HealthChoice

*Health and Dental Plans*

*Group Term Life Plan*

*Disability Plan*

# Administrative Rules

# Jan. 1, 2019


*Office of Management and Enterprise Services*

*Employees Group Insurance Division*

*3545 N.W. 58th St., Ste. 600*

*Oklahoma City, OK 73112*

# TITLE 260: OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES

## EMPLOYEES GROUP INSURANCE DIVISION

## JANUARY 1, 2019

## CHAPTER 45. EMPLOYEES GROUP INSURANCE DIVISION – ADMINISTRATIVE AND GENERAL PROVISIONS

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# TITLE 260. OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES EMPLOYEES GROUP INSURANCE DIVISION

## JANUARY 1, 2019

## CHAPTER 45. EMPLOYEES GROUP INSURANCE DIVISION – ADMINISTRATIVE AND GENERAL PROVISIONS

## SUBCHAPTER 1. PURPOSE, DEFINITIONS, RULES AND REFERENCES

### 260:45-1-1. Purpose

The purpose of this chapter is to outline the structure of the Office of Management and Enterprise Services (OMES) Employees Group Insurance Division (EGID) and to identify the availability and procedures to be used to access a grievance hearing.

### 260:45-1-2. 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 Office of Management and Enterprise Services.

**"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.

### 260:45-1-3. Rules, cumulative

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

### 260:45-1-4. 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.

### 260:45-1-5. 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.

### 260:45-1-6. 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.

### 260:45-1-7. 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

### 260:45-3-1. 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.

### 260:45-3-2. 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.

**260:45-3-3. 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.

**260:45-3-4. 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 260:45-3-2.

**260:45-3-5. 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.

**260:45-3-6. Call monitoring for quality control**

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

### 260:45-3-7. 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

### 260:45-5-1. 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 requests in writing a hearing before the Grievance Panel pursuant to 260:45-5-1(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 requests must be filed within one [1] year from the date the member is notified of a denial of the claim, benefit or coverage. After more than one [1] year from the date the member was first notified of an allowance, payment, or denial of a claim, benefit, coverage, or other matter, 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 Procedures, at 3545 N. W. 58th Street, Suite 600, Oklahoma City, Oklahoma 73112.

**260:45-5-2. Notice of hearing**

Upon receipt of a Grievance request, 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.

**260:45-5-3. 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.

**260:45-5-4. 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.

### 260:45-5-5. 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.

### 260:45-5-6. 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.

### 260:45-5-7. 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.

### 260:45-5-8. Scheduling of hearings

All requests for hearings assigned to the three [3] member Grievance Panel shall be presented to, and heard by the Grievance Panel in open court within sixty [60] days of receipt of the properly submitted written request, unless the matter is: settled to the satisfaction of both parties; continued by agreement of the parties; or the Panel orders a continuance for good cause shown.

## SUBCHAPTER 7. DECLARATORY RULINGS

### 260:45-7-1. Petitions for declaratory rulings

Petitions for declaratory rulings as to the applicability of any rule or order of EGID shall be in writing and must be filed with EGID. The petition must state with clarity the issues to be decided and any legal authority which may be applicable.

### 260:45-7-2. Final rulings

Following a hearing on the issues set forth in the Petition for a Declaratory Ruling, the Grievance Panel shall issue a written final ruling within sixty [60] days of hearing a petition for declaratory ruling. The final ruling shall be mailed to the person requesting the ruling and shall be kept on file in the EGID office for public inspection.

### 260:45-7-3. Judicial review

Final declaratory rulings of EGID are subject to judicial review pursuant to the Administrative Procedures Act, in the same manner as individual proceedings.

## CHAPTER 50. EMPLOYEES GROUP INSURANCE DIVISION - HEALTH, DENTAL, VISION AND LIFE PLANS

## SUBCHAPTER 1. PURPOSE AND DEFINITIONS

### 260:50-1-1. Purpose

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

### 260:50-1-2. 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. An education employee absent from employment, not to exceed eight [8] years, because of election or appointment as local, state, or national education association officer who is otherwise eligible prior to taking approved leave without pay will be considered an eligible, current employee. 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 [26$^{th}$] 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 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 260:50-3-18.

**"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.

**"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 hospital, rehabilitation facility, skilled nursing facility, midwifery center, ambulatory surgical center, home health agency, infusion therapy entity, hospice program, durable medical equipment vendor, radiology facility, dialysis facility, or laboratory which is duly licensed under the laws of the state of operation, Medicare certified as applicable, and accredited by a nationally recognized accreditation organization that is approved by state or federal guidelines, for example, The Joint Commission (formerly JCAHO) or The Commission on Accreditation of Rehabilitation Facilities (CARF).

**"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.

**"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 under the laws of the state in which the "Network provider" operates and/or is accredited by a nationally recognized accrediting organization such as The Joint Commission (formerly JCAHO) or The Commission on Accreditation of Rehabilitation Facilities (CARF) approved by state or federal guidelines, 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 physician or other practitioner who is duly licensed or certified 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. 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

### 260:50-3-1. 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.

### 260:50-3-2. Approval of exceptional claims and eligibility matters

The Administrator shall have the authority to approve individual exceptional claims or eligibility matters when circumstances require. The Administrator shall provide a regular report on exceptional claims approved to the Board or a committee designated by the Board.

### 260:50-3-3. 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.

### 260:50-3-4. 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.

**260:50-3-5. 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 entire employee premium.

(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.

**260:50-3-6. 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.

**260:50-3-7. 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 260:50-3-5(a)(3).

**260:50-3-8. Refunds**

(a) **Refunds.** Any refund of payment for any premium overpayment shall be made only when EGID is notified in writing no later than sixty [60] days after the actual date of the overpayment, unless lack of notification is beyond control as determined by EGID.

(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 retired employee will be capped at the overpayment amount received by EGID within twenty four [24] months of notification.

**260:50-3-9. Payment of 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.

**260:50-3-10. Timely filing of health and dental claims**

Proof of health and dental claims for services received (bill/receipt) must be furnished no later than three hundred sixty-five [365] days after the date of service. If such proof is not furnished within the time allowed, at EGID's discretion the claim will still be considered if the employee 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.

**260:50-3-11. Examination**

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

**260:50-3-12. 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.

**260:50-3-13. 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 260:50-3-22(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 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 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 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.

