HealthChoice

Disability Plan Handbook

Plan Year 2026

OKLAHOMA
Employees Group
Insurance Division

5271

HEALTHCHOICE DISABILITY PLAN HANDBOOK

This handbook replaces and supersedes any disability handbook the Employees Group Insurance Division (EGID) previously issued. This handbook will, in turn, be superseded by any subsequent disability handbook EGID issues.

The most current version of this handbook can be found on the HealthChoice website at **HealthChoiceOK.com**.

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HEALTHCHOICE PLAN CONTACT INFORMATION

Disability claims administrator
Sedgwick Claims Management Services, Inc.
855-262-0613
Fax 855-800-5116

Claims address
P.O. Box 14648
Lexington, KY 40512-4648
View claim information at **mysedgwick.com/HealthChoice**.

HEALTHCHOICE PLAN IDENTIFICATION

Plan name
HealthChoice Disability Plan

Plan administrator
Employees Group Insurance Division
405-717-8780 or toll-free 800-752-9475
P.O. Box 11137
Oklahoma City, OK 73136-9998
HealthChoiceOK.com

Member Services
405-717-8780 or toll-free 800-752-9475
TTY 711
HealthChoiceOK.com

PLAN NOTICE

The Employees Group Insurance Division (EGID) provides disability benefits to eligible State of Oklahoma, county and city employees in accordance with the provisions of 74 O.S. §§ 1331 et seq. EGID is a division of the Oklahoma Health Care Authority (OHCA).

The information provided in this handbook is a summary of the benefits, conditions, limitations and exclusions of the HealthChoice Disability Plan. It should not be considered an all-inclusive listing.

HealthChoice Disability Plan benefits are subject to conditions, limitations and exclusions, which are described and located in Oklahoma statutes and handbooks and are adopted by the plan administrator.

Any entity participating in the HealthChoice Disability Plan shall appoint an insurance coordinator or benefits partner to explain the benefits to the employee and aid the claimant in providing the necessary information for claims to be processed.

Please read this handbook carefully

A dispute concerning information contained within any plan handbook or any other written materials, including any letters, bulletins, notices, other written documents or oral communication, regardless of the source, shall be resolved by a strict application of benefit administration procedures and guidelines as adopted by the plan. Erroneous, incorrect, misleading or obsolete language contained within any handbook, other written document or oral communication, regardless of the source, is of no effect under any circumstance.

OUTLINE OF HEALTHCHOICE DISABILITY PLAN

This insurance plan is designed to provide partial replacement of income lost as a result of a disabling illness or injury. This plan is not unemployment insurance, workers' compensation, Social Security Disability Insurance or disability retirement.

If you have a qualifying disability, your date of disability is the first day you are absent from work as a result of the disability or the first date of treatment for the disability, whichever is later. There is a 30-day elimination period beginning on the date of disability before benefits begin to accumulate.

Disability benefits are calculated using your base salary at the time of your disability. Benefits are subject to all applicable state and federal taxes. Additionally, short-term and long-term disability benefits are offset or reduced by other benefits or payments you receive or are eligible to receive for any period of your disability if related to your disability.

Disability benefits are divided into two types:

- **Short-term disability** provides up to 150 days of paid disability benefits after a 30-day elimination period. The maximum monthly benefit is $2,500.

- **Long-term disability** begins after 180 days from the date of disability (as defined by the plan) and pays a maximum monthly benefit of $3,000.

Disability benefits have a maximum benefit period that is based on your disability, years of service and age at the time of the onset of your disability.

PLAN PROVISIONS

Eligibility for coverage and benefits

You are eligible to participate in the HealthChoice Disability Plan and receive benefits if you meet all the following conditions:

1. Your employer is a participating state agency, county or city government in the plan.
2. You are regularly scheduled to work at least 1,000 hours a year and are not classified as a temporary or seasonal employee.
3. You have been actively at work for at least 31 consecutive calendar days after the effective date of your coverage. The effective date is the first day of the month following your employment date or the date you become eligible with your employer.
4. You have incurred a qualifying total disability and are unable to perform the essential duties of your own occupation for more than 30 consecutive calendar days. Your documented medical condition must meet the plan's definition of a disability. Refer to Definition of Disability.
5. You notify the disability claims administrator within 60 days of the date you become disabled.
6. You must provide proof of claim to the disability claims administrator in a timely manner. Proof must cover the severity and extent of the disability along with the reasons you are unable to perform the duties of your position. Proof is appropriate medical evidence provided by a qualified doctor, as described in the Claims Procedures section. If good cause is shown, the plan administrator may waive the 60-day requirement.
7. Your claim has been approved by the disability claims administrator.

