



# 2012 HMO member handbook

[www.globalhealth.com](http://www.globalhealth.com)



701 N.E. 10th Street, Suite 300 | Oklahoma City, Oklahoma 73104-5403

MHMOMEMHB12

# Welcome to GlobalHealth

Our physicians and staff would like to take this opportunity to welcome you to GlobalHealth. We look forward to serving you. We hope that together we can build the kind of relationship that will ensure that you receive quality care and service.

This publication will help to familiarize you with your health care benefits. This publication is called a *Member Handbook*. It is a legal document that explains your health care Plan. Please use this document to learn about important topics related to your benefit coverage for all of your health care needs.

Please reference your *Schedule of Benefits* for details of your particular Plan. The *Schedule of Benefits* will provide the Copayment or Coinsurance amounts that you may have when using a health care service.

These two documents together explain your coverage. After you have read these documents, you may still need assistance.

Please contact our Customer Service Department at:

- [askcustomerservice@globalhealth.com](mailto:askcustomerservice@globalhealth.com)
- (405) 280-5600 (local)
- 1-877-280-5600 (toll free)
- 1-800-522-8506 (TTY/TDD/Voice)

Or you can log onto [www.globalhealth.com](http://www.globalhealth.com) for additional information on health care topics or benefit coverage.

**PLEASE READ THIS DOCUMENT CAREFULLY.** It is important for you to know your benefits. No oral statement shall add or take away any benefits, limitations, or exclusions, under this Plan.

**WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.**

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## Helpful Numbers and Information

### Plan Administrator:

GlobalHealth Incorporated  
PO Box 2328  
Oklahoma City, OK 73101-2328

### GlobalHealth Customer Service:

askcustomerservice@globalhealth.com  
405.280.5600 (local)  
1.877.280.5600 (toll-free)  
1.800.522.8506 (TTY/TDD/Voice)  
www.globalhealth.com

### Express Scripts Help Desk:

1.866.274.1612  
1.800.899.2114 (TTY/TDD/Voice)

### Pharmacy Benefits Manager:

Mail Claims to:  
Express Scripts  
PO Box 66583  
St. Louis, MO 63166

### Mail Order Pharmacy:

Express Scripts Customer Care Center  
1.866.274.1612  
1.800.899.2114 (TTY/TDD/Voice)  
24 hours/7 days a week  
www.express-scripts.com

### Behavioral & Mental Health/Chemical Dependency:

MHNet - 1.866.904.5234  
1.866.200.3269 (TTY/TDD/Voice)

### GlobalHealth Compliance and Privacy Officer

1.877.280.5852  
405.280.5852

# Introduction to GlobalHealth

GlobalHealth is different from other health benefit Plans. You get a wide range of services to meet your health care needs and a large Network of Primary Care Physicians (PCPs) and Specialists. You are covered 24 hours a day, every day of the year. This HMO Member Handbook will detail the information you need for using your GlobalHealth Plan. If you have any questions, please call Customer Service at 1-877-280-5600. Or, you can email your inquiry to [askcustomerservice@globalhealth.com](mailto:askcustomerservice@globalhealth.com).

## Choosing a Primary Care Physician (PCP)

As a GlobalHealth Member, you must use Plan Providers to access your Covered Services. This starts with choosing a PCP from the list of physicians in the Physician & Health Providers Directory.

You and each member of your family may choose the same PCP, or you may have different PCPs, or you may designate a pediatrician as the PCP. If you do not choose a PCP, one will automatically be assigned to you.

GlobalHealth requires the designation of a PCP. You have the right to choose any PCP who participates in our Network and who is available to accept you or your family members. Until you make a PCP selection, GlobalHealth will choose a PCP for you. For information on how to select a PCP, and for a list of the participating PCPs, contact Customer Service.

Your relationship with your PCP is an important one. That is why we strongly recommend that you choose a PCP close to your home or work. Having your PCP nearby makes receiving medical care and developing a trusting and open relationship much easier.

Once you have chosen your PCP, we recommend that you have all of your medical records transferred to his/her office. This will give your PCP access to your medical history and make him/her aware of any existing health conditions you may have.

Your PCP will coordinate all of your medical care to see that you get the care you need when you need it, whether the care is delivered in the doctor's office or in another Facility. He/she will also obtain authorization for any specialty care you may need. GlobalHealth must pre-authorize all inpatient and outpatient services at a contracting Facility, except Emergency Room Care, Urgent Care, or services for which you may self-refer. (See page 6.)

You do not need prior authorization from GlobalHealth or from any other person (including a PCP) in order to obtain access to care from a health care professional in our Network who specializes in obstetrics or gynecology for an annual well-woman visit. The health care professional, however, may be required to comply with certain procedures including obtaining prior authorization for certain services, following a preapproved treatment plan, or procedures for making referrals.

Services or supplies that are not described in the Member Handbook or Schedule of Benefits or that you do not receive the necessary authorization from GlobalHealth are not Covered Services. Services must be Medically Necessary. You must receive authorization from GlobalHealth to receive services and supplies from a Provider who is not a Network Provider before you go.

Be sure to let your PCP know your Health Plan is GlobalHealth every time you call or visit your doctor's office by showing your GlobalHealth Member ID card.

Contact GlobalHealth's Customer Service Department if you need assistance, such as linguistic or translation issues, or if you have any questions.

Email [askcustomerservice@globalhealth.com](mailto:askcustomerservice@globalhealth.com), or call Monday - Friday, 9 am - 5 pm (CST).

- (405) 280-5600 (local)
- 1-877-280-5600 (toll-free)
- 1-800-522-8506 (TTY/TDD/Voice)

# How to Get the Most from Your Health Plan

1. See or call your Primary Care Physician (PCP) first for all your medical care. Your PCP will make sure you get the care you need, whether in his/her office or from another doctor.
2. If you or a covered member of your family needs same-day Urgent Care, call your PCP's office for medical direction. See "When You Need Urgent Care" in this Handbook.
3. If you need Emergency Room Care, go immediately to the nearest medical Facility for care. Call your PCP within 48 hours of receiving the care. Emergency Room Care is covered when it is for a true medical emergency. See "When It's an Emergency" in this Handbook.

## Your GlobalHealth Member ID Card

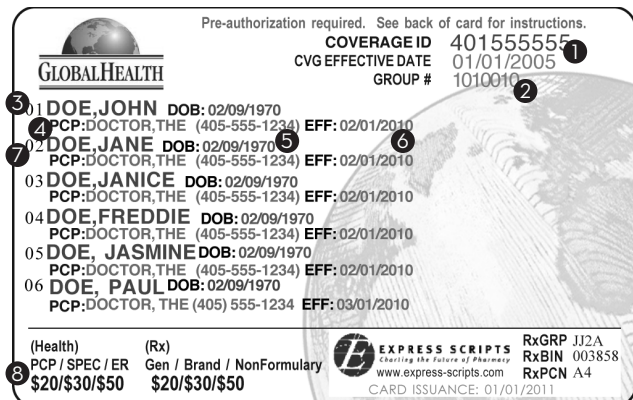
GlobalHealth will provide Member ID cards to you at the beginning of your Plan year. This card is the key to all of your health care benefits, so it is important that you carry it with you at all times.

When making an appointment with your PCP, be sure to identify yourself as a GlobalHealth Member and remember to show your ID card whenever you receive medical care. It contains valuable information about your benefits.

Please review your ID card to make sure all of the information is correct, including the name of your chosen PCP. If information on your card is not correct, if you need to order a new card, or have questions about your ID card, call GlobalHealth's Customer Service Department.

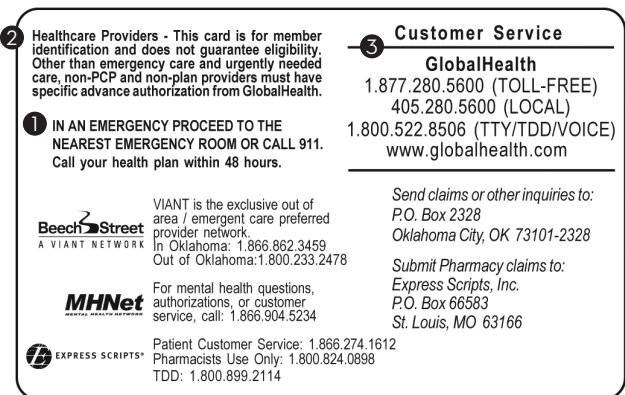
### Front of Card

1. Coverage ID
2. Employer group identification number
3. Subscriber's Name
4. The selected Primary Care Physician or Medical Group
5. Primary Care Physician phone number
6. Primary Care Physician effective date
7. Relationship code to Subscriber
8. Copayment and Benefit Information



### Back of Card

1. What to do in case of a life-threatening emergency
2. Routine and urgent care information
3. How to reach GlobalHealth's Customer Service Department including phone number, office hours, and claims address



# Changing Your Primary Care Physician (PCP)

You will receive or have your health care services arranged by your PCP. Our PCPs include doctors trained in family practice, internal medicine, and pediatrics. When you joined GlobalHealth, you and your family members chose a PCP or were assigned a PCP if one was not selected during Enrollment.

If you want to change your PCP, contact GlobalHealth's Customer Service Department. The change will be effective immediately.

GlobalHealth believes the relationship between patient and physician is an important one. It develops over time, as trust and familiarity grow. Your doctor will manage all of your health care needs to see that you receive a treatment plan that's best for you. Your PRIMARY CARE PHYSICIAN is responsible for all of your treatment, including referrals to Specialists.

We recommend against changing your PCP if the change could have an adverse effect on the quality of your health care. For example:

- If you are an organ transplant candidate.
- If you have an unstable, acute medical condition for which you are receiving active medical care.
- If you are in your third trimester of your pregnancy.

## Seeing the Doctor

### Scheduling Appointments

When you are ready to make an appointment to see your Primary Care Physician (PCP), call your PCP's office at the number listed on your GlobalHealth Member ID card.

- Please call in advance for routine, non-emergency appointments and health evaluation appointments. Making an appointment will allow you and your PCP enough time to talk about your needs.
- If you are a new Member to GlobalHealth, or to the physician, please let the office staff know so they may prepare any paperwork necessary for your medical records.
- Show your GlobalHealth Member ID card.
- Pay your Copayment at the time of your appointment.
- If your PCP orders laboratory or x-ray tests, show your GlobalHealth Member ID card when you arrive at your appointment for the services.
- If you must cancel an appointment, call as far in advance as possible.