**260:50-3-14. 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]

**260:50-3-15. 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.

**260:50-3-16. 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 the health plan, 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.

**260:50-3-17. 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. 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) When the parent is covered by health insurance, in order for an employee to retain coverage after the first forty-eight [48] hours (vaginal delivery) or ninety-six [96] hours (caesarian delivery) for his or her own newborn child, a completed insurance change form and any appropriate premium for the month of birth must be furnished to the Insurance/Benefits Coordinator within thirty [30] days after the date of birth of the newborn. Claims incurred for inpatient hospital treatment beyond the first forty-eight [48] or ninety-six [96] hours may not be processed or paid for the newborn until the newborn has been properly enrolled in the Plan. HealthChoice newborn limited benefit: a newborn has limited coverage for a birth for the first forty-eight [48] hours following a vaginal delivery or for the first ninety-six [96] hours following a C-section delivery without an additional premium. There are no benefits for services in addition to the routine hospital stay if the newborn is not enrolled for the month of the birth and premiums are not paid for that month. A Newborn Benefit Waiver must be completed to exclude a newborn from the Newborn Benefit.

(2) Newborns must be added the first of the month of the child's birth by filling out an Insurance Change Form within thirty [30] days after birth of the newborn.

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

(4) 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 or dental coverage for their spouse.

(5) If a member accepts newborn benefits for the birth of his or her child but does not retain coverage after the first forty-eight [48] hours (vaginal delivery) or ninety-six [96] hours (caesarian delivery) as a result of the member's failure to furnish his or her Insurance/Benefits Coordinator with a completed insurance change form and any appropriate premium for the month of the newborn's birth within thirty [30] days after the birth of the newborn:

(A) There is no additional premium for the newborn benefit.

(B) Enrollment of other eligible dependents is not required.

(6) If optional coverage is not selected until after the employee's effective date, but within the member's initial thirty [30] day enrollment period, the optional coverage will be effective the first [1st] day of the month following the date the optional coverage was selected.

(7) In the event a dependent is hospital confined on the day his health coverage would otherwise become effective, health coverage for that dependent is not effective until the day following his or her final discharge from the hospital.

(8) 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.

(9) Newly acquired dependents may be added if the election is made within thirty [30] days after the qualifying event, 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.

(10) 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.

(11) 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.

(12) 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.

**260:50-3-18. 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

(i) 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; and

(ii) Coverage ceases at the end of the month in which the primary member's appointment as guardian is terminated.

(C) 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.

(3) Disabled dependent status must be continued for a minimum of one [1] year. If the dependent having the disabled status is dropped from coverage, the primary member may not reapply for disabled dependent status for the dependent for a period of twelve [12] months. The twelve [12] month requirement does not apply when the dependent has lost other group coverage.

**260:50-3-19. Termination of dependent coverage**

(a) **Waiting period of twelve [12] months.** If coverage is discontinued for dependents, the employee cannot reapply for the discontinued coverage for any dependents again for at least twelve [12] months. Reinstated coverage shall be subject to penalty for orthodontic limitations.

(b) **Loss of other group health, dental, vision or life insurance coverage.** The twelve [12] month requirement does not apply when the dependent has lost other health, group dental, vision and/or group life insurance coverage and is seeking reinstatement pursuant to Rule 260:50-3-17(8). Excepted Benefits do not qualify as other health coverage for purposes of this rule.

(c) **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.

**260:50-3-20. 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 260:50-3-20(c). Excepted Benefits do not qualify as other health coverage for purposes of this rule.

**260:50-3-21. 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 State Employees 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.

**260:50-3-22. 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. All other changes not in conjunction with a qualifying event can only be made during the annual Option Period.

**260:50-3-23. 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.

**260:50-3-24. 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.

### 260:50-3-25. Basic disclosure plan for 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.

## SUBCHAPTER 5. COVERAGE AND LIMITATIONS

## PART 1. POLICY PROVISIONS

### 260:50-5-1. 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.

**260:50-5-2. 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 during regular office hours at 3545 N. W. 58, Suite 600, Oklahoma City, Oklahoma 73112.

**260:50-5-3. Approval for emergency treatment by non-Network providers**

Members may have benefits available for medical emergencies when non-Network services occur. Notification to EGID is required.

## PART 3. THE PLANS

**260:50-5-10. Plan limits**

(a) **Deductible.** Covered members or dependents may be required to meet a calendar year deductible. Only covered charges will apply to the deductible.

(b) **Family deductible.** The family deductible is met when covered family medical expenses combined exceed the Plan's specified amount. No further deductible will be required from any covered participant for the remainder of the calendar year.

(c) **Network out-of-pocket maximum.** Per person and family calendar year out-of-pocket expenses are limited under HealthChoice to the percentage based on coinsurance and copayments. When the member or dependent exceeds the specified out-of-pocket calendar year maximum EGID will pay one hundred percent [100%] of the allowable fee for treatment provided by a Network provider. The one hundred percent [100%] payment of the allowable fee will be made by HealthChoice for the remainder of the calendar year. Network out-of-pocket maximum accumulations also apply to the non-Network out-of-pocket accumulations. The out-of-pocket maximum does not include charges for non-covered services and balance billing charges from non-Network providers.

(d) **Non-Network out-of-pocket.** The Plan will pay one hundred percent [100%] of the allowable fee for treatment provided by a non-Network provider, once the member or dependent exceeds the specified out-of-pocket calendar year threshold. The one hundred percent [100%] payment of the allowable fee will be made by the Plan for the remainder of the calendar year. Specific HealthChoice plans may apply non-Network out-of-pocket accumulations to the Network out-of-pocket maximums. Unlike Network providers, non-Network providers have no contractual obligation to limit members' financial responsibility after HealthChoice has paid the claim. HealthChoice processes claims based on limited allowable fees to Network and non-Network providers. Allowable fees are not the same as charges billed by providers. Network providers

have agreed with HealthChoice to write off the remainder of their fees after all payments from HealthChoice and the member's deductible, copay and coinsurance have been determined. However, non-Network providers have no write-off agreement with HealthChoice, which means the member remains responsible for paying all outstanding billed charges for treatment which have not been paid by HealthChoice. In most cases, this leaves the member responsible for paying a substantial out-of-pocket charges for treatment by the non-Network provider. The out-of-pocket maximum does not include charges for non-covered services, balance billing charges from non-Network providers and copays. Copayments apply to the Network out-of-pocket maximum.

