically determined to be incapable of self-support because of mental or physical incapacity that currently exists and has continuously existed since before reaching the age of twenty-six [26] years.

(B) Primary members must submit a copy of their federal and/or state income tax returns for the prior year reflecting their support of the dependent.

(C) Dependents are eligible only for the coverage in which the primary insured is enrolled. Only dependent life insurance can be carried by both parents if each is a primary member under the plan; and

(D) Primary members must apply for disabled dependent status for an eligible individual who has been medically determined to be incapable of self-support because of mental or physical incapacity that currently exists and has continuously existed since before reaching the age of twenty-six [26] years at least thirty [30] days prior to the dependent's twenty-six [26th] birthday.

317:150-3-19. Termination of dependent coverage

Dependent reaches age twenty-six [26]. Coverage will be terminated for dependents reaching age twenty-six [26] on the first [1st] day of the month following their twenty-sixth [26th] birthday, except disabled dependents who are incapable of self-support and who have been deemed eligible for coverage by EGID.

317:150-3-20. Withdrawal from plan; termination or loss of coverage

(a) **Withdrawal from plan.** Those eligible entities participating on a voluntary basis that elect to withdraw cannot re-enter the Plan for one [1] year following the date of withdrawal except for extraordinary circumstances. Notice of the election to withdraw must be provided to EGID thirty [30] days prior to the actual withdrawal date.

(b) **Termination of coverage due to insolvency of carrier.** Any eligible entities who have withdrawn and purchased other coverage, then have been notified by their other health and/or group dental insurance carrier that coverage is being terminated due to insolvency of the carrier may re-enroll in the corresponding coverages within thirty [30] days after the loss of coverage by submitting a completed application form which must be approved by EGID prior to enrollment. Excepted Benefits do not qualify as other health coverage for purposes of this rule.

(c) **Individual member withdrawal and re-enrollment.** An individual employee who discontinues coverage on himself cannot re-enroll in any coverage for himself or his dependents for a period of twelve [12] months. Subsequent to the end of this twelve [12] month period, he may reapply for coverage offered by EGID provided that he is eligible through a participating entity. The orthodontic limitations will apply.

(d) **Loss of other health, group dental or group life insurance coverage.** The twelve [12] month requirement does not apply when the individual member has lost other health, group dental and/or group life insurance coverage and is seeking reinstatement pursuant to Rule 317:150-3-20(c). Excepted Benefits do not qualify as other health coverage for purposes of this rule.

317:150-3-21. Continuation of coverage for survivors

(a) The surviving dependents of a deceased employee who was on current work status or authorized leave at time of death, or of a participating retiree, or any person who has elected to receive a vested benefit under the Oklahoma Public Employees Retirement System, the Oklahoma Teachers Retirement System, the Uniform Retirement System for Justices and Judges, or the Oklahoma Law Enforcement Retirement system or is eligible to continue in force the life insurance coverage following retirement or termination of employment with the required minimum years of service with a participating employer, or who meets each and every requirement of the HealthChoice Disability Plan, may continue the health or dental benefits in force provided said dependents pay the full cost of such coverage and they were covered as eligible dependents at the time of such death. Such election must be made within sixty [60] days after death and coverage must be continuous. The eligibility for said benefits shall terminate for the surviving children when such children cease to qualify as dependents under the provisions of this plan.

(b) The surviving spouse of a deceased employee who was on active work status or authorized leave at time of death, or a surviving spouse of a participating retiree, or

surviving spouse of any person who has elected to receive a vested benefit under the Oklahoma Public Employees Retirement System, the Oklahoma Teachers Retirement System, the Uniform Retirement System for Justices and Judges, or the Oklahoma Law Enforcement Retirement system or is eligible to continue in force the life insurance coverage following retirement or termination of employment with the required minimum years of service with a participating employer, or who meets each and every requirement of the State Employees Disability Plan, and who had elected the optional dependent life benefit prior to his or her death, may continue the dependent life coverage for the surviving spouse and children that were covered as dependents on the date of deceased employee's death, provided the surviving spouse pays the full cost of such coverage and the surviving spouse and children were eligible dependents on the date of the deceased employee's death. Such election must be made within sixty [60] days after the date of the deceased employee's death and coverage must be continuous. The eligibility for life benefits shall terminate for the surviving spouse's children when the children cease to qualify as dependents under the provisions of this plan.