### When You Need Care Right Away

- If you have an urgent medical illness or injury that cannot wait for a regular appointment, call your PCP's office. Your PCP may arrange to see you immediately, give you medical advice and direction, or set up an appointment for you.
- If your PCP is not available at the time, you may ask to see another Provider in that office.
- Your PCP may direct you to an Urgent Care Facility if another physician is not available to see you. Visiting an Urgent Care Facility during your physician's office hours requires prior authorization by your PCP. See "When You Need Urgent Care" in this Handbook.

### After Hours

If you need to talk to or see your PCP after the office has closed for the day, you have two options:

- Call the number on your Member ID card for your PCP. The nurse or physician on call will return your call and advise you how to proceed. This may include directing you to an Urgent Care Facility. Please refer to the GlobalHealth Physician & Health Providers Directory for a list of in-network Urgent Care Facilities nearest you. The Directory is also available online at [www.globalheath.com](http://www.globalheath.com).
- You may also choose to self-refer to an in-network Urgent Care Facility. Please see "When You Need Urgent Care" in this Handbook.

### If You Go to the Hospital

When you need to go to the Hospital, your PCP will arrange for you to stay at a Hospital where your PCP is on staff. You can find Copayment information associated with these benefits in the *Schedule of Benefits*.

## Home Care

Your PCP may decide to have a nurse visit you at home rather than continue your stay in the Hospital. Home Health Care is covered only when authorized by your PCP and approved by GlobalHealth.

## When You Need Specialty Care

Your PCP is the person you will see first for your medical care. In most cases, your doctor will be able to take care of your medical problem. But, if your PCP believes a Specialist is needed to treat your medical condition, he or she will make the referral request on your behalf.

Certain PCPs are affiliated with integrated delivery systems or other Provider groups, such as independent practice associations (IPAs) and physician-Hospital organizations, etc. Members who select these Providers will generally be referred to Specialists and Hospitals within those systems or groups. However, if a system or group does not include a Provider qualified to meet your medical needs, you may request to have services provided by non-system or non-group Providers. Your request will require prior authorization.

Sometimes, your PCP may consult with other physicians who are members of a patient care team. This team allows PCPs to discuss special medical situations with colleagues. The team shares knowledge and experiences to recommend the course of care appropriate for you.

Your PCP decides whether to refer you to a Specialist or try other medical therapy. As the coordinator of your personal medical care, your PCP will work with you to determine a treatment plan. Most specialty care will be provided within your physician's Network of Specialists. After your PCP makes the referral, you are responsible for making the actual appointment with the Specialist.

## To See a Specialist:

- See your Primary Care Physician first. If your PCP feels you need to see a specialist, he/she will process a referral for you.
- The referral is how your PCP arranges for you to be covered for necessary, appropriate specialty care and follow-up treatment. If you see a specialist without an authorized referral, you will be responsible for paying for the services.
- After your PCP processes a referral and obtains authorization, you will receive written authorization in the mail from GlobalHealth. You may then make an appointment with the specialist as directed in the letter.

## You May Self-Refer for the Following Services:

As explained above, you will get most of your routine care from your PCP, and your PCP will coordinate the rest of the Covered Services you get as a Plan Member. But there are a few exceptions: You may self-refer for the following services as long as you go to a Provider within the GlobalHealth Provider Network.

### In-Network Well Woman Exams

You may self-refer to a GlobalHealth contracting obstetrical and gynecological (OB/GYN) Specialist within the Network for your routine well woman exam. This will include an annual routine Pap smear, pelvic exam, and breast exam.

GlobalHealth will only cover the costs of your care when provided by your PCP or an in-network well woman care Specialist. You will be responsible for the cost of your care if you obtain services from a Provider that is not in GlobalHealth's Network of Providers.

### In-Network Routine Mammograms

You may self-refer to an in-network imaging center for your covered routine mammogram. Your *Schedule of Benefits* will tell you at what age and how often your mammogram is covered. Check with your physician or Customer Service for an in-network imaging center or Facility. You will be responsible for the cost of your mammogram if you obtain services from a Provider that is not in GlobalHealth's Network of participating Providers.

### Behavioral & Mental Health/Chemical Dependency Services

You may access mental health services directly by calling Mental Health Network (MHNet) at 1- 866-904-5234 (toll-free). For more information, go to, "Using Your Behavioral and Mental Health Benefits" section.

## When You Need Urgent Care

### Urgent Care

Urgent Care is defined as care for an illness, injury, or condition serious enough that a reasonable person would seek care

right away, but not so severe as to require Emergency Room Care. Urgent Care is a covered benefit, subject to scheduled Copayments. However, use of the emergency room for Urgent Care services that are not pre-authorized by your PCP will not be covered.

### **In-Area**

1. If you need urgent medical care, call your PCP's office and inform them that you are a GlobalHealth Member.
2. Inform your PCP or office personnel that you have an urgent medical problem and need assistance, and describe your condition or symptoms.
3. During office hours, your call will be given to your PCP or a medical staff person who will give you instructions.
4. After office hours, you have two options:
  - Call the number on your Member ID card for your PCP. Your PCP's answering service will take your name and phone number. Your PCP or an on-call physician will call you back. You will be given medical direction at that time, which may include directing you to an Urgent Care Facility.
  - After your PCP's office hours or on the weekend, you may self-refer to an in-network Urgent Care Facility. For a list of in-network Urgent Care Facilities nearest you, please refer to the GlobalHealth *Physician & Health Providers Directory*, also available on-line at [www.globalhealth.com](http://www.globalhealth.com).

### **Out-of-Area**

If you are traveling and require Urgent Care that cannot be delayed until you return to the GlobalHealth Service Area:

- Contact your PCP for medical advice and direction, and/or
- Self-refer to an Urgent Care Facility.

### **Please note:**

An Urgent Care Facility is not to be used in place of accessing your PCP for routine services and continuity of care. Use of Urgent Care services are only for an unforeseen illness, injury, or condition that requires immediate, Medically Necessary care.

All follow-up care must be provided by your PCP, or arranged by your PCP, and prior authorized by GlobalHealth.

## **When It's an Emergency**

Emergency Room Care is a covered benefit. An emergency is based on the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

### **If you or someone in your family needs Emergency Room Care:**

1. Go to the nearest Hospital emergency room or call 911.
2. Identify yourself as a GlobalHealth Member by showing your Member ID card.
3. Call your PCP's office within 48 hours. Let your doctor know you have been treated in an emergency room. Remember, the condition must be a true emergency.
4. If you are admitted to the Hospital, your PCP may arrange to transfer you to a Contracting Hospital.
5. If you need preventive, routine, or follow-up care after being treated in an emergency room, the care must be provided by your PCP or arranged by your PCP and prior authorized by GlobalHealth.
6. If you receive Emergency Room Care that is approved by your PCP, you will have one Copayment for Emergency Room Care. It will include physician services associated with this visit. In addition, you may have separate Copayments for any specialty scans performed during your visit as well as Medically Necessary Durable Medical Equipment. Your emergency room Copayment may be waived if you are admitted to the Hospital. See your *Schedule of Benefits* for the emergency room Copayment and waiver information.

### **If You're in an Accident**

If you are in an accident and are outside the Service Area or have no control over where you are taken following the accident, you must notify, or take reasonable steps to notify, your PCP within 48 hours. There is a physician on call 24 hours a day to take your call.

# Using Your Behavioral and Mental Health Benefits

Members may access mental health services directly by calling Mental Health Network, Inc. (MHNet) at 1- 866-904-5234 (toll-free) or 1-866-727-2749 (TTY/TDD/Voice).

MHNet will manage and arrange all inpatient and outpatient mental health, chemical dependency, and substance abuse services to assure that you or your family members receive timely and appropriate care. You do not need to go through your PCP. Additional services available through MHNet include:

- crisis intervention;
- referrals to community resources and self-help groups; and
- assistance in arranging an appointment.

There are important things to remember about MHNet. You must call MHNet at 1-866-904-5234 to receive a referral for any inpatient or outpatient behavioral health services. MHNet is available 24 hours a day, 7 days a week to assist you.

If you are currently receiving mental health or substance abuse care, please call MHNet as soon as possible. The staff will assist you in accessing a MHNet Provider.

Treatment must be coordinated through MHNet. Should you seek behavioral health services without contacting MHNet and without prior authorization, GlobalHealth will not cover those services.

## Behavioral and Mental Health Emergencies

In an emergency situation, prior authorization for treatment of a life-threatening emergency is not required. Call 911 if you need emergency treatment. Contact MHNet or have the Provider of the Emergency Room Care contact MHNet as soon as reasonably possible.

## Utilization Management and Quality

GlobalHealth has a patient management program to assist in determining:

- 1) what health care services are covered and payable under your GlobalHealth Plan; and
- 2) the extent of such coverage and payments.

The program assists you in receiving the appropriate health care and maximizing coverage for those health care services. The Medical Director oversees all decisions denying coverage for services for reasons of medical necessity.

In the event of a denial, you and your Provider will be informed by letter of any unmet criteria, standards, guidelines, and the appeals process.

Our patient management staff uses nationally recognized guidelines and resources, such as Milliman Care Guidelines®, when conducting pre-service, concurrent, and post-service reviews in order to determine medical necessity.

### Pre-Service Authorization

Certain health care services, such as referrals to Specialists, hospitalization, and outpatient surgery, require prior authorization from GlobalHealth. If you do not obtain prior authorization, you will be financially responsible for the services.

Your GlobalHealth Network PCP should process referrals for services on your behalf. All behavioral and mental health/chemical dependency services are arranged and authorized through Mental Health Network (MHNet).

### Concurrent Review

The concurrent review process assesses:

- the necessity for continued stay;
- level of care; and
- quality of care for Members receiving inpatient services.

All inpatient services extending beyond the initial authorized period will require concurrent review.

## **Discharge Planning**

Discharge planning is initiated at the time of admission to the Hospital or when the admission is authorized. The discharge plan may include initiation of a variety of services or benefits to be utilized upon discharge from an inpatient stay.

## **Post-Service Review**

The purpose of a post-service review is to retrospectively evaluate the services rendered and analyze potential quality and utilization issues.

