TITLE 260. OFFICE OF MANAGEMENT AND ENTERPRISE SERVICES
CHAPTER 40. EMPLOYEE BENEFITS DEPARTMENT

Subchapter 1. General Provisions

260:40-1-1. Purpose

(a) The purpose of this Chapter is to establish policies, procedures and standards that apply to the State Employee Benefits Department (EBD).

(b) The Employee Benefits Department is a department of the Human Capital Management Division of the Office of Management and Enterprise Services to implement provisions of the Oklahoma State Employees Benefits Act. The EBD is responsible for the general administration and for the proper design, selection and operation of the benefits offered under the Flexible Benefits Plan.

260:40-1-2. Authority

The authority for the rules in this Title is the Oklahoma State Employees Benefits Act, 74 O.S. Supp 1992, Section 1361 et seq. The rules in this Chapter are promulgated by the Office of Management and Enterprise Services to establish the EBD's organization and its administration policies and procedures.

260:40-1-3.1. Definitions

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

"Act" means the Oklahoma State Employees Benefits Act, 74 O.S. Supp 1992, Section 1361 et seq.

"EGID" means the Employees Group Insurance Department.

"EBD" means the Employee Benefits Department.

"Director" means the Director of the EBD.

"Flexible Benefits Plan" means the Flexible Benefits Plan authorized pursuant to the State Employees Flexible Benefits Act as modified by the provisions under the State Employees Benefits Act.

"Rules" mean the Rules of the EBD.

260:40-1-4. Computation of time

To compute any period of time prescribed or allowed by this Chapter, the day of the act or event from which the period of time begins to run shall not be included. The last day of the period shall be included unless it is a Saturday, Sunday, legal holiday, or other day when the EBD's offices are not open for business until 4:30 p.m. In such case the period shall run through the end of the next day the offices are open until at least 4:30 p.m.

Subchapter 3. Organization and Administration

260:40-3-1. Location for information and for filing

(a) Any person may obtain information from, make submission to, or make a request of the Employee Benefits Department by writing to: Employee Benefits Department, Jim Thorpe Bldg., 2101 N. Lincoln Blvd, Rm 560, Oklahoma City, Oklahoma 73105.

(b) Written submissions and requests may be submitted in person between the hours of 8:00 a.m. and 4:45 p.m., Monday through Friday.

(c) The date on which papers are actually received at the EBD will be recorded as the date of filing.

260:40-3-2. Documents and records

(a) Documents filed with or presented to the EBD will be retained in the files of the EBD for the length of time required by state laws. Documents will be disposed of in a manner consistent with the Records Management Act, Section 201 through 216 of Title 67 of the Oklahoma statutes, and Sections 564 through 576 of Title 74 of the Oklahoma Statutes, which pertain to archive and records. The records disposition schedule for EBD will be available for public inspection.

(b) The EBD shall act at all times in accordance with the provisions of the Oklahoma Open Records Act, 51 O.S. 1991, §§ 24A.1, et seq., as amended.

(c) The public may obtain information relative to the operation of the EBD by submitting a written request in the prescribed form to the Director or his/her designee. All records shall be available for

inspection and copying during normal business hours. The Director, or his/her designee, shall be available during normal business hours to receive and, where appropriate, act upon requests for record review and copying.

(d) All records of EBD shall be public unless protected by a mandatory or permissive privilege of confidentiality. In the event a request is made for the release of records subject to a permissive privilege of confidentiality, the Director shall determine whether or not disclosure is made.

(e) Provisions for copying and search fees are contained in the statute, with these exceptions being noted: no copy fee is charged to other public entities, to applicants, state employees or their representatives, or former employees seeking information from their file or employment records; and no search fee is charged to news media, schools, authors, or "taxpayers seeking to determine whether those entrusted with the affairs of its government are honestly, faithfully, and competently performing their duties as public servants." The fees listed in (1)-(4) of this Subsection may stand alone or be charged in combination. For example, a person may be charged a search fee in addition to a fee for photocopying.

(1) **Fees for photocopying**. The EBD has established a fee schedule for photocopying documents having the dimension of 8.5 × 14.0 inches or smaller:

(A) 25 cents per page;

(B) One dollar ($1.00) per copied page for a certified copy.

(2) **Fees for search**. Requests that are for a commercial purpose or clearly would cause excessive disruption of office function will be charged a search fee equal to the hourly rate of the designated Document Manager for each hour of staff time spent in the search.

(3) **Fees for other types of reproduction**. Requests for computer runs, microfilming or reproduction other than photocopying, will be charged at cost to the EBD of duplicating the information involved. Such requests are to be forwarded to the State Office where the fee will be developed with the appropriate division.

(4) **Payment of fees**. All fees are paid prior to delivering the copies, and if the request is for search only, the fee is paid before the person is allowed to review the material. All fees are paid by check or money order; cash is not accepted. The fee payment is transmitted to the Employees benefits EBD, Attention Accounting Division. In addition, a receipt is to be given upon payment. A copy of the manual material is maintained to explain the fee schedule to interested persons.

260:40-3-3. Benefits Coordinators

(a) Each participating employer shall designate at least one person as a Benefits Coordinator to serve as a representative between the EBD and the participating employer. Each participating employer shall communicate its Benefits Coordinator designation to the EBD in writing.

(b) A Benefits Coordinator shall be responsible for assisting the EBD in handling employee enrollment and changes in the flexible benefits plans offered by the EBD. A Benefits Coordinator shall be responsible for ensuring that each participant is notified of and has an opportunity to receive flexible benefit plan enrollment materials from the EBD, materials from the vendors identified in Chapter 20 of this title, and other notifications from the EBD.

(c) A Benefits Coordinator shall keep participant enrollment information confidential.

SUBCHAPTER 5. FORMAL AND INFORMAL PROCEDURES

260:40-5-1. Purpose

The rules in this Subchapter describe general formal procedures the EBD uses to take action and make decisions.

260:40-5-2. EBD may take action

The EBD may take any action which is consistent with the rules in this Title to carry out the duties of the EBD and accomplish the objectives of any program within its authority.

260:40-5-3. [Reserved]

260:40-5-4. [Reserved]

260:40-5-5. General complaints

(a) Anyone may complain to the EBD about any matter under its authority. A complaint shall be in writing and shall include the following information:

(1) The name, address and telephone number of the person making the complaint;

(2) The name, address and telephone number of the organization the person represents, if applicable;

(3) The name, address, telephone number and title of any representative of the person filing the complaint;

(4) A brief, clear description of each charge, problem or issue that is the basis for the complaint including names, dates, places and actions;

(5) The numbers and headings of the laws and rules that may apply;

(6) The remedy, if any, the person making the complaint seeks;

(7) The signature of the person making the complaint; and

(8) The date.

(b) If the complaint concerns a matter that has already been resolved by the EBD, the EBD will notify the complainant of the resolution by including a copy of any document that demonstrates resolution of the matter. If the matter is outside the authority of the EBD, the EBD will notify the complainant in writing that the complaint is outside the scope of the EBD's authority.

(c) The EBD may provide others with written notice of the complaint and give them an opportunity to respond in writing within fifteen (15) days. The response must contain all of the following information:

(1) The name, address, and telephone number of the person responding;

(2) The name, address, and telephone number of the organization the person represents, if applicable;

(3) The name, address, telephone number and title of any representative of the person responding;

(4) A specific admission, denial or explanation of each charge;

(5) A brief, clear description of the facts including names, dates, places and actions;

(6) A brief, clear explanation of the reasons for the action (or inaction) that is the basis for the complaint if the person admits to any charge;

(7) The numbers and headings of the laws and rules that may apply;

(8) The signature of the person responding; and

(9) The date.

(d) The EBD or the Director may refer complaints to informal procedures, such as telephone calls, letters, meeting, mediation, investigations or other appropriate procedures.

(e) Unless the EBD or Director determines individual proceedings are necessary, none shall be conducted.

(f) Unless the EBD requires more time, the EBD shall make a decision about a complaint within ninety (90) days after its receipt. If more than ninety (90) days is required to resolve a complaint, the Director shall notify the person filing the complaint and persons filing any responses to the complaint.

260:40-5-6. [RESERVED]

260:40-5-7. [RESERVED]

260:40-5-8. [RESERVED]

260:40-5-9. Forms

The EBD shall create forms as necessary to implement the provisions of this subchapter. The EBD shall accept written requests for hearings that are in substantial compliance with the forms.

260:40-5-10. Claims Procedure

(a) The EGID has written rules in Title 260 of the Oklahoma Administrative Code which define the EGID's benefits and grievance procedure;

(1) Employees Health, Life, and Dental Plans;
(2) The Disability Program; and
(3) Hearings Procedures.
(b) Participants covered by the plans of the EGID shall use the EGID's grievance procedure.
(c) The EBD may contract with one or more health maintenance organizations, insurance companies, or other agencies to provide benefits to a participant. If a benefit plan provides for a specific grievance process, the procedure for that benefit plan shall be used.
(d) The EBD shall make the final determination as to whether provider plans are being administered consistently with the provisions of the EBD's Basic Plan or as otherwise contracted. Upon its determination that any benefit provider is not satisfying the requirements of the Basic Plan or the terms of its contract, the EBD may order corrective action as needed.
(e) The EBD shall only have authority to determine the rights of any participant or beneficiary in a Health Care Reimbursement Account Option or a Dependent Care Reimbursement Account Option.
(f) If any claim for benefits under a Health Care Reimbursement Account Option or a Dependent Care Reimbursement Account Option is wholly or partially denied, the claimant shall be given notice in writing no later than forty-five (45) days after the claim is filed. The notice shall include the following information:
(1) The specific reason for the denial;
(2) Specific reference to the provisions used as the basis for the denial;
(3) A description of any additional materials or information necessary for the claimant to perfect the claim and an explanation why such material or information is necessary;
(4) An explanation that a full and fair review of the decision denying the claim may be requested in writing within ninety (90) days and with whom such request shall be filed; and
(5) If such request is filed, the claimant or authorized representative may review pertinent documents and submit issues and comments in writing anytime during the ninety (90) days after notice of denial but before filing the request for hearing.
(g) The request for a review of a denial of a claim for benefits under a Health Care Reimbursement Account Option or a Dependent Care Reimbursement Account Option shall be mailed or delivered to the Director at the address given in subchapter 3 of this chapter.
(h) The EBD may contract with a claims administrator to process participant claims against health care spending accounts and dependent care spending accounts. The EBD and its claims administrator, if any, shall process claims according to subsection (f) of this section.
(i) All hearings for review of the EBD or its hearing examiner conducted under this section shall be conducted no later than sixty (60) days after the EBD receives a request for a hearing. Upon notice of special circumstances by any party, the EBD may postpone the hearing but the hearing must be conducted within 120 days of the request for hearing.

260:40-5-11. Request for hearing on denial of claim [Reserved]

260:40-5-12. Notice of hearing

Upon the receipt of a Request for Hearing form, the Director shall assign a case number and the Director shall notify the claims administrator by mail. The employee shall be notified of the hearing date by first class mail. A copy of all rules pertinent to the hearing shall be forwarded with the notice along with a statement of claimant's rights and the basis for denial.

260:40-5-13. Individual proceedings

(a) The EBD follows the provisions of Article II of the Administrative Procedures Act, Sections 309 through 323 of Title 75 of the Oklahoma Statutes, and this Chapter. The EBD or a person named as the Hearing Examiner shall conduct hearings. This section does not apply to public hearings to receive comments on proposed rules or to the EBD's selection of contractors or benefit providers.
(b) The Director shall set the date for the hearing and shall send notice of the hearing to all parties.
(c) All hearings shall be held before the EBD or a Hearing Examiner designated by the Director. The Director may set cases for original hearing by the EBD upon his determination of special policy considerations for the EBD. The EBD may agree to hear any part or all of the matter or direct any part or all of the matter to the Hearing Examiner for a hearing.

(d) Rulings on admissibility of evidence shall be made by the EBD Chairperson or Hearing Examiner. The remaining quorum of the EBD may overrule the Chairperson's decision on their own motion or upon motion of any party to the hearing. Formal rules of evidence shall not be used. The agency may admit and give effect to documents, testimony, and other evidence which tend to prove or disprove facts as commonly accepted.
(e) The Chairperson or Hearing Examiner shall have the authority to administer oaths; and the Director or designated Hearing Examiner for the EBD shall have the authority to issue subpoenas for witnesses or subpoenas duces tecum to compel the production of books, records, papers and other objects. These subpoenas may be served by any duly qualified officer of the law, any employee of the EBD, or other person in any manner prescribed for the service of a subpoena in a civil action.
(f) All hearings shall be electronically recorded by the presiding officer. Any party may obtain a copy of the recording under OAC 260:40-3-7.
(g) Any party may request a full stenographic record of the proceedings be made by a certified court reporter. The party requesting the court reporter shall be required to post an appropriate cash deposit and shall remain responsible for the full cost of the court reporter. If transcribed, this record shall be a part of the EBD's record of the hearing. A copy of the record shall be furnished to any other party having a direct interest in the hearing at the expense of the party requesting the copy.
(h) In all hearings, opportunity to respond and present evidence and argument on all issues involved shall be provided to all requesting parties. The hearing shall be conducted in an orderly manner. The party or parties requesting the hearing shall be heard first; those, if any, who oppose the relief sought by the requesting party shall next be heard. Each party shall have the opportunity to present closing arguments, subject to reasonable time limits set by the EBD or the Hearing Examiner.

260:40-5-14. Representation

In an individual proceeding, any party has the right to have an attorney who is licensed to practice law by the Oklahoma Supreme Court. The attorney shall be given authority to act for and bind the party he or she represents. If a party names an attorney, the EBD or Director shall communicate with the attorney and not with the party. It shall be the responsibility of the party's attorney to communicate with the party.

260:40-5-15. Prehearing conference

A pre-hearing conference shall be held two (2) weeks prior to the hearing date. At the pre-hearing conference each party shall:
(1) Exchange witness and exhibit lists;
(2) Agree to a date for discovery cut-off;
(3) Submit a short written statement of facts; and
(4) Agree as to the issues to be tried at the hearing.

260:40-5-16. Informal disposition

Unless precluded by law, informal disposition may be made of any individual proceeding or other hearing, agreed settlement, consent order, or default. Other authorized representatives may request a full and fair review of decisions denying claims and may review documents and submit comments in writing within ninety (90) days after notice of denial.

260:40-5-17. Certificate of mailing

All filings, including orders, notices and briefs, shall include a certificate of mailing showing the names and mailing addresses of adverse parties, their attorneys of record, or other authorized representatives.