Once you qualify for disability benefits, you must periodically submit additional medical evidence as proof of continued disability.

Employees reinstated to eligibility to participate in the disability plan after having waived disability coverage will be considered to have no prior service and no continuous employment prior to their reinstated eligibility.

For employees returning from active military service: If you have already satisfied plan eligibility requirements, you are eligible to continue disability coverage once you return to your employment and are at your job for five consecutive workdays.

If you are absent from work because of a furlough, holiday, vacation or nonscheduled working day, or you were on the job or on paid leave other than for injury, illness, or unpaid leave on a scheduled working day immediately preceding the eligibility date, the eligibility date for disability benefits will not be altered.

If you are absent from work because of injury or illness on the date you would become eligible for disability coverage, you shall not become eligible until you obtain an unconditional release from your physician and have returned to the job for five full-time consecutive workdays, performing all your normal duties.

If you are absent from work because of other unpaid leave, you are not eligible for coverage until you have returned to the job for five consecutive workdays.

Preexisting conditions

No benefits are payable for any disability caused by a preexisting condition. A condition will no longer be considered preexisting after the disabled person has been actively at work at his/her usual job for five consecutive days following the expiration of:

- A 180-day period following the entry on duty (EOD) date during which the employee has not received medical care, diagnosis, consultation or treatment, durable medical equipment or taken prescribed medications for the preexisting condition. The term preexisting condition shall also include any condition related to such injury or illness, including the diagnosis of pregnancy and any related condition.
- A 360-day period following the EOD date.

Definition of disability

You are considered disabled if, as a result of pregnancy, injury or illness, you are unable to perform the material duties of your own occupation. Disability begins on the date you first receive treatment or advice from a physician after your last date worked, and said disability is expected to last 31 consecutive calendar days or longer.

After 24 months, disability is defined as the inability to perform each of the material duties of any gainful occupation you are qualified for or may become qualified for through training, education or experience.

- Your medical documentation must clearly indicate that you are unable to perform any occupation.
- A labor market survey and/or a transferrable skills analysis may be performed to access the local labor market conditions for your return-to-work options and wage-earning capacity.

Note: Some jobs require a license for performance of the duties. If such license has been suspended due to a mental or physical illness or injury, benefits will be payable during a loss of license only while you are disabled or while you are pursuing reinstatement of your license when your condition meets the criteria. You must provide information and forms requested by the licensing agency in a timely manner until your license is reinstated. Loss of license

for reasons other than injury or illness (such as failure to renew it or violations that cause the license to be suspended) is not considered in determining disability benefit payments.

While receiving disability benefits, you may experience a second, unrelated disability. The second condition may be eligible for benefits if it meets the definition of disability. If the second disability claim is eligible for benefits, the two claims will be combined to form one continuous disability period.

Medical proof of disability

You must submit medical evidence provided by a qualified doctor stating that you are totally disabled as defined by the plan. Qualified doctors are legally licensed physicians and practitioners who are not related to you and who are performing services within the scope of their licenses, including medical doctors (M.D.), osteopaths (D.O.), nurse practitioners, physician's assistants, psychiatrists, psychologists or other medical practitioners. The practitioner must specialize in the condition being treated.

In addition, you must be under the continuous care of a qualified doctor or practitioner and follow the course of treatment prescribed. New diagnoses that do not occur before your employment is terminated are not eligible for benefits.

