GlobalHealth

2016 HMO Member Handbook

For State, Education, and Local Government Employees

MHMOMH16

GlobalHealth, Inc.
701 NE 10th Street, Suite 300
Oklahoma City, OK 73104-5403
www.globalhealth.com/state

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INTRODUCTION

Welcome to GlobalHealth

We look forward to serving you! We work hard to help you get the highest quality care and service.

This *Member Handbook* will help to familiarize you with your healthcare benefits. Please read this document in full. It contains important topics about your benefit coverage. If a word or phrase starts with a capital letter, it has a special meaning in this Handbook. It is defined in the Glossary. Keep this Handbook and refer to it whenever you have a question.

You will also need to read your *Schedule of Benefits*. The *Schedule of Benefits* states the details of your Plan such as Copayment or Coinsurance amounts that you may be responsible for when using a covered healthcare service.

These two documents together explain your coverage. If you have questions after reading the *Schedule of Benefits* and *Member Handbook*, contact our Customer Care Department at:

CommercialAnswers@globalhealth.com
(405) 280-5600 (local)
1-877-280-5600 (toll-free)
1-800-722-0353 or 711 (TTY/TDD/Voice)
Monday – Friday, 9 am – 5 pm Central Time

Or you can log onto www.globalhealth.com/state for additional information on healthcare 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.

GlobalHealth, Inc. does not discriminate on the basis of race, ethnicity, national origin, religion, gender, sexual orientation, gender identity, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), source of payment, or geographic location within the service area.

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.

Helpful Numbers

Plan Issuer:
GlobalHealth, Inc.
PO Box 2393
Oklahoma City, OK 73101-2393
www.globalhealth.com/state

GlobalHealth Customer Care:
CommercialAnswers@globalhealth.com
405.280.5600
1.877.280.5600 (toll-free)
1.800.722.0353 or 711 (TTY/TDD/Voice)

Language Assistance – just ask for an interpreter:
405.280.5600
1.877.280.5600 (toll-free)
1.800.722.0353 or 711 (TTY/TDD/Voice)

24/7 Nurse Help Line:
Nurse Help Line
1.877.280.2993 (toll-free)

Disease Management:
CommercialAnswers@globalhealth.com
405.280.5600
1.877.280.5600 (toll-free)

GlobalHealth Compliance and Privacy Line:
1.877.280.5852 (toll-free)
405.280.5852
compliance@globalhealth.com

Behavioral & Mental Health/Chemical Dependency:
MHNet Behavioral Health
1.866.904.5234 (toll-free)
1.866.200.3269 (TTY/TDD/Voice)
www.mhnet.com

Mail Claims to:
Mental Health & Substance Abuse Claims
MHNet Claims Department
PO Box 7802
London, KY 40742

Pharmacy Benefits Manager:
Express Scripts Holding Company
1.866.274.1612 (toll-free)
1.800.899.2114 (TTY/TDD/Voice)

Medication Prior Authorizations:
918.878.7361

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

Mail Order Pharmacy:
Express Scripts Customer Service Center
1.866.274.1612 (toll-free)
1.800.899.2114 (TTY/TDD/Voice)
24 hours/7 days a week
www.express-scripts.com

Introduction to GlobalHealth

With GlobalHealth Inc. ("GlobalHealth"), you get a wide range of services to meet your healthcare needs. You also have access to a large Network of Primary Care Physicians ("PCPs") and Specialists.

We want your feedback. Each year we invite you to participate in surveys. They help us understand your needs and experience with GlobalHealth. We hope to exceed all your expectations and look forward to helping you reach your health goals!

Your Health

Each year, we will send you a health appraisal that asks questions about your current health. Your answers help us know how to best serve you and your healthcare needs. The information you give us will remain confidential as required by law. It will not be used against you in any way or prevent you from obtaining services and treatment.

Your Satisfaction

We distribute Member satisfaction surveys to see how well you believe your doctors and Health Plan are serving your needs. This may include:

- New Member Survey;
- Customer Satisfaction Study; and
- Consumer Assessment of Healthcare Providers and Systems ("CAHPS®").

GlobalHealth performs an audit that is approved by the National Committee for Quality Assurance ("NCQA") called [1]HEDIS® (Healthcare Effectiveness Data Information Systems). It measures the quality of preventive care our Network Providers deliver. One part of this audit is the [2]CAHPS® survey. It is very important that you complete and return it. Your answers will help us improve the quality of our Network of Providers.

Your Health Plan

Get to know us better by going online! Go to www.globalhealth.com/state to access:

- Schedule of Benefits
- Summary of Benefits and Coverage
- HMO Member Handbook
- Drug Formulary
- Provider Directory
- Wellness Program
- PCP Select/Change Request Form
- Forms
- Member Rights and Responsibilities
- Notice of Privacy Practices
- Quality Improvement Program
- Disease and Case Management
- Self-Management Tools
- Member ID Card Request

Contact Customer Care if you prefer a print version of any material at no charge.

Accessibility and Translation Services

You may receive information that is critical for obtaining health coverage or access to healthcare services in plain language and in a manner that is accessible and timely if you are an:

- Individual living with disabilities; or
- Individual with limited English proficiency.

[1]HEDIS® is a registered trademark of the National Committee for Quality Assurance ("NCQA").
[2]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality ("AHRQ").

GlobalHealth offers translation services for over 150 languages from professional certified medical interpreters at no cost to you. Contact Customer Care for help.

Our Focus:

- Being #1 in customer care.
- Effective care management that improves health outcomes and reduces healthcare costs.
- Building strong, collaborative relationships with our Providers.
- Innovative use of technology.

How to Get the Most Out of Your GlobalHealth Plan

1. **Choose a Primary Care Physician ("PCP") from the GlobalHealth Network.**
   Each family member may choose a different PCP, including a pediatrician for children. You may change your PCP selection at any time throughout the year. Your PCP change will be effective the same day. If you need to see a PCP before you receive your new Member ID card, contact Customer Care.

2. **See your PCP first for all of your medical care.**
   - Your PCP will coordinate and manage your medical care.
   - For same-day Urgent Care, call your PCP's office for medical direction.
   - After-hours, you may self-refer to a Network Urgent Care center.
   - When it's an emergency, go to the nearest Hospital emergency room. Follow these steps:
     - Show your Member ID card.
     - Call your PCP's office within forty-eight (48) hours. Tell them you were treated in the ER.
     - If you are admitted, GlobalHealth may arrange to transfer you to a Hospital in the Network.
     - All follow-up care must be provided or arranged by your PCP. Prior authorization by GlobalHealth may also be needed.
     - Be aware, an Out-of-Network Provider may balance bill you. An In-Network Provider may not balance bill you.
   - Ask which preventive services are right for you.

3. **To see a SPECIALIST, you need a Referral***
   - When appropriate, your PCP will submit a Referral on your behalf for specialty care.
   - Prior authorization from GlobalHealth is required. See "Pre-Service Authorization" on page 20.
   - When approved, you will receive a letter in the mail.
   - Make your appointment with the Specialist as directed in the letter.
   - The Specialist may submit Referrals for procedures and follow-up care after the initial visit.

4. **To go to the HOSPITAL, you need a Referral***
   - A Referral and prior authorization from GlobalHealth are required for scheduled stays.
   - You may only go to a Hospital in the Network. Follow these steps:
     - When approved, you will receive a letter of authorization from GlobalHealth.
     - Go only to the Hospital listed in the letter.
   - You do not need Preauthorization for stays in connection with childbirth. However, you must go to an In-Network Hospital.

Please Note:
Generally, Inpatient and certain Outpatient services must be prior authorized. You do not have to obtain Preauthorization for Emergency Services or stays in connection with childbirth. If you obtain other services without an authorized Referral, you will be responsible for the costs. You must go to a Network Facility for non-Emergency Services including childbirth. You may go to any emergency room, but you may be balance billed if you choose an ER that is not In-Network. See "Balance Billing by an Out-of-Network Provider" on page 62.

5. **You may SELF-REFER for the following services:**
    - In-Network obstetrical/gynecological services and well-woman exams
    - In-Network routine mammograms
    - Behavioral & mental health/chemical dependency services – Call MHNet Behavioral Health ("MHNet") directly at 866-904-5234 (toll-free)
    - In-Network routine eye exams
    - In-Network hearing and speech evaluations for children
    - In-Network physical therapy

For a list of In-Network, contracted Providers and Facilities, visit www.globalhealth.com/state or contact Customer Care.

GETTING CARE

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 medical and prescription benefits. Carry it with you at all times.

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

Services are for your personal benefit. Never lend your card to someone else. If your card is lost or stolen, please notify Customer Care immediately.

Your membership card is valid only as long as you are enrolled in the Plan. Possession of a card does not guarantee the benefits of Plan membership.

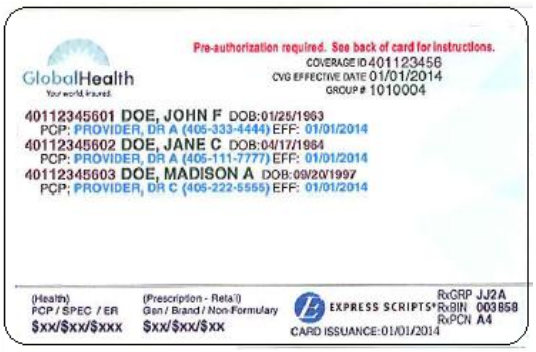
Please review your Member ID card to make sure all of the information is correct, including the name of your chosen PCP. Contact the Customer Care Department:

- If information on your card is not correct.
- If you need to order a new card.
- If you have questions about your card.

GlobalHealth Member ID Card:

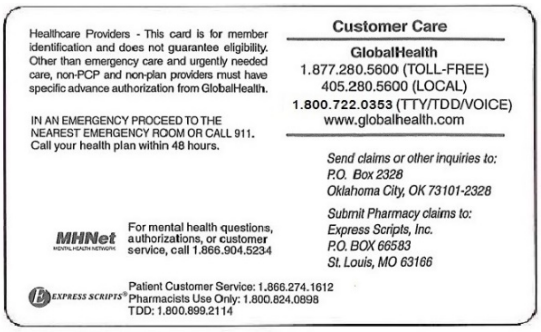
Front of Card

1. Coverage ID
2. Employer group identification number
3. Member ID number
4. The selected Primary Care Physician
5. PCP phone number
6. PCP 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 Care Department including phone number, office hours, and claims address



Choosing a Primary Care Physician ("PCP")

As a GlobalHealth Member, you must use Plan Providers for your Covered Services. This starts with choosing a PCP from the list in the *Physician & Health Providers Directory ("Provider Directory")*. The online *Provider Directory* is updated monthly. It indicates which physicians are accepting new patients. Our PCPs include doctors trained in:

- Family practice;
- General practice;
- Internal medicine; and
- Pediatrics.

Each member of the family may have a different PCP. You may choose a pediatrician for your children. Choose any PCP in our Network who is accepting new Members. A PCP will automatically be assigned to you if you do not choose one. For more information and for a list of PCPs, contact Customer Care. Information is also available on www.globalhealth.com/state.

Your relationship with your PCP is an important one. 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.

Medical Records

Once you have chosen your PCP, we recommend you have your medical records transferred to his/her office. This will make him/her aware of any health conditions you may have. Providers are required by law to protect patient medical information. You can be assured that your information will be handled with complete confidentiality.

You can find the *Oklahoma Standard Authorization To Use Or Share Protected Health Information ("PHI")* form on our website. The release form is required for requesting release of your medical records.

Referrals

Your PCP will coordinate all of your medical care. He/she will see that you get the care you need when you need it. The care may be delivered in the doctor's office or in another Facility. He/she will also submit a Referral for any specialty care or tests you may need. Most services not provided by your PCP need to be approved in advance by GlobalHealth. This process is called Preauthorization. It applies to almost all services except Emergency Room Care, after hours Urgent Care, or services for which you may self-refer. You will receive a letter once services are approved. See "Pre-Service Authorization" on page 20. You must receive this authorization letter prior to obtaining Covered Services.

Contact GlobalHealth's Customer Care Department if you need help or if you have any questions.
Email: CommercialAnswers@globalhealth.com
Call Monday - Friday, 9 am - 5 pm Central Time: (405) 280-5600 (local) 1-877-280-5600 (toll-free) 1-800-722-0353 or 711 (TTY/TDD/Voice)

Physician Credentials: How Can I Check Them?

How can I find out about a doctor's training? Information about a doctor's training and experience can usually be obtained from the doctor's office, a local medical society (if the doctor is a member), or a local Hospital (if the doctor is on staff). A few state licensing boards issue information about disciplinary actions, but getting it may be cumbersome.

Several online organizations provide easy access to various amounts of information. The American Medical Association's ("AMA") Doctor Find offers limited information on the certification status of all of the more than 814,000 medical physicians currently licensed in the United States. For more information, visit www.ama-assn.org. It does not list disciplinary actions. Searches can be done only one state at a time. This service is free of charge.

Check MDs
The Oklahoma Board of Medical Licensure and Supervision ("OMB") provides access to a physician's license and disciplinary action as well as Hospital privileges and languages spoken. For information, visit www.okmedicalboard.org. This service is free of charge.

Check DOs
The Oklahoma State Board of Osteopathic Examiners provides access to a physician's license and disciplinary action as well as Hospital privileges and languages spoken. For information, visit www.ok.gov/osboe/. This service is free of charge.

Check Specialists
The American Board of Medical Specialties ("ABMS") Certified Doctor Verification Service can be used to check whether a doctor is certified by one of the twenty-four (24) recognized specialty boards. For more information, visit www.abms.org. The searches yield no other information. All states can be searched simultaneously. This site is primarily useful for checking the certification status of a doctor whose location is unknown. Registration at the site is required, but this service is free of charge.

Changing Your PCP

If you want to change your PCP, contact Customer Care. You can email or call if you want help changing from a pediatrician to an adult care physician. You may also change your PCP on our website. The change will be effective right away. If you need to see your PCP before you receive your new Member ID card, contact Customer Care.

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

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

Be sure to ask your former PCP to send your medical records to your new PCP. It is important that your new PCP knows your medical history.

If Your PCP Leaves GlobalHealth's Network

Enrolling in GlobalHealth does not guarantee services by a particular Provider on the list of Network Providers. A Provider may no longer be part of GlobalHealth's Network. This may happen when:

- A PCP leaves GlobalHealth's Provider Network.
- A PCP is not able to be a PCP anymore.
- A PCP has a closed panel or is open to existing patients only.

We will let you know within thirty (30) days of the date we become aware that a PCP has or will be leaving our Network. We will send you a letter with the name of your newly assigned PCP. You will also get a new Member ID card in a separate mailing. If you do not want the PCP we have chosen for you, you may change at any time.

When a Provider's Contract is terminated for reasons other than cause, you may continue to see that Provider for up to ninety (90) days from the date of notice if you:

- Have a degenerative and disabling condition or disease.
- Are in the third trimester of pregnancy. Your services are covered through at least six (6) weeks of postpartum evaluation.
- Are terminally ill.

When a Provider voluntarily chooses to leave GlobalHealth's Network, you may continue an ongoing course of treatment during a transitional period. The transitional period is ninety (90) days from the date the Provider notifies GlobalHealth. You may continue to see your Provider for delivery and postpartum care if you were in the third trimester of pregnancy at the time the Provider notifies GlobalHealth. See "Continuity and/or Transition of Care" on page 57.

Seeing the Doctor

Your PCP is the person you will see first for your medical care. In most cases, your PCP will be able to take care of your medical problem.

Scheduling Appointments

When you are ready to make an appointment to see your PCP, call his or her office. The number is listed on your Member ID card.

- Call in advance for routine or health evaluation appointments. This 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. They need to prepare paperwork for your medical records. Make your first-time appointment early in the year to get established.
- Show your Member ID card.
- Pay your Copayment, if you have one, at the time of your appointment.
- If your PCP orders tests, show your Member ID card when you arrive at your appointment.
- *If you must cancel an appointment, call as far in advance as possible.*

When You Need Care Right Away - Urgent Care
Refer to the *Provider Directory* for a list of Network Urgent Care Facilities nearest you. The Directory is also available online at www.globalheath.com/state. See "Urgent Care" on page 16.

Going to the Hospital
When you need to go to the Hospital, your PCP will arrange for you to stay at a Network Hospital where he/she is on staff. To receive non-emergency services (other than for childbirth), you must have Preauthorization from GlobalHealth. Without a Referral and Preauthorization, you will be responsible for the charges.

Consultations
Your PCP may discuss special medical situations with colleagues. The team shares knowledge and experiences to recommend the best course of care for you.

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

Specialty Care

If your PCP believes a Specialist is needed to treat your medical condition, he/she will make the Referral request on your behalf.

Some PCPs are affiliated with integrated delivery systems or other Provider groups. 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 another Network Specialist.

To See a Specialist:
- See your PCP first. If your PCP believes you need to see a Specialist, he/she will submit a Referral for you.
- If you see a Specialist without an authorized Referral, you will be responsible for the charges.
- You are notified when GlobalHealth authorizes the visit. See "Pre-Service Authorization" on page 20.
- Make an appointment with the Specialist as directed in the letter. You are only approved to have the services described in the letter. Follow-up tests, services, or procedures require additional authorization.

Tests
Some tests are included in the Specialist visit authorization. You do not need separate Preauthorization for these tests performed in the doctor's office during the authorized visit:
- Routine lab work
- Ultrasound
- X-ray
- EKG

Please Note:
Any additional tests, services, or procedures require specific authorization from GlobalHealth. If you do not obtain authorization before receiving tests, services, or procedures, you may be financially responsible for payment.

Steps to Improve Your Healthcare Quality and Safety

1. Visit your PCP at least annually.
2. Have preventive care services. See "Preventive Care Guidelines" on page 45.
3. Write down your questions before your scheduled appointment.
4. Ask questions if you have any doubts or concerns regarding your treatment.
5. Keep and bring a list of all the medicines you take to each appointment. Include any over-the-counter medications.
6. Get the results of any test or procedure.
7. Talk to your doctor about all treatment options available to you. Discuss which choice is recommended for your health needs and why.
8. Make sure you understand what will happen if you need surgery.
9. Make sure you understand what will happen if you choose not to treat medical conditions.

Emergency Room ("ER") Care

An emergency involves a medical condition manifesting itself by acute symptoms of severity (including severe pain) such that a Prudent Layperson, who has an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual in serious jeopardy; (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part.

An ER visit should not be used in place of your PCP for routine services and non-emergency situations.

ER Care

1. Go to the nearest Hospital ER or call 911. You do not need Preauthorization for emergency care.
2. Show your Member ID card.
3. Call your PCP's office and GlobalHealth's Care Management Department at 405-280-5600 within 48 hours after being seen in the ER.
4. If you are admitted to the Hospital, GlobalHealth may arrange to transfer you to a Hospital in the Network.
5. ***All follow-up, preventive, or routine care after being treated in the ER*** must be:
   - Provided or arranged by your PCP.
   - Preauthorized by GlobalHealth if a Referral service. You will receive a letter in the mail once you are approved. If you need care urgently, contact the Utilization Management Department at 405-280-5600 or 1-877-280-5600.
6. If you receive ER Care, you will have one Copayment. It includes Physician Services, tests, procedures, and treatment associated with this visit. Your ER Copayment will be waived if you are admitted to the Hospital. The new Copayment will apply.
7. An Out-of-Network Provider may balance bill you. An In-Network Provider may not balance bill you. See "Balance Billing by an Out-of-Network Provider" on page 62.

Prescriptions
Fill your prescriptions at any Network pharmacy. See page 39. Pay your Copayment. Call Express Scripts Holding Company ("ESI"), go to our website, or see our *Provider Directory* for a list of Network pharmacies. Utilization Management rules may apply. See chart on page 42.