260:40-5-18. Final order

(a) The EBD or designated Hearing Examiner shall enter an order in all cases heard. The order shall separately state in writing all findings of fact, conclusions of law and an order denying or approving the claim. The order of the EBD shall be the final order of the agency. The order of the Hearing Examiner shall be the final order upon the expiration of ten (10) calendar days unless the Director orders the matter

for further hearing by the EBD. If ordered by the Director, the Hearing Examiner's order shall be reviewed by the EBD as a proposed order. Upon review of the evidence, pleadings and record, the EBD may approve or modify the proposed order of the Hearing Examiner. If approved, the proposed or modified order shall become the final order of the agency. The EBD may hear oral arguments during its review as it determines to be useful or necessary. The EBD may limit the time of the oral arguments.
(b) The final order shall be considered a final decision of the EBD. The Director shall mark all final orders and shall provide certification of the disposition of the final orders.

260:40-5-19. Rehearings
(a) A final order of the agency shall be subject to rehearing, reopening or reconsideration by the EBD. Any application or request for such rehearing, reopening or reconsideration shall be made by any party aggrieved by the final order of the agency within ten (10) days from the date of entry of the order. The aggrieved party shall set forth clearly in writing all grounds for rehearing, reopening or reconsideration. The grounds for such action shall include only:
(1) Newly discovered or newly available evidence relevant to the issues;
(2) Need for additional evidence to adequately develop the facts essential to proper decision;
(3) Probable error committed by the agency in the proceeding or in its decision such as would be ground for reversal on judicial review of the final agency order;
(4) Need for further consideration of the issues and the evidence in the public interest; or
(5) A showing that the issues not previously considered ought to be examined in order to properly dispose of the matter.
(b) The order of the EBD granting rehearing, reconsideration or review, or the petition of a party therefore, shall set forth the grounds which justify such action.
(c) On reconsideration, reopening, or rehearing, the matter may be heard by the EBD or it may be referred to a hearing examiner. The hearing shall be confined to those: grounds upon which the reconsideration, reopening, or rehearing was ordered.

260:40-5-20. Judicial review
Any party to the hearing may have the right to appeal to District Court from final orders entered pursuant to the Administrative Procedures Act, Title 75, Section 318, of the Oklahoma Statutes.

SUBCHAPTER 7. FLEXIBLE BENEFITS PLAN

Part 1. GENERAL PROVISIONS

260:40-7-1. Purpose
(a) The purpose of this Chapter is to establish the State Employees Flexible Benefits Plan pursuant to Section 1361 et seq. of Title 74 and Article I of the Administration Procedures Act, Sections 250.3 through 308.2 of Title 75 of the Oklahoma Statutes.
(b) The Flexible Benefits Plan shall incorporate all the Benefit Plans adopted by the Plan Administrator including a cafeteria plan as defined in the Internal Revenue Code Section 125. The cafeteria plan is intended to provide benefits for election by participants as described in this Title and is intended to be a qualified plan under Section 125(d) of the Internal Revenue Code. This cafeteria plan is intended to continue as long as it qualifies under Section 125 and is advantageous to the state and state employees. The individual selections available under the cafeteria plan consist only of a choice between certain statutory taxable and nontaxable benefits as defined in Section 125(f) of the Internal Revenue Code and regulations promulgated thereunder. The Flexible Benefits Plan may also include other Benefit Plans ineligible for inclusion under Section 125 but adopted by the Plan Administrator to be offered to state employees.

260:40-7-1.1. Authority
The authority for the rules in this Title is the Oklahoma State Employees Benefits Act, 74 O.S. Supp 1992, Section 1361 et seq. The rules in this Chapter are promulgated by the Plan Administrator to establish the Flexible Benefits Plan for the State of Oklahoma.

260:40-7-2. Definitions

The following words or terms, when used in this Chapter, shall have the following meanings unless the context clearly indicates otherwise, and wherever appropriate, the singular shall include the plural, the plural shall include the singular, and the use of any gender shall include the other gender.

"Account" means a record keeping account established on the books of the Plan Administrator.

"Act" means the Oklahoma State Employees Benefits Act, 74 O.S. Supp 1992, Section 1361 et seq.

"Authorized Submission Procedure" means an acceptable method of submitting enrollment and/or change documents which may include submission via electronic transmissions to the Plan Administrator.

"EGID" means the Employees Group Insurance Department

"Cafeteria plan" means an employer-maintained benefit plan under which participants are employees and the participants may choose between cash and nontaxable benefits, as defined in Internal Revenue Code Section 125(d) and regulations promulgated thereunder.

"Change in Status" means a change that a participant may be allowed to make during a Plan Year provided that the change is based on prevailing IRS guidance, is allowed by the Plan Administrator, and complies with all eligibility rules and consistency requirements.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985 as it applies to an employee's right to continue certain coverage under the Flexible Benefits Plan.

"Dependent" means the primary member's spouse (if not legally separated), including common law. Dependents also include a member's unmarried or married natural born child, a step child, an adopted child, or a foster child up to the child's twenty-sixth [26th] birthday, regardless of residence, or a child under legal guardianship. A child may also be covered regardless of age if the child is incapable of self-support because of mental or physical incapacity that existed prior to reaching age twenty-six [26]. Coverage is not automatic and must be approved with a review of medical information. A disabled dependent deemed disabled by Social Security does not automatically mean that this disabled dependent will meet the Plan requirements. [74 O.S.Supp.2006, §1303(13)].

"Effective date of the plan" means January 1, 1990 or as restated.

"Employer" or **"Employing agency"** has the same meaning as "Participating employer" as defined in Section 1363(14) of Title 74.

"Enrollment period" means the period of time, as determined and announced by the Plan Administrator each Plan Year during which eligible employees shall make an election of benefits. The period of time shall end no later than thirty (30) days before the beginning of the Plan Year for which the elections are to be effective.

"Entry date" means the first day of the Plan Year except for an employee who first satisfies the requirements for eligibility during the Plan Year (including rehired employees), in which case the entry date shall be the first day of the month next following the satisfaction of the application requirements for eligibility, in accordance with 260:40-7-1.

"FMLA" means the Family and Medical Leave Act of 1993.

"Flexible Benefits Plan" means the Flexible Benefits Plan authorized pursuant to the State Employees Flexible Benefits Act as modified by the provisions under the State Employees Benefits Act.

"Flexible Benefits Plan Rules" means the rules promulgated by the Plan Administrator to implement and administer the State Employees Flexible Benefits Plan.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996.

"Internal Revenue Code" means the Internal Revenue Code of 1986 of the United States, 26 USC, I et seq. as amended from time to time.

"Irrevocability Rule" means the rule that requires an enrollment election in any Plan benefit to remain in force throughout the entire Plan Year.

"Period of coverage" means the Plan Year during which coverage of benefits under the Flexible Benefits Plan is available to a participant. An employee who becomes eligible to participate during a Plan Year may participate for a period lasting until the end of that Plan Year. In this case, the interval commencing on the employee's entry date, and ending as of the last day of eligibility, for that Plan Year.

"Permitted Exception" means an exception allowed to the Irrevocability Rule by the Plan. Any changes based on these exceptions must be on account of and correspond with the underlying event.

"Plan Administrator" means the Oklahoma State Employee Benefits Department.

"QMCSO" means a Qualified Medical Child Support Order.

"Statutory nontaxable benefit" means a benefit provided to a participant under the Flexible Benefits Plan, the value of which is not included in the participant's gross income by a specific provision in the Internal Revenue Code and is permissible under the Flexible Benefits Plan in accordance with Section 125 of the Internal Revenue Code.

"USERRA" refers to the Uniformed Services Employment and Reemployment Rights Act of 1994.

Part 3. Flexible Benefits Plan Provisions

260:40-7-31. Adoption of the Flexible Benefits Plan

(a) Each year the Plan Administrator shall adopt the Flexible Benefits Plan, including the basic plan and other benefit plans to be made available for election by state employees.

(b) Each year the Plan Administrator shall adopt, prior to January 1, an authorized procedure appropriate to and/or electronic web enrollment transmissions, restrictions and procedures regarding the effectively administer the Flexible Benefits Plan during the year. This procedure may include, but is not limited to, enrollment forms elections of various benefit plans and levels of coverage, eligibility requirements, and information collection and retention procedures.

260:40-7-32. Benefit plans offered as part of the Flexible Benefits Plan

(a) The basic plan shall be the minimum level of benefits an employee is required to purchase and shall include the basic medical plan, the basic dental plan, the basic life plan, and the basic disability plan as referenced in 74 O.S.Supp.2006, § 1371 unless an employee opts not to choose any benefits pursuant to 74 O.S.Supp.2007, § 1370(A). The Plan Administrator shall establish all the terms, conditions, and details necessary to communicate and administer these plans. The EGID shall offer the basic medical plan of benefits as an indemnity plan. All benefits plans, whether offered by the EGID, a health maintenance organization or others shall at least meet the minimum requirements of the basic plan. The Plan Administrator shall evaluate all benefit plans to determine if this requirement has been satisfied.

(b) Only those benefit plans officially offered by the Plan Administrator shall be considered a part of the Flexible Benefits Plan. In addition to the basic plan the Plan Administrator may elect to offer other optional benefit plans. The Plan Administrator shall evaluate and select optional plans for inclusion in the Flexible Benefits Plan.

(c) Each year the Plan Administrator shall contract with each insurance provider other than the EGID. In lieu of a contract, the Plan Administrator shall deliver a letter of understanding each year to the EGID outlining the basic plan to allow the EGID to administer the EGID's offered benefit plans adopted as part of the basic plan. The EGID shall provide the Plan Administrator a complete description of any enhanced benefit plans the EGID elects to offer. The Plan Administrator shall determine that these elected plans meet the minimum benefit levels of the basic plan. All insurance providers shall provide claims and other financial information as the Plan Administrator may require.

260:40-7-33. Applicability of the Flexible Benefits Plan

The Flexible Benefits Plan shall be applicable to all employers as defined in the Act.

260:40-7-34. Flexible Benefits Plan not a contract of employment

Nothing contained in the Flexible Benefits Plan shall be construed as a contract of employment between the employer and any employee or participant, or as a right of any employee or participant to be continued in the employment of the employer, or as a limitation of the right of the employer to discharge any employee or participant with or without cause.

260:40-7-35. No rights to employer's Plan assets

No employee, participant, dependent, or beneficiary of an employee or participant, nor their heirs, successors, or assignees shall have any right to, or interest in any assets of the employer, the Plan, the Plan Administrator, the EBD or the employees, agents, representatives, or designees of same upon termination of a participant's employment or otherwise, except as provided under the Flexible Benefits Plan, and then only to the extent of the benefits payable under the Flexible Benefits Plan to such employee, participant, dependent, or beneficiary.

260:40-7-36. Non-alienation of benefits

Benefits payable under the Flexible Benefits Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the employee, prior to actually being received by the person entitled to the benefit under the terms of the Flexible Benefits Plan. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to benefits payable pursuant to the Flexible Benefits Plan, shall be void. The employer or the Plan Administrator shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to benefits as provided in this Chapter.

SUBCHAPTER 9. FLEXIBLE BENEFITS PLAN

260:40-9-1. Plan Administrator

The Plan Administrator shall name an Director to carry out its duties in the administration of the Flexible Benefits Plan.

260:40-9-2. Records and reports of the Plan Administrator

The Plan Administrator shall keep written records as necessary or proper.

260:40-9-3. Administrative powers and duties

(a) The Plan Administrator may contract with private firms or organizations to administer the State Employees Flexible Benefits Plan. The contract(s) for the administration of the Flexible Benefits Plan may include the development of benefit standards and options, and may involve design, development, communications and administrative functions relating to the Oklahoma State Employees Benefits Act.

(b) The Plan Administrator establishes procedures as necessary for implementation and administration of the Flexible Benefits Plan.

(c) The Plan Administrator shall file or cause to be filed all annual reports, returns, schedules, descriptions, financial statements, and other information as may be required by any federal or state law or regulation, agency or authority.

260:40-9-4. Notice of claim

Prior to making any payment of benefits pursuant to the Flexible Benefits Plan, the Plan Administrator may require the participant to provide information and to complete any appropriate documents or forms necessary for the proper administration of the Flexible Benefits Plan. The Plan Administrator shall determine the rights of any participant to a benefit under the Flexible Benefits Plan in accordance with the rules in this Title.

260:40-9-5. Availability of Flexible Benefits Plan information and documents

Any participant having a question concerning the operation of the Flexible Benefits Plan or the participant's eligibility for the payment of benefits under the Flexible Benefits Plan shall contact the Plan Administrator in accordance with OAC 260:40-3-6 of this Title.

260:40-9-6. Right of the Plan Administrator to initiate action

The Plan Administrator may initiate formal or informal action to accomplish the objectives of the Act and to carry out the duties of the Plan Administrator.

SUBCHAPTER 11. AMENDMENT OR TERMINATION OF THE FLEXIBLE BENEFITS PLAN

260:40-11-1. Amendment of the Flexible Benefits Plan

Any amendments to the Flexible Benefits Plan shall conform to the provisions of the Internal Revenue Code, and the regulations promulgated thereunder, and the Act.

[Source: Added at 10 Ok Reg 4435, eff 8-10-93 (emergency); Added at 11 Ok Reg 3117, eff 7-15-94]

260:40-11-2. Termination of the Flexible Benefits Plan

The Flexible Benefits Plan is intended to be permanent; however, it may be terminated by the Plan Administrator in the event the Flexible Benefits Plan ceases to be effective under 74 O.S. Section 1345.

260:40-11-3. Preservation of rights and responsibilities

Termination or amendment of the Flexible Benefits Plan under the provisions of Section 1345 of Title 74 of the Oklahoma Statutes shall not affect the rights of any participant to claim reimbursement for expenses incurred prior to such termination or amendment, to the extent such amount is payable under the terms of the Flexible Benefits Plan, prior to the effective date of such termination or amendment. If the Flexible Benefits Plan is terminated, payroll deductions may be made for expenses included in a participant's salary adjustment agreement in accordance with the rules in this Title.

SUBCHAPTER 13. ELIGIBILITY REQUIREMENTS

260:40-13-1. Flexible Benefits Plan eligibility

Eligible individuals as defined in 74 O.S. sections 1363 and 1369 will be notified of their eligibility by the Plan Administrator or its designated representative. The method of notifying eligible individuals shall be determined by the Plan Administrator prior to the start of each enrollment period.

260:40-13-2. Enrollment period

An eligible employee who wishes to participate in the Flexible Benefits Plan must elect to participate during one of the following periods:

(1) Before the beginning of each new Plan Year during the announced enrollment period, or

(2) Within thirty (30) days after becoming eligible during a Plan Year.

260:40-13-3. Termination of participation

(a) A participant will cease participation in the Flexible Benefits Plan as of the earliest of the following events:

(1) The last day of the month of termination of employment with the employer; or

(2) The last day of the month the participant ceases to be eligible to participate in the Flexible Benefits Plan; or

(3) The date of termination of the Flexible Benefits Plan.