GlobalHealth's effort to manage the services provided to you includes a retrospective review of claims submitted for payment and the corresponding medical records.

You may contact GlobalHealth's Utilization Management Department during regular business hours, Monday - Friday, 9 am - 5 pm (CST).

- (405) 280-5600 (local),
- 1-877-280-5600 (toll-free),
- 1-800-522-8506 (TTY/TDD/Voice)

You may contact the Utilization Management Department outside of regular business hours.

- um@globalhealth.com
- (405) 280-5398 FAX
- (405) 819-7574 (local)

Leave your name and contact information and you will receive a response on the next business day.

## **Policy on Ensuring Appropriate Utilization**

GlobalHealth ensures that all utilization management decisions are based on the appropriateness of care and existence of coverage. GlobalHealth does not provide any reward or incentive to practitioners or other individuals for issuing denials of coverage. No financial incentives are provided to utilization management decision-makers that would encourage decisions to deny or withhold Medically Necessary treatment.

## **Technology Assessment Process**

GlobalHealth has a technology assessment and guideline review process. It is designed to research and review requests for coverage of newly available special devices, procedures, or treatments that are not considered established benefits, but for which you may be eligible.

GlobalHealth ensures that all requests for new technology are reviewed by a physician-directed committee using available scientific medical evidence. An appropriate regulatory agency, such as the U.S. Food and Drug Administration, must have approved the new device, procedure, or treatment before it will be considered.

Before approving coverage, GlobalHealth requires documented evidence to ensure the efficacy and safety of the new technology. The new technology must:

- Improve the net health outcome of the Member;
- Be as beneficial as established alternatives;
- Be available outside the investigation setting;
- Significantly improve the quality of life of the Member; and,
- Clearly demonstrate safe medical care to the Member.

## **Steps to Improve Your Health Care Safety**

1. Have your questions written down before your scheduled appointment.
2. Ask questions if you have any doubts or concerns regarding your treatment or PCP recommendations.
3. Keep and bring a list of all the medicines you take to each appointment.
4. Get the results of any test or procedure.
5. Talk to your doctor about what treatments are best for your health needs and why.
6. Make sure you understand what will happen if you need surgery.

## Your Medical Information

Your individually identifiable health information is protected by federal and state laws.

You have the right to access or restrict the release of your identifiable personal health information in accordance with federal and state laws.

When transferring to a new PCP, a signed authorization for release of information is required to transfer your medical records. Your current PCP's office can provide you with the form.

Medical records and/or information may be collected and used for:

- Clinical review.
- Satisfaction and quality studies.
- Complaint and/or appeal investigation.
- Fraud detection.
- State, federal, or accreditation reviews.
- Other matters as required by law.

Please refer to the GlobalHealth *Notice of Privacy Practices* for more information.

## Your Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum of the most current benefit Plan applies if you change GlobalHealth benefit Plans during the calendar year. Copayments, Coinsurance, and Deductibles paid under the previous GlobalHealth benefit Plan within the same calendar year are applied to the current benefit Plan maximum. You are not entitled to a refund if the current annual Out-of-Pocket Maximum is less than the previous maximum.

Subscriber Enrollment means a Subscriber Only with no enrolled Dependents. Family Enrollment means a Subscriber with any number of enrolled Dependents.

The Subscriber does not need to pay further Copayments or Coinsurance once he/she exceeds the Subscriber Only Out-of-Pocket Maximum during the calendar year.

A Member does not need to pay further Copayments or Coinsurance once any combination of family members under the same Subscriber exceeds the family annual Out-of-Pocket Maximum during the calendar year.

Copayments, Coinsurance, and Deductibles for Covered Benefits under the *Prescription Drug Supplemental Benefit Plan and the Durable Medical Equipment Supplemental Benefit Plan* are not applied toward the base medical Plan annual Out-of-Pocket Maximum. Copayments and Coinsurance for supplemental benefit Plans are not waived when the base medical Plan annual maximum has been reached.

## Your Prescription Drug Benefits

### How to use your prescription drug benefit

1. Fill your prescription at any GlobalHealth participating pharmacy. A list of Network pharmacies can be found in the GlobalHealth *Physician & Health Providers Directory* and on the website at [www.globalhealth.com](http://www.globalhealth.com). You may also call Customer Service for help in locating a pharmacy.
2. Present your GlobalHealth Member ID card to the pharmacist.
3. Pay the applicable Copayment.

### Mail-order Pharmacy Service

Mail order pharmacy service is available through Express Scripts. For more information, visit [www.express-scripts.com](http://www.express-scripts.com) or contact Express Scripts Customer Service at 1-866-274-1612, 24 hours a day, 7 days a week.

### Sovereign Medical Solutions Medications by Mail

Sovereign Medical Solutions is a Native American-owned pharmacy located in Oklahoma providing prescription medications to Native Americans. Complete the Native American Prescription Benefit Program Patient Enrollment form available at [www](http://www).

globalhealth.com and submit to Sovereign Medical Solutions. Proof of Native American status in one of the federally recognized tribes is required. Once Native American heritage is established with Sovereign Medical Solutions, GlobalHealth Members can receive Copayment discounts for medications mailed directly to their home or designated location.

### **GlobalHealth's Preferred Drug List**

The GlobalHealth preferred drugs are listed in the *Drug Formulary*. Medications on the list are selected based on quality (effectiveness and safety) as well as cost-effectiveness. Doctors and pharmacists have worked together to develop the formulary. It includes generic and brand name medications that are approved by the U.S. Food and Drug Administration (FDA). The list of drugs is subject to change.

Please check your *Schedule of Benefits* for detailed information regarding your specific drug coverage, benefit limitations, and exclusions. For specific questions about your coverage, please call the phone number printed on your Member ID card.

**Tier one Copayment:** Generic medications contain the same active ingredients in the same amounts as brand name products. However, they may be a different color, shape, or size. You will pay the lowest Copayment for generics.

**Tier two Copayment:** Approved brand name medications on the formulary have the next highest Copayment.

**Tier three Copayment:** If your GlobalHealth Plan has a third tier, the cost for non-formulary medications will be the highest of the three tiers. You will pay either a Copayment or Coinsurance.

In addition to using the *Drug Formulary*, you are encouraged to ask your doctor to prescribe generics when possible. Generics not only save you money, they also help GlobalHealth continue to offer prescription coverage at such reasonable rates.

The Copayments must be met each time a prescription is filled or refilled. You will pay the Copayment or the cost of the prescription drug, whichever is less.

### **Prior Authorization, Step Therapy, Quantity Limits, and Exceptions**

Your Plan may include prior authorization, step therapy, or quantity limit requirements. These programs are based on current medical findings, FDA-approved manufacturer labeling information, cost, and manufacturer rate agreements.

#### **Prior Authorization:**

Physicians are required to obtain prior authorization for certain medications to promote appropriate, cost-effective use. GlobalHealth may not cover the drug without prior authorization.

#### **Step Therapy:**

Step therapy requires one or more prerequisite, clinically equivalent drugs to be tried before a step therapy drug will be covered. Your physician can contact GlobalHealth to request an exception to this restriction if a specific step therapy drug is Medically Necessary.

#### **Quantity Limits:**

For certain drugs there are limits to the amount of the medication that you may receive. These drugs, if taken inappropriately for too long a time period, could be unsafe and cause adverse effects. Your Provider must obtain authorization from GlobalHealth in order for you to receive coverage for an amount of medication in excess of the set limit.

#### **Requesting an Exception:**

You can request GlobalHealth to waive coverage restrictions and limits. Generally, GlobalHealth will only approve your request for an exception if:

- the alternative drug is included on the Plan's formulary;
- the lower-tiered drug or additional utilization restrictions would not be as effective in treating your condition; and/or,
- would cause you to have adverse medical effects.

You or your physician should contact GlobalHealth for instructions on obtaining an initial coverage decision for a utilization restriction exception. Your physician may have to submit a prior authorization request form with information supporting the request for an exception. Generally, a decision is made within 72 hours or less of your request.

You can find additional information in the *Drug Formulary* on our website, [www.globalhealth.com](http://www.globalhealth.com).

# Your Medical Benefits

This section explains your medical benefits, including what is and is not covered by GlobalHealth.

There are definitions below that you may find helpful when reading through this section. While the following Covered Services are representative of most of GlobalHealth Plans, it is not all inclusive. For details of your particular Plan, please refer to your *Schedule of Benefits*.

The *Schedule of Benefits* will provide the specific covered benefits with Copayments or Coinsurance that you may have when utilizing your Health Plan.

The benefits described in this section are covered if they are determined to be Medically Necessary by your PCP or GlobalHealth and are provided by your PCP or authorized by GlobalHealth.

## Covered Services

All services must be Medically Necessary and authorized as required by GlobalHealth or your PCP. You will only be admitted to acute care, Subacute Care, and Skilled Nursing Facilities for services that are authorized in advance by GlobalHealth. This applies to all services with the exception of Emergency Room Care, Urgent Care Services, or services for which you may self-refer. (See page 6.)

1. **Allergy Serum** – Allergy serum and supplies for the administration of serum are covered for the treatment of allergies. All services must be obtained through a contracting Provider.
2. **Allergy Testing** – Services and supplies used in determining an appropriate plan for treatment of allergies are covered.
3. **Allergy Treatment** – Services for the treatment of allergies using an established treatment plan are covered.
4. **Ambulance** – Ambulance transport is covered when a medical or psychiatric condition requires Medically Necessary emergency services and an ambulance is **required** to receive these services. Non-emergency ambulance services are only covered when specifically authorized by your PCP or by GlobalHealth.
5. **Anesthesia** – Eligible services for covered illness and Medically Necessary surgery.
6. **Attention Deficit/Hyperactivity Disorder (ADHD)** – Medical management of ADHD is covered, including diagnostic evaluation and laboratory services associated with monitoring prescribed drugs. This medical benefit does not include non-crisis mental health or behavior modification programs.
7. **Blood and Blood Products** – Self-donated, donor-directed, and donor designated blood processing costs are limited to blood collected for a scheduled procedure. Any other blood and blood products are excluded, unless specifically covered by your group Plan. Refer to your *Schedule of Benefits*.
8. **Bone Density Test** – Women age 45 years and older are covered when testing is requested by a PCP or referral physician, subject to Deductibles, Copayments, and Coinsurance of your Plan. Reimbursement is limited to \$150.00. Routine osteoporosis screening will begin at age 60 for women at increased risk for osteoporotic fractures with no cost-sharing. Osteoporosis screening is covered for all women at age 65 with no cost-sharing.
9. **Bone Marrow and Stem Cell Transplants** – Transplants of this nature that are not considered experimental or investigational are covered. Donor costs are not covered.
10. **Breast Cancer (and other breast conditions)** – With respect to the treatment of breast cancer and other breast conditions, coverage is provided for not less than forty-eight (48) hours of inpatient care following a mastectomy and not less than twenty-four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer.
11. **Chemical Dependency** – Medically Necessary services for chemical dependency will be covered subject to all policy provisions and limitations. These services include diagnosis, medical treatment, and referral services. Chemical dependency services are managed by MHNNet. All care for non-emergency chemical dependency must be directed by MHNNet.

