

**TITLE 360. OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP  
INSURANCE BOARD**

**CHAPTER 10. STATE AND EDUCATION EMPLOYEES HEALTH,  
DENTAL, VISION AND LIFE PLANS**

**SUBCHAPTER 3. ADMINISTRATION OF PLANS**

**360:10-3-13. 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 OSEEGIB 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 OSEEGIB, 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, OSEEGIB, 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 OSEEGIB'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.

**360:10-3-24. 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 verifiable group health, 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 group 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.

(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.

(2)(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 [1<sup>st</sup>] day of the month following the date the optional coverage was selected.

(3)(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.

(4)(8) Eligible dependents who lose other group health, dental or vision insurance coverage may be added to the equivalent health, dental or vision coverage offered through OSEEGIB within thirty [30] days after the loss of other group insurance coverage without penalty for orthodontia if those dependents have been continuously covered by other group dental 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 and the application of the orthodontia limitations, coverage under this Plan shall become effective on the first [1<sup>st</sup>] 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 [1<sup>st</sup>] day of the month following notice of the loss of other coverage, and any break in coverage will result in the application of the orthodontia limitations.

(5)(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 OSEEGIB. Documentation proving the qualifying event may be required. The effective date of coverage will be the first [1<sup>st</sup>] day of the month following notification to OSEEGIB of the qualified event except for newborn or adopted dependent children.

(6)(10) Provided all other eligibility requirements are satisfied, ~~newly born or~~ 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 [1<sup>st</sup>] 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 OSEEGIB within thirty [30] days after

obtaining physical custody. Copies of all documents relating to the matter are also required.

~~(7)~~(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 OSEEGIB.

~~(8)~~(12) In the absence of a court order indicating adoption, guardianship, legal separation or divorce, an insured may apply for coverage on other unmarried minor 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 [1<sup>st</sup>] day of the month following approval, and will never apply retroactively; and (4) all other applicable eligibility requirements must be satisfied; and (5) all necessary premiums have been paid. OSEEGIB 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.

#### **360:10-3-25. 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 orthodontia 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 group health, dental, vision and/or life insurance coverage and is seeking reinstatement pursuant to Rule ~~360:10-3-24(4)~~360:10-3-24(8).

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

#### **360:10-3-29.1. 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 OSEEGIB reserves the right to decide which form of single enrollment coverage to allow, whether primary or dependent.

### **SUBCHAPTER 5. COVERAGE AND LIMITATIONS PART 3. THE PLANS**

#### **360:10-5-16. 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) **Out-of-pocket expenses.** Per person and family calendar year out-of-pocket expenses are limited under HealthChoice to the percentage based coinsurance only. Copayments which have been established at specific dollar amounts will continue to apply after the out-of-pocket percentage based coinsurance has been met. Out-of-pocket expenses owed by members as a result of non-confined emergency room visits and non-Network inpatient hospital confinements are not considered to be deductibles. These out-of-pocket expenses are copays that are not considered when calculating a member's out-of-pocket maximum accumulations.

(d) **Network out-of-pocket maximum.** When the member or dependent exceeds the specified out-of-pocket calendar year maximum OSEEGIB 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.

(e) **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 costs for treatment which have not been paid by HealthChoice. In most cases, this leaves the member responsible for paying a substantial out-of-pocket fee for treatment by the non-Network provider.

(f) **Lifetime maximum benefit.** There is a lifetime maximum benefit that will be paid by the Plan for a member or dependent, with regard to pharmacy benefits.

(g) **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 OSEEGIB 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.

## PART 11. MEDICARE SUPPLEMENT

### 360:10-5-79. 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 360:10-5-76, must be enrolled in a Medicare Supplement Plan, offered through OSEEGIB, regardless of age.

(b) **Effective date of Medicare Supplement coverage.** Medicare Supplement coverage shall become effective on the first [1<sup>st</sup>] day of the month following the date OSEEGIB 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 OSEEGIB. 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 OSEEGIB within thirty [30] days after the member's notification of the Social Security Administration award. A member's sixty-fifth [65<sup>th</sup>] 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 OSEEGIB's regular health plan; however, individuals eligible to purchase Medicare coverage are excluded.

**TITLE 360. OKLAHOMA STATE AND EDUCATION EMPLOYEES GROUP  
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**CHAPTER 15. THE DISABILITY PLAN**

**360:15-1-2. 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 [1<sup>st</sup>] day of the benefit period will be the day benefits commence as defined at 360:15-1-4(a) and (b). The end of the benefit period will be the last day of eligibility as defined at 360:15-1-11(d). A recurrent disability as defined at 360:15-1-7 will not alter the beginning date of the benefit period.

**"The Board"** means the eight [8] members designated by statute [74 O.S. §1303(1)].

**"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.

**"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.

"**OSEEGIB**" means the Oklahoma State and Education Employees Group Insurance Board.

"**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.

### **360:15-1-20. 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) OSEEGIB 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) OSEEGIB 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.