Accidents
If you are in an accident and outside the Service Area, or have no control over where you are taken, you must notify your PCP and GlobalHealth within forty-eight (48) hours. We may arrange to transfer you to a Hospital in the Network. An Out-of-Network Provider may balance bill you. An In-Network Provider may not balance bill you.

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 ER Care. An Urgent Care Facility offers an alternative when there is not an emergency and you don't have access to your PCP. It is generally less expensive than an ER visit. An Urgent Care Facility usually has immediate access. In an ER, you may have to wait longer. Urgent Care Facilities may treat simple situations such as:

- A sprained ankle
- Ear infections
- Minor burns or injuries
- Coughs, colds, sore throats

During Normal Office Hours

- 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.

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.
- You may choose to self-refer to a Network Urgent Care Facility. See the *Provider Directory*.

Out of Service 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; or
- Self-refer to an Urgent Care Facility.

Please Note:

- An Urgent Care Facility should not be used in place of your PCP for routine services and continuity of care.

- Use of Urgent Care Facilities is only for an unforeseen illness, injury, or condition that requires immediate, Medically Necessary care.
- All follow-up care must be provided or arranged by your PCP.
- Preauthorization may be necessary, depending on the care needed.
- An Out-of-Network Provider may balance bill you. An In-Network Provider may not balance bill you. See "Balance Billing by an Out-of-Network Provider" on page 62.

Self-Referral Services

As explained elsewhere in this Handbook, your PCP will coordinate the Covered Services you get as a GlobalHealth Member. But there are a few exceptions. You may self-refer to a Network Provider for the following services. You do not need a Referral from your PCP before you go.

In-Network Obstetrical/Gynecological Services and Well-Woman Exams
You do not need Preauthorization from GlobalHealth or from your PCP in order to obtain care from a Network health professional who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures including:

- Obtaining Preauthorization for certain services. You will receive a letter in the mail once your services are approved;
- Following the authorized treatment plan; and
- Following procedures for Referrals.

For a complete list of preventive services related to your well-woman exam, please see "Your Medical Benefits" on page 36, number 73, "Well-woman Exam." You may be required to pay a Copayment if you have other services that are not preventive.

GlobalHealth will only cover the costs of your care when provided by your PCP or a Network Provider specializing in obstetrics or gynecological care. You will be responsible for the cost of your care if you obtain services from an Out-of-Network Provider. For a current list of Network healthcare professionals who specialize in obstetrics or gynecology, refer to the online *Provider Directory* or contact Customer Care.

In-Network Routine Mammograms
You may self-refer to a Network imaging center for your routine mammogram. Your *Schedule of Benefits* will tell you at what age and how often your routine mammogram is covered at no cost. Check our website or contact Customer Care for a Network imaging center or Facility. You will be responsible for the cost of your mammogram if you obtain services from an Out-of-Network Provider.

Behavioral & Mental Health/Chemical Dependency Services
You may access mental health services directly by calling Mental Health Behavioral Health ("MHNet"). For more information, see "Your Behavioral and Mental Health Benefits". See page 37.

In-Network Routine Eye Exams
You may self-refer to a Network optometrist. For more information, see your *Schedule of Benefits*.

In-Network Hearing and Speech Exams
You may self-refer to a Network audiologist for your child for an evaluation only. You will need Preauthorization for any additional treatment. For more information, see your *Schedule of Benefits*.

In-Network Physical Therapy
You do not need Preauthorization from GlobalHealth or from your PCP in order to have an evaluation from a Network healthcare professional who specializes in physical therapy. The healthcare professional, however, may be required to comply with certain procedures including:

- Obtaining Preauthorization for certain services. You will receive a letter in the mail once your services are approved;
- Following the authorized treatment plan; and
- Following procedures for Referrals.

UTILIZATION AND CARE MANAGEMENT PROGRAMS

GlobalHealth has a Utilization Management ("UM") program to assist in determining:

1. The healthcare services that are covered and payable under your GlobalHealth Plan.
    - Services must be covered. Services that are listed in Limitations (see page 48) will be covered only as listed. Services that are listed in Exclusions (see page 50) are not covered.
    - Services must be Medically Necessary. That is, healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, disease, or its symptoms. Services must meet generally accepted standards of medicine.
2. The extent of such coverage and payments.
3. The appropriate level of care.

Our staff uses nationally recognized guidelines and resources, such as Milliman Care Guidelines® and Hayes®, when conducting reviews. All medical necessity determinations are made by the GlobalHealth Medical Director. The Medical Director is a licensed physician in good standing.

Pre-Service Authorization

Certain healthcare services, such as Referrals for Specialists, Hospitalization, and Outpatient surgery, require Preauthorization from GlobalHealth. There are a few exceptions, such as Hospitalization for childbirth (Network Facility) or emergencies. Otherwise, if you do not obtain Preauthorization, you will have to pay the entire cost of the services.

Please Note:

- GlobalHealth will send you a letter once services are approved. This letter will provide you with the name and contact information for the authorized doctor or Facility and the services that have been authorized. You must receive this letter before obtaining Covered Services.
- Any additional treatment, tests, or procedures beyond what is authorized require additional authorization from GlobalHealth. If you do not obtain authorization before receiving tests, services, or procedures, you may be financially responsible for payment.
- Although some services do not require Preauthorization, you must use in In-Network Providers. See "Self-Referral Services" on page 18.

Medical Authorizations

Your PCP should submit Referrals for services on your behalf. But, ultimately it is your responsibility to make sure services are authorized by GlobalHealth. "Services" includes any treatment, tests, or procedures.

Behavioral Authorizations

All behavioral, mental health, and chemical dependency services are arranged and authorized by MHNet. You do not need your PCP to contact MHNet. You can contact them directly by calling 1-866-904-5234 (toll-free) or 1-866-200-3269 (TTY/TDD/Voice).

Non-Urgent Decisions
Non-urgent pre-service decisions are made within fifteen (15) calendar days after receiving the request. This period may be extended one time by the Plan for up to fifteen (15) days if:

- It is necessary due to matters beyond the control of GlobalHealth;
- You are notified, prior to the expiration of the initial 15-day period, of why it is necessary; and
- You are notified of the date by which GlobalHealth expects to render a decision.

If such an extension is necessary because GlobalHealth does not have the information necessary to decide the claim:

- We will tell you specifically what information is needed; and,
- You will have forty-five (45) days from receipt of the notice to provide the specified information.

Urgent Decisions
Urgent pre-service decisions are made within seventy-two (72) hours after receiving the request. Your treating physician may act as your authorized representative.

Concurrent Review

GlobalHealth's review process assesses:

- The necessity for continued treatment;
- Level of care; and
- Quality of care for Members receiving Inpatient services.

Inpatient services extending beyond the authorized period require concurrent review.

If GlobalHealth has approved a course of treatment (to be provided over a period of time or number of treatments):

- Any change before the end of the course of treatments is considered an Adverse Determination. A change may be either a reduction or termination of the course of treatment. GlobalHealth will notify you in advance of the change. You will be given time to Appeal and obtain a review of that Adverse Determination before the benefit is changed. This does not apply when your Plan is amended or ended. GlobalHealth will provide continued coverage pending the outcome of an Appeal.
- You may request to extend the course of treatment beyond what is approved. GlobalHealth will notify you of the decision, whether adverse or not. You are not entitled to continued coverage pending the outcome of the request.
- Urgent concurrent review decisions are made within twenty-four (24) hours after receiving the request. GlobalHealth will notify you of the decision, whether adverse or not.

See "Appeals and Grievances" on page 67.

Discharge Planning

Transition of care management / discharge planning starts at the time of Hospital admission or when the admission is authorized. The plan may include benefits to be used upon discharge.

Services needed upon discharge may require Preauthorization to an In-Network Provider or Facility.

Post-Service Review

After you have received services, a post-service review evaluates the services rendered to identify any quality or utilization issues. It includes a retrospective review of claims submitted for payment and the corresponding medical records.

You may contact the UM Department.
During regular business hours: Monday - Friday, 9 am - 5 pm Central Time (405) 280-5600 (local) 1-877-280-5600 (toll-free) 1-800-722-0353 or 711 (TTY/TDD/Voice)
Outside of regular business hours: Leave your name and contact information and you will receive a response on the next business day. um@globalhealth.com (405) 280-5398 (FAX) (405) 819-7574 (local) 1-877-280-5600 (toll-free) 1-800-722-0353 or 711 (TTY/TDD/Voice)

Policy on Ensuring Appropriate Utilization

- GlobalHealth's Utilization Management ("UM") decision-making is based on appropriateness of care and service and existence of coverage.
- GlobalHealth does not specifically reward Practitioners or other individuals for issuing denials of coverage.
- GlobalHealth does not provide financial incentive for UM decision-makers which would encourage decisions that result in underutilization.
- GlobalHealth does not use incentives to encourage barriers to care and service.
- GlobalHealth does not make decisions regarding hiring, promoting or terminating its Practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits.

Technology Assessment Process

GlobalHealth has a technology assessment and guideline review process. It is designed to review requests for coverage of newly available devices, procedures, or treatments that are not considered established benefits.

A physician-directed committee reviews requests for approval of new technology. This includes both new technology and new application of existing technology.

The committee reviews medical and behavioral healthcare procedures, drugs, and devices using scientific medical evidence. An appropriate regulatory agency, such as the U.S. Food and Drug Administration ("FDA"), 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 investigational setting;
- Significantly improve the quality of life of the Member; and,
- Clearly demonstrate safe medical care to the Member.

Disease Management

A critical aspect of care is ongoing communication between you and your physician. Following your prescribed treatment plan, including healthy lifestyle choices, is equally important. GlobalHealth actively works to improve the health status of its Members with Chronic Conditions, supporting the patient-doctor relationship.

Targeted diseases include:

- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Coronary Artery Disease

GlobalHealth uses a patient-centered approach. This includes sending you educational letters to help you learn better health habits. These letters have information to help you slow the progress of disease. In turn, this helps you avoid unnecessary healthcare costs.

Self-refer for disease management and enroll
Website: www.globalhealth.com/state Click on Case Management under Wellness Tools and Resources
Call: (405) 280-5600 1-877-280-5600 (toll-free) 1-800-722-0353 or 711 (TTY/TDD/Voice)

Complex Case Management

Case Management is a collaborative process. A case manager works with the Provider and Member to assess, plan, and facilitate treatment options. He/she uses communication and available resources to promote quality, cost-effective outcomes.

You may self-refer or your physician may refer you for Complex Case Management
Call: (405) 280-5600 1-877-280-5600 (toll-free) 1-800-722-0353 or 711 (TTY/TDD/Voice)
Website: www.globalhealth.com/state

YOUR BENEFITS

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

Your Medical Benefits

While the following Covered Services are representative of most of GlobalHealth Plans, it is not all inclusive. Certain services may be performed in either an Outpatient department of a Hospital (Hospital-owned Facility) or in a Free-standing/Low-cost Facility. Be sure to ask when you make an appointment which type of Facility it is. Your Cost-Share may be different depending on where you receive services. For details of cost-sharing you may have, refer to your *Schedule of Benefits*. Please contact GlobalHealth Customer Care to verify if additional cost-sharing may apply.

Covered Services
The benefits described in this section are covered if they are determined to be Medically Necessary by your PCP or GlobalHealth. Most services must be preauthorized. You must receive authorization from GlobalHealth to receive services and supplies before you go. See page 18 for exceptions.

1. **Allergy Serum –**
   Allergy serum and supplies for the administration of serum are covered.
2. **Allergy Testing –**
   Services and supplies used in determining an appropriate plan for allergy treatment.
3. **Allergy Treatment –**
   Services for the treatment of allergies using an established treatment plan.
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 covered when preauthorized by GlobalHealth. Emergency ambulance transport does not require Preauthorization.

Not covered:
• Wheelchair van services • Gurney van services • Air ambulance when you do not require the assistance of medically trained personnel and can be safely transferred or transported by other means • Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered Inpatient Hospital care

5. **Anesthesia –**
   Eligible services in conjunction with a Medically Necessary procedure or surgery.
6. **Attention Deficit/Hyperactivity Disorder (ADHD) –**
   Medical management, 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. Those programs are covered by MHNet. See "Your Behavioral and Mental Health Benefits" on page 37.

7. **Autism Spectrum Disorder –**
   Autism screening is covered for children at age eighteen (18) months and twenty-four (24) months. Counseling is covered by MHNet. See "Your Behavioral and Mental Health Benefits" on page 37.

8. **Blood and Blood Products –**
   Processing, storage, and administration, including collection and storage of autologous blood. Donated blood is a non-billable item.

9. **Bone Density Test –**

Age	Benefit
Women age forty-five (45) years and older	When testing is requested by a PCP or referral physician, subject to Copayments and Coinsurance of your Plan. Reimbursement is limited to $150.00
Women age sixty (60) years and older	Routine osteoporosis screening when at increased risk for osteoporotic fractures for no Cost-Share
Women age sixty-five (65) years and older	All women for no Cost-Share

10. **Bone Marrow and Stem Cell Transplants –**
    Transplants of this nature that are not considered Experimental or Investigational are covered. Donor costs are covered only if the recipient is a GlobalHealth Member and only for transplant-related services. Transplants must be performed at a Network transplant Facility.

11. **Breast Cancer (and other breast conditions) –**

In addition to treating the condition, coverage is provided for:
• Not less than forty-eight (48) hours of Inpatient care following a mastectomy; • Not less than twenty-four (24) hours of Inpatient care following a lymph node dissection for the treatment of breast cancer; • Surgery and reconstruction of the other breast to produce symmetrical appearance; • Prostheses; and • Treatment of physical complications of the mastectomy, including lymphedema.

12. **Cardiac and Pulmonary Rehabilitation –**

Rehabilitation specific to patients with one of the following conditions:
• Recovering from heart transplant; • Recovering from bypass surgery; • Recovering from heart attack; or • Chronic obstructive pulmonary disease.

13. **Chemical Dependency –**
    Services for chemical dependency, including alcohol, Prescription Drugs, and illegal drugs. These services include diagnosis, medical treatment, and Referrals. Chemical dependency services are managed by MHNet. All care for non-emergency chemical dependency must be directed by MHNet. See "Your Behavioral and Mental Health Benefits" on page 37.

14. Chiropractic Care –

Medically Necessary manipulative therapy or other services within a chiropractor's scope of practice. Limited to fifteen (15) visits per Plan year.

15. Clinical Trials –

Routine Costs associated with an Approved Clinical Trial are covered. In order to be approved, the subject or purpose of the clinical trial must be the evaluation of an item or service that falls within a benefit category (e.g., Physician Services, diagnostic test) and not excluded from coverage (e.g., cosmetic surgery). The trial must have therapeutic intent and not designed solely to test disease pathophysiology. The trial must be sponsored by an approved organization and must be in compliance with federal regulations relating to the protection of human subjects.

Routine Costs associated with an Approved Clinical Trial include those costs that are associated with reasonable and necessary medical care typically provided absent a clinical trial. This includes costs associated with diagnosis and treatment of complications arising from participation in the clinical trial. Routine Costs do not include the cost of an investigational drug or item itself, or costs for items and services provided solely for data collection and analysis.

16. Cochlear Implant Device –

An implantable cochlear device for bilateral, profoundly hearing-impaired Members that do not benefit from conventional hearing aids. Coverage is for Members at least eighteen (18) months of age or for pre-lingual Members with minimal speech perception using hearing aids.

17. Cochlear Implant Services –

Implantation of a cochlear device that meets the coverage guidelines to receive the device.

18. Colorectal Cancer Preventive Screening –

Examination and laboratory tests for any non-symptomatic Members at least fifty (50) years of age. Members less than fifty (50) years of age are covered if at high risk for colorectal cancer as determined by your physician. Preventive screening includes the removal of polyps during the screening procedure when necessary.

19. 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 are not Complications of Pregnancy.

20. Contraception Services –

Family planning services, including:
• Contraceptive counseling • Surgically implanted contraceptives • Injectable contraceptives • Intrauterine devices • Diaphragms (insertion and/or removal) • Voluntary sterilization, limited to women only at no Cost-Share. Procedures for men covered under medical/surgical benefit with applicable Copayment.

21. Cosmetic Surgery –

See "Reconstructive Surgery" on page 35. Cosmetic surgery is limited to:
• Repair conditions resulting from an accidental injury; • Breast reconstruction following a Medically Necessary mastectomy. and

See "Reconstructive Surgery" on page 35. Cosmetic surgery is limited to:

- Improvement of the physiological functioning of a malformed body member not related to dentistry or dental processes to the teeth and surrounding tissue.

22. Dental Emergencies –

Immediate stabilization of sound natural teeth due to accident or injury is covered. All replacement, re-implantation, and follow-up care of those teeth are NOT covered, even if the teeth are not saved by emergency stabilization.

23. Dental Treatment Anesthesia –

Covered for Members who are:

- Under the age of nine (9) when he or she has a medical or emotional condition that requires Hospitalization or general anesthesia for dental care;
- For severely disabled Members;
- 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; and
- Includes Inpatient and Outpatient services required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. The dental procedure itself is not covered.

24. Diabetic Management –

Outpatient self-management training, education, and medical nutrition therapy services. These services must be provided under the direction of a Network Provider.

25. 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. Diabetic supplies including disposable needles and syringes for the administration of covered medication, test strips, and lancets, with a prescription are covered. Visual aids (talking glucometer for the blind, not eyeglasses or contact lenses) for Members who have a visual impairment that would prevent proper dosing. Any meter not provided by GlobalHealth requires Preauthorization.

26. Diagnostic Tests –

Including, but not limited to:

- Blood tests.
- Non-routine pap tests.
- X-rays/ultrasounds.
- Pathology.
- Non-routine mammograms.

Routine pap tests and mammograms are covered under Preventive Care. X-rays received from a Network Provider do not require Preauthorization.

27. Dialysis –

Acute and chronic hemodialysis services and supplies. Requires Preauthorization and must be provided by an In-Network Provider/Facility.

28. Durable Medical Equipment ("DME") –

Equipment and supplies ordered by a healthcare Provider for everyday or extended use.

Coverage for DME may include:
• Oxygen and oxygen equipment • Wheelchairs • Crutches • Blood testing strips for diabetics

DME does not include equipment, or electrical or mechanical features to enhance basic equipment, that serves as comfort or convenience. Equipment used for environmental setting or surroundings of an individual are not covered.

GlobalHealth determines whether an item is rented or purchased. All DME must be preauthorized and obtained from a Network Provider.

Repairs, maintenance, and delivery costs of equipment are covered. Repair and replacement are not covered if the equipment is lost, damaged, or destroyed due to improper use or abuse.

29. **Emergency Medications –**
Medications prescribed by an ER Provider are covered when filled at either a preferred Network pharmacy or non-preferred Network pharmacy.

30. **Emergency Services –**
Emergency Room Care is a covered benefit. An emergency is a medical condition manifesting itself by acute symptoms of severity (including severe pain) such that a Prudent Layperson, who has an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual in serious jeopardy; (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part. This includes evaluation of an emergency medical condition and treatment to keep the condition from getting worse. Emergency Services do not require Preauthorization. An Out-of-Network Provider may balance bill you. An In-Network Provider may not balance bill you. See "Balance Billing by an Out-of-Network Provider" on page 62.

31. **Eyeglasses –**
First set of basic frames and lenses following cataract surgery up to the maximum allowance of $100. Also see "Limitations and Exclusions" on page 48.

32. **Foot Care (Routine) –**
Limited to Members with a diagnosis of diabetes or peripheral vascular disease.

