TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA~~/OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE~~
SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-1. Purpose and general program provisions

The purpose of this ~~Chapter~~ chapter is to provide rules, in compliance with all applicable federal and state regulations, for the Insure Oklahoma~~/Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC)~~ program that establishes access to affordable health coverage for low-income working adults, ~~their spouses~~ their dependents, and qualified college students. ~~The Oklahoma Health Care Authority (OHCA) contracts with a Third Party Administrator (TPA) for administration of the program.~~

317:45-1-2. Program limitations

(a) The Insure Oklahoma~~/O-EPIC~~ program is contingent upon sufficient funding that is collected and dispersed through a revolving fund within the State Treasury designated as the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund". This fund is a continuing fund, not subject to fiscal year limitations.

(1) All monies accruing to the credit of the fund are budgeted and expended by the OHCA to implement the program.

(2) The program is funded through a portion of monthly proceeds from the Tobacco Tax, ~~O.S.S.~~ Okla. Stat. '68-302-5 et seq., collected and dispersed through the HEEIA revolving fund, pursuant to Title 68, Section 302-5 (B.1. and D.1.) and Section 402-3 (B.1 and C.1.) of the Oklahoma Statutes.

(3) The program is limited in scope such that available funding is not exceeded. Available funding includes the estimated annual deposits from tax collections, accrued interest, federal matching funds and any other revenue source deposited in the HEEIA Revolving Fund for the purpose of this program. If at any time it becomes apparent there is risk the available funding may be exceeded, OHCA must take action to ensure the Insure Oklahoma~~/O-EPIC~~ program continues to operate within its fiscal capacity.

(A) Insure Oklahoma~~/O-EPIC~~ may limit eligibility based on:

(i) the federally-approved ~~capacity of the Insure Oklahoma/O-EPIC services for the~~ Health Insurance Flexibility and Accountability (HIFA) Waiver/1115 Waiver; ~~and~~

(ii) Tobacco Tax collections~~.~~; and

(iii) the State Child Health Plan for the State Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

(B) The Insure Oklahoma~~/O-EPIC~~ program may limit eligibility when the utilization of services is projected to exceed the spending authority, or, may suspend new eligibility determinations instead, establishing a waiting list.

(i) Applicants, not previously enrolled and participating in the program, submitting new applications for the Insure Oklahoma~~/O-EPIC~~ program are placed on a waiting list. ~~These applications are date and time stamped when received by the TPA.~~ Applications, with the exception of college students, are identified by region and Insure Oklahoma~~/O-EPIC~~ program. Regions are established based on population density statistics as determined through local and national data and may be periodically adjusted to assure statewide availability. Insure Oklahoma~~/O-EPIC~~ program size is determined by OHCA and may be periodically adjusted.

(ii) The waiting list utilizes a "first in - first out" method of selecting eligible applicants by region and program.

(iii) When an applicant is determined eligible and moves from the waiting list to active participation, the applicant must submit a new application.

(iv) Enrolled applicants who are currently participating in the program are not subject to the waiting list.

(v) For approved employers, if the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate during the employer's current eligibility period.

(vi) For approved employers, if the employer has an employee who has a ~~Qualifying Event~~ qualifying event after the employer's program eligibility begins, the employee is allowed to make changes pertaining to the ~~Qualifying Event~~ qualifying event.

(b) College ~~students=~~ student eligibility and participation in the Insure Oklahoma~~/O-EPIC~~ program is contingent upon sufficient funding from the Oklahoma legislature. This funding is separate from the funding described in subsection (a) of this ~~Section~~ section.

317:45-1-3. Definitions

The following words or terms, when used in this ~~Chapter~~ chapter, will have the following meanings unless the context clearly indicates otherwise:

"Carrier" means:

(A) an insurance company, insurance service, insurance organization, or group health service, which is licensed to engage in the business of insurance in the State of Oklahoma and is subject to State law which regulates insurance, or Health Maintenance Organization (HMO) which provides or arranges for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both and is subject to State law which regulates Health Maintenance Organizations (HMOs);

(B) a Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department;

(C) a domestic MEWA exempt from licensing pursuant to Title 36 O.S., Section 634(B) that otherwise meets or exceeds all of the licensing and financial requirements of MEWAs as set out in Article 6A of Title 36; or

(D) any entity organized pursuant to the Interlocal Cooperation Act, Section 1001 et seq. of Title 74 of the Oklahoma Statutes as authorized by Title 36 Section 607.1 of the Oklahoma Statutes and which is eligible to qualify for and hold a certificate of authority to transact insurance in this State and annually submits on or before March 1st a financial statement to the Oklahoma Insurance Department in a form acceptable to the Insurance Commissioner covering the period ending December 31st of the immediately preceding fiscal year.

"Child Care Center" means a facility licensed by OKDHS which provides care and supervision of children and meets all the requirements in OAC 340:110-3-1 through OAC 340:110-3-33.3.

"College Student" means an Oklahoma resident between the age of 19 through 22 that is a full-time student at an Oklahoma accredited University or College.

"Dependent" means the spouse of the approved applicant and/or child under 19 years of age or his or her child 19 years through 22 years of age who is attending an Oklahoma qualified institution of higher education and relying upon the insured employee or member for financial support.

"Eligibility period" means the period of eligibility extending from an approval date to an end date.

"Employee" means a person who works for an employer in exchange for earned income. This includes the owners of a business.

"Employer" means the business entity that pays earned income to employees.

"Employer Sponsored Insurance" means the program that provides premium assistance to qualified businesses for approved applicants.

"EOB" means an Explanation of Benefits.

"Explanation of Benefit" means a statement issued by a carrier that indicates services rendered and financial responsibilities for the carrier and Insure Oklahoma~~/O-EPIC~~ member.

"Full-time Employment" means a normal work week of 24 or more hours.

"Full-time Employer" means the employer who employs an employee for 24 hours or more per week to perform work in exchange for wages or salary.

"Gross Household Income" or "Annual Gross Household Income" means the countable income (earned or unearned) that is computed pursuant to OHCA's waiver and/or state plan using rules found in OAC 317:35.

"Individual Plan" means the safety net program for those qualified individuals who do not have access to Insure Oklahoma~~/O-EPIC~~ ESI.

"Insure Oklahoma~~/O-EPIC~~" means a health plan purchasing strategy in which the State uses public funds to pay for a portion of the costs of health plan coverage for eligible populations.

"Insure Oklahoma~~/O-EPIC~~ IP" means the Individual Plan program.

"Insure Oklahoma~~/O-EPIC~~ ESI" means the Employer Sponsored Insurance program.

