

STATE OF OKLAHOMA BENEFIT PLAN 2012



schedule of **benefits**

FOR MEMBER HANDBOOK

January 1, 2012 - December 31, 2012

www.globalhealth.com



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MSBST12A

Welcome to GlobalHealth

State of Oklahoma Schedule of Benefits

Helpful Numbers and Information

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Express Scripts
 PO Box 66583
 St. Louis, MO 63166

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 1-866-274-1612

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State of Oklahoma 2012 Benefit Plans

This *Schedule of Benefits* lists Copayments and Coinsurance amounts for this specific Plan. A Copayment is a specific dollar amount associated with a benefit. Coinsurance is a percentage of the negotiated fee schedule or a percentage of the cost of a benefit if the provider is not contracted with GlobalHealth.

Benefit	Standard Option	Alternative and Wellness Alternative Plus Options
Primary Care Physician Visits	\$30 Copayment per visit	\$25 Copayment per visit
Specialist Physician Visits	\$40 Copayment per visit	\$50 Copayment per visit
X-Rays & Labs	\$0 Copayment	\$0 Copayment
Specialty Scans	\$150 Copayment per scan	\$250 Copayment per scan
Inpatient Hospital Stay	\$350 Copayment per admission	\$250 Copayment per day with \$750 maximum per admission
Outpatient Surgery	\$250 Copayment	\$250 Copayment
Emergency Room Service	\$150 Copayment waived if admitted to Hospital	\$150 Copayment waived if admitted to Hospital
Prescriptions	\$4/\$5/\$30/\$60	\$4/\$10/\$50/\$75
Annual Out-of-Pocket Maximum		
Subscriber Only	\$2,500 per calendar year	\$3,000 per calendar year
Family	\$5,000 per calendar year	\$5,000 per calendar year

GlobalHealth wants to ensure that Copayments and Coinsurance are not a barrier to receiving health care. Providing an annual Out-of-Pocket Maximum is one way GlobalHealth helps to meet this goal. 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 exceed the family annual Out-of-Pocket Maximum during the calendar year.

The annual Out-of-Pocket Maximum of the most current benefit plan applies if the Subscriber changes GlobalHealth benefit plans during the calendar year. Copayments and Coinsurance paid under the previous GlobalHealth benefit Plan within the same calendar year are applied to the current benefit Plan maximum. The Subscriber is not entitled to a refund if the current annual Out-of-Pocket Maximum is less than the previous maximum.

Copayments and Coinsurance 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 GlobalHealth's medical plan annual maximum has been reached.

Benefit Description	Standard Option	Alternative and Wellness Alternative Plus Options
Physician Services Provided - In a physician's office - In an Urgent Care Facility - For the purpose of a second surgical opinion - In the home	\$30 Copayment per PCP visit \$40 Copayment per Specialist visit	\$25 Copayment per PCP visit \$50 Copayment per Specialist visit
Lab, X-ray and Other Diagnostic Tests - Blood tests - Non-routine Pap tests - X-rays - Pathology - Non-routine mammograms	No Copayment	No Copayment
Specialized Scanning Diagnostic Exams, including, but not limited to: - CT scans - PET scans - SPECT scans - MRI - Nuclear scans	\$150 Copayment per scan	\$250 Copayment per scan
Preventive Care (Adult) Routine Screenings - Total Blood Cholesterol - Colorectal exam - Prostate Specific Antigen (PSA) - Routine Pap test Routine Mammogram - Covered for women age 35 and older - Age 35-39, one during this 5 year span - Age 40 and over, one per calendar year Routine Physical Exams - Covered one per calendar year - One well woman exam per calendar year NOTE: Physical exams required for obtaining or continuing employment or insurance, for participating in sports or recreation, or for travel are not covered. Routine Immunizations (Adult) - Including but not limited to: DPT, DT, tetanus every 10 years, oral polio, measles, mumps, rubella, and small pox NOTE: Immunizations required for work or travel are not covered.	No Copayment However, if received during an office visit other than routine physical exam, the office visit Copayment will apply	No Copayment However, if received during an office visit other than routine physical exam, the office visit Copayment will apply
Routine Basic Hearing & Vision Screening (Adult) - Covered one per calendar year	\$30 Copayment	\$25 Copayment
Preventive Care (Children) Routine Exams for Children Up To Age 21 · Eye exams to determine the need for vision correction · Ear exams to determine the need for hearing correction · Well-child visits Routine Immunizations - Routine Immunizations Childhood immunizations recommended by the ACIP including, but not limited to: Diphtheria, Haemophilus Influenza Type B, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella, Hepatitis A, and any other immunization required by state law	No Copayment However, if received during an office visit other than routine physical exam, the office visit Copayment will apply	No Copayment However, if received during an office visit other than routine physical exam, the office visit Copayment will apply
Maternity Care - Prenatal and postnatal care - Physician delivery services - Routine newborn care (during covered portion of mother's maternity stay) NOTE: If your PCP or Specialist refers you to another Provider or Facility for additional services, you will pay the Copayment applicable for the services rendered.	\$30 Copayment for entire pregnancy \$350 Copayment per Hospital admission \$0 Copayment	\$25 Copayment for entire pregnancy \$250 Copayment per day admission (\$750 maximum per Hospital admission) \$0 Copayment

