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Peggy Coe, Editor-in-Chief

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Emergency Adoptions

An agency may adopt new rules, or amendments to or revocations of existing rules, on an emergency basis if the agency determines that "an imminent peril exists to the preservation of the public health, safety, or welfare, or that a compelling public interest requires an emergency rule[s] [A]n agency may promulgate, at any time, any such [emergency] rule[s], provided the Governor first approves such rule[s]" [75 O.S., Section 253(A)].

An emergency action is effective immediately upon approval by the Governor or on a later date specified by the agency in the preamble of the emergency rule document. An emergency rule expires on July 15 after the next regular legislative session following promulgation, or on an earlier date specified by the agency, if not already superseded by a permanent rule or terminated through legislative action as described in 75 O.S., Section 253(H)(2).

Emergency rules are not published in the *Oklahoma Administrative Code*; however, a source note entry, which references the *Register* publication of the emergency action, is added to the *Code* upon promulgation of a superseding permanent rule or expiration/termination of the emergency action.

For additional information on the emergency rulemaking process, see 75 O.S., Section 253.

TITLE 87. OKLAHOMA STATE EMPLOYEES BENEFITS COUNCIL CHAPTER 10. FLEXIBLE BENEFITS PLAN

[OAR Docket #11-1021]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 1. General Provisions
87:10-1-2. Definitions [AMENDED]
Subchapter 17. Benefit Plan Election
87:10-17-3. Employee election of benefit plans [AMENDED]
Subchapter 19. Benefit Allowance
87:10-19-1. Flexible benefit allowance [AMENDED]

AUTHORITY:

Oklahoma State Employees Benefits Council; 74 O.S.2001 §1366(B)

DATES:

Adoption:

July 26, 2011

Approved by Governor:

August 31, 2011

Effective:

Immediately upon Governor's approval

Expiration:

Effective through July 14, 2012, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY ACTIONS:

n/a

INCORPORATIONS BY REFERENCE:

n/a

FINDING OF EMERGENCY:

These emergency administrative rules are necessary to amend Chapter 10 of Title 87 of the Oklahoma Administrative Code to comply with state law enacted during the 53rd Legislature, 1st regular session by Sections 2, 3, and 4 of House bill 1062 (*Title 74, Section 1308.3[new law]* and *74 O.S. 2001, Sections 1370 and 1371[amendatory]*).

ANALYSIS:

These emergency administrative rules will amend Subchapters 1, 17, and 19 of Chapter 10 of Title 87. Chapter 10 serves as the "Plan Document" for the administration of the flexible benefits plan for active Oklahoma state employees. The above referenced new and amended state laws enable participants, or those eligible to participate, in the state's flexible benefits plan to opt out of the Basic Plan if they show proof of other group health insurance coverage. The Basic Plan is comprised of the four "core" insurance benefit plans: health, dental, life, and disability.

Participants opting out may not purchase any of the four "core" benefits and shall not receive the flexible benefit allowance dollars provided to participants in the flexible benefits plan. In lieu of the flexible benefit allowance, participants who opt out shall receive \$150.00, per month, which can be used to purchase optional benefits, which include, but are not limited to, vision insurance, early medical alert, voluntary payroll options, and deferred compensation plans offered by the Oklahoma Public Employees Retirement System, or will be added to gross pay.

CONTACT PERSON:

Craig A. Cates, Executive Manager, Agency & Regulatory Affairs and Human Resources, (405) 609-3440

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S., SECTION 253(D):

SUBCHAPTER 1. GENERAL PROVISIONS

87:10-1-2. 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.

"**Basic Plan**" means the plan that provides the least amount of benefits each participant is required to purchase. The Basic Plan contains four components: medical, dental, life and disability insurance.

"**Board**" means the Oklahoma State and Education Employees Group Insurance Board.

"**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.

Emergency Adoptions

"**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 87:10-3-1.

"**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 Employees Benefits Council.

"**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.

SUBCHAPTER 17. BENEFIT PLAN ELECTION

87:10-17-3. 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 purchase the Basic Plan which comprises four components: medical, dental, life and disability insurance. As a result, eligible employees must elect medical, dental, life and disability plans during the enrollment period 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 Board, 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 Basic 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 Basic Plan.~~

~~(2) The Council has the authority to determine the type of information that satisfies the requirements of this subsection. An eligible employee who has health insurance coverage under another group health plan can elect not to participate in the Basic Plan if the following conditions are met prior to the close of each annual enrollment period:~~

~~(A) The employee must provide proof, in a manner prescribed by the Plan Administrator, that he or she is currently covered under another group health insurance plan; and~~

~~(B) The employee must make a proper election not to participate in the Basic Plan.~~

~~(3) The Council has the authority to determine the type of information that satisfies the requirements of subsections (1) and (2).~~

~~(34) An eligible employee making an election not to participate under paragraph (1) or (2) 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) or (2) of this subsection and has never previously made an election not to participate under paragraph (1) or (2) of this subsection, may, during the enrollment period, enroll in the Flexible Benefits Plan Basic Plan or may make an election not to participate under paragraph (1) or (2) of this subsection. If the employee who is eligible to, but has never previously made an election not to participate under paragraph (1) or (2) of this subsection, fails to enroll in the Flexible Benefits Plan Basic Plan and fails to make an election not to participate under paragraph (1) or (2) 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) or (2) of this subsection and has previously made an election not to participate under paragraph (1) or (2) of this subsection, may, during the enrollment period, enroll in the ~~Flexible Benefits Plan~~ Basic Plan, or may make an election not to participate under paragraph (1) or (2) of this subsection. If an employee who has previously made an election not to participate under paragraph (1) or (2) of this subsection fails to enroll in the ~~Flexible Benefits Plan~~ Basic Plan and fails to make an election not to participate under paragraph (1) or (2) 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.

~~(45) Except as provided by the applicable provisions of OAC 87:10-17-4, an eligible employee making an election not to participate under paragraph (1) or (2) 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 or active state employees who opted out under subsection (2) will not automatically be reinstated. The retired military employee or active state employees who opted out under subsection (2) 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.~~

~~(56) Except as provided by the applicable provisions of OAC 87:10-17-4, an eligible employee making an election not to participate under paragraph (1) or (2) 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.~~

~~(67) An eligible employee making an election not to participate under paragraph (1) or (2) 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~~

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(D) Insurance Premium Conversion Option.

(fd) 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.

(ge) 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.

(hf) 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.

(ig) 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.

(jh) 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.

(i) 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 Board, benefits will be paid to the decedent's estate.

(j) 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.

SUBCHAPTER 19. BENEFIT ALLOWANCE

87:10-19-1. Flexible benefit allowance

(a) Each participating employer shall credit to each of its participating employees the specified amount as determined by law, as ~~the~~ employee's 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 87:10-17-3(c)(1) or (2) will receive one hundred and fifty dollars (\$150) per month and will not be

eligible for or credited with any amount of the employee or dependent flexible benefit allowance.

[OAR Docket #11-1021; filed 9-30-11]

TITLE 210. STATE DEPARTMENT OF EDUCATION CHAPTER 10. SCHOOL ADMINISTRATION AND INSTRUCTIONAL SERVICES

[OAR Docket #11-1020]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

Subchapter 1. General Provisions
210:10-1-9. Transfers [REVOKED]

AUTHORITY:

70 O. S. § 3-104, State Board of Education

DATES:

Adoption:

July 28, 2011

Approved by Governor:

September 12, 2011

Effective:

Immediately upon Governor's approval

Expiration:

Effective through July 14, 2012, unless superseded by another rule or disapproved by the Legislature.