"Member" means an individual enrolled in the Insure Oklahoma~~/O-EPIC~~ ESI or IP program.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"PCP" means Primary Care Provider.

"PEO" or "Professional Employer Organization" means any person engaged in the business of providing professional employer services. A person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma Professional Employer Organization Recognition and Registration Act as provided in Title 40, Chapter 16 of Oklahoma Statutes, Section 600.1 et.seq.

"Primary Care Provider" means a provider under contract ~~to~~ with the Oklahoma Health Care Authority to provide primary care services, including all ~~medically-necessary~~ medically necessary referrals.

"Premium" means a monthly payment to a carrier for health plan coverage.

~~**"QHP"** means Qualified Health Plan.~~

"Qualified Health Plan" means a health plan that has been approved by the OHCA for participation in the Insure Oklahoma~~/O-EPIC~~ program.

"Qualifying Event" means the occurrence of an event that permits individuals to join a group health plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying events are defined by the employer's health plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"State" means the State of Oklahoma, acting by and through the Oklahoma Health Care Authority ~~or its designee~~.

~~**"TPA"** means the Third Party Administrator.~~

~~**"Third Party Administrator"** means the entity contracted by the State to provide the administration of the Insure Oklahoma/Oklahoma Employer and Employee Partnership for Insurance Coverage program.~~

317:45-1-4. Reimbursement for out-of-pocket medical expenses

(a) ~~Members are responsible for all out-of-pocket expenses. Out-of-pocket expenses for services covered by the health plan, as defined by the health plan's benefit summary and policies, that exceed five percent of the employee's gross annual household income during the current eligibility period may be reimbursable.~~ Out-of-pocket medical expenses for all approved and eligible members (and/or their approved and eligible dependents) will be limited to 5 percent of their annual gross household income. The OHCA will provide reimbursement for out-of-pocket medical expenses in excess of the 5 percent annual gross household income. A medical expense must be for an allowed and covered service by a qualified health plan to be eligible for reimbursement. For the purpose of this section, an allowed and covered service is defined as an in-network service covered in accordance with a qualified health plan's benefit summary and policies.

(b) ~~The member must submit a reimbursement claim form with appropriate documentation to the TPA. Information may be submitted at any time but no later than 90 days after the close of their eligibility period to be considered for reimbursement. Appropriate supporting documentation includes an original EOB or paid receipt if no EOB is issued. Both EOB and paid receipts must include required information listed in OAC 317:45-5-1(c)(1)-(6). Reimbursement for out-of-pocket medical expenses is made for the amount indicated as the member's responsibility~~

~~on the EOB or receipt reflecting the amount paid for medical expenses. Appropriate supporting documentation for prescribed prescriptions must be an original receipt and include information about the pharmacy at which the drug was purchased, the name of the drug dispensed, the quantity dispensed, the prescription number, the name of the person the drug is for, the date the drug was dispensed and the total amount paid.~~ For all eligible medical expenses as defined above in OAC 317:45-1-4(a), the member must submit the OHCA required form and all OHCA required documentation to support that the member incurred and paid the out-of-pocket medical expense. The required documentation must be submitted no later than 90 days after the close of the member's eligibility period. The OHCA required documentation must substantiate that the member actually incurred and paid the eligible out-of-pocket expense. The OHCA may request additional documentation at any time to support a member's request for reimbursement of eligible out-of-pocket medical expenses.

~~(c) Reimbursement for qualified medical expenses is subject to a fixed cap amount. The fixed cap for reimbursement is established annually and is calculated using local and national data concerning individual out-of-pocket health care expenses. The objective of the fixed cap is to set the amount high enough such that, in the great majority of households, all of the costs above the five percent threshold would be absorbed.~~

SUBCHAPTER 3. INSURE OKLAHOMA~~/O-EPIC~~ CARRIERS

317:45-3-1. Carrier eligibility

Carriers must be able to submit all required and requested information and documentation to OHCA for each health plan to be considered for qualification. Carriers must be able to supply specific claim payment scenarios as requested by OHCA. Carriers must also provide the name, address, telephone number, and, if available, email address of a contact individual who is able to verify employer enrollment status in a ~~QHP~~ qualified health plan.

317:45-3-2. Audits

Carriers are subject to audits related to health plan qualifications. These audits may be conducted periodically to determine if ~~QHPs continue~~ each qualified health plan continues to meet all requirements as defined in OAC 317:45-5-1.

SUBCHAPTER 5. INSURE OKLAHOMA~~/O-EPIC~~ QUALIFIED HEALTH PLANS

317:45-5-1. Qualified Health Plan requirements

(a) Participating ~~QHPs~~ qualified health plans must offer, at a minimum, benefits that include:

(1) hospital services;

(2) physician services;

(3) clinical laboratory and radiology;

(4) pharmacy; ~~and~~

(5) office visits~~.~~;

(6) well baby/well child exams;

(7) age appropriate immunizations as required by law; and

(8) emergency services as required by law.

(b) The health plan, if required, must be approved by the Oklahoma Insurance Department for participation in the Oklahoma market. All health plans must share in the cost of covered services and pharmacy products in addition to any negotiated discounts with network providers, pharmacies, or pharmaceutical manufacturers. If the health plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits described in this subsection.

(1) An annual in-network out-of-pocket maximum cannot exceed ~~an amount that is established by OHCA. This amount includes any non-pharmacy, annual deductible amount for in-network services~~ $3,000 per individual, excluding pharmacy deductibles.

(2) Office visits cannot require a co-payment exceeding $50 per visit.

(3) Annual in-network pharmacy deductibles cannot exceed $500 per individual.

(c) ~~QHPs may~~ Qualified health plans will provide an EOB, an expense summary, or required documentation for paid ~~or~~ and/or denied claims subject to member co-insurance or member deductible calculations. ~~If an EOB is provided it~~ The required documentation must contain, at a minimum, the:

(1) provider's name;

(2) patient's name;

(3) date(s) of service;

(4) code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);

(5) reason code(s) and description(s) for any denied service(s); and

(6) amount due and/or paid from the patient or responsible party.

317:45-5-2. Closure criteria for health plans

Eligibility for the carrier's health plans ends when:

(1) changes are made to the design or benefits of the ~~QHP~~ health plan such that it no longer meets the requirements ~~for~~

~~QHPs~~ to be considered a qualified health plan. Carriers are required to report to OHCA any changes in health plans potentially affecting ~~its~~ their qualification for participation in the program not less than 90 days prior to the effective date of such change(s).

(2) the carrier no longer meets the definition set forth in OAC 317:45-1-3.