(1) Upon the death of the surviving spouse, life benefits granted under this paragraph are payable to the beneficiary designated by the surviving spouse.

(2) Upon the death of any covered dependent children under this paragraph, life benefits are payable to the surviving spouse.

(3) The amount of life insurance coverage elected by the surviving spouse or, if no spouse, the surviving eligible dependent children shall not exceed the amount elected by the deceased employee prior to the date of the employee's death.

(4) Coverage for all dependent children of the surviving spouse, if any, terminates simultaneously with the death of the surviving spouse or termination of the surviving spouse's life insurance coverage.

317:150-3-22. Mid-year benefit election changes

(a) Mid-year elections will be allowed in accordance with and under those circumstances stated within Title 26 Treasury Regulations, Section 125 of the Internal Revenue Code. The determination of Title 26 Treasury Regulations, Section 125 of the Internal Revenue Code compliance for the current employee will be through certification from the employer.

(b) EGID will accept any change for any current employee certified as being compliant by the employer of that current employee so long as the notification of change is received by EGID within thirty [30] days of the employee's mid-year plan election. The employer must further certify that the documentation supporting compliances is available to EGID and will be provided upon written request. An employer's cafeteria plan may permit an employee to revoke an election during a period of coverage and to make a new election only as provided in Title 26 Treasury Regulations 1.125-4. This is discretionary with the employer. Employees should be aware that Title 26 Treasury Regulations, Section 125 of the Internal Revenue Code does not require a cafeteria plan to permit any of these changes.

(c) For all other members not on current employee status or whose employer does not operate his employee benefit plan under a Section 125 plan, the rules for mid-year changes will be subject to the Section 125 guidelines as detailed in Title 26 Treasury Regulations 1.125-4.

(d) In all cases, mid-year election changes will only be considered in the event of a qualifying status change as described within Title 26 Treasury Regulations, Section 125 of the Internal Revenue Code and other federally required mandates. All other changes not in conjunction with a qualifying event can only be made during the annual Option Period.

317:150-3-23. Corrections to benefit elections

Members shall review their confirmation of coverage statement to ensure that the coverage elected is correct. Any corrections shall be submitted to the member's Insurance/Benefits Coordinator and EGID within sixty [60] days of the election. Errors reported after the sixty [60] days shall be effective the first [1st] day of the month following the notification of the error.

317:150-3-24. Double coverage prohibited

An eligible person shall not be insured as a primary insured and also as a dependent for any benefit options except dependent life, nor can any dependent be covered simultaneously by more than one primary insured, except for dependent life. Double enrollment, whether it occurs intentionally or by error, shall be deemed void from the inception, and EGID reserves the right to decide which form of single enrollment coverage to allow, whether primary or dependent.

317:150-3-25. Basic disclosure plan for HealthChoice Medicare beneficiaries

(a) The following words and terms as defined by EGID, when used in this section, shall have the following meaning: "Medicare beneficiary" means individuals eligible for HealthChoice Medicare plan coverage who are also entitled to Medicare benefits as designated by the United States Social Security Administration.

(b) In order to assure Medicare beneficiaries with an understanding of the medical and pharmacy benefits provided by, and the operation of, the HealthChoice Medicare plans; EGID shall maintain, adopt, and implement a basic disclosure plan for Medicare beneficiaries. This basic disclosure plan includes but is not limited to informational materials such as:

(1) A Medicare beneficiary benefits handbook providing a summary of medical and pharmacy benefits available under EGID's Medicare HealthChoice plan. Such handbooks shall be updated when material benefits or covered services change, or when reductions occur. A separate notification of material changes will be sent to all Medicare beneficiaries in a timely fashion prior to the updating of the Medicare beneficiary benefits handbook.