SUPERSEDED EMERGENCY ACTIONS:

N/A

INCORPORATIONS BY REFERENCE:

N/A

FINDING OF EMERGENCY:

If this rule is not revoked, it could lead to further confusion, delays or improper denials regarding student transfer requests.

ANALYSIS:

The rules regarding transfers were effective prior to the implementation of the Open Transfer Act. The rules directly conflict with several provisions within the Open Transfer Act found at 70 O. S. § 8-101.1, and are creating confusion amongst districts and State Department of Education personnel.

CONTACT PERSON:

Connie Holland, 405-521-3308

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O. S., SECTION 253 (D):

SUBCHAPTER 1. GENERAL PROVISIONS

210:10-1-9. Transfers [REVOKED]

~~(a) Regular transfers (70-8-101, 102, 103). Regular transfers may be approved by the County Superintendent if both the sending and receiving boards of education approve. Provided, however, if the grade such child is entitled to pursue is not offered in the district where such child resides, the transfer must be approved. A special education transfer must be approved with the consent of the receiving board. The following statutory time lines must be followed for the regular transfer process:~~

- (1) ~~Not later than May 15—Application by parents or guardian filed with county superintendent.~~
- (2) ~~Not later than May 25—County superintendent must notify the clerk of each affected board of education of the proposed transfers and a hearing date.~~
- (3) ~~On or before June 5—County superintendent conducts a hearing for either board of education to show cause as to whether or not the transfer should be granted.~~
- (4) ~~Not later than June 15—County superintendent must notify the clerk of each affected board of education as to whether or not the transfer was granted.~~
- (5) ~~Anytime before June 20—Either district or parent or guardian may appeal the action of the county superintendent to the district court, in writing.~~
- (6) ~~Not later than June 30—The decision must be rendered by the court and the decision is final.~~

(b) **Emergency transfers (70-8-104).** Emergency transfers ordered by the county superintendent of schools, subject to approval of the State Board of Education, are based upon any one of the following: ~~destruction of a building, inability to furnish the grade of study the pupil is entitled to pursue, inability to offer the subject a pupil desires to pursue, nonavailability of science, mathematics, or foreign language, total failure of transportation facilities previously had or contemplated, approval of the boards of education of the sending and receiving districts.~~ Emergency transfers must be filed with the State Department of Education within 30 days of date of order by county superintendent.

(c) **Special education transfers.**

- (1) **Regular special education transfer:** In order that a child, identified pursuant to the provisions of Title 70 O.S. 1981 § 13-101 may be transferred, a written application for such transfer, designating the district to which the transfer is desired, shall be made by either of his/her parents, or by his/her guardian, and such application shall be filed with the county superintendent of schools for transfers to school districts in the State of Oklahoma and with the State Board of Education for transfers to school districts in another state not later than May 15, preceding the school year for which the transfer is desired. The county superintendent of schools shall notify, no later than May 25, the clerk of the board of education of the district from which the transfer is proposed to be made and the clerk of the board of education of the district to which the transfer is proposed to be made. The notices of the application for transfer shall so state that the board of education, from which the transfer is proposed, will submit information as required by STATE BOARD OF EDUCATION POLICIES AND PROCEDURES MANUAL FOR SPECIAL EDUCATION IN OKLAHOMA for the delivery of Special Education Services for each identified child with a disability and that on or before June 5, the board of education of either district affected by the proposed transfer shall have an opportunity to show cause, if any, why the transfer should or should not be granted. This information will include (1) a current individual evaluation, (2)

a categorical eligibility statement and (3) a current Individualized Education Program (IEP). The county superintendent of schools shall, not later than June 15, notify, in writing, the clerk of each board of education affected as to whether or not the transfer has been granted. Provided that at any time before June 20, the board of education of either district or the parent or guardian of the child may appeal, in writing, from the action of the county superintendent of schools to the district court of the county in which the child resides, and such appeal shall be heard, and a decision rendered thereon not later than June 30, and such decision shall be final.

(2) **Emergency special education transfer.** A written application for an emergency special education transfer for a child, identified pursuant to the provisions of Title 70 O.S. 1981 § 13-101, designating the district to which the transfer is desired shall be made by either the parent or guardian, and on an adequate showing of emergency based on information as required by STATE BOARD OF EDUCATION POLICIES AND PROCEDURES MANUAL FOR SPECIAL EDUCATION IN OKLAHOMA for the delivery of Special Education Services for each identified child with a disability. This information will include (1) a current individual evaluation, (2) a categorical eligibility statement and (3) a current Individualized Education Program (IEP) and shall be submitted to the county superintendent who may make and order a transfer, subject to approval by the State Board of Education.

(3) **Cancellation of regular or emergency special education transfer.** A transfer made may be canceled with the concurrence of the board of the receiving district, and a transfer granted. Also, on affidavit of parent or guardian, or of the school board of the transferring district, disclosing removal of residence from the transferring district, a transfer previously made may be canceled. Cancellation of special education transfers are subject to the rules and regulations of the State Board of Education and the procedural due process requirements outlined at 20 U.S.C. § 1415, of the Individuals With Disabilities Education Improvement Act.

(4) **Residence of child—attendance in transportation area.** Any child, identified pursuant to the provisions of Title 70 O.S. 1981 § 13-101, residing in a school district in the State of Oklahoma that does not offer the grade such child is entitled to pursue shall be entitled to attend the school of the school district in the transportation area in which such pupil resides that offers the grade he is entitled to pursue.

(d) **Kindergarten transfers (70-18-108).** It is the duty of every school district in this state to provide and offer kindergarten free of tuition for every child residing in such district who attains the age of five (5) years by the second day of September of the school year such kindergarten is offered. This duty may be satisfied by transferring kindergarten children to other school districts which accept them and provide kindergarten for such children with the district in which the child resides paying seventy five percent (75%) of the average daily

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attendance per capita cost of the receiving district. The average daily attendance of such child shall be credited to the sending district of the child. When tuition is paid to a public school district for an underage kindergarten student during a given year, said student can legally enroll as a first grade student the following year in the same district without paying tuition. (70-1-114)

~~(e) Gifted and talented transfers (70-1210. — 307). Beginning with the school year 1983-84, it shall be the duty of each school district to provide gifted child educational programs for all identified gifted children, as defined in Section 1210.301 of Title 70 of the Oklahoma Statutes, who reside in that school district. This duty may be satisfied by: The district transferring identified gifted and talented children to other school districts which provide the appropriate gifted child educational programs, provided, no transfer shall be made without the consent of the board of education of the receiving school district. The district in which the child resides shall provide transportation for the transferred student and pay an amount of tuition equal to the proportion of the operating costs of the program to the receiving district. Transfers authorized by this section shall be made under such rules and regulations as the State Board of Education may prescribe; or the district located wholly or in part in a county participating in any program established by that county superintendent of schools.~~

[OAR Docket #11-1020; filed 9-27-11]

TITLE 365. INSURANCE DEPARTMENT CHAPTER 10. LIFE, ACCIDENT AND HEALTH

[OAR Docket #11-1014]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

- Subchapter 29. External Review Regulations [NEW]
- 365:10-29-1. Purpose [NEW]
- 365:10-29-2. Applicability and Scope [NEW]
- 365:10-29-3. Definitions [NEW]
- 365:10-29-4. Notice of Right to an External Review and External Review Procedures [NEW]
- 365:10-29-5. Authorization to Disclose Protected Health Information [NEW]
- 365:10-29-6. External Review Requests [NEW]
- 365:10-29-7. Notice of Initiation Determination [NEW]
- 365:10-29-8. Independent Review Organization Application [NEW]
- 365:10-29-9. Independent Review Organization Recordkeeping and Reporting Requirements [NEW]
- 365:10-29-10. Health Carrier Recordkeeping and Reporting Requirements [NEW]
- Appendix PP. Notice of Appeal Rights [NEW]
- Appendix QQ. External Review Request Form [NEW]
- Appendix RR. Application for Registration as an Independent Review Organization [NEW]
- Appendix SS. Independent Review Organization External Review Annual Report Form [NEW]
- Appendix TT. Health Carrier External Review Annual Report Form [NEW]