(3) the health plan is no longer an available product in the Oklahoma market.

(4) the health plan fails to meet or comply with all requirements for a ~~QHP~~ qualified health plan as defined in OAC 317:45-5-1.

SUBCHAPTER 7. INSURE OKLAHOMA~~/O-EPIC~~ ESI EMPLOYER ELIGIBILITY

317:45-7-1. Employer application and eligibility requirements for Insure Oklahoma~~/O-EPIC~~ ESI

(a) In order for an employer to be eligible to participate in the Insure Oklahoma~~/O-EPIC~~ program the employer must:

(1) have no more than a total of 250 employees on its payroll. The increase in the number of employees from 50 to 250 will be phased in over a period of time as determined by the Oklahoma Health Care Authority. The number of employees is determined based on the third month employee count of the most recently filed OES-3 form with the Oklahoma Employment Security Commission (OESC) ~~and that is in compliance with all requirements of the OESC~~. Employers may provide additional documentation confirming terminated employees that will be excluded from the OESC employee count. If the employer is exempt from filing an OES-3 form or is contracted with a PEO or is a Child Care Center, in accordance with OHCA rules, this determination is based on appropriate supporting documentation, such as the W-2 Summary Wage and Tax form to verify employee count. Employers must be in compliance with all OESC requirements to be eligible for the program. As requested by the OHCA, employers that do not file with the OESC must submit documentation that proves compliance with state law;

(2) have a business that is physically located in Oklahoma;

(3) be currently offering, or at the contracting stage to offer a ~~QHP~~ qualified health plan. The ~~QHP~~ qualified health plan coverage must begin on the first day of the month and continue through the last day of the month;

(4) offer ~~QHP~~ qualified health plan coverage to employees; and

(5) contribute a minimum 25 percent of the eligible employee monthly health plan premium or an equivalent 40 percent of premiums for covered dependent children~~;~~.

(b) An employer who meets all of the requirements listed ~~in subsection (a) of this Section must complete and submit an employer enrollment packet to the TPA~~ in OAC 317:45-7-1(a) must complete and submit the OHCA required forms and application to be considered for participation in the program.

(c) The employer must provide its Federal Employee Identification Number (FEIN).

(d) ~~The employer must notify the TPA, within 5 working days from occurrence, of any Insure Oklahoma/O-EPIC employee's termination or resignation.~~ It is the employer's responsibility to notify the OHCA of any changes that might impact eligibility in the program. Employers must notify the OHCA of any participating employee terminations, resignations, or new hires within 5 working days of the occurrence.

317:45-7-2. Employer eligibility determination

Eligibility for employers is determined ~~by the TPA~~ using the eligibility requirements listed in OAC 317:45-7-1. An employer determined eligible for Insure Oklahoma~~/O-EPIC~~ is approved for up to a 12 month period. The eligibility period begins on the first day of the month following the date of approval. The eligibility period ends the last day of the 12th month. The eligibility period will renew automatically unless the employer's eligibility has been closed (refer to OAC 317:45-7-8). ~~The TPA notifies the employer of the eligibility decision for employer and employees.~~ Employers will be notified of their eligibility decision.

317:45-7-3. Employer cost sharing

Employers are responsible for a portion of the eligible employee's monthly health plan premium as defined in OAC 317:45-7-1. ~~Employers are not required to contribute to an eligible dependent's coverage.~~

317:45-7-4. Qualifying Event

Employers must allow an employee to enroll or change coverage following a ~~Qualifying Event~~ qualifying event. The employer ~~files form OEPIC-4, Small Business Employer Change Form, with the TPA for that~~ must submit the required form for each employee experiencing the ~~Qualifying Event~~ qualifying event.

317:45-7-5. Reimbursement

In order to receive a premium subsidy, the employer must submit all pages of the current health plan invoice ~~or other approved documentation to the TPA~~.

317:45-7-6. Credits and adjustments

When an overpayment ~~has occurred~~ occurs, the employer must immediately ~~refund~~ report the erroneous payment. ~~TPA, by check, to the attention of the Finance Division. The TPA system has the capability of automatic credits and debits. When an erroneous payment occurs, that results in an overpayment, an automatic recoupment is made to the employer's account against monies owed to the employer on behalf of their employee(s).~~ When such an overpayment(s) occurs, an automatic recoupment is made to the employer's account against future reimbursements.

317:45-7-7. Audits

Employers are subject to audits related to program eligibility ~~status~~ requirements found at OAC 317:45-7-1 and subsidy payments. Eligibility may be revoked at any time if inconsistencies are found. Any monies paid in error are subject to recoupment.

317:45-7-8. Closure

Eligibility provided under the Insure Oklahoma~~/O-EPIC~~ ESI program may end during the eligibility period when:

(1) the employer no longer meets the eligibility requirements in OAC 317:45-7-1;

(2) the employer fails to pay premiums to the carrier;

(3) the employer fails to provide an invoice verifying the monthly health plan premium has been paid; or

(4) an audit indicates a discrepancy that makes the employer ineligible.

SUBCHAPTER 9. INSURE OKLAHOMA~~/O-EPIC~~ ESI EMPLOYEE ELIGIBILITY

317:45-9-1. Employee eligibility requirements

(a) ~~Employee applications are submitted to the TPA~~ Employees must complete and submit the OHCA required forms and application to be considered for participation in the program.

(b) The eligibility determination ~~is~~ will be processed within 30 days from the date the application is received ~~by the TPA~~. The employee ~~is~~ will be notified in writing of the eligibility decision.

(c) All eligible employees described in this ~~Section are enrolled in their Employer's QHP~~ section must be enrolled in their employer's qualified health plan. Eligible employees must:

(1) have ~~a countable~~ an annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level (FPL). The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member;
(2) be a US citizen or alien as described in OAC 317:35-5-25;
(3) be Oklahoma residents;
(4) provide social security number for all household members;
(5) not be receiving benefits from ~~SoonerCare/Medicare~~ SoonerCare or Medicare;
(6) be employed with a qualified employer at a business location in Oklahoma;
(7) be age 19 through age 64 or an emancipated minor;
(8) be eligible for enrollment in the employer's ~~QHP~~ qualified health plan;
(9) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and
(10) select one of the ~~QHPs~~ qualified health plans the employer is offering.

(d) An employee's dependents are eligible when:
(1) the employer's health plan includes coverage for dependents;
(2) the employee is eligible;
(3) if employed, the spouse may not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and
(4) the dependents are enrolled in the same health plan as the employee.

(e) If an employee or their dependents are eligible for multiple ~~QHPs~~ qualified health plans, each may receive a subsidy under only one health plan.