(2) A pre-enrollment package which shall be provided to all plan eligible Medicare beneficiaries. The pre-enrollment package shall, within a reasonable person's determination, be written in clear and understandable language providing the Medicare beneficiary detailed and necessary information upon which to make a selection of coverage for an upcoming plan year.

(3) A confirmation of benefit coverage form which will be distributed in a timely fashion after enrollment of a Medicare beneficiary, and by which HealthChoice shall notify the Medicare beneficiary of the plan coverage for the upcoming year.

(4) An explanation of benefit determination letter explaining the outcome of each medical or pharmacy claim processed for payment or denial. In the case of denial the

explanation of benefit determination letter shall provide information of the appeals process available to the Medicare beneficiary.

(5) Material which provides all Medicare beneficiaries with basic disclosure information on special enrollment rights, medical child support orders, and any Medicare service or benefit that EGID by law has been directed to provide.

317:150-3-26. Termination of benefits

(a) **Termination of coverage.** The coverage under this plan will terminate at the earliest time stated below:

(1) On the last day of the calendar month in which employment terminates.

(2) When the plan is discontinued.

(3) When any required premiums cease to be paid.

(4) The individual does not begin or continue coverage as an eligible participating former employee and/or dependent.

(5) For a dependent when said dependent becomes ineligible for coverage.

(6) A participating entity ceases to participate in this plan.

(b) **Representation of eligibility.** Individuals who enroll a family member in the plan are representing that the individual is eligible under the terms of the plan and must provide evidence of eligibility upon request. The plan relies upon the member's representation of eligibility in accepting the enrollment of the family member, and the intentional provision of false evidence or the failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation. The intentional provision of false evidence or the failure to provide evidence of eligibility will result in disenrollment of the individual, which may be retroactive to the date as of which the individual became ineligible for plan coverage, as determined by the plan.

(c) **Rescission of coverage obtained through false information.** If material facts are submitted as a result of fraud, substantive error, inaccuracy, omission, misrepresentation, or any illegal or unauthorized activity, on any form or application for insurance coverage by or on behalf of a member or dependent, the coverage will be rescinded retroactively to the effective date. Written notice shall be sent by first class mail by EGID to the member's last known address of record no less than thirty [30] days prior to retroactive rescission of coverage. EGID reserves the right to recover the costs of any and all claims paid through such falsely obtained coverage from the ineligible member and/or dependent through all available means, at the discretion of EGID.

(d) **Dependent termination of coverage.** In addition to (a), (b), (c) and (e) of this section, the coverage terminates with respect to an individual dependent on the last day of the calendar month in which such person ceases to be an eligible dependent.

(e) **Unlimited contestability period.** There shall be no time limitation imposed upon EGID during which coverage based on materially false information submitted to EGID can be rescinded,

if it is found that information as listed above in paragraph (c) was provided in order to obtain coverage, and that such information was material to EGID providing such coverage.

317:150-3-27. Procedures and implementation

Notice of right to continue coverage. EGID shall advise each covered employee of his right to continue coverage under Federal COBRA provisions. COBRA coverage applies only to health, dental, and vision benefits. Life and disability coverage are not available through COBRA.

317:150-3-28. COBRA administration

(a) **COBRA coverage is identical to coverage provided at date of the qualifying event.** The coverage elected shall be identical to the coverage provided at the date of the qualifying event. Should a beneficiary move out of the service area of their current plan, the beneficiary will be allowed to change to a plan whose service area covers the beneficiary's new location.

(b) **Payment of back premiums.** All back premiums from the termination of coverage to the election and approval of continuation must be paid before coverage is effective. Coverage will then be retroactive to provide continuous coverage. All time limits are mandatory and cannot be waived under any circumstances.

