DISABILITY PLAN HANDBOOK

PLAN YEAR 2021

4515

HEALTHCHOICE DISABILITY PLAN HANDBOOK

This disability handbook replaces and supersedes any disability handbook the Office of Management and Enterprise Services Employees Group Insurance Division previously issued. This disability handbook will, in turn, be superseded by any subsequent disability handbook EGID issues.

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

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HEALTHCHOICE PLAN CONTACT IDENTIFICATION

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
Office of Management and Enterprise Services Employees Group Insurance Division
405-717-8701 or toll-free 800-543-6044
2401 N. Lincoln Blvd., Ste. 300
Oklahoma City, OK 73105

Member Services
405-717-8780 or toll-free 800-752-9475
TTY 711
Fax 405-717-8942
healthchoiceok.com

PLAN NOTICE

The Office of Management and Enterprise Services Employees Group Insurance Division provides disability benefits to eligible State of Oklahoma, county and city employees in accordance with the provisions of 74 O.S. § 1331, et. seq.

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/benefits coordinator 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 document 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.

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 not classified as a temporary or seasonal employee.
3. You have been actively at work 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 more than 30 consecutive calendar days. Your documented medical condition must meet the plan's definition of a disability. Refer to Definition of Disability for details.
5. You notify the disability claims administrator within 60 days of the date you become disabled or as soon as reasonably possible.
6. You provide proof of claim to the disability claims administrator no later than one year after the start of the disability. 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. Or if good cause is shown, the plan administrator may waive the 60-day requirement. No claim may be reopened when request is made more than one year after benefits have ended for any reason.
7. Your claim has been approved by the disability claims administrator.
8. 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 work days.

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 normally become eligible for disability coverage, you shall not become eligible until you obtain an unconditional release from your physician, and you have returned to the job for five full-time consecutive workdays, performing all of 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 enter on duty 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

Up through the first 24 months of disability, you are considered totally disabled if, as a result of pregnancy, injury or illness you are unable to perform the essential duties of your own occupation for 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 substantiate 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 and pursuing reinstatement of your license on a timely basis. Timely pursuit of reinstatement means you apply for reinstatement when your condition meets the criteria and you provide information and forms requested by the licensing agency on a timely basis until your license is reinstated. Loss of license in and of itself is not sufficient for meeting the definition of disability. A loss of your license due to reasons other than your disabling condition (such as failure to renew it or violations that cause the license to be suspended) is not considered in determining disability.

While receiving disability benefits, you may experience a second, unrelated disability. The second condition must meet the definition of disability. If the second disability claim is eligible for benefits, the two claims are combined to form one continuous disability period.

Medical proof of disability

You must submit medical evidence provided by a qualified doctor 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 following the course of treatment prescribed. New diagnoses that occur after 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, psychiatrist, psychologist, psychiatric-mental health nurse, clinical nurse specialist, certified nurse practitioner, or a 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:

- Resulting from intentionally self-inflicted injuries of any kind while sane or insane.
- Resulting from war or an act of war, whether such war is declared or undeclared.
- Resulting from your commission of or attempt to commit a crime; e.g., assault, battery, felony or any illegal occupation or activity.
- Caused by taking part in an insurrection, rebellion or a riot or civil disorder.
- Resulting from a preexisting condition. Refer to Preexisting Condition in Plan Definitions.
- During any period of confinement in a penal or correctional institution for conviction of a crime or public offense.
- For a claim filed with the disability claims administrator more than one year after the date of disability.
- While on active military service.
- Which is diagnosed or occurs after your employment is terminated.

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 offsets). Refer to Offsets/Reductions in Benefits.

The maximum monthly benefit is $2,500. 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
x 60%	Percentage of base salary
$1,200	**Monthly short-term disability benefit (less 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	**Short-term disability benefit for that month (less any other offsets)**

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 offsets). Refer to the Offsets/Reductions in Benefits section.

The maximum monthly benefit is $3,000, and the minimum monthly benefit is $50, after appropriate 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
x 60%	Percentage of base salary
$1,200	**Monthly long-term disability benefit (less 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 (an offset)
$ 500	**Monthly long-term disability benefit (less any other offsets)**

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 $550 and disability retirement benefits of $700 (offsets) for this same disability.

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

$550	Social Security Disability benefits
+$700	Disability retirement benefits
$1,250	**Total offsets**

$1,200	Monthly base long-term disability benefit
–$1,250	Total offsets
–$50	**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 also apply for Social Security Disability Insurance 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 appeal a denial of SSDI benefits, your plan benefits can be terminated. Refer to Help Filing for Social Security Disability Insurance.

