2018 Member Handbook

For State, Education, and Local Government Employees

HIOS Plan ID – 85408OK0100001

MLGMH18 – ST

GlobalHealth, Inc.
210 Park Avenue, Suite 2800
Oklahoma City, OK 73102-5621
1-877-280-5600
www.GlobalHealth.com/state

WELCOME TO GLOBALHEALTH

Thank you for choosing GlobalHealth. We value you as our member and want to gain your confidence in all we do.

As your chosen health Plan, we want to:

1. Help you ***achieve positive health outcomes***. If needed, our Care Management team can work with you and your doctor to create a plan to address your specific health needs.
2. Assist you in getting ***the most value out of your benefits***, such as Preventive Care.
3. ***Earn and keep your satisfaction***.

Please call our friendly, local Customer Care team if you have any questions at 1-800-280-5600 or visit www.GlobalHealth.com/state for more information on your Plan.

We are happy you are part of the GlobalHealth family and wish you good health.

Sincerely,
R. Scott Vaughn, CPA
President and CEO

CERTIFICATE OF COVERAGE

This Certificate of Coverage is issued according to the terms of your group health Plan.

Your employer group has contracted with GlobalHealth, Inc. to provide the benefits described. GlobalHealth, Inc., having been awarded a contract, certifies that all persons who have:

- Enrolled in coverage under this certificate;
- Paid for the coverage; and
- Met the conditions in the Eligibility and Enrollment section.

are covered by this certificate.

Beginning on your effective date, we agree to provide you the benefits described. You can find the effective date on your Member ID card.

Amendments may be added to this Certificate of Coverage because of changes in law, changes in your coverage, or the special needs of your group. Any provision in conflict with law is automatically amended to meet the minimum requirements of the statute on the effective date of this coverage or the law, whichever is later. No person or entity has authority to waive any provision or to make changes or amendments unless approved in writing by a GlobalHealth, Inc. officer. Attach any amendment to this Certificate of Coverage.

You are subject to all terms, conditions, limitations, and exclusions, and to all the rules and regulations of the Plan. By paying Premiums or having Premiums paid on your behalf, you accept the provisions of this Certificate of Coverage.

This certificate replaces any previous certificates that you may have been issued.

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.

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.

HELPFUL NUMBERS

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

GlobalHealth Customer Care and Language Assistance:
StateAnswers@globalhealth.com
405.280.5600
1.877.280.5600 (toll-free)
711 (TTY)
Mon – Fri, 9 a.m. – 5 p.m.

Appeals and Grievances:
405.280.5600
1.877.280.5600 (toll-free)
711 (TTY)
Mon – Fri, 9 a.m. – 5 p.m.
appeals@globalhealth.com

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

GlobalHealth Compliance Officer:
405.280.5852
1.877.280.5852 (toll-free)
compliance@globalhealth.com

GlobalHealth Privacy Officer:
405.280.5524
privacy@globalhealth.com

Behavioral Health:
StateAnswers@globalhealth.com
405.280.5600
1.877.280.5600 (toll-free)
711 (TTY)
Mon – Fri, 9 a.m. – 5 p.m.

Pharmacy Benefits Manager:
Magellan Rx Management, LLC
Customer Service
1.800.424.1789 (toll-free)
711 (TTY)

Medication Prior Authorizations:
gh.pharmacy@globalhealth.com
918.878.7361

Mail Claims to:
Magellan Rx Management, LLC
PO Box 85042
Richmond, VA 23261-5042

Mail Order Pharmacy:
Magellan Rx Management, LLC
1.800.424.1789 (toll-free)
711 (TTY)
P.O. Box 620968
Orlando, FL 32862

Have your Member ID card with you when you call.

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INTRODUCTION

Important Information

GlobalHealth, Inc. ("GlobalHealth") is a health maintenance organization ("HMO"). HMOs emphasize Preventive Care in addition to treatment for illness and injury. With us, you get a wide range of services to meet your healthcare needs.

Member Materials

This *Member Handbook* applies to you if you enrolled in the State, Education, and Local Government Employees Plan.

Your comprehensive Member handbook has three booklets. Each one has a different purpose. **These documents are important legal documents. Keep them in a safe place.**

Booklet	Purpose

Member Handbook for State, Education, and Local Government Employees **("*Member Handbook*")**	• Tells you about your benefits.
	  ○ What benefits are covered and how much you will pay.
	  ○ How they are covered (including limitations and exclusions).
	  ○ How to use them.

Physicians and Health Providers Directory **("*Provider Directory*")**	• Lists our Network of doctors, Facilities, and pharmacies. • Tells you if a Facility is preferred or not.
Formulary Drug List for State, Education, and Local Government Employees **("*Drug Formulary*" or "Formulary")**	• Lists drugs we cover. • Tells you what Tier a drug is in. • Tells you if there are any rules to getting a drug.

In order to get the most out of your benefits, it is important that you understand how they work. Read your booklets carefully. Many of the sections are interrelated. Reading only parts may mislead you. If you do not follow the rules, you might have to pay for care we would usually cover. It is your responsibility to understand the terms and conditions.

- When these booklets say "we", "us", or "our", it means GlobalHealth, Inc.
- We tell you what words or phrases that start with a capital letter mean in the glossary.
- We tell you what abbreviations mean in the acronyms list.
- Hyperlinks lead to the glossary, the acronyms list, a specific section of this *Member Handbook*, or a specific document.

Unless we specifically tell you otherwise:

- "Hours" mean clock hours.
- "Days" mean calendar days.
- "Months" mean consecutive calendar months. We count the months from the last time you had the service, not the date of the month.
- "Year" means calendar year.

You can see and print these booklets online. You will need your group ID number to see materials for your Plan. It is on your Member ID card.

The *Drug Formulary* and *Provider Directory* are updated from time to time. You will find the most recent booklets online. Printed copies are current as of the date shown on the front cover.

Talk to your employer about documents for other benefits you may have.

Forms, Tools, and Resources:
Besides your comprehensive Member handbook booklets, our website has forms and tools to help you.

- *Common Law Marriage Affidavit*
- Disease and Case Management Enrollment form
- Member ID card request
- *Member Rights and Responsibilities*
- *Notice of Privacy Practices*
- *PCP Select/Change Request Form*
- QIP information
- Self-management tools
- *Summary of Benefits and Coverage*
- Transition of care forms
- Wellness information

Accessibility and Translation Services
We give you information that you need to get coverage or use services in plain language. There is no charge.

Discrimination is Against the Law
We comply with civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently.

Need	Service
Living with disabilities	• We provide free aids and services if you need them to communicate effectively with us. • Materials on our website are accessible to those with visual disabilities. We provide written information in other formats. • Hearing impaired Members may use the TTY number. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Limited English proficiency	• We offer over 150 languages from medical interpreters. • You may ask for materials and forms written in other languages.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a Grievance.

Contact Method	Contact Information
Mail	GlobalHealth, Inc. ATTN: Compliance Attorney 210 Park Avenue, Ste 2800 Oklahoma City, OK 73102-5621
Fax	(405) 280-5894
E-mail	compliance@globalhealth.com

You can file a Grievance in person or by mail, fax, or e-mail. If you need help filing a Grievance, ask us to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

Contact Method	Contact Information
Call	1-800-368-1019 (toll-free) 800-537-7697 (TDD)
Mail	U.S. Department of Health and Human Services 200 Independence Avenue SW Room 509F, HHH Building Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index/html.

For more information, see "Section 1557 of the Affordable Care Act Grievance Procedure" on page 128.

For help with other types of complaints and Grievances, see "Appeals and Grievances" on page 101.

Get Care

Here is a short overview of how to use your GlobalHealth benefits.

Step	What To Do
1	Choose a PCP. See "Provider Network" starting on page 18 for more information. • Each family member may choose a different PCP. • You may choose a pediatrician for your child. • You may change your PCP at any time during the year. Your PCP change starts the same day. If you need to see a PCP before you get your new Member ID card, contact us.
2	See your PCP first for all of your medical care. • Your PCP will coordinate and manage your medical care. • Ask which Preventive Services are right for you. • For same-day Urgent Care, call your PCP's office for medical direction. • After-hours, you may self-refer to an Urgent Care center. • When it's an emergency, go to the nearest Hospital ER or call 911.
3	To see a SPECIALIST, you need a Referral. • If you need specialty care, your PCP or BHP will send us a Referral. • PA from us is required. • When approved, we will send you 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 PA are required for scheduled stays.
	  o When approved, we will send you a letter of authorization.
	  o Go only to the Hospital listed in the letter.

Step	What To Do
	• You do not need PA for stays in connection with childbirth or ER.
5	You may SELF-REFER for the following care (no Referral or PA needed): • After hours or out-of-area Urgent Care • Behavioral health care • Eyeglasses or contacts • Physical therapy evaluations • Routine eye exams • Routine mammograms • Services within an OB/GYN's scope of practice

Generally, Inpatient and certain Outpatient services must be preauthorized. You do not have to get PA for Emergency Services, stays in connection with childbirth, or self-referral services. If you get other care without an authorized Referral, you will have to pay for it. You must go to Network Providers for non-emergency services. You may go to any ER, but the Provider may send you a bill if you go to an ER that is not In-network. See "Balance Billing by an Out-of-network Provider" on page 96.

Member ID Cards

We will send a Member ID card to you at the start of your new year. Your GlobalHealth card is the key to all of your benefits. Carry it with you at all times.

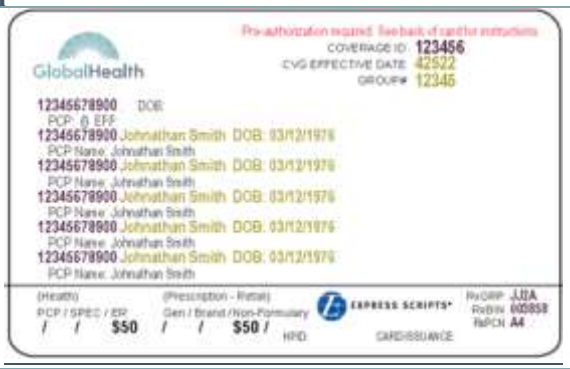
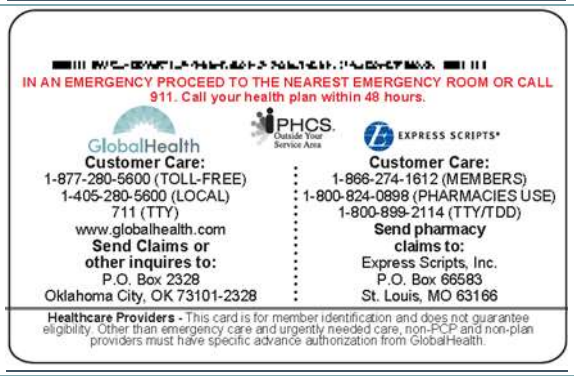
When making an appointment with your PCP, let them know you are a GlobalHealth Member. Show your Member ID card each time you get medical care. It contains valuable information about your benefits.

Please Note:

- Services are for your personal benefit. Never lend your cards to someone else. You cannot share your benefits.
- Protect your cards. If they are lost or stolen, tell us right away. We will send you new cards at no charge. You should get new or additional cards within two weeks after we receive the request.
- Your Member ID card is valid only as long as you are enrolled in the Plan. Having a card does not guarantee benefits.

Look at your Member ID card to make sure everything is correct, including the name of your PCP. Contact us if:

- Information is wrong.
- You need to order a new card.
- You have questions about your card.

Information	Sample
Front of Card: 1. Coverage ID number 2. Group ID number 3. Member ID number 4. The selected PCP 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 us including phone number, office hours, and Claims address	

Get Help

Contact Customer Care if you have any questions. Our team of representatives can answer questions such as:

- How can I get printed copies of materials or forms at no cost?
- What are my benefits and how do they work? How much do I have to pay?
- What doctors and Hospitals can I use?
- How can I file a Grievance or an Appeal?
- Why did I get a letter or bill in the mail? What does it mean?
- How can I enroll in one of the Special Programs?
- How can I get access to MyGlobal®?
- How can I change my PCP?
- What is the status of my Referral?

We tell you in this booklet if you need to contact someone else. For example, you will need to call Magellan Rx Management, LLC ("Magellan Rx Management") if you have questions about Prescription Drug mail order.

Steps to Improve Your Healthcare Quality and Safety

Step	What To Do
1	If you are new to GlobalHealth, visit your PCP early in the year to get established. Have your medical records sent to your new PCP.
2	Visit your PCP at least once each year. Have Preventive Care services. See "Preventive Care Benefits" on page 74.
3	Write down your questions before your doctor visit.
4	Ask questions if you have any doubts or concerns about your treatment.

Step	What To Do
5	Keep and bring a list of all the drugs you take to each appointment. Include any OTC drugs and supplements. Your PCP will look for drug interactions. Ask questions about new prescriptions – when and how to take them, if they have side effects, and what to avoid while taking them.
6	Get the results of any test or procedure.
7	Make sure you understand what will happen if you need surgery.
8	Talk to your doctor about all treatment options. Discuss which choice your doctor recommends for you and why. Make sure you understand what will happen if you choose not to treat medical conditions.
9	Make sure your PCP gets copies of records from any other doctors or Facilities where you get care.

PROVIDER NETWORK

You must almost always use Network Providers. We have a large Network of PCPs, Specialists, and Facilities to care for you. Providers follow generally-accepted medical practices when prescribing any Course of Treatment.

Provider Type	Examples
Agencies	• Home health • Hospice
Facilities	• Hospital • Laboratory • Imaging center • Outpatient Facility • Pharmacy • Skilled Nursing Facility • Urgent Care Facility
Physicians and Practitioners	• BHP • Medical group • PCP • Specialist • Other healthcare professional, (such as, physician assistant, nurse practitioner, etc.)
Suppliers	• DME supplier

Network Providers are not employees, agents, or other legal representatives of GlobalHealth. That means, among other things, that there is no employer/employee relationship between GlobalHealth and its Network Providers, and vice versa.

You could get care from Providers outside of our Network in very limited situations.

Notice: Although healthcare services may be or have been provided to you at a healthcare Facility that is a member of the Provider Network used by your health benefit Plan, other professional services may be or have been provided at or through the Facility by physicians and other healthcare Providers who are not members of that Network. You may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by your health benefit Plan.

See "Balance Billing by an Out-of-network Provider" on page 96.

Network Changes

You should join an HMO because you like the Plan's benefits, not because a certain doctor is available.

- We cannot guarantee that any one doctor, Hospital, or other Provider will stay contracted.
- We cannot guarantee that any one pharmacy will stay contracted with our pharmacy benefit manager, Magellan Rx Management.
- Facilities may change from preferred to non-preferred status during the year.

- You cannot change Plans mid-year because a Provider leaves our Network or becomes non-preferred.

For more information, see "Physicians Leaving the Network" on page 24.

Provider Directory

We list Network doctors, Facilities, pharmacies, and suppliers in the *Provider Directory*. It shows which doctors are taking new patients. Contact us if you see a mistake in our *Provider Directory*.

BHPs

The Network includes:

- BHCM;
- Hospital, psychiatric Hospital;
- Licensed Clinical Psychologist;
- LADC;
- LBP;
- LCSW;
- LMFT;
- LPC;
- Psychiatric Clinical Nurse Specialist;
- Psychiatrist – Child, adolescent, adult, geriatric, addiction medicine Specialist;
- Psychologist;
- RTC; and
- Other mental healthcare Facilities and professionals as allowed under state law.

Medical Service Providers

We update our online list of Providers at least weekly.

Search for doctors by first and last name, county, and zip code. You can narrow your search by Network, specialty, clinic affiliation, or languages spoken. Click on the doctor's name to view information such as:

- Acceptance of new patients.
- Board certification;
- Gender;
- Hospital affiliation;
- Languages spoken;
- Office location(s);
- Medical group affiliation (if any);
- Specialty; and
- Telephone number(s).

You can search by type of Facility.

- Some types of Facilities tell you if you will pay a Preferred Facility or Non-preferred Facility Copayment. They may or may not be part of a Hospital. For example:
  - Outpatient surgery centers.
  - Imaging centers.
- Other Facilities are either in our Network or not. They are neither preferred nor non-preferred. You pay the only Copayment listed. For example:
  - ER departments.
  - Inpatient Hospitals.

Pharmacy Networks

You have different ways to get your prescribed drugs. Your Cost-share may change based on where you fill your prescription. We limit where you can get a drug when:

- The FDA allows only certain Facilities or doctors to distribute the drug; or

- The drug requires:
  - Special handling;
  - Provider coordination; or
  - Patient education that a retail pharmacy cannot meet.

