
POLICY TRANSMITTAL NO. 06-46	DATE: OCTOBER 16, 2006
OKLAHOMA HEALTH CARE AUTHORITY/FAMILY SUPPORT SERVICES DIVISION	DEPARTMENT OF HUMAN SERVICES OFFICE OF LEGISLATIVE RELATIONS & POLICY

TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:45-1-2 through 45-1-4; 45-5-1; 45-7-2; 45-7-8; 45-9-1; 45-9-3; 45-9-5; 45-9-7; 45-11-1; 45-11-2; 45-11-10; 45-11-11; and 45-11-20 through 45-11-28.

EXPLANATION: **Policy revisions were approved by the Board and the Governor as required by the Administrative Procedures Act.**

Agency rules are issued to establish criteria that implements the Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC) Individual Plan. The O-EPIC Individual Plan program extends affordable health coverage to low income employees who cannot afford to participate in their employer's health plan, employees of non-participating employers, self-employed, unemployed seeking work, and workers with a disability. In addition, rules for the O-EPIC Premium Assistance program are revised to: (1) allow employees with multiple employers to qualify for inclusion in the O-EPIC PA program if their primary employer meets eligibility guidelines; (2) add several definitions to rules; and (3) remove unnecessary requirements that are not being used in the current program.

Original signed on 10-13-06

Mary Stalnaker, Director
Family Support Services Division

Sharon Neuwald, Coordinator
Office of Legislative Relations and Policy

WF # 06-S (DT)

INSTRUCTIONS FOR FILING MANUAL MATERIAL

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following a “DHS” number, such as personnel policy at DHS:2-1 and personnel rules at OAC 340:2-1. The “340” is the Title number that designates DHS as the rulemaking agency; the “2” specifies the Chapter number; and the “1” specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, DHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, DHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at (405) 521-6392.

<u>REMOVE</u>	<u>INSERT</u>
317:45-1-2	317:45-1-2, pages 1-2, revised 9-1-06
317:45-1-3	317:45-1-3, pages 1-3, revised 9-1-06
-----	317:45-1-4, 1 page only, issued 9-1-06
317:45-5-1	317:45-5-1, pages 1-2, revised 9-1-06
317:45-7-2	317:45-7-2, 1 page only, revised 9-1-06
317:45-7-8	317:45-7-8, 1 page only, revised 9-1-06
317:45-9-1	317:45-9-1, pages 1-2, revised 9-1-06
317:45-9-3	317:45-9-3, 1 page only, revised 9-1-06
317:45-9-5	-----
317:45-9-7	317:45-9-7, 1 page only, revised 9-1-06
-----	317:45-11-1, 1 page only, issued 9-1-06
-----	317:45-11-2, 1 page only, issued 9-1-06
-----	317:45-11-10, pages 1-4, issued 9-1-06
-----	317:45-11-11, pages 1-2, issued 9-1-06
-----	317:45-11-20, pages 1-3, issued 9-1-06
-----	317:45-11-21, 1 page only, issued 9-1-06

REMOVE

INSERT

317:45-11-22, 1 page only, issued 9-1-06

317:45-11-23, pages 1-2, issued 9-1-06

317:45-11-24, 1 page only, issued 9-1-06

317:45-11-25, 1 page only, issued 9-1-06

317:45-11-26, 1 page only, issued 9-1-06

317:45-11-27, pages 1-2, issued 9-1-06

317:45-11-28, 1 page only, issued 9-1-06

317:45-1-2. Program limitations

(a) The 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.

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

(c) The Program is funded through a portion of monthly proceeds from the Tobacco Tax, O.S.S. '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.

(d) 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 O-EPIC program continues to operate within its fiscal capacity.

(1) O-EPIC may limit eligibility based on:

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

(B) Tobacco Tax collections.

(2) The 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.

(A) Applicants, not previously enrolled and participating in the program, submitting new applications for the O-EPIC program are placed on a waiting list. These applications are date and time stamped when received by the TPA. Applications are identified by region and 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. O-EPIC program size is determined by OHCA and may be periodically adjusted.