(b) Benefit plan coverage shall terminate as follows:

(1) For termination as a result of voluntary election, the coverage shall terminate on the last day of the month of receipt and approval of a valid change form at the offices of the Plan Administrator.

(2) For termination of coverage as a result of ineligibility, the coverage shall terminate on the last day of the month of the event causing the loss of eligibility.

(c) No vendor, including the EGID, shall terminate coverage on any participant unless authorized by the Plan Administrator.

260:40-13-4. Elections and changes

The elections and changes are to indicate an employee's choice of flexible benefit plan options, change elections, provide personal data, or effect other actions permitted by the provisions of this Chapter; to allow the employing agency to record the employee's choices and provide information to the Plan Administrator; for the Plan Administrator to record acceptance or denial of the employees choices and to provide procedures effecting an employee's elections or changes.

260:40-13-5. Premium collection

The employing agency of each participant shall collect premiums for all coverages in effect. The agency shall remit all premiums due to the Plan Administrator for all coverages provided to the participant.

260:40-13-6. [RESERVED]

260:40-13-7. Premium waiver during disability

During any period in which an employee is receiving disability payments from the State of Oklahoma, the premium for basic life insurance, dependent life insurance, supplemental and accidental death and dismemberment coverage shall be waived, provided that proper physician certification is submitted and accepted. The employee shall resume payment of these life insurance coverage premiums upon a return to active pay status, or if the employee is placed on any other type of leave status. Premium waiver is not retroactive.

SUBCHAPTER 15. [RESERVED]

SUBCHAPTER 17. BENEFIT PLAN ELECTION

260:40-17-1. Election of benefits and salary adjustment agreement

Prior to the first day of an applicable period of coverage, an eligible employee may elect coverage under the provisions of the Flexible Benefits Plan. The election shall be made by the eligible employee at the time and in the manner specified by the Plan Administrator. Prior to an applicable period of coverage the employer shall provide to eligible employees the necessary authorized submission procedure information prescribed by the Plan Administrator for electing coverage. This procedure shall include a method of authorizing a salary adjustment agreement whereby the participant shall agree to a reduction in compensation equal to the participant's share of the cost of each optional benefit elected under the provisions of the Flexible Benefits Plan. The eligible employee shall be required to submit an election via an authorized submission procedure and in the time and manner required by the Plan Administrator. Prior to the due date for the next ensuing applicable period of coverage, a Participant who has participated in the plan during the previous Plan Year shall elect basic and optional benefits and execute a salary adjustment agreement. Failure of such participant to submit the required election shall be deemed an election of the default benefits as defined in 74 O.S. Section 1371.

260:40-17-2. Benefits available for election by participant

In accordance with the procedures set forth in this subchapter, a participant may elect among the benefit plans adopted by the Plan Administrator as a part of the Flexible Benefits Plan.

260:40-17-3. Employee election of benefit plans

(a) Choices of benefit plans shall be made by a new eligible employee within thirty (30) days after date of employment. This thirty (30) day period shall be known as the employee's enrollment period. Each new employee failing to make such a valid election will be deemed to have elected employee-only coverage under the HealthChoice High Option Health Plan, HealthChoice Dental Plan, HealthChoice basic term life policy, and the HealthChoice disability plan.

(b) Choices of benefit plans shall be made on a Plan Year basis by the eligible employees during the enrollment period as set by the Plan Administrator. The Plan Administrator will establish eligibility requirements for all benefit plan options each year.

(c) Eligible employees are required to elect medical, dental, life and disability plans except as provided in the following paragraphs. Employees who fail to make a valid election during each designated enrollment period will be deemed to have elected the same plans elected during the most recent enrollment period during which a valid election was made. Where the plan(s) will no longer be available

for the upcoming Plan Year, employees will be deemed to have elected HealthChoice High Option Health Plan and/or HealthChoice Dental.

(d) A former employee who is reemployed by the same participating employer within twenty-four (24) months after the date of termination of previous employment shall not be enrolled for a greater amount of life insurance than the individual had at the time of termination of previous employment with the employer, unless the individual provides satisfactory evidence of insurability. The amount of coverage provided by the employer is specified in the benefit administration procedures or guidelines as adopted by the Plan. In the event of death, the proceeds of this coverage are payable to the beneficiary listed on the most recently signed beneficiary designation subject to the limitations in Title 15. [15 O.S. §178] If no beneficiary form is on file at the EGID, benefits will be paid to the decedent's estate.

(e) A former active State employee who is reemployed by the State after thirty (30) days from termination will not be eligible to reenroll in vision plans, Health Care Reimbursement Accounts and Dependent Care Reimbursement Accounts throughout the remainder of the current Plan Year unless the employee maintained the Health Care Reimbursement Account under the COBRA provisions.

(1) An eligible employee who has retired from a branch of the United States military and has been provided with health coverage through a federal plan can elect not to participate in the Flexible Benefits Plan if the following conditions are met prior to the close of each annual enrollment period:

(A) The employee must provide proof that he or she is retired from a branch of the United States military; and

(B) The employee must provide proof of health coverage through a federal plan; and

(C) The employee must make a proper election not to participate in the Flexible Benefits Plan.

(2) The EBD has the authority to determine the type of information that satisfies the requirements of this subsection.

(3) An eligible employee making an election not to participate under paragraph (1) of this subsection must make such an election each Plan Year.

(A) An employee who is eligible to make an election not to participate under paragraph (1) of this subsection and has never previously made an election not to participate under paragraph (1) of this subsection, may, during the enrollment period, enroll in the Flexible Benefits Plan or may make an election not to participate under paragraph (1) of this subsection. If the employee who is eligible to, but has never previously made an election not to participate under paragraph (1) of this subsection, fails to enroll in the Flexible Benefits Plan and fails to make an election not to participate under paragraph (1) of this subsection, the employee will be deemed to have elected coverage that was in effect during the previous Plan Year. Where the plan(s) will no longer be available for the upcoming Plan Year, employees will be deemed to have elected HealthChoice High Option Health Plan and/or HealthChoice Dental.

(B) An employee who is eligible to make an election not to participate under paragraph (1) of this subsection, and has previously made an election not to participate under paragraph (1) of this subsection, may, during the enrollment period, enroll in the Flexible Benefits Plan, or may make an election not to participate under paragraph (1) of this subsection. If an employee who has previously made an election not to participate under paragraph (1) of this subsection fails to enroll in the Flexible Benefits Plan and fails to make an election not to participate under paragraph (1) of this subsection during the annual enrollment period, the employee will be deemed to have elected employee-only coverage under the HealthChoice High Option Health Plan, the HealthChoice Dental Plan, the HealthChoice basic term life policy, and the HealthChoice Disability Plan.

(4) Except as provided by the applicable provisions of OAC 260:40-17-4, an eligible employee making an election not to participate under paragraph (1) of this subsection is prohibited from participating in any health plan, dental plan, life plan, supplemental life plan, dependent life plan, and disability plan at any time during the Plan Year for which he or she made the election. Upon re-entry into the state benefits package either through an acceptable midyear event or at the annual Option Period enrollment, benefit options which were declined through the opt-out election by retired military state employees will not automatically be reinstated. The retired

military employee must reapply for and be approved through satisfactory evidence of coverage (EOI) before any amounts of Supplemental Life Insurance will again be issued. Only the Basic Life amount (20,000) will be automatically reinstated upon such re-entry. No Guaranteed Issue levels of Supplemental Life will be available.

(5) Except as provided by the applicable provisions of OAC 260:40-17-4, an eligible employee making an election not to participate under paragraph (1) of this subsection is prohibited from electing coverage for his or her dependents under any health plan, dental plan, life plan, supplemental life plan, dependent life plan, and disability plan prior to or at any time during the Plan Year for which he or she made the election.

(6) An eligible employee making an election not to participate under paragraph (1) of this section may continue participation in any of the following:

(A) Benefit plans available under the flexible benefit plan other than a health plan, dental plan, life plan, supplemental life plan, dependent life plan, and a disability plan;

(B) Health Care Reimbursement Account Option;

(C) Dependent Care Reimbursement Account Option; and the

(D) Insurance Premium Conversion Option.

(f) Each employee who meets the eligibility requirements but fails to make a proper election under the Flexible Benefits Plan shall be deemed a participant in the Flexible Benefits Plan.

(g) Coverage shall be effective for a new participant beginning on the first day of the month following the participant's first day in an active pay status.

(h) Eligible employees may elect to cover a dependent under the following insurance plans: health insurance, dental insurance, dependent life insurance, or vision insurance. When one eligible dependent is covered, all eligible dependents must be covered for all plans except the dependent life insurance plan. An eligible employee cannot be enrolled as a principal insured and also as a dependent for any benefit options except dependent life.

(i) Primary participants electing coverage for eligible dependents cannot enroll the dependents in a benefit plan or a coverage that differs from the benefit plan or coverage chosen by the primary participant.

(j) In order for an eligible employees to choose health plan coverage under a Health Maintenance Organization (HMO) plan, the eligible employee must reside or be employed within the selected HMO's service area.

260:40-17-4. Changes to benefit elections

(a) A participant may change an election only in accordance with the provisions of this Plan. This Section does not remove the requirement that every employee must enroll in at least the basic plan of coverage except for those employees declining participation pursuant to 260:40-17-3(c)(1).

(b) All requests for changes submitted to the Plan Administrator must be in a format as determined by the Plan Administrator.

(c) Provided that all other eligibility requirements are met, and written or electronic notice is provided to the Plan Administrator within thirty (30) days of a qualifying event, including receipt of a Qualified Medical Child Support Order, the effective date of such change of benefits coverage will be the first of the month following receipt of acceptable notice as determined by the Plan Administrator as long as the correct premium is paid. All enrollments and elections are for the entire Plan Year and are irrevocable during same Plan Year unless a change is requested based on one of the following permitted exceptions to the irrevocability rule. A change must comply with the IRS consistency rule as found in Treasury Regulations 1.125-4 as may be amended. Only the permitted exceptions provided for in this chapter shall be allowed as changes to benefits elections unless those changes are prohibited under the Premium Conversion Option, the Dependent Care Reimbursement Account Option or the Health Care Reimbursement Account Option as provided for in subchapters 23, 25, and 27 respectively. All changes shall become effective on a prospective basis and not earlier than the first day of the month following receipt of acceptable notice of the requested change which must be on account of and corresponding with the event with the exception of termination of coverage for a spouse and/or dependents who have ceased to satisfy eligibility as a result of death, which shall become effective the first of the month following the date of the event. Permitted exceptions to the irrevocability rule as allowed within Plan guidelines are as follows:

(1) HIPAA Special Enrollment Rights (marriage, birth, adoption or placement for adoption, loss of other coverage including exhaustion of COBRA coverage)
(2) Change in Employee's Legal Marital Status
(3) Change in the Number of Employee's Dependents
(4) Change in Employment Status of Employee, Spouse or Dependent that affects eligibility
(5) Event Causing Employee's Dependent to satisfy or cease to satisfy Eligibility Requirements
(6) Change in Place of Residence of Employee, Spouse or Dependent
(7) Commencement or Termination of Adoption Proceedings
(8) Judgments, Decrees or Orders (changes allowed only to Health, Health Care Reimbursement Account and Dental)
(9) Medicare or Medicaid (changes allowed only to Health and Health Care Reimbursement Account)
(10) Significant Change in Cost or a Change in Coverage (changes allowed only to Dependent Care Reimbursement Account)
(11) Changes in Coverage of Spouse or Dependent under Other Employer's Plan
(12) FMLA Leave
(13) Such other events, which may permit such modification or election under the IRS consistency rule as found in Treasury Regulations 1.125-4 and in accordance with other applicable and prevailing Internal Revenue Code regulations promulgated thereunder, and in accordance with this chapter.

(d) The following are the only permitted exceptions that may become effective on a retroactive basis beginning the first day of the event month. Such events require receipt of acceptable notice by the Plan Administrator or its designee within thirty (30) days of the event:
(1) Newborn children who may be covered from the first of the birth month provided the proper documentation is submitted within thirty (30) days of the birth event and provided that the full monthly premium is paid.
(2) Adopted eligible dependent children, those placed for adoption, and eligible children for whom guardianship has been newly granted to the insured or to the insured's spouse and for whom coverage may begin from the first day of physical custody even though a full month's premium must be paid; or at the insured's option may be covered beginning the first of the month following placement.

(e) The Plan Administrator reserves the right to make any corrections necessary if an error was made regarding the effective date.

260:40-17-5. Authorized member signature

A signature other than that of the employee will not be accepted on any enrollment form or application unless the individual signing presents a power of attorney, papers of guardianship, conservatorship, or a legal court order.

SUBCHAPTER 19. BENEFIT ALLOWANCE

260:40-19-1. Flexible benefit allowance

(a) Each participating employer shall credit to each of its participating employees the specified amount as determined by law, as a flexible benefits allowance. Each participant must use a portion or all of their flexible benefit allowance to purchase at least the basic plan.
(b) An eligible employee making an election not to participate under OAC 260:40-17-3(c)(1) will not be eligible for or credited with any amount of the employee or dependent flexible benefit allowance.

260:40-19-2. Costs in excess of flexible benefits allowance

If a participant elects benefits whose cost exceeds the participant's flexible benefits allowance, the excess cost shall be paid for with pay conversion dollars. At the participant's option, pay conversion dollars may be designated as pre-tax (premium conversion) dollars or after-tax dollars. *The elected amount shall be deducted from the participant's compensation in equal amounts each pay period over the plan year* [74 O.S.Supp.2007, §1370(F)].

260:40-19-3. Costs less than the flexible benefits allowance

If a participant elects benefits whose cost is less than the participant's flexible benefits allowance, the excess flexible benefit allowance will be paid to the participant as taxable compensation. This taxable compensation shall be paid to the participant in substantially equal amounts during the participant's period of coverage.

260:40-19-4. Effect of change in cost of benefit

During an applicable period of coverage, there shall be an automatic adjustment in the amount of flexible benefit dollars used to purchase optional benefits in the event of a change of the cost of providing the optional benefits. The automatic adjustment shall be equal to the increase (or decrease) in such cost.

SUBCHAPTER 21. NONDISCRIMINATION

260:40-21-1. Provisions to prevent discrimination

In the event the Plan Administrator determines that prohibited discrimination described under any applicable provision of the Internal Revenue Code regarding discrimination may occur, the Plan Administrator shall be authorized to cause the election made by any participants to be modified to avoid or cure such discrimination. Upon executing the requisite application for participation, these participants shall be deemed to have expressly consented to any modification of the application and salary adjustment agreement deemed necessary by the Plan Administrator to prevent the occurrence of prohibited discrimination.