We will tell you before the pharmacy you have been using leaves the Network. You will have to find a new pharmacy that is in the Network.

Pharmacy Type	Description
Retail pharmacies	• Get up to a 30-day supply. Fill once each month. For prescription eye drops, refills are available after 70% of the dosage units have been used according to the instructions or 21 days after you receive either the original or most recent refill of the prescription (if refills are available). • The *Provider Directory* shows retail Network pharmacies. • We tell you which pharmacies are open 24 hours.
Home delivery pharmacy service	• Get up to a 90-day supply of maintenance drugs (drugs you take on a regular basis for a Chronic Condition). Fill once each three-month period. *If less than a 90-day supply is ordered, you will still pay the home delivery Cost-share. Your Provider must prescribe the drug as a 90-day supply. • Magellan Rx Pharmacy mails them to you. Allow 7 to 10 days from when your order is received for your drugs to reach you. • You may get a discount on your drugs, depending on the drug Tier. • Contact Magellan Rx Management at 1-800-424-1789 about how to use this service. Help is available 24 hours a day, seven days a week.
Extended supply retail pharmacies	• Get up to a 90-day supply of maintenance drugs (drugs you take on a regular basis for a Chronic Condition). Fill once each three-month period. *If less than a 90-day supply is ordered, you will still pay the extended supply Cost-share. Your Provider must prescribe the drug as a 90-day supply. • You can find extended supply retail Network pharmacies in the *Provider Directory*. • We tell you which pharmacies offer extended supplies.
Chickasaw Nation Refill Center medications by mail	• Get either a 30-day or a 90-day supply. Your doctor may write the prescription for either. • Chickasaw Nation Refill Center is a Native American-owned retail pharmacy in Oklahoma. It provides Prescription Drugs to Native Americans. Your non-Native American spouse is also covered. • Complete the *Native American Prescription Benefit Program Patient Enrollment* form on our website and send to Chickasaw Nation Refill Center. You must send proof of Native American status in one of the federally-recognized tribes with the form. Once enrolled, you may get Cost-share discounts. • Chickasaw Nation Refill Center will let you know your Cost Sharing when you ask to have a prescription filled. Drugs are mailed directly to your home or designated location.

Pharmacy Type	Description
	• Online services available at cnrefillcenter.net. • Call 1-855-478-8725 if you have questions.
Specialty pharmacies	• Get up to a 30-day supply. Fill once each month. • Magellan Rx Specialty Pharmacy will fill your Specialty Drugs and mail them. • Contact Magellan Rx Management for information about specialty medications at 1-800-424-1789. • You pay the office visit Cost-share if given to you by your doctor. • You pay the Specialty Drugs Cost-share if you take them at home.
Vaccine Network pharmacies	• You may go to some pharmacies for your covered preventive vaccinations at no cost. • We tell you which pharmacies offer vaccines.

*You pay a pro-rated amount for drugs that you are moving the refill date to be the same refill date as other drugs you take, subject to the following rules:

- Allowed only once per year per maintenance drug.
- Drugs cannot be schedule II, III, or IV.
- Must be drugs that can be safely split into short-fill periods.

Online Search

Step	What To Do
1	Select your Network or Plan type – GlobalHealth State Network. Or enter your group number from your Member ID card.
2	Choose a search method.
3	Select the type of Provider you are looking for.
4	Narrow your search if you get too many results.

PCP

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.

Choose a PCP

Start your care with choosing a PCP from the list in the *Provider Directory*. Our PCPs include doctors trained in:

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

You have complete freedom of choice in your selection. Choose any PCP in our Network who is accepting new Members. Each member of the family may have a different PCP. You may choose a pediatrician for your children.

Although you have direct access to your OB/GYN and BHP, they are not your PCP. You will need to choose a PCP to coordinate medical care that they do not handle.

Your relationship with your PCP is an important one. It should be open and trusting. We recommend that you choose a PCP close to your home or work. Having your PCP nearby makes getting care much easier.

We will assign a PCP to you if you do not choose one. You can find a current list of PCPs on our website.

Get Established
Once you choose a PCP, try to make an appointment within the first 30 days if you can.

- Tell the office staff that you are new to GlobalHealth or to the doctor. They need to prepare paperwork for your medical records.
- Have your medical records sent from your prior Providers before your first visit. See "Medical Records" on page 26.
- Discuss any specialty care you are receiving. See "Continuity and/or Transition of Care" on page 90.
- Discuss your medications – what they are, what they are for, what you need to have refilled. If any of the drugs are not on our Formulary, discuss your options. See "Prescription Drug Transition of Care" on page 91.
- Discuss Preventive Care that is right for you. You may have some of the Screenings during this visit. You may need to schedule more visits for other Preventive Care.

Schedule Routine Appointments
Call your PCP's office when you are ready to make an appointment. Your Member ID card lists the number.

- Call ahead for routine, sick, or follow-up visits. This will allow you and your PCP enough time to talk about your needs.
- Make an appointment for your routine adult or well-child visit early in the year to have or schedule your Preventive Care services.
- Make and go to follow-up visits if you have a Chronic Condition such as high blood pressure or asthma.
- Write a list of questions before the visit.
- Show your Member ID card at each visit.
- If your PCP orders tests, show your Member ID card when you arrive for the tests.
- If you must cancel an appointment, call your doctor as soon as you can.

When You Need Care Right Away
Call your PCP. If no urgent appointments are available, he or she may send you to an Urgent Care Facility. See "Urgent Care" on page 24.

Consultations
Your doctor may discuss special medical situations with colleagues. The team shares knowledge and experiences to recommend the best course of care for you. They follow state and federal privacy laws.

PCP Changes
You may change your PCP for any reason. It starts right away. Contact us to:

- Change your PCP. The form is also on our website.

- Get help changing from a child care doctor to an adult care doctor.
- See your PCP before you get your new Member ID card.

We recommend against changing your PCP if the change would be harmful to you. For example:
- You are an organ transplant candidate.
- You are receiving active medical care.
- You are in the third trimester of your pregnancy.

We cannot let you change if the new PCP:
- Is not taking new patients; or
- Is not in our Network.

You will need to choose another PCP.

Self-referral Services

Your PCP coordinates most Covered Services you get as a GlobalHealth Member, but there are a few exceptions. See the table below for a list of these services.
- You do not need a Referral from your PCP before you go. You do not need PA from us.
- You pay the Copayment, if any, for non-preventive services.
- You must go to a Network Provider. You pay for care from an Out-of-network Provider.
- See "Coverage Requirements" on page 36.

Help your PCP manage your care. Be sure your PCP:
- Gets the results of any exams or tests. See "Medical Records" on page 26; and
- Gets a list of any new prescriptions.

Service	Description
Eye exams	You may go to an optometrist for a routine eye exam each year. See "Vision Benefits" on page 81.
Eyewear	You may go to an eyewear Provider for eyeglasses or contacts. See "Vision Benefits" on page 81.
Mammograms	You may go to an imaging center for your routine mammogram. See Mammogram on page 57.
Mental health/substance use services	You may go to a therapist, counselor or psychologist for assessment, therapy, and testing. See "Behavioral Health Benefits" on page 37.
OB/GYN services	You may go to a healthcare professional who specializes in obstetrics or gynecology. The Provider must comply with procedures including: • Following the process for Referrals; • Obtaining PA for some services, such as non-routine pap tests; and • Following the authorized Course of Treatment. Contraception Services: You have direct access to either your PCP or OB/GYN for contraceptive services. See Contraception services on page 48.

Service	Description
	Maternity: You have direct access to your OB/GYN for all of your maternity care – prenatal, delivery, and postnatal. See Maternity and newborn care on page 57. Well-woman Exam: For a list of Preventive Services related to your well-woman exam, see Women's benefits on page 75. Other Services: You have direct access to your OB/GYN. He/she may perform any Covered Services within his/her scope of practice.
Physical therapy	You may go to a physical therapist for an evaluation only. The therapist must comply with procedures including: • Following the process for Referrals; • Obtaining PA for up to 30 days of therapy; and • Following the authorized Course of Treatment. See Physical therapy on page 63.
Urgent Care	First, call your PCP during office hours. But, you may self-refer to an Urgent Care Facility when your PCP's office is closed or when you are out of our Service Area. The care must be urgent, non-preventive, and non-routine. See "Urgent Care" on page 24.

Specialty Care

See your PCP first. If your PCP believes you need to see a Specialist, he/she will send us a Referral. See "Pre-service Authorization" on page 29.

- If you see a Specialist without authorization, you will have to pay for the care. This does not include self-referral services.
- You are only approved to have the services listed in the letter. But, some Specialist visits include Diagnostic Tests. You do not need separate PA for these tests. They should be performed in the doctor's office during the authorized visit:
  - Routine lab work
  - Ultrasound
  - X-ray
  - EKG
- Any other care requires specific authorization from us.

Some PCPs work with integrated delivery systems or Provider groups. These doctors will most likely refer you to Specialists and Hospitals within those systems or groups. However, you may ask to get your care from any Network Provider qualified to meet your needs. You may ask the doctor to refer you to a Preferred Facility.

Physicians Leaving the Network

Enrolling in GlobalHealth does not guarantee services by a particular Provider listed in the *Provider Directory*. A Provider may no longer be part of our Network. This may happen when:

- He/she leaves our Provider Network.
- He/she is not able to be a Provider anymore.
- He/she has a closed panel or is open to existing patients only.

We will tell you within 30 days of the date we find out that your Provider has or will be leaving our Network. If the Provider is your PCP, we will send you a letter with the name of your new PCP. You will also get a new Member ID card in a separate mailing. If you do not want the PCP we chose for you, let us know. See "PCP Changes" on page 21.

You may be able to keep seeing your doctor for a short time. See "Continuity and/or Transition of Care" on page 90.

Urgent Care

Urgent Care is care for an illness, injury, or condition serious enough that you need care right away, but you do not need to go to the ER.

An Urgent Care Facility offers a choice when it is not an emergency and you cannot see your PCP. It costs you less than an ER visit. A doctor may see you right away in an Urgent Care Facility. In an ER, you may have to wait longer.

Urgent Care Facilities may treat situations such as:

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

Urgent Care Facilities do not take the place of your PCP. You should see your PCP first when you need non-emergency medical care. If you do need to go to an Urgent Care Facility:

- Go to a Network Facility.
- Have them send your records to your PCP. That helps maintain continuity of care.
- Have them send a list of new prescriptions. Your PCP needs to prescribe any refills.
- Go to your PCP for follow-up care.

When	What To Do
Normal Office Hours	If you have an urgent medical illness or injury, call your PCP's office. Some PCPs have extended office hours. • Your PCP may arrange to see you right away or give you medical advice and direction. • If your PCP cannot set up an urgent appointment, you may ask to see another Provider in that office. You may see another doctor, physician's assistant, or nurse practitioner. • Your PCP may send you to an Urgent Care Facility if another Provider cannot see you. You pay the Urgent Care Copayment.
After Office Hours	If you need to see your PCP after the office has closed, you have two options:

When	What To Do
	1. Call your PCP. • Leave a message. • When a nurse or doctor is on call, he/she will call you back and let you know what to do. Give the reason for your call. Be sure to leave your name and a call-back number. • Otherwise, follow the PCP's after-hours voicemail instructions. It may include sending you to an Urgent Care Facility or ER. 2. You may choose to go to an Urgent Care Facility if your condition cannot wait. You pay the Urgent Care Copayment. You do not need PA.
Out of Service Area	If you are traveling and need Urgent Care before you come back to our Service Area: • Call your PCP; or • Go to an Urgent Care Facility. You do not need PA. • You will pay your In-network Urgent Care Copayment, but the Provider may also send you a bill. See "Balance Billing by an Out-of-network Provider" on page 96.

Emergency Care

An emergency is when you have sudden symptoms (including severe pain, psychiatric disturbances, and/or substance abuse symptoms) and a Prudent Layperson could expect failure to get medical help right away to result in:

a) Placing his/her health (or the health of an unborn child) at serious risk;
b) Serious impairment of body functions; or
c) Serious dysfunction of a part of the body.

In addition, an Emergency Medical Condition includes a pregnant woman who is having contractions when:

a) There is not enough time to go to another Hospital before delivery; or
b) Transfer may be harmful to the mother or the unborn child.

Access

Do not use an ER visit in non-emergency situations. However, in a true emergency, follow these steps:

Step	What To Do
1	Go to the nearest Hospital ER or call 911. You do not need PA for emergency care. You will pay your In-network ER Copayment, but the Providers may also send you a bill if you go to an Out-of-network ER. See "Balance Billing by an Out-of-network Provider" on page 96.
2	Show your Member ID card.
3	Call your PCP's office and us within 48 hours.
4	If you: • Are in an accident and outside the Service Area; • Have no control over where you are taken; or

Step	What To Do
	• Could not go to a Network Hospital. We may arrange to move you to a Hospital in our Network if you are admitted to an Out-of-network Hospital.
5	***All follow-up care after being treated in the ER must be:*** • Provided or arranged by your PCP. Do not go back to the ER for follow-up care. • Preauthorized by us if required. If you need care urgently, contact the UM Department. See "Urgent Decisions" on page 30.

Hospital Care

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

Home Healthcare

Your doctor may decide to have a nurse visit you at home rather than keep you in the Hospital or Skilled Nursing Facility. We cover:

- Part-time or intermittent Medical Services you get in your home. A licensed nurse, or licensed speech, occupational, or physical therapist must provide care.
- Diabetes self-management training when given by a registered, certified, or licensed healthcare professional.
- Medical nutrition therapy training from a licensed registered dietician or licensed certified nutritionist.

Medical Records

Since your PCP manages your care, it is important that he/she knows your medical history. We recommend you have your medical records sent to your new PCP's office before your first visit.

Your Providers are expected to visit on a regular basis about your care, especially when you are taking medication. Coordination of care between your doctors promotes patient safety and quality of care. The easiest way to be sure your PCP knows about other care you get is to have copies of your medical records from other Providers sent to him/her as it happens.

Have the results of any exams or tests sent to your PCP every time you seek care for:

- Emergency Services;
- Mental health or substance use services;
- Self-referral services;
- Specialist services;
- Urgent Care Facility services.

Your PCP will provide follow-up care if appropriate. Be sure to share a list of any new prescriptions. Your PCP will be able to check for drug interactions.

The law requires Providers to protect patient medical information. You can find the *Oklahoma Standard Authorization to Use or Share Protected Health Information* ("PHI") form on our website. **The form is required for requesting release of your medical records.**

You have the right to sign a release or not, but it is important for you to consider allowing these communications to happen.

Physician Credentials

Before our Credentialing Committee accepts a Provider to include in our Network, we conduct full credentialing and National Practitioner Database ("NPDB") checks. The NPDB is a federal information repository. The Credentialing Committee reviews our Providers at least every 36 months. This process helps to ensure the quality of our Network.

Check Behavioral Health Providers

There are several websites to check certifications.

Specialty	Website Address
LADC	http://www.okdrugcounselors.org/members.php
LCSW	https://pay.apps.ok.gov/medlic/social/licensee_search.php
LMFT **LPC** **LBP**	https://www.ok.gov/health/counselor/app/index.php
Licensed Psychologists **Psych Techs (testing only for techs)**	https://www.ok.gov/psychology/Public/License_Verification/index.html

Check Medical Physicians

You can check a doctor's training and experience 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 have information about disciplinary actions, but getting it may not be easy.

Several online organizations give you information such as:

- Name, address, telephone numbers;
- Professional qualifications;
- Specialty;
- Medical school attended;
- Residency completion; and
- Board certification status.

Name	Information	Website Address
American Board of Medical Specialties ("ABMS") Certified Doctor Verification Service	• Check whether a doctor is certified by one of 24 specialty boards. No other information. • You can search all states at the same time. Use when you do not know where the doctor is. • Registration at the site is required.	www.abms.org

Name	Information	Website Address
	• Free of charge.	
American Medical Association's ("AMA") Doctor Find	• Gives some information on the certification status of all medical doctors currently licensed in the U.S. • It does not list disciplinary actions. • You can do searches only one state at a time. • Free of charge.	www.ama-assn.org
Oklahoma Board of Medical Licensure and Supervision ("OMB")	• Check a MD's (Medical Doctor) license and disciplinary action. • See Hospital privileges and languages spoken. • Free of charge.	www.okmedicalboard.org
Oklahoma State Board of Osteopathic Examiners	• Check a DO's (Doctor of Osteopathic Medicine) license and disciplinary action. • See Hospital privileges and languages spoken. • Free of charge.	www.ok.gov/osboe/

UTILIZATION MANAGEMENT

Medical and Behavioral Health UM

We have rules to make sure you get the right care at the right time. When a Provider prescribes care, it does not always mean it is a Covered Service or Medically Necessary.