Benefit Description	Standard Option	Alternative and Wellness Alternative Plus Options
Family Planning - Surgically implanted contraceptives - Injectable contraceptives, Intrauterine devices - Diaphragms	\$40 Copayment for services performed in an office setting	\$50 Copayment for services performed in an office setting
Infertility Services - Diagnosis and treatment of Infertility; basic services and fertility medications NOTE: Some Infertility treatments are limited or not covered. Please refer to <i>Member Handbook</i> for additional information.	25% Coinsurance NOTE: Office visit Copayments apply.	50% Coinsurance for basic services/fertility medications NOTE: Office visit Copayments apply.
Temporomandibular Joint Dysfunction - Medically Necessary professional and Hospital services (Lifetime non-surgical maximum of \$1,500. Surgery is under medical.)	\$50 Copayment per treatment plan	\$100 Copayment per treatment plan
Allergy Care - Testing and treatment - Injections.	\$30 Copayment per PCP visit \$40 Copayment per Specialist visit NOTE: Copayment for allergy injections \$30 applied once per 6 weeks of treatment.	\$25 Copayment per PCP visit \$50 Copayment per Specialist visit NOTE: Copayment for allergy injections \$30 applied once per 6 weeks of treatment.
Treatment Therapies Chemotherapy - Radiation therapy - Dialysis - Respiratory/ Inhalation therapy - Infusion therapy - Growth Hormone Therapy (GHT) NOTE: Cost of treatments included in office Copayment.	\$30 Copayment per PCP visit \$40 Copayment per Specialist visit	\$25 Copayment per PCP visit \$50 Copayment per Specialist visit
Physical, Occupational, Speech Therapy (in/outpatient) Limited to 60 consecutive days combined inpatient and outpatient per acute illness or injury	No Copayment for Inpatient \$40 per visit for Outpatient	No Copayment for Inpatient \$50 per visit for Outpatient
Chiropractor	\$40 Copayment per Specialist visit	\$50 Copayment per Specialist visit
Cardiac and Pulmonary Rehabilitation - Covered after heart transplant - Bypass surgery - Myocardial infarction	\$40 Copayment per visit	\$50 Copayment per visit
Foot Care - Diabetic foot care NOTE: Routine foot care is not covered for any diagnoses other than metabolic or peripheral vascular diseases such as diabetes.	\$40 Copayment per visit	\$50 Copayment per visit
Hospice Care - Supportive and palliative care in the home or hospice Facility for Members that have been diagnosed with a terminal illness, a life expectancy of 6 months or less, and has elected hospice care for such illness	No Copayment	No Copayment
Ambulance - Emergent ambulance transport - Local professional ambulance service when Medically Necessary and prior approved by GlobalHealth	No Copayment	No Copayment