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.

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, there is no obligation for you to use this service. For more information, please contact the disability claims administrator. Contact Information is at the front of the handbook.

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 actually disabled, which often means benefits must be 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 (less 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

Five or More Years of Service	
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

Mental health and substance abuse 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 90 days.
- If you are rehospitalized 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 an additional 90 days.

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

Refer to the Medical Proof of Disability section 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, of the duties of any occupation and earn less than 80% of your pre-disability 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 occur:

- You recover.
- You reach the maximum benefit period.
- Your gross salary from part-time or full-time employment equals 80% or more of your pre-disability 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 been back to your regular full-time job for less than six months and performed all the assigned duties of that job.

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.
- Social Security benefits related to your disability as follows:
    - 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.
- Social Security benefits not included:
    - Social Security benefits effective prior to the established date of disability, unless awarded as a result of the same disability.
    - Social Security widow's/widower's benefits that are not connected or related to your disability or Supplemental Security Income Program awards – refer to the United States Social Security Act for specific details.

- Benefits received under the State of Oklahoma or county retirement systems, except those benefits which began prior to your disability.
- Benefits related to your disability and provided under any state's workers' or workman's 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.
- 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 the following conditions:
  - 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 non-qualified deferred compensation plan.

Statutory or cost of living increases from pension or pension disability programs, Social Security or workers' compensation do not reduce your monthly disability benefit.

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.

CLAIM PROCEDURES

Filing a claim

First, report your claim to the disability claims administrator by telephone within 60 days of the date you become disabled, or as soon as reasonably possible. No claim is accepted if submitted after one year from the date of disability.

After you contact the disability claims administrator, a disability initial packet is mailed to you that 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. Contact Information is at the front of the handbook.

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.
- You must submit medical evidence provided by a qualified doctor 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 on the basis of 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 submit the information below which is certified by the administrator or payroll officer at your work at the beginning of your claim and monthly following the initial claim approval. Your monthly disability benefit payments cannot be released until this information is received. Upon termination or retirement this information will no longer be needed:

- A copy of your job description and a copy of your work record and salary information.

Under some circumstances, you are asked to provide proof of income documents, such as income tax reports or payroll records.

To appeal a denied claim

If your claim for disability benefits is denied for any reason, you have the right to 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 as listed in the Plan Contact Information section. Please include any additional information you wish to provide.

If your claim is again denied, you can appeal that decision to the grievance panel. The grievance panel is an independent review group established by Oklahoma statute.

You can submit a request for a grievance panel hearing and represent yourself in these proceedings. If you are unable to submit a request for a grievance panel hearing yourself, only attorneys licensed to practice in Oklahoma are permitted to submit your hearing request for you or represent you through the hearing process.

To file an appeal with the grievance panel, call 405-717-8701 or toll-free 800-543-6044. TTY user call 711. Or write to:

Legal Grievance Department
2401 N. Lincoln Blvd., Ste. 300
Oklahoma City, OK 73105

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 and 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 statute.

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:

- 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 requirements of the plan.

In the event 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 the To Appeal a Denied Claim section.

GENERAL PROVISIONS

Any and 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 benefits payable are to an employee who is a minor or who 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 in regard to 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.

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 lump sum settlement is made.

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.

The recurrent disability provisions do not apply in the event of a lump sum settlement payment.

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 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 application to EGID to request a waiver of this requirement. The waiver will be granted only upon good cause shown when it is determined to be in the best interest of the employee. EGID may also waive this requirement when it is necessary in the best interest of EGID to do so.

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 or modify the HealthChoice Disability Plan, retroactively or otherwise, or to terminate or partially terminate the plan.

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/benefits coordinator to determine if this applies.

If your sick 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 in turn 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/benefits coordinator.

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

If employment has been terminated

Any health, dental, life or vision coverage in effect at the time of your termination can be continued as long as 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. Contact information is at the front of the handbook.

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 photocopy of your Social Security award letter and/or Medicare card to EGID as proof of your Medicare and/or Social Security benefits. 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.
- Waiver of disability coverage.

Benefits will be continued during the period you remain disabled; subject to plan provisions. 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 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 which occur after 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 or not the terms are used in medical or legal documents supplied as proof of disability under this plan. Uses of such terms are intended to be disregarded by this plan. Determinations rendered by or for workers compensation or social security are not considered prima facie evidence of disability for this plan.