(e) **Treatment by non-Network providers.** Any treatment at a non-Network provider will remain subject to the fee schedule or any other form of maximum claim payment limitation. Claims paid pursuant to the benefit administration procedures or guidelines as adopted by EGID at any non-Network hospital or provider are subject to the limited maximum allowable fee in every case, regardless of the reason why the member sought and received treatment at the non-Network provider, and will usually result in substantial out-of-pocket expenses to the insured. Exceptions allowed by Statute at 74 O.S. §1304(12) and (13) may be made, when appropriate.

**260:50-5-11. Covered charges**

Items which will be considered for payment under the state's comprehensive health plan (HealthChoice) will be referred to as covered charges that are medically necessary and are as follows:

(1) **Hospital services**. Charges made by a hospital for:

(A) Semi-private room and board;

(B) Other hospital services and supplies used for treatment;

(C) Charges for use of intensive care facility, coronary care facility and other special care facilities;

(D) Outpatient expense incurred within twenty-four [24] hours of a surgical operation or injury.

(2) **Provider's services**. Charges for the services of a duly qualified provider for:

(A) Performing a surgical procedure;

(B) In-hospital medical treatment by a provider other than the surgeon;

(C) Care and treatment of an illness;

(D) Approved preventive medical treatment.

(3) **Skilled Nurse facility expense.** Coverage for facility expenses applies only when the skilled nursing care to be provided is medically necessary as evidenced by a written statement from the attending provider and approved by the managed care vendor. The maximum number of days per benefit period shall be no greater than one hundred [100] days.

(4) **Skilled Nurse care.** Skilled Nurse care that is rendered in the home must be medically necessary as evidenced by a written order and treatment plan from the attending provider and approved by the Health Care Management Unit. Services must be provided by an agency that is Medicare certified as applicable, and accredited by a nationally recognized accreditation organization that is approved by state or federal guidelines, for example, The Joint Commission (formerly JCAHO) or The Commission on Accreditation of Rehabilitation Facilities (CARF). The maximum number of visits per benefit period shall be according to the benefit administration procedures or guidelines as adopted by EGID.

(5) **Dentist's or oral surgeon's services.** Charges made by a duly qualified dentist or oral surgeon for treatment of fractures and dislocations of the jaw, and for cutting procedures and treatment covered under the oral surgery benefit. Dental services by Network providers shall be covered by HealthChoice for oral surgeries and related expenses which are covered medical benefits.

(6) **Oral surgery.** Reimbursement for oral surgeries for removal of exostosis, tumors, or cysts when medically necessary; for surgical correction of prognathism, retrognathism, hyperplasia, temporomandibular joint dysfunction, dysfunctional mandibular disorder. Hospital confinement and related ancillary services [including anesthesia] for dental surgery when the confinement is necessary for illness, severe disability, a minor eight [8] years of age or under, or other health conditions, even though the surgery itself may not be covered.

(7) **Rehabilitative care.** Charges for medical care that are considered primarily rehabilitative will be covered under the Plan. Out-of-hospital care must be prescribed by a provider and must begin within twelve [12] months after the onset of the condition being treated. Inpatient care must be rendered in a facility Medicare certified as applicable, and accredited by a nationally recognized accreditation organization that is approved by state or federal guidelines, for example, The Joint Commission (formerly JCAHO) or The Commission on Accreditation of Rehabilitation Facilities (CARF). Both inpatient and outpatient care must be approved.

(8) **Outpatient expense.** This coverage includes services and supplies provided by the hospital or licensed surgical center, or any center duly licensed for performing certain other surgical procedures, within twenty-four [24] hours following and in connection with a surgical procedure. The limit for outpatient expense incurred for any one surgery is stated in the benefit administration procedures or guidelines as adopted by EGID.

(9) **Hospice care.** Professional services provided by personnel recognized by this Plan as practitioners of the healing arts will be reimbursed according to the benefit administration procedures or guidelines as adopted by EGID. Specific criteria and limitations apply.

(10) **Approval of exceptional claims**

(A) The Health Care Management Unit may recommend exceptions to the benefits provided by the plan 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 the standards of the community, and

(iii) cost effective, and/or

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

**260:50-5-12. 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.

## PART 5. LIFE BENEFITS

**260:50-5-20. Term life coverage**

(a) **Group Term Life Benefits.** A former employee who is reemployed by the same 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. Additionally, the amount of life insurance cannot exceed the amount of the guaranteed issue based on the employee's current salary, unless the individual provides satisfactory evidence of insurability. The amount of coverage provided by the employer is specified in the benefit 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 group 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.

**260:50-5-21. 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.

**260:50-5-22. 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 260:50-7-1.

(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.

### 260:50-5-23. 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 LIFE PLANS

### 260:50-5-24. 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:

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.

(1) 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. DENTAL BENEFITS, LIMITATIONS, AND EXCLUSIONS

### 260:50-5-30. Scope of coverage; four classes 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 group coverage. It is not necessary for dependents to be covered by health benefits to receive the benefits of this Plan. Coverage under this Plan is divided into four classes which are: Class A, Class B, Class C, and Class D.

### 260:50-5-31. 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.

### 260:50-5-32. HealthChoice Dental limitations and exclusions

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

(1) Dental care and supplies for which there are no charges made or no payment would be required if the insured individual did not have coverage.

(2) Charges incurred after the covered individual's benefit ends.

(3) Dental care or supplies which are furnished in a facility operated under the direction of or at the expense of the U.S. Government [or its Agency] or by a provider employed by such a facility.

(4) Dental care or supplies to the extent that they are payable under other provisions of the policy.

(5) Charges for any dental services and supplies which are in excess of the fee schedule and deductible for such services and supplies.

(6) Adult orthodontic without a diagnosis of temporomandibular joint dysfunction.

(7) Cosmetic procedures.

(8) Medical expenses for the treatment of temporomandibular joint dysfunction.

(9) Medical services treating an oral condition.

(10) Dental care or supplies resulting from taking part in committing or attempting to commit an assault or felony.

(11) Dental care or supplies due to sickness or injury covered by Workers' Compensation, occupational disease law or similar laws.

(12) Dental care or supplies as a result of Act of War declared or undeclared, Insurrection, or release of nuclear energy.

(13) Expenses relating to an intentionally self-inflicted injury, except when the injury results from a physical or mental medical condition covered under the health plan.