(c) **Responsibility of qualified beneficiary to inform EGID of ineligibility.** It is the responsibility of the qualified beneficiary to provide timely notice if he is not eligible for any reason. Failure to do so will result in cancellation of COBRA insurance coverage, retroactive to the time of ineligibility.

(d) **Primary member premium.** For any benefit continued under COBRA, one person must pay the primary member premium. In cases where a spouse, child, or children are insured for a particular benefit where the primary member did not retain coverage, one person will be billed at the primary member rate.

(e) **Federal regulations.** Federal regulations regarding COBRA extension of coverage shall be controlling in all situations where applicable.

SUBCHAPTER 5. COVERAGE AND LIMITATIONS

PART 1. POLICY PROVISIONS

317:150-5-1. Selection of health plans

(a) **Requirements for selection of HMO.** Eligible employees may select either the state's comprehensive health plan (HealthChoice) or an HMO option. In order to select an HMO option, the employee must reside or be employed within the selected HMO's service area. The HMO election will apply not only to the employee, but also to all covered dependents. Eligible retirees, vested, non-vested, COBRA or survivor members and eligible dependents must reside within the selected HMO's service area to participate in the HMO.

(b) **Selection of HMO during enrollment period.** A choice of comprehensive benefits or the HMO may be made on an annual basis by the member during the enrollment period as set by EGID. The eligibility requirements set by EGID as applied to the comprehensive health plan will apply to the HMO. Eligible members in all cases will retain eligibility for dental, basic life and

AD&D. Selection of the comprehensive health plan or the HMO option will not affect eligibility for life and AD&D, dependent dental, or dependent Life.

PART 3. HEALTHCHOICE PLANS

317:150-5-2. Schedule of benefits and benefit administration procedures or guidelines as adopted by EGID

All benefits for HealthChoice plans offered through EGID as described in the rules in this title shall be paid according to the handbooks, schedule of benefits and benefit administration procedures or guidelines as adopted by EGID. The schedule of benefits and benefit administration procedures or guidelines as adopted by EGID shall be available for inspection by the public. To make an appointment to review, please submit a written request to OHCA EGID, PO Box 11137, Oklahoma City, OK 73136-9998.

317:150-5-10. Plan limits

EGID will adopt handbooks, policies and procedures for the implementation of the HealthChoice benefit plans. These documents shall clearly describe any limits associated with:

(1) Individual and family deductibles;

(2) Network and Non-Network out-of-pocket maximums; and

(3) Charges associated with Non-Network providers.

317:150-5-11. Covered charges

Items which will be considered for payment under HealthChoice will be referred to as covered charges that are medically necessary. Specific criteria and limitations apply. Covered charges may include:

(1) **Hospital services**;

(2) **Provider's services**;

(3) **Skilled Nurse facility expense**;

(4) **Skilled nurse care**;

(5) **Dentist's or oral surgeon's services**;

(6) **Oral surgery**;

(7) **Rehabilitative care**;

(8) **Outpatient expense**; and

(9) **Hospice care**.

(10) Approval of exceptional claims

(A) EGID's Health Care Management Unit may recommend exceptions to the benefits provided by HealthChoice for situations which would otherwise be denied or subject to limited coverage.

(B) Each request for exception must first be reviewed by the Health Care Management Unit on an individual basis. All responsibility for providing the documentation necessary to complete the review falls to the member. Recommendations will then be given to the Medical Director and Administrator both of whom must review all requested exceptions. Exceptions that have been reviewed but not approved in writing by the Medical Director and Administrator are deemed not approved. Approval of exceptions shall not establish precedent for other requests. All requests shall confirm that the requested exception is:

(i) medically necessary, and

(ii) within medically-accepted standards of care, and

(iii) cost effective, and/or

(iv) in compliance with all criteria as established by the Medical Director or designee.

(C) Requests conforming with all listed criteria shall remain subject to approval or denial at the discretion of the Medical Director or designee.