260:40-21-2. Nondiscrimination not guaranteed

Neither the employer, the Plan Administrator, nor any agent or representative thereof, represents that the Flexible Benefits Plan, the benefits provided, or contributions made pursuant to the Flexible Benefits Plan are at any particular point in time nondiscriminatory as determined in accordance with the applicable provisions of the Internal Revenue Code and regulations promulgated thereunder. The employer, the Plan Administrator, and any agent or representative thereof shall be held harmless by any employee, participant, their representatives, heirs, beneficiaries, administrators, or assigns from any and all tax liability of any nature that might arise by reason of the Flexible Benefits Plan being deemed discriminatory at any time and in any regard or by reason of plan qualification requirements.

260:40-21-3. Inclusion in income

If any portion or all of a benefit or benefits becomes taxable, by reason of the Flexible Benefits Plan being deemed discriminatory, the benefit(s) shall be treated as received or accrued in the taxable year of the participant in which the Plan year ends unless applicable law requires inclusion in income at some other time, in which case, such law shall be controlling.

SUBCHAPTER 23. INSURANCE PREMIUM CONVERSION OPTION

260:40-23-1. Premium conversion option

(a) This option allows a participant to pay premiums of elected qualified benefits with pre-tax dollars. This option is intended to be qualified under Section 125 of the Internal Revenue Code and is included as part of the cafeteria plan described in OAC 260:40-7-1.

(b) The Plan Administrator shall at all times administer this option in a manner consistent with the terms and provisions hereof, in a uniform and nondiscriminatory manner, and in accordance with the Internal Revenue Code and applicable regulations promulgated thereunder.

260:40-23-2. Definitions

The following words and terms, when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Qualified benefits expenses" means any expenses incurred by a participant as payment for the amount of premium expense for any benefit offered by the Plan Administrator providing those qualified benefits expenses are for those amounts that exceed the flexible benefits allowance and are employee's expenses for employee group term life insurance up to $50,000, health, dental, vision, accidental death

and dismemberment, long and short term disability and similar benefits which may be offered pursuant to Section 125 of the Internal Revenue Code and regulations promulgated thereunder.

"Qualified benefits" means one or more benefits plans offered by the Plan Administrator in the Cafeteria Plan for use in the Flexible Benefits Plan. For the Cafeteria Plan, the Plan Administrator shall only permit insurance premium expenses to be made by a participant on a pre-tax basis under those insurance plans which qualify for pre-tax contributions under Section 125 of the Internal Revenue Code and regulations promulgated thereunder. The Plan Administrator shall certify its selections and related periods of coverage, a record of which shall be permanently maintained as part of the written State Employees Benefits Plan documents.

260:40-23-3. Requirements for participation

Upon submission of an application for participation any eligible employee may participate in the insurance premium conversion option for qualified insurance plans, if:

(1) The employee's total premium costs exceed the employee's benefits allowance; or

(2) Prior to the beginning of a period of coverage, the eligible employee has made application to increase insurance coverage under a qualified benefit plan offered by the Plan Administrator, the premium for which will exceed the employee's flexible benefits allowance during the ensuing period of coverage; or

(3) Any employee has an election change consistent with OAC 260:40-23-10 that causes the employee's total premium costs to exceed the benefit allowance; or

(4) If the eligible employee chooses to participate.

260:40-23-4. Amount of insurance premium expense benefit available

Subject to the limitations in the Internal Revenue Code to avoid discrimination, the amount of insurance premium expenses under the insurance premium conversion option shall be that amount required to pay the participant's portion of the premiums for coverage under each qualified insurance plan included in this plan option. For purposes of the Internal Revenue Code and regulations promulgated thereunder, the amount required to pay the participant's portion of the premiums for coverage shall be the maximum amount of benefit available.

260:40-23-5. Reduction of benefits

(a) The Plan Administrator shall reduce amounts of benefits payable to a participant to assure that this option is nondiscriminatory in compliance with any provision of the Internal Revenue Code or other applicable law or regulation. Any such reduction of benefits shall be made by the Plan Administrator on a reasonable and nondiscriminatory basis.

(b) Upon executing the requisite application for participation, a participant shall be deemed to have expressly consented to any modifications of the application and salary adjustment agreement which are necessary to assure nondiscrimination.

260:40-23-6. Claims for insurance premium expenses [Reserved]

260:40-23-7. Payment of insurance premium expense

The insurance premium conversion option shall be paid for according to the participant's salary adjustment agreement.

260:40-23-9. Other governing provisions

The insurance premium conversion option shall be administered under the terms of this subchapter and Title.

260:40-23-10. Benefit election irrevocable unless a permitted exception exists

(a) Except as otherwise provided in this Section, a participant's election of benefits described in this Chapter, made in accordance with subchapter 17 of this Chapter, shall be irrevocable during the Plan Year

with regard to any benefit or portion of benefit elected for the period of coverage to which the election pertains. Conversion from one type of benefit to another or modification of the salary adjustment agreement shall not be permitted during the applicable period of coverage.

(b) A participant shall be entitled to modify the premium conversion option election after a period of coverage has commenced for which the election applies or make a new election, subject to acceptance by the Plan Administrator, with respect to the remainder of the current period of coverage, if the modification or new election is on account of and corresponds with a permitted exception which shall include all of the exceptions indicated in 260:40-17-4 unless they are prohibited herein. PROHIBITED EXCEPTIONS TO CHANGING PREMIUM CONVERSION OPTION ELECTION:

(1) Change in place of residence

(2) COBRA events

(3) Significant Cost Increases

(c) The participant shall furnish the Plan Administrator with information relative to a permitted exception to the irrevocability rule. The Plan Administrator shall determine whether a change in benefit election meets the criteria in subchapter 17-4 and is not prohibited by this subchapter, nor by the Plan, or by the prevailing Internal Revenue Code and regulations promulgated thereunder.

(d) The employee must provide a request to make a change by way of an authorized submission procedure as set forth by the Plan Administrator.

(e) Any request to make a change must be submitted by the employee to the Plan Administrator within thirty (30) days of the family status event described in subsection (b) of this Section. If the request is not submitted under an authorized submission procedure within thirty (30) days of the event the participant shall waive the option to make changes under this section during such Plan Period.

SUBCHAPTER 24. HEALTH SAVINGS ACCOUNT

260:40-24-1. Health Savings Account

(a) This is an optional benefit within the State Employees Flexible Benefits Plan. This option is qualified under Section 223 of the Internal Revenue Code(IRC) and is, therefore, included as part of the cafeteria plan described in OAC 260:40-7-1.

(b) The Plan Administrator shall, at all times, administer this option in a manner consistent with the terms and provisions hereof in a uniform and nondiscriminatory manner and in accordance with the prevailing Internal Revenue Codes and applicable regulations promulgated thereunder.

260:40-24-2. Definitions

The following words and terms, when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Dependent" means an individual, who qualifies as a dependent under Section 125 of the Internal Revenue Code, taking into account Section 105(b) of the Internal Revenue Code.

"Health Savings Account (HSA)" means the bookkeeping account maintained by the HSA Administrator/Trustee/Custodian used for crediting contributions and accounting for benefit payments.

"HSA Administrator/Trustee/Custodian" Insured banks and credit unions are automatically qualified to handle HSAs. Any bank, credit union or any other entity that currently meets the IRS standards for being a trustee or custodian for an IRA or Archer Medical Savings Account (MSA) can be an HSA trustee or custodian. The law also allows insurance companies to be HSA trustees or custodians.

260:40-24-3. Requirements for eligibility

(a) Upon submission of the election through an authorized procedure as prescribed by the Plan Administrator, an employee eligible to participate under the Flexible Benefits Plan who has elected a qualified high deductable health care option shall be eligible to participate in the Health Savings Account option, provided they have not attained the age of 65 years and become Medicare eligible.

(b) Additionally, an employee enrolled in a high deductable health plan may not enroll in a Health Reimbursement account.

260:40-24-4. Amount of benefits available

(a) Subject to the limitations imposed by federal law, the maximum benefit which a participant may receive in any Plan Year for a health savings account shall be subject to the annual maximums set by the IRC 223. The maximum is indexed and is set each year. Individuals age 55 and older can also make additional "catch-up" contributions. An employee may also elect catch up benefits as directed by IRC 223 and the catch up provision is also indexed annually.

(b) The monthly or biweekly amount taken on this pre tax method will be based on the following deduction schedule as directed by the IRC Notice 2004-2. The maximum annual contribution to an HSA is the sum of the limits determined separately for each month, based on status, eligibility and health plan coverage as of the first day of the month. This will be calculated as the maximum annual limit plus catch up, if applicable, divided by 12 then multiplied by the number of monthly periods remaining in the Plan Year. If biweekly, this will be calculated as the maximum annual limit plus catch up, if applicable, divided by 26 then multiplied by the number of biweekly periods remaining in the Plan Year.

(c) Contributions to the HSA may be made pre-tax under a Section 125 Cafeteria Plan. Individual contributions are deducted pre-tax via payroll deduction. The employee, the employer, or both may make contributions to the HSA account.

(d) The non-discrimination rules applicable to a Cafeteria Plan are applicable to HSA contributions made under a Cafeteria Plan. This includes both employer and employee contributions. The following Cafeteria Plan rules do not apply to HSAs:

(1) The prohibition against a benefit that defers compensation by permitting employees to carry over unused elective contributions or plan benefits from one Plan Year to another (the Use-It-Or-Lose-It rule).

(2) The mandatory 12-month period of coverage.

(3) Change-in-status rules.

260:40-24-5. Internal Revenue Code and regulations

The health savings account option, the benefits provided thereunder, or contributions made pursuant to it, shall be in compliance with all provisions of this Plan and all applicable Internal Revenue Codes.

260:40-24-6. Mid-year changes of benefits

Section 125 plans (also known as "salary reduction" or "cafeteria" plans) must meet a different set of rules. Under these plans, contributions (both from employer and/or employee) must meet "non-discrimination" rules. These rules require the employer to ensure that contributions do not favor higher compensated employees. The Plan Administrator shall reduce amounts of benefits payable to a participant to assure that the health savings account option is nondiscriminatory and in compliance with any provision of the Internal Revenue Code or other applicable law or regulation. Any such reduction of benefits shall be made by the Plan Administrator on a reasonable and nondiscriminatory basis. Enrollees may change their salary reduction amounts, prospectively, on a monthly basis. An ineligible participant will be allowed to revoke their election, prospectively.

260:40-24-7. Health Savings Account option

The Plan Administrator shall establish for each participant a health savings account for each period of coverage. Each health savings account shall initially contain zero dollars ($0.00). A participant's health savings account for a period of coverage shall be increased by the portion of the participant's salary adjustment dollars that may be accrued from month to month for that period of coverage that he or she has elected to apply toward medical care expenses. A participant's health savings account for a period of coverage shall be reduced by the amount of any health savings account transferred to the HSA Custodian per the employees signed enrollment form. The HSA Custodian will provide the employee all annual statements except for W2. The Custodian also will account for prior year payments and properly account for catch up contributions and any distributions to the employee. The Employee Benefits Department expressly disclaims any fiduciary obligation to manage the member's HSA funds or accounts. HSA account information concerning contributions, IRS determinations, withdrawals, or any matters regarding the HSA is the sole responsibility of the HSA Trustee/Custodian chosen by the member.

260:40-24-8. Claims for reimbursement

A participant who has elected to participate in the health savings account option shall make application to their respective HSA Custodian for reimbursement of health care expenses incurred by the participant during the Plan Year. The Employee Benefits Department expressly disclaims any fiduciary obligation to manage the member's HSA funds or accounts. HSA account information concerning contributions, IRS determinations, withdrawals, or any matters regarding the HSA is the sole responsibility of the HSA Trustee/Custodian chosen by the member.

260:40-24-9. Forfeiture of unused benefits

The Employee Benefits Department will forward all contributions to the designated HSA Custodian on a monthly basis as determined by the EBD. No Contributions will remain with the Employee Benefits Department and, as such, there cannot be any forfeiture (See 260:40-24-8).

[Source: Added at 27 Ok Reg 490, eff 12-18-09 (emergency); Added at 27 Ok Reg 2077, eff 7-11-10]

260:40-24-10. Other governing provisions

The health savings account option shall be administered under the terms of this subchapter and Title.

260:40-24-11. Benefit changes

(a) A participant shall be entitled to modify the health savings account election after a period of coverage has commenced for which the election applies or make a new election, subject to acceptance by the Plan Administrator, with respect to the remainder of the current period of coverage, if the modification or new election is on account of and corresponds with a permitted elections as provided in IRC 223.

(b) The participant shall furnish the Plan Administrator with information and documentation relative to a request for a change in enrollment. The Plan Administrator shall determine whether a change in benefit election meets the criteria thereunder and is permitted by the Internal Revenue Code and regulations promulgated thereunder and is allowed by the Plan.

(c) The employee must provide a request to make a change via the authorized submission procedure as defined by the Plan Administrator.

260:40-24-12. Report to participants

Statements reflecting account balances will be accessible to participants via the Employee Benefits Department, Benefits Administration System (BAS) and shall satisfy the notification requirement reflecting contributions and transmittals to Custodians during such periods. The State will also accumulate and report on the annual W-2 statement all IRC Section 223 deductions based on the tax year the deduction was made.

SUBCHAPTER 25. DEPENDENT CARE REIMBURSEMENT ACCOUNT OPTION

260:40-25-1. Dependent care reimbursement account option

(a) This option allows a participant to receive reimbursements for dependent care expenses which are excludable from gross income. This option is intended to be qualified under Section 129 of the Internal Revenue Code and is an optional benefit within the State Employee Flexible Benefits Plan. This option is intended to be qualified under Section 125 of the Internal Revenue Code and is therefore, included as part of the cafeteria plan described in OAC 260:40-7-1.

(b) The Plan Administrator shall at all times administer this option in a manner consistent with the terms and provisions hereof, in a uniform and nondiscriminatory manner, and in accordance with the Internal Revenue Code and applicable regulations promulgated thereunder.

260:40-25-2. Definitions

The following words and terms, when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Dependent" means any individual who is:

(A) A dependent of the participant who is under the age of 13 and with respect to whom the participant is entitled to an exemption under Section 15(c) of the Internal Revenue Code or, is otherwise, a qualifying individual as provided in Section 21(d)(2) of the Internal Revenue Code, or

(B) A dependent or spouse of the participant who is physically or mentally incapable of caring for himself or herself.

"Dependent care expenses" means expenses incurred by a participant which are incurred for the care of a dependent of the participant or for related household services, and are eligible expenses as allowed under and defined in the prevailing Internal Revenue Code and rules promulgated thereunder and as allowed by the Plan Administrator.