33. **Health Education Services and Programs –**
Wellness services and disease management programs for:

Wellness Services	Disease Management Programs
• Asthma • Behavioral Health • Diabetes • Obesity • Smoking Cessation	• Chronic Heart Failure • Chronic Obstructive Pulmonary Disease • Coronary Artery Disease

Additional resources are on our website.

34. **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 (two molds for each ear).

Replacement parts and repairs are also 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.

Hearing aid accessories or supplies (including remote controls and warranty packages) are not covered.

35. Hearing Screening –

Hearing screenings are covered for no Cost-Share for children up to the age of eighteen (18).

36. Home Healthcare –

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 Healthcare services. Limited to 100 visits per Plan year.

37. 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 your interdisciplinary team which includes, but is not limited to: you; your 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 • 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

38. Hospitalization –

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

Coverage includes:
• Room and board • General nursing care • Anesthesia and physician visits/services • Laboratory/radiology/diagnostic testing • Medical supplies and equipment • All other Medically Necessary preauthorized services

39. Immunizations –

Immunizations for children and adults are covered, when appropriate, following the recommendation of the Advisory Committee on Immunization Practices ("ACIP") of the Centers for Disease Control and Prevention or as required by law. Immunizations for travel, work, sports, or recreation are not covered.

40. Infertility Services –

Diagnosis, testing, and medication dispensed by a Network physician for the treatment of Infertility are covered. Treatment for men and women is covered. Oral and self-injectable fertility drugs subject to prior authorization to confirm diagnosis.

Infertility Services not covered:
• In Vitro Fertilization ("IVF") • Intracervical insemination ("ICI") • Gamete Intrafallopian Transfer ("GIFT") • Zygote Intrafallopian Transfer ("ZIFT") • Services associated with these procedures • Genetic counseling and genetic screening • Insemination procedures and all services related to insemination • Reversal of a sterilization procedure • Cost of donor sperm or donor egg • Cryopreservation or storage of sperm (sperm banking), eggs, or embryos

41. Infusion Therapy –

The therapeutic use of drugs or other substances that are prepared and administered by a Network Provider through a needle or catheter are covered. Your PCP must authorize these services.

Infusion services must be provided in:
• The home; • A free standing clinic or doctor's office; • A Hospital; • A Skilled Nursing Facility; or • A rehabilitation Facility.

42. Injectable Drugs –

Outpatient Injectable Medications and Self-Injectable Medications
• Injectable drugs given in the physician's office are covered when part of the medical office visit. • Self-injectable drugs are covered at the applicable pharmacy Cost-Share when the drug has been prescribed by a Network Provider.

43. Laboratory Services –

Medically Necessary diagnostic and therapeutic laboratory services are covered when provided by a Network laboratory. Non-emergent diagnostic or laboratory testing by a non-network laboratory are covered only when preauthorized.

44. Mammogram (routine) –

Not subject to Preauthorization when provided by a Network Provider. Non-routine mammograms require Preauthorization. 3D mammograms are not covered.

Age Range	Frequency
Women between the ages of 35 and 40	One routine mammogram during this 5-year span
Women over the age of forty (40)	One routine mammogram annually (every 12 months)

45. 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 healthcare Provider whose scope of practice includes providing postpartum care is also covered.

Services are not subject to Preauthorization.

Prenatal care includes:	Inpatient care and/or visits include:
• Routine obstetric care; • Screening for gestational diabetes; • Routine lab work; and • Routine ultrasounds.	• Physical assessment of the mother and the newborn infant; • Parent education; • Training or assistance with breast or bottle feeding; and • Performance of any Medically Necessary and appropriate clinical tests.

Breastfeeding supplies limited to purchase or rental of breast pump from an In-Network supplier with Preauthorization. Limited to one pump per year for women who are pregnant and/or nursing. Contact Customer Care for a list of Network suppliers.

When the maternity care is for a Dependent child, coverage is only for the mother. Children born to Dependent children do not have coverage.

46. Medical Supplies and Materials –

Medical supplies and materials used in the course of an office visit such as:
• Gauze • Ointments • Bandages • Slings

These materials are generally not covered for any other purpose. Over-the-counter items are not covered.

47. Mental/Behavioral Health Services –

Includes both Inpatient and Outpatient care managed by MHNet. See "Your Behavioral and Mental Health Benefits" on page 37.

48. Newborn Services –

Routine newborn care is covered in the Hospital under the mother's maternity benefit as described in #45 above. Newborns hospitalized beyond the 48/96 hour approved mother's stay

will have a separate Inpatient Hospital Cost-Share. The newborn will have coverage for Medically Necessary services for up to the first thirty-one (31) days of life. However, if the newborn is not enrolled in the Plan, coverage will automatically end after the thirty-one (31) days.

49. Obesity Screening and Counseling –

- 12 – 26 sessions in the first year
- Group and/or individual sessions
- Help Members make healthy eating choices
- Address barriers to change
- Help Members monitor behavior
- Help Members maintain physical activity

50. Oral and Maxillofacial Surgery –

- Biopsy and excision of cysts or tumors of the jaw;
- Treatment of malignant neoplastic disease;
- Tooth extraction prior to a major organ transplant; and
- Radiation of the head or neck, and non-dental surgical treatment procedures for congenital defects.

Medically Necessary surgical procedures occurring within or adjacent to the oral cavity are covered. Surgery primarily for dental purposes is not covered.

Orthognathic surgery is covered when it is determined to be Medically Necessary. There should be sufficient clinical documentation to support:

- The malocclusion is affecting the patient's physical health, not just dental health;
- The malocclusion has not been amenable to other standard and less invasive forms of treatment; and
- Other medical problems such as difficulty swallowing, speech abnormalities, malnutrition related to inability to chew, and/or significant intraoral trauma that produce significant inability to function.

51. Outpatient Surgery –

Same day surgical procedures performed in an Outpatient surgical Facility as a substitute for Inpatient care. It may be performed in either an Outpatient surgical department of a Hospital (Hospital-owned Facility) or in a Free-standing/Low-cost Facility. Your Cost-Share may be different depending on where you receive services.

52. Phenylketonuria ("PKU") Testing and Treatment –

Medically Necessary and authorized services to:

- Diagnose and treat PKU;
- Prevent the onset of serious medical and mental disabilities; and
- Promote normal development or function as a result of PKU enzyme deficiency.

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

53. Physical Therapy –

Evaluation by a licensed physical therapist at regular Cost-Share without a Referral or Preauthorization. The physical therapist may submit a Referral request for up to thirty (30) days of treatment. Services beyond the thirty (30) days require a physician's Referral and

GlobalHealth's authorization. All physical therapy visits count toward the total combined physical, occupational, and speech therapy visit limits for Rehabilitation Services.

54. **Physician Services –**
Diagnostic and treatment services provided by your PCP. PCP-authorized services of a Specialist are covered. Services provided by physicians in Inpatient, Outpatient, ER, and observation settings are covered subject to necessary referrals and authorizations. See appropriate sections for requirements.

55. **Prescription Drugs –**
Drugs and medications that by law require a prescription. See "Your Prescription Drug Benefits" on page 39.

56. **Preventive Care –**
Evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF"). Evidence-informed exams, screenings, immunizations, and counseling in the comprehensive guidelines 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. See "Preventive Care Guidelines" on page 45.

57. **Prostate Cancer –**
In addition to treating the condition, screening is covered.

58. **Prosthetics and Orthotics –**
Orthotics are ONLY covered for Members with diagnoses pertaining to peripheral vascular disease or diabetes.

The following guidelines must be followed:
• Prosthetics must be Medically Necessary as determined by your PCP or GlobalHealth. • Bionic and myoelectric prosthetics are not covered. • Replacements, repairs, and adjustments to prosthetics are covered. Coverage is 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 and by GlobalHealth.

59. **Radiation Therapy –**
Standard and complex radiation is covered.

60. **Radiology Services –**
Standard x-rays for the diagnosis of an illness or injury. Standard x-rays from a Network Provider do not require Preauthorization.

61. **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.

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;

This benefit is limited to:
• Trauma, infection, tumors, or disease; and • Reduction mammoplasty if Medically Necessary.

62. Rehabilitation Facility –
A non-Hospital Facility that specializes in physical, speech, and/or occupational therapy.

63. Rehabilitation Services –
Services and devices provided by a registered physical, speech, or occupational therapist for the treatment of an illness or injury. Limited to sixty (60) visits, combination of physical, occupational, and speech therapies per course of therapy. Massage therapy is covered if provided during physical therapy, but is not covered if billed as a separate service.

64. Severe Mental Illness –
Illnesses, defined by the American Psychiatric Association as "Severe Mental Illness", are covered as a standard medical benefit. Inpatient or Outpatient Medically Necessary services authorized by MHNet will be covered as any other illness.

These diagnoses include, but are not limited to:
• Schizophrenia • Bipolar Disorders • Major Depressive Disorders • Schizo-affective Disorders • Pervasive Developmental Disorders • Obsessive-Compulsive Disorders

65. Skilled Nursing Care –
Care prescribed by a Plan doctor and performed in a Skilled Nursing Facility. Limited to 100 days per Plan year.

66. Sleep Studies –
Tests that measure how well you sleep and how your body responds to sleep problems. These tests can help your doctor find out whether you have a sleep disorder and how severe it is.

67. Specialized Scans, Imaging, and Diagnostic Exams –
Including, but not limited to: CT scans, PET scans, SPECT scans, MRIs, nuclear scans, and sleep studies. Your Cost-Share may be different depending on where you receive services. Must be obtained from a Network Provider.

68. Transplants –
Medically Necessary organ transplants and bone marrow transplants which are not Experimental or Investigational in nature. Transplant costs for the donor and recipient are covered when the recipient is a GlobalHealth Member. Transplants must be performed at an In-Network transplant Facility.

69. Treatment Therapies –

- Chemotherapy;
- Radiation therapy;
- Dialysis;
- Respiratory/inhalation therapy;
- Infusion therapy; and

- Growth Hormone Therapy ("GHT").

70. Urgent Care –

Services received in an Urgent Care Facility. You may go to an Out-of-Network Urgent Care Facility for the same Copayment under certain circumstances. However, an Out-of-Network Provider may balance bill you. An In-Network Provider may not balance bill you. See "Urgent Care" on page 17.

71. Vision –

You may self-refer to a Network optometrist for one eye exam with refraction per Plan year. Coverage for contact lenses is excluded. Eyeglasses limited to first set of basic frames and lenses (up to $100) are covered for adults following cataract surgery.

72. Well-child Care –

Routine child health services are covered at:

- Birth, two months, four months, six months, nine months, twelve months in the first year;
- 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.

73. Well-woman Exam –

Each service is covered once per calendar year. Multiple visits may be required to obtain all recommended services as determined by your physician. Not subject to Preauthorization when provided by a Network Provider. Non-routine tests require Preauthorization and a Copayment.

Services including, but not limited to:

- Routine pap test
- Human papillomavirus ("HPV") testing
- Counseling for sexually transmitted infections
- Counseling/screening for HIV
- Contraceptive methods and counseling
- Counseling/screening for interpersonal and domestic violence

74. Wigs –

Wig or other scalp prostheses necessary for the comfort and dignity of the Member are covered when required due to loss of hair resulting from chemotherapy or radiation therapy. Subject to the same annual Copayments or Coinsurance limits as established for all other covered benefits under the Plan. Benefit limited to $150 annually.

Your Behavioral and Mental Health Benefits

Members access mental health services by calling MHNet.

Call MHNet Behavioral Health
1-866-904-5234 (toll-free) 1-866-200-3269 (TTY/TDD/Voice)

If you are currently receiving mental health or substance abuse care, please call MHNet as soon as possible. The staff will assist you in finding the MHNet Provider who is right for you.

MHNet will manage, authorize (for services that require prior authorization), and arrange all Inpatient and Outpatient care for:

- Mental and behavioral health;
- Chemical dependency; and
- Substance abuse.

Additional services available through MHNet include:

- Crisis intervention.
- Referrals to community resources and self-help groups.
- Help in locating a Provider.

You do not need to go through your PCP. But, you must call MHNet to receive a Referral for any Inpatient or Outpatient behavioral and mental health services and most Hospital-based services. Most routine Outpatient services for behavioral and mental healthcare do not require prior authorization. MHNet is available twenty-four (24) hours a day, seven (7) days a week to assist you.

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. It 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.

Treatment Setting	**Benefit Description**
Outpatient Therapy	Non-emergent therapy that may include medication management, therapy, and/or psychiatric testing. Standard therapy session or medication management does not require Preauthorization from MHNet. Other Outpatient therapy requires Preauthorization from MHNet.
Intensive Outpatient Program	Treatment multiple times a week for a predetermined number of hours a day, depending on treatment plan. Requires Preauthorization from MHNet.
Partial Hospitalization (Day Treatment)	Treatment multiple times a week for a predetermined number of hours a day, depending on treatment plan. This treatment requires

Treatment Setting	Benefit Description
	more days and/or hours per day than an intensive Outpatient program. Requires Preauthorization from MHNet.
Residential Treatment Center	Non-acute Inpatient program. Requires Preauthorization from MHNet. Limited to 100 days per Plan year.
Acute Hospitalization	24-hour Inpatient program. Requires Preauthorization from MHNet.

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 Network Provider. Any treatment Facility must be contractually affiliated with a Hospital.

myStrength.com. The health club for your mind.™
An online wellness portal to help you improve your mental health and overall well-being. It is available 24/7. Go to www.mhnet.com.

- Complete your free wellness assessment and profile.
- myStrength.com will deliver a structured week by week action plan tailored to your needs and specifications.
- Powerful eLearning modules lead you towards rediscovering your inner peace and mental well-being.

Release of Mental Health Information
GlobalHealth encourages coordination of care between mental health services and your PCP. It is important to discuss the release of your medical information with the mental health Provider or Facility. You may elect not to sign a release. However, it is important that your PCP knows about services that you have received, particularly if medications were prescribed. Your PCP will be able to check for potentially dangerous interactions of medications. The *Oklahoma Standard Authorization To Use Or Share Protected Health Information* release form is on our website.

Mental Health Emergencies
Call 911 if you need emergency treatment. Preauthorization is not required. Contact MHNet or have the ER Provider contact MHNet as soon as reasonably possible. An Out-of-Network Provider may balance bill you. An In-Network Provider may not balance bill you. See "Balance Billing by an Out-of-Network Provider" on page 62.

Your Prescription Drug Benefits

Your Prescription Drug benefit covers Outpatient, self-administered medications that require a prescription. "Prescription" refers to an order written by any licensed physician, or others licensed to prescribe for a medicinal substance which, under the Federal Food, Drug, and Cosmetic Act ("FD&C Act"), is required to bear on the packaging label the following legend: "Caution: Federal law prohibits dispensing without a prescription" or "Rx Only".

The Affordable Care Act requires some over-the-counter medications be covered. Please see the "Affordable Care Act" section on page 41.

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 *Provider Directory* and on the website at www.globalhealth.com/state. You may also contact Customer Care for help in locating a pharmacy.
2. Present your Member ID card to the pharmacist.
3. Pay the applicable Copayment or Coinsurance.

Preferred and Non-Preferred Retail Network Pharmacies

When you purchase your prescriptions at a preferred retail Network pharmacy, you will pay your Plan's published Cost-Share for each tier. This is where you will experience the greatest savings. You may still go to non-preferred retail Network pharmacies, but you will pay a higher Cost-Share for each prescription. A list of both preferred and non-preferred retail Network pharmacies can be found on www.globalhealth.com/state.

Home Delivery Pharmacy Service

ESI offers the convenience of home delivery. Maintenance medications are mailed to your home in a 90-day supply when prescribed as a 90-day supply by a Network Provider. You may receive a discount on your medications, depending on the drug tier. See your *Schedule of Benefit*s. Allow fourteen (14) days for your prescription to reach you.

For more information about this optional service, contact ESI.
Contact Express Scripts Customer Service: Representatives are available 24 hours a day, 7 days a week. 1-866-274-1612 (toll-free)
Visit the website: www.express-scripts.com

Extended Supply Retail Pharmacy Network

You may receive up to a 90-day supply of a maintenance drug at an extended supply retail Network pharmacy for the applicable home delivery Copayment. Medications must be prescribed as a 90-day supply by a Network Provider. You will pay your home delivery Copayments or Coinsurance. An extended supply retail Network pharmacy can be found on www.globalhealth.com/state.

Sovereign Medical Solutions Medications by Mail

Sovereign Medical Solutions is a Native American-owned retail pharmacy located in Oklahoma. It provides prescription medications to Native Americans. Complete the *Native American Prescription Benefit Program Patient Enrollment* form available on www.globalhealth.com/state 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, you can receive Cost-Share discounts. Medications are mailed directly to your home or designated location.

Specialty Pharmacies

Contracted specialty pharmacies fill your specialty medications and mail them to your home. Specialty medications sent to and administered by your doctor are covered under your office visit cost-sharing responsibility. Specialty medications sent to and administered by you are assessed your

Prescription Drug Copayment. A specialty Network pharmacy can be found on www.globalhealth.com/state.

GlobalHealth's Preferred Formulary Drug List

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 FDA.

The list of drugs is subject to change.

- New medications may be introduced or a generic may become available.
- Coverage will not be discontinued or reduced for a drug except:
  - when a new or lower cost therapeutic equivalent medication becomes available; or
  - when new adverse information about the safety or effectiveness of a drug is released.
- If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher tier, we will notify affected Members of the change at least sixty (60) days before the change becomes effective.
- If the FDA deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, the drug will be removed immediately from our formulary and you will be notified.

GlobalHealth's Pharmacy and Therapeutics Committee excludes some Prescription Drugs from coverage because other therapeutic equivalents are considered:

- Clinically safe;
- Having fewer health risks; and/or
- Providing a reduction in overall healthcare costs.

A 60-day notice of exclusion will be listed on the GlobalHealth website prior to the exclusion becoming effective.

You can find additional information about the *Drug Formulary* on our website or by contacting Customer Care.

Drug Tiers

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

Tier Level	Benefit Description
Tier One	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 Cost-Share for select, low-cost generics. All other generics in this tier have a higher Cost-Share. Please refer to your *Schedule of Benefits*.
Tier Two	Preferred brand name medications on the formulary have the next highest Copayment.
Tier Three	Non-preferred medications have the highest of these three (3) generic and brand name tiers. This tier contains non-preferred name brand and specified high-cost generic drugs.

Tier Level	Benefit Description
Tier Four	Preferred and non-preferred specialty medications are filled through a specialty pharmacy. Specialty drugs are limited to no more than a one-month supply per fill. These medications must be pre-approved by GlobalHealth. Refer to your *Schedule of Benefits*.

The Cost-Share for orally administered anticancer medications is no greater than for IV-administered or injected cancer medications.

The *Drug Formulary* will tell you which tier a drug is in. The Cost-Share for each tier remains the same for the entire Plan year. During the Plan year, individual drugs may move to a different tier. The new tier Cost-Share will apply after the 60-day Member notice. The *Drug Formulary* is available on our website. Please contact Customer Care for a printed copy.

The applicable Copayment must be paid each time a prescription is filled or refilled. You will pay your Cost-Share or the cost of the drug, whichever is less.

Affordable Care Act – No Cost-Share Drugs
Some FDA-approved over-the-counter ("OTC") medicines and products are covered at no Cost-Share.

Medicine or Product	Eligible Population
Iron supplements	For children from birth - 12 months
Oral fluoride supplements	For children from birth - 5 years
Folic acid supplements	For women of childbearing age
Aspirin	For men age 45 - 79 and women age 55 – 79 For women at increased risk of preeclampsia after twelve (12) weeks gestation
*Tobacco cessation products	For adults age eighteen (18) and older
Vitamin D supplement	For adults age sixty-five (65) and older

*See the *Drug Formulary* for a list of covered medications. Not all products that may be used for tobacco cessation are included.