AUTHORITY:

Insurance Commissioner; 36 O.S. §§ 307.1, 36 O.S. § 6475.5(A)(3), 36 O.S. § 6475.6(A)(2), 36 O.S. § 6475.12(G)

DATES:

Adoption:

September 9, 2011

Approved by Governor:

September 12, 2011

Effective:

Immediately upon approval by the Governor

Expiration:

Effective through July 14, 2012, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY RULES:

n/a

INCORPORATION BY REFERENCE:

n/a

FINDING OF EMERGENCY:

A compelling public interest requires emergency rules due to House Bill 2072 enacted during the 2011 legislative session. House Bill 2072 created a new section of law codified as 36 O.S. § 6475 et seq., entitled the "Uniform Health Carrier External Review Act". The Act mandates the Insurance Commissioner to promulgate rules to implement uniform standards for the establishment and maintenance of external procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in the Act.

ANALYSIS:

The new Subchapter 29 creates rules for the implementation and regulation of the Uniform Health Carrier External Review Act. 365:10-29-1 sets forth the purpose of new subchapter 29. 365:10-29-2 sets forth the applicability and scope of subchapter 29. 365:10-29-3 sets forth that all terms used in subchapter 29 shall have the same meaning as defined in 36 O.S. § 6475.4(B). 365:10-29-4 provides for the manner a health carrier shall provide notice as set out in the Notice of Appeal Rights form in Appendix PP. 365:10-29-5 requires that health carriers providing notice shall provide a form authorizing the health care provider to disclose protected health information as set out in the Oklahoma State Department of Health Standard Authorization form, ODH 206, or in the alternative, a form that complies with 45 CFR § 164.508 and 43A O.S. § 1-109. 365:10-29-6 provides for the manner a covered person or authorized representative shall request an external review as set out in the External Review Request form in Appendix QQ. 365:10-29-7 provides that a notice of initial determination shall be made in writing to the same address as the External Review Request form in Appendix QQ. 365:10-29-8 provides that an independent review organization certified by the Oklahoma State Department of Health to do external review as of August 25, 2011, may apply one time before December 31, 2011, for temporary approval effective for 180 days and sets out the necessary information required to be submitted for the temporary application. It also references the Application for Registration as an Independent Review Organization form in Appendix RR as the application to be otherwise used by independent review organizations seeking approval to conduct external reviews. 365:10-29-9 relates to the recordkeeping and reporting requirements that each independent review organization shall follow as set out in the Independent Review Organization External Review Annual Report form in Appendix SS. 365:10-29-10 relates to the recordkeeping and reporting requirements each health carrier shall follow as set out in the Health Carrier External Review Annual Report form in Appendix TT.

CONTACT PERSON:

Julie Meaders, Oklahoma Insurance Department, (405) 521-2746

**PURSUANT TO THE ACTIONS DESCRIBED HEREIN,
THE FOLLOWING EMERGENCY RULES ARE
CONSIDERED PROMULGATED AND EFFECTIVE
UPON APPROVAL BY THE GOVERNOR AS SET
FORTH IN 75 O.S., SECTION 253 (D):**

SUBCHAPTER 29. EXTERNAL REVIEW REGULATIONS

365:10-29-1. Purpose

The purpose of this subchapter is to set forth rules regarding external review regulations as authorized by the Uniform

Health Carrier External Review Act ('the Act'), 36 O.S. § 6475 et seq. The general purposes of the Act and this Subchapter are to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination, as defined in the Act.

365:10-29-2. Applicability and scope

This Subchapter shall apply to all health carriers, except as excluded from the Act by 36 O.S. § 6475.4(B).

365:10-29-3. Definitions

For the purpose of this Subchapter, all terms shall have the meanings set forth in 36 O.S. § 6475.3.

365:10-29-4. Notice of right to an external review and external review procedures

A health carrier providing notification of the right of a covered person to request an external review pursuant to 36 O.S. § 6475.5(A) shall provide the notice as set out in Appendix PP.

365:10-29-5. Authorization to disclose protected health information

A health carrier providing an authorization form to a covered person regarding the disclosure of protected health information pursuant to 36 O.S. § 6475.5(B)(3) shall either provide the form as set out in the Oklahoma State Department of Health Standard Authorization, ODH 206, which may be accessed at [www.ok.gov/health/Organization/HIPAA Privacy Rule/Oklahoma Standard Authorization Forms.html](http://www.ok.gov/health/Organization/HIPAA_Privacy_Rule/Oklahoma_Standard_Authorization_Forms.html), or, in the alternative, a form that complies with 45 CFR § 164.508 and 43A O.S. § 1-109.

365:10-29-6. External review requests

A covered person or authorized representative requesting an external review pursuant to 36 O.S. § 6475.6 shall do so by submission of the External Review Request Form as set out in Appendix QQ.

365:10-29-7. Notice of initial determination

A notice of initial determination issued pursuant to Section 6475.8(C), 6475.9(B), 6475.10(A), or 6475.10(C) of Title 36 shall, in addition to providing notice of a right to appeal external review ineligibility to the Commissioner, provide that appeals shall be made in writing to the Oklahoma Insurance Department, Five Corporate Plaza, 3625 NW 56th Street, Suite 100, Oklahoma City, OK, 73112-4511.

365:10-29-8. Independent review organization application

(a) An independent review organization seeking approval to conduct external reviews pursuant to 36 O.S. § 6475.12(D)

shall submit the application in Appendix RR as instructed, including all materials required by the application. Approval by this application will be effective until December 31, 2012.

(b) Notwithstanding Subsection (a) of this section, an independent review organization certified by the Oklahoma State Department of Health to do external review as of August 25, 2011, may apply one time for temporary approval as an independent review organization. This temporary approval will be in effect for 180 days, is non-renewable and must be replaced by approval pursuant to Subsection (a) of this section for continued approval to conduct external reviews. Applications for temporary approval must be received by the Insurance Department prior to December 31, 2011. To apply for temporary approval, an eligible independent review organization must provide:

(1) Contact information for initiating external reviews, including:

(A) Name and title of contact person, or department;

(B) Phone number of contact person or department;

(C) Email of contact person or department;

(D) Mailing address, city, state, and zip;

(E) Website;

(F) Toll-free telephone number operating 24 hours a day;

(G) Fax number; and

(H) Any other necessary contact information used by the applicant;

(2) A copy of the applicant's most recent certificate from URAC for Independent Review Organizations;

(3) A list of specific areas of clinical expertise in which the applicant conducts independent reviews, if applicable;

(4) A schedule of the applicant's fees;

(5) A copy of the applicant's current Certificate of Authority provided by the Oklahoma Secretary of State;

(6) An attestation and certification acknowledging understanding and compliance with the requirements of the Act.

365:10-29-9. Independent review organization recordkeeping and reporting requirements

Each independent review organization approved to conduct external reviews pursuant to 36 O.S. § 6475.12(D) shall maintain written records for the information required by 36 O.S. § 6475.15(A)(3) and Appendix SS, and shall submit Appendix SS within 31 calendar days of the end of each calendar year.