Benefit Description	Standard Option	Alternative and Wellness Alternative Plus Options
<p>Durable Medical Equipment (DME)</p> <ul style="list-style-type: none"> - Hearing aids for children up to age 18, 1 per ear, every 48 months, unless Medically Necessary. - For children up to age 2, four additional ear molds may be obtained per year <p>NOTE: All other DME is not covered unless covered as a Supplemental Benefit in addition to this plan. Please consult GlobalHealth's Customer Service Department for additional information.</p>	20% Coinsurance	20% Coinsurance
<p>Orthotics and Prosthetics</p> <ul style="list-style-type: none"> - Breast prostheses and bras including replacements - Implants following mastectomy - Wigs following cancer treatment, limited to a maximum of \$150 <p>NOTE: All other Prosthetics, Replacement, and Orthotics are not covered unless covered as a Supplemental Benefit in addition to this plan. Please consult GlobalHealth's Customer Service Department for additional information.</p>	20% Coinsurance	20% Coinsurance
<p>Home Health Services</p> <ul style="list-style-type: none"> - Home Health Care ordered by a plan physician and provided by a registered nurse (RN) or home health aide for Members who are homebound or confined to an institution that is not a Hospital - Services provided by a home health agency such as oxygen therapy, infusion therapy, and injectable medication 	No Copayment	\$25 Copayment
<p>Outpatient Surgery Facility Services</p> <ul style="list-style-type: none"> - Services of an Ambulatory Surgical Center or outpatient Hospital related to surgical procedures - Includes all physician services 	\$250 Copayment	\$250 Copayment
<p>Inpatient Hospital Facility Services</p> <p>Room & board - General nursing care - Anesthesia and physician visits & services - Observation bed day in excess of 8 hours - Laboratory/Radiology/Diagnostic testing - All other Medically Necessary/authorized services - Medical supplies and equipment</p>	\$350 Copayment per admission	\$250 Copayment per day (\$750 maximum per admission)
<p>Emergency Room Services</p> <p>Emergency care at a Hospital, including</p> <ul style="list-style-type: none"> - Physician's services - All procedures including but not limited to: Lab, x-rays, scans for MRI, MRA, PET, or CAT <p>NOTE: Copayment is waived if you are admitted as an inpatient from the emergency room.</p>	\$150 Copayment	\$150 Copayment
<p>Urgent Care</p>	\$30 Copayment in PCP office \$40 Copayment in an Urgent Care Facility and all other Providers	\$25 Copayment in PCP office \$50 Copayment in an Urgent Care Facility and all other Providers
<p>Skilled Nursing Facility</p> <ul style="list-style-type: none"> - Subacute Care is limited to 100 consecutive days per calendar year - All care must be prescribed by a plan physician 	No Copayment	\$250 Copayment per day (\$750 maximum per admission)

Benefit Description	Standard Option	Alternative and Wellness Alternative Plus Options
Outpatient Mental Health	\$30 Copayment per visit	\$25 Copayment per visit
Inpatient Mental Health	\$350 Copayment per admission	\$250 Copayment per day (\$750 maximum per admission)
Chemical Dependency Substance Abuse	\$30 Copayment per outpatient visit \$350 Copayment per admission	\$25 Copayment per outpatient visit \$250 Copayment per day (\$750 maximum per admission)
Vision - One eye refraction exam per year	\$40 Copayment	\$50 Copayment
Diabetic Supplies - Diabetic self-management items including shoes, orthotics, needles, and syringes	20% Coinsurance	20% Coinsurance
Blood and Blood Products - Includes processing and administration	No Copayment	No Copayment

The services that are covered under the OK Health Wellness program are covered one time per year and include:

1. Biometric information including:
 - a. Height
 - b. Weight
 - c. Blood Pressure
 - d. Resting Pulse Rate
 - e. Hip & Waist Circumference Measurements
2. Lab Information including:
 - a. Fasting Lipid Profile (Total Cholesterol, LDL, HDL, Triglycerides)
 - b. Fasting Blood Glucose (A1C - if applicable)

The OK Health Benefit will only be available to state employees.