Rule	What It Means
Care must be covered under your Plan	• Care must be a Covered Service. • Care must meet Coverage Requirements. • We cover services listed in limitations only as listed. • We do not cover services listed in Excluded Services. • See "Benefits" starting on page 35.
Care must be safe and effective	• Care must meet generally-accepted standards of care. • Care must be in the Provider's scope of practice.

Care must be right for your illness, injury, or disease	• Care must be Medically Necessary.
	  ○ Type of care;
	  ○ Frequency of visits or treatments;
	  ○ Extent of care;
	  ○ Site of care; and
	  ○ Duration of care.

When we are reviewing your services, we use guidelines, such as, but not limited to:

- Milliman Care Guidelines®
- Hayes®
- Beacon
- American Society of Addiction Medicine
- Medicare guidelines (Local Coverage Determinations and National Coverage Determinations)

You may ask for the criteria if you are:

- A current Member;
- A potential Member; or
- A Network Provider.

Our Medical Director makes all medical necessity Adverse Determinations. The Medical Director is a licensed doctor in good standing.

Pre-service Authorization

We need to approve most services before you get them when your PCP does not provide them. Otherwise, you will have to pay the entire cost of the services. "Services" includes any treatment, tests, procedures, supplies, or equipment.

This process ensures:

- You get the right care at the right time and place for you.
- You pay the lowest Cost-share for your benefit.
- You stay In-network.

Behavioral Health Service Steps:

Step	Description
1	You can go to any Network Provider to be assessed for the services you may need. If these services require PA, the Provider will send us the request for you.
2	We will send a letter after we approve the service. This letter will tell you the name and contact information for the doctor or Facility. It will tell you what services we authorized. Any other service requires separate authorization from us.
3	Once we give PA to the Provider, he/she may begin services right away.

Medical Service Steps:

Step	Description
1	Your PCP will send us a Referral for other care you need. After the initial visit, Specialists may send Referrals directly to us for services such as surgery. You may ask to use any Provider in our Network. If your doctor refers you to an Out-of-network doctor or Facility, we may select one in our Network for you.
2	We will send a letter after we approve the service. This letter will tell you the name and contact information for the doctor or Facility. It will tell you what services we authorized. Any other service requires separate authorization from us.
3	Make an appointment. Wait until you get the letter before making any appointments. You must get this letter before you have care.

Non-urgent Decisions:
We make non-urgent pre-service decisions within 15 days after we get the request. We may extend this period one time for up to 15 days if:

- It is necessary due to matters beyond our control;
- We tell your doctor, before the initial 15-day period ends, why it is needed; and,
- We tell your doctor the date by which we expect to make a decision.

If we have to extend the time because we do not have enough information to decide the authorization:

- We will tell your doctor what information we need; and,
- Your doctor will have 45 days from the time he/she gets our notice to send it.

Urgent Decisions:
We make urgent pre-service decisions within 72 hours after we get the request.

You or your doctor may call us during regular business hours (Monday – Friday, 9 a.m. – 5 p.m. Central Time).

You or your doctor may contact the UM Department outside of regular business hours. Leave your name and contact information and we will respond on the next business day.

Contact Method	Contact Information
Local	(405) 819-7574
Toll-free	1-877-280-5600
TTY	711

Contact Method	Contact Information
E-mail	um@globalhealth.com
FAX	(405) 280-5398

Please Note:

- Your doctor should send us Referrals for your services. But, it is your responsibility to make sure we have authorized your services.
- You should get all care from a Network Provider including ancillary services such as:
  - x-rays
  - lab services
  - anesthesia
- Although some services do not require PA, you must use Network Providers:
  - Emergency Services;
  - Hospitalization related to childbirth; or
  - Self-referral services. See "Self-referral Services" on page 22.
- You must have services while you are a Member. We will not pay for benefits, even if authorized, after your coverage ends.
- You may track your Referral through your MyGlobal® account.
- If we deny a requested service, in whole or in part, we will send a letter telling you why. We will also send a copy of *Appeal Rights*.

Concurrent Review

We may assess your care while you are still in treatment. We want to be sure you are getting the right care at the right time and place. Our process checks:

- Need for continued treatment;
- Level of care; and
- Quality of care.

If you are in the Hospital past the authorized period, we will conduct a concurrent review.

If we have approved a Course of Treatment:

- Any change before the end of the Course of Treatment is an Adverse Determination. A change may be either fewer treatments or ending treatments. We will tell you before we make the change. We will allow you time to Appeal before we make the change. We will cover the benefit during the Appeal process.
- You may ask us to extend the Course of Treatment beyond what we approved. We will tell you our decision, whether or not it is in your favor. We do not cover the benefit during the Appeal process.
- We make urgent review decisions within 24 hours after we get your request. We will tell you the decision, whether or not it is in your favor.

You may not Appeal when your Plan is amended or ended. See "Appeals and Grievances" on page 101.

Discharge Planning
Proper planning can improve your health outcome. You may need services as you move to the next level of care. Some care may require PA to a doctor or another Facility. We work with your doctor and the Hospital case manager to have PAs in place before you leave.

We start discharge planning either:
- When you are admitted to the Hospital; or
- When we authorize the stay.

Post-service Review
After you get services, we review them to find quality or utilization issues, if any. We review Claims submitted for payment and the corresponding medical records.

Prescription Drug UM

For certain Prescription Drugs, special rules restrict how and when we cover them. A team of doctors and pharmacists made these rules to:
- Help you use drugs in the way that works best.
- Help control overall drug costs, which keeps your Premium lower.
- Encourage you and your Provider to use a lower-cost option when possible that:
  - Works for your condition; and
  - Is just as safe.

If there is a rule for your drug, it means that you or your Provider will have to take extra steps in order for us to cover the drug. If you want us to waive the rule for you, you will need to use the exception request process. We may or may not agree to waive the rule for you. See "Exception Requests" on the next page.

Sometimes a drug may appear more than once in our drug list. This is because different rules or Cost Sharing may apply for the drug prescribed by your Provider based on:
- Strength (for example, 10 mg versus 100 mg);
- Amount (for example, one per day versus two per day); or
- Form (for example, tablet versus liquid).

You or your doctor can view the *Drug Formulary* on our website to see which, if any, rules apply to each drug.

Call us to ask about these rules:

Type	Description
Prior Authorization	Doctors must get PA for some drugs. Any corresponding supplies or equipment also require PA. It promotes appropriate, cost-effective use.
Quantity Limits	We limit the amount of some drugs. These drugs, if taken inappropriately, could be unsafe and cause side effects. All Specialty Drugs are limited to 30-day supplies.
Step Therapy	Step therapy means that you try one or more other drugs before we cover this drug.

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

Others that may help with this process include.

- Your doctor or pharmacist.
- The parent of a child under 18 years of age.
- Your power of attorney with medical decision authority. We must have a copy of the signed power of attorney form on file.
- Your authorized representative. See "Appointment of Authorized Representative" on page 104. You will need to complete the form if you want us to share your PHI with anyone else, for example:
  - Your parent, if you are age 18 or over.
  - Your spouse.
  - Your caregiver, friend, neighbor, or other.

Type	Process

Standard Exception	You can ask us to waive coverage rules and limits. You may ask us by mail, e-mail, or telephone. Generally, we will only approve a request if:
	• The alternative drug is included on the Formulary;
	• The drug in the lower Tier or with utilization rules would not work as well for you; and
	• It would cause you to have harmful side effects.
	
	If you ask us to cover a drug that is not on our Formulary, your doctor must send:
	• The reason you need the non-formulary drug; and
	• A statement that all Formulary drugs on any Tier:
	  ○ Will not or have not worked;
	  ○ Would not work as well; or
	  ○ Would have harmful side effects.
	
	You should contact us to find out how to get an exception. Your doctor will have to send us information. We make a decision within 72 hours if we have enough information.
	• If we agree, we also cover appropriate refills of the prescription.
	• If we deny your request, you may ask for an External Review. See "External Review" on page 103. They will send you their decision within 72 hours after getting your request for review.
	
	We will cover your drug during the time we are reviewing. We will also cover your drug during an External Review.

Expedited Exception	You may ask for a fast exceptions process when: • You are suffering from a health condition that may risk your life, health, or ability to regain maximum function; or • You are already using a non-formulary drug. See "Prescription Drug Transition of Care" on page 91. We will tell you our decision within 24 hours after you ask us for a review if we have enough information.

Type	Process
	• If we agree, we also cover refills of the prescription. • If we deny your request, you may ask for an External Review. See "External Review" on page 103. They will send you their decision within 24 hours after getting your request for review. We will cover your drug during the time we are reviewing. We will also cover the drug during an External Review.

Policy on Ensuring Appropriate Utilization

- The UM Department bases its decisions on:
  - Whether the care is appropriate; and
  - Whether the care is covered.
- We do not reward anyone for denying coverage.
- We do not use financial incentives to encourage decisions that result in using fewer benefits.
- We do not use incentives to make it harder for you to get care.
- We do not make decisions regarding hiring, promoting, or terminating anyone because they are likely, or we think they are likely, to deny or support the denial of benefits.

Technology Assessment Process

We have a review process for new devices, procedures, or treatments.

- A doctor-directed committee reviews requests.
- We look at both new technology and new ways to use existing technology.
- We use scientific evidence to review technology. You or your doctor must send us evidence that it works and is safe. It must:
  - Be approved by a regulatory agency, such as the FDA;
  - Improve your net health outcome;
  - Be as beneficial as current treatments;
  - Be available outside of clinical tests;
  - Significantly improve your quality of life; and
  - Clearly show safe medical care.

BENEFITS

This section explains your Plan's benefits. It tells you what is and is not covered and how much you pay. It is not all-inclusive.

Your Share of the Cost

Benefit Charts

The benefit charts show your benefits and Cost Sharing.

- Behavioral Health Benefits on page 37.
- Medical Benefits on page 42.
- Prescription Drug Benefits on page 69.
- Preventive Care Benefits on page 74.
- Vision Benefits on page 81.

Copayments and Coinsurance

Copayments and Coinsurance are listed in the charts for each type of service. Your Cost-share is due for each visit, treatment, admission, prescription fill or refill, or occurrence (unless otherwise noted) up to your MOOP.

Our benefits are bundled. That means that if you have multiple services during a single office visit or Facility stay, you only pay the one Copayment for the office visit or Facility.

The Facility Copayment for Inpatient Hospital or Outpatient surgery includes:

- Anesthesia;
- Diagnostic Tests;
- Doctor and professional services;
- Drugs;
- General nursing care;
- Laboratory/radiology;
- Medical supplies and equipment;
- Procedures and surgeries;
- Room and board at all levels of care;
- Specialized scans/imaging/diagnostic exams; and
- Treatment therapies.

The Copayment for other settings (when provided during the visit) includes:

- Diagnostic Tests;
- Doctor and professional services;
- Drugs;
- Laboratory/radiology;
- Medical supplies and equipment;
- Procedures;
- Specialized scans/imaging/diagnostic exams; and
- Treatment therapies.

We cover benefits that are gender-specific for all Members for whom the service would be appropriate, without regard to gender assigned at birth, gender identity, or gender of record at GlobalHealth.

Unless we specifically tell you otherwise, "child benefits" are covered through the end of the month in which you or your child(ren) turn 19 years old. "Adult benefits" start the next month.

Deductible

This Plan does not have a Deductible. You pay the listed Copayment or Coinsurance up to the MOOP.

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 for Covered Services. All types of Covered Services count toward your MOOP.

Some expenses do not count toward your MOOP.

- Premium payments;
- Non-covered services; and
- Balance Billing from an Out-of-network Provider.

Level	How To Meet It
Member MOOP **$3,500 per year**	• The Member MOOP is met when a single Member pays Copayments and/or Coinsurance up to this level. • If you reach the Member MOOP, you will not pay any more Cost Sharing for Covered Services you need for the rest of the year. • This applies even if you have other family members also enrolled under the same Subscriber.
Family MOOP **$10,500 per year**	• The family MOOP is met when any combination of family members under the same Subscriber pays Copayments and/or Coinsurance up to this level. • The amount paid for the Member MOOP contributes toward the family MOOP. • If one family member meets the Member MOOP, that person will not have to pay anything for Covered Services. Each other family member will continue to pay applicable Cost Sharing until either that family member also meets the Member MOOP or the family MOOP is met. Then they will not pay any more Cost Sharing for Covered Services for the rest of the year.

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

Tracking Expenses

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

Coverage Requirements

We cover benefits only when they meet the rules below.

Rule	Description
All rules must be met for all types of benefits	• The care is Medically Necessary; • Services meet generally-accepted standards of care; • You continue to show progress and improvement; • A Network Provider provides your care unless: ○ It is for Emergency Services or out-of-area Urgent Care; or

Rule	Description
	○ You get PA to go to an Out-of-network Provider; • The Provider acts within the scope of his/her license; and • Usually, we require PA. We tell you which care does not need PA.
We limit some benefits and do not cover others	• We do not cover services: ○ When you can no longer improve from treatment; or ○ The care is either custodial or only for the convenience of others. • See "Excluded Services and Limitations" on page 81.

Behavioral Health Benefits

We cover Inpatient and Outpatient behavioral health services for the diagnosis and treatment of:

- Mental health; and
- Substance use, including alcohol, Prescription Drug, and illicit drug abuse.

If you are a new Member and receiving care, call us as soon as possible. If your Provider is not contracted, we will help you find another Provider who is right for you. See "Behavioral Health and Medical Transition of Care" on page 91.

Covered Services

Also see "Coverage Requirements" on page 36.

Outpatient services in a behavioral health therapy visit do not require a PA when given to you by:

- Licensed Clinical Psychologist;
- LCSW;
- LADC;
- LMFT;
- LPC;
- BHCM; or
- LBP.

A psychiatrist is a Specialist and you will pay a Specialist Copayment.

Behavioral Health Benefits Chart

Benefit	Description	You Pay
ASD	• Behavioral health treatment includes: ○ Applied behavioral analysis ("ABA") limited to a total of 25 hours per week; ○ Psychiatric care; and ○ Psychological care. • You do not need PA for behavioral health therapy office visits. • See ASD treatment on page 44 for other ASD care.	Behavioral health therapy office visit: No Copayment Psychiatric Specialist office visit: No Copayment ABA: Home: No Copayment Natural environment training: $50 Copayment/day Office visit: $50 Copayment/visit
Case	• We cover home-based support to	No Copayment

Benefit	Description	You Pay
Management	help you find community resources, services, and self-help at no cost. • You do not need PA.	
Convulsive therapy treatment	• We cover electroshock treatment or convulsive drug therapy. • Includes anesthesia when given with treatment by the same Provider.	Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Counseling	• We cover individual, group, and/or family therapy sessions. • You do not need PA for behavioral health therapy office visits.	Behavioral health therapy office visit: No Copayment Psychiatric Specialist office visit: No Copayment Included in RTC or Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Crisis intervention	• We cover non-life threatening crisis assistance. • Available 24/7. • You do not need PA for behavioral health therapy office visits.	Behavioral health therapy office visit: No Copayment Psychiatric Specialist office visit: No Copayment Included in RTC or Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Diagnostic evaluation and assessment	• We cover services to diagnose a condition. • You do not need PA for behavioral health therapy office visits.	Behavioral health therapy office visit: No Copayment Psychiatric Specialist office visit: No Copayment Included in RTC or Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay

Benefit	Description	You Pay
Eating disorders treatment	• We cover all levels of care and treatment settings. • You do not need PA for behavioral health therapy office or ER visits.	Behavioral health therapy office visit: No Copayment Psychiatric Specialist office visit: No Copayment Included in ER Copayment, which is $300 Copayment/visit and waived if admitted to Inpatient care Included in RTC or Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Emergency services	• We cover life threatening crises. • Use the steps from "Emergency Care" on page 25. • You do not need PA.	$300 Copayment/visit Waived if admitted to Inpatient care from the ER department

Inpatient Hospital Facility	• We cover Inpatient Hospital Services.
	• In addition, behavioral health services:
	  ○ Group psychotherapy;
	  ○ Individual psychotherapy;
	  ○ Medication management; and
	  ○ Psychological and neuropsychological testing.
	• You must have treatment in a Hospital, psychiatric Hospital, or RTC setting.
		$250 Copayment/day up to $750 Copayment/stay