(14) Charges for treatment of accidental injury to natural teeth or gums.

(15) All other conditions, services, procedures, treatments, expenses, items, and supplies excluded by EGID's benefit guidelines.

(16) Orthodontic benefits are only available to plan participants who have been enrolled in the HealthChoice dental plan for at least one year.

## PART 11. MEDICARE SUPPLEMENT

### 260:50-5-40. 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.

### 260:50-5-41. 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.

### 260:50-5-42. 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.

### 260:50-5-43. Enrollment in Medicare Supplement

(a) **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 260:50-5-41, must be enrolled in a Medicare Supplement Plan, offered through EGID, regardless of age.

(b) **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.

(c) **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.

## PART 13. COORDINATION OF HEALTH AND DENTAL BENEFITS

### 260:50-5-44. Application of retiree benefit allowance

When calculating premium rates for the retired population, EGID shall first apply in whole or in part, benefit allowances funded by the retirement systems to offset costs projected for the pharmacy portion of the health insurance plan. Remaining amounts, if any, will then be applied toward the medical coverage premium.

### 260:50-5-45. Definitions

The following words and terms, when used in this part, shall have the following meaning, unless the context clearly indicates otherwise:

**"Allowable expense"** means any medically necessary item of expense at least a portion of which is covered under at least one of the plans covering the person for whom the claim is made except where a statute requires a different definition. An expense or service, or a portion of an expense or service that is not covered by EGID's medical and or dental plan is not an allowable expense. The maximum liability under EGID's medical and or dental plan as a secondary or subordinate payer is the member's actual liability under any coordinating plan or EGID's standard benefit, whichever is less. However, items of expense under coverage such as, but not limited to dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of allowable expense. A plan which provides benefits only for any such items of expense may limit its definition of allowable expense to like items of expense. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid. The difference between the cost of a private hospital room and the cost of a semi-private hospital room shall not be deemed to be an allowable expense, except for the period of time during which the patient's confinement to a private hospital room is deemed medically necessary in terms of generally accepted medical practice.

**"Plan"** means the following:

(A) "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by:

(i) group, blanket or franchise insurance coverage,

(ii) service plan contracts, group practice, individual practice and other prepayment coverage,

(iii) any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans, and

(iv) any coverage under governmental programs, and any coverage required or provided by any statute.

(B) The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

(C) Individually underwritten and issued contracts which provide a contractual right to renewal regardless of membership in or connection with any particular organization or group shall not be considered group-type contracts, irrespective of the mode or channel of premium payment and regardless of any reduction in premium the covered person may receive by virtue of such method of premium collection.

(D) The definition of a "Plan" within the coordination of benefits provision of group contracts enumerates the types of coverage which the insurer may consider in determining whether other insurance exists with respect to a specific claim. Such definition:

(i) May not include individual or family policies, or individual or family subscriber contracts, except as provided in (ii) of this part and in (E) of this definition.

(ii) May include all group or group subscriber contracts as well as such group-type contracts as are not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition, at the option of the insurer and its policyholder client, whether or not individual policy forms are utilized and whether the group-type coverage is designated as "franchise" or "blanket" or in some other fashion.

(E) The definition of "Plan" may include both group and individual automobile "no fault" contracts but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis may be included.

(F) Interpretation of the definition of a "Plan" may not include group or group-type hospital indemnity benefits (written on a non-expense incurred basis) of thirty dollars [$30] per day or less unless they are characterized as reimbursement type benefits but are designed to administer so as to give the insured the right to elect indemnity type benefits, in lieu of such reimbursement type benefits at the time of the claim. In any event, the amount of group and group-type hospital indemnity benefits which exceed thirty dollars [$30] per day may be construed as being included under the definition of "Plan".

(G) School accident type coverages, written on either an individual, blanket, group or franchise basis should not be taken into consideration in coordination of benefits. In this context, school accident type coverages are defined to mean coverage covering grammar school, middle school, and high school students for accidents only, including athletic injuries, either on a twenty-four [24] hour basis or "to and from school" for which the parent pays the entire premium.

(H) If "Medicare" or similar governmental benefits are included in the definition of "Plan", such benefits may be taken into consideration without expanding any of the definitions of this provision beyond the hospital, medical, and surgical benefits which may be provided by the governmental program.

(I) A plan may not coordinate or design benefits so that the benefits payable are altered solely on the basis that:

(i) another plan exists; or

(ii) except with respect to Part B of Medicare, that the claimant is or could have been covered under another plan; or

(iii) the claimant has elected an option under another plan providing a lower level of benefits than another option for which the claimant was eligible.

(J) With regard to plans offered by EGID 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.

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.

**"This Plan"** means that portion of the benefits that are subject to this part.

**260:50-5-46. Effect on benefits**

(a) **Determining benefits.** This section shall apply in determining the benefits as to a person covered under the plan for any claim determination period if, for the allowable expense incurred as to such person during such period, the sum of:

(1) the benefits that would be payable under this plan in the absence of this provision, and

(2) the benefits that would be payable under all other plans in the absence therein of provisions of similar purpose to this provision would exceed such allowable expenses.

(b) **Claim determination period.** As to any claim determination with respect to which this section is applicable, the benefits that would be payable under this plan in the absence of this provision for the allowable expenses incurred as to such person during such claim determination period shall be reduced to the extent necessary so that the sum of such reduced benefits and all the benefits payable for such allowable expenses under all other plans, except as provided in (c) of this section, shall not exceed the total of such allowable expenses. Benefits payable under another plan include the benefits that would have been payable had claim been duly made therefore.

(c) **Coordination of benefits.** The benefits of another plan will be ignored for the purpose of determining the benefits under this plan if:

(1) the other plan which is involved in (b) of this section and which contains a provision coordinating its benefits with those of this plan would, according to its rules, determine its benefits after the benefits of this plan have been determined, and

(2) the rules are set forth in (d) of this section would require this plan to determine its benefits before such other plan.

(d) **Order of benefit determination.** For the purpose of (c) of this section, the rules establishing the order of benefit determination are:

(1) The benefits of a plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a plan which covers such person as a dependent.

(2) The following guidelines apply with respect to claims regarding dependent children:

(A) Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a plan which covers the person on which expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be

determined before the benefit of a plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either plan does not have the provisions of this paragraph regarding dependents, which results either in each plan determining benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the plan which does not have the provisions of this paragraph shall determine the order of benefits.