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

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

(D) Enrolled applicants who are currently participating in the O-EPIC program are not subject to the waiting list.

(E) For approved employers of O-EPIC, if the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate in O-EPIC during the employer's current eligibility period.

(F) For approved employers of O-EPIC, if the employer has an employee who has a Qualifying Event after the employer's program eligibility begins, the employee is allowed to make changes pertaining to the Qualifying Event.

317:45-1-3. Definitions

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

"Carrier" means:

(A) an insurance company, group health service or Health Maintenance Organization (HMO) that provides health benefits pursuant to Title 36 O.S., Section 6512;

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

(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.

"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.

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

"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 O-EPIC PA member.

"Individual Plan" means the O-EPIC program that provides services to those individuals who do not meet the criteria for O-EPIC PA.

"O-EPIC" means the Oklahoma Employer and Employee Partnership for Insurance Coverage program.

"O-EPIC IP" means the Individual Plan program.

"O-EPIC PA" means the Premium Assistance program.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"Oklahoma Employer and Employee Partnership for Insurance Coverage" means a health plan purchasing strategy in which a state uses public funds to pay for a portion of the costs of health plan coverage for eligible populations.

"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.

"Premium Assistance" means the O-EPIC program that provides premium assistance to small business for certain employees.

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

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

"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 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 Oklahoma Employer and Employee Partnership for Insurance Coverage program.

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

(a) O-EPIC 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 5% of the employee's gross annual household income during the current eligibility period may be reimbursable.

(b) The O-EPIC 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. 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.

(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 5% threshold would be absorbed.

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

(a) Qualified Health Plans participating in O-EPIC 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.

(b) The health plan, if required, must be approved by the Oklahoma Department of Insurance 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 out-of-pocket maximum cannot exceed \$3,000 per individual. This amount includes any individual, annual deductible amount, except for pharmacy.
- (2) Office visits cannot require a co-payment exceeding \$50 per visit.
- (3) Annual pharmacy deductibles cannot exceed \$500 per individual.

(c) Qualified Health Plans may provide an Explanation of Benefits (EOB) for paid or denied claims subject to member co-insurance or member deductible calculations. If an EOB is provided it 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.

317:45-7-2. 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 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 TPA notifies the employer of the eligibility decision for employer and employees.

317:45-7-8. Closure

Eligibility provided under the O-EPIC program ends during the eligibility period when:

- (1) the employer terminates its contract with all Qualified Health Plans;
- (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;
- (4) an audit indicates a discrepancy that makes the employer ineligible;
- (5) the employer no longer has a business location in Oklahoma;
- (6) the Qualified Health Plan or Carrier no longer qualifies for O-EPIC;
- (7) the employer's eligibility period ends and is not renewed;
or
- (8) the employer seeks to add a QHP.

317:45-9-1. Employee eligibility requirements

(a) Employee premium assistance applications are made with the TPA.

(b) The TPA electronically submits the application to the Oklahoma Department of Human Services (OKDHS) for a determination of eligibility. The eligibility determination is processed within 30 days from the date the application is received by the TPA. The employee is notified in writing of the eligibility decision.

(c) All O-EPIC eligible employees described in this Section are enrolled in their Employer's QHP. Employees eligible for O-EPIC must:

(1) have a household income at or below 185% of the Federal Poverty Level;

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

(3) be Oklahoma residents;

(4) provide his/her social security number;

(5) be not currently enrolled in, or have an open application for, Medicaid/Medicare;

(6) be employed with a qualified employer at a business location in Oklahoma;

(7) be age 19 through age 64;

(8) be eligible for enrollment in the employer's Qualified Health Plan;

(9) be working for primary employer(s) who all meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and

(10) select one of the Qualified Health Plans the employer is offering.

(d) An employee's spouse is eligible for O-EPIC if:

(1) the employer's health plan includes coverage for spouses;

(2) the employee is eligible for O-EPIC;

(3) if employed, the spouse's primary employer(s) meets employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and

(4) the spouse is enrolled in the same health plan as the employee.