Doctors may prescribe risk-reducing medications, such as tamoxifen or raloxifene, for women who are at increased risk for breast cancer and at low risk for medication side effects. These medications are available at no Cost-Share, subject to reasonable medical management.

To receive benefits, you must use an In-Network retail pharmacy and present a written prescription from your physician to the pharmacist. Benefits are limited to recommended prescribing limits.

Contraception Drugs and Devices for Women
Selected FDA-approved contraception prescriptions are provided to women of childbearing age for no Cost-Share. All others are subject to prescription Copayment and possible Utilization Management. Over-the-counter contraceptives are only covered when they are FDA-approved and

prescribed by a Network physician. See the *Drug Formulary* for a list of prescription contraceptives available for no Cost-Share.

Prior Authorization, Step Therapy, Quantity Limits, and Exceptions
Your Plan may include Utilization Management. These programs are based on current medical findings, FDA-approved manufacturer labeling information, cost, and manufacturer rate agreements.

Medication Utilization Management
Call 918-878-7361 to request information on one of the following:

Type	Description
Prior Authorization	Physicians are required to obtain prior authorization for certain medications, including *compound drugs. This promotes appropriate, cost-effective use. Any corresponding supplies or equipment also require prior authorization. GlobalHealth may not cover the drug, supply, or equipment 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.
Quantity Limits	There are limits to the amount of certain medications that you may receive. These drugs, if taken inappropriately for too long a time period, could be unsafe and cause adverse effects.

*See our *Drug Formulary* for our policy on compound drugs.

Exception Requests
Call (918) 878-7361 to request an exception.

Time Frame	Process
Standard Exception	You can request GlobalHealth to waive coverage restrictions and limits. You may submit your request in writing, electronically, or telephonically. Generally, GlobalHealth will only approve your request for an exception if: • The alternative drug is included on the Plan's formulary. • The drug in the lower tier or additional utilization restrictions would not be as effective in treating your condition. • It would cause you to have adverse medical effects. In the case of a request to cover a non-formulary drug, the physician must include: • A justification supporting the need for the non-formulary drug to treat your condition; and • A statement that all covered formulary drugs on any tier will be or have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects.

Time Frame	Process
	You, your designee, or your physician should contact GlobalHealth for instructions on obtaining a utilization restriction exception. Your physician may have to submit a prior authorization request form with supporting information. Generally, a decision is made within seventy-two (72) hours of receiving your request and sufficient information to begin the review. • If granted, the exception will be for the duration of the prescription, including refills. • If GlobalHealth denies your exception request, you may request an External Review. You will receive the Oklahoma Insurance Department's ("OID's") determination within seventy-two (72) hours of receiving your request for review. Your medication will be covered during the time GlobalHealth is reviewing, and if applicable, during the External Review.
Expedited Exception	You, your designee, or your prescribing physician may request an expedited exceptions process when: • You are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or • You are undergoing a current course of treatment using a non-formulary drug. We will provide a decision to you, your designee, or the prescribing physician within twenty-four (24) hours after receiving the request and sufficient information to begin the review. • If granted, the exception will be for the duration of the prescription, including refills. • If GlobalHealth denies your exception request, you may request an External Review. You will receive the OID's determination within twenty-four (24) hours of receiving your request for review. Your medication will be covered during the time GlobalHealth is reviewing, and if applicable, during the External Review.

Transition of Care

If you are new to GlobalHealth, you may request coverage for:

- Non-formulary medications; or
- Medications on the formulary that require prior authorization or step therapy.

You must make the request within the first thirty (30) days of Enrollment. The coverage is for only one (1) 30-day prescription fill per medication. You are encouraged to work with your physician and the Pharmacy Department as soon as possible to transition to GlobalHealth's *Drug Formulary*. Contact Customer Care for more information.

Complete the *Transition of Care Request Form - Prescriptions*. It is on page 82, on our website, or you can contact Customer Care.

Off-label Uses
Off-label uses of medication(s) used in the treatment of cancer or the study of oncology are covered. Certain investigational uses of chemotherapy for cancer treatment may be covered if administered as part of an Approved Clinical Trial.

GlobalHealth does not cover any other non-FDA approved off-label utilization of medications or medical devices. This exclusion includes non-FDA approved:

- Indication;
- Dosage;
- Length of therapy;
- Safety and efficacy standards within clinical studies; and
- Warnings, precautions, and potential serious drug interactions.

Prescriptions Received in an Emergency Room or Urgent Care Facility
Medications prescribed by ER physicians may be filled at a Network pharmacy. You will pay your pharmacy Cost-Share. Utilization Management rules may apply.

Pharmacy Coordination of Benefits
If you are covered by more than one Health Plan, we will coordinate your prescription benefits. Give both Prescription Drug cards to the pharmacy staff and tell them which is primary. The pharmacy staff will enter the information for both the primary and secondary coverage. The primary coverage will apply your Cost-Share. Then the secondary coverage will be billed the remaining Cost-Share.

Medication Therapy Management Program
If you are taking multiple medications for Chronic Conditions, you can receive support from our Medication Therapy Management program. You receive personalized service from registered pharmacists and staff. The goals of this program are:

- To help eliminate duplicate drug therapies;
- To reduce potential for negative drug interactions and side effects; and
- To optimize Member benefits by advising of the lowest cost alternatives.

Preventive Care Guidelines

Covered Services include exams, evaluations, immunizations, screenings, and tests for:
• Prenatal and perinatal care • Care for infants, children, and adolescents • Care for adults • Geriatric care

The following preventive services are covered without you having to pay a Copayment or Coinsurance. NOTE: This applies only when these services are delivered by a Network Provider.

You may be required to pay your normal Cost-Share if the service is for treatment rather than preventive screenings. Services are preventive when there are no prior symptoms. Services are for treatment purposes when you are having symptoms or you have been diagnosed with a particular condition. You may go to your PCP for one annual routine physical regardless of prior diagnoses.

For more detailed information on each service below, see the USPSTF website, http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

Not everyone needs every preventive service. Your PCP will determine which services are right for you.

Covered Preventive Services for Adults:

- Abdominal aortic aneurysm one-time screening for men of specified ages who have ever smoked;
- Alcohol misuse screening and counseling;
- Aspirin use for men and women of certain ages;
- Blood pressure screening for all adults;
- Cholesterol screening for adults of certain ages or at higher risk;
- Colorectal cancer screening for adults over age fifty (50);
- Depression screening for adults;
- Type 2 diabetes screening for adults with high blood pressure;
- Diet counseling for adults at higher risk for chronic disease;
- Falls prevention counseling and preventive medication for adults age sixty-five (65) and older;
- Healthy diet and physical activity counseling for adults with high risk of CVD;
- Hepatitis B screening for adults at high risk for infection;
- Hepatitis C virus infection screening for adults at high risk and one-time screening for adults born between 1945 and 1965;
- HIV screening (testing) for all adults to age sixty-five (65);
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:

Hepatitis A
Hepatitis B
Herpes Zoster (Shingles)
Human Papillomavirus (:HPV")
Influenza (Flu Shot)
Measles, Mumps, Rubella ("MMR")
Meningococcal (Meningitis)
Pneumococcal (Pneumonia)
Tetanus, Diphtheria, Pertussis ("TDaP")
Varicella (Chicken Pox)

- Lung cancer screening for adults ages 55 - 80 years who have a thirty (30) pack-year smoking history;
- Obesity screening and counseling for all adults;
- Sexually transmitted infection ("STI") prevention counseling for adults at higher risk;
- Syphilis screening for all adults at higher risk; and

- Tobacco use screening for all adults and cessation interventions for tobacco users.

Covered Preventive Services for Women, Including Pregnant Women:

- Anemia screening on a routine basis for pregnant women;
- Aspirin as preventive medication after twelve (12) weeks of gestation in women who are at high risk for pre-eclampsia.
- BRCA counseling about genetic testing for women at higher risk
- Breast cancer mammography screenings every 1 - 2 years for women over age forty (40);
- Breast cancer chemoprevention counseling for women at higher risk;
- Breastfeeding comprehensive support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women;
- Cervical cancer screening for sexually active women;
- Chlamydia infection screening for younger women and other women at higher risk;
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
- Domestic and interpersonal violence screening and counseling for all women;
- Folic acid supplements for women who may become pregnant;
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;
- Gonorrhea screening for all women at higher risk;
- Hepatitis B screening for pregnant women at their first prenatal visit;
- HIV screening (testing) and counseling for all pregnant women;
- HP) DNA test every three years for women with normal cytology results who are age thirty (30) or older;
- Osteoporosis screening for women over age sixty (60) depending on risk factors;
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
- STI counseling for sexually active women;
- Syphilis screening for all pregnant women or other women at increased risk;
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users;
- Urinary tract or other infection screening for pregnant women; and
- Well-woman visits to obtain recommended preventive services for women under age sixty-five (65).

Covered Preventive Services for Children:

- Autism screening for children at ages 18 and 24 months;
- Behavioral assessments for children at ages 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years;
- Blood Pressure screening for children at ages 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years;
- Cervical Dysplasia screening for sexually active females;
- Congenital Hypothyroidism screening for newborns;
- Dental caries screening for children from birth through age five (5);
- Depression screening for adolescents;

- Developmental screening for children under age three (3), and surveillance throughout childhood;
- Dyslipidemia screening for children at higher risk of lipid disorders at ages 1-4 years, 5-10 years, 11-14 years, 15-17 years;
- Fluoride Chemoprevention supplements for children without fluoride in their water source;
- Gonorrhea preventive medication for the eyes of all newborns;
- Hearing screening for all newborns;
- Height, Weight and Body Mass Index measurements for children at ages 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years;
- Hematocrit or Hemoglobin screening for children;
- Hemoglobinopathies or sickle cell screening for newborns;
- HIV screening for children age fifteen (15) and older and younger adolescents at higher risk;
- Immunization vaccines for children from birth to age eighteen (18) —doses, recommended ages, and recommended populations vary:

Diphtheria, Tetanus, Pertussis ("TDaP')
Haemophilus influenzae type b ("Hib")
Hepatitis A
Hepatitis B
Human Papillomavirus ("HPV")
Inactivated Poliovirus (Polio)
Influenza (Flu Shot)
Measles, Mumps, Rubella ("MMR")
Meningococcal (Meningitis)
Pneumococcal (Pneumonia)
Rotavirus ("RV")
Varicella (Chicken Pox)

- Iron supplements for children ages 6 - 12 months at risk for anemia;
- Lead screening for children at risk of exposure;
- Medical History for all children throughout development at ages 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years;
- Obesity screening and counseling;
- Oral Health risk assessment for young children at ages 0-11 months, 1-4 years, 5-10 years;
- Phenylketonuria ("PKU") screening for this genetic disorder in newborns;
- STI prevention counseling and screening for adolescents at higher risk;
- Skin cancer behavioral counseling for children, adolescents, and young adults;
- Tobacco use interventions, including education or brief counseling, for school-aged children and adolescents;
- Tuberculin testing for children at higher risk of tuberculosis at ages 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years; and
- Vision screening for all children.

For details of when and how often you should have these services, discuss with your PCP. For more information, visit our website or contact Customer Care.

Exclusions and Limitations

All benefits described below are excluded (not covered) or limited under this GlobalHealth medical Plan.

Limitations

Ancillary Services and Supplies

- GlobalHealth will determine whether Durable Medical Equipment ("DME") items will be obtained by rental or purchase. All approved DME must be supplied by an In-Network Provider.
- Replacement, repair, or adjustments of purchased DME items are covered only when determined to be Medically Necessary.
- Rental equipment must be returned when it is no longer Medically Necessary.
- DME maintenance, only when preauthorized by GlobalHealth.
- Hearing aids are covered only for children less than eighteen (18) years of age.
- Routine corrective lenses and fittings for adults limited to first set of basic frames and lenses (up to $100.00) following cataract surgery.
    - Deluxe lens features for eyeglasses such as special coating, polarization, UV treatment, etc. are not covered.
    - Contact lenses are not covered.

Chiropractic Care

- Limited to fifteen (15) visits per Plan year.

Cosmetic or Plastic Surgery

- Operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form. Coverage limited to:
    - Repairing conditions resulting from an accidental injury.
    - Improvement of the physiological functioning of a malformed body member not related to dentistry or dental processes to the teeth and surrounding tissue.
    - Breast reconstruction following a Medically Necessary mastectomy.

Dental Services – Medical Coverage

- Emergency room services necessary to stabilize naturally sound teeth due to accidental injury will be covered. Replacement, re-implantation, and follow-up care of those teeth are not covered, even if the teeth are not saved by emergency stabilization.
- Orthognathic surgery is covered only when Medically Necessary (e.g., malocclusion has produced significant inability to function). Sufficient clinical documentation must be provided and services must be preauthorized.

Genetic Analysis, Services, or Testing

- Genetic counseling and testing is limited to women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 and BRCA 2 genes.

Home Healthcare

- Limited to 100 visits per Plan year.

Physical Therapy and Rehabilitation Services

- Physical, occupational, and/or speech therapy services limited to sixty (60) combined visits for you to regain, maintain, or prevent deterioration of a skill or function that has been acquired, but then lost or impaired due to illness, injury, or disabling condition per course of therapy.

Prescription Drugs

- Inhaler extender devices, peak flow meters, Ana-Kits, and EpiPens are limited to three (3) per Plan year.
- Prescription diaphragms are limited to two (2) per Plan year.
- The GlobalHealth Pharmacy and Therapeutics Committee's standard quantity limits, prior authorization criteria, and step therapies apply.
- Prescription benefits cover pharmacy vaccine Network contracted immunizations that are prescribed by a Network physician and administered at a contracted vaccine Network pharmacy Provider.
- Specialty medications are limited to a one-month supply.
- 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 your PCP. This benefit is available to you as well as your enrolled Dependents who are at least eighteen (18) years old. The covered medications are listed in the formulary and include: Chantix™ (varenicline), Nicotrol® Inhaler (nicotine), Nicotrol® Nasal Spray (nicotine), and bupropion SR 150 mg (generic for Zyban®). Over-the-counter products (such as nicotine patches and gum) may be covered. See your *Drug Formulary*.
- Medications prescribed or administered by Out-of-Network physicians in non-emergencies is limited to those prescribed by dentists.

Psychiatric and Behavioral Health Services – Medical Coverage

- Autism screening is limited to children at ages eighteen (18) months and twenty-four (24) months.
- Developmental screening is limited to children up to the age of three (3) years.
- Compulsive disorders treatment is limited to programs for anorexia and bulimia when Medically Necessary.
- Other services may be covered by behavioral benefits. Call MHNet for details of coverage.

Skilled Nursing and Residential Treatment Center Care

- Limited to 100 days per Plan year.

Vision

- Limited to one (1) routine check-up, including eye refraction, per year.

Exclusions

Ancillary Services and Supplies

- Routine foot care, shoes, and shoe inserts, except for Medically Necessary foot care for those persons diagnosed with diabetes or peripheral vascular disease.
- Orthopedic shoes unless permanently attached to a Denis Browne splint for children.

- Corrective shoes, arch supports, and supportive devices for the feet.
- Mattresses and other bedding or bed-wetting alarms.
- Equipment or devices not medical in nature such as braces worn for athletic or recreational use, ear plugs, elastic supports, corsets, or garter belts.
- Jacuzzi/whirlpools.
- Power-operated vehicles that may be used as wheelchairs.
- Purchase or rental of equipment or supplies for common household use including, but not limited to: Physical fitness equipment, traction tables, air conditioners, water purifiers, air-cleaning machines or filtration devices, cervical or lumbar pillows, grab bars, raised toilet seats, shower benches, beds, or chairs.
- Bandages, pads, or diapers.

Dental Services – Medical Coverage

- General dental services.
- Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and the alveolar bones).
- Correction of occlusive jaw defects, dental implants, or grafting of alveolar ridges.
- Treatment of soft tissue for the purpose of facilitating dental procedures or dentures.

Experimental or Investigational Therapies

- Medications, items, devices, and procedures that are Experimental or Investigational, except:
  - Off-label uses of certain medications used in the treatment of cancer or the study of oncology.
  - Certain investigational uses of drugs, including chemotherapy for cancer treatment, if administered as part of an Approved Clinical Trial.
- Medications prescribed for a non-FDA approved indication, dosage, or length of therapy.
- Medications, 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.
- New procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost-effectiveness and approved by GlobalHealth.

Medical Care or Hospital Services

- Services that are provided without an authorization and complications arising from those services.
- Services or medications received before your start date of coverage or after the time coverage ends, even if authorized.
- Care or services provided outside the GlobalHealth Service Area if the need for such care or services could have been foreseen before leaving the Service Area.
- Services for which you do not allow the release of information to GlobalHealth.
- Services for travel, insurance, licensing, employment, school, camp, sports, premarital, or pre-adoption purposes.
- Private rooms and personal or comfort items.
- Services received while outside of the United States.

- 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.
- Treatment of injuries or illnesses resulting from an attempt or commission of a felony, or as a result of being engaged in an illegal occupation.
- Alopecia.
- Treatment for orthoptics or visual training for any diagnosis other than mild strabismus.
- Separate charges for missed or canceled appointments, penalty or finance charges, maintenance and/or record-keeping, record copying, or Case Management services.
- Medical care, supplies, medications, and devices for which no charge was made. Medical care, medication, and supplies for which no payment would be requested if you did not have this coverage.
- Custodial care, respite care, homemaker services, domiciliary, or convalescent care.
- Treatment of injuries or illnesses sustained or contracted as the result of being under the influence of any narcotic, unless prescribed by a physician.
- Treatment for injury resulting from extreme activities including, but not limited to:
  - Base jumping
  - Bungee jumping
  - Bull riding
  - Car racing
  - Skydiving
  - Motorcycle stunts
- Services that are not Medically Necessary.
- Medical and/or mental health treatment of any kind which is excessive or where medical necessity has not been proven.
- Alternative Medicines and/or treatments used in the place of standard therapy, to treat any condition or illness.
- Screening services requested solely by the Member, such as commercially advertised heart scans.

Obstetrical and Infertility Services

- Elective abortions.
- Home uterine monitoring.
- Expenses related to surrogate parenthood.
- 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. Full-term delivery is defined as a delivery within thirty (30) days of your due date, as specified by your GlobalHealth In-Network Provider.
- 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.

Other Coverage

- 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).
- Services that are provided as a result of Workers' Compensation laws or similar laws.
- Medications for which the cost is recoverable under any other coverage, including Workers' Compensation, Occupational Disease law, or any state or government agency.

Other Exclusions

- Services resulting in whole or in part from an excluded condition, item, or service.

Physical Therapy and Rehabilitation Services

- Kinesiology, movement therapy, or biofeedback.
- Rolf technique.
- Rehabilitation treatment that will not result in measurable improvement.
- Massage therapy.
- Acupuncture/acupressure.
- Recreational therapy including, but not limited to:
  - Animal-facilitated therapy
  - Music therapy

Prescription Drugs

- Medications and dietary supplements available without a prescription (over-the-counter) or for which there is a non-prescription therapeutic equivalent available, even if ordered by a physician, unless an exception applies.
- Saline and medications for irrigation.
- 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.
- All non-prescription contraceptive jellies, ointments, foams, or devices unless they are FDA-approved and prescribed by a Network physician for a woman.
- 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 Limitations above.
- Dietary formulas, including but not limited to total parenteral nutrition and other enteral formulas. Exception: FDA-approved low-protein formulas are covered if medically necessary for the treatment of PKU.
- Lost or stolen prescriptions.
- Prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy, hyporgasmy, or decreased libido. (Sexual dysfunction drugs are covered only for post-prostate surgery indications and must be preauthorized by GlobalHealth.)
- Topical testosterone products (e.g., AndroGel®, Fortesta®, etc.)