(f) Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA).

(g) Dependent children in families whose annual gross household income is from 185 up to and including 300 percent of the Federal Poverty Level may be eligible. The inclusion of children into the Insure Oklahoma program will be phased in over

a period of time as determined by the OHCA. No other deductions or disregards apply.

(1) Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.

(2) Children are not eligible for Insure Oklahoma if they are a member of a family eligible for employer-sponsored dependent health insurance coverage under any Oklahoma State Employee Health Insurance Plan.

(3) Children who already have coverage through another source must undergo, or be excepted from, a 6 month uninsured waiting period prior to becoming eligible for Insure Oklahoma. Exceptions to the waiting period may include:

(A) the cost of covering the family under the ESI plan meets or exceeds 10 percent of the annual gross household income. The cost of coverage includes premiums, deductibles, co-insurance, and co-payments;

(B) loss of employment by a parent which made coverage available;

(C) affordable ESI is not available; "Affordable" coverage is defined by the OHCA annually using actuarially sound rates established by the Oklahoma State and Education Employee Group Insurance Board (OSEEGIB); or

(D) loss of medical benefits under SoonerCare.

317:45-9-2. Employee eligibility period

(a) Employee eligibility is contingent upon the employer's program eligibility.

(b) The employee's eligibility is determined ~~by the TPA~~ using the eligibility requirements listed in OAC 317:45-9-1.

(c) If the employee is determined eligible, he/she is approved for a period not greater than 12 months. ~~The length of the eligibility period is based on the remaining number of months the employer has left in its eligibility period.~~

(d) The employee's eligibility period begins on the first day of the month following the date of approval.

317:45-9-3. Qualifying Event

~~(a) Employees are allowed to apply following a Qualifying Event.~~

~~(b) An employee's dependents may become eligible for coverage and are allowed to apply following a Qualifying Event.~~ Employees and/or an employee's dependents may apply for the ESI program following a qualifying event.

317:45-9-4. Employee cost sharing

Employees are responsible for up to ~~15%~~ 15 percent of their health plan premium. The employees are also responsible for up to ~~15%~~ 15 percent of their dependent's health plan premium if

the dependent is included in the program. The combined portion of the employee's cost sharing for health plan premiums cannot exceed ~~three~~ 3 percent of his/her annual gross ~~annual~~ household income computed monthly.

317:45-9-6. Audits

Individuals participating in the Insure Oklahoma~~/O-EPIC~~ program are subject to audits related to their eligibility, subsidy payments, and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.

317:45-9-7. Closure

(a) Employer and employee eligibility are tied together. If the employer is no longer eligible, then the associated employees enrolled under that employer are also ineligible. Employees are mailed a notice 10 days prior to closure of eligibility.

(b) The employee's certification period may be terminated when:

(1) termination of employment, either voluntary or involuntary, occurs;

(2) the employee moves out-of-state;

(3) the covered employee dies;

(4) the employer ends its contract with the ~~QHP~~ qualified health plan;

(5) the employer's eligibility ends;

(6) an audit indicates a discrepancy that makes the employee or employer ineligible;

(7) the employer is terminated from the program;

(8) the employer fails to pay the premium;

(9) the ~~QHP~~ qualified health plan or carrier ~~is no longer qualified~~ no longer meets the requirements set forth in this chapter;

(10) the employee becomes eligible for ~~Medicaid/Medicare~~ SoonerCare or Medicare;

(11) the employee or employer reports ~~to the OHCA or the TPA~~ any change affecting eligibility;

(12) the employee is no longer listed as a covered person on the employer's health plan invoice; or

(13) the employee requests closure.

317:45-9-8. Appeals

(a) Employee appeal procedures based on denial of eligibility due to income are described at OAC 317:2-1-2.

(b) ~~Employee appeals regarding out-of-pocket expenses are made to the TPA. If the employee disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final~~ Employee appeals regarding out-of-

pocket medical expense reimbursements may be made to the OHCA. The OHCA may request documentation to support the out-of-pocket appeal. The decision of the OHCA is final.

SUBCHAPTER 11. INSURE OKLAHOMA~~/O-EPIC~~ IP
PART 1. INDIVIDUAL PLAN PROVIDERS

317:45-11-1. Insure Oklahoma~~/O-EPIC~~ Individual Plan providers

Insure Oklahoma~~/O-EPIC~~ Individual Plan (IP) providers must comply with existing SoonerCare rules found at OAC 317:25 and OAC 317:30. In order to receive reimbursement, the IP provider:

(1) must enter into a SoonerCare contract; and

(2) must complete Insure Oklahoma~~/O-EPIC~~ IP addendum if provider wants to provide primary care services as a PCP.

317:45-11-2. Insure Oklahoma~~/O-EPIC~~ IP provider payments

Payment for covered benefits rendered to Insure Oklahoma~~/O-EPIC~~ IP members~~, as shown in OAC 317:45-11-10 and not listed as a non-covered service in OAC 317:45-11-11,~~ is made to contracted Insure Oklahoma~~/O-EPIC~~ IP healthcare providers for medical and surgical services within the scope of OHCA's medical programs, provided the services are medically necessary as defined in OAC 317:30-3-1(f).

(1) Coverage of certain services requires prior authorization ~~as shown in OAC 317:45-11-10~~ and may be based on a determination made by a medical consultant in individual circumstances;

(2) The decision to charge a ~~copayment~~ co-payment for a missed visit is at the provider's discretion;

(3) The provider may collect the member's ~~co-pay~~ co-payment in addition to the SoonerCare reimbursement for services provided; and

(4) The provider may refuse to see members based on their inability to pay their ~~co-pay~~ co-payment.

PART 3. INSURE OKLAHOMA~~/O-EPIC~~ IP MEMBER HEALTH CARE BENEFITS

317:45-11-10. Insure Oklahoma~~/O-EPIC~~ IP adult benefits

(a) All IP adult benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this ~~Section~~ section. The scope of IP adult benefits described in this ~~Section are~~ section is subject to specific non-covered services listed in OAC 317:45-11-11.