365:10-29-10. Health carrier recordkeeping and reporting requirements

Each health carrier subject to the Act shall maintain written records for the information required by 36 O.S. § 6475.15(B)(3) and Appendix TT, and shall submit Appendix TT within 31 calendar days of the end of each calendar year.

APPENDIX PP. NOTICE OF APPEAL RIGHTS [NEW]

NOTICE OF APPEAL RIGHTS

You have a right to appeal any decision we make that denies payment on your claim or your request for coverage of a health care service or treatment.

You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered.

Contact¹ us when you:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.¹

Appeals: All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to [INSERT ADDRESS OF WHERE APPEALS SHOULD BE SENT TO THE HEALTH CARRIER] within **180 days** of the date you receive our denial.² We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You may provide us with additional information that relates to your claim and you may request copies of information

that we have that pertains to your claims. We will notify you of our decision in writing. Once our internal appeal process is exhausted (or waived by us), you may be entitled to file a request for external review.³

External Review³: We have denied your request for the provision of or payment for a health care service or course of treatment. You may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you request by submitting a request for external review within **4 months** after receipt of this notice to the Oklahoma Insurance Department, which can be contacted by mail at 3625 NW 56th Street, Oklahoma City, OK, 73112-4511, or by phone at 800-522-0071 or 405-521-2828. For standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may be entitled to file a request for external review of our denial. For details, please review your Benefit Plan Document, contact us or contact your state insurance department.¹

¹ See address and telephone number on the enclosed Explanation of Benefits if you have questions about this notice.

² Unless your plan or any applicable state law allows you additional time.

³ See your Benefit Plan Document for your state's appeal process and to determine if you're eligible to request an external review in your state (e.g. some state appeal processes require you to complete your insurer's appeal process before filing an external review request unless waived by your insurer; while some states do not have such a requirement).

APPENDIX QQ. EXTERNAL REVIEW REQUEST FORM [NEW]

This **EXTERNAL REVIEW REQUEST FORM** must be filed with the Oklahoma Insurance Department within **FOUR (4) MONTHS** after receipt from your insurer of a denial of payment on a claim or request for a health care service or treatment.

EXTERNAL REVIEW REQUEST FORM

APPLICANT NAME

Please Check One: Covered person/Patient Authorized Representative

COVERED PERSON/PATIENT INFORMATION

Covered Person Name: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Covered Person Phone #: Home (____) _____ Work (____) _____

INSURANCE INFORMATION

Insurer/HMO Name: _____

Covered Person Insurance ID#: _____

Insurance Claim/Reference #: _____

Insurer/HMO Mailing Address: _____

City: _____ State: _____ Zip: _____

Insurer Telephone #: (____) _____

EMPLOYER INFORMATION

Employer's Name: _____

Employer's Phone #: (____) _____

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Is the insurance you have through your employer a self-funded plan? _____. If you are not certain please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

HEALTH CARE PROVIDER INFORMATION

Treating Physician/Health Care Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Phone #: (_____) _____

Medical Record #: _____

REASON FOR HEALTH CARRIER DENIAL (Please check one)*

- The health care service or treatment is not medically necessary.
- The health care service or treatment is experimental or investigational.

*You can describe in your own words the health care service or treatment in dispute using the attached pages below.

EXPEDITED REVIEW

If you need a fast decision, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function. Is this a request for an expedited appeal? Yes No

SIGNATURE AND RELEASE OF MEDICAL RECORDS

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I, _____, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize by insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Oklahoma Insurance Department. I understand that the independent review organization and the Oklahoma Insurance Department will use this information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

Signature of Covered Person (or legal representative)*

Date

*(Parent, Guardian, Conservator or Other – Please Specify)

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APPOINTMENT OF AUTHORIZED REPRESENTATIVE

(Fill out this section only if someone else will be representing you in this appeal.)

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

Signature of Covered Person (or legal representative)*

Date

*(Parent, Guardian, Conservator or Other—Please Specify)

Address of Authorized Representative: _____

City: _____ State: _____ Zip: _____

Phone #: Daytime (_____) _____ Evening (_____) _____

Emergency Adoptions

WHAT TO SEND AND WHERE TO SEND IT

PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL FOUR (4) ITEMS BELOW ARE INCLUDED*)

1. **YES**, I have included this completed application form signed and dated.
2. **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;
3. **YES****, I have enclosed the letter from my health carrier or utilization review company that states:
 - (a) Their decision is final and that I have exhausted all internal review procedures; or
 - (b) They have waived the requirement to exhaust all of the health carrier's internal review procedures.

****You may make a request for external review without exhausting all internal review procedures under certain circumstances. You should contact the Oklahoma Insurance Department for more information.**

4. **YES**, I have included a copy of my certificate of coverage or my insurance policy benefit booklet, which lists the benefits under my health benefit plan.

***Call the Oklahoma Insurance Department at 800-522-0071 or 405-521-2828 if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.**

If you are requesting a standard external review, send all paperwork to:

Oklahoma Insurance Department
External Review
Five Corporate Plaza
3625 NW 56th Street, Suite 100
Oklahoma City, OK, 73112-4511

If you are requesting an expedited external review, call the Insurance Department at 800-522-0071 or 405-521-2828 before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.

**CERTIFICATION OF TREATING HEALTH CARE PROVIDER
FOR EXPEDITED CONSIDERATION OF A PATIENT'S EXTERNAL REVIEW APPEAL**

NOTE TO THE TREATING HEALTH CARE PROVIDER

Patients can request an external review when a health carrier has denied a health care service or course of treatment on the basis of a utilization review determination that the requested health care service or course of treatment does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. The Oklahoma Insurance Department oversees external appeals. The standard external review process can take up to 45 days from the date the patient's request for external review is received by our department. Expedited external review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited external review must be completed at most within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #: (____) _____ Fax #: (____) _____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

Patient's Insurer Member ID#: _____

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CERTIFICATION

I hereby certify that: I am a treating health care provider for _____
(hereafter referred to as 'the patient'); that adherence to the time frame for conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that, for this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

Treating Health Care Provider's Name (Please Print)

Signature

Date

**PHYSICIAN CERTIFICATION
EXPERIMENTAL/INVESTIGATIONAL DENIALS
(To Be Completed by Treating Physician)**

I hereby certify that I am the treating physician for _____
(covered person's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements:

**In my medical opinion as the Insured's treating physician, I hereby certify to the following:
(Please check all that apply) (NOTE: Requirements #1 - #3 below must all apply for the covered person to qualify for an external review).**

1) <input type="checkbox"/>	The covered person has a terminal medical condition, or a life threatening condition, or a seriously debilitating condition.
2) <input type="checkbox"/>	The covered person has a condition that qualifies under one or more of the following: [please indicate which description(s) apply]:
i. <input type="checkbox"/>	Standard health care services or treatments have not been effective in improving the covered person's condition;
ii. <input type="checkbox"/>	Standard health care services or treatments are not medically appropriate for the covered person; or
iii. <input type="checkbox"/>	There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment.
3) <input type="checkbox"/>	The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments.
4) <input type="checkbox"/>	The health care service or treatment I have recommended would significantly less effective if not promptly initiated. Explain: _____ _____
5) <input type="checkbox"/>	It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments. Explain: _____ _____

APPENDIX RR. APPLICATION FOR REGISTRATION AS AN INDEPENDENT REVIEW ORGANIZATION [NEW]

Oklahoma Insurance Department
 Five Corporate Plaza
 3526 NW 56th Street, Suite 100
 Oklahoma City, OK 73112
 405-521-2828

Application for Registration as an Independent Review Organization

Type of Entity: Corporation Partnership LLC Other _____

Contact Information for Application

Legal Name of Applicant	State of Domicile	Federal EIN	
Contact Person (Name and Title)	Phone ()	Email	
Business Address (Do not use PO Box)	City	State	Zip
Mailing Address (if different from business address)	City	State	Zip

Contact Information for Initiating External Reviews (also to be made available to carriers and consumers)

Contact Person (Name and Title) or Department		Phone ()	Email	
Mailing Address		City	State	Zip
Website	Toll-Free Telephone Number		Fax ()	
Other Contact Information				

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Applicant Attestation and Certification

Applicant certifies that it will notify the Oklahoma Insurance Department immediately if its accreditation is lost with the American Accreditation Healthcare Commission/URAC. Applicant acknowledges that the Oklahoma Insurance Department may terminate this license if the applicant loses accreditation or no longer satisfies the minimum requirements for licensure.