(11) **Facility of benefit payment**. Whenever payments which should have been made under this plan in accordance with this section have been made under any other plans, EGID shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this section, and amounts so paid shall be deemed to be benefits paid under this plan and, to the extent of such payments, EGID shall be fully discharged from liability under this plan.

(12) **Right of recovery**. Whenever payment has been made by EGID with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this section, EGID shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as EGID shall determine:

(A) any persons to or for or with respect to whom such payments were made;

(B) any other insurers; or

(C) service plans or any other organizations.

317:150-5-12. HealthChoice plan limitations and exclusions

For the health plans provided by EGID, there is no coverage for expenses incurred for or in connection with conditions, services, procedures, treatments, expenses, items, and supplies excluded by EGID's benefit guidelines. There is no coverage or reimbursement for services or supplies provided by ineligible providers. [317:150-1-2]

317:150-5-13. Payment of HealthChoice health, dental and life benefits

(a) Life insurance benefits are payable to the beneficiary designated by the employee. Premiums and overpaid disability benefits due and payable to EGID at the time of the insured's death may be withheld from life insurance benefits before payment of the remainder to the beneficiary or estate. Life proceeds are not assignable, except a beneficiary may assign proceeds in an amount equal to the decedent's burial expenses. If no beneficiary form is on file with EGID, benefits will be paid to the decedent's estate.

(b) Health and dental benefits are payable to the employee or the provider. If any health or dental benefits remain unpaid at the employee's death, EGID, may at its option, pay the benefits to the employee's estate or to any one or more relatives such as follows: spouse, father, mother, children, brothers or sisters. Any such payment will constitute complete discharge of EGID's obligation to the extent of the amount paid.

(c) If a minor or person otherwise legally incapable of giving a valid receipt of discharge of any payment is selected as a beneficiary, a guardian must be appointed by a court of competent jurisdiction before benefits shall be paid.

317:150-5-14. Timely filing of HealthChoice health and dental claims

Proof of health and dental claims for services received (bill/receipt) must be furnished per the Plan policy. If such proof is not furnished within the time allowed, at EGID's discretion the claim will still be considered if the Insured or Provider shows that it was not reasonably possible to furnish the notice of proof within the specified time and that the notice of proof was furnished as soon as reasonably possible.

317:150-5-15. HealthChoice examination

EGID reserves the right and opportunity to order the examination of the person whose injury or sickness is the basis of a claim as often as may be reasonable during the pending of the claim.

317:150-5-16. Action to recover

No action at law or in equity shall be brought to recover on this Plan unless brought pursuant to the Administrative Procedures Act, nor shall such action be brought at all unless brought within three [3] years from the expiration of the time within which proof of loss is required by the policy.

317:150-5-17. Program integrity

EGID may have a Program Integrity Initiative. The purpose is to identify, recover, and prevent inappropriate provider billings and payments through provider audits. The provider shall

furnish any and all claims information and medical documentation, upon request and at no cost, to EGID. The requested documentation will be verified to substantiate the provision of medical, dental, or durable medical equipment/supplies, and the charges for such services, if the member and the provider are seeking reimbursement through EGID. EGID will ensure appropriate payment to providers and recovery of misspent funds, while providers shall ensure they only provide appropriate services and exercise appropriate billing practices. EGID may implement additional procedures and processes to effectuate this section.

PART 5. HEALTHCHOICE LIFE BENEFITS

317:150-5-20. Term life coverage

(a) **Group Term Life Benefits.** A former employee who is reemployed by a participating employer within twenty-four [24] months after the date of termination of previous employment shall not be enrolled for a greater amount of life insurance than the individual had at the time of termination of previous employment with the employer, unless the individual provides satisfactory evidence of insurability or the guaranteed issue based on the employee's current salary exceeds his or her prior coverage. Any life insurance amount requested exceeding both prior coverage and the guaranteed issue based on the employee's current salary would require the individual to provide satisfactory evidence of insurability. The amount of coverage provided by the employer is specified in the administration procedures or guidelines as adopted by EGID. However, to elect this benefit, the member must be either a) enrolled in one of the group health plans offered through EGID or b) be enrolled in other qualified health coverage. In the event of death, the proceeds of this coverage are payable to the beneficiary listed on the most recently signed beneficiary designation subject to the limitations in Title 15. [15 O.S. §178] If no beneficiary form is on file at EGID, benefits will be paid to the decedent's estate.