Psychiatric and Behavioral Health Services – Medical Coverage

- Education, therapy, and services for the purpose of diagnosing or treating a learning disability, disruptive behavioral disorder, oppositional defiance disorder, or conduct disorder.

- 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.
- Marital counseling.
- Residential treatment programs.
- Applied behavioral analysis.
- Services may be covered by behavioral benefits. Call MHNet for details of coverage.

Sex Transformation/Sexual Dysfunction

- Services related to sex transformation or sexual dysfunction of any nature, including drugs and supplies.

Transplants

- Artificial or non-human organ transplants or transplants considered experimental, investigative, or unproven.
- Transplant services rendered at a non-participating or Out-of-Network transplant Facility.
- Donor screening tests and donor search expenses.
- Lodging, meals, and transportation costs associated with organ transplantation (donor or recipient).

Transportation/Lodging

- Routine, non-emergent ambulance transport unless preauthorized by GlobalHealth.
- Lodging, meals, and transportation costs.

Vision

- Eye exercises and orthoptics.
- LASIK, INTACS, radial keratotomy, and other refractive surgery.
- Computer programs of any type, including, but not limited to, those to assist with vision therapy.
- Special multifocal ocular implant lenses.

Weight Reduction Programs

- Gastric stapling, gastric balloon services, or any surgical treatment for obesity or weight-loss purposes.

ENROLLMENT AND ELIGIBILITY

Service Area

You must live or work in GlobalHealth's Service Area in order to obtain coverage. If you are away from our Service Area for more than six (6) months, contact your benefits coordinator or insurance coordinator. You should enroll in a new Plan that has a Network of Providers in your new area. There is a Special Enrollment Period during which you may enroll in another Plan that includes your new location in their Service Area.

GlobalHealth's Service Area includes all seventy-seven (77) Oklahoma counties in their entirety.

Who Is Eligible for GlobalHealth Benefits?

You are eligible to enroll with GlobalHealth if:

- You live or work in GlobalHealth's Service Area.
- You are a United States citizen or national or are a non-citizen who is lawfully present in the U.S.
  - You reasonably expect to be a citizen or national, and
  - You are lawfully present for the entire period for which enrollment is sought.
- You are not incarcerated.
- You meet the eligibility requirements defined by your employer.

Since your employer contracts for your healthcare benefits, you are the Subscriber to the Health Plan. Your spouse and children are Dependents.

Please note that all Enrollment forms should be submitted through your employer. Make your Premium contribution through your employer. GlobalHealth must receive your Enrollment during Open Enrollment or within the time periods below.

Your Spouse
Your spouse is eligible to enroll with GlobalHealth if he/she meets the Dependent eligibility requirements defined by your employer. He/she must live or work in GlobalHealth's Service Area.

Your Children
Your children may continue as eligible Dependents to the limiting age of twenty-six (26). They must live or work in GlobalHealth's Service Area.

College students are covered for emergent or Urgent Care while out of the Service Area. Routine care should be managed by a Network PCP.

The Dependents of your Dependents are not covered.

Newborns
To enroll your newborn, you must submit an Enrollment form to add the newborn for coverage within the first 31 days from the date of birth.

Adopted Children and Foster Children
Adopted and foster children are covered from the date placed in the home. You must enroll them within thirty-one (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. You must enroll them within thirty-one (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 twenty-six (26) may continue Enrollment in the Health Plan beyond the limiting age if:
1. The Dependent lives with you or your separated or divorced spouse;
2. The Dependent is incapable of self-sustaining employment by reason of mental 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 has exhausted COBRA under another group Health Plan.
    b. Termination or reduction of hours of the 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.
    e. Death, divorce, or legal separation of the 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 coverage. GlobalHealth requires proof of loss of the other coverage. Enrollment will be effective the first day of the calendar month after GlobalHealth receives a completed Enrollment form and Premium.

When Coverage Begins

You and your eligible Dependents are covered as of 12:01 am on the effective date of your Enrollment. Your employer must certify your eligibility.

Continuity and/or Transition of Care

Transition of Care

If you are enrolling in GlobalHealth and are currently under care utilizing a different health carrier, you may be eligible for care with your present Provider.

You will need to complete the GlobalHealth *Transition of Care Request* form. This is necessary, even if your current Provider is also a GlobalHealth Provider. Some Specialists and Facilities currently scheduled for your care may differ from GlobalHealth's Network.

You may need to also complete the *Transition of Care Request Form - Prescriptions*. See "Transition of Care" under "Your Prescription Drug Benefits" on page 44.

The forms can be found on our website or copied from this *Member Handbook*. See pages 80 and 82.

You must get approval from GlobalHealth to continue care. Approval from the health carrier you had prior to GlobalHealth is not the same as Preauthorization from us.

Requests for ongoing treatment or services with a healthcare Provider who is not in the GlobalHealth Network are reviewed case-by-case. Once we have the request to continue care, we will review your case. You must have received services from the requested Provider under an ongoing course of treatment in the ninety (90) days prior to your effective date with GlobalHealth.

We will notify you and your healthcare Provider if continued services have been authorized or if we are going to transition your care to one of our Network Providers. If approved, you may receive up to thirty (30) days of ongoing course of treatment. If we do not approve continued care, you and your healthcare Provider will receive a letter that includes our decision. We will provide information about your right to Appeal the decision.

Continuity of Care

If you are a current GlobalHealth Member and your Provider leaves the Network, you may continue to receive care from that Provider in certain cases.

Examples of Member conditions that may require continuity or transition of care are:
• Third trimester pregnancies • Undergoing treatment for a degenerative and disabling condition • Undergoing a course of chemotherapy, or radiation therapy • Terminal illness • Currently on a transplant list • Currently hospitalized • Impending Hospitalization • Currently taking medications for which GlobalHealth requires Utilization Management review

You must get approval from GlobalHealth to continue care.

We will not cover continuing care when:

- The Provider's contract has ended because of quality of care issues.
- The Provider did not comply with regulatory or other contract requirements.

Changes to Enrollment

It is your responsibility to notify GlobalHealth of any changes that affect eligibility for services and benefits.

Changes that must be reported include, but are not limited to:

- Social Security numbers for newborn children;
- Termination or addition of any other group health coverage;
- Permanently moving out of GlobalHealth's Service Area; or
- Change in:
  - Name
  - Mailing address and zip code
  - Telephone number (home and work)
  - PCP
  - Disability status
  - Medicare status
  - COBRA
  - Family status
  - Retirement
  - Death
  - Divorce

Any change should be made as soon as possible, but always within thirty (30) days. Call your benefits coordinator or insurance coordinator.

If You Stop Working or Have a Significant Change

Talk to your employer about COBRA coverage if you stop working because of:

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

See "When Coverage Stops" On page 58.

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

See "Continuation Coverage Rights Under COBRA" on page 91.

When Coverage Stops

Coverage stops automatically on the earliest of the following:

- The effective date is variable if enrollment was based on Fraud.
- The last day of the month in which you or a Dependent were enrolled in a GlobalHealth Plan and you are enrolled into another Plan through an SEP because you permanently moved outside GlobalHealth's Service Area.
- You are no longer eligible as defined by your employer.

- The date the group's coverage terminates. Unless otherwise provided, your policy will expire at 12:01 am on the stated expiration date.
- 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 Premium was paid.
- If the Subscriber dies, coverage for Dependents ends on the last day of the month of the Subscriber's death. Contact your benefits coordinator or insurance coordinator for the Dependents' continuation rights.

If a Dependent's coverage is terminated, it does not affect the coverage of other family members. If the Subscriber's coverage ends, the membership of all Dependents stops as well. Coverage ends at 12:01 am on the day that the termination is effective. See "Continuation Coverage Rights Under COBRA" on page 91.

Continuation of Coverage
You may continue coverage for sixty-three (63) days beyond these timeframes. You will be required to continue paying your Premium.

Continuation of coverage may not be available:
- If you fail to make timely Premium payments.
- If the group coverage terminates in its entirety during your continuation period.
- If you become entitled to similar coverage from another source during the continuation of coverage period.
- If you intentionally misuse your Member ID card.

Conversion Privilege
If you lose your GlobalHealth group coverage, you may be eligible for COBRA continuation coverage. Check with your benefits coordinator or insurance coordinator.

If You Are in the Hospital When Coverage Ends
Benefits may be continued for treatment of the illness or injury for which you are hospitalized while you are hospitalized and under a doctor's care.
- Women giving birth will be covered through delivery and discharge.
- If your GlobalHealth group coverage is ending due to termination of the group's coverage by your employer, your coverage ends on the termination date.
- If your group coverage is ending due to termination of the group's coverage by GlobalHealth, your coverage will continue through discharge from the Hospital or expiration of benefits.

All services must be Medically Necessary. No benefits are provided for services treating any other illness, injury, or condition.

Insolvency
In the unlikely event of Plan insolvency, your benefits will be continued as follows:
- For the duration of the period for which Premiums have been paid.
- If you are confined in a Hospital on the date of insolvency, until you are discharged or your benefits end.

- If you are pregnant, through delivery and discharge.

When GlobalHealth May Deny Coverage

- The services are not covered according to your *Schedule of Benefits*, "Exclusions and Limitations".
- You received services or treatment, including Prescription Drugs, before your coverage began or after your coverage ended.

Changes to Your GlobalHealth Plan

GlobalHealth may change certain benefits after having given you at least sixty (60) days' written notice. GlobalHealth will tell you when the change will become effective.

Your employer may cancel your group's coverage. Your employer will notify you in writing of the cancellation at least sixty (60) days before the coverage expires.

GlobalHealth or your employer may make changes to the benefits without Member consent or concurrence. If you are eligible to elect health coverage under the group's Plan and you decide to elect coverage, you agree to all stated terms, conditions, and provisions. All changes to the Plan must be in writing to be valid. No agent or employee, other than a duly authorized corporate officer, has the authority to modify the Plan or to waive any of its provisions. Your employer is responsible for notifying you in writing within seventy-two (72) hours of any change to your GlobalHealth Plan.

CLAIMS AND PAYMENT

Your Deductible and Out-of-Pocket Maximum

Plan Year
The group Plan year begins on January 1 and is in effect for the following twelve (12) months. If you join a group Health Plan after the group effective date because of adding dependents, late enrollment, or as a new hire, your Plan year begins when you enroll and ends at the same time as the group Plan year. Your next Plan year will coincide with the group's Plan year.

Deductible
This Health Plan does not have a Deductible.

Maximum Out-of-Pocket ("MOOP")
A MOOP is a dollar amount that limits how much you have to pay for healthcare services. It includes Copayments and Coinsurance that you pay. See your *Schedule of Benefits* for your MOOP.

Covered Services that count toward your MOOP:	**Some expenses do not count toward your MOOP:**

• Medical Services and treatment
  o Office visits
  o Tests
  o Hospitalization
  o Outpatient Surgery
  o Durable Medical Equipment
• Prescription Drugs
• Mental/behavioral and substance abuse services and treatment
	• Premium payments
	• Non-Covered Services
	• Balance Billing from an Out-of-Network urgent or emergent care Provider

If you reach your MOOP for the Plan year, any Covered Services you need for the rest of the Plan year will be covered without a Copayment or Coinsurance.

- The per Member MOOP is met when a single Member pays Copayments and/or Coinsurance up to the level of his or her Plan.
- The family MOOP is met when any combination of family members under the same Subscriber pays Copayments and/or Coinsurance up to that level of his or her Plan.

The Per Member MOOP must be met through expenses paid by any one Member. The Family MOOP may be met through expenses paid by any combination of family members under the same Subscriber.

The MOOP of the most current benefit Plan applies if you change GlobalHealth benefit Plans during the Plan year. Copayments and Coinsurance paid under the previous GlobalHealth benefit Plan within the same Plan year will be applied to the current benefit Plan MOOP. You are not entitled to a refund if the current MOOP is less than the previous MOOP.

Deductibles, Copayments, and Coinsurance paid before you enroll in a GlobalHealth Plan do not apply toward your MOOP.

It is a good idea for you to keep track of your expenses. You will know when you are close to meeting your MOOP.

Responsibility for Payment

You Are Responsible for Payment of:	You Are Not Responsible for:

• Your Copayments or Coinsurance for approved Covered Services.
• The charges for services provided by a physician or medical Facility without an authorized Referral from your PCP.
• The cost of services not included in the GlobalHealth Plan benefits.
• Full billed charges when:
  o The services were non-Covered Services;
  o The services were received Out-of-Network and were not authorized by GlobalHealth; or
  o The services were obtained through your own Fraud.
	• Any amounts owed by GlobalHealth to a Provider for approved Medically Necessary services that are covered by your Plan benefits.
	• Any amounts requested as Balance Billing (after GlobalHealth has paid the contracted Allowed Amount), provided that:
	  o The services were preauthorized Covered Services;
	  o The services were approved by GlobalHealth;
	  o The services were provided by a Network Provider; and
	  o You have paid your required Cost-Share.

Balance Billing by an Out-of-Network Provider

Balance Billing occurs when a Provider bills you the difference between its billed charge and the total amount the Provider received from your Cost-Share and GlobalHealth's contracted or Usual and Customary reimbursement for approved Covered Services. In-Network Providers may not balance bill you. Out-of-Network Providers may balance bill you and you will be responsible for the difference between our payment and the Provider's billed amount.

Please note: If you choose to go to an Out-of-Network Provider, except in the case of emergency, you may be responsible for 100% of the cost.

If You Receive a Bill

Medical

Services provided by Network Providers will be billed directly to GlobalHealth. However, if you receive urgent or emergent medical care out of GlobalHealth's Network, you might receive a bill from those Providers.

If the bill is for ER Care you already paid for, contact Customer Care for direction within 120 days of the date of service. GlobalHealth will pay according to GlobalHealth's contracted or Usual and Customary reimbursement. An Out-of-Network Provider may balance bill you. An In-Network Provider may not balance bill you.

If you receive a bill for medical care that is covered under your benefit Plan and authorized by your PCP, contact Customer Care.

Mental/Behavioral Health/Substance Abuse
Services provided by Network Providers will be billed directly to MHNet. However, if you receive urgent or emergent care out of MHNet's Network, you might receive a bill from those Providers.

If you receive a bill for care that is covered under your benefit Plan, immediately contact MHNet for a Member Reimbursement Form. Call 1-866-904-5234 (toll-free) or 1-866-200-3269 (TTY/TDD/Voice).

Prescription Drugs
Medications filled at a Network Pharmacy will usually be billed directly to ESI. However, if you fill a prescription without your Member ID card, you may be required to pay the pharmacy. If this happens, call ESI at 1-866-274-1612 (toll-free) or 1-800-899-2114 (TTY/TDD/Voice).

Claims Payment Recovery

If GlobalHealth pays a claim for services you received and you were not eligible for coverage at the time services were rendered, GlobalHealth may request a refund.

We will request a refund from your Provider within twenty-four (24) months after the payment was made, unless:

- The payment was made because of Fraud committed by you or the healthcare Provider; or
- You or the healthcare Provider has otherwise agreed to make a refund to us for overpayment of a claim.

You are then responsible for paying the Provider.

If Your Claim Is Denied

If any part of a claim submitted for payment is denied, GlobalHealth will review the claim upon written request for Appeal. See "Appeals and Grievances" on page 67.

GlobalHealth will notify you of the Adverse Determination within thirty (30) days after receipt of the claim. This period may be extended one time by GlobalHealth for up to fifteen (15) days, provided that GlobalHealth determines:

- An extension is necessary due to matters beyond its control;
- GlobalHealth notifies you, prior to the end of the initial 30-day period, of why the extension is needed; and,
- The date by which GlobalHealth expects to render a decision.

If an extension is necessary because GlobalHealth does not have the information to decide the claim, the notice will specifically describe the required information, and you will have forty-five (45) days from receipt of the notice to provide the specified information.

When You're Covered by More Than One Plan

You must notify GlobalHealth if you have other healthcare coverage.

If you have healthcare coverage in addition to your GlobalHealth group Plan, either as a Dependent or a Subscriber, GlobalHealth will coordinate benefits in accordance with applicable law. This means that we will determine which Plan will pay as primary (first) and which Plan will pay as secondary (second). If GlobalHealth benefits are secondary, we will pay for approved benefits less the amount paid by the primary payer and your Cost-Share.

Even when GlobalHealth is the secondary payer, you must have your care authorized by GlobalHealth in order for the claim to be paid. Some cost-sharing may still apply.

Other healthcare coverage includes:

- Group and individual insurance coverage and Subscriber coverage;
- Uninsured arrangements of group or group-type coverage;
- Group and individual coverage through Plans no longer accepting new Members;
- Group-type coverage;
- The medical care benefits of long-term care coverage, such as skilled nursing care;
- The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type coverage;
- Medicare or other governmental benefits, as permitted by law, except as provided in a state Plan under Medicaid. That type of Plan may be limited to Hospital, medical, and surgical benefits of the governmental program; and
- Group and individual insurance coverage and Subscriber coverage that pay or reimburse for the cost of dental care.

Coordination of Benefits Table

Group health benefits provided by GlobalHealth are subject to the Coordination of Benefits ("COB") provision. We apply COB rules in accordance with the National Association of Insurance Commissioners' guidelines. Your case may be different.

Provisions	*COB Order of Benefit (Primary/Secondary) Determination Rules
Only one Plan has COB provisions	• The Plan without a COB provision is primary over the Plan with a COB provision.
Both Plans have COB provisions	• If both Plans have a COB provision, the Plan covering the Member as a Subscriber is primary over the Plan covering the Member as a Dependent.
Both Plans have COB provisions - Dependent Child - Parents not separated or divorced	• The Plan of the parent with a birthday earlier in the calendar year, regardless of the year of birth, is primary. This is referred to as the "Birthday Rule". • If both Plans do not follow the Birthday Rule, then the rules of the Plan that does not have the Birthday Rule provision apply.
Both Plans have COB provisions - Dependent Child - Parents separated or divorced	• A Dependent child whose parents are separated or divorced, and the parent with custody has not remarried - the Plan of the parent with custody is primary over the Plan of the parent without custody. • A Dependent child whose parents are divorced, and the parent with custody has remarried - the Plan of the parent with custody is primary over the Plan of the stepparent. The Plan of the stepparent (in this case, secondary) assumes responsibility before the Plan of the parent without custody of the Dependent (in this case, tertiary, or third). • A Dependent child whose parents are separated or divorced and a court decree establishes financial responsibility for healthcare expenses - the Plan of the parent with such financial responsibility is primary.

*This is for general information only. It may not apply to your specific situation. It does not apply to Prescription Drug coverage.

Coordination of Benefits

When verification of other coverage is needed for processing a claim, GlobalHealth will request that you complete a *Coordination of Benefits* form. Your failure to provide the completed form when requested will cause the claim to be delayed or denied. You may be asked to complete a form annually.

Submit your form
Mail: GlobalHealth, Inc. Enrollment and Eligibility PO Box 2328 Oklahoma City, OK 73101-2328
E-Mail: CommercialAnswers@globalhealth.com

For information about coordination of benefits, contact Customer Care.

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, GlobalHealth will pay secondary for approved benefits less the amount paid by Medicare. If you have questions about Medicare, contact your local Social Security office or visit www.medicare.gov.

Even when GlobalHealth is the secondary payer, you must have your care authorized by GlobalHealth in order for the claim to be paid. Some cost-sharing may still apply.

Third Party Liability

Workers' Compensation

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. It allows the Provider to bill Workers' Compensation. GlobalHealth benefits are not designed to replace or duplicate any benefits you receive under Workers' Compensation law. You must notify your employer of your condition in order to file for Workers' Compensation benefits.