For mental health and substance use disorders, you must submit medical evidence provided by a qualified mental health doctor/practitioner that you are totally disabled as defined by the plan. This includes a medical doctor or osteopath who specializes in mental health, a psychiatrist, psychologist, psychiatric-mental health nurse, clinical nurse specialist, certified nurse practitioner, doctor of nursing practice, licensed clinical social worker, licensed professional counselor or other medical practitioner whose mental health services are eligible for reimbursement by the HealthChoice health plan.

Elimination period

The elimination period is the first 30 calendar days following your date of disability. During this time, no disability benefits are payable, and you must use any available sick or annual leave. If you work any time during this elimination period, the 30-day count starts over. Once you complete the elimination period, you are eligible for disability benefits.

Effective date for short-term disability

You can begin receiving short-term disability benefits when:

- All eligibility criteria are met.
- Your documented medical condition meets the plan's definition of a disability.

Disability benefits begin no earlier than the date you first receive treatment or advice from a qualified provider. This date must be followed by a continuous absence from work due to your disability for 30 consecutive calendar days (the elimination period).

EXCLUSIONS

There are no benefits available for an illness or injury that:

- Results from intentionally self-inflicted injuries of any kind while sane or insane.
- Results from war or an act of war, whether such war is declared or undeclared.
- Results from your commission of or attempt to commit a crime, e.g., assault, battery, felony or any illegal occupation or activity.
- Is caused by taking part in an insurrection, rebellion or a riot or civil disorder.
- Results from a preexisting condition. Refer to Preexisting Condition in Plan Definitions.
- Is during any period of confinement in a penal or correctional institution for conviction of a crime or public offense.
- Happened while on active military service.
- Is not diagnosed or does not occur before your employment has ended.

SHORT-TERM DISABILITY BENEFITS

The plan pays a monthly short-term disability benefit that is equal to 60% of your base salary at the time of your disability (minus any offsets). Refer to Offsets/Reductions in Benefits.

The maximum monthly benefit is $2,500, and there is no minimum monthly benefit. Short-term disability benefits are paid for a maximum of 150 days (after the elimination period). Once you qualify for short-term disability benefits, you must periodically provide proof of continued disability.

Examples of short-term disability benefits:

Your monthly base salary is $2,000. You file a disability claim under the plan that meets all qualifications. Your monthly short-term disability benefit is calculated as follows:

$2,000	Base salary at the time of disability
x60%	Percentage of base salary
$1,200	**Monthly short-term disability benefit (before offsets)**

The first 30 days of your disability fall under the elimination period when no benefits are paid. The next month, you receive $200 from your employer for annual leave (an offset). Your monthly short-term disability benefit for that month is calculated as follows:

$1,200	Monthly short-term disability benefit
-$200	Annual leave paid by employer (offset)
$1,000	**Net monthly short-term disability benefit**

Disability benefits are subject to state, federal, Medicare and Social Security taxes; however, Social Security taxes do not apply to benefits after six months of disability.

LONG-TERM DISABILITY BENEFITS

If you continue to meet eligibility requirements, you may qualify for long-term disability benefits. Long-term disability begins after 180 days of disability and follows the end of short-term disability.

The plan pays a monthly long-term disability benefit that is equal to 60% of your base salary at the time of your disability (minus any offsets). Refer to the Offsets/Reductions in the Benefits section.

The maximum monthly benefit is $3,000, and the minimum monthly benefit is $50 after any offsets.

Examples of long-term disability benefits:

Your monthly long-term disability benefit is calculated as follows:

$2,000	Base salary at the time of disability
x60%	Percentage of base salary
$1,200	**Monthly long-term disability benefit (before offsets)**

Your monthly long-term disability benefit is $1,200. However, you also receive disability retirement benefits of $700 (an offset) for this same disability.

Your monthly long-term disability benefit is calculated as follows:

$1,200	Monthly long-term disability benefit
-$700	Disability retirement benefits (offset)
$500	**Net monthly long-term disability benefit**

Disability benefits are subject to state, federal, Medicare and Social Security taxes. However, Social Security taxes do not apply after six months of disability.

Example of minimum benefit for long-term disability:

Your monthly long-term disability benefit is $1,200. However, you also receive Social Security disability benefits of $600 and disability retirement benefits of $700 (offsets) for this same disability.