Medical detoxification is covered for problems associated with acute alcohol, drug, or substance abuse.

A series of treatments is a structured, organized, and needed program which may include different Facilities and is complete when the covered Member is discharged on medical advice from inpatient detoxification, inpatient rehabilitation, partial hospitalization, or intensive outpatient treatment, or when a person fails to materially comply with the treatment program.

- Inpatient – 24-hour program of services for the treatment of chemical dependency services must be provided in an acute Hospital setting.
- Residential – 24-hour or partial day care Facility. Partial day must be at least three (3) hours a day. Less intensive partial day will be covered as outpatient.

A chemical dependency treatment center is a Facility that provides a program for the treatment of chemical dependency using a treatment plan approved and monitored by a contracting Provider.

Any treatment Facility must be contractually affiliated with a Hospital.

12. **Cochlear Implant Device** - An implantable cochlear device for bilateral, profoundly hearing impaired Members that do not benefit from conventional hearing aids is covered. Coverage is for Members at least eighteen (18) months of age or for prelingual Members with minimal speech perception using hearing aids.
13. **Cochlear Implant Services** - Implantation of a cochlear device that meets the coverage guidelines to receive the device.
14. **Contraceptive Services** - Family planning services, including surgical sterilization, injections, IUDs, and internally time-released implants for contraceptive purposes.
15. **Dental Emergencies** - Immediate stabilization of sound natural teeth due to accident or injury is covered. All follow-up care is NOT covered even if the teeth are not saved by emergency stabilization.
16. **Dental Treatment Anesthesia** - Covered for Members under the age of eight (8) when that Member has a medical or emotional condition that requires hospitalization or general anesthesia for dental care, for severely disabled Members, or a minor four (4) years of age or under, who in the judgment of the practitioner treating the child, is not of sufficient emotional development to undergo a medically necessary dental procedure without the use of anesthesia.
17. **Diabetic Management** - Outpatient self-management training, education, and medical nutrition therapy services are covered. These services must be provided under the direction of a contracting Provider.
18. **Diabetic Self-Management Equipment and Supplies** - Equipment and supplies including but not limited to, podiatry services and devices to prevent or treat diabetes-related complications are covered. Visual aids (not including eyeglasses or contact lenses) are covered for Members who have a visual impairment that would prevent proper dosing. Other diabetic supplies are covered under the *Prescription Drug Supplemental Benefit Plan* or the *Durable Medical Equipment Supplemental Benefit Plan*.
19. **Dialysis** - Acute and chronic hemodialysis services and supplies.
20. **Durable Medical Equipment** - Hearing aids for children up to the age of eighteen (18) are covered. This benefit is limited to one (1) aid per ear every forty-eight (48) months unless Medically Necessary to replace more often. For Members under the age of two (2), four (4) additional ear molds may be obtained per year. All other Durable Medical Equipment is not covered unless covered as a supplement to this Plan.
21. **Emergency Services** - Emergency Room Care is a covered benefit. An emergency is based on the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.
22. **Health Education Services and Programs** - Wellness services and disease management programs for Diabetes, Smoking Cessation, Congestive Heart Failure, Chronic Pain, and Chronic Respiratory Disease are covered subject to authorization requirements.
23. **Hearing Aids and Devices** - Hearing aids for children up to the age of eighteen (18) are covered. This benefit is limited to one (1) aid per ear every forty-eight (48) months unless Medically Necessary to replace more often. For Members under the age of two (2), four (4) additional ear molds may be obtained per year.

Replacement parts and repairs of the hearing aid are covered. You will be responsible for any charge above the cost of a standard hearing aid. Hearing loss means a hearing deficiency of thirty (30) decibels or greater in the frequency region important for speech recognition and comprehension in one or both ears, approximately five hundred (500) through four thousand (4,000) Hertz.

24. **Hearing Screening** - Hearing screenings are covered at no cost-sharing for children when prescribed and authorized by a contracting PCP. Any child up to the age of eighteen (18) is covered for audiological services and standard hearing aids if there is documented hearing loss requiring Medically Necessary hearing aids. Refer to your *Schedule of Benefits* for your Plan's benefits.
25. **Home Health Care** - Part-time or intermittent services, including Skilled Nursing Care and Skilled Rehabilitation, are covered. A licensed nurse, or licensed speech, occupational, or physical therapist must provide home health services.
26. **Hospice Services** - Hospice services for Members with a terminal illness where the prognosis results in a life expectancy of six (6) months or less are covered.

Hospice services are provided in accordance with the plan of care developed by the Member's interdisciplinary team which includes, but is not limited to: the Member; the Member's PCP; a registered nurse; a social worker; and a spiritual caregiver.

Hospice services include: skilled nursing; certified home health aide, and homemaker services under the supervision of a

qualified registered nurse; bereavement services; social services; medical direction; pharmaceuticals; medical equipment, and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions; and physical, occupational, and speech pathology services for purposes of symptom control, or to enable the Member to continue activities of daily living and basic functional skills.

27. **Immunizations** - Immunizations for children through the age of eighteen (18) are covered. This benefit includes, but is not limited to, immunizations for diphtheria, haemophilus influenza type B, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella (chicken pox), hepatitis A, and any other immunization required by law. Routine boosters and immunizations must be obtained through the Member's PCP.

Immunizations for Members nineteen (19) years of age or older are covered as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. This benefit includes, but is not limited to, DPT, DT, tetanus, oral polio, measles, mumps, rubella, and small pox.

Immunizations for travel, work, sports, or recreation are not covered.

28. **Infertility Services** - Diagnosis, testing, and medication dispensed by a contracting physician for the treatment of Infertility are covered. In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), and Zygote Intrafallopian Transfer (ZIFT), and services associated with these procedures, are not covered. Insemination procedures and all services related to insemination are not covered. Reversal of a sterilization procedure is not covered.
29. **Infusion Therapy** - The therapeutic use of drugs or other substances that are prepared and administered by a contracting Provider through a needle or catheter are covered. Infusion services must be provided in the home, or in a Facility that is not a Hospital, skilled nursing or rehabilitation Facility. Your PCP must authorize these services.
30. **Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications)** - Outpatient injectable medications administered in the physician's office are covered when part of the medical office visit. Self-injectable medications are covered when the medication has been prescribed by a contracting Provider and authorized by your PCP. Pen devices other than for insulin are not covered. Insulin is covered as a pharmacy benefit provided through your Prescription Drug Supplement.
31. **Laboratory Services** - Medically Necessary diagnostic and therapeutic laboratory services are covered when provided by a GlobalHealth participating Network Provider. GlobalHealth will not pay for non-emergent diagnostic or laboratory testing by non-network Providers without prior written authorization from GlobalHealth.
32. **Mammogram (routine)** - Covered for women age 35 and older. Women between the ages of 35 and 40 are allowed one routine mammogram during this 5-year span. Women over the age of 40 are allowed one routine mammogram annually (every 12 months).
33. **Maternity Care** - A minimum of forty-eight (48) hours of inpatient care is allowed at a Hospital, or a birthing center licensed as a Hospital, following a vaginal delivery, for the mother and newborn infant after childbirth. A minimum of ninety-six (96) hours of inpatient care at a Hospital following a delivery by caesarean section is covered. Postpartum home care is covered following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. One home visit within forty-eight (48) hours of childbirth by a licensed health care Provider whose scope of practice includes providing postpartum care is also covered. Inpatient care and/or visits include:
1. Physical assessment of the mother and the newborn infant;
  2. Parent education;
  3. Training or assistance with breast or bottle feeding; and
  4. Performance of any Medically Necessary and appropriate clinical tests.
34. **Medical Supplies and Materials** - Medical supplies and materials such as gauze, ointments, bandages, and slings used in the course of an office visit are covered. These materials are generally not covered for any other purpose. Over-the-counter items are not covered.
35. **Oral Surgery** - Biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease, tooth extraction prior to a major organ transplant or radiation of the head or neck, and non-dental surgical treatment procedures for congenital defects are covered. Medically Necessary surgical procedures occurring within or adjacent to the oral cavity are covered. Oral surgical procedures primarily for dental purposes are not covered.
36. **Outpatient Surgery** - Same day surgical procedures, performed in an outpatient surgical Facility as a substitute for inpatient care, are covered.
37. **Phenylketonuria (PKU) Testing and Treatment** - Medically Necessary and authorized services to diagnose and treat PKU to prevent the onset of serious medical and mental disabilities or to promote normal development or function as a result of

PKU enzyme deficiency are covered.

FDA-approved low-protein formulas are covered. Food products naturally low in protein are not covered.

38. **Physician Care** - Diagnostic and treatment services provided by your PCP. PCP-authorized services of a Specialist are covered.
39. **Prosthetics and Orthotics** - Are not covered by the base medical benefit Plan. Orthotics are NOT covered except for diabetics and other Members with diagnoses pertaining to peripheral vascular disease. Prosthetics and orthotics may be covered under a *Durable Medical Equipment Supplemental Benefit Plan* purchased in addition to the base medical benefit Plan.