(B) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

(C) In the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parents without custody.

(D) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding (B) and (C) of this paragraph, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

(3) When (1) and (2) of this subsection do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time, provided that:

(A) the benefits of a plan covering the person on whose expenses claim is based as a laid-off or retired employee, or dependent of such person, shall be determined after the benefits of any other plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person; and

(B) if either plan does not have a provision regarding laid-off or retired employees, which results in each plan determining its benefits after the other, then the provisions of (A) above shall not apply.

(4) When a claim under a plan with a coordination of benefits provision involves another plan which also has a coordination of benefits provision, the carriers involved should use the rules in (1) through (3) of this subsection to decide the order in which the benefits payable under the respective plans will be determined. Note:

(A) In determining the length of time an individual has been covered under a given Plan, two successive plans of a given group shall be deemed to be one

continuous plan so long as the claimant concerned was eligible for coverage within twenty-four [24] hours after the prior plan terminated. Thus, neither a change in the amount of scope of benefits provided by a plan, a change in the carrier insuring the plan, nor a change from one type of plan to another, (e.g. single employer to multiple employer plan, or vice versa, or single employer to a Taft-Hartley Welfare Plan) would constitute the start of a new plan for purposes of this paragraph.

(B) If a claimant's effective date of coverage under a given plan is subsequent to the date the carrier first contracted to provide the plan for the group concerned (employer, union, association, etc.), then, the absence of specific information to the contrary, the carrier shall assume, for purposes of this paragraph, that the claimant's length of time covered under that plan shall be measured from claimant's effective date of coverage. If a claimant's effective date of coverage under a given plan is the same as the date the carrier first contracted to provide the plan for the group coverage, then the carrier shall request the group concerned to furnish the date the claimant first became covered under the earliest of any prior plans the group may have had. If such date is not readily available, the date the claimant first became a member of the group shall be used as the date from which to determine the length of time his coverage under that plan has been in force.

(5) A plan with order of benefit determination rules which complies with this section (herein called a Complying Plan) may coordinate its benefits with a plan which is "excess" or "always secondary" or which uses order of benefit determination rules which are inconsistent with those contained in this section (herein called a Noncompliance Plan) on the following basis:

(A) If the Complying Plan is the Primary Plan, it shall pay or provide its benefits on a primary basis.

(B) If the Complying Plan is the Secondary Plan, it shall, nevertheless, pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the Complying Plan were the Secondary plan. In such a situation, such payment shall be the limit of the Complying Plan's liability.

(C) If the Noncompliance Plan does not provide the information needed by the Complying Plan to determine its benefits within a reasonable time after it is requested to do so, the Complying Plan shall assume that the benefits of the Noncompliance Plan are identical to its own, and shall pay its benefits accordingly. However, the Complying Plan must adjust any payments it makes based on such assumption whenever information becomes available as to the actual benefits of the Noncompliance Plan.

**260:50-5-47. 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.

### 260:50-5-48. 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:

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

(2) any other insurers; or

(3) service plans or any other organizations.

## PART 15. SUBROGATION

### 260:50-5-49. 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.

## SUBCHAPTER 7. TERMINATION OF BENEFITS

### 260:50-7-1. 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.

## SUBCHAPTER 9. COBRA HEALTH INSURANCE CONTINUATION

### 260:50-9-1. 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.

### 260:50-9-2. 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, unless a beneficiary moves outside an HMO's service area. In that event, coverage is continued under HealthChoice, EGID's self-insured plan.

(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.

## CHAPTER 55. EMPLOYEES GROUP INSURANCE DIVISION - THE DISABILITY PLAN

### 260:55-1-1. Purpose

The rules of this chapter outline the coverage and limitations available under the Disability plan.

### 260:55-1-2. Definitions

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

**"Base compensation"** means the rate of earnings in effect on the date disability begins. Base compensation does not include overtime, commissions, bonuses, longevity pay, salary increases, productivity enhancement program payments and all other extra compensation.

**"Benefit period"** means the first [1st] day of the benefit period will be the day benefits commence as defined at 260:55-1-4(a) and (b). The end of the benefit period will be the last day of eligibility as defined at 260:55-1-11(d). A recurrent disability as defined at 260:55-1-7 will not alter the beginning date of the benefit period.

**"Disability"** means a person is considered to be disabled when he is unable, as a result of injury or illness, to perform the material duties of his own occupation. Disability will be considered to have commenced on the date the employee first receives treatment or advice from a physician after his last date worked and said disability is expected to last thirty-one [31] consecutive calendar days or longer. After the first twenty-four [24] months of disability, disability will be defined as inability to perform each of the material duties of any gainful occupation for which a person is or may become reasonably qualified by training, education or experience. None of the classes of disability used in other plans or programs such as temporary, permanent, total, or partial, etc., are to be used to limit or define this plan's disability criteria, whether or not the terms are used in medical or legal documents supplied as proof of disability under this plan. Uses of such terms are intended to be disregarded by this plan. Determinations rendered by or for workers compensation or social security are not considered prima facie evidence of disability for this plan.

**"EGID"** means the Employees Group Insurance Division of the Office of Management and Enterprise Services.

**"Eligibility period"** means the first thirty-one [31] consecutive calendar days of employment. No benefit is payable for this period. For employees with less than one [1] year of service, proof of continuous presence at the regularly assigned work place and verification by the appointing authority that the employee was performing all of the material duties of the employee's regular occupation continuously during the eligibility period shall be required as conditions of satisfaction of the eligibility period. Employees reinstated to eligibility to participate in the disability plan after having waived disability coverage pursuant to 74 O.S. §1308.3 will be considered to have no prior service and no continuous employment prior to their reinstated eligibility.

**"Elimination period"** means the first thirty [30] consecutive calendar days of disability. No benefit is payable for this period.

**"Employee"** means, for purposes of this chapter only, the term employee includes but is not limited to persons who are currently drawing disability benefits under this Disability Plan or who meet each and every requirement of this Disability Plan.

**"Furlough"** means a nonscheduled working day, in addition to regular nonscheduled working days requested by the employer.

**"Illness"** means sickness or disease, including pregnancy and complications of pregnancy. Disability resulting from the illness must begin while the employee is participating in the Plan.

**"Injury"** means bodily injury resulting directly from an accident, independent of all other causes. The resulting disability must occur while the employee is participating in the Plan.