(b) A PCP referral is required to see any other provider with the exception of the following services:

(1) behavioral health services;

(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;
(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;
(4) women's routine and preventive health care services;
(5) emergency medical condition as defined in OAC 317:30-3-1; and
(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

(c) IP covered adult benefits for in-network services, limits, and applicable co-payments are listed in this subsection. In addition to the benefit-specific limits, there is a maximum lifetime benefit of $1,000,000. Dependent children coverage is found at OAC 317:45-11-12. Children are not held to the maximum lifetime benefit. Coverage includes:

(1) Anesthesia / Anesthesiologist Standby. Covered in accordance with OAC 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA).
(2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.
(3) Chelation Therapy. Covered for heavy metal poisoning only.
(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with OAC 317:30-5-22(b)(2). PCP referral is required. Standard radiology (X-ray or Ultrasound): $0 co-pay. Specialized scanning and imaging (MRI, MRA, PET, or CAT Scan); $25 co-pay per scan.
(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a $30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.
(6) Inpatient Hospital Benefits. Covered in accordance with OAC 317:30-5-41, 317:30-5-47 and 317:30-5-95; $50 co-pay per admission.
(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year with a $10 co-pay. This visit counts as an office visit.
(8) Office Visits/Specialist Visits. Covered in accordance with OAC 317:30-5-9, 317:30-5-10, and 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits; $10 co-pay per visit.

(9) Outpatient Hospital/Facility Services.

(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures; $25 co-pay per visit.

(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections; $10 co-pay per visit.

(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year; $10 co-pay per visit.

(10) Maternity (Obstetric). Covered in accordance with OAC 317:30-5-22. Nursery care paid separately under eligible child; $50 inpatient hospital co-pay.

(11) Laboratory/Pathology. Covered in accordance with OAC 317:30-5-20; $0 co-pay.

(12) Mammogram (Radiological or Digital). Covered in accordance with OAC 317:30-5-901; $0 co-pay.

(13) Immunizations. Covered in accordance with OAC 317:30-5-2.

(14) Assistant Surgeon. Covered in accordance with OAC 317:30-5-8.

(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility; $0 co-pay.

(16) Oral Surgery. Services are limited to the removal of tumors or cysts; Inpatient Hospital $50 or Outpatient Hospital/Facility; $25 co-pay applies.

(17) Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with OAC 317:30-5-95.1; $50 co-pay per admission.

(18) Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient).

(A) Agency services. Covered in accordance with OAC 317:30-5-241; $10 co-pay per visit.

(B) Individual provider services. Licensed Behavioral Health Professionals (LBHPs) are defined as follows for the purpose of Outpatient ~~Mental~~ Behavioral Health Services and Outpatient Substance Abuse Treatment:

(i) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(ii) Practitioners with a license to practice in the state in which services are provided or those actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (I) through (VI) below. The exemptions from licensure under ~~59 §1353(4) and (5)~~ 59 Okla. Stat. §1353(4) and (5), 59 §1903(C) and (D), 59 §1925.3(B) and (C), and 59 §1932(C) and (D) do not apply to Outpatient Behavioral Health Services.

(I) Psychology,
(II) Social Work (clinical specialty only),
(III) Professional Counselor,
(IV) Marriage and Family Therapist,
(V) Behavioral Practitioner, or
(VI) Alcohol and Drug Counselor.

(iii) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.

(iv) A Physician's Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(v) LBHPs must have a valid Insure Oklahoma contract in order to bill for services rendered.

(vi) LBHP services require prior authorization and are limited to 8 therapy services per month per member and 8 testing units per year per member; $10 co-pay per visit.

(19) Durable Medical Equipment and Supplies. Covered in accordance with OAC 317:30-5-210 through 317:30-5-218. A PCP referral and prior authorization is required for certain items. DME/Supplies are covered up to a $15,000 annual maximum; exceptions from the annual DME limit are diabetic supplies, oxygen, home dialysis, and parenteral therapy; $5 co-pay for durable/non-durable supplies and $25 co-pay for durable medical equipment.

(20) Diabetic Supplies. Covered in accordance with OAC 317:30-5-211.15; not subject to $15,000 annual DME limit; $5 co-pay per prescription.

(21) Oxygen. Covered in accordance with OAC 317:30-5-211.11 through 317:30-5-211.12; not subject to $15,000 annual DME limit; $5 co-pay per month.

(22) Pharmacy. Covered in accordance with OAC 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits; $5/$10 co-pay per prescription.
(23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with OAC 317:30-5-72.1; $5/$10 co-pay per product.
(24) Nutrition Services. Covered in accordance with OAC 317:30-5-1076; $10 co-pay per visit.
(25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with OAC 317:30-5-211.13; $25 co-pay per prosthesis.
(26) Surgery. Covered in accordance with OAC 317:30-5-8; $50 co-pay per inpatient admission and $25 co-pay per outpatient visit.
(27) Home Dialysis. Covered in accordance with OAC 317:30-5-211.13; not subject to $15,000 annual DME limit; $0 co-pay.
(28) Parenteral Therapy. Covered in accordance with OAC 317:30-5-211.14; not subject to $15,000 annual DME limit; $25 co-pay per month.
(29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with OAC 317:30-3-57; $0 co-pay.
(30) Home Health Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with OAC 317:30-5-211.15 and 317:30-5-42.16(b)(3).
(31) Ultraviolet Treatment-Actinotherapy.
(32) Fundus photography.
(33) Perinatal dental care for pregnant women. Covered in accordance with OAC 317:30-5-696; $0 co-pay.

317:45-11-11. Insure Oklahoma~~/O-EPIC~~ IP adult non-covered services

Certain health care services are not covered in the Insure Oklahoma~~/O-EPIC~~ IP adult benefit package listed in OAC 317:45-11-10. These services include, but are not limited to:

(1) services ~~that the member's PCP or Insure Oklahoma/O-EPIC does not consider~~ not considered medically necessary;

(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;

(3) organ and tissue transplant services;

(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;

(5) procedures, services and supplies related to sex transformation;
(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
(7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);
(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
(9) experimental procedures, drugs or treatments;
(10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) except for pregnant women and as covered in OAC 317:30-5-696;
(11) vision care and services (including glasses), except services treating diseases or injuries to the eye;
(12) physical medicine including chiropractic~~, acupuncture and osteopathic manipulation~~ and acupuncture therapy;
(13) hearing services;
(14) transportation [~~emergent~~ emergency or ~~non-emergent~~ non-emergency (air or ground)];
(15) rehabilitation (inpatient);
(16) cardiac rehabilitation;
(17) allergy testing and treatment;
(18) home health care with the exception of medications, intravenous (IV) therapy, supplies;
(19) hospice regardless of location;
(20) Temporomandibular Joint Dysfunction (TMD) (TMJ);
(21) genetic counseling;
(22) fertility evaluation/treatment/and services;
(23) sterilization reversal;
(24) Christian Science Nurse;
(25) Christian Science Practitioner;
(26) skilled nursing facility;
(27) long-term care;
(28) stand by services;
(29) thermograms;
(30) abortions (for exceptions, refer to OAC 317:30-5-6);
(31) services of a Lactation Consultant;
(32) services of a Maternal and Infant Health Licensed Clinical Social Worker; and
(33) enhanced services for medically high risk pregnancies as found in OAC 317:30-5-22.1.