Third-Party

If you are injured through an act or omission of a third-party (e.g., motor vehicle accident) and are entitled to medical expense coverage, you agree:

- To make a claim for such expenses.
- To reimburse GlobalHealth for the cost of all such services upon obtaining a monetary recovery or settlement.
- 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, the claim may be delayed or denied by GlobalHealth. GlobalHealth may waive its option to deny the claim for good cause in certain specific cases.

Note: Please see Subrogation, Third-Party Recovery, and Reimbursement on page 96.

Notify GlobalHealth

Notify GlobalHealth of potential third-party liability or Workers' Compensation situations as soon as possible so that your benefits can be coordinated.

APPEALS AND GRIEVANCES

Complaints and Grievances

You may file a complaint by contacting Customer Care. A Grievance is a more formal complaint that is made in writing by you, or your authorized representative.

It may concern:

- Any aspect of the Plan operations
- Policies
- Procedures
- Quality of care
- Access
- Attitude/Service
- Billing/Financial
- Quality of Provider office site
- Other issue

Submit Complaints
Call: (405) 280-5600 (local) 1-877-280-5600 (toll-free) 1-800-722-0353 or 711 (TTY/TDD/Voice)
E-Mail: Appeals@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; and
- Copies of claims, records, or other relevant information.

Submit Grievances
Mail: GlobalHealth, Inc. ATTN: Grievances PO Box 2393 Oklahoma City, OK 73101-2393
E-Mail: Appeals@globalhealth.com

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. Language assistance is available. Contact Customer Care and ask for an interpreter.

You will receive an acknowledgement letter within five (5) days of GlobalHealth's receipt of your written 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

You have the right to Appeal any decision we make that denies payment on your claim, denies your request for coverage of a healthcare service or treatment, or changes or reduces a previously approved course of treatment. You are not entitled to an Appeal if the benefit change is due to Plan amendment or termination.

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

Contact us when you:

- Do not understand the reason for the denial;
- Do not understand why the healthcare service or treatment was not fully covered;
- Do not understand why a request for coverage of a healthcare service or treatment was denied;
- Cannot find the applicable provision in your *Schedule of Benefits*, *Member Handbook*, or other Health Plan benefit documents;
- Want a copy (free of charge) of documents, records, and other information relevant to your claim;
- Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to Appeal.

If your claim was denied due to missing or incomplete information, you or your healthcare Provider may resubmit the claim to us with the necessary information to complete your claim.

Your Appeal request must be submitted in writing **within 180 days** of the Adverse Determination notice 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; and
- Copies of documentation to support the Appeal request (e.g., claims, medical records, physician statements, and any other relevant information).

Appeal request forms are available on our website or by contacting Customer Care. Use of the form is optional, but you must include all required information in your request.

Submit Appeals
Mail: GlobalHealth, Inc. ATTN: Appeals PO Box 2393 Oklahoma City, OK 73101-2393
E-Mail: Appeals@globalhealth.com

Full and Fair Review

GlobalHealth will conduct a full and fair review of your claim or request for coverage of a healthcare service or treatment. The review is conducted by individual(s) associated with us, but who were not involved in making the initial denial. You may provide us with additional information, evidence, or testimony that relates to your claim and you may request copies of information that we have that pertains to your claim(s).

We will notify you of our decision in writing within thirty (30) days of receiving your Appeal. GlobalHealth will provide you with any new or additional evidence considered, relied upon, or generated by GlobalHealth in connection with the Appeal and the rationale for using it. This will be provided to you free of charge upon request. You may request the identification of any medical or vocational experts whose advice GlobalHealth obtained in connection with the Adverse Determination, regardless of whether the advice was relied upon in making the determination.

Initial Appeals Process

You will receive an acknowledgement letter within five (5) business 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.

GlobalHealth may extend this period one time for up to fifteen (15) days, provided that:

- An extension is necessary due to matters beyond the control of GlobalHealth;
- GlobalHealth notifies you, prior to the expiration of the initial 30-day period, of why the extension of time is needed; and,
- GlobalHealth notifies you of the date by which a decision is expected.

If such an extension is necessary because GlobalHealth does not have the information necessary to decide the claim, the notice will specifically describe the required information. You will have forty-five (45) days from receipt of the notice within which to provide the information.

Depending on the nature of the Adverse Determination, there are two different type of internal review:

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

Expedited Appeal

You may be entitled to request an expedited internal review of our denial if:

- You have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed; and,
- Our Adverse Determination concerns an admission, availability of care, or continued stay or healthcare service for which you received Emergency Services and you have not been discharged from a Facility.

You, or someone authorized to act on your behalf, may submit a request for an expedited internal review to the address listed on page 68. Or a request may be made by telephone to Customer Care at (405) 280-5600 or 1-877-280-5600. TTY/TDD users call 1-800-722-0353, or 711. If we agree to process your Appeal as an expedited internal review, a determination will be made within seventy-two (72) hours of receipt of your request. If your Appeal does not qualify for an expedited review, we will process the Appeal under the standard timeframe of thirty (30) days.

External Review

If we have denied your request for the provision of or payment for a healthcare service or treatment, you may have a right to have our decision reviewed by independent healthcare professionals, who have no association with us, if our decision involved a judgment as to:

- Medical necessity;
- Appropriateness;
- Healthcare setting;
- Level of care;
- Effectiveness of the healthcare service or treatment you requested; or,
- A determination that the service or treatment is Experimental or Investigational.

Your request for an External Review must be submitted in writing **within four (4) months** of the final Adverse Determination to:

Request for External Review
The request for External Review must be submitted to: Oklahoma Insurance Department ATTN: External Review Request Five Corporate Plaza 3625 NW 56th St Suite 100 Oklahoma City, OK 73112-4511
Telephone: 1-800-522-0071 (toll-free) (405) 521-2828
Website: www.ok.gov/oid/Consumers/External_Review_Process

The Insurance Department will randomly select a qualified Independent Review Organization ("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. You are not required to pay the costs of the IRO.

Note: 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.

Expedited External Review

If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, or if our Adverse Determination concerns an admission, availability of care, continued stay or healthcare service for which you received Emergency Services and you have not been discharged from a Facility, you may be entitled to request an expedited External Review of our denial.

Additionally, if our decision was based on a determination that the service or treatment is Experimental or Investigational, you may be entitled to request an expedited External Review if your treating physician certifies in writing that the recommended or requested healthcare service or treatment would be significantly less effective if not promptly initiated.

To request an expedited External Review, call the Oklahoma Insurance Department at 1-800-522-0071 before sending your paperwork. You will receive instructions on the quickest way to submit your request and supporting information.

The Insurance Commissioner will randomly select an IRO to complete the review. The IRO will make a determination within 72 hours after the date of receipt of your request for expedited External Review.

Note: An expedited External Review may not be provided for retrospective Adverse Determinations.

Notices

A written Appeal determination will be mailed to you after each level in the Appeal process. It will include additional Appeal rights, when applicable.

Appointment of Representative

You or your authorized representative may request an Appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act as your authorized representative. If you want someone to act on your behalf as your authorized representative, you must send us a statement, in writing, authorizing that person to do so. Both you and the authorized representative must sign and date this document. You can represent yourself, or you may ask another person to act as your authorized representative. Your treating healthcare Provider may act as your authorized representative. An *Appointment of Representative* form is available on our website or by contacting Customer Care. A signed form must be on file before the Appeal or Grievance can proceed if someone other than you is acting as your authorized representative.

Pharmacy Appeals

ESI pays claims on your behalf for Prescription Drugs. However, GlobalHealth handles all Prescription Drug Appeals. Follow the process for Appeals beginning on page 67.

Mental/Behavioral Health Appeals

MHNet preauthorizes your services and treatment for mental and behavioral health as well as substance abuse and chemical dependency. MHNet also pays those claims on your behalf.

You must contact MHNet for your Appeal rights or to file an Appeal.
Call: 1-800-336-2030 (toll-free) 1-866-200-3269 (TTY/TDD/Voice)
Mail: MHNet Behavioral Health P.O. Box 7811 London, KY 40742

Appeal Questions?

If you have any questions or would like a copy of the benefit provision, policy, guidelines, protocol, or other criteria used to make a determination, please call Customer Care. Your physician may contact GlobalHealth's Medical Director to discuss Adverse Determinations or authorization denials.

SPECIAL PROGRAMS

Health and Wellness Program

GlobalHealth is excited to provide you with an Internet-based Health and Wellness Program. In addition to the 24/7 nurse line, a wide variety of information is available at www.globalhealth.com/state. Contact Customer Care to request printed materials. This program can be used to enhance the health of you and your family.

24/7 Nurse Help Line

Life happens, and the GlobalHealth Nurse Help Line is available 24/7 each day of the year. It's not always easy to determine when to seek emergency care, treat symptoms yourself, or see a PCP. The Nurse Help Line helps Members make confident decisions. Call 1-877-280-2993 anytime for access to the care advice you are seeking.

The Nurse Help Line gives access to:

- Experienced registered nurses to triage your symptoms using clinically proven guidelines.
- 24/7 access to care.

GlobalHealth.com/state

The GlobalHealth website offers links to interactive assessment tools and information on key topics for better health. Many topics are available in English and Spanish.

Category	Information Available

Maintain Your Health	• Read about
	  o Healthy eating.
	  o The importance of exercise.
	  o Health screenings for preventive care.
	• Access tips and interactive tools to incorporate healthy diet and exercise into daily life.
	• View wellness and prevention checklists for all age groups.
	• Access links to clinical guidelines.
	• Take surveys to help you decide if you are right on track.

Improve Your Health	This section includes education material and interactive tools. Find resource links about medication and treatment adherence, stress, smoking cessation, and alcohol/drug abuse.
Manage Long-Term Conditions	• Find information on many health conditions and other medical management information. Use the interactive tools that encourage compliance. Learn about treatment options to discuss with your doctor. • Enroll in a GlobalHealth-sponsored program if you or a family member has one of five targeted diseases. See "Disease Management" on page 23. • You can call MHNet for behavioral health or chemical dependency information. MHNet will help you get the care you need.

Category	Information Available
	• Members taking multiple medications for Chronic Conditions can receive support. See "Medication Therapy Management Program" on page 45.
Tools/Calculators	Includes: • The Annual Health Appraisal. • Body Mass Index ("BMI") calculator. • Drug guide. • Information about our health information line.
Health Coach 4 Me	• Additional education material for your needs. • Easy to use interactive management tools and tracking goals. • Reminders. • Support.

Tobacco Cessation

Smoking is the most preventable cause of death and disease in the United States. Studies show that the most effective method to stop smoking involves:

- Counseling;
- Social support; and,
- The use of cessation medication.

Follow these steps to quit:

1. Call 1-800-QUIT-NOW (1-800-784-8669) for free support and to set up your quit plan.
2. Talk with your doctor about medicines to help you quit.
3. Set a quit date within the next two (2) weeks.
4. Make small changes. For example: Throw away ashtrays in your home, car, and office so you aren't tempted to smoke.
5. Make your home and car smoke-free.
6. If you have friends who smoke, ask them not to smoke around you.
7. Plan for how you will handle challenges like cravings.

You can refer to the Wellness section on the GlobalHealth website to get more helpful hints to quit smoking.

Counseling:

For counseling, call 1-800-QUIT-NOW (1-800-784-8669). You will talk to a trained cessation expert. He or she will tailor a plan for your specific needs.

Prescriptions:

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 your PCP. This benefit is available to your as well as your enrolled Dependents who are at least eighteen (18) years old.

The covered medications are listed in the formulary and include: Chantix™ (varenicline), Nicotrol® Inhaler (nicotine), Nicotrol® Nasal Spray (nicotine), and bupropion SR 150 mg (generic for Zyban®).

FDA-approved over-the-counter products (such as nicotine patches, gum, and lozenges) are also covered with a prescription written by your physician.

Your *Drug Formulary* will indicate if the prescription is available without a Cost-Share as part of preventive services.

Not all products that may be used for tobacco cessation are included. GlobalHealth does not cover electronic cigarettes available over-the-counter (e-cigarettes).

Cessation Attempts:
You are covered for two (2) tobacco cessation attempts per Plan year. One attempt is considered:

- Four (4) tobacco cessation counseling sessions without prior authorization; and
- All FDA-approved tobacco cessation medications (including both prescription and OTC) without prior authorization.

Clinical Practice Guidelines

GlobalHealth has approved and published clinical practice guidelines for the following medical and behavioral healthcare services including, but not limited to:

Preventive Clinical Practice Guidelines

- Obesity Assessment
- Breast Cancer
- Colorectal Cancer
- Hypertension

Medical Conditions - Clinical Practice Guidelines

- Chronic Obstructive Pulmonary Disease ("COPD")
  - Diagnosis and management of acute exacerbations
  - Diagnosis and management of stable COPD
  - Pulmonary rehabilitation
- Congestive Heart Failure ("CHF")
  - Diagnosis and evaluation
  - Management of chronic heart failure in adults in primary and secondary care
- Coronary Artery Disease ("CAD")
  - CAD clinical practice guidelines
- Diabetes Mellitus ("DM")
  - Management of micro vascular complications
  - Nutritional management

Behavioral Health Clinical Practice Guidelines

- Attention Deficit Hyperactive Disorder ("ADHD")
  - ADHD assessment and management
- Depression
  - Treatment and management of depression in adults

GlobalHealth has posted evidence based preventive health guidelines on care for:

- Perinatal
- Children up to twenty-four (24) months old
- Children 2-19 years old
- Adults 20-64 years old
- Adults sixty-five (65) years and older

Clinical practice guidelines and preventive health guidelines can be found on the GlobalHealth online Wellness Program. Go to www.globalhealth.com/state.

Quality Improvement Program ("QIP")

GlobalHealth is committed to supporting quality healthcare and the preservation of good health. The QIP helps GlobalHealth improve Health Plan functions and services from Network Providers.

The QIP provides the framework to assess and improve the quality of care and services. It is based on a model that stresses a systematic, integrated approach to quality. The QIP is designed to meet statutory requirements. It adheres to standards, guidelines, and contractual requirements for Health Plans, including those published by:

- The National Committee for Quality Assurance ("NCQA").
- The Centers for Medicare and Medicaid Services ("CMS").

The program identifies issues and opportunities for improvement. Multi-disciplinary work groups, comprised of GlobalHealth employees and participating Providers who:

- Monitor performance indicators.
- Analyze data.
- Implement changes to improve performance.

With a focus on providing high-quality, cost-effective healthcare, the use of the QIP will positively impact the:

- Improvement in processes and outcomes of care.
- Satisfaction of Members and Providers.
- Cost of healthcare services.

Quality Improvement Work Plan

GlobalHealth develops and implements a Quality Improvement Work Plan each year. The Work Plan monitors and evaluates healthcare delivery systems and Health Plan management activities. Its purpose is to ensure quality care and service.

Quality Improvement activities are evaluated annually. We implement changes to address identified opportunities. We follow up in areas that need improvement.

You may request information on our Quality Improvement Program and Work Plan by contacting Customer Care.

SPECIAL NOTICES AND INFORMATION

FAQs

Chiropractic

Q. Does the Plan cover chiropractor visits?

A. Yes, to Network chiropractors. Preauthorization is required.

Diabetic Supplies

Q. Are my diabetic supplies covered?

A. Yes.

Dependent Coverage

Q. If I enroll in GlobalHealth, is my child who lives in another state covered?

A. Only if the child resides in the Service Area. College students must establish a relationship with a PCP before leaving. When needing Urgent Care, they may call their PCP or go to an Urgent Care center. Routine care out-of-area is not covered.

Q. What about Dependents over eighteen (18) years of age?

A. We cover eligible children through the end of the month in which they turn twenty-six (26) years of age.

Emergencies and Urgent Care

Q. When I go to the emergency room, is my copay waived if I am then admitted to the Hospital?

A. Yes. However, Coinsurance is not waived if you have a Coinsurance Plan.

Q. What if I get sick when I am out of the Service Area? Am I still covered?

A. Emergency and Urgent Care is covered. In a true emergency, go immediately to the nearest medical Facility for care. Call the PCP and GlobalHealth within forty-eight (48) hours of receiving the care. When same-day Urgent Care is needed, self-refer to an Urgent Care center. An Out-of-Network Provider may balance bill you. An In-Network Provider may not balance bill you.

Q. What if I need to see a doctor on the weekend? Or I become sick after hours?

A. Call your PCP for direction. Or self-refer to a Network Urgent Care center.

Hearing

Q. Does the Plan cover hearing aids?

A. Yes, for children up to age eighteen (18) only.

Hospital Admission

Q. Does my Hospital copay cover doctor visits to the Hospital?

A. Yes, if you chose a Plan with a Hospital Copayment. However, if you chose a Coinsurance Plan, you must pay Coinsurance on all treatments and services you receive during your Hospital stay.

Q. Does the Plan cover private rooms in the Hospital?
A. When Medically Necessary.

Q. What Hospitals are in your Network?
A. They are listed in the *Provider Directory* and on the website: www.globalhealth.com/state.

Mental Health

Q. Does the Plan cover mental health services?
A. Yes. Call MHNet, our mental health Provider, at 1-866-904-5234. You do not have to go through your PCP. MHNet assesses and makes arrangements. Ask for and sign a release with the mental health Provider or Facility. It is important that the PCP is aware of services that have been received and medication prescribed.

Q. How can I find out who the MHNet Providers are?
A. Call the MHNet number. There is also a partial listing in the *Provider Directory* and on our website.

Network

Q. How can I find out if my Specialist is in the Network?
A. Refer to the *Provider Directory* or visit our website.

PCP

Q. Do I have to choose one of the Network doctors?
A. Yes. You choose a PCP at Enrollment. Each family member may choose a different PCP, including a pediatrician for children. *Provider Directories* are available and you may also go to our website, www.globalhealth.com/commercial, Provider Search.

Q. Can I change my PCP or am I stuck with them all year?
A. Yes, you may change PCPs at any time during the year, and the change is effective right away. Changes may be made on our website. If you need to see a PCP before you receive your new Member ID card, contact Customer Care.

Pre-existing

Q. Does the Plan accept pre-existing conditions?
A. Yes.

Prescriptions

Q. Are dental prescriptions covered?
A. Yes.

Q. What is a *Drug Formulary*?
A. The *Drug Formulary* is a list of drugs most commonly prescribed and approved by GlobalHealth. It is a preferred list. Because the development of the *Drug Formulary* is an ongoing process, this list is subject to change.

Q. Does the Plan have mail order?

A. Yes, through ESI. A discount may be available for using home delivery rather than a retail pharmacy.

Q. Where can I get my prescriptions filled?

A. We have over 800 participating pharmacies across the state of Oklahoma. ESI, our pharmacy benefit manager, has a nation-wide Network that you can access.

Preventive Care

Q. Is preventive care covered?

A. GlobalHealth covers all preventive services covered under the Affordable Care Act for no Cost-Share to you when delivered by a Network Provider. See "Preventive Care Guidelines" on page 45 for a current list of services.

Referrals

Q. Do I need a Referral to see a Specialist?

A. Yes. Your PCP is responsible to manage all of your care. He or she submits a Referral on your behalf to a Specialist within our Network when needed. All procedures must also receive Preauthorization.