"Dependent care reimbursement account" means the bookkeeping account maintained by the Plan Administrator used for crediting contributions and accounting for benefit payments.

"Eligible period of coverage" means that time period in which the participant contributes to the dependent care reimbursement account and that the participant is on an active pay status.

"Grace Period" means the period from the end of the Plan Year through March 15th of the subsequent Plan Year during which reimbursable expenses can be incurred and attributable to the previous Plan Year's account balance.

"Run Out Period" means the ninety (90) day period following a Plan Year in which claims can be made for reimbursable expenses incurred during the Plan Year.

260:40-25-3. Requirements for participation

Upon submission of the election through an authorized procedure prescribed by the Plan Administrator, any employee eligible to participate under the Flexible Benefits Plan shall be eligible to participate in the dependent care reimbursement account option.

260:40-25-4. Amount of benefit available

(a) Subject to any limitations imposed by federal law, the maximum amount which a participant may receive in a Plan Year in the form of dependent care expenses under the dependent care reimbursement account option shall be the least of the following:

(1) The participant's earned income for the Plan Year (after all reductions in compensation including the reduction related to dependent care expenses);

(2) The earned income of the participant's spouse for the Plan Year; or

(3) $5,000 ($2,500 in the case of a married individual who files a separate income tax return,) but not to exceed the monthly maximum contribution of $416.67 as defined and allowed by the Plan Administrator.

(b) The minimum salary adjustment amount for participation in the dependent care reimbursement account option shall be $50 per month.

260:40-25-5. Internal Revenue Code and regulations

The dependent care option, the benefits provided pursuant to it, and contributions made pursuant to it shall be in compliance with all applicable Internal Revenue Code provisions and regulations promulgated thereunder.

260:40-25-6. Reduction of benefits

The Plan Administrator shall reduce amounts of benefits payable to a participant to assure that the dependent care reimbursement account option is nondiscriminatory and in compliance with any provision of the Internal Revenue Code or other applicable law or regulation. Any such reduction of benefits shall be made by the Plan Administrator on a reasonable and nondiscriminatory basis. Contributions which may not be paid out because of benefit reductions imposed by this subchapter shall be forfeited per OAC 260:40-25-10.

260:40-25-7. Dependent care reimbursement account option

The Plan Administrator shall establish for each participant a dependent care reimbursement account for each Plan Year. Each dependent care reimbursement account shall initially contain zero dollars

($0.00). A participant's dependent care reimbursement account for a period of coverage shall be credited with the portion of the participant's flexible reimbursement account dollars that may be accrued from month to month for that Plan Year that he or she has elected to apply toward such account. A participant's dependent care reimbursement account for a Plan Year shall be reduced by the amount of any dependent care expenses paid to a participant.

260:40-25-8. Claims for reimbursement

A participant who has elected to participate in the dependent care reimbursement account option shall apply in writing to the Plan Administrator for reimbursement of dependent care expenses incurred by the participant during the period of coverage. The claim shall be made in a manner and on forms prescribed by the Plan Administrator.

260:40-25-9. Reimbursement or payment of dependent care expenses

(a) Subject to limitations contained in this section, the Plan Administrator shall reimburse the participant from the participant's dependent care reimbursement account for dependent care expenses incurred during the Plan Year for which the participant submits documentation in accordance with OAC 260:40-25-8. No reimbursement or payment of dependent care expenses incurred during a Plan Year shall exceed the balance available in the participant's dependent care reimbursement account.

(b) Participants shall be reimbursed for dependent expenses on a weekly or other reasonable basis during the Plan Year as determined by the Plan Administrator. Reimbursement can also be made for expenses incurred by any participant during the Grace Period. The final payment of benefits for any Plan Year may be made following the close of such Plan Year based on accepted claims filed with the Plan Administrator no later than the end of the Run Out Period.

(c) Upon demand a participant shall immediately refund any overpayment made by the Plan Administrator on behalf of the participant. Likewise, items charged to a debit card that are unacceptable to the Plan Administrator will require a participant to immediately refund such an overpayment to the Plan Administrator.

(d) If a participant ceases to be a participant or terminates employment, such participant shall be entitled to continue receiving benefits pursuant to the dependent care reimbursement account option to the extent of the amount remaining in the participant's dependent care reimbursement account for the expenses incurred during the eligible period of coverage in which termination of participation occurs.

260:40-25-10. Forfeiture of unused benefits

Amounts remaining in a participant's dependent care reimbursement account following final payment of all dependent care expenses incurred during the periods described in OAC 260:40-25-9(b) shall be forfeited to pay administrative expenses of the Flexible Benefits Plan.

260:40-25-11. Report to participants

On or before January 31 of each year, or at such other time as may be specified by federal law or regulation, the Plan Administrator shall furnish each participant who has received dependent care reimbursement during the prior Plan Year a written statement showing the amount of reimbursement during the prior Plan Year. Statements reflecting account balances shall be provided to participants no less than once each calendar quarter.

260:40-25-12. Other governing provisions

The dependent care reimbursement account option shall be administered under the terms of this subchapter and rules of this title promulgated by the Plan Administrator.

260:40-25-13. Benefit election irrevocable unless a permitted exception exists

(a) A participant's election of benefits described in this Chapter, made in accordance with subchapter 17 of this Chapter, shall be irrevocable during the Plan Year with regard to any benefit or portion of benefit elected for the period of coverage to which the election pertains except in those situations which qualify as permitted exceptions to the irrevocability rule and are not prohibited as changes by the Plan

Administrator. Conversion from one type of benefit to another or modification of the salary adjustment agreement shall not be permitted during the applicable period of coverage.

(b) A participant shall be entitled to modify a benefit election after a period of coverage has commenced for which the election applies or make a new election, subject to acceptance by the Plan Administrator, with respect to the remainder of the current period of coverage, if the modification or new election is on account of and corresponds with a permitted exception to the irrevocability rule as provided for in 87: 10-17-4 and is not a prohibited change as indicated in this subchapter. THE FOLLOWING ARE PROHIBITED CHANGES UNDER THE DEPENDENT CARE REIMBURSEMENT ACCOUNT OPTION:

(1) Significant Changes in Cost will not be allowed to effect any change to the Dependent Care Reimbursement Account Option if that increase is imposed by a dependent care provider who is a relative of the employee. Otherwise the exception is permitted.

(2) HIPAA Special Enrollment Rights will not be allowed to effect any change to the Dependent Care Reimbursement Account (See subchapter 17-4 for Permitted Exceptions)

(3) COBRA events will not be allowed to effect any change to the Dependent Care Reimbursement Account

(4) Judgments, Decrees, or Orders will not be allowed to effect any change to the Dependent Care Reimbursement Account Option (See subchapter 17-4 for Permitted Exceptions)

(5) Neither Medicare nor Medicaid eligibility or loss thereof will be allowed to effect any change to the Dependent Care Reimbursement Account

(c) The participant shall furnish the Plan Administrator with information and documentation relative to a request for an exception to the irrevocability rule. The Plan Administrator shall determine whether a change in benefit election meets the criteria thereunder and is permitted by the Internal Revenue Code and regulations promulgated there under and is allowed by the Plan.

(d) The employee must provide a request for an exception in a timely manner that is compliant with the authorized submission procedure established by the Plan Administrator.

(e) Any request to make a change must be submitted to the Plan Administrator or its designee within 30 days of the event which provides the basis for an exception to the irrevocability rule as provided for in 260:40-17-4 and this subchapter. If the request is not submitted via an authorized submission procedure as determined by the Plan Administrator within thirty (30) days of the event, the participant shall waive the option to make changes under this section.

SUBCHAPTER 26. QUALIFIED TRANSPORTATION ACCOUNT OPTION

260:40-26-1. Qualified Transportation account option

(a) This option allows an employee to receive reimbursements for qualified mass transportation expenses which are excludable from gross income. This option is intended to be qualified under Section 132 of the Internal Revenue Code and is an optional benefit within the State Employee Flexible Benefits Plan. As a result, it is excluded as part of the cafeteria plan described in OAC 260:40-7-1.

(b) The Plan Administrator shall at all times administer this option in a manner consistent with the terms and provisions hereof, in a uniform and nondiscriminatory manner, and in accordance with the Internal Revenue Code and applicable regulations promulgated thereunder.

260:40-26-2. Definitions

The following words and terms, when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Eligible period of coverage" means that time period in which the employee contributes to the Qualified Transportation account and that the employee is on an active pay status.

"Mass Transit expense" means any pass, token, fare card, voucher, or similar item (including an item exchangeable for fare media) entitling a person to transportation. The pass must be used for transportation on a public or privately-owned mass transit system, or on transportation provided by a person in the business of transporting people in a vehicle, seating at least six adults, excluding the driver and are eligible expenses as allowed under and defined in the prevailing Internal Revenue Code and rules promulgated thereunder and as allowed by the Plan Administrator.

"Qualified Transportation account" means the bookkeeping account maintained by the Plan Administrator used for crediting contributions and accounting for benefit payments.

"Run Out Period" means the ninety (90) day period following a Plan Year in which claims can be made for reimbursable expenses incurred during the Plan Year.

260:40-26-3. Requirements for participation

Upon submission of the election through an authorized procedure prescribed by the Plan Administrator, any employee eligible to participate under the Flexible Benefits Plan shall be eligible to participate in the Qualified Transportation account option.

260:40-26-4. Amount of benefit available

The maximum amount which an employee may receive in a Plan Year in the form of Mass Transit expense reimbursement or payment under the Qualified Transportation account option shall be the maximum amount as determined on a yearly basis by the Internal Revenue Service pursuant to 26 U.S.C. Section 132(f) and 26 C.F.R. Section 1.132-9.

260:40-26-5. Internal Revenue Code and regulations

The Qualified Transportation option, the benefits provided pursuant to it, and contributions made pursuant to it shall be in compliance with all applicable Internal Revenue Code provisions and regulations promulgated thereunder.

260:40-26-6. Elections/mid-year changes

(a) Employees may elect to participate during the open enrollment Option Period prior to the plan year.

(b) New Hires and employees not previously enrolled may elect to participate during the plan year.

(c) Employees who have elected to participate may drop the option any time during the plan year. However, once the account has been dropped, the employee may not re-enroll during the same plan year. Any amounts remaining in the account after the option has been dropped are subject to forfeiture pursuant to OAC 260:40-26-10.

(d) Employees' requests to participate, or drop participation, in Qualified Transportation accounts must be made in a manner and on forms prescribed by the Plan Administrator.

260:40-26-7. Qualified Transportation account option

Each Plan Year, the Plan Administrator shall establish a Qualified Transportation account for each employee who elects to participate in a Qualified Transportation account. During the Plan Year, the applicable payroll office shall on a monthly basis deduct from the employee's payroll the amount designated by the employee and credit the employee's Qualified Transportation account. An employee's Qualified Transportation account for a Plan Year shall be reduced by the amount of any qualified Mass Transit expenses paid to the employee.

260:40-26-8. Claims for reimbursement

Claims for reimbursement of qualified Mass Transit expenses incurred during the period of coverage shall be made in a manner and on forms prescribed by the plan administrator.

260:40-26-9. Reimbursement or payment of Mass Transit expense

(a) Subject to limitations contained in this section, the Plan Administrator shall reimburse the employee from the employee's Qualified Transportation account for Mass Transit expenses incurred during the Plan Year for which the employee submits documentation in accordance with OAC 260:40-26-8. No reimbursement or payment of Mass Transit expenses incurred during a Plan Year shall exceed the balance available in the employee's Qualified Transportation account. The reimbursement must be for the state employee to utilize Mass Transit. Reimbursement for spousal or dependant expenses is not allowed. The Mass Transit pass must be a monthly pass; passes less than one month will not be reimbursed.

(b) The final payment of benefits for any Plan Year may be made following the close of such Plan Year based on accepted claims filed with the Plan Administrator no later than the end of the Run Out Period.

(c) Upon demand an employee shall immediately refund any overpayment made by the Plan Administrator on behalf of the employee.
(d) If an employee ceases to be an active state employee or terminates employment with the state, such employee shall be entitled to continue receiving benefits pursuant to the Qualified Transportation account option to the extent of the amount remaining in the employee's Qualified Transportation account for the expenses incurred during the eligible period of coverage in which termination of participation occurs.

260:40-26-10. Forfeiture of unused benefits

Amounts remaining in an employee's Qualified Transportation account following final payment of all Mass Transit expenses incurred during the periods described in OAC 260:40-26-9(b) shall be forfeited to pay administrative expenses of the Flexible Benefits Plan. An employee who elects to continue to enroll into a Qualified Transportation account in subsequent years, without periods of interruption, will be permitted to roll over unused amounts from previous years subject to the limitations in OAC 260:40-26-4

260:40-26-11. Report to employees

On or before January 31 of each year, or at such other time as may be specified by federal law or regulation, the Plan Administrator shall furnish each employee who has received Qualified Transportation payments during the prior Plan Year a written statement showing the amount of reimbursement during the prior Plan Year. Statements reflecting account balances shall be provided to employees no less than once each calendar quarter.

SUBCHAPTER 27. HEALTH CARE REIMBURSEMENT ACCOUNT OPTION

260:40-27-1. Health care reimbursement account option

(a) This option is an optional benefit within the State Employees Flexible Benefits Plan. This option is intended to be qualified under Section 125 of the Internal Revenue Code and is, therefore, included as part of the cafeteria plan described in OAC 260:40-7-1.
(b) The Plan Administrator shall at all times administer this option in a manner consistent with the terms and provisions hereof in a uniform and nondiscriminatory manner and in accordance with the prevailing Internal Revenue Code and applicable regulations promulgated thereunder.

260:40-27-2. Definitions

The following words and terms, when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Dependent" means an individual, who qualifies as a dependent under Section 125 of the Internal Revenue Code, taking into account Section 105(b) of the Internal Revenue Code.

"Health care reimbursement account" means the bookkeeping account maintained by the Plan Administrator used for crediting contributions and accounting for benefit payments.

"Medical care expenses" means any expenses incurred by a participant or by a spouse or dependent of such participant for medical care as described in Section 213 of the Internal Revenue Code and subject to the limitations of section 125 and this Flexible Benefits Plan, but only to the extent that the participant or other person incurring the expense is not reimbursed for the expense through insurance or otherwise.

"Grace Period" means the period from the end of the Plan Year through March 15th of the subsequent Plan Year during which reimbursable expenses can be incurred and attributable to the previous Plan Year's account balance.

"Rollover Distributions" means distributions to a Health Savings Account of balances remaining at year end for employees who qualify pursuant to State and federal law.

"Run-Out Period" means the ninety (90) day period following a Plan Year in which claims can be made for reimbursable expenses incurred during the Plan Year.