317:45-11-12. Insure Oklahoma IP children benefits

(a) IP covered child benefits for in-network services, limits, and applicable co-payments are listed in this subsection. All IP benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this section. All services provided

must be medically necessary as defined in OAC 317:30-3-1(f). The scope of IP child benefits described in this section is subject to specific non-covered services listed in OAC 317:45-11-13. Dependent children are not held to the maximum lifetime benefit of $1,000,000. Coverage includes:

(1) Ambulance services. Covered as medically necessary; $50 co-pay per occurrence; waived if admitted.

(2) Blood and blood products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.

(3) Chelation therapy. Covered for heavy metal poisoning only.

(4) Chemotherapy and radiation therapy. Covered as medically necessary; $10 co-pay per visit.

(5) Clinic services including renal dialysis services. Covered as medically necessary; $0 co-pay for dialysis services; $10 co-pay per office visit.

(6) Diabetic supplies. One glucometer, one spring-loaded lancet device, three replacement batteries per year- 100 glucose strips and lancets per month; not included in DME $15,000 max/year; $5 co-pay per billable service. Additional supplies require prior authorization.

(7) Diagnostic X-ray services. Covered as medically necessary; $25 co-pay per scan for MRI, MRA, PET, CAT scans only.

(8) Dialysis. Covered as medically necessary.

(9) Durable medical equipment and supplies. Covered as medically necessary with $15,000 annual maximum; $5 co-pay per item for durable/non-durable supplies; $25 co-pay per item for DME.

(10) Emergency department services. Covered as medically necessary; $30 co-pay per occurrence; waived if admitted.

(11) Family planning services and supplies. Birth control information and supplies; pap smears; pregnancy tests.

(12) Home health services. Home health visits limited to 36 visits per year, prior authorization required, includes medications IV therapy and supplies; $10 co-pay per visit, appropriate pharmacy and DME co-pays will apply.

(13) Hospice services. Covered as medically necessary, prior authorization required; $10 co-pay per visit.

(14) Immunizations. Covered as recommended by ACIP; $0 co-pay.

(15) Inpatient hospital services (acute care only). Covered as medically necessary; $50 co-pay per admission.

(16) Laboratory services. Covered as medically necessary.

(17) Psychological testing. Psychological, neurological and development testing; outpatient benefits per calendar

year, prior authorization required issued in 4 unit increments- not to exceed 8 units/hours per testing set; $0 co-pay.

(18) Mental health/substance abuse treatment-outpatient. All outpatient benefits require prior authorization. Outpatient benefits limited to 48 visits per calendar year. Additional units as medically necessary; $10 co-pay per outpatient visit.

(19) Mental health/substance abuse treatment-inpatient. Acute, detox, partial, and residential treatment center (RTC) with 30 day max per year, 2 days of partial or RTC treatment equals 1 day accruing to maximum. Additional units as medically necessary; $50 co-pay per admission. Requires prior authorization.

(20) Nurse midwife services. Covered as medically necessary for pregnancy-related services only; $0 co-pay.

(21) Nutrition services. Covered as medically necessary; $10 co-pay.

(22) Nutritional support. Covered as medically necessary; not included in DME $15,000 max/year. Parenteral nutrition covered only when medically necessary; $25 co-pay.

(23) Other medically necessary services. Covered as medically necessary.

(24) Oral surgery. Covered as medically necessary and includes the removal of tumors and cysts; $25 co-pay for outpatient; $50 co-pay for inpatient hospital.

(25) Outpatient hospital services. Covered as medically necessary and includes ambulatory surgical centers and therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for children with proven malignancies or opportunistic infections; $25 co-pay per visit; $10 co-pay per visit for therapeutic radiology or chemotherapy.

(26) Oxygen. Covered as medically necessary; not included in DME $15,000 max/year; $5 co-pay per month.

(27) PCP visits. Blood lead screen covered as medically necessary. Hearing services limited to one outpatient newborn screening. Well baby/well child exams follow recommended schedule to age 19; $0 co-pay for preventive visits and well baby/well child exams; $10 co-pay for all other visits.

(28) Physical, occupational, and speech therapy. Covered as medically necessary; prior authorization required; $10 co-pay per visit.

(29) Physician services, including preventive services. Covered as medically necessary; $0 co-pay for preventive visits; $10 co-pay for all other visits.

(30) Prenatal, delivery and postpartum services. Covered as medically necessary; $0 co-pay for office visits; $50 co-pay for delivery.
(31) Prescription drugs and insulin. Limited to six per month; generic preferred. Prenatal vitamins and smoking cessation products do not count toward the six prescription limit; $5-$10 co-pay.
(32) Smoking cessation products. Limited coverage; 90-day supply; products do not count against prescription drug limit; $5-$10 co-pay.
(33) Specialty clinic services. Covered as medically necessary; $10 co-pay.
(34) Surgery. Covered as medically necessary; $25 co-pay for outpatient facility; $50 co-pay for inpatient hospital.
(35) Tuberculosis services. Covered as medically necessary; $10 co-pay per visit.
(36) Ultraviolet treatment-actinotherapy. Covered as medically necessary; prior authorization required after 1 visit per 365 sequential days; $5 co-pay.

(b) A PCP referral is required to see any other provider with the exception of the following services:
(1) behavioral health services;
(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;
(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;
(4) women's routine and preventive health care services;
(5) emergency medical condition as defined in OAC 317:30-3-1; and
(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

317:45-11-13. Insure Oklahoma IP children non-covered services

Certain health care services are not covered in the Insure Oklahoma IP benefit package for children listed in OAC 317:45-11-12. These services include, but are not limited to:
(1) services not considered medically necessary;
(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
(3) organ and tissue transplant services;
(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;

(5) procedures, services and supplies related to sex transformation;
(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
(7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);
(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
(9) experimental procedures, drugs or treatments;
(10) transportation [non-emergency (air or ground)];
(11) rehabilitation (inpatient);
(12) cardiac rehabilitation;
(13) allergy testing and treatment;
(14) Temporomandibular Joint Dysfunction (TMD) (TMJ);
(15) genetic counseling;
(16) fertility evaluation/treatment/and services;
(17) sterilization reversal;
(18) Christian Science Nurse;
(19) Christian Science Practitioner;
(20) skilled nursing facility;
(21) long-term care;
(22) stand by services;
(23) thermograms;
(24) abortions (for exceptions, refer to OAC 317:30-5-6);
(25) donor transplant expenses; and
(26) tubal ligations and vasectomies.

