TITLE 365. INSURANCE DEPARTMENT
CHAPTER 40. HEALTH MAINTENANCE ORGANIZATIONS (HMO)

SUBCHAPTER 3. FINANCIAL

PART 1. HMO FORMS AND INSTRUCTIONS

365:40-3-2. Deposit of securities forms
(a) **Deposit form.** The deposit form is used by all companies depositing securities with the Insurance Department~~ to be held by the State Treasurer's Office~~. A description of the securities and value must be itemized on this form and said form must accompany securities being deposited when presented to the Insurance Commissioner for approval. After completion of transaction, a copy of this form is sent to said company for use to obtain release of deposited securities. Prior to the withdrawal of said securities, the deposit form must be executed by a company official authorized to make such withdrawals and presented to the Insurance Commissioner for approval.
(b) **Deposits in the name of Insurance Commissioner and HMO.** Deposits with the Insurance Commissioner made pursuant to 36 O.S. § 6913(B) shall be in the name of the Insurance Commissioner and the HMO making the deposit, and shall not be released by any company holding such security without the signatures of the Insurance Commissioner and the authorized personnel of the HMO. The deposit shall be held by the ~~State Treasurer of Oklahoma~~Insurance Commissioner unless the Insurance Commissioner approves, pursuant to 36 O.S. § 6913(B), the holding of said deposit by an organization or trustee acceptable to the Insurance Commissioner through which a custodial or controlled account is utilized.
(c) **Resolution form.** Each company having securities on deposit with the Insurance Department must adopt a resolution and file it with the Insurance Commissioner's Office authorizing and empowering certain persons designated by said company to deal with the securities on deposit. Requests for exchange or withdrawal of deposited securities will not be honored unless made by designated persons.

SUBCHAPTER 5. LIFE, ACCIDENT & HEALTH DIVISION AND CONSUMER ASSISTANCE AND CLAIMS DIVISION RULES

PART 11. COORDINATION OF BENEFITS

365:40-5-51. Definitions
The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

"Allowable expense" means, unless otherwise mandated by law, any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made except where a statute requires a different definition. However, items of expense under coverage such as dental care, vision care, prescription drug or hearing aid programs may be excluded from the definition of allowable expense. A plan which provides benefits only for any such items of expense may limit its definition of allowable expense to like items of expense. When a Plan provides benefits in the form of services rather than cash payments, the reasonable

cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid. The difference between the cost of a private hospital room and the cost of a semi-private hospital room shall not be deemed to be an "Allowable Expense," except for the period of time during which the patient's confinement to a private hospital room is deemed medically necessary in terms of generally accepted medical practice.

"Plan" ~~means~~ includes the following:

~~(A) "Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by:~~

~~(i) Group, blanket or franchise insurance coverage,~~

~~(ii) Service plan contracts, group practice, individual practice and other prepayment coverage,~~

~~(iii) Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans, and~~

~~(iv) Any coverage under governmental programs, and any coverage required or provided by any statute.~~

~~(B) The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.~~

~~(C) Individually underwritten and issued contracts which provide a contractual right to renewal regardless of membership in or connection with any particular organization or group shall not be considered group type contracts, irrespective of the mode or channel of premium payment and regardless of any reduction in premium the covered person may receive by virtue of such method of premium collection.~~

~~(D) The definition of a "Plan" within the COB provision of group contracts enumerates the types of coverage which the insurer may consider in determining whether other insurance exists with respect to a specific claim. Such definition:~~

~~(i) May not include individual or family policies, or individual or family subscriber contracts, except as provided in (ii) of this subparagraph and in (E) of this definition.~~

~~(ii) May include all group or group subscriber contracts as well as such group type contracts as are not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with a particular organization or group. Group-type contracts answering this description may be included in the definition, at the option of the insurer and its policyholder client, whether or not individual policy forms are utilized and whether the group-type coverage is designated as "franchise" or "blanket" or in some other fashion.~~

~~(E) The definition of "Plan" may include both group and individual automobile "no fault" contracts but, as to the traditional automobile "fault" contracts, only the medical benefits written on a group or group-type basis may be included.~~

~~(F) Interpretation of the definition of a "Plan" may not include group or group-type hospital indemnity benefits (written on a non-expense incurred basis) of $30~~

~~per day or less unless they are characterized as reimbursement type benefits but are designed to administer so as to give the insured the right to elect indemnity type benefits, in lieu of such reimbursement type benefits, at the time of claim. In any event, the amount of group and group-type hospital indemnity benefits which exceed $30 per day may be construed as being included under the definition of "Plan".~~

~~(G) School accident type coverages, written on either an individual, blanket, group or franchise basis should not be taken in to consideration in coordination of benefits. In this context, school accident type coverages are defined to mean coverage covering grammar school, middle school, and high school students for accidents only, including athletic injuries, either on a 24 hour basis or "to and from school" for which the parent pays the entire premium.~~

~~(H) If "Medicare" or similar governmental benefits are included in the definition of a "Plan", such benefits may be taken into consideration without expanding any of the definitions of this provision beyond the hospital, medical, and surgical benefits which may be provided by the governmental program.~~

~~(I) A Plan may not coordinate or design benefits so that the benefits payable are altered solely on the basis that:~~

~~(i) Another plan exists; or~~

~~(ii) Except with respect to Part B of Medicare, that the claimant is or could have been covered under another Plan, or~~

~~(iii) The claimant has elected an option under another Plan providing a lower level of benefits than another option for which the claimant was eligible.~~

(A) Group and nongroup insurance contracts and subscriber contracts;

(B) Uninsured arrangements of group or group-type coverage;

(C) Group and nongroup coverage through closed panel plans;

(D) Group-type contracts;

(E) The medical care components of long-term care contracts, such as skilled nursing care;

(F) The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts;

(G) Medicare or other governmental benefits, as permitted by law, except as provided in a state plan under Medicaid. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program; and

(H) Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

"**Plan**" does not include:

(A) Hospital indemnity coverage benefits or other fixed indemnity coverage;

(B) Accident only coverage;

(C) Specified disease or specified accident coverage;

(D) Limited benefit health coverage;

(E) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis;

(F) Benefits provided in long-term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;

(G) Medicare supplement policies;

(H) A state plan under Medicaid; or

(I) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

"This plan" means that portion of the policy which provides the benefits that are subject to this subchapter.

365:40-5-58. ~~Retroactivity~~Applicability

(a) Group policies or contracts which are in force at the time of promulgation of this subchapter which contain an "excess" clause, "anti-duplication" provision, or any other provision by whatever name designated under which benefits would be reduced because of other existing coverages, other than the COB provisions established in this subchapter, shall be brought into compliance by the later of the next anniversary or renewal date of the group policy or contract or the expiration of the applicable collectively bargained contract, pursuant to which they are written, if any.

(b) The definition of "Plan" in Section 51 of this Subchapter applies to plans that are delivered, issued for delivery, or renewed on or after January 1, 2016. A contract that is in force on January 1, 2016, must be brought into compliance with the definition of "Plan" on the next anniversary date or renewal date of the contract, or the expiration of any applicable collective bargaining contract under which it was written.