260:40-27-3. Requirements for eligibility

(a) Upon submission of the election through an authorized procedure as prescribed by the Plan Administrator, an employee eligible to participate under the Flexible Benefits Plan shall be eligible to participate in the health care reimbursement account option.

(b) A former employee who is reemployed by the same participating employer after thirty (30) days from termination will not be eligible to reenroll in a Health Care Reimbursement Account throughout the remainder of the current Plan Year unless the employee maintained the Health Care Reimbursement Account under the COBRA provisions.

260:40-27-4. Amount of benefits available

(a) Subject to the limitations imposed by federal law to avoid discrimination, the maximum benefit which a participant may receive in any Plan Year for medical care expenses under the health care reimbursement account option shall be subject to a monthly maximum of $350.00 or other amount as determined by the Plan Administrator.

(b) The minimum salary adjustment amount for participation in this option shall be $10.00 per month.

260:40-27-5. Internal Revenue Code and regulations

The health care reimbursement account option, the benefits provided thereunder, or contributions made pursuant to it, shall be in compliance with all provisions of this Plan and all applicable Internal Revenue Code provisions and regulations promulgated thereunder.

260:40-27-6. Reduction of benefits

The Plan Administrator shall reduce amounts of benefits payable to a participant to assure that the health care reimbursement account option is nondiscriminatory and in compliance with any provision of the Internal Revenue Code or other applicable law or regulation. Any such reduction of benefits shall be made by the Plan Administrator on a reasonable and nondiscriminatory basis. Contributions which may not be paid out because of benefit reductions imposed by this section shall be forfeited.

260:40-27-7. Health care reimbursement account option

The Plan Administrator shall establish for each participant a health care reimbursement account for each period of coverage. Each health care reimbursement account shall initially contain zero dollars ($0.00). A participant's health care reimbursement account for a period of coverage shall be increased by the portion of the participant's salary adjustment dollars that may be accrued from month to month for that period of coverage that he or she has elected to apply toward medical care expenses. A participant's health care reimbursement account for a period of coverage shall be reduced by the amount of any health care expenses paid to a participant.

260:40-27-8. Claims for reimbursement

A participant who has elected to participate in the health care reimbursement account option shall apply in writing to the Plan Administrator for reimbursement of health care expenses incurred by the participant during the Plan Year. The claim for account reimbursement shall be made in a manner and on a form furnished by the Plan Administrator.

260:40-27-9. Reimbursement of health care expenses

(a) Subject to limitations contained in this section, the Plan Administrator shall reimburse the participant from the participant's health care reimbursement account for health care expenses incurred during the eligible period of coverage, for which the participant submits documentation, in accordance with OAC 260:40-27-8. No reimbursement of health care expenses incurred during a Plan Year shall exceed the maximum amount defined in the salary adjustment agreement.

(b) Participants shall be reimbursed for medical care expenses on a weekly or other reasonable basis during the Plan Year in accordance with Flexible Benefits Plan Administration Rules. Reimbursement can also be made for expenses incurred by any participant during the Grace Period. The final payment of benefits for any Plan Year may be made following the close of such Plan Year based on accepted claims filed with the Plan Administrator no later than the end of the Run Out Period.

(c) Upon demand a participant shall immediately refund any overpayment made by the Plan Administrator on behalf of the participant. Likewise, items charged to a debit card that are unacceptable to the Plan Administrator will require a participant to immediately refund such an overpayment to the Plan Administrator.

(d) If a participant ceases to be a participant or terminates employment, the participant shall be entitled to continue receiving benefits pursuant to this health care option to the extent of the amount remaining in the participant's health care reimbursement account for expenses incurred during the eligible period of coverage of the current Plan Year.
(e) If a participant ceases to be a participant or terminates employment, claims incurred after the last day of the month of termination or the date participation ceased shall not be considered for reimbursement, unless the participant elects to continue participation in this option by elected coverage continuation as provided for in this section.
(f) Any participant may continue this option under the coverage continuation guidelines for COBRA, as provided under OAC 260:40-33-1 on a post tax basis.

260:40-27-10. Forfeiture of unused benefits

Following final payment of all health care expenses incurred during the periods described in OAC 260:40-27-9(b), amounts remaining in the health care reimbursement account shall be forfeited to pay administrative expenses of the Flexible Benefits Plan.

260:40-27-11. Other governing provisions

The health care reimbursement account option shall be administered under the terms of this subchapter and Title.

260:40-27-12. Benefit election irrevocable unless a permitted exception exists

(a) Except as otherwise provided in this Section, a participant's election of benefits described in this Chapter, made in accordance with subchapter 17 of this Chapter, shall be irrevocable during the Plan Year with regard to any benefit or portion of benefit elected for the period of coverage to which the election pertains. Conversion from one type of benefit to another or modification of the salary adjustment agreement shall not be permitted during the applicable period of coverage.
(b) A participant shall be entitled to modify a benefit election after a period of coverage has commenced for which the election applies or make a new election, subject to acceptance by the Plan Administrator, with respect to the remainder of the current period of coverage, if the modification or new election is on account of and corresponds with a permitted exception to the irrevocability rule as provided for in 260:40-17-4 and is not a prohibited change as indicated in this subchapter. THE FOLLOWING ARE PROHIBITED CHANGES UNDER THE HEALTH CARE REIMBURSEMENT ACCOUNT OPTION:
(1) HIPAA Special Enrollment Rights will not be allowed to effect any change to the Health Care Reimbursement Account. (See subchapter 17-4 for Permitted Exceptions)
(2) COBRA events
(3) Significant Changes in Cost or a Change in Coverage
(4) Change in coverage of spouse or dependent under Other Employer's plan (See subchapter 17-4 for Permitted Exceptions)
(c) The participant shall furnish the Plan Administrator with information and documentation relative to a request for an exception to the irrevocability rule. The Plan Administrator shall determine whether a change in benefit election meets the criteria thereunder and is permitted by the Internal Revenue Code and regulations promulgated there under and is allowed by the Plan.
(d) The employee must provide a request to make a change via the authorized submission procedure as defined by the Plan Administrator.
(e) Any request to make a change must be signed by the employee and submitted to the Plan Administrator within thirty (30) days of the event described in subsection17-4 of this document. If the request is not submitted under an authorized procedure and submitted to the Plan Administrator within thirty (30) days of the event, the participant shall waive the option to make changes under this section.

260:40-27-13. Report to participants

Statements reflecting account balances shall be provided to participants no less than each calendar quarter and shall satisfy the notification requirement reflecting contributions and reimbursements during such periods.

260:40-27-14. Health Savings Accounts Distributions

The EBD has discretion to permit rollover distributions to a Health Savings Account as allowed by State and federal law.

[Source: Added at 25 Ok Reg 79, eff 9-4-07 (emergency); Added at 25 Ok Reg 2139, eff 7-11-08]

SUBCHAPTER 28. EARLY MEDICAL ALERT OPTIONAL BENEFIT

260:40-28-1. Early medical alert optional benefit

(a) This option is a qualified benefit under Section 125 of the Internal Revenue Code. This benefit is an optional benefit within the State Employees Flexible Benefits Plan and is included as part of the cafeteria plan described in Subchapter 1 of this Chapter.

(b) The Plan Administrator shall at all times administer this option in a manner consistent with the terms and provisions hereof, in a uniform and nondiscriminatory manner, and in accordance with the Internal Revenue Code and applicable regulations promulgated thereunder.

260:40-28-2. Definitions

The following words and terms, when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Period of Coverage" The period of coverage for this benefit runs from January 1 through December 31 of a given Plan Year. For new hires electing this benefit, the period of coverage begins on the first day of the month following date of hire through December 31.

260:40-28-3. Requirements for participation

Upon submission of the election through an authorized procedure prescribed by the Plan Administrator, any employee eligible to participate under the State Employees Flexible Benefits Plan shall be eligible to participate in the early medical alert optional benefit.

260:40-28-4. Internal Revenue Code and regulations

The early medical alert optional benefit, the benefits provided pursuant to it, and contributions made pursuant to it shall be in compliance with all applicable Internal Revenue Code provisions and regulations promulgated thereunder.

260:40-28-5. Period of coverage - enrollment

The period of coverage will be on a calendar year basis beginning January 1 and ending December 31 of a given Plan Year. For new hires electing this benefit, the period of coverage begins on the first day of the month following date of hire through December 31. Midyear enrollees must pay the annual cost regardless of entry date. Pro-rated premiums are not available. Participation requires re-enrollment on an annual basis. Members wishing to participate for successive Plan Years must make a positive enrollment.

260:40-28-6. Enrollment

(a) Employees may elect to enroll in this benefit during the Option Period prior to each Plan Year.

(b) New Hires may elect to participate in this optional benefit when completing the new hire benefits election form within thirty (30) days following date of hire.

(c) Requests for enrollment must be made in a manner and on forms prescribed by the Plan Administrator.

260:40-28-7. Early medical alert account option

The Plan Administrator shall establish for each employee an early medical alert account for each Plan Year. An employee's early medical alert account for a period of coverage shall be credited with the portion of the employee's early medical alert account dollars that may be deducted from payroll through a single payroll deduction. An employee's early medical alert account for a Plan Year shall be reduced by the amount of any early medical alert dollars paid on behalf of the employee.

SUBCHAPTER 29. PROCESSING AND REVIEW OF HEALTHCARE AND DEPENDENT CARE SPENDING ACCOUNT CLAIMS

260:40-29-1. Processing and payment of claims

The Plan Administrator shall authorize and establish a claims reimbursement procedure under which all claims will be processed.

SUBCHAPTER 31. COVERAGE CONTINUATION AND REFUNDS

260:40-31-1. Individual remittances to the Plan Administrator

(a) The following individuals are eligible to make direct remittances to the Plan Administrator for health, life, dental, disability, and any other elected options.

(1) An eligible employee on approved leave without pay; or

(2) Disability recipients.

(b) While on suspension without pay, an employee may continue coverage. If the agency which has suspended the employee fails to pay the employee's flexible benefit allowance, the agency shall provide written notice to the Plan Administrator that the employee has been given reasonable, written notice that the agency has failed to pay the employee's flexible benefit allowance and that the premium payments must be paid by the employee if the coverage is to remain in force and in effect. Coverage is limited to ninety (90) days following the date of suspension or the duration of the administrative appeals process, whichever is greater.

(c) Unless authorized by the rules of this Chapter for a different method of payment, all premiums due shall be remitted directly to the Plan Administrator by the tenth of the month for which the payment is due. All checks, money orders, and cashier's checks shall be made payable to the Employee Benefits Department. The full amount of the payment for the coverage elected by the individual must be remitted each month. All remittances shall be the sole responsibility of the member, subject to final approval by the Plan Administrator.

(d) If payment is not received by the end of the month for which the payment is due, coverage may be canceled effective the end of the month in which the last premium was received, except those premiums withheld through the disability program. If the participant proves that the failure to pay premiums was not due to the participant's negligence, the Plan Administrator may reinstate coverage within sixty (60) days. The reinstated coverage shall be subject to payment of any required premiums and submission of evidence of insurability of the employee if required by the insurance company providing the coverage. The employee shall be notified in writing of cancellation of coverage.

(e) Coverage may be canceled if the participant's payment is returned or refused due to insufficient funds or closed account, unless the check is returned due to no fault of the participant.

260:40-31-2. Refund for over deductions

(a) It is the participant's duty to notify the agency coordinator of a change in eligibility for himself, his spouse or his dependents. Any refund of payment for any over deduction shall be made only when the Plan Administrator is notified in writing no later than sixty (60) days from the actual date of the over deduction. No refund will be made for over deductions which occurred more than sixty (60) days prior to the date written notification is received by the Plan Administrator.

(b) Refunds for excess deductions due to administrative error of the agency shall be limited to either the beginning of the Plan Year in which the error was discovered or the beginning of the calendar year in which the error was discovered, whichever is later.

(c) A refund of premium form shall be completed by the employee and submitted to the Plan Administrator for approval. If approved, the applicable payroll office will issue a payroll voucher to the employee for the amount of refund due. When the Plan Administrator does not approve a refund, the Plan Administrator shall notify the employee.

(d) Any benefits paid under this plan for an ineligible employee, spouse or dependent may be offset against any refund due for over deduction.

260:40-31-3. Family and medical leave

(a) A participant who is on approved FMLA leave may remit any optional or dependent premiums directly to the Plan Administrator under OAC 260:40-7-1.

(b) Any participant who chooses not to remit dependent or optional premiums during approved FMLA leave may resume those same coverages effective the first day of the month following the participant's return from approved family and medical leave. Any coverage that lapsed during the approved FMLA leave period shall be reinstated with no evidence of insurability or pre-existing condition exclusions for those dependents covered prior to the FMLA leave commencement date.
(c) The employing agency of a participant who is on approved FMLA leave shall remit the actual cost of the employee-only coverage for health, dental, life and disability to the Plan Administrator.

260:40-31-4. Uniformed Services Employment and Reemployment Rights Act

(a) Under USERRA, "uniformed service" means the performance of duty with the Armed Services, the Coast Guard, the Army National Guard, the Air National Guard and the Commissioned Corps of the Public Health Service and does not consider if this duty is performed on a voluntary or involuntary basis.
(b) Under USERRA the employer shall restore benefits which employees and their dependents were receiving when the uniformed service began. In addition, the employer shall make available any new benefits that may have gone into effect during the uniformed service period.

SUBCHAPTER 33. COBRA COVERAGE

260:40-33-1. Workers' compensation insurance not affected

The coverage set forth in this title is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance.

260:40-33-2. Procedures and implementation

(a) Each agency or employer participating in the Flexible Benefits Plan shall advise each covered employee of his legal right to continue coverage upon separation from state employment. Each covered employee shall sign a notice of right to continue coverage. This notice shall be kept by the agency/employer in each employees' permanent personnel file. An affidavit shall be signed by each agency head/employer and the coordinator and returned to the Plan Administrator's office for permanent record.
(b) COBRA qualifying event notices are to be submitted by the Coordinator any time an employee dies, terminates employment, or reduces work hours so as to be no longer eligible for insurance coverage. Qualifying event notices on behalf of eligible spouses and dependents will also be submitted. These submissions must be sent to the Plan Administrator and or to the COBRA Administrator (Group Insurance EGID) within thirty (30) days of the qualifying event.
(c) COBRA forms are to be filled out by the covered employee or dependent if the qualifying event is divorce, legal separation or the dependent becoming ineligible, for health insurance coverage. This form must be filed within sixty (60) days from the date of the qualifying event in order to obtain continued coverage. If the qualifying event is divorce or legal separation, a copy of the petition or decree shall be furnished along with the COBRA form.
(d) After a beneficiary elects to continue coverage under COBRA, the beneficiary shall become an inactive member. The beneficiary shall remit all premiums including a two (2) percent administrative fee to the designated COBRA administrator.
(e) If the beneficiary is entitled to continue the insurance because he or she is a surviving spouse, the beneficiary shall be informed of the right to choose to continue under the health plan currently provided for survivors or to elect to continue under COBRA. If the beneficiary wishes to continue the insurance as a surviving dependent, this election must be made within sixty (60) days from the date of death of the employee. If the beneficiary wishes to keep his/her insurance through COBRA, this election shall be made within sixty (60) days of the date of the letter sent with the COBRA application from the COBRA Administrator. The beneficiary shall be informed of his/her rights under each of these options and that all election decisions are irrevocable.