If a Supplemental Benefit Plan is purchased for prosthetics, the following guidelines must be followed:

1. Prosthetics must be Medically Necessary as determined by your PCP or GlobalHealth.
  2. Bionic and myoelectric prosthetics are not covered.
  3. Replacements, repairs, and adjustments to prosthetics are covered, limited to normal wear and tear or because of a significant change in your physical condition. Repair or replacement must be authorized by your PCP or by GlobalHealth.
40. **Radiation Therapy** - Standard and complex radiation authorized by your PCP is covered.
41. **Radiology Services** - Standard x-ray films and specialized scans for the diagnosis of an illness or injury are covered.
42. **Reconstructive Surgery** - This benefit is limited to: post-mastectomy reconstructive surgery to restore or achieve symmetry, including treatment of physical complications; cranial facial abnormalities to improve function of or attempt to create a normal appearance of an abnormal structure caused by congenital defects or developmental abnormalities; trauma, infection, tumors, or disease; and reduction mammoplasty when the Member meets medical necessity guidelines to receive this service.
43. **Rehabilitation Services** - Services provided by a registered physical, speech, or occupational therapist for the treatment of an illness or injury are covered, subject to medical necessity coverage/visit limitations.
44. **Routine Exams and Preventive Care** - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force and evidence-informed exams, screenings, immunizations, and counseling provided for in the comprehensive guidelines supported by the Health Resources and Services Administration are covered. GlobalHealth updates the list of Covered Services annually as released by The Department of Health and Human Services.
- For example:
- Annual gynecological exam for women.
  - Annual screening for prostate cancer for men at no cost, consisting of a prostate antigen blood
    1. At least fifty (50) years of age; or
    2. At least forty (40) years of age and at high risk for prostate cancer.
  - Colorectal cancer examinations and laboratory tests for cancer for any non-symptomatic covered Member, in accordance with standard, accepted published medical practice guidelines for colorectal cancer screening, who is:
    1. At least fifty (50) years of age; or
    2. Less than fifty (50) years of age and at high risk for colorectal cancer according to the standard, accepted published medical practice guidelines.
45. **Severe Mental Illness** - Illnesses defined by the American Psychiatric Association as "Severe Mental Illness" are covered as a standard medical benefit for all Plan groups that have 51 or more employees. These diagnoses include, but are not limited to: Schizophrenia; Bipolar Disorders; Major Depressive Disorders; Schizo-affective Disorders; Pervasive Developmental Disorders; and Obsessive-Compulsive Disorders. Inpatient or outpatient Medically Necessary services authorized by MHNnet will be covered as any other illness.
46. **Vision** - Refer to your *Schedule of Benefits* for your Plan's benefits. Coverage for lenses, frames or contact lenses are excluded except for the initial set of basic eyeglasses or contact lenses following cataract surgery.
47. **Well-child Care** - Child health supervision services are covered at birth, two months, four months, six months, nine months, twelve months, eighteen months, two years, three years, four years, five years, six years, eight years, ten years, twelve years, fourteen years, sixteen years, and eighteen years.
48. **Wigs** - Wig or other scalp prostheses necessary for the comfort and dignity of the covered person are covered subject to the same annual Deductibles, Copayments, or Coinsurance limits as established for all other covered benefits under the Plan not to exceed one hundred fifty dollars (\$150) annually.

# Who Is Eligible for GlobalHealth Benefits?

**You** are eligible to enroll with GlobalHealth if:

- You live or work in GlobalHealth's Service Area (see the Physician and Health Providers Directory for a listing of participating Providers in the GlobalHealth Service Area) and
- You meet the eligibility requirements defined by your employer's *Group Agreement* with GlobalHealth.

Since your employer contracts for your health care benefits, you are the Subscriber to the Health Plan. Your spouse and children are Dependents. Please note that all applications for Enrollment should always be submitted through your employer.

**Your Spouse** is eligible to enroll with GlobalHealth if he/she meets the Dependent eligibility requirements defined by your employer *Group Agreement* with GlobalHealth.

**Your Children** may continue as eligible Dependents to the limiting age of 26.

## **Newborns**

To enroll your newborn, you must submit an application for Enrollment to add the newborn for coverage within the first 31 days from the date of birth. Send your application and make your applicable Premium contribution through your employer.

## **Adopted Children**

Adopted children are covered from the date placed in the home. For the coverage to be valid, you must submit an application for Enrollment to GlobalHealth within 31 days of date placed in the home.

## **New Dependents as a Result of Marriage**

If you marry, new family members will be covered from the date of your marriage as long as you submit an Enrollment application within 31 days of the date of marriage.

## **Qualified Medical Child Support Order**

Children for whom you or your spouse are required to provide Health Plan coverage to comply with a Qualified Medical Child Support Order.

## **Disabled Dependents**

Enrolled Dependents who attain the limiting age of 26 may continue Enrollment in the Health Plan beyond the limiting age if:

1. The Dependent resides with you or your separated or divorced spouse;
2. The Dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap;
3. The Dependent is chiefly dependent upon you for support and maintenance; and
4. The mental or physical condition existed continuously prior to reaching the limiting age.

## **Late Enrollment**

There are circumstances when employees and their eligible family members may enroll outside of the employer's Open Enrollment period. These situations include:

1. You declined coverage in writing when you were first eligible because you had other coverage and the other coverage is no longer available due to:
  - a. you or your eligible family member have exhausted COBRA under another group Health Plan;
  - b. termination or reduction of hours of a person through whom you or your eligible family member were covered;
  - c. termination of the other Health Plan coverage;
  - d. the employer ceased to contribute toward you or your eligible family member's coverage; or
  - e. death, divorce, or legal separation of a person through whom you or your eligible family member was covered.

If you or an eligible family member meets these conditions, you must request Enrollment with GlobalHealth no later than thirty-one (31) days following the termination of the other Health Plan coverage. GlobalHealth will require proof of loss of the other coverage. Enrollment will be effective the first day of the calendar month following receipt by GlobalHealth of a completed request for Enrollment.

## **When Are You Covered?**

You and your eligible Dependents are covered as of 12:01 am on the effective date of your *Group Agreement*. Your employer must certify your eligibility by submitting your properly executed Enrollment form as identified in the *Group Agreement*.

## If You Stop Working or Have a Significant Change

Talk to your employer about COBRA or an individual conversion plan coverage if you stop working because of:

- Retirement
- Disability
- Leave of absence
- Temporary layoff
- Termination of employment

Talk to your employer about your options if you have a life changing event such as:

- Divorce
- Death of a spouse
- Your Dependent child is no longer eligible because of age

## When Benefits May Be Unavailable

There are rare instances when you may not be able to use your GlobalHealth benefits:

- You refuse Medical Services against the advice of your PCP or specialty physician for any condition, illness, or injury, GlobalHealth may deny coverage of Medical Services for the condition if you have been informed of:
  1. The reasons for such Medical Services and when your PCP or Specialist believes no medically acceptable alternative exists
  2. The consequences if Medical Services are refused.
- Major disaster or epidemic causes demand for services beyond the capacity of available personnel or Facilities.
- Circumstances beyond GlobalHealth's control prevent delivery of services, such as complete or partial destruction of Facilities, war, riot, or disability of a significant part of personnel. In such situations, GlobalHealth and its contracting Providers will perform to the best of their abilities to provide services. If the service is Medically Necessary to prevent serious jeopardy to you or an unborn child, serious impairment of bodily functions, or serious dysfunction of an organ, you may go to the nearest medical Facility. GlobalHealth will reimburse you for the charges for the care.

## When Coverage Stops

Coverage stops automatically when you are no longer eligible as defined by your employer or on the earliest of the following:

- The date your *Group Agreement* terminates. Unless otherwise provided, your policy will expire at 12:01 am on the expiration date stated in the policy.
- You or your employer fail to make a Premium payment by the last day of the month for which a contribution has been paid.
- The last day of the month a Dependent becomes ineligible.
- If your employment is terminated or you are no longer eligible through your employer, the last day of the month for which the last payment was made for your coverage.
- The date you or a Dependent enters military service. If a Dependent enters military service, only that Dependent is no longer covered.
- The date you commit Fraud, such as if you presented false information or permitted another person to use your GlobalHealth Member ID card.
- If you receive a notice of violation and continue to act in a way that interferes with the effective delivery of medical care, on the first day of the month in which you receive notice of disenrollment.
- The last day of the month in which you permanently move outside GlobalHealth's Service Area.
- If the Subscriber dies, coverage for Dependents ends on the last day of the month of the Subscriber's death.

### **GlobalHealth may also deny coverage if:**

- You do not pay Copayments you owe to contracting Providers.
- You do not pay for services delivered by contracting Providers and the services are not covered according to your *Schedule of Benefits*, Limitations and Exclusions.

- You refuse a prescribed treatment or procedure if the attending physician believes such treatment or procedure is necessary to restore and maintain health or maintain life.

If your coverage is terminated because of nonpayment, intentional misuse of your Member ID card, or detrimental conduct, you are not eligible for continuation of coverage.

In all cases, if a Dependent's coverage is terminated, it does not affect the coverage of other family members. If the Subscriber's coverage stops, the membership of all Dependents stops as well. Coverage ends at 12:01 am on the day that the termination is effective.

### **If You Are in the Hospital When Coverage Ends**

If your GlobalHealth group coverage is ending due to termination of the *Group Agreement* by your employer or your employer's participation in the *Group Agreement* is terminated, your coverage ends on the termination date of the *Group Agreement*.

## **Changes to Your GlobalHealth Plan**

GlobalHealth may change the *Group Agreement* or any benefits after having given you at least sixty (60) days written notice. GlobalHealth must also tell you when the change will become effective.

Your employer may cancel your *Group Agreement*. Your employer will notify you in writing of the cancellation at least 60 days before the contract expires.

There may be a time when a physician is no longer part of the GlobalHealth Provider Network. GlobalHealth or your Medical Group will notify you within thirty (30) days if this happens. You will be asked to select a new personal PCP from the current *Physician and Health Providers Directory*. If you do not choose a PCP, GlobalHealth will choose one for you. You can change PCPs by notifying GlobalHealth Customer Service Department.

GlobalHealth or your employer may make changes to the *Group Agreement* or benefits without Member consent or concurrence. If you are eligible to elect medical and Hospital coverage under the *Group Agreement* or accept benefits presented in the *Group Agreement*, and you decide to elect coverage, you agree to all stated terms, conditions, and provisions. Your employer is responsible for notifying you in writing within seventy-two (72) hours of any change to your GlobalHealth Plan.

## **Renewals and Rate Changes**

GlobalHealth must provide your employer thirty (30) days written notice before a rate change may take effect.

GlobalHealth and your employer contract for your benefits at a guaranteed price for a one year period. Typically, the *Group Agreement* is automatically renewed each year unless there is a change in benefits or rates. GlobalHealth will let your employer know in writing thirty (30) days before any rate change takes effect. GlobalHealth will notify you if there are any material changes to the *Group Agreement*.