**"Participation"** means participation in the Disability Plan shall be limited to employees who have been employees for a period of not less than one [1] month prior to the onset of the disability. The employee must have been continuously employed by the employer for a period of not less than one [1] month, and must have satisfied the requirements of the eligibility period as defined herein. For the purposes of this chapter, one [1] month shall mean thirty-one [31] consecutive days.

**"Physician"** means a person licensed to practice medicine and surgery, osteopathy, chiropractic, podiatry, optometry, or dentistry and legally qualified as a medical practitioner under the insurance statutes of the State of Oklahoma, and operating within the scope of his license. An employee or an employee's spouse, child, father, mother, sister, or brother will not be included in this definition.

**"Preexisting condition"** means, for the purposes of this chapter only, an illness or injury for which the employee received medical care, diagnosis, consultation, treatment or took prescribed drugs or medicines during the ninety [90] day period immediately preceding his/her entry-on-duty (EOD) date. The term "preexisting condition" shall also include any condition which is related to such injury or illness.

**"Years of service"** means time spent as an active employee performing full-time duties for remuneration with an entity participating in the Disability Plan. Time on partial disability or leave (with or without pay) after an established disability date will not be counted toward years of service for disability benefit purposes. Time on leave without pay status after an established disability date will also not be counted toward years of service for disability benefit purposes. Under no circumstances will time for which an insured receives disability benefits under this Plan be counted toward years of service.

### 260:55-1-3. Gender reference

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

### 260:55-1-4. Absence on eligibility date

(a) **Eligibility date for disability.** If an employee is absent from work because of a furlough, holiday, vacation or nonscheduled working day and he was on the job or on paid leave other than

for injury, illness, or unpaid leave, on a scheduled working day immediately preceding the eligibility date, the eligibility date for disability benefits will not be altered.

(b) **Release from physician for determination of eligibility.** If an employee is absent from work because of injury or illness on the date he would normally become eligible for disability coverage, he shall not become eligible until he obtains an unconditional release from his physician, and returns to the job for five [5] full-time consecutive work days, performing all of his normal duties.

(c) **Unpaid leave.** If an employee is absent from work because of other unpaid leave, he is not eligible for coverage until he returns to the job for five [5] consecutive work days.

**260:55-1-5. Commencement of disability**

(a) **Short-term disability.** Short-term disability will be considered to have commenced on the date the employee first receives treatments or advice from a physician followed by a continuous absence from work due to disability, in accordance with the criteria under the definitions of 260:55-1-2. Short-term disability ends after the first one hundred eighty [180] days of disability.

(b) **Long-term disability**. Long-term disability commences after one hundred eighty [180] days of disability and coincides with the end of the short-term period.

**260:55-1-6. Multiple disability claims**

In the event of a second eligible disability claim within the period of the first claim:

(1) the second claim must meet the definition of disability, and

(2) even though the second claim has no physical relationship to the first claim, the two will be combined so as to form one continuous disability period.

**260:55-1-7. Recurrent disability**

(a) **Recurrent disability.** A recurrent disability is a disability related to or due to the same cause of a prior disability for which the employee received a monthly benefit:

(1) A recurrent disability is treated as part of the prior disability if:

(A) the employee returns to his regular occupation full-time for less than six [6] months, and

(B) performs all the material duties of his occupation.

(2) If the employee returns to his regular occupation full-time for six [6] months or more, a recurrent disability will be treated as a separate disability.

(b) **Lump sum settlement.** The recurrent disability provisions do not apply in the event of a lump sum settlement payment.

**260:55-1-8. Partial disability**

(a) **Partial disability.** If a person is performing at least one, but not all, of the material duties of any occupation, and is earning less than eighty percent [80%] of pre-disability base compensation, that person is considered to be partially disabled. The partial disability must result from the same cause as the disability. Proof of partial disability must be received within thirty-one [31] days after the end of a period during which disability benefits were paid in order to be eligible for monthly partial disability benefits.

(b) **Payment of benefits for partial disability.** Partial disability benefits are payable, after total disability, for up to twenty-four [24] months, or until recovery, or until maximum benefit limits as set out at 260:55-1-11 are met as defined, or until employee's gross rate of compensation reaches eighty percent [80%] of pre-disability base gross rate of compensation, whichever occurs first. Partial disability benefits are also subject to offsets described at 260:55-1-12.

**260:55-1-9. Preexisting conditions**

(a) **Unavailability of benefits due to preexisting conditions.** No benefits are payable for any disability caused by a preexisting condition.

(b) **Non-applicability of preexisting conditions.** A condition will no longer be considered preexisting after the disabled person has been actively at work at his usual job for five [5] consecutive days following the expiration of:

(1) A one hundred eighty [180] day period following the EOD date during which the employee has not received medical care, diagnosis, consultation or treatment, or taken prescribed drugs or medicines for the preexisting condition, or

(2) A three hundred sixty [360] day period following the EOD date.

**260:55-1-10. Proof of claim**

(a) **Notice**.

(1) Written notice of claim for disability benefits must be given to the disability claims administrator within sixty [60] days after the date disability starts. For good cause shown, EGID's Administrator may waive the sixty [60] day requirement. If that is not possible, EGID must be notified as soon as it is reasonably possible to do so.

(2) No claim may be reopened when request is made more than one [1] year after benefits have ended for any reason.

(b) **Proof**.

(1) Proof of the claim, as specified by EGID, must be given to the third party administrator no later than one [1] year after the start of disability. Proof must cover the severity and extent of the disability and the reasons the employee is unable to perform the duties of his/her position.

(2) The employee must provide proof of continued disability and regular attendance of a physician within thirty [30] days following the request for proof. Regular care of a

physician means appointments with the physician at least once per month. Less frequent appointments may be approved by EGID.

**260:55-1-11. Duration and amounts of benefits**

(a) **Determination of monthly disability benefits.** To determine monthly disability benefits:

(1) Multiply the employee's base compensation by sixty percent [60%], subject to short-term and long-term benefit maximums as established by the Board.

(2) Deduct any benefit offsets.

(3) Monthly benefit will be (1) minus (2), subject to any minimum long-term disability benefit as established by EGID.

(b) **Prorating of benefit for part of a month.** Any benefit that is payable for part of a month will be prorated using the number of days in that month as the denominator and the number of days of disability during that partial month as the numerator.