(e) If an employee or spouse is eligible for multiple O-EPIC Qualified Health Plans, each may receive a subsidy under only one health plan.

317:45-9-3. Qualifying Event

(a) Employees are allowed to apply for O-EPIC following a Qualifying Event.

(b) An employee's spouse may become eligible for coverage and is allowed to apply for O-EPIC following a Qualifying Event of the employee or spouse.

317:45-9-7. Closure

(a) Employer and employee eligibility are tied together. If the employer no longer meets the requirements for O-EPIC then eligibility for the associated employees enrolled under that employer are also ineligible. Employees are mailed a written 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 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 O-EPIC;
- (8) the employer fails to pay the premium;
- (9) the Qualified Health Plan or Carrier is no longer qualified;
- (10) the employee becomes eligible for Medicaid/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.

317:45-11-1. O-EPIC Individual Plan providers

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 SoonerCare reimbursement, the IP provider:

(1) must enter into a SoonerCare contract;

(2) may collect the member's co-pay in addition to the
SoonerCare reimbursement;

(3) may refuse to see members based on their inability to pay
their co-pay; and

(4) must complete O-EPIC IP addendum if provider wants to
provide primary care services as a PCP.

317:45-11-2. O-EPIC IP provider payments

Payment for covered benefits, as shown in OAC 317:45-11-10, rendered to O-EPIC IP members is made to contracted 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). 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.

317:45-11-10. O-EPIC IP benefits

(a) All O-EPIC IP benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this Section.

(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.

(6) specialty care for members with special health care needs as defined by OHCA; and

(7) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

(c) O-EPIC IP covered benefits, 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. Coverage includes:

(1) Anesthesia / Anesthesiologist Standby. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA). Prior authorization is required for outpatient services.

(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. 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, limited to 24 days per person
per state fiscal year (July 1 through June 30). The 24 day
limit applies to both hospital and physician services. There
are no exceptions or extensions to the 24 day inpatient services
limitation. PCP referral is required: \$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.

(8) Office Visits/Specialist Visits. 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; PCP referral required. 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.

(10) Maternity (Obstetric). All routine care, laboratory, one
ultrasound per maternity cycle (one additional ultrasound as
medically necessary when referred to a maternal fetal specialist
for a complete level II ultrasound), anesthesia, delivery, and
postpartum care. Prenatal vitamins do not count against monthly
prescription limits. Nursery care paid separately under
eligible child. \$10 co-pay for initial visit once diagnosis of

pregnancy is confirmed; \$50 inpatient hospital co-pay.

(11) Laboratory/Pathology. As medically necessary; \$0 co-pay.

(12) Mammogram (Radiological or Digital). One screening mammogram and one follow-up mammogram every year for women beginning at age 30. Additional follow-up mammograms are covered when medically necessary; \$0 co-pay.

(13) Immunizations for Adults. Covered in accordance with the current Centers for Disease Control and Prevention guidelines, excluding vaccines for travelers. Member pays preventive office visit; \$10 co-pay per visit.

(14) Assistant Surgeon. Covered in accordance with Medicare guidelines.

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

(16) Oral Surgery, removal of wisdom teeth is not a covered service. Service includes the removal of tumors or cysts, for emergency oral surgery, see Emergency Room Treatment. Prior authorization is required for certain outpatient services; Inpatient Hospital \$50 or Outpatient Hospital/Facility \$25 co-pay applies.

(17) Mental Health Treatment (Inpatient), limited to 24 days per person per state fiscal year (July 1 through June 30). The 24 day limit applies to both hospital and physician services. There are no exceptions or extensions to the 24 day inpatient services limitation. Prior authorization is required; \$50 co-pay per admission.

(18) Mental Health Treatment (Outpatient). Outpatient benefits, which exceed 12 visits per calendar year, require prior authorization. Outpatient benefits are limited to 26 visits per calendar year. Exceptions apply to diagnoses of schizophrenia, bipolar disorder/manic-depressive illnesses, major depressive disorder, panic disorder, obsessive-compulsive disorder, and schizo-affective disorder; these diagnoses are allowed up to 48 maximum visits; \$10 co-pay per visit.