Intensive Outpatient program	• We cover behavior modification therapies. • Multiple times a week for a set number of hours a day.	Psychiatric Specialist office visit: No Copayment
Medical detoxification	• We cover Facilities that provide a chemical dependency treatment program.	Included in the RTC or Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Medication evaluation and management	• We cover services for Prescription Drug evaluation and management. Drugs may be for mental health and/or substance use. • Your PCP or BHP may monitor maintenance drugs. • You do not need PA for PCP visits.	PCP: No Copayment Psychiatric Specialist office visit: No Copayment Included in RTC or Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750

Benefit	Description	You Pay
		Copayment/stay
Non-severe mental illness treatment	• We cover treatment for diagnoses including, but not limited to: o Adjustment disorders o Anxiety disorders o Mood disorders o Personality disorders • You do not need PA for behavioral health therapy office or ER visit.	Behavioral health therapy office visit: No Copayment Psychiatric Specialist office visit: No Copayment Included in ER Copayment, which is $300 Copayment Included in RTC or Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Partial Hospitalization (day treatment)	• We cover treatment multiple times a week for a set number of hours a day. This care requires more days and/or hours per day than an intensive Outpatient program.	$250 Copayment/day up to $750 Copayment/stay
Prescription Drugs	• We cover Prescription Drugs.	See "Prescription Drug Benefits Chart" on page 69
Psychiatric Specialist office visit	• We cover care in an office setting.	No Copayment
Psychosocial education	• We cover home-based education at no cost. Learn daily living and social skills.	No Copayment
RTC	• We cover care in Facilities licensed as RTCs including: o Diagnostics, assessments, and treatment; o Educational and support services; o Individual, family, and group counseling; o Medical, nursing, and dietary services; and o Room and board.	$250 Copayment/day up to $750 Copayment/stay
Severe mental illness treatment	• Diagnoses include, but are not limited to: o Bipolar disorders o Major depressive disorders o Obsessive-compulsive disorders o Pervasive developmental disorders	Behavioral health therapy office visit: No Copayment Psychiatric Specialist office visit: No Copayment Included in the ER Copayment, which is $300 Copayment/visit and waived if

Benefit	Description	You Pay
	○ Schizophrenia ○ Schizo-affective disorders • You do not need PA for behavioral health therapy office or ER visits.	admitted to Inpatient care Included in RTC or Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Substance use treatment	• We cover diagnosis and treatment including medication-assisted programs for the misuse and abuse of or addiction to alcohol and drugs. "Drugs" may be illegal, prescription, or OTC. • Also see "Prescription Drug Benefits" on page 69. • We will also connect you with community resources to help you in your recovery process. Most of these services are at no cost to you. • You do not need PA for behavioral health therapy office, Case Management, or ER visits.	Case Management: No Copayment Behavioral health therapy office visit: No Copayment Psychiatric Specialist office visit: No Copayment Included in the ER Copayment, which is $300 Copayment/visit and waived if admitted to Inpatient care Included in RTC or Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Testing	• We cover clinical evaluation using recognized assessment tools: ○ Developmental; ○ Neuropsychological; ○ Psychological; and ○ Substance abuse. • You do not need PA for behavioral health therapy office visits.	Behavioral health therapy office visit: No Copayment Psychiatric Specialist office visit: No Copayment Included in RTC or Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Tobacco cessation	• We cover treatment to help you quit using tobacco products. Also see, "Tobacco Cessation" on page 114. • You do not need PA for behavioral health therapy or PCP office visits.	No Copayment

Healthy Living Resources
Having a plan to manage your healthcare needs goes beyond visits and medications. It is also about finding balance in work, family, home, and social life.

When you make us a part of your plan, you get the attention of a team dedicated to seeing you live your healthiest life every day.

To access your GlobalHealth team and free materials go to www.GlobalHealth.com:

- Annual HRA;
- Tools to improve and maintain your health;
- Information on how to manage long-term conditions;
- Website satisfaction survey;
- Health materials; and
- Powerful eLearning modules lead you towards rediscovering your inner peace and mental well-being.

Medical Benefits

Covered Services

You may get some Covered Services in either a Non-preferred Facility or a Preferred Facility. We tell you below which services have the choice. Be sure to check when you make an appointment which type of Facility it is. Your Cost Sharing is different based on where you get care.

Note: If you are having surgery in a Hospital Facility, you should ask your Provider about whether you will be an Inpatient or Outpatient. Unless the Provider writes an order to admit you as an Inpatient, you are an Outpatient and pay the Cost Sharing amounts for Outpatient surgery. Even if you stay in the Hospital overnight, you might still be considered an "Outpatient".

Also see "Coverage Requirements" on page 36.

Medical Benefits Chart

Benefit	Description	You Pay
ADHD	• We cover medical management, including: o Diagnostic evaluation; o Laboratory services for monitoring prescribed drugs; and o Treatment.	PCP: No Copayment Counseling: See "Behavioral Health Benefits Chart" on page 37
Allergy Care	• Serum o Allergy serum and supplies for the administration of serum. o Not covered under Prescription Drug Benefits. Only covered if given to you during an office visit or if the doctor prepares it for you to give to yourself. • Testing o Services and supplies used in determining a plan for allergy treatment. • Treatment o Medical care of allergies. • You do not need PA for PCP	PCP: No Copayment Included in Specialist Copayment, which is $50 Copayment/visit Serum: $30 Copayment/6 week supply of antigen and administration

Benefit	Description	You Pay
	services.	

Ambulance	• Covered Services
	  ○ Transport when you must have Emergency Services and an ambulance is required in order to get this care. You do not need PA;
	  ○ Air ambulance when you cannot be safely moved by other means. You do not need PA; and
	  ○ Non-emergency ambulance services when any other mode of transportation is unsafe.
	• We do not cover:
	  ○ Wheelchair van services;
	  ○ Gurney van services; and
	  ○ Commercial or public transportation.
		$100 Copayment

Anesthesia	• We cover services as part of a procedure or surgery. • Also see Dental care – anesthesia on page 50.	Included in Specialist Copayment, which is $50 Copayment/visit Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay

ASD treatment	• Limited to Members with the following diagnoses:
	  ○ Autistic disorder – childhood autism, infantile psychosis, and Kanner's syndrome;
	  ○ Childhood disintegrative disorder – Heller's syndrome;
	  ○ Rett's syndrome; and
	  ○ Specified pervasive developmental disorders – Asperger's disorder, atypical childhood psychosis, and
		See below

Benefit	Description	You Pay
	borderline psychosis of childhood.	
ASD – pharmacy	• See "Prescription Drug Benefits" on page 69.	See "Prescription Drug Benefits Chart" on page 69
ASD – Screening	• Given during well-child visits. • You do not need PA.	No Copayment
ASD – therapeutic care	• We cover therapeutic care: o Physical, occupational, and speech therapies. o Does not count toward the Rehabilitation Services visit limitations you may otherwise be entitled to.	$50 Copayment/visit Included in rehabilitation Outpatient Facility, which is $250 Copayment/day up to $750 Copayment/stay Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay Included in the Home Healthcare Copayment, which is no Copayment
Blood and blood products	• We cover processing, storage, and administration, including collection and storage of autologous blood. Donated blood is a non-billable item.	Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Bone density test	• We cover measurements used to detect low bone mass and to determine risk for osteoporosis. • Age 45 years and older: o Have an estrogen hormone deficiency; o Have vertebral abnormalities, primary hyperparathyroidism, or a history of fragility bone fractures; o Receive long-term glucocorticoid; or o Be under current treatment for osteoporosis. • Age 60 years and older:	No Copayment

Benefit	Description	You Pay
	○ Routine Screening when at higher risk for osteoporotic fractures. • Age 65 years and older. • You do not need PA.	
Breast cancer – Inpatient care	• At least 48 hours after a mastectomy; • At least 24 hours after a lymph node dissection; • Reconstruction of the diseased breast; • Surgery and reconstruction of the other breast to produce symmetrical appearance when performed within 24 months of reconstruction of the diseased breast; and • Treatment of physical complications of the mastectomy, including lymphedema.	Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Breast cancer – Preventive Care	• Genetic counseling. ○ If indicated, BRCA testing for women with a family history of breast, ovarian, tubal, or peritoneal cancer that may increase risk of having a harmful gene mutation. • Coverage is available at no cost: ○ If you do not currently have symptoms of or getting active treatment for breast, ovarian, tubal, or peritoneal cancer. ○ Even if you have previously been diagnosed with cancer.	No Copayment
Breast cancer – prosthetic appliance	• We cover surgically implanted and external appliances.	External appliances: 20% Coinsurance Internal appliances: Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Breast cancer – treatment	• We cover all types of treatment.	Treatment therapy in a radiation or chemotherapy Facility: $50 Copayment/treatment Equipment, services, drugs, and supplies in an office: Included in

Benefit	Description	You Pay
		Specialist Copayment, which is $50 Copayment/visit Equipment, services, drugs, and supplies in a Facility: Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay Equipment, services, and supplies billed from Home Healthcare agency: No Copayment Prescription Drug at pharmacy: See "Prescription Drug Benefits Chart" on page 69

Cardiac and pulmonary rehabilitation – Outpatient	• Covered conditions:
	  ○ Recovering from:
	  ▪ Heart transplant;
	  ▪ Bypass surgery; or
	  ▪ Heart attack.
	  ○ COPD.
	• Covered Services
	  ○ Exercise;
	  ○ Education; and
	  ○ Counseling.
		$50 Copayment/visit

Chiropractic care	• Services during an office visit. • Limited to 15 visits per year.	$25 Copayment/visit

Cleft lip and cleft palate treatment	• We cover Inpatient and Outpatient care for cleft lip or cleft palate or both including:
	  ○ Oral surgery;
	  ○ Orthodontics; and
	  ○ Otologic, audiological, and speech/language treatment.
		Speech/language treatment: $50 Copayment/visit
		
		Included in rehabilitation Outpatient Facility, which is $250 Copayment/day up to $750 Copayment/stay
		
		Included in Specialist Copayment, which is $50 Copayment/visit
		
		Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment
		
		Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment

Benefit	Description	You Pay
		Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Clinical trials	• We cover Routine Costs only. • The clinical trial must be for cancer or another Life-threatening Disease or Condition. • The subject or purpose of the clinical trial must be the evaluation of an item or service that falls within a benefit category (such as, Diagnostic Test) and not excluded from coverage (such as, elective procedures).	Lab: No Copayment Included in Specialist Copayment, which is $50 Copayment/visit Included in the ER Copayment, which is $300 Copayment/visit and waived if admitted to Inpatient care Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay

Colorectal cancer preventive Screening	• See "Preventive Care Benefits" on page 74.
	• Colonoscopy – Once every 10 years, the preventive Screening process includes:
	  ○ Consultation before the Screening procedure if your doctor determines that it would be right for you;
	  ○ Anesthesia services with the colonoscopy if the attending doctor determines that it would be right for you;
	  ○ Removal of any polyps during the Screening procedure; and
	  ○ Pathology to determine whether the polyp is malignant.
	• CT Colonoscopy – Every five years.
	• Fecal immunochemical test ("FIT") – Every 12 months.
	• Fecal occult blood testing
		No Copayment

Benefit	Description	You Pay

	("FOBT") – Every 12 months.
	• FIT-DNA – Every three years.
	  o Doctor's prescription required.
	• Sigmoidoscopy
	  o Once every three years.
	  o Once every five years with FOBT every 12 months.
	  o Once every 10 years with FIT every 12 months.
	• You do not need PA for FIT or FOBT.	

Contraception services	• We cover counseling, contraceptive use, and follow-up care (such as, management, evaluation, changes, and removal or discontinuation).
	• We do not cover reversal of voluntary surgical sterilization or genetic counseling for family planning.
	• Surgical coverage includes (hysterectomies are covered with regular Copayments):
	  o Sterilization surgery;
	  o Surgical sterilization implant for women;
	  o Implantable rod; and
	  o Cervical cap.
	• Office visit coverage without a PA includes:
	  o Shot/injection;
	  o IUD copper;
	  o IUD with progestin; and
	  o Diaphragm.
	• Prescription Drug Coverage includes:
	  o Oral contraceptives (combined pill);
	  o Oral contraceptives (progestin only);
	  o Oral contraceptives extended / continuous use;
	  o Patch;
	  o Sponge;
	  o Female condom;
	  o Spermicide;
	  o Shot/injection;
		No Copayment

Benefit	Description	You Pay
	○ Vaginal contraceptive ring; ○ Emergency contraception (Plan B/Plan B One Step/Next Choice); and ○ Emergency contraception (Ella). • Services and items at no cost include the office visit or Facility at no cost.	
Cosmetic and Reconstructive Surgery	• Cosmetic surgery limited to: ○ Repair due to an accidental injury; ○ Breast reconstruction after a mastectomy; and ○ Improvement of the functioning of a malformed part of the body. Does not include dentistry or dental processes. • Reconstructive Surgery limited to: ○ Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions; ○ Surgery after a mastectomy 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 birth defects or developmental abnormalities; ○ Trauma, infection, tumors, or disease, and ○ Breast reduction.	Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Dental care – anesthesia	• Anesthesia; • Anesthesiologist; and • Hospital or surgical center Facility required for dental procedures. • Members must: ○ Have a condition that requires Hospitalization or general anesthesia for dental care; ○ Be severely disabled;	Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment Included in the Inpatient Hospital

Benefit	Description	You Pay
	○ In the judgment of the treating doctor, not be of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia; and ○ Require Inpatient or Outpatient services because of an underlying medical condition or because of the severity of the dental procedure.	Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Dental care – emergencies	• Care for accidental injury to the jaw, sound natural teeth, mouth, or face. • Replacement, re-implantation, and follow-up care of those teeth are not covered, even if the teeth are not saved by emergency stabilization. • You do not need PA.	Included in the ER Copayment, which is $300 Copayment/visit and waived if admitted to Inpatient care
Diabetic care	• We cover medical care for: ○ Pre-diabetes; ○ Insulin dependent (type I); ○ Non-insulin dependent (type II); and ○ Elevated blood glucose levels during pregnancy.	See below
Diabetic care – Diabetes Prevention Program	• Services at no cost limited to pre-diabetic Members (higher than normal blood sugar level, but not yet diagnosed with diabetes). • Support to learn new skills: ○ Eating healthy; ○ Being active; and ○ Losing weight.	No Copayment
Diabetic care – diabetic supplies	• We cover: ○ Syringes; ○ Test strips for glucose monitors; ○ Visual reading and urine testing strips; ○ Injection aids; ○ Cartridges for the legally blind; and ○ Other diabetes equipment and related services that are	20% Coinsurance Supplies in office or Facility visit: Included in Specialist Copayment, which is $50 Copayment/visit Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay

Benefit	Description	You Pay
	determined Medically Necessary by the Oklahoma State Board of Health, provided the FDA has approved such equipment and supplies. • You do not need PA for monitors we provide. See your *Drug Formulary* for what, if any, restrictions apply to supplies and drugs.	Supplies billed by a Home Healthcare or Hospice Services agency: No Copayment
Diabetic care – DME and supplies	• Blood glucose monitors; • Blood glucose monitors for the legally blind; • Insulin pumps and needed accessories; • Insulin infusion devices; and • Appliances for feet to prevent complications from diabetes.	20% Coinsurance Equipment during office or Facility visit: Included in Specialist Copayment, which is $50 Copayment/visit Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay Equipment billed by a Home Healthcare or Hospice Services agency: No Copayment
Diabetic care – medications	• Insulin; and • Oral agents for controlling blood sugar.	See "Prescription Drug Benefits Chart" on page 69
Diabetic care – self-management training, education, and medical nutrition	• Services at no cost limited to: o Visits at the diagnosis of diabetes; o Visits your doctor recommends due to a change in your symptoms or condition that mean you need changes in self-management; and o Visits for re-education or refresher training.	No Copayment

Benefit	Description	You Pay
	• Training may be from your doctor. Or, your doctor may send us a Referral for visits to a diabetic educator, nutritionist, or dietitian. • You may pay the Specialist Copayment if you have other services during the visit.	