State of Oklahoma

Durable Medical Equipment and Prosthetic Devices

Supplemental Benefit Plan

Benefit Description	Member Responsibility - Standard and Alternative
<p>Durable Medical Equipment (DME) - Rental or purchase, at GlobalHealth's option, including repair and adjustment</p> <p>NOTE: Not all DME is covered. Please see Limitations and Exclusions listed in the supplement or consult GlobalHealth's Customer Service Department for additional information.</p>	20% Coinsurance
<p>Orthotics and Prosthetics - Artificial limbs and eyes - - Replacement prosthetics when device is beyond repair or patient has a physical change requiring a new device</p> <p>NOTE: Not all Prosthetics, Prosthetic Replacements or Orthotics are covered. Please see Limitations and Exclusions listed in this supplement or consult GlobalHealth's Customer Service Department for additional information.</p>	20% Coinsurance

I. Benefit Coverage Description

Benefits are payable for Durable Medical Equipment (DME), prosthetic devices, and orthotics when Medically Necessary for the treatment of an illness or injury, or to improve the functioning of a malformed body part. All services covered under this benefit must be authorized by your Primary Care Physician (PCP) and GlobalHealth and obtained from a participating Provider.

II. Annual and Lifetime Maximum

DME, prosthetics, and orthotics are not limited to an annual maximum or a lifetime maximum under this supplement.

III. Limitations and Exclusions

Limitations

1. GlobalHealth will determine whether the items covered under this supplement will be obtained by rental or purchase.
2. Replacement, repair or adjustments of purchased items are covered when determined to be Medically Necessary by GlobalHealth.
3. Rental equipment must be returned when it is no longer Medically Necessary.
4. Eyeglasses limited to first set of basic frames and lenses (up to \$75.00) following cataract surgery.

Exclusions

1. Comfort and convenience items
2. Mattresses and other bedding
3. Exercise equipment
4. Hygiene equipment
5. Corrective shoes, arch supports, and supportive devices for the feet
6. Experimental or research equipment, supplies, or devices
7. Equipment or devices not medical in nature
8. Hearing aids (Hearing aids for children under the age of 18 are covered under basic medical benefits.)
9. Elastic supports, corsets, or garter belts
10. Air-cleaning machines or filtration devices
11. Bed-wetting alarms
12. Breast pumps

13. Ear plugs
14. Jacuzzi/whirlpools
15. Medijector (Covered under prescription drug benefits.)
16. Orthopedic shoes (except those permanently attached to a Dennis Brown splint for children)
17. Power operated vehicles that may be used as wheelchairs
18. Braces worn for athletic or recreational use
19. Purchase or rental of supplies of common household use, including but not limited to: Physical fitness equipment, air conditioners, water purifiers, cervical or lumbar pillows, grab bars, raised toilet seats, shower benches, beds, or chairs
20. Bandages, pads, or diapers
21. DME, prosthetic devices, or orthotics for which no charge is made to you

Member responsibility Coinsurance does NOT apply toward your basic health benefit Plan Annual Out-of-Pocket Maximum.

If you have any questions or concerns regarding the benefits outlined in this supplement, please contact GlobalHealth's Customer Service Department at askcustomerservice@globalhealth.com, (405) 280-5600 (local), 1-877-280-5600 (toll-free), or 1-800-522-8506 (TTY/TDD/Voice), Monday - Friday, 9 am - 5 pm CST.