(19) Substance Abuse Treatment (Outpatient). Outpatient benefits, which exceed 12 visits per calendar year require prior authorization. Outpatient benefits are limited to 26 visits per calendar year; \$10 co-pay per visit.

(20) Durable Medical Equipment and Supplies. A PCP referral and prior authorization is required. DME/Supplies are covered up to a \$15,000 lifetime maximum; \$5 co-pay for durable/non-durable supplies and \$25 co-pay for durable medical equipment.

(21) Diabetic Supplies. A PCP referral is required. Prior authorization is only required beyond quantity limits; \$5 co-pay per perscription.

(22) Oxygen. Documentation must meet medical necessity; \$5 co-pay per month.

(23) Pharmacy. Six prescriptions per month with 3 brand name limit; Quantity limits, step therapy, tiered co-payment and prior authorization apply, see member handbook; \$5/\$10 co-pay.

(24) Smoking Cessation Product Therapy. If prescribed by a physician, will reimburse for prescription medications used to treat nicotine addiction; One smoking cessation therapy (90 day session) per calendar year; prior authorization required beyond one session; \$0 co-pay.

317:45-11-11. O-EPIC IP non-covered services

Certain health care services are not covered in the O-EPIC IP 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 O-EPIC does not consider medically necessary;
- (2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
- (3) organ transplants;
- (4) treatment of obesity;
- (5) sterilization procedures for persons 21 years of age or older without proper consent forms;
- (6) procedures, services and supplies related to sex transformation;
- (7) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
- (8) cosmetic surgery;
- (9) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
- (10) experimental procedures, drugs or treatments;
- (11) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident);
- (12) vision care and services (including glasses), except services treating diseases or injuries to the eye;
- (13) physical medicine including speech, physical, occupational, chiropractic, acupuncture and osteopathic manipulation therapy;
- (14) hearing services;
- (15) transportation [emergent or non-emergent (air or ground)];

- (16) rehabilitation (inpatient);
- (17) cardiac rehabilitation;
- (18) allergy testing and treatment;
- (19) home health care including medications, intravenous (IV) therapy, supplies;
- (20) hospice regardless of location;
- (21) nurse midwife services;
- (22) Temporomandibular Joint Dysfunction (TMD) (TMJ);
- (23) ultraviolet treatment-actinotherapy;
- (24) genetic counseling;
- (25) fertility evaluation/treatment/and services;
- (26) sterilization reversal;
- (27) Christian Science Nurse;
- (28) Christian Science Practitioner;
- (29) fundus photography;
- (30) skilled nursing facility;
- (31) longterm care;
- (32) stand by services; and
- (33) thermograms.

317:45-11-20. O-EPIC Individual Plan eligibility requirements

(a) Employees not eligible for participating in an employer's Qualified Health Plan (QHP), employees of non-participating employers, self-employed, unemployed seeking work, and workers with a disability may apply for the O-EPIC Individual Plan. Applicants cannot obtain O-EPIC IP coverage if they are eligible for O-EPIC PA.

(b) Applications may be found on the World Wide Web or may be requested by calling the O-EPIC helpline. Completed applications are submitted to the TPA.

(c) The TPA electronically submits the application to the Oklahoma Department of Human Services (OKDHS) for a determination of eligibility. The eligibility determination is processed within 30 days from the date the complete application is received by the TPA. The applicant is notified in writing of the eligibility decision.

(d) 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 his/her social security number;

(5) be not currently enrolled in, or have an open application for, Medicaid/Medicare;

(6) be age 19 through 64; and

(7) make premium payments by the due date on the invoice.

(e) If employed and working for an approved O-EPIC employer who offers a QHP, the applicant must meet the requirements in subsection (d) of this Section and:

(1) have household income at or below 185% of the Federal Poverty Level.

(2) be ineligible for participation in their employer's QHP due to number of hours worked.