PART 5. INSURE OKLAHOMA~~/O-EPIC~~ IP MEMBER ELIGIBILITY

317:45-11-20. Insure Oklahoma~~/O-EPIC~~ IP eligibility requirements

(a) ~~Employees~~ Working adults not eligible to participate in an employer's ~~QHP~~ qualified health plan, employees of non-participating employers, self-employed, unemployed seeking work, ~~and~~ workers with a disability, and qualified college students may apply for the Individual Plan. Applicants cannot obtain IP coverage if they are eligible for ESI. Applicants, unless a qualified college student, must be engaged in employment as defined under state law, or must be considered unemployed as defined under state law.

(b) The eligibility determination ~~is~~ will be processed within 30 days from the date the complete application is received ~~by the IPA~~. The applicant ~~is~~ will be notified in writing of the eligibility decision.

(c) In order to be eligible for the IP, the applicant must:

(1) choose a valid PCP according to the guidelines listed in OAC 317:45-11-22, at the time they make application;

(2) be a US citizen or alien as described in OAC 317:35-5-25;

(3) be an Oklahoma resident;
(4) provide social security numbers for all household members;
(5) be not currently enrolled in, or have an open application for~~, SoonerCare/Medicare~~ SoonerCare or Medicare;
(6) be age 19 through 64 or an emancipated minor;
(7) make premium payments by the due date on the invoice; ~~and~~
(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and
(9) be not currently covered by a private health insurance policy or plan.

(d) If employed and working for an approved Insure Oklahoma~~/O-EPIC~~ employer who offers a ~~QHP~~ qualified health plan, the applicant must meet the requirements in subsection (c) of this ~~Section~~ section and:
(1) have annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.
(2) be ineligible for participation in their employer's ~~QHP~~ qualified health plan due to number of hours worked.
(3) have received notification from Insure Oklahoma~~/O-EPIC~~ indicating their employer has applied for Insure Oklahoma~~/O-EPIC~~ and has been approved.

(e) If employed and working for an employer who ~~doesn't~~ does not offer a ~~QHP~~ qualified health plan, the applicant must meet the requirements in subsection (c) of this ~~Section~~ section and have ~~a countable~~ an annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member.

(f) If self-employed, the applicant must meet the requirements in subsection (c) of this ~~Section~~ section and:
(1) must have an annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority;
(2) verify self-employment by providing the most recent federal tax return with all supporting schedules and copies of all 1099 forms;
(3) verify current income by providing appropriate supporting documentation; and

(4) ~~must not be employed by any full-time employer who meets the eligibility requirements in OAC 317:45-7-1(a)(1)-(2)~~ must not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2).

(g) If unemployed seeking work, the applicant must meet the requirements in subsection (c) of this ~~Section~~ section and the following:

(1) Applicant must have an annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority. In determining income, payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010 and any amount of emergency unemployment compensation paid through May 31, 2010, will not be counted, as authorized under the American Recovery and Reinvestment Tax Act of 2009.

(2) Applicant must verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:

(A) OESC eligibility letter,

(B) OESC weekly unemployment payment statement, or

(C) bank statement showing state treasurer deposit.

(h) If working with a disability, the applicant must meet the requirements in subsection (c) of this ~~Section~~ section and:

(1) Applicant must have an annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level based on a family size of one~~; and~~. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.

(2) Applicant must verify eligibility by providing a copy of their:

(A) ticket to work, or

(B) ticket to work offer letter.

317:45-11-21. Dependent eligibility

(a) If the spouse of an Insure Oklahoma~~/O-EPIC~~ IP approved individual is eligible for Insure Oklahoma~~/O-EPIC~~ ESI, they must apply for Insure Oklahoma~~/O-EPIC~~ ESI. Spouses cannot obtain Insure Oklahoma~~/O-EPIC~~ IP coverage if they are eligible for Insure Oklahoma~~/O-EPIC~~ ESI.

(b) The employed or self-employed spouse of an approved applicant must meet the guidelines listed in OAC 317:45-11-20(a) through (g) to be eligible for Insure Oklahoma~~/O-EPIC~~ IP.

(c) The dependent of an applicant approved according to the guidelines listed in OAC 317:45-11-20(h) does not become automatically eligible for Insure Oklahoma~~/O-EPIC~~ IP.
(d) The applicant and the dependents' eligibility are tied together. If the applicant no longer meets the requirements for Insure Oklahoma~~/O-EPIC~~ IP, then the associated dependent enrolled under that applicant is also ineligible.
(e) Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA).
(f) Dependent children in families whose annual gross household income is from 185 up to and including 300 percent of the Federal Poverty Level may be eligible. The inclusion of children into the Insure Oklahoma program will be phased in over a period of time as determined by the OHCA. No other deductions or disregards apply.

(1) Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.
(2) Children are not eligible for Insure Oklahoma if they are a member of a family eligible for employer-sponsored dependent health insurance coverage under any Oklahoma State Employee Health Insurance Plan.
(3) Children who already have coverage through another source must undergo, or be excepted from, a 6 month uninsured waiting period prior to becoming eligible for Insure Oklahoma. Exceptions to the waiting period may include:

(A) the cost of covering the family under the ESI plan meets or exceeds 10 percent of the annual gross household income. The cost of coverage includes premiums, deductibles, co-insurance, and co-payments;
(B) loss of employment by a parent which made coverage available;
(C) affordable ESI is not available; “Affordable” coverage is defined by the OHCA annually using actuarially sound rates established by the Oklahoma State and Education Employee Group Insurance Board (OSEEGIB); or
(D) loss of medical benefits under SoonerCare.

317:45-11-21.1. Certification of newborn child deemed eligible
(a) A newborn child is deemed eligible on the date of birth for SoonerCare benefits when the child is born to a member of Insure Oklahoma~~/O-EPIC~~ IP and the ~~household countable~~ annual gross household income does not exceed SoonerCare requirements. ~~(For~~

~~purposes of this subparagraph, a newborn child is defined as any child under the age of one year).~~ The newborn child is deemed eligible through the last day of the month the child attains the age of one year.
(b) The newborn child's eligibility is not dependent on the mother's continued eligibility ~~for~~ in Insure Oklahoma~~/O-EPIC~~ IP. The child's eligibility is based on the original eligibility determination of the mother for Insure Oklahoma~~/O-EPIC~~ IP and consideration is not given to any income or resource changes that occur during the deemed eligibility period.
(c) The newborn child's certification period is shortened only in the event the child:
~~(1) leaves the mother's home;~~
~~(2)~~ (1) loses Oklahoma residence; or
~~(3) has medical needs included in another assistance case; or~~
~~(4)~~ (2) expires.
(d) No other conditions of eligibility are applicable, including social security number enumeration~~; however, it~~ and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the child's birth.