Your monthly long-term disability benefit is calculated as follows:

$600	Social Security Disability benefits
+$700	Disability retirement benefits
$1,300	**Total offsets**

$1,200	Monthly base long-term disability benefit
-$1,300	Total offsets
–$100	**Your monthly offsets are greater than your monthly benefit**

Since your offsets are more than your monthly disability benefit, you are paid the minimum monthly long-term disability benefit of $50.

To remain eligible for benefits

To remain eligible for long-term disability benefits:

- You must provide proof of continued disability (when requested) and provide confirmation that you are following the prescribed treatment as appropriate.
- You may be requested to submit to an Independent Medical Examination to continue receiving benefits. Refer to Independent Medical Examination in the Claims Procedures section.
- You must apply for Social Security Disability Insurance (SSDI) benefits by the seventh month of your disability and continue to pursue SSDI benefits until the entire appeals process is exhausted.
    - If you do not provide proof of application for SSDI benefits by the seventh month of your disability, your plan benefits can be terminated.
    - If you do not appeal a denial of SSDI benefits, your plan benefits can be terminated.
    - If you appeal a denial of SSDI benefits, you must provide proof of appeal to continue receiving plan benefits.
    - If you are awarded SSDI benefits, you must provide the notice of award to continue receiving plan benefits.

After 24 months of disability, you may no longer qualify for benefits from the plan if:

- Social Security has not found you eligible for disability benefits.
- Medical information indicates you could be able to perform other jobs.
- You reach the maximum plan benefits based on your condition or years of service.

Help filing for Social Security Disability Insurance

The HealthChoice disability claims administrator can provide you with free assistance when you file for SSDI benefits; however, you are not required to have them help you. For more information, please contact the disability claims administrator. Refer to HealthChoice Plan Contact Information.

You can hire a private attorney at your own expense for assistance in filing for SSDI benefits.

Prorating benefits for a partial month

Benefits are paid only for the days you are disabled and unable to work, which often means benefits are prorated for a partial month.

Example of benefits prorated for a partial month

Your monthly disability benefit is $1,200. There are 30 days in the month that you qualify, and you qualify on the 15th of the month.

Your benefit is calculated as follows:

$1,200	Monthly disability benefit
÷30	Days in the month
$40	**Benefit per day**

$40	Benefit per day
x15	Days of eligibility for benefits
$600	**Disability benefit for the month (before offsets)**

MAXIMUM BENEFIT PERIODS

Benefit periods are calculated from the time of your disability and include the 30-day elimination period when no benefits are paid. Maximum benefit periods are listed in the charts below:

Less than one year of service	
Age at disability	Maximum Benefit Period
Any age	6 months

More than one year but less than five years of service	
Age at disability	Maximum Benefit Period
Under 66	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

Five or more years of service	
Age at disability	Maximum Benefit Period
Under 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

Mental health and substance use disorder disability benefits are subject to separate guidelines.

Mental health and substance use disorder disability benefits

Mental health and substance use disorder disability benefits have a maximum benefit period of 24 months from the date of disability.

The following exceptions may apply:

- If you are in a hospital at the end of the 24-month period, your benefits continue for the time of your confinement.
- If your total disability continues following discharge, you may be able to extend the benefit period for up to 90 days.
- If you are hospitalized again for at least 14 consecutive days during a 90-day extension, you may be able to extend the benefit period through the time of your second hospitalization for up to an additional 90 days.

A maximum lifetime benefit period of 60 months applies to all mental health and substance use disorders; however, other maximums also apply, and in no event shall benefits exceed the maximums listed in the Maximum Benefit Periods section.

Refer to Medical Proof of Disability for related requirements.

Partial disability

A time of partial disability may follow a period of total disability. You are considered partially disabled if you can perform at least one but not all duties of any occupation and earn less than 80% of your predisability base salary.

Partial disability must result from the same condition as your total disability. Proof of partial disability must be submitted within 31 days of the date your total disability period ends.