(c) **Cooperation required.** Continued benefits shall be contingent upon cooperation and participation in the rehabilitation program herein.

(1) In order to remain eligible for long-term benefits, the insured must make application for Social Security benefits by the seventh [7th] month of disability and continue pursuing Social Security benefits until the appeals process is exhausted. Refusal to appeal denial of Social Security benefits through the entire appeals process is grounds for termination of benefits. Exceptions may be granted by EGID in certain cases where application for Social Security benefits is not practical due to the type of disability.

(2) If, after twenty-four [24] months of disability, the Social Security Administration has not deemed the insured eligible for Social Security disability benefits, the insured will no longer be eligible for benefits from this plan.

(3) Exceptions to (c), (1), and (2), above may be granted by EGID on a case-by-case basis.

(d) **Mental health and substance abuse.** Disability claims due to mental health disorders or substance abuse are limited to twenty-four [24] months per disability.

(1) Provided, however, if the employee is confined in a hospital, as defined in 260:50-10-2, of these rules, at the end of the twenty-four [24] month period, benefits will be paid for the length of that confinement. If the employee continues to be totally disabled upon discharge from the hospital, the monthly benefit will be payable for a period not to exceed ninety [90] days. If the insured employee is reconfined during this recovery period for at least fourteen [14] consecutive days, the monthly benefit will resume during that confinement and one additional recovery period not to exceed ninety [90] days.

(2) Provided, also, that each employee shall have a lifetime maximum of no greater than sixty [60] months of disability benefits for all mental or substance abuse disorders;

however, other maximums apply, and in no event shall benefits exceed the maximums listed in 260:55-1-11 of this section.

(e) **Payment of benefits monthly.** Benefits are paid monthly subject to the maximums listed below. These maximums apply to all disabilities, but are subject to (b) and (d) of this section. These maximums are computed from the first [1st] day of disability.

(1) Less than one year of service: 6 month maximum coverage

(2) From one to five years of service:

| | | | |
|---|---|---|---|
| (A) | Under age 66 at disability | - | 24 month maximum coverage |
| (B) | at age 66 at disability | - | 21 month maximum coverage |
| (C) | at age 67 at disability | - | 18 month maximum coverage |
| (D) | at age 68 at disability | - | 15 month maximum coverage |
| (E) | at age 69 or over at disability | - | 12 month maximum coverage |

(3) More than five years of service:

| | | | |
|---|---|---|---|
| (A) | Under age 60 at disability | - | coverage to age 65 |
| (B) | at age 60 at disability | - | 60 month maximum coverage |
| (C) | at age 61 at disability | - | 48 month maximum coverage |
| (D) | at age 62 at disability | - | 42 month maximum coverage |
| (E) | at age 63 at disability | - | 36 month maximum coverage |
| (F) | at age 64 at disability | - | 30 month maximum coverage |
| (G) | at age 65 at disability | - | 24 month maximum coverage |
| (H) | at age 66 at disability | - | 21 month maximum coverage |
| (I) | at age 67 at disability | - | 18 month maximum coverage |
| (J) | at age 68 at disability | - | 15 month maximum coverage |
| (K) | at age 69 or over at disability | - | 12 month maximum coverage |

**260:55-1-12. Benefit offsets**

(a) **Offset by benefits received from other sources.** The disability benefit due from this plan shall be offset by benefits received from other sources. These sources are:

(1) Any sick leave benefits for which the employee is eligible.

(2) Social Security benefits as follows:

(A) Any amount of primary disability benefits provided under the United States Social Security Act for which the employee is eligible because of this disability; and

(B) Any amount of primary and/or family retirement benefits provided under the United States Social Security Act which the employee receives.

(C) The following benefits under the Social Security Act are not to be considered offsets under this program:

(i) Social Security benefits effective prior to the established date of disability, unless awarded as a result of the same disability;

(ii) Social Security widow's/widower's benefits not connected to the claimant's disability; and

(iii) benefits awarded under the Supplemental Security Income Program.

(3) Any benefits received under the provisions of State of Oklahoma or county retirement systems, except those benefits which began prior to onset of disability.

(4) Benefits related to the disability provided by another group plan, including Veteran's Administration (VA) benefits. Such benefit becomes due as a result of the disability and not by a voluntary election to receive the benefit. This does not include:

(A) plans funded entirely by employee contribution;

(B) plans where payment of these benefits reduce the benefit the claimant would be due at a normal retirement age; or

(C) payments for conditions established one [1] year or more, prior to the established date of this disability claim. This does not include a profit-sharing plan, a 401K, a thrift plan, an Individual Retirement Account, stock ownership plan, tax sheltered annuity or any benefits from a non-qualified deferred compensation plan.

(5) Benefits related to this disability that are provided under any state's Worker's or Workman's Compensation Law, any occupational disease law, or any other similar act or law.

(6) Any salary, wages, holiday pay, commissions or similar earnings the employee receives from any gainful employment, including salary increases as well as shared or annual leave payments. Neither longevity pay nor one-time bonuses are considered offsets.

(7) Subrogation (loss of earnings for employee only).

(8) Fifty percent [50%] of any earnings while partially disabled or during rehabilitative employment prior to final release.

(9) Any overpayment of previous disability payments.

(10) Any unemployment compensation benefits.

(b) **Non-reduction of benefits due to increases in other benefits.** Once a disability benefit begins, monthly benefits will not be further reduced due to any statutory or cost of living increases payable from pension or pension disability programs, Social Security or Workers' Compensation.

(c) **Lump sum payments.** If any benefits from the sources mentioned in (a) of this section are paid in a lump sum, EGID will prorate the benefits on a monthly basis, either over the period for which the benefit is established or over the actuarially expected life time of the employee, if no time period is established.

(d) **Payment of any overpayment or underpayment.** Benefits will be estimated if they have not yet been awarded, have not been denied or have been denied and the denial is being appealed. Any overpayment or underpayment that results from estimating these benefits will be repaid by the responsible party after the actual benefit is determined.

**260:55-1-13. Payment of benefits**

(a) **Payment of benefits to employee only.** All benefits due to the employee from the disability plan are payable only to the employee. If the benefit is payable to an employee who is a minor or who is not competent, EGID may only pay the court-appointed guardian or conservator. In the event of the employee's death, payment of any benefits still outstanding shall be made to the designated beneficiary or to the employee's estate.