317:45-11-22. PCP choices
(a) The applicant (and dependents if also applying for Insure Oklahoma~~/O-EPIC~~ IP) is required to select a valid PCP ~~choices as required on the application~~.
(b) If a valid PCP is selected by the applicant or dependents and they are not enrolled with the first PCP choice, they are enrolled with the next available PCP choice. The applicant is notified in writing why their initial choice was not selected.
(c) After initial enrollment in Insure Oklahoma~~/O-EPIC~~ IP, the applicant or dependents can change their PCP selection by calling the Insure Oklahoma~~/O-EPIC~~ helpline. ~~Changes take effect the first day of the next month or the first day of the 2nd consecutive month. Applicant and dependents are only allowed to change their PCP a maximum of four times per calendar year.~~

317:45-11-23. Employee eligibility period
(a) The rules in this subsection apply to applicants eligible according to OAC 317:45-11-20(a) through (e).
(1) The employee's coverage period begins only after receipt of the premium payment.
(A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month,

eligibility begins the first day of the 3rd consecutive month. (Examples: An application is received and approved on January 14th and the premium is received before February 15th, eligibility begins March 1st; or an application is received and approved January 15th and the premium is received on March 15th, eligibility begins April 1st.)

(B) If premiums are paid early, eligibility still begins as scheduled.

(2) Employee eligibility is contingent upon the employer meeting the program guidelines.

(3) The employee's eligibility is determined ~~by the TPA~~ using the eligibility requirements listed in OAC 317:45-9-1 or OAC 317:45-11-20(a) through (e).

(4) If the employee is determined eligible for Insure Oklahoma~~/O-EPIC~~ IP, he/she is approved for a period not greater than 12 months. ~~The length of the eligibility period is based on the remaining number of months the employer has left in its eligibility period as defined in OAC 317:45-7-1, 317:45-7-2 and 317:45-7-8.~~

(b) The rules in this subsection apply to applicants eligible according to OAC 317:45-11-20(a) through (c) and OAC 317:45-11-20(f) through (h).

(1) The applicant's eligibility is determined ~~by the TPA~~ using the eligibility requirements listed in OAC 317:45-11-20(a) through (c) and OAC 317:45-11-20(f) through (h).

(2) If the applicant is determined eligible for Insure Oklahoma~~/O-EPIC~~ IP, he/she is approved for a period not greater than 12 months.

(3) The applicant's eligibility period begins only after receipt of the premium payment.

(A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is approved on January 14th and the premium is received before February 15th, eligibility begins March 1st; or an application is approved January 15th and the premium is received on March 15th, eligibility begins April 1st.)

(B) If premiums are paid early, eligibility still begins as scheduled.

317:45-11-24. Member cost sharing

(a) Members are given monthly invoices for health plan premiums. The premiums are due, and must be paid in full, no later than the 15th day of the month prior to the month of IP coverage.

(1) Members are responsible for their monthly premiums, in an amount not to exceed ~~four~~ 4 percent of their ~~gross monthly~~ monthly gross household income.
(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed ~~4%~~ 4 percent of their ~~gross monthly~~ monthly gross household income, based on a family size of one and capped at ~~200%~~ 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.

(b) IP coverage is not provided until the premium and any other amounts due are paid in full. Other amounts due may include but are not limited to any fees, charges, or other costs incurred as a result of Insufficient/Non-sufficient funds.

317: 45-11-25. Premium payment

IP health plan premiums are established by the OHCA. Employees and college students are responsible for up to 20 percent of their IP health plan premium. The employees are also responsible for up to 20 percent of their ~~spouse=s~~ dependent's IP health plan premium if the dependent is included in the program. The combined portion of the employee's or college student=s cost sharing for IP health plan premiums cannot exceed ~~four~~ 4 percent of his/her ~~gross annual~~ annual gross household income computed monthly.

317:45-11-26. Audits

Members participating in the Insure Oklahoma~~/O-EPIC~~ program are subject to audits related to their eligibility, subsidy payments, premium payments and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.

317:45-11-27. Closure

(a) Members are mailed a notice 10 days prior to closure of eligibility.
(b) The employer and employees' eligibility are tied together. If the employer no longer meets the requirements for Insure Oklahoma~~/O-EPIC~~ then eligibility for the associated employees enrolled under that employer are also ineligible.
(c) The employee's certification period may be terminated when:
(1) the member requests closure;
(2) the member moves out-of-state;
(3) the covered member dies;
(4) the employer's eligibility ends;
(5) an audit indicates a discrepancy that makes the member or employer ineligible;

(6) the employer is terminated from Insure Oklahoma~~/O-EPIC~~;
(7) the member fails to pay the amount due within 60 days of the date on the bill;
(8) the ~~QHP~~ qualified health plan or carrier ~~is no longer qualified~~ no longer meets the requirements set forth in this chapter;
(9) the member begins receiving ~~SoonerCare/Medicare~~ SoonerCare or Medicare benefits;
(10) the member begins receiving coverage by a private health insurance policy or plan; or
(11) the member or employer reports ~~to the OHCA or the TPA~~ any change affecting eligibility.

(d) This subsection applies to applicants eligible according to OAC 317:45-11-20(a) through (c) and 317:45-11-20(f) through (h). The member's certification period may be terminated when:
(1) the member requests closure;
(2) the member moves out-of-state;
(3) the covered member dies;
(4) the employer's eligibility ends;
(5) an audit indicates a discrepancy that makes the member or employer ineligible;
(6) the member fails to pay the amount due within 60 days of the date on the bill;
(7) the member becomes eligible for ~~SoonerCare/Medicare~~ SoonerCare or Medicare;
(8) the member begins receiving coverage by a private health insurance policy or plan; or
(9) the member or employer reports ~~to the OHCA or the TPA~~ any change affecting eligibility.

317:45-11-28. Appeals

(a) Member appeal procedures based on denial of eligibility due to income are described at OAC 317:2-1-2.

(b) ~~Member appeals related to premium payments and/or out-of-pocket expenses are made to the TPA. If the member disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final.~~

~~(c) Employee appeals regarding out-of-pocket expenses are made to the TPA. If the employee disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final~~ Employee appeals regarding out-of-pocket medical expense reimbursements may be made to the OHCA. The OHCA may request documentation to support the out-of-pocket appeal. The decision of the OHCA is final.