Partial disability benefits may be available after total disability for up to 24 months or until one of the following occurs:

- You recover.
- You reach the maximum benefit period.
- Your gross salary from part-time or full-time employment equals 80% or more of your predisability base salary.

Partial disability benefits are subject to offsets. Refer to Offsets/Reductions in Benefits.

Limited return to work

If you receive long-term disability benefits and are able to return to work on a limited basis, you may qualify for partial disability benefits. Your disability benefits are reduced by only 50% of the income you earn from your employment, subject to partial disability provisions.

If you receive partial disability benefits and again become unable to work (totally disabled), your regular long-term disability benefits resume without a new elimination period, except as limited by partial disability provisions.

Limited return to work is subject to the same guidelines as partial disability.

Recurrent disability (relapse)

A recurrent disability is related to or caused by a disability for which you previously received benefits under the plan. A recurrent disability is considered a continuation of your prior disability if you have returned to your regular full-time job for less than six months. This means that you have returned to work for the participating employer where you qualified for prior disability and performed all the assigned duties of that job. The employer must have been participating in the plan both at the time of prior disability and currently.

A recurrent disability does not alter the beginning date of a benefit period. If you have been back to your regular full-time job for more than six months, the recurrent disability is treated as a new disability, and a new 30-day elimination period applies.

OFFSETS/REDUCTIONS IN BENEFITS

Short-term and long-term disability benefits are offset or reduced by other benefits or payments you receive or are eligible to receive for any period of your disability. Offsets, or reductions in benefits, include but are not limited to:

- Available sick leave.
- Salary, wages, holiday pay, commissions or similar earnings you receive from any employment, including self-employment, any salary increases, annual leave and shared leave; however, longevity pay and one-time bonuses are not considered offsets.
- Unemployment compensation benefits.
- Any amount of primary disability benefits provided under the United States Social Security Act for which the employee is eligible because of this disability.
- Any amount of primary and/or family retirement benefits provided under the United States Social Security Act that the employee receives.
- Benefits received under the State of Oklahoma or county retirement systems, except those benefits that began prior to your disability.
- Benefits related to your disability and provided under any state's workers' compensation law, any occupational disease law or any other similar act or law.
- Fifty percent of any wages you earn while partially disabled or during limited return to work (rehabilitative employment).
- Subrogation payments.
- Overpayment of previous disability payments, including retroactive Social Security disability awards.

- Veterans Administration benefits related to this disability where such benefit becomes due as a result of the disability and not by a voluntary election to receive the benefit.
- Disability benefits paid by another group plan, except in certain conditions. Refer to the following list of items that do not reduce your monthly disability benefit.

The following items do not reduce your monthly disability benefit:

- Social Security benefits effective prior to the established date of disability unless awarded because of the same disability.
- Social Security survivor (widow/widower) benefits that are not connected or related to your disability or Supplemental Security Income program awards. Please refer to the United States Social Security Act for specific details.
- Plans funded entirely by your contributions.
- Plans where payment of benefits would reduce benefits at retirement.
- Benefits paid for conditions documented one year or more before the date of this disability claim.
- A profit-sharing plan, 401K, thrift plan, individual retirement account, stock ownership plan, tax-sheltered annuity or benefits from a nonqualified deferred compensation plan.
- Statutory or cost of living increases from pension or pension disability programs, Social Security or workers' compensation.

EGID prorates any benefits received in a lump sum over the benefit period or your actuarially expected lifetime if no benefit period is established.

Benefit offsets may be estimated if they have not yet been awarded or denied or if the denial is being appealed. Any overpayment or underpayment that results from estimating offsets must be repaid by the responsible party once the actual benefit is determined. If an overpayment is not repaid, HealthChoice has the authority to reduce the benefit from a life insurance claim or to place a Tax Warrant Intercept through the Oklahoma Tax Commission.

CLAIM PROCEDURES

Filing a claim

First, report your claim to the disability claims administrator through **mysedgwick.com/HealthChoice** or by phone as soon as reasonably possible but no later than 60 days of the date you become disabled.

After you contact the disability claims administrator, a disability initial packet will be mailed to you, which includes the information and forms you need to facilitate the processing of your claim.