Applicant acknowledges that payment of any fees associated with any external reviews conducted pursuant to 36 O.S. § 6475.1 et seq. are the sole responsibility of the health carrier whose medical decision is being reviewed. Applicant understands that it has no recourse against the Oklahoma Insurance Department or the state of Oklahoma to the extent that any health carrier fails to pay any medical reviewer fees. Applicant authorizes the Oklahoma Insurance Department to verify information with any federal, state, or local government agency, insurance company or accrediting organization.

Applicant acknowledges and represents that it understands and will comply with Oklahoma's insurance laws and the rules of the Oklahoma Insurance Department. Applicant hereby represents that it will comply with all requirements imposed under 36 O.S. § 6475.1 et seq. and assures that no conflict of interest or improper controlling interest as outlined in the statute exists. Applicant further agrees to maintain and provide to the Oklahoma Insurance Department the information set out in 36 O.S. § 6475.15.

I certify that, under penalty of perjury, I am the person named herein and know the contents thereof, and that all of the information submitted in this application and its attachments is true and complete. I attest that I have the authority and capacity to execute this certification on behalf of the applicant. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license denial or revocation and may subject me to civil or criminal penalties.

Signature of person who completed application

Signature of Officer, Director, or Board Member

Printed Name

Printed Name

Title

Title

Date

Date

Please provide the following as separate attachments:

1. A narrative description and an organizational chart to provide an overview of the applicant's operations.
2. A list of names and official capacities of all persons responsible for the applicant's external review program, including:
 - a. all members of the governing body, the officers and directors of a corporation, and the partners or associates of a partnership or association; and,
 - b. disclosure of any contracts or arrangements between those persons and the applicant, including any appearance of a conflict of interest as specified in 36 O.S. 6475.13.
3. A written statement addressing the determination of any conflicts of interest involving the applicant and all clinical reviewers.
4. A copy of your most recent certificate from American Accreditation HealthCare Commission/URAC for Independent Review Organizations.
5. A list of specific areas of clinical expertise in which you conduct independent reviews, if applicable.
6. A schedule of fees.
7. A copy of your current Certificate of Authority provided by the Oklahoma Secretary of State.
8. A narrative description of the quality assurance mechanism in place to meet the requirements of 36 O.S. 6475.13(A)(1).
9. A narrative description of the process utilized to maintain the confidentiality of personally identifiable health information and of clinical reviewers' and contract specialists' identities.
10. A copy of the policy and procedures that govern all aspects of the external review process for both standard and expedited reviews, including experimental and investigational treatments.

Please submit this application and all required attachments to:

Oklahoma Insurance Department
External Review Program
Five Corporate Plaza
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112

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APPENDIX SS. INDEPENDENT REVIEW ORGANIZATION EXTERNAL REVIEW ANNUAL REPORT FORM [NEW]

Oklahoma Insurance Department

Independent Review Organization External Review Annual Report Form

External Review Annual Summary for 20_____		Due by January 31 for the previous calendar year.	
Each independent review organization (IRO) shall submit an annual report with information for each health carrier in the aggregate on external reviews performed in Oklahoma only.			
1. IRO name:		Filing date:	
2. IRO license/certification no:			
3. IRO address:			
City, State, Zip:			
4. IRO Website:			
5. Name of person completing this form:			
Email:	Phone:	Fax:	
6. Person responsible for regulatory compliance and quality of external reviews:			
Name:	Title:		
7. Total number of requests for external review received from the Oklahoma Insurance Department during the reporting period:			
8. Number of standard external reviews:			
9. Average number of days IRO required to reach a final decision in standard reviews:			
10. Number of expedited reviews completed to a final decision:			
11. Average number of days IRO required to reach a final decision in expedited reviews:			
12. Number of medical necessity reviews decided in favor of the health carrier:			
Briefly list procedures denied:			

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Briefly list procedures approved:		
14. Number of experimental/investigational reviews decided in favor of the health carrier:		
Briefly list procedures denied:		
15. Number of experimental/investigational reviews decided in favor of the covered person:		
Briefly list procedures approved:		
16. Number of reviews terminated as the result of a reconsideration by the health carrier:		
17. Number of reviews terminated by the covered person:		
18. Number of reviews declined due to possible conflict with	health carrier:	
	covered person:	
	health care provider:	
Describe possible conflicts of interest:		
19. Number of reviews declined due to other reasons not reflected in #18 above:		
Briefly list these reasons:		

Please submit to:
 Oklahoma Insurance Department
 Five Corporate Plaza
 3625 NW 56th Street, Suite 100
 Oklahoma City, OK 73112-4511

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APPENDIX TT. HEALTH CARRIER EXTERNAL REVIEW ANNUAL REPORT FORM [NEW]

Oklahoma Insurance Department

Health Carrier External Review Annual Report Form

External Review Annual Summary for 20_____		Due by January 31 for the previous calendar year.	
Each health carrier shall submit an annual report with information in the aggregate by State and by type of health benefit plan.			
1. Health carrier name:		Filing date:	
2. Health carrier address:			
City, State, Zip:			
3. Health carrier Website:			
4. Name of person completing this form:			
Email:	Phone:	Fax:	
5. Total number of external review requests received from the Oklahoma Insurance Department during the reporting period:			
6. From the total number of external review requests provided in Question 5, the number of requests determined eligible for a full external review:			

Please submit to:
Oklahoma Insurance Department
Five Corporate Plaza
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112-4511

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[OAR Docket #11-1014; filed 9-21-11]

TITLE 675. STATE BOARD OF LICENSED SOCIAL WORKERS CHAPTER 1. ADMINISTRATIVE OPERATIONS

[OAR Docket #11-1017]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

- 675:1-1-1.1. Definitions [AMENDED]
675:1-1-4. Officers of the Board [AMENDED]
675:1-1-9. Fee schedule [AMENDED]

AUTHORITY:

State Board of Licensed Social Workers, 59 O.S. §§ 1256.1(A)(10), 1255, and 1261.1.

DATES:

Adoption:

July 29, 2011

Approved by Governor:

August 31, 2011

Effective:

November 1, 2011

Expiration:

Effective through July 14, 2012, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY RULES:

n/a

INCORPORATION BY REFERENCE:

n/a

FINDING OF EMERGENCY:

A compelling public interest requires an emergency rule due to the need to amend the rules of the State Board of Licensed Social Workers to reflect the amendments made to the Social Workers Licensing Act, 59 O.S. § 1250, et seq., by the Oklahoma Legislature during its 2011 session in House Bill 1715; and due to the need to address questions regarding whether face to face supervision of licensees includes supervision through electronic interaction such as video conferencing.

ANALYSIS:

These emergency rules address changes to the Social Workers Licensing Act, 59 O.S. § 1250, et seq., passed by the Oklahoma Legislature during its 2011 session in House Bill 1715, and address questions regarding whether face to face supervision of licensees includes supervision through electronic interaction such as video conferencing.