Weight loss and Cosmetic Surgery

Q. Does the Plan cover gastric bypass or surgery for obesity?

A. No.

Q. Does the Plan cover cosmetic surgery?

A. Only in specific limited circumstances. See page 27.

Worldwide Coverage

Q. Am I covered worldwide?

A. No.

GlobalHealth Transition of Care Request Form

This form needs to be completed if you are currently under care utilizing a different health carrier. This is necessary, even if your current provider is also a GlobalHealth provider. Some specialists and facilities currently scheduled for your care may differ from GlobalHealth's network. • *Use separate form for each condition. Photocopies of this form are acceptable. Attach additional information if necessary.*

Employer	Policy #	Date of Enrollment in GlobalHealth Benefit Plan (mm/dd/yyyy)	
Employee Name		Employee Social Security #	Work Phone
Home Address Street	City	State Zip	Home Phone
Patient's Name	Patient's Soc. Sec. #	Patient's D O B (mm/dd/yyyy)	Relationship to Employee ❑ Spouse ❑ Child ❑ Self

1. Is the patient pregnant and in the second or third trimester of pregnancy? ❑ Yes ☐ No
2. If yes, when is the due date? (mm/dd/yyyy)
3. Is the patient currently receiving treatment for any acute conditions or trauma? ❑ Yes ☐ No
4. Is the patient scheduled for surgery or hospitalization after your effective date with GlobalHealth? ❑ Yes ☐ No
5. Is the patient involved in a course of Chemotherapy, Radiation Therapy, Cancer Therapy or a candidate for Organ Transplant? ❑ Yes ☐ No
6. Is the patient receiving treatment as a result of a recent major surgery? ❑ Yes ☐ No
7. Is the patient receiving mental health/substance abuse care? ❑ Yes ☐ No
8. If you did not answer "Yes" to any of the above questions, please describe the condition for which the patient requests Transition of Care. Utilize space on back of page. Utilize space on back of page

9. Please complete the treating physician's information below.

Group Practice Name		
Physician's Name	Telephone # of Physician	
Physician's Specialty		
Address of Physician		
Name of Hospital at Which Your Physician Practices	Telephone # of Hospital	
Address of Hospital		
Reason/Diagnosis		
Date(s) of Admission (mm/dd/yyyy)	Date of Surgery (mm/dd/yyyy)	Type of Surgery
Treatment Being Received and Expected Duration		

10. Is this patient expected to be in the hospital when coverage with GlobalHealth begins or during the next 60 days? ❑ Yes ❑ No

11. Newly selected Globalhealth Primary Physician's Name_____

I hereby authorize the above physician(s) to provide GlobalHealth or any affiliated GLOBALHEALTH company with any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care Benefits under GlobalHealth. This authorization will expire 24 months from the date signed. I

understand I may revoke this authorization at any time by writing to the address listed at the bottom of this form. I understand that I cannot restrict information that may have already been shared based on this authorization. I understand I am entitled to a copy of this authorization form.	
Signature of Patient, Parent or Guardian	Date (mm/dd/yyyy)

Describe condition from #8 requiring transition of care:

INSTRUCTIONS FOR COMPLETING TRANSITION OF CARE REQUEST FORM

A separate Transition of Care Request Form must be completed for each condition for which you or your dependents are seeking Transition of Care benefits. Please make certain that all questions are answered completely. When the form has been completed, the patient for whom Transition of Care benefits have been requested should sign it. If the patient is a minor, a guardian's signature is necessary.

To help ensure a timely review of your transition case, please return the form as soon as possible. The completed forms should be marked "Confidential" and forwarded to the below address.

The first few sections of the form apply to the Employee. When the form asks for the patient's name, only the name of the person, who is actually undergoing care and is requesting Transition of Care, should be reflected.

Please send the form to:

- **GlobalHealth Inc.**
- Customer Care Department
- P.O. Box 2393
- Oklahoma City, OK 73101-2393
- 1-405-280-5600 (phone) 1-877-280-5600 Toll Free; 1-405-280-5240 Fax

GlobalHealth Transition of Care Request Form – Prescriptions

Please complete and fax back to 405-280-5613
or mail to **GlobalHealth Pharmacy Dept. | 6120 S. Yale Ave. Ste. 925 | Tulsa OK 74136**

Please complete this form if you are taking prescription medications that are currently covered by another insurance company. This is necessary, even if your current doctor and pharmacy are in GlobalHealth's network. Please complete a separate form for each patient. Photocopies of this form are acceptable.

Employer	Cardholder ID # (if available)	Date of Enrollment in GlobalHealth Benefit Plan (mm/dd/yyyy)
Employee Name	Employee SSN	Work Phone ( )_____-_____
Home Address (Street, City, State, Zip)		Home Phone ( )_____-_____

Patient's Name	Patient's SSN	Patient's DOB (mm/dd/yyyy)	Relationship to Employee ☐Self ☐Spouse ☐Child

Which of the following BRAND-NAME prescriptions does this patient take? Check all that apply.
(Most generic medications do not require prior authorization.)

☐AcipHex	☐Celebrex	☐Enbrel	☐Janumet	☐Olysio	☐Sovaldi	☐Trilipix
☐Actonel	☐Copaxone	☐Frova	☐Lidoderm	☐Oracea	☐Strattera	☐Vascepa
☐Adderall/XR	☐Crestor	☐Gilenya	☐Lunesta	☐OxyContin	☐Suboxone	☐Vesicare
☐Advair	☐Cymbalta	☐Glumetza	☐Lyrica	☐Pegasys	☐Symbicort	☐Victoza
☐Atralin	☐Dexilant	☐Humira	☐Modafinil	☐Pradaxa	☐Tazorac	☐Voltaren
☐Avinza	☐Doryx	☐Incivek	☐Nasonex	☐Pristiq	☐Tecfidera	☐Vyvanse
☐Benicar	☐Dymista	☐Intuniv	☐Nexium	☐Provigil	☐Testim	
☐Byetta	☐Edarbi	☐Januvia	☐Nuvigil	☐Remicade	☐Treximet	

This is intended to be a representative list and should not be considered an exhaustive or conclusive list of medications that are subject to prior authorization, step therapy, or other utilization management reviews. If you are taking one or more BRAND-NAME medications similar to one of those named above, please list them below. Feel free to attach a medication history from your pharmacy.

_____

Please provide as much information as possible about the physician(s) who prescribe these medications for you. Attach additional pages if necessary.

Physician Name	Physician's Phone # ( )_____-_____	Physician's Fax # ( )_____-_____
Physician's Practice Address (Street, City, State, Zip)		Type of prescriber ☐MD ☐Nurse Practitioner ☐DO ☐Physician's Asst.
Medication(s) prescribed by this physician:		If NP or PA, who is the collaborating Dr?

I hereby authorize the above physician(s) to provide GlobalHealth or any affiliated GlobalHealth company with any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care Benefits under GlobalHealth. This authorization will expire 24 months from the date signed. I understand I may revoke this authorization at any time by writing to the address listed at the top of this form. I understand that I cannot restrict information that may have already been shared based on this authorization. I understand I am entitled to a copy of this authorization form.

_____
Signature of patient, parent, or guardian Date

Your Personally Identifiable Information ("PII")

PII is information that can be used to distinguish or trace an individual's identity. It may be information used alone. It may be combined with other information that may be linked to a specific individual. It is protected by federal and state laws.

Anyone who receives information that you are required to provide may use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of your health coverage. GlobalHealth may receive the information directly, from another person, or from a Federal agency. GlobalHealth will not share PII with anyone else except to carry out the functions of providing your health coverage and for which you have provided consent for your information to be used or disclosed.

Your Protected Health Information ("PHI")

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

You have the right to access or restrict the release of your PHI in accordance with federal and state laws. You may also request an accounting of disclosures of your PHI. Forms are available by contacting Customer Care.

When changing PCPs, 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. You may also obtain the *Oklahoma Standard Authorization To Use Or Share Protected Health Information* release form on our website.

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.

Notice of Privacy Practices ("NPP")

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 healthcare Provider, Hospital, or other healthcare Facility in order to arrange for or facilitate treatment for you.

For Payment. We may use and/or disclose your PHI for purposes of paying claims from physicians, Hospitals, and other healthcare 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 Healthcare Operations. We may use and/or disclose PHI about you for Health Plan operational purposes. Some examples include: risk management, patient safety, quality improvement, internal auditing, utilization review, medical or peer review, certification, regulatory compliance, internal training, accreditation, licensing, credentialing, investigation of complaints, performance improvement, etc.

Health-Related Business and Services. We may use and disclose your PHI to tell you of health-related products, benefits, or services related to your treatment, care management, or alternate treatments, therapies, Providers, or care settings.

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, accreditation, audits, investigations, inspections, and 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;
- 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, Insurance Department, 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 coordination of insurance or Medicare benefits, 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); and
- In the course of any administrative or judicial proceeding, where required by law.

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

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

Family, Friends, Caregivers. We may disclose your PHI to a family member, caregiver, or friend who accompanies you or is involved in your medical care or treatment, or who helps pay for your medical care or treatment. If you are unable or unavailable to agree or object, we will use our best judgment in communicating with your family and others.

Emergencies. We may use and/or disclose your PHI if necessary in an emergency if the use or disclosure is necessary for your emergency treatment.

Military / Veterans. If you are a member or veteran of the armed forces, we may disclose your PHI as required by military command authorities.

Inmates. If you are an inmate of a correctional institute or under the custody of law enforcement officer, we may disclose your PHI to the correctional institute or law enforcement official.

Appointment Reminders. We may use and/or disclosure your PHI to contact you as a reminder that you have an appointment for treatment or medical care. This may be done through direct mail, email, or telephone call. If you are not home, we may leave a message on an answering machine or with the person answering the telephone.

Medication and Refill Reminders. We may use and/or disclose your PHI to remind you to refill your prescriptions, to communicate about the generic equivalent of a drug, or to encourage you to take your prescribed medications.

Limited Data Set. If we use your PHI to make a "limited data set," we may give that information to others for purposes of research, public health action, or healthcare operations. The individuals/entities that receive the limited data set are required to take reasonable steps to protect the privacy of your information.

Any Other Uses. We will disclose your PHI for purposes not described in this notice only with your written authorization. Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing or fundraising purposes, and disclosures that constitute a sale of PHI require your written authorization.

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

Right to Inspect and Copy

You have the right to inspect and copy your PHI as provided by law. This right does not apply to psychotherapy notes. Your request must be made in writing. We have the right to charge you the amounts allowed by state and federal law for such copies. We may deny your request to inspect and copy your records in certain circumstances. If you are denied access, you may appeal to our Privacy Officer.

Right to Confidential Communication

You have the right to receive confidential communication of your PHI by alternate means or at alternative locations. 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.

Right to Accounting of Disclosures

You have the right to request an accounting of certain disclosures of your PHI to third parties, except those disclosures made for treatment, payment, or healthcare or Health Plan operations and disclosures made to you, authorized by you, or pursuant to this Notice. To receive an accounting, you must submit your request in writing and provide the specific time period requested. You may request an accounting for up to six (6) years prior to the date of your request (three years if PHI is an electronic health record). If you request more than one (1) accounting in a 12-month period, we may charge you for the costs of providing the list. We will notify you of the cost and you may withdraw your request before any costs are incurred.

Right to Request Restrictions on Uses or Disclosures

You have the right to request restrictions or limitations 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 we do agree, we will make all reasonable efforts to comply with your request unless the information is needed to provide emergency treatment to you or the disclosure has already occurred or the disclosure is required by law. Any agreement to restrictions must be signed by a person authorized to make such an agreement on our behalf.

Right to Request Amendment of PHI

You have the right to request an amendment of your PHI if you believe the record is incorrect or incomplete. You must submit your request in writing and state the reason(s) for the amendment. We will deny your request if: (1) it is not in writing or does not include a reason to support the request; (2) the information was not created by us or is not part of the medical record that we maintain; (3) the information is not a part of the record that you would be permitted to inspect and copy, or (4) the information in the record is accurate and complete. If we deny your amendment request, you have a right to file a statement of disagreement with our Privacy Officer.

Right to Be Notified of a Breach

You have the right to receive notification of any breaches of your unsecured PHI.

Right to Revoke 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.

Right to Receive a Copy of this Notice

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

Changes to this Notice

GlobalHealth reserves the right to change this notice and make the new provisions effective for all PHI that we maintain.

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

ATTN: Privacy Officer
GlobalHealth, Inc.
701 NE 10th
Suite 300
Oklahoma City, OK 73104-5403

Phone: (405) 280-5711 • 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 penalized or retaliated against for filing a complaint.

Effective Date 4/1/2013.

A stand-alone printable version of the current NPP is available on our website.

Advance Directives

An Advance Directive is a written document that allows you to inform physicians and others of your wishes to receive, decline, or withdraw life-sustaining medical care. It may include a living will, appointment of a health proxy or both.

Who can have an Advance Directive?
Any individual of sound mind and eighteen (18) years of age or older can have an Advance Directive for healthcare. Your Advance Directive becomes effective when it is communicated to your physician and you are no longer able to make decisions regarding administration of life-sustaining treatment.

You may revoke your Advance Directive in whole or in part at any time upon your communication to your attending physician or other healthcare Provider or by a witness to the revocation.

You are not required to have an Advance Directive. It is entirely your choice.

Helpful Information
- If you are admitted to a Hospital, give the Hospital a copy of your Advance Directive.
- Ask your physician to make your Advance Directive part of your permanent medical record.
- Keep a second copy of your Advance Directive in a safe place where it can be easily found.
- If you have appointed a healthcare proxy, give a copy of the Advance Directive to this individual.
- Keep a small card in your purse or wallet which states that you have an Advance Directive and where it is located. State who your healthcare proxy is if you have one.

For more information on Advance Directives, ask your PCP or contact Customer Care at (405) 280-5600 or 1-877-280-5600.

Member Rights and Responsibilities

Your Rights

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

- Receive information about GlobalHealth's organization, its services, and its Practitioners and Providers.
- Be treated with dignity and respect.
- Participate with Practitioners in making decisions about your healthcare.
- A candid discussion of all appropriate, Medically Necessary treatment options for your condition, regardless of the cost of care or benefit coverage.
- Voice complaints or Appeals about GlobalHealth or the care provided.
- Make recommendations regarding GlobalHealth's Member Rights and Responsibilities policy.
- Freely communicate with Practitioner about treatment options, regardless of benefit coverage limitations.
- A right to ask about any healthcare concerns, request medical advice or obtain additional information about a prescribed treatment in order to make an informed decision or refuse a course of treatment.
- 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.
- 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.
- 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.
- 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.
- Expect problems to be fairly examined and appropriately addressed.

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

Your Responsibilities

You or your legal designee has the responsibility to:

- Supply information, to the extent possible, that GlobalHealth and its Practitioners and Providers need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your Practitioner.
- Understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.

- Identify yourself by presenting your Member ID card (to physician, laboratory, Hospital, etc.) when receiving Medical Services.
- 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 healthcare services.
- 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/state. A copy can be printed from our website or you may request a copy from Customer Care.

If you have any questions or concerns regarding the benefits outlined in this *Member Handbook*, please contact Customer Care.

Fraud and Abuse

Fraud is knowingly and willfully carrying out, or attempting to carry out, a plan or scheme to defraud a healthcare benefit program, or to obtain, by means of a lie or false pretenses, a benefit for which the individual is not entitled.

Abuse includes requesting payment for items and services when there is no entitlement for payment of those items or services. Unlike Fraud, the individual or entity has not knowingly or intentionally misrepresented facts to obtain payment.

Examples of Fraud and/or Abuse
Healthcare Providers: • Billing or charging you for services that GlobalHealth covers (other than your Cost-Share). • Offering you gifts or money to get treatment or services that you do not need. • Offering you free services, equipment, or supplies in exchange for using your GlobalHealth Member ID number. • Giving you treatment or services that you do not need. • Billing GlobalHealth for services that were not actually provided.
Members: • Selling or lending your Member ID card to someone else. • Lying to a healthcare Provider in order to receive items or services that are not Medically Necessary.

Reporting Fraud and Abuse
GlobalHealth is committed to detecting and preventing healthcare Fraud and Abuse. You can help in this effort by reporting suspected Fraud and/or Abuse by calling our 24-hour hotline toll-free at 1-877-280-5852. If you call this number, please provide as much detailed information as possible. You may remain anonymous if you choose.

GlobalHealth's Fraud, Waste, and Abuse, Compliance, and Privacy Hotline:
Call and leave message twenty-four (24) hours. (405) 280-5852 (local) 1-877-280-5852 (toll-free) compliance@globalhealth.com

Your ERISA Rights

You may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). These rights only apply to Members enrolled through a group Health Plan. Check with your Plan Administrator (your employer) to see if your group Health Plan is governed by ERISA.

Continue Group Health Plan Coverage

Continue healthcare coverage for yourself, spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. See "Continuation Coverage Rights Under COBRA" on page 91.

Enforce Your Rights

If your claim for benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan Administrator and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact your Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from your Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Continuation Coverage Rights Under COBRA

This provision may not apply to your Plan's coverage. Please check with your employer to determine if your group Health Plan is subject to COBRA regulations.

Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact your employer.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual Plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly Premiums and lower Out-of-Pocket costs. Additionally, you may qualify for a 30-day Special Enrollment Period for another group Health Plan for which you are eligible (such as a spouse's Plan), even if that Plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event. This is also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;

- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "Dependent child."

When is COBRA Continuation Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (Part A, Part B, or both), the Plan Administrator must be notified of the qualifying event.

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the employer within 60 days after the qualifying event occurs.

How is COBRA Continuation Coverage Provided?
Once the employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for eighteen (18) months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of thirty-six (36) months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage:
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify your employer in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of twenty-nine (29) months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage:
If your family experiences another qualifying event during the eighteen (18) months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any Dependent children getting continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (Part A, Part B, or both); gets divorced or legally separated; or if the Dependent child stops being eligible under the Plan as a Dependent

child. This extension is only available if the second qualifying event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Options Besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group Health Plan coverage options (such as a spouse's Plan) through what is called a "Special Enrollment Period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your employer. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group Health Plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes
To protect your family's rights, let both your employer and GlobalHealth know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer.

Plan Contact Information
You can obtain information about the Plan and COBRA continuation coverage by sending a request to your employer.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). Coverage will be provided in a manner determined by you and your doctor, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Copayments and Coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, contact Customer Care.

Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group Health Plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with

childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending Provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also under federal law, Plans and issuers may not set the level of benefits or out-of-pockets costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a Plan or issuer may not, under federal law, require that a physician or other healthcare Provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours (or 96 hours). However, to use certain Providers or Facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, call Customer Care.

We will coordinate coverage.

Creditable Coverage Disclosure Notice for Medicare Eligible Members

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current Prescription Drug coverage and about your options under Medicare's Prescription Drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare Prescription Drug coverage in your area. Information about where you can get help to make decisions about your Prescription Drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's Prescription Drug coverage:

1. Medicare Prescription Drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly Premium.

2. GlobalHealth has determined that this Prescription Drug coverage is, on average for all Plan participants, expected to pay out as much as standard Medicare Prescription Drug coverage pays and is therefore considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher Premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable Prescription Drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period ("SEP") to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current coverage will not be affected. You can keep this coverage if you elect part D and this Plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within sixty-three (63) continuous days after your current coverage ends, you may pay a higher Premium (a penalty) to join a Medicare drug plan later.

If you go sixty-three (63) continuous days or longer without creditable Prescription Drug coverage, your monthly Premium may go up by at least 1% of the Medicare base beneficiary Premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your Premium may consistently be at least 19% higher than the Medicare base beneficiary Premium. You may have to pay this higher Premium (a penalty) as long as you have Medicare Prescription Drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact Customer Care for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer Prescription Drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription Drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare Prescription Drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher Premium (a penalty).

Subrogation, Third-Party Recovery, and Reimbursement

Benefits Subject to This Provision

This provision applies to all benefits provided under any section of this plan to:

a) Covered Persons (or Members) and Dependents, COBRA beneficiaries, family members, and any other person who may recover on behalf of a Covered Person or beneficiary including, but not limited to, the estate of a deceased Covered Person or beneficiary, (collectively referred to as "Covered Person"); and,

b) All other agents, attorneys, representatives, and persons acting for, on behalf of, in concert with, or at the direction of a Covered Person (sometimes referred to as "Covered Person's Representatives") with respect to such benefits.