(b) **Unlimited contestability period.** There shall be no time limitation imposed upon EGID, during which coverage based on evidence of insurability submitted to EGID can be contested, if it is found that materially erroneous, false, inaccurate, or misleading information was provided in order to obtain optional or supplemental coverage in excess of any guaranteed amounts of coverage. In the event EGID determines coverage was granted based upon erroneous, false, inaccurate or misleading information, and that such information was material to EGID providing any optional or supplemental coverage, EGID shall extinguish its liability by tendering a refund of premiums paid to the insured or the beneficiary.]

317:150-5-21. Optional dependent life coverage

(a) **Current employees.** Current employees may select life insurance coverage for eligible dependents if the employee is enrolled in basic life. This coverage does not include accidental death or dismemberment benefits. This benefit is available even if the dependent is a participating employee.

(b) **Former employees.** Former employees may continue this coverage if the member is enrolled in basic life.

317:150-5-22. Optional supplemental life coverage for eligible employees

(a) **Supplemental life coverage.** Supplemental life coverage is available for eligible employees who are covered by the basic term life coverage.

(b) **Enrollment.** At the time of initial enrollment, supplemental life may be requested up to the pre-established level set forth in the benefit administration procedures or guidelines as adopted by EGID, without submitting evidence of insurability. All supplemental life insurance requested which exceeds the pre-established level will require evidence of insurability. Coverage selected in the supplemental life insurance program begins on the first [1st] day of the month following the date of employment. Optional coverages not selected within the member's initial enrollment period may be added only during the next enrollment period. Members who waive or do not select supplemental life insurance coverage shall be required to obtain approval of current evidence of insurability to obtain coverage at a later date. Coverage obtained under this provision will be subject to certain additional restrictions as adopted by EGID. Individuals who waived this coverage because they were covered by other group life insurance coverage will be allowed to enroll without being subject to these additional restrictions if they request the coverage in writing and supply proof of the loss of other group coverage within thirty [30] days following the loss of the other group life coverage.

(c) **Changes in levels of coverage.** Increases or reductions in coverage limits (except termination of coverage) are only accepted during the option period. Beneficiary changes may be made at any time, but must be communicated to EGID in writing. All changes in coverage levels will be subject to the benefit administration procedures or guidelines as adopted by EGID.

(d) **Waiver of life insurance premiums.** In the event the employee becomes disabled, life insurance premiums may be waived for employee and dependent life insurance coverage. Provider certification shall be required, as specified by EGID, and premium waiver shall start on the first [1st] day of the month after the employee has been disabled for thirty [30] consecutive days, and shall continue for as long as the employee remains disabled. The waiver shall terminate on the earliest of the following events: the employee has been found to be able to return to current duty in any capacity by any provider; the employee returns to any active duty for any period of time; the employee changes in status to former or retired; the employee notifies EGID in writing that life insurance coverage is to be terminated; the employee is terminated for any reason, including, but not limited to resignation or discharge from his or her position; any termination of life insurance coverage occurs as set forth in 317:150-3-26.

(e) **Accidental Death and Dismemberment and loss of sight benefit.** The basic term life and the first twenty thousand dollars [$20,000] of the supplemental life coverage includes the accidental death and dismemberment and loss of sight benefit and will pay a scheduled benefit in the event of accidental death and dismemberment or loss of sight injury within ninety [90] days after the date of accident or accidental injury. Death must be a direct result of the accidental bodily injury independent of all other causes.