Diagnostic Tests	• We cover laboratory and radiological services including, but not limited to:
	  o Blood tests
	  o Non-routine mammograms
	  o Non-routine pap tests
	  o Routine ultrasounds
	  o Standard x-rays
	• We cover routine pap tests and mammograms under Preventive Care. We cover routine ultrasounds related to pregnancy under prenatal care.
	• Routine services do not require PA.
		No Copayment

DME	• We cover equipment and supplies your Provider orders for everyday or extended use. Certain items, although durable in nature, may fall into other coverage categories. Examples are prosthetic appliances or orthotic devices.
	• We determine whether to rent or buy an item. You must return rental equipment when medical necessity ends.
	• Covered Services examples include:
	  o Oxygen and oxygen equipment
	  o CPAP and supplies
	  o Wheelchairs
	  o Crutches
	  o Some equipment and supplies for diabetes self-management
	• Replacement, repairs, adjustments, maintenance, and delivery costs.
	• We do not cover:
	  o Equipment that serves as comfort or convenience.
	  o Upgrade features to enhance
		20% Coinsurance
		
		Equipment during office or Facility visit: Included in Specialist Copayment, which is $50 Copayment/visit
		
		Included in the ER Copayment, which is $300 Copayment/visit and waived if admitted to Inpatient care
		
		Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment
		
		Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment
		
		Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
		
		Equipment billed by a Home

Benefit	Description	You Pay
	basic equipment. o Changes to your home or vehicle. o Repair and replacement if the equipment is destroyed due to improper use or abuse or is lost or sold. o Multiple DME items for the same or like purposes.	Healthcare or Hospice Services agency: No Copayment
Emergency medications	• We cover emergency medications as other Prescription Drugs.	See "Prescription Drug Benefits Chart" on page 69
Emergency Services	• See "Emergency Care" on page 25. • You do not need PA.	$300 Copayment/visit Waived if admitted to Inpatient care from the ER department
Eyeglasses	• We cover eyewear for adults and children.	See "Vision Benefits" on page 81
Foot care	• We cover care for injuries or conditions that affect your feet. • Routine care is limited to Members with diabetes or a blood circulation disease. We cover: o Nail trimming, cutting, and debridement; and o Hygienic and preventive foot care. • You do not need PA for PCP visits.	PCP: No Copayment Included in Specialist Copayment, which is $50 Copayment/visit
Hearing services – Cochlear®	• An implantable device for bilateral, profoundly hearing-impaired Members that do not benefit from conventional hearing aids. • Coverage is for Members at least 18 months of age or for pre-lingual Members with minimal speech perception using hearing aids. • Surgery to implant a device.	Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment
Hearing services – hearing aids and devices	• Limited to one aid per ear every 48 months unless Medically Necessary to replace more often. • Members under age two, four additional ear molds may be obtained per year (two molds for each ear). • Repairs and replacement parts (except when lost, sold, damaged,	Hearing aids and devices: 20% Coinsurance Repairs, replacement parts, adjustments, maintenance, delivery: 20% Coinsurance Lost, sold, damaged, or destroyed due to improper use or abuse: You pay the manufacturer's Deductible for any

Benefit	Description	You Pay
	or destroyed due to improper use or abuse), adjustments, maintenance, and delivery costs. • We do not cover upgrade features. • We do not cover accessories or supplies.	warranty included with your standard hearing aid – does not count toward your MOOP Upgrade features: You pay the charge above the cost of a standard hearing aid if you choose upgrades – the extra amount does not count toward your MOOP
Hearing services – Screening	• Screening by PCP. • Evaluation by audiologist. • You do not need PA.	No Copayment
Hearing services – testing	• Testing to determine need for hearing aid. • Related services needed to access, select, and fit or adjust a hearing aid.	Included in Specialist Copayment, which is $50 Copayment/visit
Home Healthcare	• See "Home Healthcare" on page 26. • Limited to a total of 100 visits per year.	Services, drugs, supplies, and equipment billed by a Home Healthcare agency: No Copayment Equipment billed separately: 20% Coinsurance

Hospice Services	• We cover Hospice Services in the care plan developed by your team of Providers and caregivers.
	• Care may be in a Network Hospital hospice Facility or an in-home hospice program.
	• Services
	  ○ Skilled nursing
	  ○ Certified home health aide, and homemaker services supervised by a qualified registered nurse
	  ○ Bereavement services
	  ○ Social services
	  ○ Medical direction
	  ○ Physical, occupational, and speech pathology services for purposes of symptom control, or to enable you to continue activities of daily living and basic functional skills
	  ○ Drugs
	  ▪ Pharmaceuticals billed by the hospice agency
		Services, drugs, supplies, and equipment billed by a hospice agency: No Copayment

Benefit	Description	You Pay
	○ Supplies and equipment ○ Medical equipment and supplies billed by the hospice agency for the palliation and management of the terminal illness and related conditions	
Immunizations	• See "Preventive Care Benefits" on page 74. You do not need PA. • Unless also a Preventive Service, we do not cover shots you must have for: ○ Employment; ○ The military; ○ Travel; or ○ A vocational school or institute of higher education.	No Copayment
Infertility services	• Covered Services ○ Diagnosis, testing, and drugs given to you by a doctor ○ Treatment for men and women ○ PCP visits do not require PA. • We do not cover: ○ Cost of donor sperm or donor egg ○ Cryopreservation or storage of sperm (sperm banking), eggs, or embryos ○ Gamete Intrafallopian Transfer ("GIFT") ○ Genetic counseling and genetic Screening ○ Insemination procedures and all services related to insemination ○ Intracervical Insemination ("ICI") ○ In Vitro Fertilization ("IVF") ○ Reversal of a sterilization procedure ○ Zygote Intrafallopian Transfer ("ZIFT") ○ Services associated with these procedures	PCP: No Copayment Included in Specialist Copayment, which is $50 Copayment/visit Other treatment: 50% Coinsurance
Injectable drugs	• Outpatient injectable drugs ○ Drugs your doctor gives you in the office.	PCP: No Copayment Included in Specialist Copayment,

Benefit	Description	You Pay
	• Self-injectable drugs ○ Drugs you inject that you buy at a pharmacy.	which is $50 Copayment/visit See "Prescription Drug Benefits Chart" on page 69.

Inpatient Hospital Facility	• We cover care in a Hospital when you need to be admitted. It usually requires an overnight stay.
	• Care includes:
	  ○ Administration of whole blood and blood plasma;
	  ○ Anesthesia and oxygen services;
	  ○ Drugs, medications, biologicals;
	  ○ General nursing care;
	  ○ Meals and special diets
	  ○ Radiation therapy, inhalation therapy, perfusion;
	  ○ Room and board;
	  ○ Special-duty nursing;
	  ○ Use of operating room and related Facilities;
	  ○ Use of intensive care unit and services; and
	  ○ X-ray services, laboratory, and other Diagnostic Tests.
	• We also cover Rehabilitation Services when we expect you will have significant improvement within two months.
		$250 Copayment/day up to $750 Copayment/stay
		
		ER transfers: ER Copayment waived

Laboratory services	• We cover diagnostic and therapeutic laboratory services. • You do not need PA.	No Copayment

Mammogram	• Screening:
	  ○ Between the ages of 35 and 40
	  ▪ One routine mammogram during this 5-year span
	  ○ Over the age of 40
	  ▪ One routine mammogram every 12 months
	• 2D and 3D mammograms
	• You do not need PA for routine mammograms.
		No Copayment

Maternity and newborn care	• We cover pregnancy, labor, and delivery. It includes Complications of Pregnancy, medical care for abortion when the mother's life is endangered, or miscarriage.	Included in the delivery and Inpatient services for mother Copayment, which is $500 Copayment/stay Included in the ER Copayment, which

Benefit	Description	You Pay
	○ Morning sickness is not a Complication of Pregnancy. • Emergencies and office visits to your OB/GYN do not require PA.	is $300 Copayment/visit and waived if admitted to Inpatient care Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment Included in the Inpatient Hospital Facility Copayment (not delivery admission), which is $250 Copayment/day up to $750 Copayment/stay
Maternity and newborn care – breastfeeding supplies	• Breastfeeding supplies limited to purchase or rental of breast pump and related supplies. • Limited to one pump per year for women who are pregnant and/or nursing. • Rental or purchase of breastfeeding equipment is for the duration of breastfeeding.	No Copayment
Maternity and newborn care – delivery and Inpatient services for mother	• We cover at least 48 hours of Inpatient care at a Hospital, or a birthing center licensed as a Hospital, following a vaginal delivery. • We cover at least 96 hours of Inpatient care at a Hospital following a delivery by caesarean section. • The 48/96 hour period begins at the time of delivery. If you deliver outside the Hospital and you are later admitted in connection with childbirth (as determined by your doctor), the period begins at the time of admission. • Care includes: ○ Appropriate clinical tests; ○ Delivery; ○ Inpatient Hospital Services; ○ Parent education;	$500 Copayment/stay

Benefit	Description	You Pay
	○ Physical assessment; and ○ Training or assistance with breast or bottle feeding. • We do not cover the costs resulting from normal, full-term delivery outside of our Network. "Normal, full-term delivery" is defined as a delivery (vaginal or caesarean) within 30 days of your due date. See "Emergency Care" on page 25 for exceptions. • You do not need PA for these services. • Other non-emergency admissions or admissions beyond the 48/96 hour routine care require PA.	
Maternity and newborn care – lactation support services	• Lactation support, education, and counseling services: ○ Antenatal; ○ Perinatal; and ○ Postpartum period. • One-on-one or group session includes: ○ In-person conversations; ○ Online support; ○ Phone calls; ○ Print materials; and ○ Videos.	No Copayment
Maternity and newborn care – newborn services	• Newborns hospitalized beyond the 48/96 hour approved mother's stay require separate Inpatient Hospital Copayment. • We cover Medically Necessary services for up to the first 31 days of life. However, if you do not enroll your newborn in the Plan, coverage will automatically end after the 31 days. We will coordinate benefits for these 31 days if you enroll your newborn in another Plan and the effective date is between birth and day 31. See "When You're Covered by More Than One Plan" on page 97. • When the maternity care is for a Dependent child, the newborn (a	Inpatient services during mother's 48/96 hour stay: Included in the mother's delivery and Inpatient services Copayment, which is $500 Copayment/stay Inpatient services after mother's 48/96 hour stay: $250 Copayment/day up to $750 Copayment/stay Pediatrician office visits: No Copayment

Benefit	Description	You Pay
	Dependent of a Dependent) does not have coverage beyond the 48/96 hour approved mother's stay. • We cover circumcision for newborns. • You do not need PA for the 48/96 hour mother's stay or pediatrician visits. Also see "Well Visit Checklists" on page 110.	
Maternity and newborn care – postpartum visits	• We cover up to six weeks of postpartum care. • If childbirth occurs at home or in a birthing center licensed as a birthing center, we cover: o Postpartum home care following a vaginal delivery; and o One home visit within 48 hours of childbirth by a Provider whose scope of practice includes providing postpartum care. • Visits include: o Appropriate clinical tests; o Depression Screening; o Parent education; o Physical assessment of the mother and newborn; and o Training or assistance with breast or bottle feeding. • You do not need PA.	One-time $25 Copayment for all postpartum visits
Maternity and newborn care – prenatal care	• We cover Case Management services at no cost. You do not need PA. See "Prenatal Outreach Program" on page 108. • Your doctor decides how many visits are right for you and what care you get in each visit. Routine services include, but are not limited to: o Lab work o Obstetrical care o Screenings o Ultrasounds • You do not need PA. See "Well Visit Checklists" on page 110.	Routine care: No Copayment Non-routine, non-preventive, or high-risk prenatal services: Included in Specialist Copayment, which is $50 Copayment/visit Included in the ER Copayment, which is $300 Copayment/visit and waived if admitted to Inpatient care Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment

Benefit	Description	You Pay
		Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay

Medical supplies and materials	• OTC items limited to disposable supplies needed for DME, diabetic supplies, and ostomy supplies.
	• The office visit or Facility Copayment includes medical supplies and materials used in the course of a visit or admission such as:
	  ○ Bandages
	  ○ Gauze
	  ○ Ointments
	  ○ Slings
	• We do not cover these types of items for any other purpose.
		DME and ostomy supplies: 20% Coinsurance
		
		Diabetic supplies: 20% Coinsurance
		
		Supplies during office or Facility visit: Included in Specialist Copayment, which is $50 Copayment/visit
		
		Included in the ER Copayment, which is $300 Copayment/visit and waived if admitted to Inpatient care
		
		Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment
		
		Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment
		
		Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
		
		Included in Home Healthcare or Hospice Services Copayment, which is no Copayment

Mental/ behavioral health services	• We cover Inpatient and Outpatient services.	See "Behavioral Health Benefits Chart" on page 37
Obesity Screening and weight loss counseling and treatment	• We cover Screening and counseling for all Members. See "Preventive Care Benefits" on page 74. • We cover adult benefits for weight management treatment for	No Copayment

Benefit	Description	You Pay
	Members with BMI of 30 kg/m^2 or higher: o 12 – 26 nutritional counseling sessions in the first year; o Group and/or individual sessions to help Members; ▪ Make healthy eating choices; ▪ Address barriers to change; ▪ Monitor behavior; and ▪ Maintain physical activity. • We do not cover commercial weight loss programs or OTC weight loss products. • Services are from your PCP or a Network dietitian or nutritionist. • You do not need PA for PCP services.	
Oral surgery	• We cover surgery within or next to the oral cavity for medical purposes only. • Oral and maxillofacial surgery for: o Biopsy and excision of cysts or tumors of the jaw; o Treatment of cancer; o Tooth extraction prior to a major organ transplant; and o Radiation of the head or neck, and non-dental surgical treatment for birth defects. • Orthognathic surgery when: o The bite alignment affects your physical health, not just dental health, such as problems with: ▪ Swallowing; ▪ Speaking; or ▪ Chewing. o You had trauma to the mouth that affects function. o Other forms of treatment have not worked.	Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Orthotic devices	• Limited to Members with diagnoses pertaining to diabetes or a blood circulation disease. • We cover replacements, repairs, and adjustments. Limited to: o Normal wear and tear; or	20% Coinsurance Devices during your office or Facility visit: Included in Specialist Copayment, which is $50 Copayment/visit

Benefit	Description	You Pay
	○ Due to a significant change in your physical condition.	Included in the ER Copayment, which is $300 Copayment/visit and waived if admitted to Inpatient care Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay Devices billed by a Home Healthcare or Hospice Services agency: No Copayment
Outpatient services	• We cover care including diagnostic, treatment, and x-ray services. You must not be bedridden. • Services may be given in a doctor's office, non-hospital based Facility, or a Hospital. • We cover Rehabilitation Services when we expect you will have significant improvement within two months.	Included in Specialist Copayment, which is $50 Copayment/visit Included in the ER Copayment, which is $300 Copayment/visit and waived if admitted to Inpatient care Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment
Outpatient surgery	• We cover surgery performed in an Outpatient Facility instead of during an Inpatient stay when appropriate.	Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment
Phenylketonuria ("PKU") testing	• We cover newborn testing. See "Preventive Care Benefits" on page 74.	No Copayment

Benefit	Description	You Pay
Physical therapy	• We cover evaluation by a licensed physical therapist. • The physical therapist may send a Referral for up to 30 days of treatment. Services beyond the 30 days require a doctor's Referral and another authorization. • All visits count toward the total combined physical, occupational, and speech therapy Outpatient visit limits for Rehabilitation Services. • We cover massage therapy if given during physical therapy. We do not cover massage therapy if that is the purpose of the visit or it is billed separately. • You do not need PA for the evaluation only.	Services in office: $50 Copayment/visit Rehabilitation Outpatient Facility: which is $250 Copayment/day up to $750 Copayment/stay Services as Inpatient: Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay Included in Home Healthcare Copayment, which is no Copayment
Physician Services	• We cover diagnostic, treatment, consultant, and Referral services provided by your PCP or a Specialist. • Services doctors and other health professionals provide o Allopathic; o Chiropractic; o Optometric; o Osteopathic; o Podiatric; o Psychological; and o Second surgical opinion. • Locations o ER; o Home; o Inpatient; o Outpatient; and o Skilled Nursing Facility. • We cover telemedicine if your Provider offers the service and has contracted with us to provide it. • You do not need PA to see doctors in a PCP, Urgent Care, self-referral, or ER visit setting.	PCP: No Copayment Specialist: $50 Copayment/visit Included in Urgent Care Copayment, which is $25 Copayment/visit Home Healthcare and Hospice Services: No Copayment Included in the ER Copayment, which is $300 Copayment/visit and waived if admitted to Inpatient care Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay

Benefit	Description	You Pay
		Included in Skilled Nursing Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Prescription Drugs	• We cover drugs and products with a written prescription.	See "Prescription Drug Benefits Chart" on page 69
Preventive Care	• We update the list of Covered Services each year or as required by law. See "Preventive Care Benefits" on page 74. • Most services your PCP or OB/GYN performs in his or her office do not require PA.	No Copayment
Prostate cancer Screening	• We cover one Screening for men over the age of 40 at no cost. It may be either a prostate-specific antigen blood test or a digital rectal exam.	No Copayment
Prosthetic appliances	• We only cover implantation or removal of breast prostheses and bras after a mastectomy. • We cover replacements, repairs, and adjustments. Limited to: o Normal wear and tear; or o Due to a significant change in your physical condition. • We do not cover bionic and myoelectric prosthetics.	External appliances: 20% Coinsurance External appliances during office visit: Included in Specialist Copayment, which is $50 Copayment/visit External appliances billed by a Home Healthcare or Hospice Services agency: No Copayment Internal appliances: Included in the Outpatient Preferred Facility Copayment, which is $250 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is $750 Copayment Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay
Rehabilitation Facility	• We cover care in a Facility that specializes in physical, speech, and/or occupational therapy. The Outpatient visits count toward the total Outpatient visit limitations for	$250 Copayment/day up to $750 Copayment/stay