## **If You Receive a Bill**

Services prescribed by your PCP will be billed directly to GlobalHealth. You are responsible for any Copayment at the time of service. However, if you receive medical care out of GlobalHealth's Service Area or in an emergency room, you might receive a bill from those Providers.

If you receive a bill for medical care that is covered under your *Group Agreement* and authorized by your PCP, immediately send it to:

GlobalHealth, Customer Service Department  
PO Box 2328  
Oklahoma City, OK 73101-2328

If the bill is for Emergency Room Care you already paid for, be sure to send the bill and proof of payment for reimbursement to GlobalHealth within 120 days of the date of service. Contact GlobalHealth's Customer Service Department if you have any questions.

## **If a Claim Is Denied**

If you submit a claim for payment and any part of it is denied, GlobalHealth will reconsider the claim upon written request for appeal. See "How to File a Complaint, Grievance, or Appeal" in this Handbook.

## Responsibility of Payment

You Are Responsible for Payment of:

- Your Copayments or Coinsurance when Covered Services are provided by a contracting Provider.
- The portion of the charges GlobalHealth does not pay when services are provided by a physician or medical Facility without an authorized referral from your PCP.
- The cost of services for benefits not included in the GlobalHealth Plan benefits offered by your employer.

You Are Not Responsible for:

- Any amounts owed by GlobalHealth to a Provider for Medical Services covered by GlobalHealth.

## When You're Covered by More Than One Plan

If you have health care coverage in addition to your GlobalHealth Plan, either as a Dependent or a Subscriber, you can coordinate the benefits to get the most coverage at the lowest cost to you. At times, you may be able to coordinate benefits so that 100% of your health care costs are covered.

**THIS POLICY CONTAINS A NON-DUPLICATION PROVISION WHICH MAY REDUCE THE BENEFITS OF THIS POLICY TO THE EXTENT THAT THERE ARE BENEFITS UNDER OTHER HEALTH PLANS, AS DEFINED ON THIS PAGE. Other Health Plans include any plan which provides insurance, reimbursement, or service benefits for Hospital, surgical, or medical expenses; this includes coverage under group or individual insurance policies, non-profit health service plans, Subscriber contracts and pre-payment plans.**

Remember, even when GlobalHealth is the secondary payer, you must have your care authorized by GlobalHealth in order for the claim to be paid. Some Copayments and Coinsurance may still apply.

For information about coordination of benefits, call the GlobalHealth Customer Service Department.

Note: When verification of other coverage is needed for processing a claim, GlobalHealth will request that you complete a Verification of Other Coverage form. Your failure to provide the completed Verification of Other Coverage form when requested will cause the claim to be delayed or denied for non-compliance with GlobalHealth's request for information. You may be asked to complete a Verification of Other Coverage form annually.

## If You're Injured on the Job

If you are injured on the job and require medical care, you will need to sign an Assignment of Benefits form at your Provider's office to allow the Provider to bill Workers' Compensation directly for their treatment of your injury. Your GlobalHealth benefits are not designed to duplicate any benefits you receive under Workers' Compensation law.

## Third-Party Liability

If you are injured through an act or omission of a third-party (e.g., motor vehicle accident) and are entitled to recovery from that third-party for medical expenses, you agree to make a claim for such expenses and agree to reimburse GlobalHealth for the cost of all such services upon obtaining a monetary recovery or settlement. You agree that GlobalHealth's right to reimbursement is the first priority claim against any third-party. This means that GlobalHealth will be reimbursed from any recovery before payment of any other existing claims, including any claim by you for general damages.

GlobalHealth may collect from the proceeds of any settlement or judgment recovered for you regardless of whether you have been fully compensated.

When you have released the responsible party for a wrongful act or negligence of another, this may cause the claim to be delayed or denied by GlobalHealth. GlobalHealth may waive its option to deny the claim for good cause in certain specific cases.

## Subrogation, Third-Party Recovery and Reimbursement

You may print a copy of the Subrogation, Third-Party Recovery and Reimbursement section from our website, [www.globalhealth.com](http://www.globalhealth.com). Or, you may request a copy from Customer Service.

# Your GlobalHealth Plan and Medicare

If you are a Medicare recipient, either through yourself or your spouse, GlobalHealth will coordinate benefits with Medicare and determine which payer is primary. If Medicare benefits are primary, they will take the place of your GlobalHealth Plan benefits. GlobalHealth will pay for approved benefits less the amount paid by Medicare. If you have questions about Medicare, contact your local Social Security office or [www.medicare.gov](http://www.medicare.gov).

## How to File a Complaint, Grievance, or Appeal

### Complaints and Grievances

You may file a complaint by calling Customer Service. A Grievance is a more formal complaint that is made in writing by you, or on your behalf, concerning any aspect of the Plan operations, policies, procedures, quality of care, level of service, or other issue. If you wish to file a complaint or Grievance, you should provide as much information as possible to describe the nature and substance of the matter.

For telephone complaints, call:

(405) 280-5600 (local)  
1-877-280-5600 (toll-free)  
1-800-522-8506 (TTY/TDD/Voice)

Or, email [askcustomerservice@globalhealth.com](mailto:askcustomerservice@globalhealth.com)

For written Grievances, please include:

- Member's name and address
- GlobalHealth Member ID#
- Provider of services
- A description of the complaint and resolution desired
- Copies of claims, records, or other relevant information

Submit written Grievances to:

GlobalHealth, Inc.  
ATTN: Grievance  
PO Box 2393  
Oklahoma City, OK 73101-2393

You will receive an acknowledgement letter within five (5) days of GlobalHealth's receipt of your correspondence. This letter will let you know when you can expect a response or resolution in writing from GlobalHealth. You will generally receive a final response within thirty (30) days unless otherwise specified.

### Appeals

Any Member dissatisfied with an adverse determination (or denial) has the right to request an Appeal of that determination. The request for Appeal must be submitted in writing and include the following:

- Member's name and address
- GlobalHealth Member ID#
- Provider of services
- Date of service if appealing a denied claim
- Description of the denied service and why the Appeal is being requested
- Copies of documentation to support the Appeal request (e.g., claims, medical records, physician statements, and any other relevant information)

### Initial Appeals Process

You will receive an acknowledgement letter within five (5) days of GlobalHealth's receipt of your Appeal request. This letter will let you know when you can expect a determination in writing from GlobalHealth. Appeals are generally completed within thirty (30) days of receipt of the request.

Depending on the nature of the adverse determination, there are two internal levels of review:

1. General Review (e.g., claims processing or clerical errors).
2. Independent Internal Review (e.g., adverse medical necessity or coverage determinations). This review is conducted by an independent party not involved in the original adverse determination.

### **Appeals Standards**

- Pre-service Appeals will be completed within thirty (30) days after receipt of the Appeal request.
- Post-service Appeals will be completed within sixty (60) days after receipt of the Appeal request.
- If an Appeal cannot be completed within the above timeframes, you will be notified in writing with an explanation as to why the Appeal may not be completed and when you can expect to receive a final determination notice.

### **Expedited Appeal**

You, or someone authorized to act on your behalf, may request an “expedited” review if an emergency exists and the time frames established would jeopardize your life or health. In such case, a review will be conducted and determination provided to you within 72 hours.

### **External Review**

If an adverse determination is upheld on Appeal and involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness, you, or your authorized representative, may request an external review by an Independent Review Organization (IRO).

You, or your authorized representative, may also request an external review if the adverse determination is that the requested health care service or treatment is experimental or investigational and the treating physician certifies in writing that the requested service or treatment would be significantly less effective if not promptly initiated.

Requests for external reviews must be made in writing within four (4) months of the final Appeal determination notice. Note: When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision. The request for external review must be submitted to:

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

Telephone: 1-800-522-0071  
405-521-2828

The Insurance Commissioner will randomly select a qualified IRO to conduct the external review. The IRO will notify you of its determination within forty-five (45) days of the receipt of the request for review.

### **Expedited External Review**

You may request an Expedited External Review if the adverse determination involves a medical condition where the time frame for completion of a standard review would seriously jeopardize your life or health or jeopardize your ability to regain maximum function, or if the final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a Facility.

Requests for Expedited External Review are submitted to the Insurance Commissioner (See External Review above). The Insurance Commissioner will randomly select an IRO to expeditiously complete the review and render a determination within 72 hours after the date of receipt.

Note: An Expedited External Review may not be provided for retrospective adverse determinations.

To request an external Appeal or Grievance, call the Oklahoma Insurance Department at 1-800-522-0071 before sending your paperwork, and you will receive instructions on the quickest way to submit your request and supporting information.

## Advance Directives

An Advance Directive (also referred to as a Living Will) is a document that allows an individual 18 years or older to inform physicians and others of his or her wishes to receive, decline, or withdraw life-sustaining medical care. This document may also include the appointment of a Health Care Proxy in the event you become incapacitated and/or describe your wishes as to the donation of bodily organs upon death.

If you have completed an Advance Directive, provide a copy to your PCP. Also, provide a copy to the Hospital if you are admitted as a patient.

## GlobalHealth Member Rights and Responsibilities

As a partner with your GlobalHealth Plan, your physician and other health care professionals who may be involved in your care, you or your legal designee have the right to:

- Ask questions about any medical advice or prescribed treatment if you need an explanation or want more information in order to make an informed consent or refuse a course of treatment.
- A candid discussion of all appropriate, Medically Necessary treatment options that are recommended for your condition, regardless of the cost of care. You also have the right to participate in decisions regarding your medical care.
- Appeal any unfavorable medical or administrative decisions by following the established Appeal and Grievance procedures of your Plan. You have the right to an external or expedited review of an adverse determination when applicable.
- Completely understand your medical condition, health status, and the medications prescribed for you - what they are, what they are for, how to take them properly, and possible side effects.
- Know how your Health Plan operates - as stated in your *Member Handbook* and *Schedule of Benefits*.
- Have access to your PCP and referrals to Specialists when Medically Necessary or urgent.
- Use Emergency Services when you, as a Prudent Layperson acting reasonably, believe that an Emergency Medical Condition exists.
- Be treated with dignity and respect.
- Confidential treatment of all protected or individually identifiable health information as required by federal and state law.
- Information about contracted physician payment agreements, as well as explanations of benefits or claims processing determinations.
- Voice complaints about GlobalHealth or the care provided without discrimination, retaliation, or adverse effect.
- Expect problems to be fairly examined and appropriately addressed.
- Contact GlobalHealth's Customer Service Department for assistance with issues regarding your Health Plan or to make recommendations regarding GlobalHealth's Member Rights and Responsibilities.