(3) have received notification from O-EPIC indicating their employer has applied for O-EPIC and has been approved.

(f) If employed and working for an employer who doesn't offer a QHP, the applicant must meet the requirements in subsection (d) of this Section and:

(1) have household income at or below 185% of the Federal Poverty Level; and

(2) have received notification from O-EPIC indicating their employer has applied and has been approved with the attestation that they are not offering a QHP.

(g) If self-employed, the applicant must meet the requirements in subsection (d) of this Section and:

(1) must have household income at or below 185% of the Federal Poverty Level;

(2) verify self-employment by providing the most recent federal tax return with all supporting schedules and copies of all 1099 forms; and

(3) verify current income by providing appropriate supporting documentation.

(h) If unemployed seeking work, the applicant must meet the requirements in subsection (d) of this Section and:

(1) must have household income at or below 185% of the Federal Poverty Level; and

(2) 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.

(i) If working with a disability, the applicant must meet the requirements in subsection (d) of this Section and:

(1) must have household income at or below 200% of the Federal Poverty Level based on a family size of one; and

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

(A) ticket to work, or

(B) ticket to work offer letter.

317:45-11-21. Spouse eligibility

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

(b) The spouse of an applicant approved according to the guidelines listed in OAC 317:45-11-20(a) through (h) is eligible for O-EPIC IP.

(c) The spouse of an applicant approved according to the guidelines listed in OAC 317:45-11-20(i) does not become automatically eligible for O-EPIC IP. The spouse may choose to apply separately.

(d) The applicant and the spouses' eligibility are tied together. If the applicant no longer meets the requirements for O-EPIC IP, then the associated spouse enrolled under that applicant is also ineligible.

317:45-11-22. PCP choices

(a) The applicants (and spouse if also applying for O-EPIC IP) are required to select valid PCP choices as required on the application.

(b) If a valid PCP is selected by the applicant or spouse 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 choice was not selected.

(c) After initial enrollment in O-EPIC IP, the applicant or spouse can change their PCP selection by calling the O-EPIC helpline. Changes take effect the first day of the next month or the first day of the 2nd consecutive month. Applicant and spouse 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)-(f).

(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 1-14-06 and the premium is received before 2-15-06, eligibility begins 3-1-06; or an application is received and approved 1-15-06 and the premium is received on 3-15-06, eligibility begins 4-1-06.)

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

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

(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)-(f).

(4) If the employee is determined eligible for 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)-(d) and 317:45-11-20(g)-(i).

(1) The applicant's eligibility is determined by the TPA using the eligibility requirements listed in OAC 317:45-11-20(a)-(d) and 317:45-11-20(g)-(i).

(2) If the applicant is determined eligible for 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 1-14-06 and the premium is received before 2-15-06, eligibility begins 3-1-06; or an application is approved 1-15-06 and the premium is received on 3-15-06, eligibility begins 4-1-06.)

(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 percent of their gross monthly household income.

(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed 4% of their gross monthly household income, based on a family size of one and capped at 151% of the Federal Poverty Level.

(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 result of Insufficient/Non-sufficient funds.

317: 45-11-25. Premium payment

(a) O-EPIC IP premiums are based upon a percentage of the Federal Poverty Level (FPL) income guidelines. The FPL income guidelines are determined annually by the Federal Government.

(b) Monthly premiums in the IP program vary based on:

(1) income reported on the member's application; and

(2) a family size of one for single coverage or a family size of two for dual coverage.

317:45-11-26. Audits

Members participating in the 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 written notice 10 days prior to closure of eligibility.

(b) Employer and employees eligibility are tied together. If the employer no longer meets the requirements for 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 O-EPIC;

(7) the member fails to pay the premium as well as any other amounts on or before the due date;

(8) the Qualified Health Plan or Carrier is no longer qualified;

(9) the member becomes eligible for Medicaid/Medicare; or

(10) 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)-(d) and 317:45-11-20(g)-(i). 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 premium;

(7) the member becomes eligible for Medicaid/Medicare; or

(8) 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.