Benefit	Description	You Pay
	Rehabilitation Services.	
Rehabilitation Services	• We cover services and devices provided by a registered physical, speech/language, or occupational therapist for the treatment of an illness or injury. • Limited to 60 Outpatient visits, combination of therapies. Outpatient visits include office visits and/or rehabilitation Outpatient Facility visits.	Services in office: $50 Copayment/visit Rehabilitation Outpatient Facility: which is $250 Copayment/day up to $750 Copayment/stay Services as Inpatient: Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay Included in Home Healthcare Copayment, which is no Copayment
Routine exam – adult	• One routine exam per year. • It includes a general checkup when the PCP discusses Preventive Care. You may have some Preventive Care services during the visit. You may need to schedule other services. See "Well Visit Checklists" on page 110. • You do not need PA.	No Copayment
Routine exam – child	• Your child benefits include well-child visits. • You do not need PA.	No Copayment
Severe mental illness treatment	• We cover "Severe Mental Illness", as defined by the American Psychiatric Association, the same as medical conditions.	See "Behavioral Health Benefits Chart" on page 37
Skilled Nursing Facility care	• A Plan doctor must prescribe treatment. • Limited to 100 days per year.	$250 Copayment/day up to $750 Copayment/stay
Special Programs	• We cover education services and disease and Case Management programs. See "Special Programs" on page 106. • You do not need PA.	No Copayment
Specialized scans, imaging, and diagnostic exams	• We cover services, including, but not limited to: o CT scans o MRIs o Nuclear scans o PET scans o Sleep studies	Imaging Facility – Preferred Facility: $250 Copayment Imaging Facility – Non-preferred Facility: $750 Copayment Included in Specialist Copayment,

Benefit	Description	You Pay
	○ SPECT scans • Your Copayment includes interpretation.	which is $50 Copayment/visit Included in the ER Copayment, which is $300 Copayment/visit and waived if admitted to Inpatient care Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay Sleep studies at home: No Copayment
Speech services	• Screening by PCP. • Evaluation and testing. • Speech/language therapy ○ All visits count toward the total combined physical, occupational, and speech therapy Outpatient visit limits for Rehabilitation Services. • You do not need PA for PCP.	PCP: No Copayment Included in Specialist Copayment, which is $50 Copayment/visit Therapy in rehabilitation office: $50 Copayment/visit Rehabilitation Outpatient Facility: which is $250 Copayment/day up to $750 Copayment/stay Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay Included in Home Healthcare Copayment, which is no Copayment
Substance use services	• We cover medical complications including, but not limited to: ○ Cirrhosis of the liver ○ Delirium tremens ○ Detoxification ○ Electrolyte imbalances ○ Hepatitis ○ Malnutrition	Lab and Diagnostic Tests: No Copayment PCP: No Copayment Included in Specialist Copayment, which is $50 Copayment/visit Included in the ER Copayment, which is $300 Copayment/visit and waived if admitted to Inpatient care Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750

Benefit	Description	You Pay
		Copayment/stay See "Behavioral Health Benefits Chart" on page 37

Temporo-mandibular joint dysfunction	• Medical professional and Hospital Services.
	• Non-surgical treatment limited to a lifetime maximum of $1,500:
	  ○ Professional services, physical therapy, chiropractor, physician;
	  ○ X-rays, laboratory services; and
	  ○ DME appliances, orthotic devices.
	• We do not cover dental care.
	• You do not need PA for x-rays and laboratory services.
		$100 Copayment/treatment plan

Transplants	• We cover organ, tissue, bone marrow, and stem cell transplants. They must not be Experimental or Investigational in nature. • We cover office visits, lab work, tests, and Inpatient Hospital Facility expenses related to a transplant for the living donor and recipient. ○ When only the recipient is a GlobalHealth Member, donor benefits are limited to those not provided or available to the donor from any other source. • You must use a Plan-designated center of excellence. • You do not need PA for lab work.	Lab and Diagnostic Tests: No Copayment Included in Specialist Copayment, which is $50 Copayment/visit Included in Preferred Facility: $250 Copayment Included in Non-preferred Facility: $750 Copayment Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay

Treatment therapies	• Your Cost-share covers services and supplies.
	• Chemotherapy drugs and administration
	• Dialysis services and supplies
	• Growth Hormone Therapy ("GHT") drugs and administration
	• Infusion therapy drugs and administration in:
	  ○ The home;
	  ○ A free standing clinic or doctor's office;
		Treatment therapy in a dialysis, radiation, or chemotherapy Facility: $50 Copayment/treatment
		
		Included in Specialist Copayment, which is $50 Copayment/visit
		
		Included in the Inpatient Hospital Facility Copayment, which is $250 Copayment/day up to $750 Copayment/stay

Benefit	Description	You Pay
	○ A Hospital; ○ A Skilled Nursing Facility; or ○ A rehabilitation Facility. • Radiation therapy • Respiratory/inhalation therapy	Equipment, services, and supplies billed from Home Healthcare agency: No Copayment Pharmacy: See "Prescription Drug Benefits Chart" on page 69
Urgent Care	• We cover care you get in an Urgent Care Facility. See "Urgent Care" on page 24. You do not need PA.	$25 Copayment/visit
Vision	• We cover vision services for adults and children.	See "Vision Benefits Chart" on page 81 for benefits
Well-child care	• We cover routine child care. See "Well Visit Checklists" on page 110. • You do not need PA.	No Copayment
Well-woman exam	• We cover each Preventive Care service once every 12 months at no cost. See "Well Visit Checklists" on page 110. • You do not need PA for routine tests and counseling when provided by your PCP or OB/GYN.	No Copayment
Wigs	• We cover wigs or other scalp prostheses necessary for your comfort and dignity when required due to loss of hair resulting from chemotherapy or radiation therapy. • Limited to one synthetic wig or scalp prosthesis per year.	20% Coinsurance

Prescription Drug Benefits

Covered Services

Your Prescription Drug benefit covers Outpatient drugs that need a prescription. "Prescription" means an order written for a medicinal substance which, under the Federal Food, Drug, and Cosmetic Act ("FD&C Act"), is required to state: "Caution: Federal law prohibits dispensing without a prescription" or "Rx Only". Doctors or others licensed to prescribe may write a prescription.

We also cover some OTC drugs and products. See "ACA" on page 71.

Please note:

- All drugs and products must be FDA-approved.
- Quantity limits, prior authorization criteria, and step therapies may apply. See your *Drug Formulary* for any restrictions.

- A Network Provider must write the prescription. Exceptions are limited to:
  - ER or Urgent Care Providers; and
  - Dentists.
- If an Out-of-network Provider writes a prescription, you will get a letter that other prescriptions written by the same Provider are not covered. Your regular doctor should handle all follow-up care, including writing or refilling your prescriptions.
- A Network pharmacy must fill the prescription.
- You will pay your Cost-share or the cost of the drug, whichever is less.
- A generic equivalent will be dispensed if available, unless your doctor specifically requires a brand name. If you receive a brand name drug when an FDA-approved generic drug is available, and your doctor has not specified Dispense as Written for the brand name drug, you will have to pay the difference in cost between the brand name drug and the generic.

Also see "Coverage Requirements" on page 36.

Prescription Drug Benefits Chart

Tier	Description	You Pay 30-day Supply	You Pay 90-day Supply
ACA	• Preventive Care Prescription Drugs and OTC drugs with a prescription. • Each drug has rules for when it is prescribed for Preventive Care. You pay the Tier Cost-share shown in the *Drug Formulary* if you do not meet the criteria for Preventive Care coverage. • The list is subject to change as ACA guidelines are updated or modified.	No Copayment	No Copayment

Tier One	• This Tier has two Cost Sharing levels:
	  ○ Low-cost generics ("LCG") are noted in the *Drug Formulary*.
	  ○ All other generics show Tier 1 in the *Drug Formulary*.
		LCG: $5 Copayment/ prescription fill or refill
		
		Generics: $10 Copayment/ prescription fill or refill
			LCG: $10 Copayment/ prescription fill or refill
			
			Generics: $20 Copayment/ prescription fill or refill

Tier Two	• This Tier has preferred brand name drugs on the Formulary.	$50 Copayment/ prescription fill or refill	$100 Copayment/ prescription fill or refill
Tier Three	• This Tier includes non-preferred brand name and high-cost generic drugs. • If we allow coverage of non-formulary drugs, you will pay the Cost-share for this Tier. See	$75 Copayment/ prescription fill or refill	$150 Copayment/ prescription fill or refill

Tier	Description	You Pay 30-day Supply	You Pay 90-day Supply
	"Exception Requests" on page 33.		
Tier Four	• This Tier has three Cost Sharing levels: o Preferred Specialty Drugs. o Non-preferred Specialty Drugs. o Chemotherapy drugs have a separate list in the *Drug Formulary*.	Preferred: $100 Copayment/ prescription fill or refill Non-preferred: $200 Copayment/ prescription fill or refill Chemotherapy drugs: $100 Copayment/ prescription fill or refill	Limited to a one-month supply per fill.

Formulary Drug List
We list preferred drugs in the *Drug Formulary*. We choose the drugs on the list based on quality (effectiveness and safety) as well as cost. It includes generic and brand name drugs.

P&T Committee:
The P&T Committee oversees the Formulary drug list.

The committee meets at least every three months. The committee reviews UM rules at least once each year.

All new FDA-approved drugs are reviewed within 90 days. Within 180 days of its release onto the market, the committee decides whether or not to add the new drug to the Formulary.

Committee members include:
- Practicing doctors;
- Practicing pharmacists licensed to prescribe drugs; and
- Other practicing professionals licensed to prescribe drugs.

Drug Tiers:
The *Drug Formulary* will tell you which Tier a drug is in and any UM rules that apply. The Cost-share and description for each Tier remains the same for the entire year. During the year, individual drugs may move between Tiers. You will pay the new Tier Cost-share after we give you 60 days' notice. You can see the latest *Drug Formulary* on our website.

The Prescription Drug Cost-share for anticancer drugs you take by mouth is no greater than for drugs you take by IV or injection.

For questions about your coverage, call the phone number printed on your Member ID card.

Changes:
The list of drugs can change during the year.

- The FDA may release new brand name drugs or generic drugs.
- We will only stop or lower coverage for a drug when the FDA releases:
  - A new or lower cost drug that has the same purpose and effect; or
  - Information that the drug is not safe or does not work.
- If we make changes to a drug that you take, we will tell you at least 60 days before the changes take effect. Changes may be:
  - Removing a drug from our Formulary;
  - Adding new rules to getting a drug; or
  - Moving a drug to a higher Tier.
- If the FDA decides a drug on our Formulary is unsafe or the drug's manufacturer removes the drug from the market, we will remove the drug from our Formulary right away and tell you.

Exclusions:
We don't cover some Prescription Drugs because other drugs for the same purpose and effect:

- Are safe;
- Have fewer health risks; and/or
- Have lower overall healthcare costs.

We post a 60-day notice on our website before the exclusion takes effect.

ACA
Some products are available at no cost. Others have some Cost Sharing. This happens when there are multiple FDA-approved items that are for the same purpose. See the *Drug Formulary* for a list of drugs covered with and without Cost Sharing.

Benefits are limited to recommended prescribing limits.

Breast Cancer:
Doctors may prescribe risk-reducing drugs for women who are at higher risk for breast cancer and at low risk for drug side effects. Examples are tamoxifen or raloxifene.

Cholesterol:
Doctors may prescribe statin drugs for adults age 40 – 75 at higher risk for CVD.

Contraception Drugs and Devices for Women:
We cover at least one FDA-approved item or product in every contraceptive method. This means women can get the pill, the shot, the ring, contraceptive implants, diaphragms, cervical caps, and permanent contraceptive methods like tubal ligation. We cover some of these methods under your medical benefits. See Contraception services on page 48.

- Prescription Drug Benefits require a written prescription from your doctor, even if you buy the item OTC. See your *Drug Formulary* for any rules for getting the item.
- If the FDA has approved multiple services and items within a method, we will decide which items to cover without Cost Sharing. However, if your doctor recommends a particular service or

FDA-approved item for you, we will cover it without Cost Sharing. We defer to your doctor. See "Exception Requests" on page 33 to get coverage for Prescription Drugs.

OTC:
We cover some FDA-approved OTC drugs and products at no cost. Not all products of each type are included.

Medicine or Product	Eligible Population
Aspirin	For adults up to age 60
Contraceptives	For women capable of becoming pregnant
Folic acid supplements	For women planning a pregnancy or capable of becoming pregnant
Iron supplements	For children from birth – 12 months
Oral fluoride supplements	For children from birth – 5 years
Tobacco cessation products	For adults age 18 and older
Vitamin D supplement	For adults age 65 and older

To get benefits, you must:
- Use a Network pharmacy; and
- Have a prescription from your doctor.

Vaccines:
We cover immunizations listed in "Preventive Care Benefits Chart" on page 74 at no cost. Shots required for work, school, or travel are not covered unless also a Preventive Care immunization. Check with your PCP first.

Network Providers, including pharmacies, must give you the shots. See our website for a list of pharmacies that give them.

Off-label Uses
"Off-label use" is any use of the drug other than those on a drug's label as approved by the FDA. To be covered, the drug must be for the FDA-approved:
- Disease or medical condition;
- Dosage; and
- Length of therapy.

Also, the drug must be prescribed within FDA safety guidelines:
- Standards for safety and effectiveness in clinical studies; and
- Warnings, precautions, and potential drug interactions.

Generally, we do not cover off-label use. There are two exceptions:
1. We cover off-label uses of drug(s) used in the study or treatment of cancer.
2. We may cover certain investigational uses of chemotherapy for cancer treatment. They must be given to you as part of an Approved Clinical Trial.

Compounded Drugs
We do not cover compounded drugs.

Prescriptions Received in an ER or Urgent Care Facility
You may fill drugs prescribed by ER or Urgent Care doctors at any Network pharmacy. You will pay your Prescription Drug Cost-share. UM rules may apply. Your regular doctor should prescribe refills, if needed.

Prescription Drug Abuse and Heroin Use
Opioid abuse is a serious public health issue. Drugs may be:

- Prescribed, such as OxyContin® or hydrocodone; or
- Illegal, such as heroin.

We cover Prescription Drugs for medication-assisted treatment. Also see Substance Use page 40.

Drug Disposal
Be sure to dispose of drugs in a safe manner.

- Follow the instructions on the Prescription Drug labeling or patient information that comes with the drug. Do not flush drugs down the sink or toilet unless the instructions tell you to do so.
- Use programs that let you take unused drugs to a central location for proper disposal. Call your local law enforcement agencies to see if they sponsor drug take-back programs. Contact your local household trash and recycling service to learn about drug disposal options and guidelines for your area.
- Take unused drugs to collectors registered with the DEA. Authorized sites may be retail, Hospital or clinic pharmacies, and law enforcement locations. Some offer mail-back programs or collection drop-boxes. Visit the DEA's website or call 1-800-882-9539 for more information and to find an authorized collector in your area.

Preventive Care Benefits

Covered Services
The federal government has three agencies that are responsible for deciding what Preventive Services we must cover at no cost to you. Each agency issues guidelines.

Agency	Guidelines Description
USPSTF	• Evidence-based items or services • Have a rating of "A" or "B" • For more detailed information on each service, see the USPSTF website, http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
HRSA	• Evidence-informed exams, Screenings, shots, and counseling • Including Preventive Care and Screenings with respect to women
CDC	• Immunizations recommended by the Advisory Committee on Immunization Practices • Prevention with respect to the individual involved

The list of Preventive Services may change as guidelines are updated. We will use reasonable medical management to determine coverage when the guideline does not specify:

- Frequency;
- Method;
- Treatment; or
- Setting.

Also see "Coverage Requirements" on page 36.