You are entitled to exercise these rights regardless of race, national origin, gender, sexual orientation, marital status, or cultural, economic, educational or religious background.

### **You or your legal designee has the responsibility to:**

- Identify yourself by presenting your Member ID card (to physician, laboratory, Hospital, etc.) when receiving Medical Services.
- Provide, to the extent possible, all information and medical records that your physician and/or the Plan need to give you appropriate care.
- Understand your health problems and participate in mutually agreed upon treatment goals to the degree possible.
- Be on time for all appointments and to notify your physician's office as far in advance as possible if you need to cancel or reschedule an appointment.
- Notify your PCP within forty-eight (48) hours, or as soon as possible, if you are hospitalized or receive emergency or out-of-area Urgent Care.
- Pay all required Copayments at the time you receive health care services.
- Do your part to improve your own health condition by following treatment plans, instructions, and care that you have agreed on with your physician(s).
- Review information regarding Covered Services, policies and procedures as stated in your *Member Handbook* or *Schedule of Benefits* booklet.
- Ask questions if you do not understand your health benefits or treatment recommendations.

GlobalHealth Member Rights and Responsibilities can also be found on the GlobalHealth website at [www.globalhealth.com](http://www.globalhealth.com). A copy of the GlobalHealth's Member Rights and Responsibilities statement can be printed from the GlobalHealth website or you may request a printed copy from Customer Service.

If you have any questions or concerns regarding the benefits outlined in this *Member Handbook*, please contact GlobalHealth's Customer Service Department.

## Limitations & Exclusions

All benefits described below are excluded or limited under your basic medical Plan. There may be benefits listed in this section that are covered in a supplement purchased separately from this Plan.

### General Exclusions

1. Services that are not Medically Necessary or provided without authorization.
2. Non-emergency ambulance transport.
3. Services provided before your start date of coverage or after the time coverage ends, even if authorized.
4. Services resulting in whole or in part by a non-covered condition or service.
5. Care provided outside the GlobalHealth Service Area if the need for care could have been foreseen before leaving the Service Area.
6. Services for which you do not allow the release of information to GlobalHealth.
7. Treatment for disabilities connected to military service for which you are legally entitled and to which you have reasonable accessibility (i.e., services through a federal governmental agency); court ordered services; or treatment and/or supplies that are provided as a result of Workers' Compensation laws or similar laws.
8. Prescription drugs and non-prescription drugs for outpatient care. (Covered as a supplement purchased separately from this base medical Plan, including coverage for off-label uses of prescription drugs used in the treatment of cancer or the study of oncology.)
9. Durable Medical Equipment, unless covered as a supplement purchased separately from this Plan.
10. Elective abortions.
11. Hearing aids or speech aids. (Hearing aids are covered only for children less than eighteen (18) years of age.)
12. Sex transformation or sexual dysfunction of any nature, including services, drugs, or supplies. (Certain prescriptions may be covered under your Prescription Drug Supplement.)
13. Medications, surgeries, devices, medical treatment, or other health care procedures that are experimental or investigational. Therapies and technologies whose long-term efficacy or effect is undetermined or unproven or whose efficacy is no greater than that of traditionally accepted standard treatment.
14. New procedures, services, supplies, and medications until reviewed for safety, efficacy, and cost effectiveness and approved by GlobalHealth.
15. Artificial or non-human organ transplants. Donor costs including transportation expenses.
16. Services for travel, insurance, licensing, employment, school, camp, sports, premarital, or pre-adoption purposes.
17. Private duty nursing, custodial care, respite care, homemaker services, domiciliary, or convalescent care.
18. Private rooms and personal or comfort items.
19. Services received while outside of the United States.
20. Charges for injuries resulting from war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.
21. Charges for intentionally self-inflicted or attempted suicide injuries or death.
22. Marital counseling.
23. Illness or injury as a result of committing or attempting to commit an assault or felony. This includes participation in a riot or insurrection as an aggressor.
24. Alopecia.
25. Home uterine monitoring.
26. Kinesiology, movement therapy, biofeedback, or any treatment, device, or medication that is an exclusion of the Plan, whether or not medical necessity is established.

27. Rolf technique.
28. Surrogate mother expenses.
29. Eye examinations for the fitting of corrective lenses or any charges related to such examination. Treatment for orthoptics or visual training for any diagnosis other than mild strabismus.
30. Routine corrective lenses and fittings. (The first pair used as a prosthetic replacement after the removal of the natural lens is covered.)
31. Genetic testing is not covered. Genetic counseling coverage is limited to women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 and BRCA 2 genes.
32. Separate charges for missed or canceled appointments, penalty or finance charges, maintenance and/or record keeping, or Case Management services.
33. Medical care and supplies for which no charge was made. Medical care and supplies for which no payment would be requested if you did not have this coverage.
34. Home sleep apnea studies unless determined to be Medically Necessary and approved by GlobalHealth.
35. Gastric stapling, gastric balloon services, or any surgical treatment for morbid obesity, and any resulting complications, with or without the diagnosis of obesity.
36. Physical, occupational, and speech rehabilitation services in excess of sixty (60) treatment days (including inpatient and outpatient) per acute disability or injury per calendar year and rehabilitation treatment that will not result in significant improvement.
37. Medical and/or mental health treatment of any kind which is excessive or where medical necessity has not been proven.
38. Education, therapy, and services for the purpose of diagnosing or treating learning disabilities, disruptive behavioral disorders, oppositional defiance disorder, and conduct disorders. This includes any materials, devices and equipment.
39. Psychiatric or psychological treatment for developmental disorders, including mental retardation, pervasive developmental disorder, and other specific developmental disorders, such as autism, Rett's, or Asperger's. (Autism screening for children at age eighteen (18) months and twenty-four (24) months, and developmental screening for children less than three (3) years of age is covered.)
40. Massage therapy.
41. Acupuncture/Acupressure.
42. Alternative medicines or treatments used in the place of chemotherapy, or any other approved therapy, to treat any condition or illness.
43. Alternative programs for delivery such as home delivery and use of midwives and birthing centers. Costs resulting from a normal, full-term delivery (vaginal or caesarean section) of a baby outside of the GlobalHealth Provider Network are not covered. Full-term delivery is defined as a delivery within thirty (30) days of your due date, as specified by your GlobalHealth participating physician.
44. Compulsive disorders treatment is limited to programs for anorexia and bulimia when Medically Necessary.
45. Cosmetic Surgery.
46. General dental services are not covered. Refer to your *Schedule of Benefits* for coverage of services for the treatment of temporomandibular joint dysfunction.
47. In vitro fertilization, artificial insemination, embryo transports, reversal of voluntary sterilization, ovum transplant, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), surrogate parenting, and donor semen expenses.
48. Routine foot care and shoe inserts are excluded except for Medically Necessary foot care for those persons diagnosed with diabetes or peripheral vascular disease.
49. Artificial or non-human organ transplants or transplants considered experimental, investigation, or unproven are excluded. Donor costs including transportation, lodging, and meals are not covered. Transplant services rendered at a non-participating transplant Facility are not covered.

If you have any questions or concerns regarding the benefits outlined in the *Schedule of Benefits*, *DME and Prosthetic Device Supplement*, or *Prescription Drug Supplement*, please contact GlobalHealth's Customer Service Department at:

- [askcustomerservice@globalhealth.com](mailto:askcustomerservice@globalhealth.com)
- (405) 280-5600 (local)
- 1-877-280-5600 (toll free)
- 800-522-8506 (TTY/TDD/Voice)

# Definitions

## **Adverse Determination**

A determination that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed, and based upon the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested services or payment for the service is therefore denied, reduced, or terminated.

## **Allowed Amount**

Maximum amount on which payment is based for covered health services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your Provider charges more than the Allowed Amount, you may have to pay the difference. (See Balance Billing.)

## **Alternative Medicine**

Defined by the National Center for Complimentary and Alternative Medicine as the broad range of healing philosophies, approaches, and therapies that conventional medicine does not commonly use, accept, study, or make available.

## **Ambulatory Surgical Center**

A licensed public or private establishment with an organized medical staff of physicians with permanent Facilities that are equipped and operated primarily for the purpose of performing surgical procedures and continuous physician services and registered professional nursing services whenever a patient is in the Facility and which does not provide services or other accommodations for patients to stay overnight.

## **Annual Copayment Maximum**

See Out-of-Pocket Maximum.

## **Appeal**

A request for GlobalHealth to review a decision or a Grievance again.

## **Balance Billing**

When a Provider bills you for the difference between the Provider's charge and the Allowed Amount. For example, if the Provider's charge is \$100 and the Allowed Amount is \$70, the Provider may bill you for the remaining \$30. A Preferred Provider may **not** balance bill you.

## **Case Management**

A process to assess, plan, implement, coordinate, monitor, and evaluate options to meet your health care needs based on the benefits and resources in order to promote a quality outcome for you.

## **Chronic Condition**

A continuous or persistent condition over an extended amount of time which requires ongoing treatment.

## **COBRA**

Consolidated Omnibus Budget Reconciliation Act. This is the Federal law requiring certain group Health Plans to give employees and certain family members the opportunity to continue their health care coverage at group rates in specific instances where coverage would otherwise end.

## **Coinsurance**

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the Allowed Amount for the service. You pay the Coinsurance **plus** any Deductibles you owe. For example, if GlobalHealth's Allowed Amount for an office visit is \$100 and you've met your Deductible, your Coinsurance payment of 20% would be \$20. GlobalHealth pays the rest of the Allowed Amount.

## **Complications of Pregnancy**

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

## **Contracting Hospital**

Any general acute Hospital licensed by the State of Oklahoma that has entered into a written agreement with GlobalHealth to provide Hospital Services to GlobalHealth Members.

## **Contracting Medical Group**

A Medical Group of physicians that has entered into a written agreement with GlobalHealth to provide physician services to GlobalHealth Members.