317:150-5-23. Rights of retired and vested employees to continue life insurance coverage

(a) **Continuation of coverage.** Any person who retires or who has elected to receive a vested benefit under the provisions of the Oklahoma Public Employees Retirement System, the Oklahoma Teachers Retirement System, the Uniform Retirement System for Justices and Judges, or the Oklahoma Law Enforcement Retirement system or is eligible to continue in force the life insurance coverage following retirement or termination of employment with the required minimum years of service with a participating employer, or who meets each and every requirement of the State Employees Disability Plan, or the spouse or dependent of any such employee, may continue in force life benefits purchased prior to severance in a face amount of no less than one-fourth [1/4] of the basic life coverage amount in five thousand dollar [$5,000.00]

increments, and the full amount of any additional life insurance that was in effect prior to the date of retirement. Said individual shall pay actuarially determined cost of such coverage and shall make such election within thirty [30] days following the date of severance. Said election to continue coverage becomes effective on the first [1st] day of the month following termination of current employment. Eligible employees may continue in force the dependent life coverage in effect at time of termination of employment in five hundred dollar [$500] increments per dependent if the member is enrolled in basic life coverage.

(b) **Decrease or termination of coverage.** Coverage may be decreased or terminated after severance from current employment, but shall not be increased or reinstated after severance, except as permitted by rule or statute.

(c) **Unavailability to retirees, vested or eligible non-vested members or dependents.** Accidental death and dismemberment and loss of sight benefits are not available to retired, vested, or eligible non-vested members or dependents.

(d) **Retirees returning to active employment.** When an individual has retired and then returns to active employment, that individual may not retain any more life insurance upon termination of active employment than the amount that was retained when the individual initially retired, unless the period of active employment is for at least three [3] years.

PART 7. LIMITATIONS AND EXCLUSIONS FOR HEALTHCHOICE LIFE PLANS

317:150-5-24. Limitations and exclusions for life plans

For the life plans provided by EGID, there is no coverage for expenses incurred for or in connection with any of the items listed below:

(1) There is no coverage for employee life or dependent life benefits during the first twenty-four [24] months of coverage when death is the result of suicide. The twenty-four [24] month exclusion for death by suicide will begin on the effective dates of all elective increases in coverage, and will apply to all increased amounts of coverage which have been in effect for less than twenty-four [24] months on the date of the act causing the insured's death.

(2) There is no coverage for accidental death and dismemberment benefits or loss of sight benefits when such occurs as a result of the following:

(A) Suicide, attempted suicide or intentional self destruction, or intentionally self-inflicted injury while sane or insane,

(B) Committing an assault or felony, including participation as an aggressor in a riot or insurrection,

(C) Wholly or partly, directly or indirectly, by disease, physical or mental, or by medical or surgical treatment or the diagnosis of any of the foregoing,

(D) Wholly or partly, directly or indirectly by bacterial infection, other than septic infection of and through a visible wound sustained solely through external and accidental means,

(E) Any narcotic, drug, poison, gas or fumes, voluntarily taken, administered, absorbed or inhaled, unless prescribed for the exclusive use of the deceased, or administered by a licensed provider for a legal purpose,

(F) Hang gliding, sky diving and flying experimental aircraft.

PART 9. HEALTHCHOICE DENTAL BENEFITS, LIMITATIONS, AND EXCLUSIONS

317:150-5-30. Scope of coverage

The dental expense benefit applies to eligible covered employees and dependents. This benefit provides payment for dental expenses incurred in excess of any applicable deductible. However, to elect this benefit, the member must either be a) enrolled in one of the group health plans offered through EGID or b) be enrolled in other qualified health coverage. It is not necessary for dependents to be covered by health benefits to receive the benefits of this Plan.

317:150-5-31. Plan limits

(a) **Deductible.** The deductible amounts are the out-of-pocket expenses for a class of benefits incurred by the employee for himself or on behalf of a covered dependent during each calendar year.