Preventive Care Benefits Chart

Population	Benefits Description	You pay
Adult benefits	You do not need PA. • Alcohol misuse Screening and counseling; • Aspirin use for men and women of certain ages with certain health risks. See "ACA" on page 71; • Blood pressure Screening for all adults, including obtaining measurements outside of the clinical setting for diagnostic confirmation; • Cardiovascular intensive behavioral counseling interventions for overweight and obese adults; • Cholesterol Screening for adults of certain ages or at higher risk; • Colorectal cancer Screening for adults ages 50 – 75 (FIT, FOBT). See Colorectal cancer prevention Screening on page 47; • Depression Screening for adults; • Diabetes Screening for adults as part of CVD risk assessment in adults age 40 – 70 who are overweight or obese; • Diet counseling for adults at higher risk for chronic disease; • Falls prevention counseling and preventive medication for adults age 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 65 or older adults at higher risk; • Immunization vaccines for adults – doses, recommended ages, and recommended populations vary. This list is representative and may not be all-inclusive. See the CDC website – https://www.cdc.gov/vaccines/schedules/hcp/adult.html. See "ACA" on page 71.	No Copayment

Population	Benefits Description	You pay
	○ 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) • Obesity Screening for all adults with intensive behavioral interventions for adults who screen positive. See Obesity Screening, weight loss counseling, and treatment on page 61; • Sexually transmitted infection ("STI") prevention counseling for adults at higher risk; • Skin cancer behavioral counseling for young adults up to age 24 years at higher risk; • Statin use for the primary prevention of CVD for adults age 40 – 75 at higher risk. See "ACA" on page 71; • Syphilis Screening for all adults at higher risk; • Tobacco use Screening for all adults and Prescription Drug and behavioral interventions for tobacco users. See "Tobacco Cessation" on page 114; and • Tuberculosis infection Screening for all adults at higher risk.	
Women's benefits	You do not need PA. See Maternity and newborn care on page 57 for services related to pregnancy and postpartum. • Anemia Screening on a routine basis for pregnant women; • Aspirin as preventive medication after 12 weeks of gestation in women who are at high risk for pre-eclampsia. See "ACA" on page 71; • Breast cancer mammography Screenings every 1 – 2 years for women over age 40. See Mammogram on page 57; • Cervical cancer Screening for sexually active women; • Chlamydia infection Screening for younger women and other women at higher risk; • Contraception: FDA-approved contraceptive methods and patient education and counseling, not including abortifacient drugs. See Contraception services on page 48; • Depression Screening for pregnant and postpartum women; • Domestic and interpersonal violence Screening for all	No Copayment

Population	Benefits Description	You pay
	women age 14 – 46 with intervention services for women who screen positive; • Folic acid supplements for women who may become pregnant. See "ACA" on page 71; • Gestational diabetes Screening for women 24 to 28 weeks pregnant, and Screening for those at high risk of developing gestational diabetes at the first prenatal visit; • 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 sexually active women and all pregnant women; • HPV DNA test every three years for women with normal cytology results who are age 30 or older; • Osteoporosis Screening for women over age 60 depending on risk factors. See Bone Density Test on page 45; • 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 higher risk; • Tobacco use Screening and interventions for all women, and expanded counseling for pregnant tobacco users. See "Tobacco Cessation" on page 114; • Urinary tract or other infection Screening for pregnant women; and • Well-woman visits to have recommended Preventive Services for women under age 65. You may need multiple visits to have all services. Some services are not needed every year or may be given during other PCP visits. o Routine Pap test o Human papillomavirus ("HPV") testing o Counseling for sexually transmitted infections o Counseling/Screening for HIV o Contraceptive methods and counseling o Counseling/Screening for interpersonal and domestic violence	
Adult benefits that require PA	• Abdominal aortic aneurysm one-time Screening for men of specified ages who have ever smoked; • BRCA counseling about genetic testing and testing for women at higher risk. See Breast cancer – Preventive Care on page 45; • Breast cancer chemoprevention counseling for women at higher risk. See "ACA" on page 71;	No Copayment

Population	Benefits Description	You pay
	• Breastfeeding comprehensive support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women; • Colorectal cancer Screening for adults ages 50 – 75 (FIT-DNA, colonoscopy, CT colonoscopy or virtual colonoscopy, sigmoidoscopy). See Colorectal cancer prevention Screening on page 47; • Contraception sterilization procedures. See Contraception services on page 48; and • Lung cancer Screening (low-dose computed tomography) for adults ages 55 – 80 years who have a smoking history within the past 15 years.	
Child benefits at the listed ages	These services are performed as part of the newborn services at birth or during a well-child visit. You do not need PA. • Alcohol and drug use assessments for adolescents; • 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 cavities Screening for children from birth through age five; • Depression Screening for adolescents age 12 – 18 years; • Developmental Screening for children under age three, 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; • Hepatitis B Screening for adolescents at high risk, at ages 11 – 17 years;	No Copayment

Population	Benefits Description	You pay
	• HIV Screening (testing) for children age 15 and older and younger adolescents at higher risk; • Immunization vaccines for children from birth to age 18 – doses, recommended ages, and recommended populations vary. This list is representative and may not be all-inclusive. See the CDC website - https://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html. o Diphtheria, Tetanus, Pertussis ("TDaP") o Haemophilus influenzae type b ("Hib") o Hepatitis A o Hepatitis B o Human Papillomavirus ("HPV") o Inactivated Poliovirus (Polio) o Influenza (Flu Shot) o Measles, Mumps, Rubella ("MMR") o Meningococcal (Meningitis) o Pneumococcal (Pneumonia) o Rotavirus ("RV") o 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 age 12 – 18 at higher risk; • Skin cancer behavioral counseling for children, adolescents, and young adults; • Syphilis infection Screening for adolescents at higher risk; • Tobacco use interventions, including education or brief counseling, for school-aged children and adolescents age 10 – 17 years; • 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.	

Get Services
Make an appointment with your PCP early in the year for your routine adult exam or your child's well-child exam. Your PCP will decide which services are right for you and perform some services at that time. You can talk about which other services you need and set up more Preventive Care visits.

Your PCP will send us any Referrals you need. There are four exceptions:
1. You have direct access to your OB/GYN for services he/she handles;
2. You have direct access to an imaging center for your mammogram;
3. You have direct access to your BHP for services he/she handles; and
4. You may get shots and Preventive Services at on-site contracted employer-sponsored health fairs.

You have to pay your normal Copayment if the primary purpose of the service is for treatment rather than Preventive Care. Services are preventive when there are no prior symptoms for that condition. Services are for treatment purposes when you are having symptoms, have been diagnosed with a condition, or need more tests after a positive preventive Screening.

There are two exceptions. You may have these services at no cost even with prior symptoms:
1. You may go to your PCP for one annual routine physical; and
2. BRCA testing for women in certain situations. See Breast cancer – Preventive Care on page 45.

You will not need every Preventive Service. Each service has limits on when or how often it is covered if you have average risk factors. Talk to your doctor about any risk factors that mean you need Screenings earlier or more often.

When a doctor determines that a Preventive Service is right for an individual, we cover it without Cost Sharing regardless of sex assigned at birth, gender identity, or gender of record at GlobalHealth. For example, we cover a mammogram or pap smear for a transgender man who has residual breast tissue or an intact cervix.

Follow-up Care
We cover follow-up care for conditions found during Preventive Care services through our regular care processes. Your doctor will schedule an appointment, or send us a Referral if needed, for treatment. There is no cost for any part of the Preventive Care service that led to the diagnosis, but you must pay your regular Copayment for follow-up care should your doctor find something suspicious through the Screening process. Follow-up care begins when the doctor either tells you that you need to have more testing or start treatment.

Service Type	Description
Preventive Care – no cost	• Pre-service consultation for services that require PA; • Listed Preventive Care service or procedure, including removing tissue; • Ancillary services (anesthesiology, pathology, etc.); and • Facility.
Follow-up care – with regular Cost Sharing	• Diagnostic Tests for positive Screening result; • Care for newly discovered disease; and/or • Care for existing symptoms or disease.

Vision Benefits

Covered Services

We cover eye care services to find and treat diseases or injury.

You may go to a Network optometrist for your eye exam. Go to a Network eyewear Provider for eyeglasses or contacts. Except for other eye Specialists, you do not need PA. We cover cataract surgery under Outpatient surgery benefits and Coverage Requirements.

You may get your eye exam and eyeglasses or contacts on different dates or at different locations. However, you must get complete eyeglasses at one time, from one Provider. You may choose either eyeglasses or contact lenses, but not both.

If you need a diabetic eye exam, tell the doctor when you make the appointment.

Also see "Coverage Requirements" on page 36.

Vision Benefits Chart

Benefit	Description	You Pay

Exam	• Routine eye exam once every year
	  ○ Refraction exam
	  ○ Dilatation as necessary
	• Diabetic eye exam
	  ○ As part of routine eye exam
	  ○ For diabetics only
		$50 Copayment/visit

Frames	• Basic, after cataract surgery	No Copayment
Prescription standard plastic, glass, or poly spectacle lenses	• Single vision, after cataract surgery • We do not cover upgrades	No Copayment
Prescription contact lenses	• Soft lens and contact lens if part of treatment after cataract surgery • One set instead of eyeglasses	No Copayment

Excluded Services and Limitations

All benefits described below are excluded or limited under this Plan for all types of services. We cover some benefits only as follows. You pay for additional services.

Limitations

Benefit	Limitation
Behavioral health services	• Applied behavioral analysis limited to 25 hours per week and to the following diagnoses: ○ Autistic disorder – childhood autism, infantile psychosis, and Kanner's syndrome;

Benefit	Limitation
	○ Childhood disintegrative disorder – Heller's syndrome; ○ Rett's syndrome; and ○ Specified pervasive developmental disorders – Asperger's disorder, atypical childhood psychosis, and borderline psychosis of childhood. • Autism Screening limited to well-child visits. • Compulsive disorders treatment limited to programs for feeding and eating disorders. • Developmental Screening limited to well-child visits. • Psychiatric or psychological treatment for developmental disorders, limited to mental retardation, pervasive developmental disorder and other specific developmental disorders, such as autism, Rett's, or Asperger's.
Chiropractic care	• Limited to 15 visits per year.
Cosmetic services	• Treatment, item, supply, drug, procedure, or any portion of a procedure performed primarily to improve physical appearance limited to: ○ Repair due to an accidental injury; ○ Improve function of a malformed part of the body. Does not include dentistry or dental processes; and ○ Breast reconstruction after a mastectomy.
Dental services	• Dentistry or dental processes to the teeth and surrounding tissue limited to: ○ ER services to treat accidental injury to the jaw, sound natural teeth, mouth, or face. ○ Improve function of a malformed part of the body resulting from a birth defect. • General anesthesia/IV sedation for dental services limited to a Member who: ○ Has a medical or emotional condition that requires Hospitalization or general anesthesia for dental care; ○ Is severely disabled; ○ In the judgment of the treating Practitioner, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia; and ○ Requires Inpatient or Outpatient services because of an underlying medical condition and clinical status or because of the severity of the dental procedure.
DME, orthotic devices, and prosthetic appliances	• Breast pumps limited to one per year for women who are pregnant or nursing. • Corrective lenses and fittings following cataract surgery limited to: ○ First set of basic frames and lenses; or ○ One set of contact lenses. • Foot care limited to: ○ Routine foot care, shoes, shoe inserts, arch supports, and supportive devices for Members diagnosed with diabetes or a blood circulation disease.

Benefit	Limitation
	○ Orthopedic or corrective shoes permanently attached to a Denis Browne splint for children. • Hearing aids limited to: ○ One aid per ear every 48 months unless Medically Necessary to replace more often. ○ Four additional ear molds per year for children less than two years of age. • Orthotic devices limited to: ○ Members with diagnoses pertaining to peripheral vascular disease or diabetes. • Wigs and scalp prostheses limited to one synthetic wig or scalp prosthesis per year when required due to loss of hair resulting from chemotherapy or radiation therapy.
Experimental or Investigational therapies	• Drugs, items, devices, and procedures limited to: ○ Off-label uses of certain drugs used in the study or treatment of cancer; and ○ Certain investigational uses of drugs, including chemotherapy for cancer treatment, if given to you as part of an Approved Clinical Trial.
General care or Hospital Services	• Hospital private room limited to isolation to prevent contagion per the Hospital's infection control policy.
Genetic analysis, services, or testing	• Limited to counseling and testing for women whose family history is associated with a higher risk for deleterious mutations in BRCA 1 and BRCA 2 genes.
Home Healthcare	• Limited to 100 visits per year.
Physical, occupational, and speech therapy	• Rehabilitation Services limited to 60 combined Outpatient visits per year for: ○ Physical therapy; ○ Occupational therapy; and/or ○ Speech therapy. • ASD Treatment – Physical, occupational, and/or speech therapy services limited to the following diagnoses: ○ Autistic disorder – childhood autism, infantile psychosis, and Kanner's syndrome; ○ Childhood disintegrative disorder – Heller's syndrome; ○ Rett's syndrome; and ○ Specified pervasive developmental disorders – Asperger's disorder, atypical childhood psychosis, and borderline psychosis of childhood.
Prescription Drugs	• Inhaler extender devices, peak flow meters, Ana-Kits, and EpiPens limited to three per year. • The Pharmacy and Therapeutics Committee's standard quantity limits, prior authorization criteria, and step therapies apply. • Specialty Drugs limited to a one-month supply. • Smoking cessation products limited to: ○ Two full 90-day courses of FDA-approved tobacco cessation products

Benefit	Limitation
	per year, if prescribed by your PCP. o Members who are at least 18 years old. • Drugs prescribed or given to you by Out-of-network doctors in non-emergencies limited to those prescribed by dentists. • Non-prescription contraceptive jellies, ointments, foams, or devices limited to those that are FDA-approved and prescribed by a Network doctor for a woman. • Prescription diaphragms limited to two per year. • Biological sera, medication prescribed for parenteral use or administration, allergy sera, immunizing agents, and immunizing injectable drugs limited to immunizations covered under Preventive Care guidelines and given to you at a Network pharmacy. • Prescription Drugs for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy, hyporgasmy, or decreased libido limited to post-prostate surgery indications.
Sexual dysfunction	• Limited to drugs and supplies for post-prostate surgery indications.
Skilled Nursing Facility care	• Limited to 100 days per year.
Vision	• Routine services limited to one check-up, including eye refraction, per year. • Treatment for orthoptics or visual training limited to a diagnosis of mild strabismus.

Excluded Services

We do not cover the following benefits. We may pay for care while deciding whether or not the care falls within the Excluded Services listed below. If it is later determined that the care is excluded from your coverage, we will recover the amount we have allowed for benefits. You must give us all documents needed to enforce our rights.

Benefit	Excluded Service
Behavioral health services	• Education, tutoring, and services for the purpose of diagnosing or treating a learning disability, disruptive, impulse-control, or conduct disorder.
Dental services	• General dental services. • Procedures that involve the teeth or their supporting structures. • Correction of occlusive jaw defects, dental implants, or grafting of alveolar ridges. • Treatment of soft tissue to prepare for dental procedures or dentures.
DME, orthotic devices, and prosthetic appliances	• Bandages, pads, or diapers. • Equipment or devices not medical in nature such as: o Braces worn for athletic or recreational use o Ear plugs o Elastic stockings and supports o Garter belts • Jacuzzi/whirlpools. • Mattresses and other bedding or bed-wetting alarms.

Benefit	Excluded Service

	• Power-operated vehicles that may be used as wheelchairs.
	• Purchase or rental of equipment or supplies for common household use such as:
	  o Air-cleaning machines or filtration devices
	  o Air conditioners
	  o Beds and chairs
	  o Cervical or lumbar pillows
	  o Grab bars
	  o Physical fitness equipment
	  o Raised toilet seats
	  o Shower benches
	  o Traction tables
	  o Water purifiers

Experimental or Investigational therapies	• Drugs, therapies, and technologies:
	  o Before the long-term effect is known or proven; or
	  o That are not more effective than standard treatment.
	• New procedures, services, supplies, and drugs that have not been reviewed and approved by GlobalHealth.