260:40-33-3. COBRA administration

(a) COBRA continuation is only available to those employees and/or dependents who were covered under the plans offered by the Plan Administrator that are eligible for COBRA continuation on the date of

the qualifying event or as otherwise defined in section (c) below. A leave under FMLA is not a COBRA qualifying event.

(b) New dependents may be added to coverage, including newborns, provided the employee had all eligible dependents covered at the time of the qualifying event. New dependents must be added within thirty (30) days of acquiring eligibility.

(c) A qualified beneficiary is defined as any individual who, on the day before a qualifying event, is covered under a group health plan by virtue of being on that day either a covered employee, the spouse of a covered employee, or a dependent child of a covered employee. A qualified beneficiary is also any child who is born to a covered employee or placed for adoption with a covered employee during a period of COBRA continuation coverage. A child born to or adopted by a qualified beneficiary other than the former employee is not considered a qualified beneficiary under COBRA law.

(d) If the qualifying event is termination of employment, whether voluntary or involuntary, the employing agency shall make the determination whether or not the termination was due to gross misconduct. The Plan Administrator will not make that decision, nor will it question a decision by the employing agency on this issue. If a decision is made by the agency that the employee was terminated due to gross misconduct, the COBRA form should clearly specify that fact.

(e) Once election to continue coverage has been made, coverage will terminate in eighteen (18) months if the qualifying event is termination or reduction in hours, or thirty-six (36) months if the qualifying event is death, divorce or legal separation, or ceasing to be a dependent child. Coverage may also terminate if the Plan Administrator ceases to offer any plans eligible for COBRA continuation, or if the beneficiary fails to make timely payments of any premiums required, or if the beneficiary becomes covered under any other group plan unless the new group plan contains an exclusion or limitation with respect to any pre-existing condition of the participant.

(1) The maximum eligibility period may be extended to twenty-nine (29) months if the Social Security Administration determines that the qualified beneficiary was totally disabled under Title 11 or XVI of the Social Security Act on or before the COBRA event date or within the first sixty (60) days following the start of continuation coverage. The qualified beneficiary must provide the employer or designated COBRA administrator with a copy of the Social Security determination notice within 60 days after the determination is issued and before the end of the initial eighteen (18) months of COBRA.

(2) If the Social Security Administration reevaluates the participant's case and determines that the participant is no longer disabled, the participant must provide the agency or the designated COBRA administrator with a copy of the determination notice. This copy must be sent within thirty (30) days. Coverage will end at the end of the month that begins more that thirty (30) days after the date of the final determination. For example, if a final determination notice date is May 15, coverage would end June 30.

(3) If an employee is receiving Medicare prior to retirement or another COBRA event, he/she can continue COBRA coverage for eighteen months (18) after the retirement or other qualifying COBRA event. However, the spouse and or other qualified beneficiaries shall be allowed to have COBRA for thirty-six (36) months after the Medicare entitlement date.

(f) No evidence of insurability shall be required for continuation of coverage.

(g) The coverage elected shall be identical to the coverage provided at the date of the qualifying event, unless a beneficiary moves outside an HMO's service area. In that event, coverage is continued under the plan offered by the EGID.

(h) Each covered beneficiary has the same rights and benefits as any similarly situated person to whom a qualifying event has not occurred. There are the same limitations and exclusions, except to the extent to which it would conflict with federal law.

(i) Any election of a qualified beneficiary shall be deemed to include an election of continuation on behalf of all other qualified beneficiaries residing together, unless specified in the election.

(j) Applicable premiums shall be determined on an actuarial basis for a twelve (12) month period, on or before the start of the Plan Year each year. The premiums shall remain the same during the Plan Year.

(k) All back premiums from the termination of coverage to the election and approval of continuation must be paid before coverage is effective. Coverage will then be retroactive to provide continuous coverage. All time limits are mandatory and cannot be waived under any circumstances.

(l) If a qualified beneficiary waives continuation of coverage, he/she may revoke that waiver anytime within the 60 day election period, but no claims are payable nor will any coverage be applied to the period prior to the revocation of the waiver.

(m) It is the responsibility of the qualified beneficiary to notify the Plan Administrator if he or she is not eligible for any reason. Failure to do so will result in cancellation of COBRA insurance coverage retroactive to the time of ineligibility.
(n) The date of the qualifying event shall be the same date as the actual loss of coverage under the previous plan. The period of continuation coverage and the applicable notification periods shall begin on the date of the actual loss of other coverage. The Plan Administrator shall have the right to make a final determination as to when the actual date of termination occurred.

SUBCHAPTER 35. GROUP HEALTH PLAN DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE PLAN ADMINISTRATOR

260:40-35-1. General Provisions

A group health plan may disclose protected health information to the Plan Administrator in its capacity as plan sponsor. The Plan Administrator will use and disclose such information in a manner consistent with the HIPAA requirements of the Standards for Privacy of Individually Identifiable Health Information including the applicable requirements of 45 CFR §164.504(f).

SUBCHAPTER 37. COMPETITIVE BIDDING CRITERIA AND PROCEDURES FOR CONTRACTS AWARDED FOR FLEXIBLE BENEFITS PLANS

260:40-37-1. Purpose

The purpose of this Chapter is to describe the rules governing the procurement requirements of the Oklahoma State Employee Benefits Department (EBD) for contracts to provide flexible benefits plan choices for active State employees and their eligible dependents. Flexible benefit plans are purchased under guidelines approved by the Oklahoma State Employee Benefits Department in compliance with all applicable State statutes. This Chapter does not apply to any products or services required by the EBD outside the scope of flexible benefits plans as defined in the Oklahoma State Employees Flexible Benefits Act (74 O.S. §1341 et seq.). Other products or services shall be procured in accordance with the Central Purchasing Act (74 O.S. §85.1 et seq.).

260:40-37-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:
"Audit Clause" means in accepting any contract with the Oklahoma State Employee Benefits Department, the Bidder must agree to an audit clause which provides that books, records, documents, accounting procedures, practices or any other items of the service provider relevant to the contract are subject to examination by the EBD, State Auditor and Inspector, or other designated entities.
"Award" or "Contract award" means when the EBD votes to approve the acceptance of a proposal from a qualified Bidder meeting all requirements of the procurement as determined by the EBD.
"Bidder" means any entity submitting a competitive proposal in response to a solicitation for flexible benefit plans issued under this Chapter.
"Bidder's List" means the list maintained by the Contracts Administrator setting out the names and addresses of qualified suppliers of flexible benefit plans from whom proposals can be solicited.
"Business Day" means any day except Saturday, Sunday, or a legal holiday for State employees as proclaimed by the Governor.
"Competitive Negotiation" means the method by which the EBD may contract with qualified Bidders for flexible benefits plans through best and final offer (BFO) process.
"Confidential Information" means information clearly designated in the RFP as being proprietary information and which shall be retained as confidential. All information included in or with a Bidder's proposal lacking such a designation shall be subject to the Oklahoma Open Records Act (51 O.S.2001, § 24(A)(1) et seq.).
"Contract" means when a Bidder submits a proposal, the proposal is submitted as a legal offer and any proposal, when accepted by the EBD constitutes a contract (See Award).
"Contracts Administrator" means the Contracts Administrator employed by the EBD.
"EBD" means the Oklahoma State Employee Benefits Department.

"EEOC" means Equal Employment Opportunity Commission.
"Director" means the Director employed by the EBD.
"Formal Proposal" means a proposal which must be submitted in a sealed envelope or container and in conformance with a prescribed format, to be opened at a specified time and specified place. (See also, Proposal.)
"HEDIS" means Health Plan Employer Data and Information Set.
"Ineligible Bidder" means a prospective service provider who, by reason of financial instability, unsatisfactory performance as documented by the EBD or other deficiency, does not meet the qualifications for placement on the bidder list.
"Late Bid" or "Late Proposal" means a bid or proposal received at the place specified in the RFP after the date and time designated for all proposals to be received.
"Proposal" means the executed document submitted by a Bidder in response to a Request for Proposal (RFP) issued by the EBD.
"Readiness Reviews" means the process by which the contracting authority makes scheduled on-site visits to the service provider for purposes of testing the readiness of the provider.
"Request for Proposal" or "RFP" means the solicitation document used for competitive sealed bidding.
"State" means the State of Oklahoma, acting by and through the EBD or its/their designee.
"Vision Plan" means a company, organization, group, or person who owns, operates, and provides a health care benefit plan designed for the care of the eye or the correction or enhancement of one's eyesight.

260:40-37-3. General purchasing provisions

(a) The EBD has the statutory authority to purchase flexible benefit plans for participants as defined by the Oklahoma State Employees Benefits Act. The EBD reserves the right to cancel any given procurement of flexible benefit plans at any time for any reason.
(b) Except as otherwise specifically provided by this Chapter, all flexible benefit plan contracts required by the EBD shall be acquired by competitive bidding pursuant to the terms of this Chapter. Contracts with qualified flexible benefits plans may be awarded on the basis of best and final offer (BFO) through competitive negotiation. The EBD, at its own discretion, shall have the option of bidding and contracting any flexible benefit plan through the Department of Central Services, Central Purchasing Division.

260:40-37-4. Bidder registration

(a) Any Bidder which seeks to contract to provide flexible benefit plans to the EBD must be on the Bidder's list prior to the public release of an RFP solicitation. A Bidder desiring to be on the Bidder List must register with the Contracts Administrator to receive copies of RFP solicitations. Only those Bidders qualified under Oklahoma law to perform the services requested by the EBD and who meet the Bidder registration requirements contained herein will be added to the Bidder's List.
(b) Bidder Qualifications.
(1) A Bidder has the burden of demonstrating that it has the capability to responsibly do business with the State of Oklahoma. In the interest of providing the highest level of quality to statewide active State employees and their eligible dependents for flexible benefit choices, Bidders seeking Bidder registration with the EBD to provide flexible benefit choices in response to a benefit choice RFP solicitation must provide:
(A) Proof that the benefit provider has been operational (licensed where applicable) and enrolling members within the State of Oklahoma for a period of not less than eighteen (18) months prior to the date proposals are due.
(B) Audited financial statements for the most recent two (2) full years, and
(C) Disclosure of all State and Federal regulatory actions taken against the Bidder in the preceding eighteen (18) months.
(2) The EBD can make exception to any of the aforementioned requirements in this subparagraph at its discretion when the EBD determines doing so is in the best interest of the State and members.
(c) Bidders wishing to be added to the Bidder List must request in writing to receive a Bidder registration packet. Written requests must be addressed to: Oklahoma State Employee Benefits Department, First National Center, 120 North Robinson Avenue, Suite 1100, Oklahoma City, Oklahoma

73102, Attention: Contracts Administrator. Bidders shall be provided a packet with registration information and submission forms. All Bidders must renew registrations annually on a plan year basis.
(d) The Bidder shall complete the information requested in the Bidder registration packet and return the forms to the Contracts Administrator. The Bidder registration forms must be received by the Contracts Administrator not less than seven (7) business days before the issuance of the RFP. Upon receipt, EBD shall review the Bidder registration forms for completeness and qualification and determine prior to the public release of an RFP solicitation whether or not the Bidder shall be added to the Bidder's List. The EBD shall return the Bidder registration forms in the event the forms have not been properly completed, and shall deny the registration where the form is incomplete and/or the applicant Bidder is not qualified to perform the flexible benefits plan requested in the RFP. Entities not registered as a bidder may receive copies of RFPs pursuant to the Open Records Act.
(e) The Oklahoma State and Education Employees Group Insurance EGID is exempt from the Bidder registration requirement herein.

260:40-37-5. Bidder retention and removal from bidder list

(a) To ensure Bidders perform in the best interest of the State, it is necessary to address problems in a swift and equitable manner for all concerned. The EBD has determined that Bidder misconduct can cause irreparable harm to the EBD and its eligible participants. It is therefore recognized that penalties for poor Bidder performance and/or violation of State and Federal statutes must be addressed.
(b) The EBD may remove any Bidder for any material infraction(s) as determined by the EBD to be in the best interest of the State and members, including but not limited to the following. The amount of time a Bidder is removed from the Bidder's List shall be determined by the EBD:
(1) A Bidder which has contracted with the EBD to provide flexible benefit plan(s) and which terminates its contract with the EBD prior to the contract expiration date.
(2) Financial insolvency.
(3) A conviction or plea of guilty to a felony involving fraud, bribery or corruption to the State or to any of its political subdivisions.
(4) Giving false or misleading information in an application for inclusion on the Bidder's List.
(5) Certification by the Oklahoma Human Rights Commission that the Bidder is engaging in a discriminatory practice as defined in 25 O.S. §§ 1505 and 1604.
(6) Failure on the part of the Bidder to meet EEOC and other requirements mandated by public legislation or EBC.

260:40-37-6. Submission of proposals

(a) The Bidder's proposal must be submitted in a sealed envelope or container with the name and address of the Bidder, the RFP number, and the date and time of the RFP closing clearly marked on the outside of the envelope or container. All proposals must be complete and in compliance with the instructions provided with the RFP. It is the Bidder's responsibility to read and understand the instructions, terms and conditions provided with the RFP. Failure to comply with the instructions and terms and conditions in the RFP in any material way shall disqualify the proposal as per OAC 260:40-37-9. Proposals are to be mailed or submitted in a sealed envelope or container to the offices of the EBD. Faxed proposals shall not be accepted. Any questions regarding the RFP or contract related items shall be directed to the Contracts Administrator.
(b) If a registered Bidder does not wish to bid on the RFP, the Bidder may fill in the Bidder name, address, and write "No Bid" on the RFP form or cover letter and return the "No Bid" to the Contracts Administrator.
(c) It is the responsibility of the Bidder to ensure delivery of a proposal to the EBD at or prior to the designated date and time on the RFP. The EBD shall not be responsible for, and shall not accept, late proposals. Proposals received after the RFP closing date shall be returned unopened to the Bidder. The EBD shall not accept proposals from an ineligible Bidder, pursuant to this Chapter.