State of Oklahoma Prescription Drug Supplement

Benefit Description	Standard Option	Alternative and Wellness Alternative Plus Options
<p>Outpatient Prescription Drug Retail Pharmacy</p> <ul style="list-style-type: none"> • 31-day supply <p>NOTE: Not all prescriptions are covered. Please see Limitations and Exclusions listed in this supplement or consult GlobalHealth's Customer Service Department for additional information.</p>	<p>*\$4/\$5 Copayment Formulary generic</p> <p>\$30 Copayment Formulary brand name</p> <p>\$60 Copayment non-Formulary brand name</p>	<p>*\$4/\$10 Copayment Formulary generic</p> <p>\$50 Copayment Formulary brand name</p> <p>\$75 Copayment non-Formulary brand name</p>
<p>Outpatient Prescription Drug Home Delivery</p> <ul style="list-style-type: none"> • 90-day supply <p>NOTE: Not all prescriptions are covered. Please see Limitations and Exclusions listed in this supplement or consult GlobalHealth's Customer Service Department for additional information.</p>	<p>*\$8/\$10 Copayment Formulary generic</p> <p>\$60 Copayment Formulary brand name</p> <p>\$120 Copayment non-Formulary brand name</p>	<p>*\$8/\$20 Copayment Formulary generic</p> <p>\$100 Copayment Formulary brand name</p> <p>\$150 Copayment non-Formulary brand name</p>

***All medications included in the \$4 Copayment (low-cost generic) program are denoted with [LCG] in the Drug Formulary, also available on GlobalHealth's website.

I. Benefit Coverage Description

Benefits are payable for prescriptions prescribed by a participating physician, filled at a participating pharmacy, and received by you while you are covered for this benefit.

The formulary drug benefit will be provided for drugs contained in the current GlobalHealth *Drug Formulary*. The formulary is a continually updated list of prescription medications that represent the current clinical judgment of the Pharmacy and Therapeutics Committee, a committee comprised of physicians and pharmacists. The formulary contains FDA (Food and Drug Administration) approved brand name and generic drugs. This formulary is subject to change without prior written notice. For a copy of the current formulary you should contact Customer Service at (877) 280-5600 or visit GlobalHealth's website at www.globalhealth.com. Unless a brand name is Medically Necessary, prescriptions will be filled with a formulary generic product.

GlobalHealth may restrict the prescribing of certain drugs and medications to specific medical specialties.

II. Prescription Drug Copayment and Annual Maximum

The prescription drug Copayments are listed in the benefit table on this page. This Copayment must be met each time a prescription is filled or re-filled. You will pay the Copayment or the cost of the prescription drug whichever is less. Copayments for benefits covered under this supplemental plan are not applied toward the Standard Option or Alternative Option annual Out-of-Pocket Maximum and are not waived when the Standard Option or Alternative Option annual maximum has been reached.

III. Limitations and Exclusions

Limitations

1. Inhaler extender devices, peak flow meters, Ana-Kits, and EpiPens are limited to three (3) per calendar year.
2. Prescription diaphragms are limited to two (2) per calendar year.
3. The GlobalHealth HMO Pharmacy and Therapeutics Committee's standard quantity limits, prior authorization criteria, and step therapies apply.
4. Prescription benefits cover pharmacy vaccine Network contracted immunizations that are prescribed by a Network physician and administered at a contracted vaccine Network pharmacy Provider.
5. Specialty medications are limited to a one-month supply.
6. Smoking cessation products are limited to two (2) full 90 day courses of any FDA-approved tobacco cessation product per plan year, if prescribed by the Member's PCP. This benefit is available to Members as well as their enrolled Dependents who are at least 18 years old. The covered medications are listed in the formularies and include: Chantix™ (varenicline), Nicotrol® Inhaler (nicotine), Nicotrol® Nasal Spray (nicotine), Bupropion SR 150mg (generic for Zyban®), Bupropion 150 mg (generic for Zyban®). Over-the-counter products (such as nicotine patches and gum) are not covered.