(b) **Family deductible.** During any benefit period, EGID will pay a percentage of the covered charges incurred which exceed the family deductible amount, if applicable.

(c) **Maximum benefits.** The dental plan has a maximum benefit on a calendar year basis as established by EGID.

317:150-5-32. HealthChoice Dental limitations and exclusions

For the dental plans provided by EGID, there is no coverage for expenses incurred for or in connection with conditions, services, procedures, treatments, expenses, items, and supplies excluded by EGID's benefits guidelines.

PART 11. HEALTHCHOICE MEDICARE SUPPLEMENT

317:150-5-40. Medicare Supplement and Medicare Part D Prescription Drug Plan (PDP)

Members who are eligible for Medicare will be assumed to be enrolled in both Parts A and B of Medicare. Benefits payable under the Medicare Supplement will be determined in accordance with this assumption. The Medicare Supplement is either connected with a Medicare Part D Prescription Drug Plan or contains pharmacy benefits that are considered creditable coverage by Medicare.

317:150-5-41. Primary insurer of current employees

The health plan(s) offered through EGID may be primary for current employees eligible for Medicare and their eligible covered dependents as set forth in the Federal statutes governing Medicare.

317:150-5-42. Limitations of Medicare Supplement

The Medicare Supplement health coverage is a supplement to the coverage provided by Medicare.

(1) This Supplement applies only after Medicare benefits are determined.

(2) Coverage is limited to Medicare's scheduled amount.

PART 15. HEALTHCHOICE SUBROGATION

317:150-5-49. Right of subrogation

(a) EGID reserves the right to recover funds from members, dependents, tortfeasors, liability policies, underinsured/uninsured motorist policies, medical payments policies and/or other identifiable sources of funds, in amounts equal to any and all claim payments made on behalf of a member or dependent for injury caused by a third party's wrongful act or negligence.

(b) EGID has the right to recover any sums collected by or on behalf of a member or dependent even if the member or dependent has not been made whole. EGID is entitled to reimbursement from any recovery even if the recovery does not fully compensate the member or dependent for their injury. The make-whole doctrine shall not apply. The sole exception to this paragraph exists only to the limited extent that EGID voluntarily elects to invoke its exclusive statutory authority to waive or reduce EGID's subrogation interest in an individual case.

(c) The act of submitting claims by or on behalf of a member or dependent constitutes notice and acceptance of EGID's right of recovery against the third party and creates a lien upon any identifiable funds referenced in (a) above.

(d) A member or dependent will not take any action to prejudice EGID's right of subrogation, such as settlement of the claim without first giving notice of EGID's subrogation rights to the responsible party and any and all known liability or other insurers.

(e) The member or dependent will cooperate in doing what is reasonably necessary to assist EGID in any recovery, including but not limited to promptly providing all information requested by EGID.

(f) Subrogation will exist only to the extent of plan benefits paid.

(g) Claims submitted after a member or dependent has released the responsible party may be denied at the option of EGID, by the issuance of routine written notice to the member, dependent, or their attorney.

(h) If claims relating to a specified injury are paid by EGID after the member or dependent has released the responsible party, when the member or dependent has failed to inform EGID in a timely manner prior to executing a release, EGID at its option, may require reimbursement from the member, dependent or provider.

(i) Claims submitted will initially be pended as incomplete and subsequently denied if information regarding possible third party responsibility is not voluntarily provided to EGID within a reasonable time period [not less than ninety (90) days] after the date the information was first requested in writing by or on behalf of EGID.

CHAPTER 155. EMPLOYEES GROUP INSURANCE DIVISION - HEALTHCHOICE DISABILITY PLAN

317:155-1-1. Purpose

All terms of the HealthChoice Disability plan shall be set forth in handbooks and administrative procedures. These shall describe program and coverage eligibility, what constitutes disability, maximum length of coverage, maximum and minimum benefits for short-term disability and long-term disability, the calculation of disability income benefits, and the suspension or termination of benefits.