CONTACT PERSON:

James Marks, Executive Director, State Board of Licensed Social Workers, (405) 521-3712.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S. SECTION 253(D) AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR NOVEMBER 1, 2011, WHICHEVER IS LATER:

675:1-1-1.1. Definitions

The For purposes of this title, the following words and terms shall have the following meaning unless the context clearly indicates otherwise:

"Educational supervision" means face to face interaction between the supervisor and supervisee. Face to face supervision does not include interaction through electronic means unless said interaction is approved by the Board on a case by case basis prior to the supervision.

"LCSW" means licensed clinical social worker.

"LMSW" means licensed masters social worker.
"LSW" means licensed social worker (advanced generalist).
"LSW-Adm" means licensed social worker with a specialty of administration.
"LSWA" means licensed social worker associate.

675:1-1-4. Officers of the Board

The Oklahoma State Board of Licensed Social Workers shall elect a chairman, vice-chairman, and secretary. Election of officers will occur on an annual-a biennial basis.

675:1-1-9. Fee schedule

(a) Fees.

- (1) Licensure:
(A) Application processing fee - \$150.00
(B) National criminal-background history record check - at cost
(2) Renewal:
(A) Renewal of license - \$100.00
(B) Late fee - \$50.00
(3) Continuing education fees:
(A) Annual continuing education providers application fee - \$200.00
(B) Annual web-site link to provider - \$25.00
(C) Licensee request for program/event approval - \$40.00 each
(4) Miscellaneous:
(A) Duplicate or replaced license certificate - \$25.00
(B) Duplicate renewal card - \$10.00
(C) Written verification of licensure - \$20.00
(D) Duplication of public records - \$0.25 per page
(E) Application for Board Approved Supervisor - \$150.00
(F) Investigation/prosecution - at cost incurred
(G) Probation - \$100.00 per month
(H) Returned check processing fee - \$50.00

(b) Submission of fees.

- (1) All fees assessed by the Board as set out in this section shall be received prior to processing an application.
(2) All fees are non-refundable.

[OAR Docket #11-1017; filed 9-27-11]

TITLE 675. STATE BOARD OF LICENSED SOCIAL WORKERS CHAPTER 10. LICENSURE REQUIREMENTS

[OAR Docket #11-1018]

RULEMAKING ACTION:

EMERGENCY adoption

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RULES:

- 675:10-1-4. Requirements for Private or Independent Social Work Practice [AMENDED]
- 675:10-1-5. Titles of licenses [AMENDED]
- 675:10-1-9. Form of application [AMENDED]
- 675:10-1-10. Examinations [AMENDED]

AUTHORITY:

State Board of Licensed Social Workers, 59 O.S. §§ 1256.1(A)(10), 1261.1 and 1261.5

DATES:

Adoption:

August 22, 2011

Approved by Governor:

August 31, 2011

Effective:

November 1, 2011

Expiration:

Effective through July 14, 2012, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY RULES:

n/a

INCORPORATION BY REFERENCE:

n/a

FINDING OF EMERGENCY:

An imminent peril exists to the preservation of the public health, safety, and welfare, and a compelling public interest requires an emergency rule due to the need to amend the rules of the State Board of Licensed Social Workers to reflect the amendments made to the Social Workers Licensing Act, 59 O.S. § 1250, et seq., by the Oklahoma Legislature during its 2011 session in House Bill 1715 and due to the need to address questions regarding persons who fail to pass the social worker license examination during the provisional year of licensing when complaints are filed by the public against those persons.

ANALYSIS:

These emergency rules address amendments to the Social Workers Licensing Act, 59 O.S. § 1250, et seq., passed by the Oklahoma Legislature during its 2011 session in House Bill 1715, and effective on November 2, 2011, and address issues regarding persons who fail to pass the social worker license examination during the provisional year of licensing when complaints are filed by the public against those persons.

CONTACT PERSON:

James Marks, Executive Director, State Board of Licensed Social Workers, (405) 521-3712.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S. SECTION 253(D) AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR NOVEMBER 1, 2011, WHICHEVER IS LATER:

675:10-1-4. Requirements for Private or Independent Social Work Practice

(a) No person may engage in the private or independent practice of social work unless:

- (1) licensed under this act as ~~a LSW-Adm or an~~ LCSW,
- (2) has had 100 hours of face-to-face educational supervision in no less than two (2) years of full-time or the equivalent thereto of part-time experience, a total of 4,000 hours, supervised experience certified by the Board in the method to be offered in private practice and met the requirements set by the Board, and
- (3) ~~shall continue~~ continues to meet continuing education requirements set by the Board.

(b) No person may engage in the independent practice of social work unless:

- (1) licensed under this act as an LCSW, LSW-ADM or LSW,
- (2) has had 100 hours of face-to-face educational supervision in no less than two (2) years of full-time or the equivalent thereto of part-time experience, a total of 4,000 hours, supervised experience certified by the Board in the method to be offered in private practice and met the requirements set by the Board, and
- (3) continues to meet continuing education requirements set by the Board.

675:10-1-5. Titles of licenses

(a) **Licensed Clinical Social Worker.**

(1) **Definition.** Clinical social work is defined as set out in Section 1250.1 of Title 59 of the laws of Oklahoma practice which focuses on rendering services to individuals, families, or groups of individuals that involve the evaluation, diagnosis, treatment, and prevention of emotional disorders and mental illness as related to the total health of the client system according to social work theory and methods, providing services of a psychosocial nature pertaining to personality adjustment, behavior problems, interpersonal dysfunctioning and deinstitutionalization. Such practice is based on knowledge of psychodynamics, human relations, human development, personality development, crisis intervention, psychopathology, and group dynamics to effect change in human behavior, emotional responses, and social conditions.

(2) **Setting.** Clinical social work is practiced within a private office or under the auspices of public, voluntary, or proprietary agencies and institutions addressing familial, economic, health, recreational, religious, penal, judicial and educational concerns.

(3) **Model of clinical social work practice.** Within the practice setting, the problem is identified, and a plan of intervention is designed and implemented with the client. The plan is supported by securing historical facts and clues to the latent forces within the individual that shape personality. Individual strengths in conjunction with community resources are activated and utilized to implement the client plan.

(4) **Education and experience criteria.** A master's degree in social work from a Board approved social work program; official transcripts must be received from all applicable schools attended; two (2) years of full-time or the equivalent thereto of part-time experience, a total of 4,000 hours, of post graduate practice experience under the supervision of a licensed social worker with a clinical social work practice specialty which includes at least 3,000 hours of direct client contact; this experience shall include at least 100 hours of face-to-face educational supervision in no less than two (2) years of full-time related employment or the equivalent thereto of part-time employment. Ratings on the final evaluations completed by supervisor(s) must document performance at a level meeting or exceeding expectations as defined on the forms approved by the Board, in all areas of evaluations.

(b) **Licensed Master's Social Worker.**

(1) **Definition.** The practice of a Licensed Master's Social Worker (LMSW) means the application of social work theory, knowledge, methods and ethics and the professional use of self to restore or enhance social, psychosocial, or biopsychosocial functioning of individuals, couples, families, groups, organizations and communities. Master's Social Work practice requires the application of specialized knowledge and advanced practice skills in the areas of assessment, treatment planning, implementation and evaluation, case management, information and referral, counseling, consultation, education, research, advocacy, community organization and the development, implementation, and administration of policies, programs and activities.