Exclusions

1. Prescriptions that are taken by or administered to you while you are inpatient in a Facility where drugs are usually provided by the Facility.
2. Medications prescribed by non-contracting physicians.
3. Drugs or medications purchased and received before your start date of coverage or after the time coverage ends.
4. Medications available without a prescription (over-the-counter) or for which there is a non-prescription therapeutic equivalent available, even if ordered by a physician.
5. Therapeutic devices or appliances including items such as support garments, diabetic meters and pumps, and other non-medicinal substances.
6. Drugs or medicines delivered or administered by a physician or his/her staff. (Physician-administered injectable drugs are covered under your basic medical benefit.)
7. Dietary supplements including vitamins (except prenatal).
8. Saline and medications for irrigation.
9. Medications for which the cost is recoverable under any other coverage, including Workers' Compensation, Occupational Disease Law, or any state or government agency.
10. Medication for which no charge is made to the patient.
11. Experimental or non-FDA approved medications including non-FDA approved off-label use of medications. However, clinical trial non-FDA approved off-label uses of prescription drugs used in the treatment of cancer or the study of oncology is covered.
12. Elective or voluntary enhancement procedures, services, supplies, or medications, including but not limited to: Hair growth, sexual performance, athletic performance, cosmetic purposes, and anti-aging.
13. All non-prescription contraceptive jellies, ointments, foams, or devices.
14. Physician-administered injectable fertility drugs. (May be covered under basic medical benefit.)
15. Biological sera, medication prescribed for parenteral use or administration, allergy sera, immunizing agents, and immunizing injectable drugs with the exception of immunizations that are covered in number 4 of Limitations above.
16. Dietary formulas, including but not limited to those for phenylketonuria (PKU), as well as total parenteral nutrition and other enteral formulas. (May be covered under basic medical benefit.)
17. Lost or stolen prescriptions.
18. Prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia. (Sexual dysfunction drugs are covered only for post prostate surgery indications.)
19. New procedures, services, supplies, and medications until they are reviewed by GlobalHealth for safety, efficacy, and cost effectiveness and approved by GlobalHealth.

Member Responsibility Copayments do NOT apply toward your basic health benefit plan out-of-pocket maximum.

If you have any questions or concerns regarding the benefits outlined in this supplement, please contact GlobalHealth's Customer Service Department at askcustomerservice@globalhealth.com, (405) 280-5600 (local), 1-877-280-5600 (toll-free), or 1-800-522-8506 (TTY/TDD/Voice), Monday - Friday, 9 am - 5 pm CST.

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Limitations & Exclusions

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

GlobalHealth generally excludes:

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. Experimental or investigational procedures. 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 they are 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.
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. 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 under your DME supplemental benefits.)

31. Genetic testing. Genetic counseling 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) consecutive 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 and/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. Temporomandibular Joint Dysfunction is limited to a lifetime non-surgical maximum of \$1,500. (Surgery is covered under your basic medical benefit.)
47. In vitro fertilization, artificial insemination, embryo transfers, 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 not covered, 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, investigational, or unproven are not covered. Donor costs including transportation, lodging, and meals are not covered. Transplant services rendered at a non-participating transplant Facility are not covered.

GLOBALHEALTH, INC.
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION (“PHI”) MAY BE USED AND/OR DISCLOSED. PLEASE REVIEW IT CAREFULLY..

GlobalHealth, Inc. (“GlobalHealth”) is committed to protecting the privacy and confidentiality of our members’ Protected Health Information (“PHI”) in compliance with applicable federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and the Health Information Technology for Economic and Clinical Health (“HITECH”) Act.

How GlobalHealth May Use or Disclose Your Health Information

For Treatment. We may use and/or disclose your PHI to a health care provider, hospital, or other health care facility in order to provide treatment for you.

For Payment. We may use and/or disclose your PHI for purposes of paying claims from physicians, hospitals, and other health care providers for services delivered to you that are covered by your health plan; to determine your eligibility for benefits; to coordinate benefits; to review for medical necessity; to obtain premiums; to issue explanations of benefits to the individual who subscribes to the health plan in which you participate; and other payment related functions.