(b) **Payment of benefits to another party other than the employee.** If EGID pays benefits to a party other than the employee as specified in (a) of this section or as required by law, EGID shall be deemed to have discharged its full responsibility with respect to those benefits.

(c) **Rehabilitation services.** Documented expenses payable for rehabilitation services may be paid directly to the providers of such services or reimbursed to third party administrator; these payments shall not reduce the monthly disability benefits mentioned at 260:55-1-12.

(d) **Benefits are not assignable.** These benefits are not assignable.

**260:55-1-14. Direct deposit and insurance premium deductions**

(a) All disabled employees receiving disability benefit payments from EGID shall be required to receive monthly disability payments via electronic fund transfers to checking or savings account in a bank, credit union or savings and loan designated by the employee. The employee and receiving institution must complete the form prescribed for this purpose by EGID. In the event the electronic fund transfer creates an undue hardship on the employee, the employee may make application to EGID to request a waiver of this requirement. The waiver will be granted only upon good cause shown when it is determined to be in the best interest of the employee. EGID may also waive this requirement when it is necessary in the best interest of EGID to do so.

(b) In addition to all other required deductions, premiums for insurance coverage provided to disabled employees and their dependents as authorized at Title 74 Oklahoma Statutes Section 1332(A) and 1332.1(D) shall be deducted from disability benefit payments made pursuant to this Chapter.

**260:55-1-15. Lump sum settlement**

EGID may authorize a lump sum settlement of a disability claim if mutually agreed upon by the employee and EGID's Administrator. Such agreement shall preclude the employee from receiving any future benefits for the disability for which the lump sum settlement is made.

**260:55-1-16. Examination**

EGID, at its own expense, with travel reimbursement as set out by statute, will have the right and opportunity to have an employee whose injury or sickness is the basis of a disability claim examined by a physician or vocational expert of its choice. This right may be used as often as reasonably required.

**260:55-1-17. Rehabilitation**

(a) **Participation by any person in rehabilitation services.** Any person submitting a claim under the Disability Plan shall be required to cooperate fully with all aspects of the rehabilitation services provided herein as a condition of receiving disability benefits.

(b) **Disabled employee receiving long-term benefits.** A disabled employee who is receiving long-term disability benefits may be able to return to work on a limited basis. To encourage a return to productive employment, EGID will pay the employee his/her regular monthly long-term disability benefit, reduced by only fifty percent [50%] of the income from rehabilitation employment, subject to partial disability provisions as set out at 260:55-1-12(8). If the employee becomes totally disabled again, while receiving partial disability benefits, his/her regular long-term disability benefit will resume without a new eligibility period, except as limited by 260:55-1-7 and 260:55-1-8.

**260:55-1-18. Suspension or termination of benefits**

After notice and opportunity for a hearing according to the Oklahoma Administrative Procedures Act and these rules, disability benefits may be suspended or terminated for failure to:

(1) Fully cooperate with or implement the rehabilitation plan;

(2) Submit to examination by a physician selected by EGID;

(3) Supply recertification by a physician;

(4) Cooperate in the repayment of overpayments; or

(5) Otherwise comply with the requirements of this plan.

**260:55-1-19. Termination of benefits**

(a) **Termination of benefits.** Disability benefits will cease on the occurrence of the earliest of the following events:

(1) The date the disability ends;

(2) The date the employee dies;

(3) The end of the maximum benefit period;

(4) As provided at 260:55-1-17 and 260:55-1-18.

(b) **Participation in the Disability Plan ends when employee's current employment ceases.** An employee's participation will end when current employment ceases. Coverage may be continued in case of layoff or leave of absence as described in the section on eligibility date. EGID will operate the plan according to the provisions outlined so as not to discriminate unfairly among employees.

**260:55-1-20. Termination of coverage**

Employees cease to be insured under the Disability Plan on the earliest of the following dates:

(1) The date the Disability Plan terminates;

(2) The date employment terminates. Cessation of active employment will be deemed termination of employment, except:

(A) The insurance will be continued for a disabled employee during the period during which the employee remains disabled.

(B) EGID may continue the employee's insurance, subject to the following:

(i) Insurance may be continued for the time shown in the policy specifications for an employee on furlough or temporarily laid off; or

(ii) EGID shall act so as not to discriminate unfairly among employees in similar situations.

(3) Waiver of disability coverage pursuant to 74 O.S. §1308.3.

**260:55-1-21. Termination of plan**

Termination of the disability plan under any conditions will not prejudice any payable claim which occurs while this plan is in force.

**260:55-1-22. Retention of other insurance**

(a) **Authorization for deduction of premiums.** If eligible, the employee may elect to continue participation in the Oklahoma Employees Insurance Plan by authorizing deduction of premiums due. In the event the premium is more than the benefits being received by the employee, or in the event the benefits are suspended, EGID may accept remittance from the employee for the premium due. All premiums shall be at the rate and under such conditions as established by EGID.

(b) **Disabled employee not receiving disability benefits.** Dependent Health coverage will be continued for disabled employees during any period of time the employee is qualified as disabled but not receiving disability benefits. [74 O.S. §1332.1(D)]

(c) **Deduction of premiums.** All dependent health premiums due and owing shall be deducted by EGID from the first retroactive disability benefit payment and each payment thereafter. [74 O.S. §1332.1(E)]

**260:55-1-23. Recovery of FICA contributions**

EGID is hereby authorized to recover FICA contributions from the employer, when appropriate.

### 260:55-1-24. Insurance/Benefits Coordinator

Any entity participating in the Disability Plan shall appoint an Insurance/Benefits Coordinator to explain the benefits to the employee and aid the claimant in providing the necessary information for claims to be processed.

### 260:55-1-25. Exclusions

Benefits will not be provided for any disability that is caused by:

(1) war or any act of war, whether such war is declared or undeclared;

(2) intentionally self-inflicted injuries of any kind while sane or insane;

(3) injuries sustained by or during the commission or attempted commission of an assault or felony; or

(4) active participation in a riot.

### 260:55-1-26. Penal institution

No benefits are payable for that portion of any period of disability when the disabled person is confined in a penal or correctional institution for conviction of a criminal or other public offense.

### 260:55-1-27. Rules, cumulative

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. This chapter shall not be deemed cumulative and supplemental but shall replace all previously promulgated rules of this agency.

### 260:55-1-28. 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.