(2) The LMSW shall not engage in private practice ~~or practice independently.~~

(c) **Licensed Social Worker.**

(1) The Licensed Social Worker (LSW) shall be able to perform the following functions:

- (A) provide counseling to individuals, couples, families and groups directed toward specific goals;
- (B) assist in helping individuals or groups with difficult day-to-day problems, such as finding employment, locating sources of assistance, or organizing community groups to work on a specific problem;
- (C) consult with other agencies on problems and cases served in common and coordinate services among agencies helping multi-problem families;
- (D) conduct basic data gathering on social problems;
- (E) serve as an advocate for those clients or groups of clients whose needs are not being met by available programs or by a specific agency;
- (F) assess, evaluate and formulate a plan of action based on client need;
- (G) provide training to community groups, agencies and other professionals about health-case issues and community problems; and
- (H) maintain familiarity with professional and self-help systems in the community and will assist the client in using those services when necessary.

(2) The LSW shall not engage in private practice—~~or practice independently.~~

(d) **Licensed Social Worker-Adm.**

(1) **Definition.** Social work administration is defined as practice which focuses primarily on directing the development and/or management of social service delivery systems. Such practice is based on knowledge of organization theory, policy development, program management, personnel management, fiscal management, and public relations. Such practice is based on skills necessary for organizing, directing, supervising, staffing, program planning and program evaluating.

(2) **Setting.** Social work administration is practiced within a private setting or under the auspices of public,

voluntary or proprietary agencies or institutions addressing familial, economic, health, recreational, religious, penal, judicial and educational concerns.

(3) **Model of social work administration practice.** Within the practice setting, supervises program directors and program staff to insure that personnel, program and/or licensing standards are met and maintained and that staff members grow in skill and efficiency; develops program goals and insures that all program activities and procedures comply with regulations; interprets the services and promotes the image of the programs through regular communication with appropriate groups and individuals in order to maintain a broad base of support; manages budgets to insure a balanced and fiscally sound program is maintained.

(4) **Education and experience criteria.** A master's in social work from a school of social work approved by the Board; official transcripts must be received from all applicable schools attended; two years of full-time post master's degree related experience or the equivalent thereto of part-time experience, a total of 4,000 hours, in the delivery of social work administration. This experience shall include at least 100 hours of face-to-face educational supervision under a Licensed Social Worker with a Social Work Administration specialty in no less than two (2) years of full-time related employment or the equivalent thereto of part-time employment. Ratings on the final evaluations completed by supervisor(s) must document performance at a level meeting or exceeding expectations as defined on the forms approved by the Board, in all areas of evaluations.

(e) **Licensed Social Worker Associate.**

(1) The practice of a Licensed Social Worker Associate (LSWA) means the application of social work theory, knowledge, methods, ethics and the professional use of self to restore or enhance social, psychosocial, or biopsychosocial functioning of individuals, couples, families, groups, organizations and communities. LSWA basic generalist practice that includes assessment, planning, intervention, evaluation, case management, information and referral, counseling, consultation, education, advocacy, community organization, and the development, implementation, and administration of policies, programs and activities.

(2) The LSWA shall not engage in private practice—~~or practice independently.~~

675:10-1-9. Form of application

(a) Applicants for licensure as a LCSW, LMSW, LSW, LSW-Adm or LSWA shall make such application on the most current form prescribed by the Board, shall submit the required fee and shall supply appropriate documentation as required by the Board to validate the facts which are claimed as a part of the licensing process. Such items to include but not be limited to:

- (1) an official transcript
- (2) a notarized photograph taken within the last 12 months
- (3) a record of work experience

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- (4) a certification by employers as to the facts or an affidavit attesting to the facts by the applicant
 - (5) a notarized signature
 - (6) a signed consent authorizing the Board to conduct a national criminal background history record check and/or receive criminal history information on the applicant
 - (7) a verification of supervision
 - (8) two (2) sets of fingerprints meeting the requirements set out in Section 1261.1 of the Social Workers Licensing Act.
- (b) The fee for the national criminal background history record check shall be paid separately from the license application fee by the applicant at the time application is made.
- (c) The use of false or fraudulent information by an applicant may be grounds for denial of a license.

675:10-1-10. Examinations

- (a) The Board accepts the following licensure examinations administered by the ASWB:
- (1) Basic or Bachelors
 - (2) Intermediate or Master
 - (3) Advanced or Advanced Generalist
 - (4) Clinical
- (b) Upon approval by the Board to take the examination and issuance of a provisional license, the applicant may apply through the ASWB to sit for the examination.
- (c) In the event of failure to pass the examination, the applicant may retake the examination every ninety (90) days during the year the provisional license is valid. If an applicant's provisional license is revoked pursuant to Section 1261.5 of the Social Workers Licensing Act, the license application shall be voided, and the applicant must reapply, including approval of the Board, application and applicable fees, prior to retaking the examination.

[OAR Docket #11-1018; filed 9-27-11]

TITLE 675. STATE BOARD OF LICENSED SOCIAL WORKERS CHAPTER 12. GUIDELINES FOR SUPERVISION

[OAR Docket #11-1019]

RULEMAKING ACTION:

EMERGENCY adoption

RULES:

675:12-1-4. Supervision and private or independent practice [AMENDED]

AUTHORITY:

State Board of Licensed Social Workers, 59 O.S. §§ 1256.1(A)(10) and 1261.1.

DATES:

Adoption:

July 29, 2011

Approved by Governor:

August 31, 2011

Effective:

November 1, 2011

Expiration:

Effective through July 14, 2012, unless superseded by another rule or disapproved by the Legislature

SUPERSEDED EMERGENCY RULES:

n/a

INCORPORATION BY REFERENCE:

n/a

FINDING OF EMERGENCY:

An imminent peril exists to the preservation of the public health, safety, and welfare, and a compelling public interest requires an emergency rule due to the need to amend the rules of the State Board of Licensed Social Workers to reflect the amendments made to the Social Workers Licensing Act, 59 O.S. § 1250, et seq. (the Act), by the Oklahoma Legislature during its 2011 session in House Bill 1715.

ANALYSIS:

This emergency rule addresses changes to the Social Workers Licensing Act, 59 O.S. § 1250, et seq., passed by the Oklahoma Legislature during its 2011 session in House Bill 1715. Specifically, the changes made to Board Rule 675:12-1-4 reflect the amendments to 59 O.S. § 1261.1(D), (E) and (F). See Section 3 of HB 1715.

CONTACT PERSON:

James Marks, Executive Director, State Board of Licensed Social Workers, (405) 521-3712.

PURSUANT TO THE ACTIONS DESCRIBED HEREIN, THE FOLLOWING EMERGENCY RULES ARE CONSIDERED PROMULGATED UPON APPROVAL BY THE GOVERNOR AS SET FORTH IN 75 O.S. SECTION 253(D) AND EFFECTIVE UPON APPROVAL BY THE GOVERNOR OR NOVEMBER 1, 2011, WHICHEVER IS LATER:

675:12-1-4. Supervision and private or independent practice

- (a) ~~Engaging in the private or independent practice of social work requires holding of the LCSW or LSW-Adm license and at least two years of supervised experience certified by the Board. The supervisor must hold the appropriate license title and be a Board Approved Supervisor.~~
- (b) Engaging in the independent practice of social work requires holding of the LCSW, LSW-Adm or LSW license.

[OAR Docket #11-1019; filed 9-27-11]

Executive Orders

As required by 75 O.S., Sections 255 and 256, Executive Orders issued by the Governor of Oklahoma are published in both the *Oklahoma Register* and the *Oklahoma Administrative Code*. Executive Orders are codified in Title 1 of the *Oklahoma Administrative Code*.