For Health Care Operations. We may use and/or disclose PHI about you for routine health plan operational purposes. For example, your PHI may be disclosed to members of the medical staff, risk or quality improvement personnel, and others for auditing purposes, quality of care monitoring, utilization review, regulatory compliance, internal training, accreditation, licensing, credentialing, performance improvement, etc.

Where Permitted or Required by Law. We may use and/or disclose information about you as permitted or required by law. For example, we may disclose information

- To a regulatory agency for activities including, but not limited to, licensure, certification, audits, investigations, inspections, or medical device reporting.
- To law enforcement upon receipt of a court order, warrant, summons, or other similar process.
- In response to a valid court order, subpoena, discovery request, or administrative order related to a lawsuit, dispute or other lawful process, or in the course of any administrative or judicial proceeding where required by law.
- To public health agencies or legal authorities charged with preventing or controlling disease, injury or disability.
- For health oversight activities conducted by agencies such as the Centers for Medicare and Medicaid Services (“CMS”), State Department of Health, etc.
- For national security purposes, such as protecting the President of the United States or the conducting of intelligence operations.
- In order to comply with laws and regulations related to Workers’ Compensation.
- For Medicare coordination of benefits purposes if applicable.
- When necessary to prevent or lessen a serious and imminent threat to a person or the public and such disclosure is made to someone that can prevent or lessen the threat (including the target of the threat).

Business Associates. We may use and/or disclose your PHI to business associates with whom we contract to provide services on our behalf. Examples include consultants, accountants, lawyers, auditors, etc. We will only make these disclosures if we have received satisfactory assurance that the business associate will properly safeguard your PHI.

Personal Representative. We may use and/or disclose PHI to your legal representative.

Emergencies. We may use and/or disclose your PHI if necessary in an emergency situation.

Any Other Uses. We will disclose your PHI for purposes not described in this notice only with your written authorization. You may revoke an authorization at any time, in writing, but only as to future uses or disclosures and not disclosures that we have made already, acting on reliance on the authorization you have given us or where authorization was not required.

NOTE: The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease required to be reported pursuant to State law.

Your Health Information Rights

Confidential Communication. You have the right to request Confidential Communication of your PHI. For example, you may request to receive communication from us at an alternate address or telephone number. Your request must be in writing and identify how or where you wish to be contacted. We reserve the right to refuse to honor your request if it is unreasonable or not possible to comply with.

Accounting of Disclosures. You have the right to request an Accounting of Disclosures of your PHI for purposes other than treatment, payment, or routine health operations and/or disclosures made to you or authorized by you.

Restrictions on Uses or Disclosures. You have the right to request a restriction or limitation on certain uses and disclosures of your PHI to third parties unless the disclosure is required or permitted by law. Your request must be made in writing and specify (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want the limits to apply. We are not required to honor your request. If do we agree to honor your request, we will comply except to the extent that the disclosure has already occurred or the disclosure is required by law.

Amendment of PHI. You may request an amendment to your PHI if you believe the record is incorrect or incomplete. Your request must be in writing and provide a specific explanation for the amendment. We will deny your request if the information was not created by us, is not a part of the information that you would be permitted to inspect and copy, or if the information is accurate and complete.

Right to Receive a Copy of this Notice

You have the right to receive a paper copy of this Notice upon request.

Right to Revoke Authorization

You have the right to revoke your authorization to use or disclose your PHI, except to the extent action has already been taken by us in reliance on your authorization.

Changes to this Notice

We reserve the right to change this notice and make the new provisions effective for all PHI we maintain.

To Report a Privacy Violation

If you have a question concerning your privacy rights or believe your rights have been violated, please contact our Privacy Officer at:

GlobalHealth Privacy Officer
701 NE 10th Suite 300
Oklahoma City, OK 73104-5403
Phone: (405) 280-5852 Toll-free 1-877-280-5852

You may also report a violation to the Region VI U.S. Department of Health and Human Services Office for Civil Rights, 1301 Young St, Suite 1169, Dallas, TX 75202. You will not be retaliated against for filing a complaint.

Effective Date: 04/01/2011

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www.globalhealth.com