For more information or to file a claim, contact the disability claims administrator. Refer to HealthChoice Plan Contact Information.

Proof of claim must be submitted to the disability claims administrator.

You will have 34 calendar days from the day you call your claim in or from your first date of absence, whichever is later, to provide supporting medical documentation for your disability. The supporting medical documentation must include the following information:

- Diagnosis.
- Date and duration of your disability.
- Restrictions and limitations.
- Physical and/or cognitive exam findings and test results.
- Treatment plan.
- Reasons why you cannot perform the duties of your own occupation or any occupation, as appropriate.
- Medical evidence provided by a qualified doctor stating that you are totally disabled as defined by the plan. Refer to Medical Proof of Disability for other requirements.

The determination of whether you are disabled will be made by the disability claims administrator based on objective medical evidence. Objective medical evidence consists of facts and findings, including but not limited to X-rays, laboratory reports and tests, consulting physician reports as well as reports and chart notes from your physician. In addition, you must be under the continuous care of a qualified doctor and following the prescribed treatment.

Your employer must provide a copy of your job description, work record, and salary information certified by the administrator or payroll officer. This must be done at the beginning of your claim and monthly following the initial claim approval for your monthly disability benefit payments to be released.

Under some circumstances, you may be requested to provide proof of income documents such as income tax reports and payroll records.

Appeal a denied claim

If your claim for disability benefits is denied for any reason, you have the right to appeal and have your claim reviewed. Requests for review of your claim must be sent in writing within 180 days of receipt of your denial letter to the disability claims administrator. Please also include any additional information you wish to provide.

If your claim is again denied, you can appeal that decision through a grievance panel hearing. Submit your request for a grievance panel hearing within 60 days of your second denial. The grievance panel is an independent review group established by Oklahoma Statutes. You can represent yourself, but if you are unable to submit the request yourself, only attorneys licensed to practice in Oklahoma are permitted to submit a hearing request for you or to represent you through the hearing process.

To file an appeal with the grievance panel, call 405-717-8780 or toll-free 800-543-6044. TTY users call 711. Or write to:

Legal Grievance Department
P.O. Box 11137
Oklahoma City, OK 73136-9998

When considering complaints by insured members, the three-member grievance panel will determine by a preponderance of the evidence whether EGID has followed its statutes, rules, plan documents, policies and internal procedures. The grievance panel will not expand upon or override any EGID statutes, rules, plan documents, policies or internal procedures.

All reviews and decisions of the grievance panel are made as quickly as possible. After exhausting EGID grievance procedures, you can file an appeal in an Oklahoma District Court.

Independent medical examination

EGID has the right to require that you be examined by a provider or vocational expert of its choice. This right can be used as often as deemed necessary. EGID pays for all independent medical examinations and reimburses for travel expenses as set out by Oklahoma Statutes.

Failure to comply — suspension or termination of benefits

EGID has the right to suspend and terminate plan benefits in the event you fail to comply with requirements. Your benefits can be suspended or terminated if you fail to do any of the following:

- Comply with your prescribed treatment plan or rehabilitation program.
- Submit to an independent medical examination.
- Cooperate with the disability claims administrator.
- Supply proof of continued disability by a qualified provider.
- Cooperate in the repayment of overpaid benefits.
- Comply with the requirements of the plan.

If your benefits are suspended or terminated, EGID or the disability claims administrator will notify you or your legal representative of the claim denial in writing after the denial is processed.

If your claim is denied, please refer to Appeal a Denied Claim.

GENERAL PROVISIONS

All rights or benefits under the plan are subject to all terms and conditions of the plan. Participation in the plan does not give you any rights to retain your employment with your participating employer, nor does it interfere with the rights of your participating employer to discharge you at any time.

Payment of benefits

Disability benefits are paid only to the employee. If the employee is a minor or is not competent, EGID may only pay the court-appointed guardian or conservator. If EGID pays benefits to anyone other than the employee, as specified or as required by law, EGID has discharged its full responsibility regarding those benefits.