260:40-37-7. Proposal openings

(a) All sealed proposals shall be stamped with the time and date upon receipt at the EBD's offices. The proposals shall be placed in a secured bid room until time for the scheduled proposal opening. Access to

the room is limited to the Director, the Contracts Administrator, or their designees until the proposal opening.
(b) Proposals shall be opened at the designated date and time by the Contracts Administrator. Information clearly designated in the RFP as being proprietary or confidential shall not be made public. A proposal opening record shall be completed and maintained in the proposal file.
(c) Public openings may be requested by a Bidder and/or interested parties prior to the proposal opening. The request may be oral or written and must include the RFP number and closing date.
(d) No award will be made at routine or public openings. Award recommendations shall be made in writing upon conclusion of the proposal evaluation. The process and procedures for each proposal evaluation shall be further described in the individual RFP.

260:40-37-8. Award of contract

(a) Contracts for health plans provided by qualified Bidder(s) may be awarded based on best and final offer BFO through competitive negotiation. In the sole discretion of the EBD, a BFO process shall be conducted with qualified Bidders if it is considered by the EBD to be in the best interest of the State. In the event the EBD considers a BFO process to be in the best interest of the State, all qualified Bidders meeting the minimum requirements of the RFP shall be afforded an opportunity to negotiate a BFO with the EBD. The EBD shall issue a written request to all qualified Bidders for a BFO. Only qualified Bidders who satisfy the minimum bid requirements specified in the RFP shall be allowed to participate in any BFO negotiation process. The EBD retains the right to accept or reject qualified Bidder(s) BFO. The EBD shall retain as confidential information contained in the initial proposals submitted by qualified Bidder(s) as well as any subsequent bid offers made by qualified Bidder(s) prior to final contract award as part of the BFO negotiation process. The BFO negotiation process shall allow for modification and alteration of Bidder(s) proposal content and Bidder(s) proposal price after proposals are submitted and during the evaluation process. Upon request for a public bid opening, only the name(s) of the qualified Bidder(s) shall be revealed; neither price nor proposal content shall be revealed and made public until after the BFO process is complete and notice of intent to award is announced by the EBD. Only the final, agreed-upon price and final, agreed-upon proposal content shall be made public after the BFO process is complete and notice of intent to award is announced by the EBD. Information clearly designated in the RFP as proprietary shall be held confidential pursuant to the Employees Benefits Act, 74 Okl.St.Ann. § 1365 A.11. After an initial proposal is received and opened by the EBD following the bid closing date and time, the initial proposal offered by qualified Bidder(s) may be discussed for clarification and/or modification if the EBD deems it advantageous to do so. In this context, "discussion" shall mean clarification, modification, and negotiation, or any of these. Discussion(s) with a qualified Bidder(s) during negotiation and/or clarification shall be conducted individually and privately with qualified Bidder(s) and may be tape recorded by the EBD. The EBD shall hold all tape recordings, transcripts and notes of discussion(s) confidential. Changes shall not be allowed in qualified Bidder(s) proposal or price after BFOs are received, unless the EBD determines, in its sole discretion, that re-submission would be in the best interest of the State. The specific criteria of the BFO shall be specified in the RFP issued by the EBD.
(b) All proposals shall be forwarded to the Contracts Administrator upon completion of the evaluation. The Contracts Administrator shall review the information to determine compliance with the RFP requirements and compliance with all EBD rules, policies and procedures. The EBD shall be the sole judge in reviewing proposals and awarding contracts.
(c) The EBD shall identify and apply criteria within the RFP and the proposals for final selection and award of contracts. The evaluation process may allow for the selection of less than all of the responsive or qualifying proposals, as allowed by law and as determined to be in the best interest of the State.
(d) The Contracts Administrator has the right to waive minor deficiencies or informalities in a proposal provided that the best interest of the State would be served without prejudice to the rights of the other Bidders.
(e) The EBD reserves the right to bid and award contracts on an all or none basis, by item or groups of items, whichever is in the best interest of the State.
(f) All awards shall be made under the terms and conditions as outlined in OAC 260:40-37-9 and any additional terms and conditions as described in the RFP.

(g) All ethics rules and laws related to conflicts of interest and doing business with public officials apply to any contract with the EBD.

260:40-37-9. Terms and conditions for acceptable proposals

(a) All proposals submitted are subject to the EBD's policies and procedures and/or any special conditions and specifications listed in this Subchapter or made part of the RFP.
(b) Sealed proposals will be opened by the EBD at the time and date set in the RFP.
(c) Proposals received after the closing time will not be considered. Envelopes or containers must contain responses to only one RFP, be sealed, and the name and address of the Bidder inserted in the upper left-hand corner. The proposal number and closing date must appear on the face of the envelope or container.
(d) The proposal shall be in strict conformity with the instructions to the Bidder and shall be submitted in the approved format. All required signatures must be original and written in ink.
(e) Any questions pertaining to the clarification of the proposal shall be directed to the Contracts Administrator.
(f) The EBD may conduct scheduled on-site visits to the service provider for purposes of testing the readiness of the provider.
(g) When submitting a proposal to the EBD, the Bidder shall agree to an audit clause which provides that books, records, documents, accounting procedures, practices or any other items of the Bidder relevant to the contract are subject to examination by the EBD, the State Auditor and Inspector, and such other entities as may be specified in the RFP.
(h) Failure to comply with the terms and conditions shall subject the proposal to disqualification.

260:40-37-10. Excessive Price

(a) The EBD shall have the authority to reject the bid, or to restrict enrollment in any benefits plan, for which the EBD determines the benefit price to be excessive. The EBD shall have the authority to reject any plan that does not meet the bid requirements. One way to restrict enrollment is to freeze enrollment in the plan's membership as determined to be in the best interests of the State and the members.
(b) Factors considered by the EBD in determining excessive price may include, but are not limited to utilization data and loss ratios on the State group business, a comparison to other carriers proposed prices and/or other employers' plans and prices, actuarial analyses or underwriting principles. The EBD may at its discretion, solicit a multi-part RFP which shall be designated as such. As a condition to be eligible to bid on Part II of the RFP, the EBD shall require Bidders to provide information requested in Part I of the RFP. In the event a Bidder fails to provide the information in Part I of the RFP, the EBD shall not consider the Bidder's response to the Part II of the RFP. The EBD shall retain as confidential, any proprietary information submitted by a Bidder pursuant to this paragraph.
(c) Each year, the EBD shall specify in the RFP issued by the EBD all excessive price factors that shall be considered by the EBD for that year's selection of benefit plan options. Benefits plans that bid on the RFP are deemed by the EBD to have read and accepted all excessive price factors contained in the RFP.
(d) Although the EBD shall have the authority to reject the bid, or to restrict enrollment in any benefits plan, for which the EBD determines the benefit price to be excessive, the EBD shall have no duty to do so. Despite the fact that the EBD may determine the benefit price to be excessive, the EBD nevertheless may choose not to reject the bid or restrict enrollment for reasons the EBD determines at that time to be in the best interests of the State and the members. The determining reasons will include, coverage areas where the number of other benefits plans are limited; total number of benefits plans offered; provider networks; employee participation displacement; uniformity of choices for all eligible employee groups; and premiums charged by competing plans.
(e) The particular factors that are specified in the RFP issued by the EBD for determining excessive price may vary from year to year. The specification of particular factors in prior year(s) shall serve as no precedent of the factors that may be specified in subsequent year(s). Similarly, the failure of the EBD in prior year(s) to reject a bid or restrict enrollment in any benefits plan for which the EBD determines the benefit price to be excessive, shall serve as no precedent as to the action the EBD may take in subsequent year(s).

260:40-37-11. Challenge of award

(a) Any Bidder may challenge the award of a proposal. A challenge may be based on the following grounds:
(1) The proposal of the successful Bidder(s) did not meet the RFP requirements in a material way;
(2) The bidding procedure was done in violation of the EBD's rules; or
(3) EBD acted outside the scope of its authority. In the event a Bidder raises this ground in an allegation, said Bidder shall specify the nature of the alleged act.
(b) After the award is made, the protesting Bidder will deliver a written explanation of the reason for the challenge to the office of the Contracts Administrator within seven (7) business days of the time the EBD selects and announces a successful Bidder(s).
(c) The Contracts Administrator or a designee will review the protesting Bidder's challenge of award, as well as the EBD's selection process, and rule on the challenge. The decision will be in writing and shall address each ground raised by the Bidder challenging the proposal, specifically referring to the facts and documents supporting the decision.

260:40-37-12. Administrative review

(a) If the protesting Bidder does not agree with the Contracts Administrator's decision on the challenge of award, the protesting Bidder may request an administrative review. Any protesting Bidder may appeal a decision by the Contracts Administrator to the Director. In order for the claim to be eligible for administrative review, the appeal must have been through the challenge of award process as per OAC 260:40-37-11.
(b) The protesting Bidder must file a notice of appeal with the Director within seven (7) business days of the date of the letter notifying the Bidder of the decision by the Contracts Administrator of the challenge of award by the protesting Bidder, or the postmark of such letter, whichever is later. The letter shall contain the following:
(1) The letter must state all the facts and arguments giving rise to the claim of controversy and the appeal.
(2) The letter must also state clearly and separately the alleged error by the Contracts Administrator or other EBD personnel and the relief sought with the appeal to the Director.
(3) The letter must clearly and separately state that the Bidder is requesting an opportunity to be heard in pursuit of the appeal.
(c) Upon receipt of a properly perfected notice of appeal, the Director shall review the appeal or appoint a designee to conduct the administrative review. The Director may appoint any officer of the EBD or may appoint an attorney licensed to practice law to conduct the review. The person conducting the administrative review shall promptly set a time period in which a review will be conducted that will be not more than forty-five (45) days in length beginning from the date the notice is filed. The person conducting the administrative review will set a date in which the Bidder must produce or identify all the documents or other supporting data (verbal or written) which supports the appeal, which date must be within the forty-five (45) day time period above. The person conducting the administrative review may schedule a meeting with the Bidder to discuss the appeal and issues raised, and will examine all such documents and supporting data.
(d) Within twenty (20) business days after the administrative review period, the person conducting the administrative review shall notify the protesting Bidder by certified mail. The decision by the person conducting the administrative review shall include findings of the facts and conclusions supporting the decision to uphold the award or set the award aside.
(e) The decision shall be final.

260:40-37-13. Confidentiality

The EBD, with the cooperation of the Department of Central Services, shall be authorized to retain as confidential, any proprietary information submitted in response to the EBD's RFP; provided, however, that any such information requested by the EBD from the Bidders shall only be subject to the confidentiality provision of this paragraph if it is clearly designated in the RFP as being protected under this provision.

260:40-37-14. Vision Plan Participation

(a) A Vision Plan must notify the EBD of its intention to participate in the flexible benefits plan no later than 4:45 p.m., Central Standard Time on the first day of July prior to the beginning of each Plan Year. Such notification must conform to the requirements this section. If the first day of July is a weekend day or other day when the offices of the EBD are closed, notification of Vision Plan participation is due by 4:45 p.m., Central Time, on the next day the EBD's offices are open.
(b) Notice of a vision plan's intent to participate in the flexible benefits plan is properly provided upon submission of all of the following:
(1) A statement from the Vision Plan indicating Vision Plan's intent to participate;
(2) A list of the providers in Vision Plan's network;
(3) A document(s) indicating Vision Plan has operated in Oklahoma for at least five (5) years;
(4) Either a license issued by the Oklahoma State Insurance Department, or a certificate issued by the Oklahoma State Department of Health;
(5) A list of the rates the Vision Plan will charge during the subsequent Plan Year. Rates must be listed independently for the following categories:
(A) Employee Only,
(B) Spouse Only,
(C) One Child, and
(D) Two or More Children;
(6) Accurate product information in a format not to exceed two pages.
(c) The EBD may create forms to standardize and simply the information required by 74 O.S. § 1374 and subsection (b) of this section. If a form(s) have been created, a Vision Plan must complete the form(s) to provide proper notification.
(d) The EBD may require a Vision Plan to submit information in addition to that required in subsection (b) of this section from time to time if the EBD deems such information is essential to ensure statutory compliance.
(e) Information a Vision Plan submits to the EBD pursuant to 74 O.S. § 1374 shall be retained as confidential if such information is clearly designated as confidential when submitted.
(f) Vision Plans not eligible to be offered on a pretax basis as a part of an Internal Revenue Code Section 125 Cafeteria Plan must indicate so when the Vision Plan notifies the EBD of its desire to participate in the Flexible Benefits Plan.
(g) Vision Plans which submit notification of intent to participate in the flexible benefits plan that conform to subsection (a) of this Section and the requirements of 74 O.S. § 1374 are obligated to:
(1) Enroll employees and eligible dependents in their benefit plan, and
(2) Offer their benefit plan during the entire subsequent plan year period as that period is defined by the EBD.
(h) The EBD may remove a Vision Plan from the Flexible Benefits Plan at any time if it fails to comply or remain in compliance with 74 O.S. § 1374.

CHAPTER 39. AUTHORIZED PAYROLL DEDUCTION VENDOR MATERIAL

260:40-39-1. Purpose

The purpose of this Chapter is to describe the rules governing the process by which materials from vendors that have an authorized payroll deduction pursuant to Section 7.10 of Title 62 of the Oklahoma Statutes or Section 1701 of Title 74 of the Oklahoma Statutes shall be placed in the annual benefit enrollment materials provided to state employees and their dependents. The provisions of this Chapter do not apply to vendors who do not have authorized payroll deduction pursuant to Section 7.10 of Title 62 of the Oklahoma Statutes or Section 1701 of Title 74 of the Oklahoma Statutes.

260:40-39-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"EBD" means the State of Employee Benefits Department

"Plan Year" means the period of time, established by the EBD, for which benefits are offered to State employees and their eligible dependents.

"Vendor" means a product vendor that has been approved for an authorized payroll deduction pursuant to Section 7.10 of Title 62 of the Oklahoma Statutes or Section 1701 of Title 74 of the Oklahoma Statutes on or before the last calendar day of July prior to each Plan Year.

"Vendor Material" means a one page, front and back, eight and one-half inch by eleven inch document which, at a minimum, identifies the vendor, describes the product being offered, includes the vendor's contact information, and includes the premium or cost of the product. Vendor material must be printed on white paper with a weight equal to 50# offset or 20# bond copy paper.

260:40-39-3. General provisions

(a) A vendor must deliver its vendor material to the Employee Benefits Department no later than 4:45 p.m., Central Time, on the second Friday in August prior to the beginning of the benefits enrollment period announced by the EBD.

(b) Vendor material must be designed, printed, and reproduced by the vendor at the vendor's expense.

(c) The EBD will determine the number of copies of vendor material each vendor must supply. The amount will be communicated to vendors each year.

(d) The EBD will bind and distribute all timely and properly submitted vendor material at its own expense.

(e) The EBD may create forms to standardize and simplify the information required by this section. If a form(s) has been created, a vendor must complete the form(s) to provide proper delivery.