## **Contracting Specialist**

Physicians, surgeons, and osteopaths, licensed to practice medicine in the State of Oklahoma, who have written agreements with GlobalHealth or a Contracting Medical Group to provide specialty Medical Services.

**Copayment**

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

**Covered Services**

Medically Necessary services or supplies provided under the terms of this *Member Handbook*, your *Schedule of Benefits*, and supplemental benefit materials.

**Deductible**

The amount you owe for covered health care services GlobalHealth covers before GlobalHealth begins to pay. For example, if your deductible is \$1,000, GlobalHealth won't pay anything until you've met your \$1,000 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services. Not all GlobalHealth Plans have a Deductible. Refer to your *Schedule of Benefits* for your Plan specifics.

**Dependent**

Any spouse or child up to the age of 26 (including stepchildren and legally adopted children) of the Subscriber. GlobalHealth covers Dependents when they meet eligibility and premium requirements.

**Durable Medical Equipment (DME)**

Equipment and supplies ordered by a health care Provider for everyday or extended use. Coverage for DME may include: Oxygen equipment, wheelchairs, or crutches.

**Emergency Medical Condition**

The sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

**Emergency Medical Transportation**

Ambulance services for an Emergency Medical Condition.

**Emergency Room Care**

Emergency Services received in an emergency room.

**Emergency Services**

Evaluation of an Emergency Medical Condition and provision of necessary treatment to stabilize or keep the condition from getting worse.

**Enrolled Family Member**

A family member that is enrolled with GlobalHealth meets all eligibility requirements of the Subscriber's employer group and GlobalHealth, and for which GlobalHealth has received Premiums. An eligible family member is a family member who meets all of the eligibility requirements of the Subscriber's employer group and GlobalHealth.

**Enrollment**

The event when a person becomes a Health Plan Member. A Member is enrolled when GlobalHealth accepts the Enrollment form submitted by the Subscriber. GlobalHealth and the employer group must abide by the *Group Agreement* and the employer group must pay Premiums on time.

**Excluded Services**

Health care services that GlobalHealth doesn't pay for or cover.

**Experimental or Investigational**

Procedures and/or items determined by GlobalHealth as not FDA-approved and/or not generally accepted by the medical community.

**Extended Care Facility or Skilled Nursing Facility**

A Facility or Hospital unit primarily engaged in providing, in addition to room and board accommodations, 24 hour Skilled Nursing Care under the supervision of a licensed physician. GlobalHealth contracts with Skilled Facilities that are certified under Title XVIII of the Social Security Act (Medicare certified).

**External Review**

An Appeal process through which you may have a denied claim reviewed by an external, independent reviewer.

**Facility**

Any building in which health care services are delivered.

**Fraud**

The intentional deception by you or a Provider to provide false information to GlobalHealth, or the intentional misuse of your ID Card.

**Grievance**

A complaint that you communicate to GlobalHealth in writing.

**Group Agreement**

The contract between GlobalHealth and your employer that requires GlobalHealth to pay some or all of your health care costs in exchange for a Premium. This contract will prevail over any conflicting information.

**Habilitation Services**

Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**Health Plan**

A company providing health care benefits to its Members. The GlobalHealth Health Plan is described in the GlobalHealth *Group Agreement*, including cover sheet and attachments.

**Home Health Care**

Medically Necessary health care services a person receives in his or her home, including Skilled Nursing Care and/or Skilled Rehabilitation Services.

**Hospice Services**

Services to provide comfort, palliative care, and support for persons in the last stages of a terminal illness.

**Hospital**

A medical Facility primarily and continuously engaged in providing and operating for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made. GlobalHealth contracts with Hospitals licensed by the State of Oklahoma. Each Contracting Medical Group designates a Hospital for delivery of Hospital Services to Members.

**Hospitalization**

Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

**Hospital Outpatient Care**

Care in a Hospital that usually doesn't require an overnight stay. In certain situations, a patient may require overnight observations as an outpatient.

**Hospital Services**

Medically Necessary services provided by a Hospital. The services may be provided on an inpatient or outpatient basis. They are prescribed, directed, or authorized by your PCP.

**Independent Review Organization (IRO)**

An entity that conducts independent external reviews of adverse determinations and final adverse determinations.

**Infertility**

The inability to conceive a pregnancy or to carry a pregnancy to live birth after a year or more of regular sexual relations without contraception and the presence of a demonstrated condition recognized by a licensed physician, who is a contracting Provider, as a cause of Infertility.

**In-network Coinsurance**

The percent (for example, 20%) you pay of the Allowed Amount for covered health care services to Providers who contract with GlobalHealth. In-network Coinsurance usually costs you less than Out-of-network Coinsurance.

**In-network Copayment**

A fixed amount (for example, \$15) you pay for covered health care services to Providers who contract with GlobalHealth. In-network Copayments usually are less than Out-of-network Copayments.

**Medical Group**

Any group of licensed doctors of medicine or osteopathy. A Contracting Medical Group is a Medical Group that has entered into a written agreement with GlobalHealth to provide Medical Services to GlobalHealth Members.

**Medical Services**

The Medically Necessary professional services delivered by a physician, surgeon, or paramedical personnel. Medical Services that must be directed by your PCP or specialty physician and authorized by your PCP unless specified otherwise in your *Schedule of Benefits*.

**Medical Management Team**

A group of physicians from your Medical Group organized to promote appropriate and quality health care through prospective, concurrent, and/or retrospective review of Member cases. The committee allows discussion of special medical situations with colleagues. These may include consultative review of referrals to specialty physicians, referrals for Hospital admissions, review of urgent or elective Emergency Room Care, and referrals for specialty services such as diagnostic procedures, outpatient surgeries, lab, and x-ray.

**Medically Necessary**

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease, or its symptoms and that meet generally accepted standards of medicine.

**Member**

Any eligible Subscriber or Dependent of Subscriber.

**Network**

The Facilities, Providers and suppliers GlobalHealth has contracted with to provide health care services.

**Non-Preferred Provider**

A Provider who doesn't have a contract with GlobalHealth to provide services to you. You'll pay more to see a Non-Preferred Provider.

**Open Enrollment**

The time period determined by GlobalHealth and the Subscriber's employer group when all eligible employees and their eligible family members may enroll in GlobalHealth.

**Out-of-network Coinsurance**

The percent (for example, 40%) you pay of the Allowed Amount for covered health care services to Providers who do **not** contract with GlobalHealth. Out-of-network Coinsurance usually costs you more than In-network Coinsurance.

**Out-of-network Copayment**

A fixed amount (for example, \$30) you pay for covered health care services from Providers who do **not** contract with GlobalHealth. Out-of-network Copayments usually are more than In-network Copayments.

**Out-of-Pocket Maximum**

The most you pay during a policy period (usually a year) before GlobalHealth begins to pay 100% of the Allowed Amount. This limit never includes your Premium, balance-billed charges or health care costs that GlobalHealth doesn't cover. The *Schedule of Benefits* provides the Out-of-Pocket Maximum for your Plan.

**Physician Services**

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

**Plan**

A policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services

**Preauthorization**

A decision by GlobalHealth that a health care service, treatment plan, Prescription Drug or Durable Medical Equipment is Medically Necessary. This is sometimes called prior authorization, prior approval, or precertification. GlobalHealth may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise that GlobalHealth will cover the cost.

**Preferred Provider**

A Provider who has a contract with GlobalHealth to provide services to you at a discount. GlobalHealth may have Preferred Providers who are also "participating" Providers. Participating Providers also contract with GlobalHealth, but the discount may not be as great, and you may have to pay more.

**Premium**

The amount that must be paid for your GlobalHealth Plan. You and/or your employer usually pay it monthly, quarterly or yearly.

**Prescription Drug Coverage**

Plan that helps pay for Prescription Drugs and medications.

**Prescription Drugs**

Drugs and medications that by law require a prescription.

**Prevailing Rates**

See UCR.

**Primary Care Physician (PCP)**

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

**Primary Care Provider**

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse Specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

**Primary Residence**

The home or address where you actually live most of the time. A residence will no longer be considered a Primary Residence if you move without intent to return, you are absent from the residence for more than 90 consecutive days, or you are absent from the residence for more than 100 days in any 6-month period excluding full-time students at an accredited school or college.

**Primary Workplace**

The facility or location where you work most of the time and to which you regularly commute.

**Provider**

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care Facility licensed, certified or accredited as required by state law.

**Prudent Layperson**

A person without medical training who reasonably draws on practical experience when making a decision regarding whether Emergency Services are needed.

**Quality/Health Improvement Programs**

Programs and services aimed at improving your health through education, focusing on primary and secondary prevention, as well as disease management.

**Reconstructive Surgery**

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

**Rehabilitation Services**

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

**Schedule of Benefits**

Used in conjunction with your *Member Handbook*, providing benefit information specific to your Plan, including Copayment/Coinsurance information.

**Service Area**

A geographical area, as determined by the Oklahoma Insurance Department, within which GlobalHealth arranges for basic medical, Hospital, and supplemental health care services.

**Skilled Nursing Care**

Services provided in the home by or under the direction of a registered nurse.

**Skilled Rehabilitation Services**

Services provided in the home by licensed therapists (e.g., physical, occupational, speech).

**Skilled Nursing Facility**

See Extended Care Facility.

**Specialist**

A physician Specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician Specialist is a Provider who has more expertise in a specific area of health care.

**Subscriber**

A person meeting the eligibility requirements of the *Group Agreement* based on employment or association rules of the group, and for whom the appropriate Health Plan Premium has been received by GlobalHealth. When an employer pays the Premium, the Subscriber is the employee.

**Supplemental Benefit**

An optional health care benefit purchased by the employer group in addition to the basic benefits of the Plan.

**Transitional or Subacute Care**

The level of care needed by a Member who does not require Hospital acute care, but requires more intensive care than is provided to the majority of the patients in a Skilled Nursing Facility.

**UCR (Usual, Customary and Reasonable)**

The amount paid for a Medical Service in a geographic area based on what Providers in the area usually charge for the same or similar Medical Service. The UCR amount sometimes is used to determine the Allowed Amount.

**Urgent Care**

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Room Care.

[www.globalhealth.com](http://www.globalhealth.com)



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(405) 280-5600 (local) | 1-877-280-5600 (toll-free) | 1-800-522-8506 (TTY/TDD/Voice) | Effective date: 1/1/2012 | MHMOMEMHB12