Benefits are paid once monthly following receipt of all requested information. Benefits are paid by electronic funds transfer and deposited directly to your bank account. Disability benefits are paid in arrears, meaning payments are issued after the benefit period has passed. Your first payment may include back pay for eligible periods once your claim is approved. Payment amounts and timing depend on eligibility determination and receipt of required information.

In the event of your death, any outstanding benefits are paid to your beneficiary or to your estate.

Documented expenses payable for rehabilitation services may be paid directly to the providers of such services or reimbursed to the third-party disability claims administrator; these payments shall not reduce the monthly disability benefits.

EGID may authorize a lump sum settlement of a disability claim if mutually agreed upon by the employee and the plan administrator. Such agreement shall preclude the employee from receiving any future benefits for the disability for which the settlement is made. Recurrent disability provisions do not apply in the event of a lump sum settlement payment.

Disability benefits are not assignable.

Taxation of disability benefits

Disability benefits are subject to state, federal, Medicare and Social Security taxes. Social Security and Medicare taxes do not apply to disability benefits extending more than six months after the last calendar month the employee worked.

Recovery of FICA contributions

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

Direct deposit and insurance premium deductions

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

In addition to all other required deductions, premiums for insurance coverage provided to disabled employees and their dependents as authorized at Title 74 O.S. §§ 1332(A) and 1332.1(D) may be deducted from disability benefit payments.

Right to amend or terminate the plan

EGID reserves the right to amend, modify, terminate or partially terminate the HealthChoice Disability Plan, retroactively or otherwise.

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

CONTINUING YOUR HEALTH, DENTAL, LIFE AND VISION COVERAGE

If employment has not been terminated

Any health, dental, life or vision coverage you are enrolled in can be continued while you receive disability benefits.

If you receive payment for sick or annual leave during a month, your employer may be responsible for submitting its share of your monthly premium that month. Please check with your insurance coordinator or benefits partner to determine if this applies.

If your sick leave and annual leave are exhausted or you are on approved leave without pay and want to continue health, dental, life or vision coverage, you are responsible for all premiums. You must submit your premiums to your employer, who submits them to EGID. You can also request that your premiums be deducted from your disability benefit; however, if the disability payment (after offsets) is less than the premium amount or if the premium is for a partial month, it cannot be deducted from the disability payment. You are not responsible for the disability portion of your premium. For more information, contact your insurance coordinator or benefits partner.

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

If employment has been terminated

Any health, dental, life or vision coverage in effect at the time of your termination can be continued if you receive disability plan benefits and premiums are paid. Premiums must be submitted directly to EGID, or you can request that your premiums be deducted from your disability benefit; however, if the disability payment (after offsets) is less than the premium amount, or if the premium is for a partial month, it cannot be deducted from the disability payment. For more information, contact the disability claims administrator. Refer to HealthChoice Plan Contact Information.

When you are no longer eligible for disability plan benefits, you may be eligible to continue health, dental, life and vision coverage through retirement, vesting or years of service.

If you do not qualify to continue benefits through the above options, you may be eligible to continue health, dental and vision coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

You are required to notify EGID when Medicare and/or Social Security benefits become effective. Please send a copy of your Social Security award letter and/or Medicare card to EGID as proof. Failure to notify EGID within 30 days can adversely impact your premiums and/or benefits.

TERMINATION OF BENEFITS AND COVERAGE

Termination of benefits

Disability benefits end when any of the following occur:

- When your disability ends.
- When documentation no longer supports your continued disability.
- When the maximum benefit period ends.
- On the date of your death.
- If you fail to:
  - Comply with your rehabilitation program.
  - Submit to an independent medical exam.
  - Cooperate with the disability claims administrator.
  - Supply proof of your continued disability by a qualified provider.
  - Cooperate with the repayment of overpaid benefits.
  - Comply with other requirements of the plan.

Termination of coverage

Your participation in the HealthChoice Disability Plan ends on the earliest of the following dates:

- The date the disability plan terminates.
- The date your active employment ends.
- The date you waive your disability coverage.