Pursuant to 75 O.S., Section 256(B)(3), "Executive Orders of previous gubernatorial administrations shall terminate ninety (90) calendar days following the inauguration of the next Governor unless otherwise terminated or continued during that time by Executive Order."

TITLE 1. EXECUTIVE ORDERS

1:2011-26b.

SECOND AMENDED EXECUTIVE ORDER 2011-26

I, Mary Fallin, Governor of the State of Oklahoma, pursuant to the power vested in me by Section 2 of Article VI of the Oklahoma Constitution, hereby declare the following:

1. Due to Exceptional and Extreme Drought conditions existing in all 77 counties in Oklahoma, and the severe wildfires that have occurred, and continuing, there is hereby declared a disaster emergency caused by wildfires and drought in the State of Oklahoma that threatens the lives and property of the people of this State and the public's peace, health, and safety. All 77 counties are included in this declaration.

This declaration may be amended as conditions warrant.

2. It may be necessary to provide for the rendering of mutual assistance among the State and political subdivisions of the State with respect to carrying out disaster emergency functions during the continuance of the State emergency pursuant to the provisions of the Oklahoma Emergency Management Act of 2003.
3. State agencies, in responding to this disaster emergency, may make necessary emergency acquisitions to fulfill the purposes of this order without regard to limitations or bidding requirements on such acquisitions.
4. The State Emergency Operations Plan has been activated and resources of all State departments and agencies available to meet this emergency are hereby committed to the reasonable extent necessary to protect lives and to prevent, minimize, and repair injury and damage. These efforts shall be coordinated by the Director of the Department of Emergency Management with comparable functions of the federal government and political subdivisions of the State.
5. This Executive Order shall terminate sixty (60) days from the date of this order.

Copies of this Executive Order shall be distributed to the Director of Emergency Management who shall cause the provisions of this order to be implemented by all appropriate agencies of state government.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 19th day of September, 2011.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Mary Fallin

ATTEST:
Michelle R. Day
Assistant Secretary of State

[OAR Docket #11-1012; filed 9-19-11]

1:2011-29.

AMENDED EXECUTIVE ORDER 2011-29

I, Mary Fallin, Governor of the State of Oklahoma, pursuant to the authority vested in me by Sections 1 and 2 of Article VI of the Oklahoma Constitution and 63 O.S. §§ 683.1 et seq., hereby declare that because there is a state of emergency existing in the State of Oklahoma due to extremely dry weather and lack of significant rainfall, it is necessary to assist and expedite all efforts of drought relief and wildfire suppression. In order to accommodate this need and to provide assistance to the citizens of Oklahoma in this extraordinary situation, I hereby order the temporary suspension of the following as they apply to vehicles used in the support efforts:

1. The requirements for special permits for use of oversized vehicles under Title 47 only when transporting hay. These vehicles shall not exceed 12' in width and 13' 6" in height.
2. The requirements for licensing/operating authority as required by the Oklahoma Corporation Commission;
3. The requirements for licensing/registration as required by the Oklahoma Tax Commission;
4. The requirements contained in the Motor Carrier Safety Regulations, under the authority of CFR 49, Part 390.23. All other regulations in CFR 49 shall apply.

Due to the severe drought conditions occurring statewide it is necessary to expedite access to hay for livestock. In order to accommodate this need and to provide assistance to our farmers and ranchers in this extraordinary situation, I hereby order the temporary suspension of the requirements for special

Executive Orders

permits for use of oversized vehicles under Title 47 as they apply to vehicles used to transport round baled hay for livestock as outlined above.

This order shall terminate at the end of sixty (60) days.

This Executive Order shall be forwarded to the Oklahoma Corporation Commission, the Oklahoma Tax Commission, the Commissioner of Public Safety, and the Director of Emergency Management, who shall cause the provisions of this order to be implemented by all appropriate agencies of state government.

IN WITNESS WHEREOF, I have set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 20 day of September 2011.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Mary Fallin

ATTEST:
Michelle R. Day
Assistant Secretary of State

[OAR Docket #11-1013; filed 9-20-11]

1:2011-42.

EXECUTIVE ORDER 2011-42

I, Todd Lamb, Governor of the State of Oklahoma, pursuant to 25 O.S. § 90.19, hereby direct the appropriate steps be taken to fly all American and Oklahoma flags on State property at half-staff from 8:00 a.m. until 5:00 p.m. on Monday, September 19, 2011, to honor Sergeant Bret D. Isenhower an Oklahoma soldier, who died on September 9, 2011, at the age of 26 while on active duty supporting Operation Enduring Freedom in Afghanistan.

This executive order shall be forwarded to the Director of Central Services, who shall cause the provisions of this order to be implemented by all appropriate agencies of state government.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 16th day of September, 2011.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Todd Lamb

ATTEST:
Michelle R. Day
Assistant Secretary of State

[OAR Docket #11-1011; filed 9-16-11]

1:2011-43.

EXECUTIVE ORDER 2011-43

I, Mary Fallin, Governor of the State of Oklahoma, pursuant to 25 O.S. § 90.19, hereby direct the appropriate steps be taken to fly all American and Oklahoma flags on State property at half-staff from 8:00 a.m. until 5:00 p.m. on Friday, September 23, 2011, to honor Specialist Christopher D. Horton an Oklahoma soldier, who died on September 9, 2011, at the age of 26 while on active duty supporting Operation Enduring Freedom in Afghanistan.

This executive order shall be forwarded to the Director of Central Services, who shall cause the provisions of this order to be implemented by all appropriate agencies of state government.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 20th day of September, 2011.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Mary Fallin

ATTEST:
Michelle R. Day
Assistant Secretary of State

[OAR Docket #11-1015; filed 9-22-11]

1:2011-44.

EXECUTIVE ORDER 2011-44

I, Mary Fallin, Governor of the State of Oklahoma, pursuant to 25 O.S. § 90.19, hereby direct the appropriate steps be taken to fly all American and Oklahoma flags on State property at half-staff from 8:00 a.m. until 5:00 p.m. on Monday, September 26, 2011, to honor Sergeant Mycal L. Prince an Oklahoma soldier, who died on September 15, 2011, at the age of 28 while

on active duty supporting Operation Enduring Freedom in Afghanistan.

This executive order shall be forwarded to the Director of Central Services, who shall cause the provisions of this order to be implemented by all appropriate agencies of state government.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 20 day of September, 2011.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Mary Fallin

ATTEST:
Michelle R. Day
Assistant Secretary of State

[OAR Docket #11-1016; filed 9-23-11]

1:2011-45.

EXECUTIVE ORDER 2011-45

I, Mary Fallin, Governor of the State of Oklahoma, pursuant to the authority vested in me by 60 O.S. §§ 175.1 *et seq.* and 62 O.S. §§ 4001 *et seq.*, hereby direct and order as follows:

Whereas, there has been created a public trust known as the Oklahoma Centennial Botanical Garden Authority vesting beneficial interest in the State of Oklahoma, and

Whereas, the beneficial interest vested in the State of Oklahoma by the creation of such trust shall be accepted by the Governor of Oklahoma on behalf of the State of Oklahoma.

Now, therefore, I, Mary Fallin, Governor of the State of Oklahoma, by the authority vested in me by law, do hereby accept on behalf of the State of Oklahoma all beneficial interest vested in the State of Oklahoma by the said Oklahoma Centennial Botanical Garden Authority.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 30 day of September, 2011.

BY THE GOVERNOR OF THE
STATE OF OKLAHOMA

Mary Fallin

ATTEST:
Michelle R. Day
Assistant Secretary of State

[OAR Docket #11-1022; filed 9-30-11]