When this Provision Applies

A Covered Person may incur medical or other charges related to injuries or illnesses caused by the act or omission of Another Party including a Physician or other Provider for acts or omissions including but not limited to malpractice. Another Party may be liable or legally responsible for payment of charges incurred in connection with such Injuries or Illnesses. If so, the Covered Person may have a claim against Another Party for payment of the medical or other charges.

Defined Terms

"Another Party" means any individual or entity, other than the plan, that is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's injuries or illnesses. Another Party shall include the party or parties who caused the injuries or illness (first or third parties); the insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; a medical malpractice or similar fund; and any other person, corporation or entity that is liable or legally responsible for payment in connection with the injuries or illness.

"Recovery" means any and all money, fund, property, compensation, as well as all rights thereto, or damages paid or available to the Covered Person by Another Party through insurance payments, settlement proceeds, first or third party payments or settlement proceeds, judgments, reimbursements or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness.

"Reimbursement" or "Reimburse" means repayment to the plan for medical or other benefits paid or payable toward care and treatment of the illness or injury and for any other expenses incurred by the Plan in connection with benefits paid or payable.

"Subrogation" or "Subrogate" shall mean the plan's right to pursue the Covered Person's claims against Another Party for medical or other charges paid by the plan.

Conditions and Agreements

Benefits are payable only upon the Covered Person's acceptance of, and compliance with, the terms and conditions of this plan. The Covered Person agrees that acceptance of benefits is constructive notice of this section. As a condition to receiving benefits under this plan, a Covered Person and each other obligated party agree(s):

a) That in the event a Covered Person under this Plan, and/or the Covered Person's Representatives receives any Recovery or other benefits arising out of any injury, accident, event, or incident for which the Covered Person has, may have, or asserts any claim or right to recovery under any theory of law or equity, tort, contract, statute, regulation, ordinance or otherwise against any other person, entity or source including, without limitation, any third party, insurer, insurance, and/or insurance coverage (e.g., uninsured and underinsured motorist coverage, personal injury coverage, medical payments coverage, workers' compensation, etc.), any payment or payments made by the plan to Covered Person for such benefits shall be made on the condition and with the agreement and understanding that the Plan will be reimbursed by Covered Person and Covered Person's Representatives to the extent of, but not to exceed the Recovery amount or amounts received by Covered Person from such Another Party or source by way of any agreement, settlement judgment or otherwise;

b) That the plan shall be subrogated to all rights of Recovery the Covered Person has against Another Party potentially responsible for making any payment to Covered Person as a result of any injury, damage, loss or illness Covered Person sustains to the full extent of benefits provided or to be provided by the plan to Covered Person or on Covered Person's behalf with respect to that illness, injury, damage or loss immediately upon the plan's payment or provision of any benefits to Covered Person or on Covered Person's behalf. The plan's recovery, subrogation and reimbursement rights provided herein exist even where a party allegedly at-fault or responsible for any loss, injury, damage or illness Covered Person sustains does not admit responsibility and regardless of the designation or characterization given to the funds Covered Person receives or agrees to be disbursed from that party or that party's representative;

c) To notify GlobalHealth's Plan Administrator if a Covered Person has a potential right to receive payment from someone else; to promptly execute and deliver to the Plan Administrator, if requested by the Plan Administrator or its representatives, a Subrogation and Reimbursement agreement; and, to supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim. The Plan Administrator may determine, in its sole discretion, that it is in the plan's best interests either to pay, or to not pay, medical or other benefits for the injuries or illness before the Subrogation and Reimbursement agreement has been signed. However, in either event, the plan will still be entitled to Subrogation and Reimbursement according to the terms of this Section;

d) To serve as a constructive trustee, and to hold in constructive trust for the benefit of the plan any Recovery from Another Party, and agrees not to dissipate any such Recovery without prior written consent of the plan, or to otherwise prejudice or impair the plan's first rights to any such Recovery, regardless of how such Recovery may be characterized, designated or allocated. Covered Person agrees to hold, as trustee (or co-trustee) in trust for the benefit of the plan all Recovery and funds Covered Person receives in payment of or as compensation for any injury, illness, damage and loss Covered Person sustained resulting from any such event, incident, accident, injury, illness and occurrence. Any such Recovery or funds received by, on behalf of, with the consent of, or at the direction of Covered Person, or to which Covered Person is entitled

to receive or direct payment, or over which Covered Person (or a Covered Person's Representatives) has, or exercises, any control, are deemed and shall be considered and treated as assets of the plan. Failure to hold Recovery and such funds in trust or to abide by these Plan terms will be deemed a breach of Covered Person's (or the Covered Person's Representative's) fiduciary duty to the plan. The plan has a right of subrogation or reimbursement before any Recovery and funds are paid to Covered Person from the responsible source and no attorneys' fees or costs may be subtracted from such amount. The plan may, at its option and sole discretion, exercise either its subrogation and/or its repayment rights. The plan is also entitled to any Recovery and funds Covered Person receives or is entitled to receive regardless of whether or not the payment represents full compensation to Covered Person. The plan expressly disclaims all make whole and common fund rules and doctrines and/or any other rule or doctrine that would impair or interfere with the plan's rights herein. The plan shall be entitled to an accounting from the Covered Person of all Recovery, funds, and activities described herein;

e) To restore to the plan any such benefit paid or payable to, or on behalf of, the Covered Person when said benefits are paid or established by Another Party;

f) To transfer title to the plan for all benefits paid or payable as a result of said illness or injury. The Covered Person acknowledges that the plan has a property interest in the Covered Person's Recovery, and that the plan's Subrogation rights shall be considered a first priority claim to any Recovery, and shall be paid from any such Recovery before any other claims for the Covered Person as the result of the illness or injury, regardless of whether the Covered Person is made whole;

g) That the plan is granted a first right and priority to, as well as a first lien against, 100% of any Recovery to the extent of benefits paid or to be paid and expenses Incurred by the plan in enforcing this provision; and such lien is an asset of the plan. The plan's first lien fully supersedes any right of first payment, or Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person is made whole or has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs;

h) That the Covered Person also agrees to notify the plan of Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation with respect to any matter for which Covered Person has obtained or will obtain any benefits from the plan. Covered Person will be required to provide all information requested by the plan or its representative regarding any such claim. Covered Person also agrees to keep the plan informed as to all facts and communications that might affect the plan's rights;

i) To refrain from releasing Another Party that may be liable for or obligated to the Covered Person for the injury or condition without obtaining the plan's written approval;

j) To notify the plan in writing of any proposed settlement and obtain the plan's written consent before signing a settlement agreement;

k) Without limiting the preceding, the plan shall be subrogated to any and all claims, causes, action or rights that the Covered Person has or that may arise against Another Party for which the Covered Person claims an entitlement to benefits under this plan, regardless of how classified or characterized;

l) If the Covered Person (or guardian or estate) decides to pursue Another Party, the Covered Person agrees to include the plan's Subrogation claim in that action and if there is failure to do so, the plan will be legally presumed to be included in such action or Recovery;

m) In the event the Covered Person decides not to pursue Another Party, the Covered Person authorizes the plan to pursue, sue, compromise, or settle any such claim in their name, to execute any and all documents necessary to pursue said claims in their name, and agrees to fully cooperate with the plan in the prosecution of any such claims. Such cooperation shall include a duty to provide information and execute and deliver any acknowledgement or other legal instrument documenting the plan's Subrogation rights. The Covered Person (or guardian or estate) agrees to take no prejudicial actions against the Subrogation rights of the plan or to in any way impede the action taken by the plan to recover its Subrogation claim. This includes attempts by the Covered Person, (or by his or her attorney or other agent) to have payments characterized as non-medical in nature, or to direct or consent to have payments made to others (e.g., to or on behalf of relatives, attorneys, agents, representatives, or friends).

n) The plan will not pay, offset any Reimbursement, or in any way be responsible for any fees or costs associated with pursuing a claim unless the plan agrees to do so in writing. The plan's right of first Reimbursement will not be reduced for any reason including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;

o) The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of the plan document. The Plan Administrator may amend the plan in its sole discretion at any time without notice. This right of Subrogation shall bind the Covered Person's guardian(s), estate, executor, personal representatives, and heirs.

p) That the Plan Administrator may, in its sole discretion, require the Covered Person or his or her attorney to sign a subrogation/recovery agreement acknowledging and agreeing to the plan's rights herein as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries.

When a Covered Person Retains an Attorney

If the Covered Person retains an attorney, the Plan Administrator may, in its sole discretion, require that the attorney sign a subrogation/recovery agreement acknowledging and agreeing to the plan's rights herein as a condition to any payment of benefits and as a condition to any payment of future benefits for other illnesses or injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The plan will not pay the Covered Person's attorney's fees and costs associated with the recovery of funds, nor will it reduce its Reimbursement pro rata for the payment of the Covered Person's attorney's fees and costs. Attorneys' fees will be payable from the Recovery only after the plan has received full Reimbursement. An attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery to the plan under the terms of this provision. A Covered Person's attorney who receives any such Recovery and does not immediately tender the Recovery to the plan will be deemed to hold the Recovery in constructive trust for the Plan, because neither the Covered Person nor his attorney is the rightful owner of the Recovery and should not be in possession of the Recovery until the plan has been fully Reimbursed.

In addition, the plan may further require that

i. Covered Person utilizes the services of attorneys, representatives or agents who will execute a Reimbursement Agreement and who will not assert the make whole and common fund rule or doctrines, and

ii. Covered Person agrees to terminate any relationship with anyone who refuses to do so, or benefits will not be payable under the plan in connection with that matter.

The plan is also entitled to receive and has priority to receive the first funds from payments received by Covered Person until the plan has been repaid for all sums expended. Covered Person shall execute and deliver any instruments and documents reasonably requested by the plan and shall do whatever is necessary to fully protect all the plan's rights. Covered Person shall do nothing to prejudice the rights of the plan to such reimbursement and subrogation, including, without limitation, any attempt by Covered Person or others to have payments characterized as non-medical in nature (e.g., for emotional distress, pain and suffering, embarrassment, mental anguish, loss of consortium, etc.) or to direct or consent to have payments made to others (e.g., to or on behalf of relatives, attorneys, agents, representatives or friends).

When the Covered Person is a Minor or is Deceased

The provisions of this section apply to the parents, trustee, guardian, or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the representative has access or control of the Recovery.

When a Covered Person Does Not Comply

a. If the subrogation agreement is not properly executed and returned as provided for in this provision; (ii) information and assistance is not provided to the Plan Administrator upon request; or, (iii) any other provision or obligation of this Section is not timely complied with, no benefits will be payable under the plan with respect to costs Incurred in connection with such Illness or Injury.

b) If a Covered Person fails to Reimburse the plan for all benefits paid or to be paid, as a result of their illness or injury, out of any Recovery received as provided in this plan, or otherwise fails to comply with any other provision or obligation of this Section, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the plan's attempt to recover such money or property from the Covered Person; and, the plan shall be entitled to offset and apply any future benefits that might otherwise be due, for the benefit of the Covered Person, the Covered Person's family members, or any other person who directly or indirectly acted or cooperated to interfere with, impair, or defeat the plan's rights or interests against such reimbursements that should have been made to the plan, as well as to suspend or terminate further coverage until such reimbursements are recovered by the plan. This right of Reimbursement shall bind the Covered Person's guardian(s), estate, executor, personal representative, and heir(s).

c) Additionally, Covered Person shall be fully responsible for the actions of Covered Person's Representatives, attorneys, agents, family members, and all persons acting for, on behalf of, in concert with, or at the direction of Covered Person regarding the plan or Covered Person's obligations described herein. Covered Person shall be responsible to ensure that such persons cooperate and comply with Covered Person's obligations herein. If Covered Person or Covered Person's agents, attorneys or any other representative fails to fully cooperate with any subrogation, reimbursement, or repayment efforts, or directly or indirectly defeats, hinders,

impedes, or interferes with any such efforts, Covered Person shall be responsible to account for and pay to the plan all attorney's fees and costs incurred by or on behalf of the plan in connection with such efforts.

d) Additionally, the plan may, in the discretion of its final decision maker, terminate Covered Person's participation in the plan or the participation of any other person who directly or indirectly acted or cooperated to interfere with, impair, or defeat the plan's rights or interest. In the event that any claim is made that any wording, term or provision set forth in this Subrogation and Right of Reimbursement portion of the Summary Plan Description is ambiguous or unclear, or if any questions arise concerning the meaning or intent of any of its terms, the plan through its final decision maker, shall have the sole authority and discretion to construe, interpret and resolve all disputes regarding the interpretation of any such wording, term or provision.

e) The plan's subrogation and reimbursement rights described herein are essential to ensure the equitable character of the plan and its financial soundness, and to ensure that funds are recouped and made available for the benefit of all Covered Persons under the plan collectively.

GLOSSARY

Abuse –

Includes requesting payment for items and services when there is no entitlement for payment of those items or services. Unlike Fraud, the individual or entity has not knowingly or intentionally misrepresented facts to obtain payment.

Adverse Determination –

A determination that an admission, availability of care, continued stay or other healthcare 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, healthcare 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 GlobalHealth Allowed Amount, you may have to pay the difference. (See Balance Billing.)

Alternative Medicine –

Defined by the National Center for Complementary 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.

Approved Clinical Trial –

A clinical trial that is sponsored by a credible organization and conducted in compliance with federal regulations including those relating to the protection of human subjects. The trial must have a therapeutic intent and not designed solely to identify or test disease pathophysiology.

Balance Billing –

When a Provider bills you for the difference between the Provider's charge and the GlobalHealth Allowed Amount. For example, if the Provider's charge is $100 and the GlobalHealth Allowed Amount is $70, the Provider may bill you for the remaining $30. An In-Network Provider may ***not*** balance bill you.

Case Management –

A process to assess, plan, implement, coordinate, monitor, and evaluate options to meet your healthcare needs based on the benefits and resources needed 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 healthcare coverage at group rates in specific instances where coverage would otherwise end.

Coinsurance –

Your share of the costs of a covered healthcare 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 healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

Cost-Share –

The portion of the cost for services, treatment, and supplies that you pay. This includes Deductibles, Copayments, and Coinsurance.

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 healthcare 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 healthcare 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 twenty-six (26) (including stepchildren, foster children, and adopted children from the date placed in the home) of the Subscriber. GlobalHealth covers Dependents when they meet eligibility and Premium requirements.

Durable Medical Equipment ("DME") –

Equipment and supplies ordered by a healthcare 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.

Excluded Services –

Healthcare 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, twenty-four (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, or area in a building, in which healthcare services are delivered.

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

Free-standing/Low-cost Facility –
Any building, or area in a building, that is independent of Hospital ownership.

Grievance –
A complaint that you communicate to GlobalHealth in writing.

Health Plan –
A specific benefit package offered by an insurer, HMO, or self-funded employer Plan. The GlobalHealth Health Plan is described in the GlobalHealth *Group Agreement*, including cover sheet and attachments.

Home Healthcare –
Medically Necessary healthcare 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.

Hospital-owned Facility –
Any building, or area in a building, owned by a Hospital in which healthcare services are delivered. These Facilities may include buildings, or areas within buildings, that are separate from the Hospital itself.

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 Network Provider, as a cause of Infertility.

In-Network –

A healthcare Provider or Facility that has a Contract with GlobalHealth to provide services at a discounted rate for Members. In-Network Providers can be found in the *Physician and Health Providers Directory* or on our website Provider Search. Also see Network.

In-Network Coinsurance –

The percent (for example, 20%) you pay of the Allowed Amount for covered healthcare services to Providers who contract with GlobalHealth. In-Network Coinsurance usually costs you less than Out-of-network Coinsurance. GlobalHealth does not have different Cost-Share based on Network. You only have coverage for services in our Network, except for urgent or emergent care.

In-Network Copayment –

A fixed amount (for example, $15) you pay for covered healthcare services to Providers who contract with GlobalHealth. In-Network Copayments usually are less than Out-of-network Copayments. GlobalHealth does not have different Cost-Share based on Network. You only have coverage for services in our Network, except for urgent or emergent care.

Inpatient –

Patient who is admitted to and is assigned a bed in a healthcare facility while undergoing diagnosis and receiving treatment and care.

Life-threatening Disease or Condition –

Any disease or condition from which the likelihood of death is probable unless the course of the disease is interrupted.

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 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 healthcare 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 –

Healthcare 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 enrolled Subscriber or Dependent of Subscriber.

Network –
The Facilities and Providers that GlobalHealth has contracted with to provide healthcare services to its Members. These Facilities and Providers are referred to as In-Network.

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 –
A healthcare Provider does not have a Contract with GlobalHealth to provide services to Members.

Out-of-Network Coinsurance –
The percent (for example, 40%) you pay of the Allowed Amount for covered healthcare services to Providers who do ***not*** contract with GlobalHealth. Out-of-Network Coinsurance usually costs you more than In-Network Coinsurance. GlobalHealth does not have different Cost-Share based on Network. You only have coverage for services in our Network, except for urgent or emergent care.

Out-of-Network Copayment –
A fixed amount (for example, $30) you pay for covered healthcare services from Providers who do ***not*** contract with GlobalHealth. Out-of-Network Copayments usually are more than In-Network Copayments. GlobalHealth does not have different Cost-Share based on Network. You only have coverage for services in our Network, except for urgent or emergent care.

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 healthcare costs that GlobalHealth doesn't cover. The *Schedule of Benefits* provides the Out-of-Pocket Maximum for your Plan.

Outpatient –
Patient who is undergoing diagnosis and receiving treatment and care, but is not admitted to or assigned a bed in a healthcare Facility.

Physician Services –
Healthcare 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 healthcare services.

Plan Administrator –
The person who is identified as having responsibility for administering the Plan. It could be the employer, a committee of employees, a company executive, or someone hired for that purpose. It does not refer to GlobalHealth.

Practitioner –

A professional who provides healthcare services. Practitioners are licensed as required by law.

Preauthorization –

A decision by GlobalHealth that a healthcare 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 Usual and Customary.

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 healthcare 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 healthcare 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 ninety (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), healthcare professional, or healthcare Facility licensed, certified, or accredited as required by state law. It may also refer to an institution or organization that provides services for Health Plan Members (such as Hospitals and home health agencies).

Prudent Layperson –

A person without medical training who reasonably draws on practical experience when making a decision regarding whether Emergency Services are needed. A person, who has an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual in serious jeopardy; (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part.

Qualified Member –

You are qualified to participate in an Approved Clinical Trial if (1) you are eligible to participate in the trial according to its protocol; and (2) either a Network Provider who has referred you to the trial concludes that participation would be appropriate, or you provide medical and scientific information that establishes that your participation is appropriate.

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.

Referral –

An electronic communication submitted to us by a Member's PCP or Specialist who directs a Member to a Specialist, Hospital, or other ancillary Provider for Covered Services. GlobalHealth reviews each Referral and sends you and the Provider a letter authorizing the service, if approved.

Rehabilitation Services –

Healthcare 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.

Routine Costs –

Routine Costs associated with an Approved Clinical Trial are costs that are associated with reasonable and necessary medical care that is typically provided absent a clinical trial, including costs associated with diagnosis and treatment of complications arising from participation in the clinical trial. Routine Costs do not include the cost of an investigational drug or item itself, or costs for items and services provided solely for data collection and analysis.

***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 healthcare 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 healthcare.

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.

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.

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.

Usual and Customary –
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 amount may be used to determine the Allowed Amount.

Utilization Management ("UM") –
A process for monitoring the use, delivery, and cost-effectiveness of services.

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