Subject to plan provisions, benefits will continue during the period you remain disabled. Coverage can be continued if the date of your disability is determined to be on or before the termination date (the 30-day elimination period applies) or if you are on furlough or temporarily laid off. EGID shall not discriminate unfairly among employees in similar situations. Termination of the disability plan under any conditions will not prejudice any payable claim that occurs while the plan is in force.

New diagnoses that do not occur before your employment is terminated are not eligible for benefits.

PLAN DEFINITIONS

Base salary: The rate of earnings in effect on the date your disability begins. Base salary does not include overtime, commissions, bonuses, longevity pay, salary increases, productivity enhancement program payments or any other extra compensation.

Benefit period: The first day of the benefit period is the day you become eligible for benefits. The end of the benefit period is the last day of eligibility as determined by the maximum benefit period and/or eligibility limits. A recurrent disability will not alter the beginning date of the benefit period.

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

Disability claims administrator: Individuals or organizations hired and/or appointed to provide certain administrative services to or on behalf of the HealthChoice Disability Plan.

EGID: The Employees Group Insurance Division, the plan administrator of the HealthChoice Disability Plan.

Eligibility period: The first 31 consecutive calendar days of employment. No benefit is payable for this period. For employees with less than one year of service, proof of continuous presence at the regularly assigned workplace and verification by the appointing authority that the employee was performing all material duties of the employee's regular occupation continuously during the eligibility period shall be required as conditions of satisfaction of the eligibility period. When an employee has opted out of disability coverage as allowed by 74 O.S. § 1308.3, such employee may be reinstated but will be considered to have no prior service and no continuous employment prior to their reinstated eligibility.

Elimination period: The first 30 consecutive days of disability where no benefits are payable for this period.

Furlough: A nonscheduled working day in addition to regular nonscheduled working days requested by the employer.

Grievance Panel: An independent constitutionally created administrative court consisting of a three-member grievance panel that acts as an appeals body for complaints by insured members.

Illness: Sickness or disease, including pregnancy and complications of pregnancy. A disability resulting from illness must begin while you are participating in the plan.

Injury: Bodily injury resulting directly from an accident and independent of all other causes. A disability resulting from injury must occur while you are participating in the plan.

Partial disability: If you are performing at least one but not all material duties of any occupation and earn less than 80% of your predisability base salary.

Participant: An employee of a participating employer who is eligible and is participating in the plan.

Participating employer: Agencies of the State of Oklahoma and county and city governments who have filed a resolution to participate are eligible for the plan.

Participation: Participation in the HealthChoice Disability Plan shall be limited to employees who have been employed for a period of not less than one month prior to the onset of the disability. One month shall mean 31 consecutive days.

Plan: The HealthChoice Disability Plan administered by EGID.

Preexisting condition: A preexisting condition refers to an illness or injury for which you received medical care, diagnosis, consultation, treatment, durable medical equipment or took prescribed medications during the 90-day period immediately preceding your employment date. The term preexisting condition shall also include any condition related to such injury or illness, including the diagnosis of pregnancy and any related condition.

Proof of claim: Written documentation submitted to EGID or the disability claims administrator confirming a claim for benefits.

Proof of continued disability: To remain eligible for long-term disability benefits, you must provide proof of continued disability and continuous care when required. This means a qualified provider must objectively document and certify your disability.

Provider: A person licensed to practice medicine and surgery, osteopathy, chiropractic, podiatry, optometry or dentistry who is legally qualified as a medical practitioner under the insurance statutes of the State of Oklahoma and operating within the scope of their license. An employee or an employee's spouse, child, father, mother, sister or brother are excluded from providing treatment.

Years of service: Time spent as an active employee performing full-time duties with an employer that participates in the HealthChoice Disability Plan.

Time spent working on partial disability or on leave without pay status after an established disability date will not be counted toward years of service for disability benefit purposes. Under no circumstances will the time for which an insured receives disability benefits under this plan be counted toward years of service.

You: The term you or your includes but is not limited to persons who are currently drawing disability benefits under the plan or who meet each and every requirement of the plan. Any employee of a participating employer who is eligible and has elected to participate in the plan.

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OKLAHOMA

HealthChoice is administered by EGID,
a division of the Oklahoma Health Care Authority.