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 Office of Management and Enterprise Services 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 work place and verification by the appointing authority that the employee was performing all of the material duties of the employee's regular occupation continuously during the eligibility period shall be required as conditions of satisfaction of the eligibility period. Employees reinstated to eligibility to participate in the disability plan after having waived disability coverage pursuant to 74 O.S. § 1308.3 will be considered to have no prior service and no continuous employment prior to their reinstated eligibility.

Elimination period: 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, of the material duties of any occupation, and earn less than 80% of your pre-disability 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 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.

State Of Oklahoma
Office Of Management And Enterprise Services
PRIVACY NOTICE
Revised January 2021

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

For questions or complaints regarding privacy concerns with OMES, please contact:

OMES HIPAA Privacy Officer
2401 N. Lincoln Blvd., Ste. 300, Oklahoma City, OK 73105
405-717-8780, toll-free 800-543-6044
TTY 711
omes.ok.gov

Why is the notice of privacy practices important?

This notice provides important information about the practices of OMES pertaining to the way it gathers, uses, discloses and manages your Protected Health Information and it also describes how you can access this information. PHI is health information that can be linked to a particular person by certain identifiers including, but not limited to, names, Social Security numbers, addresses and birth dates.

Oklahoma privacy laws and the federal Health Insurance Portability and Accountability Act of 1996 protect the privacy of an individual's health information. For HIPAA purposes, OMES has designated itself as a hybrid entity. This means that HIPAA only applies to areas of OMES operations involving health care, and not to all lines of service offered by OMES. This notice applies to the privacy practices of the following OMES divisions that may share or access your PHI as needed for treatment, payment and health care operations:

- Employees Group Insurance Division.
- Legal.
- Information Services as it applies to maintenance and storage of PHI.

OMES is committed to protecting the privacy and security of your PHI as used within the components listed above.

Your Information. Your Rights. Our Responsibilities.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your health and claims records.

- You can ask to see or get an electronic copy of your medical record and other health information we have about you. Ask us how to do this using the contact information at the beginning of this notice.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records.

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may decline your request but will explain the reasons in writing within 60 days.

Request confidential communications.

- You can ask us to contact you in a specific manner, e.g., home or office phone, or to send mail to an alternate address.
- We will consider all reasonable requests.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment or our operations.
    - We are not required to approve your request.

Get a list of those with whom we've shared information.

- You can ask for an accounting of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why.
- We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one free accounting per year but will charge a reasonable fee if you request an additional accounting within 12 months.

Get a copy of this privacy notice.

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will promptly provide you with a paper copy.

Choose someone to act for you.

- If you have named a medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make decisions about your health information.
- We will verify the person has this authority and can act for you before any action is taken.

File a complaint if you feel your rights are violated.

- You can file a complaint if you feel we have violated your rights by contacting us using the information at the beginning of this notice.

- You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave., S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.
- Include your information in a hospital directory.
- Contact you for fundraising efforts.

If you are not able to tell us your preference, e.g., if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent health or safety threat.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes.
- Sale of your information.
- Most sharing of psychotherapy notes.

In the case of fundraising:

We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our uses and disclosures

How do we typically use or share your health information?

Your PHI is used and disclosed by OMES employees and other entities under contract with OMES according to HIPAA Privacy Rules and the “minimum necessary” standard, which releases only the minimum necessary health information to achieve the intended purpose, or to carry out a desired function within OMES.

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive.

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization.

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Examples: We use health information about you to develop better services for you, provide customer service, resolve member grievances, member advocacy, conduct activities to improve members' health and reduce costs, assist in the coordination and continuity of health care, and to set premium rates.

Pay for your health services.

We can use and disclose your health information as we pay for your eligible health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan.

We may disclose summarized health information to your health plan sponsor for plan administration.

Example: Your employer contracts with us to provide a health plan, and we provide the employer with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must comply with the law to share your information for these purposes. For more information, refer to **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues.

We can share your health information for certain situations such as:

- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.
- Reporting suspected abuse, neglect or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.

Do research.

We can use or share your information for health research, as permitted by law.

Comply with the law.

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to ensure we are complying with federal privacy laws.

Respond to organ and tissue donation requests.

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director.

We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address workers' compensation, law enforcement and other government requests.

We can use or share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions.

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our responsibilities

When it comes to your health information, we have specific obligations such as:

- We are required by law to maintain the privacy and security of your Protected Health Information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your PHI other than as described here unless you notify us in writing that we can. You may change your mind at any time but must let us know in writing if you do.

For more information, refer to **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes to the terms of this notice.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will deliver a copy to you. You may also subscribe online to receive notice of changes to this page via email or text message.

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HealthChoice is administered by EGID, a division of the
Oklahoma Office of Management and Enterprise Services.