General care or Hospital Services	• Treatment of any kind which is excessive or not Medically Necessary.
	• Services received without an authorization when one is required. Complications arising from those services.
	• Treatment of any kind 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, other than Hospital Services for behavioral health, 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.
	• Personal or comfort items.
	• Services received while outside of the U.S. (50 states and District of Columbia).
	• 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.
	• Elective enhancement procedures, services, supplies, or medications, including but not limited to:
	  o Anti-aging
	  o Athletic performance
	  o Cosmetic purposes
	  o Hair growth

Benefit	Excluded Service
	○ Sexual performance • Separate charges for missed or canceled appointments, penalty or finance charges, maintenance and/or record-keeping, record copying, or Case Management services. • Treatment, supplies, drugs, and devices for which no charge was made. Treatment, supplies, drugs, and devices for which no payment would be requested if you did not have this coverage. • Custodial care, respite care, homemaker services, or domiciliary care. • Treatment for injury resulting from extreme activities including, but not limited to: ○ Base jumping ○ Bungee jumping ○ Bull riding ○ Car racing ○ Skydiving ○ Motorcycle stunts • Alternative drugs and/or treatments used in the place of standard therapy, to treat any condition or illness. • Screening services requested solely by you, such as commercially advertised heart scans.
Obstetrical and Infertility services	• Alternative programs for delivery such as home delivery and use of midwives and birthing centers. • Elective abortions. • Expenses related to surrogate parenthood. • Home uterine monitoring. • 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 (that is, services through a federal governmental agency). • Services that are provided as a result of Workers' Compensation laws or similar laws. • Treatment for which the cost is recoverable under any other coverage, including Workers' Compensation, Occupational Disease law, or any state or government agency.
Other Excluded Services	• Services resulting in whole or in part from an excluded condition, item, or service.
Physical, occupational, and speech therapy	• Kinesiology, movement therapy, or biofeedback. • Rolf technique. • Massage therapy. • Acupuncture/acupressure. • Recreational therapy including, but not limited to: ○ Animal-facilitated therapy

Benefit	Excluded Service
	○ Music therapy
Prescription Drugs	• Non-preventive care drugs, dietary supplements, formulas, foods, and products available without a prescription (OTC). • OTC drugs that are for the same purpose and have the same effect as Prescription Drugs, even if ordered by a doctor. • Saline and medications for irrigation. • Drugs prescribed for a non-FDA approved indication, dosage, or length of therapy.
Repair and replacement	• Drugs, eyewear, devices, appliances, equipment, or other items that are lost, missing, sold, or stolen. • Items that have been damaged or destroyed due to improper use or abuse.
Transplants	• Artificial or non-human organ transplants. • Transplants considered experimental, investigative, or unproven.
Transportation/ lodging	• Routine, non-emergent ambulance transport unless preauthorized by GlobalHealth. • Lodging, meals, and transportation costs.
Vision	• Computer programs of any type, including, but not limited to, those to assist with vision therapy. • Insurance for contact lenses. • LASIK, INTACS, radial keratotomy, and other refractive surgery. • Multiple pairs of glasses in lieu of bifocals or trifocals. • Non-prescription lenses. • Special multifocal ocular implant lenses.
Weight Reduction Programs	• Gastric stapling, gastric balloon services, or any surgical treatment for obesity or weight-loss purposes. • Commercial weight loss programs.

ELIGIBILITY AND ENROLLMENT

Eligibility

Your employing agency determines your eligibility. In general, you are eligible to enroll with GlobalHealth if:

- You live or work in our Service Area (Subscriber or spouse).
- You are a U.S. 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.

The employee is the Subscriber to the Plan. The spouse and children are Dependents.

You should contact your Insurance Coordinator or Benefits Coordinator to enroll during Option Period or make changes to your coverage if you have a change in family status or coverage.

Unless COBRA-eligible, an employee's Dependents may only enroll if:

- The employee is also enrolled in the same Plan; and
- They meet the employer's eligibility requirements.

Spouses

Your spouse may enroll with us, subject to the group's eligibility requirements, if he/she lives or works in our Service Area.

Children

Your children may be Dependents through the end of the month in which they turn 26 years of age, whether or not:

- They depend on you for financial support;
- They live with you;
- They are in school;
- They have a job;
- They are married;
- They are eligible for other coverage; or
- They have any combination of these factors.

Also see Aging-off terminations under "Coverage Terminations" on page 93.

Disabled Dependents

Enrolled Dependents who reach the age of 26 may stay enrolled in the Plan if:

- He/she lives with you or your separated or divorced spouse;
- He/she is incapable of self-sustaining employment because of mental or physical handicap;
- He/she is chiefly dependent upon you for support and maintenance; *and*
- The mental or physical condition existed continuously before turning 26.

Dependents of Dependents

The Dependents of your Dependents are not covered. We do not cover your Dependent child's spouse or children, including newborns beyond the 48/96 hour routine Hospital admission.

Service Area

Our Service Area includes all 77 Oklahoma counties in their entirety.

Subscribers and spouses must live or work in our Service Area in order to enroll. If you are away from our Service Area for more than six months, contact your Insurance Coordinator or Benefits Coordinator. You should enroll with a different carrier that has a Network of Providers in your new area. There is an SEP during which you may enroll with another carrier that includes your new location in its Service Area.

Dependents Living Out-of-Area

Dependents under the age of 26 who live outside of our Service Area may enroll. He/she must have an assigned Network PCP to manage routine or chronic care. Out-of-network coverage is for Emergency Services and Urgent Care only unless we authorize specific Out-of-network coverage. See "Balance Billing by an Out-of-network Provider" on page 96.

Enrollment Periods

In order to get coverage, an eligible person must enroll in the Plan. You should submit your Enrollment through your employer. Make your Premium contribution through your employer. We must receive your Enrollment during Option Period or within the time periods below.

Open Enrollment Period

You may enroll during Option Period each year. This is the time when eligible employees can:

- Enroll in coverage;
- Change Plans or drop coverage; and/or
- Add or drop Dependents from coverage.

Mid-year Change

You may be able to enroll outside of Option Period in limited circumstances. You must have one of the Qualifying Life Events below to be eligible for a mid-year change. If you have an event, see your Insurance Coordinator or Benefits Coordinator to find out if you are eligible.

- You will have 30 days to enroll if you have a change in family status or coverage.
- You will have 60 days to enroll if you have a change in Medicaid or CHIP eligibility. See "Medicaid and CHIP Notice" on page 124.

Change in family status:

Your Premium will change if your coverage type changes (such as, employee only to employee plus spouse). Your Insurance Coordinator or Benefits Coordinator will let you know what your Plan options are.

Dependent Type	Description
Adopted children	• We cover adopted children from the date placed in the home. • Subject to the "Excluded Services and Limitations" on page 81, we cover

Dependent Type	Description
	the medical costs related to the birth of the child who is 18 months or younger. o Send us copies of the medical bills and records related to the birth of the child. o Send us proof that you have paid or are responsible to pay those bills and that the cost was not covered by another Plan, including Medicaid.
Foster children	• We cover foster children from the date placed in the home.
Newborns	• We cover your newborn from the date of birth. • We cover newborns for the first 31 days of life for all Medically Necessary services. If you do not add a newborn as a Dependent during the first 31 days, the newborn's coverage ends on day 31. • You may make a mid-year change due to change in Medicaid or CHIP eligibility. If you enroll your newborn within 60 days, we will cover your newborn back to the date of birth. • We cover newborns of Dependent children for the approved mother's stay of 48/96 hours.
New Dependents as a result of marriage	• If you marry, we cover new family members from the first day of the month after your marriage.
Qualified Medical Child Support Order	• We cover children to comply with a Qualified Medical Child Support Order. If an order is issued concerning your child, contact us. We have to follow certain procedures. • You must keep your child enrolled unless you are no longer eligible to be a Plan Member or you send us written evidence that: o The court or administrative order has ended; or o The child is or will be enrolled in health coverage through another insurer. It must take effect no later than the last day of coverage in this Plan. There cannot be a gap in coverage.

Change in coverage:

You may enroll when:

- You move from your carrier's Service Area.
- You lose Medicaid coverage.
- You lose limited Medicaid coverage not recognized as Minimum Essential Coverage.
- You gain lawful presence in the U.S. See "Eligibility" on page 87.
- You are enrolled in a Plan for which you don't qualify due to Enrollment errors.
- You declined coverage in writing when you were first eligible because you had other coverage and you no longer have the other coverage due to:
  - You or your eligible family member has exhausted COBRA under another group health Plan;
  - Work hours of the Subscriber end or are reduced;
  - Any other health Plan coverage ends;
  - The employer stopped paying part of your Premium; or
  - Death, divorce, or legal separation of the Subscriber.
- You are no longer incarcerated.

- You lose Minimum Essential Coverage.
- You have exceptional circumstances such as in the case of a child of an incarcerated parent.

To ask for a mid-year change or get more information, see your Insurance Coordinator or Benefits Coordinator.

When Coverage Begins

Coverage for you and your eligible Dependents begins as of 12:01 a.m. on the effective date of your Enrollment. Your employer must certify your eligibility.

The coverage period is January 1st through December 31st if you enrolled during Option Period.

If you join a Plan after the group effective date because you qualify for a mid-year change or you are a new hire, see your Insurance Coordinator or Benefits Coordinator to find out when your benefits start. Your benefits end December 31st.

Continuity and/or Transition of Care

If we authorize you for transition care through an Out-of-network Provider, we will pay at least Usual and Customary amounts for your services. You pay your In-network Copayment, but the Provider may send you a bill. See "Balance Billing by an Out-of-network Provider" on page 96.

Examples of conditions that may require continuity or transition of care:

- Behavioral health conditions during active treatment
- Currently hospitalized
- Currently taking drugs for which we require UM review
- Currently on a transplant list
- Impending Hospitalization
- Second or third trimester pregnancies
- Terminal illness
- Undergoing chemotherapy or radiation therapy

These approved provisions end when:

- You transfer to a Network Provider;
- You reach benefit limitations; or
- Care is excessive or not Medically Necessary.

Provisions apply only to the condition and the Provider shown on the request form. An In-network Provider must treat all other conditions. If you need Referral services, we may authorize for In-network Providers only.

Others that may help with this process include.

- Your doctor or pharmacist.
- The parent of a child under 18 years of age.
- Your power of attorney with medical decision authority. We must have a copy of the signed power of attorney form on file.
- Your authorized representative. See "Appointment of Authorized Representative" on page 104. You will need to complete the form if you want us to share your PHI with anyone else, for example:

- Your parent, if you are age 18 or over.
- Your spouse.
- Your caregiver, friend, neighbor, or other.

If we do not approve ongoing care through the Out-of-network Provider, you may Appeal the decision. See "Appeals and Grievances" on page 101.

Behavioral Health and Medical Transition of Care
If you are enrolling in GlobalHealth and changing from another 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 PCP is also a GlobalHealth Provider. Some Specialists and Facilities currently scheduled for your care may differ from our Network. You can find the form on our website.

You must get approval from us to continue care with your current Provider. Approval from your prior health carrier is not the same as authorization from us.

Requests for ongoing medical care are reviewed case-by-case. Once we have the request, we will review your case. You must have received services from the requested Provider under an ongoing Course of Treatment in the 90 days prior to your effective date with us to be considered.

We will tell you and your Provider if we are going to:
- Authorize continued services. You may have up to 30 days of ongoing treatment; or
- Move your care to one of our Network Providers. We will tell you about your right to Appeal the decision.

If approved for transition care, we cover care for up to 30 days. If you are pregnant, we cover transition care through six weeks postpartum, even if it is more than 30 days. If you remain enrolled in the same Plan across calendar years, these timeframes apply across calendar years.

Prescription Drug Transition of Care
If you are new to GlobalHealth, you may ask us to cover:
- Non-formulary drugs; or
- Drugs on the Formulary that have restrictions.

You must make the request within the first 90 days of your effective date of coverage. We urge you to work with your doctor and the Pharmacy Department as soon as possible to move to our *Drug Formulary*.
1. Complete the *GlobalHealth Transition of Care Request Form - Prescriptions* from our website.
2. We will verify previous drug therapy.
3. We will tell you our decision, whether or not it is in your favor. If approved, you will get one 30-day prescription fill per drug.

Behavioral Health and Medical Continuity of Care
If you are a current GlobalHealth Member and your Provider leaves the Network, you may keep getting care from that Provider in certain cases. Treatment for the condition must have been within the previous 30 days.

You must be in active treatment. "Active treatment" means:

- Ongoing treatment for a Life-threatening Disease or Condition;
- Ongoing treatment for a Serious Acute Condition;
- The second or third trimester of pregnancy through the postpartum period; or
- Ongoing treatment for which a treating doctor or other Provider attests that changing care to another doctor or Provider would make the condition or expected outcome worse.

If approved for continuity care, we cover care for up to 90 days. If you are pregnant, we cover continuity care through six weeks postpartum, even if it is more than 90 days. If you remain enrolled in the same Plan across calendar years, these timeframes apply across calendar years.

You must get approval from us to continue care. We will not cover continuing care when:

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

Changes to Enrollment

It is your responsibility to tell us about any changes that affect your eligibility. Changes that you must report include, but are not limited to:

- Social Security numbers for new Dependents;
- If you gain or lose any other group health coverage;
- Moving out of our 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

You should make any change as soon as possible, but always within 30 days. See "Enrollment Periods" on page 88 for deadlines for mid-year changes. Call your Insurance Coordinator or Benefits Coordinator.

Contact Method	Contact Information
Mail	GlobalHealth, Inc. Attn: Benefits, Enrollment, and Eligibility P.O. Box 2328 Oklahoma City, OK 73101-2328
E-mail	ghenrollment@globalhealth.com

Talk to your Insurance Coordinator or Benefits Coordinator about coverage options if you stop working because of:

- Retirement
- Disability
- Leave of absence
- Temporary layoff

- Termination of employment

Or, 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 117.

Changes to Your GlobalHealth Plan

If any federal or state law requires a change in benefits, we may change the contract or certain benefits. We will give you at least 60 days' written notice. We will also tell you when the change starts.

GlobalHealth or OMES may make changes to the contract or benefits without your consent or concurrence. Your employer is responsible for telling you in writing within 72 hours of any change to your Plan.

Coverage Terminations

A termination is when your coverage ends. It may be your choice to end it or not. If it was not your choice, we will tell you and we will tell you why. We will mail your notice within five business days.

Coverage ends at 12:01 a.m. on the day that the termination is effective. If a Dependent's coverage ends, it does not affect the coverage of other family members. If the Subscriber's coverage ends, the membership of all Dependents stops as well. See "Continuation Coverage Rights Under COBRA" on page 117.

Unless otherwise provided, your coverage ends on the earliest of the following:

Reason	Description	When Coverage Stops
Aging-off	• Children are eligible for Dependent coverage until the end of the month they turn 26 years of age. • We will send a notice that your coverage is ending and information about how to select a new Plan. You should get the notice before the month you are to be disenrolled. • You may ask for continued coverage for disabled Dependents.	The last day of the month turning 26
Death	• If the Subscriber dies, that Member's coverage as well as coverage for all Dependents ends. • If a Dependent dies, only that Member's coverage ends.	Member: The date of death Dependent: The last day of the month of the Subscriber's death
Eligibility	• Your employer defines eligibility for employees and Dependents. • It is your employer's responsibility to tell you when you are no longer eligible.	The last day of the month for which Premium was paid

Reason	Description	When Coverage Stops
Employer requested terminations	• Your employer makes termination decisions for employer groups. • It is your employer's responsibility to tell you when they ask us to end your group's coverage. They should tell you at least 60 days before your benefits end.	The last day of the month for which Premium was paid
Fraud	• We may stop your coverage if you commit Fraud. For example, it is Fraud if you willingly gave your Member ID card to another person so that person could get services. See "Fraud and Abuse" on page 123. • We can take actions that have serious effects on your coverage. These include, but are not limited to: o Retroactive loss of coverage. o Loss of coverage going forward. o Denial of benefits. o Recovery of amounts we already paid. o We may also report Fraud to criminal authorities. • We will provide written notice at least 30 days before we end your coverage. That will allow you time to appeal. o If we decide that the termination stands, we will return your Premium for that period, if we received any. You may ask for an External Review. • Retroactive terminations may be for up to 30 days plus the current month. This means that a termination cannot be for more than 60 days before we tell you.	The effective date is variable
Medicaid/CHIP	• Oklahoma Health Care Authority defines eligibility.	The day before the new coverage starts with Medicaid/CHIP
Moving from Service Area	• You should enroll in a Plan that has a Network of Providers in your new Service Area.	The last day of the month for which Premium was paid
Non-payment of Premium	• You are not eligible for a mid-year change for loss of Minimum Essential Coverage: o If your coverage or your Dependents' coverage ends for failure to pay COBRA Premium; or o If your coverage or your Dependents' coverage ends for failure to enroll in COBRA within the timeframe to elect COBRA.	The last day of the month for which Premium was paid
Plan error	• We may discover that we have enrolled you when you were not eligible.	The same day as the original effective date

Continuation of Coverage
You may be able to keep coverage in the same Plan for 63 days beyond these timeframes. You must keep paying your Premium.

Continuation of coverage may not be available:

- If you fail to make timely Premium payments;
- If the group coverage ends in its entirety during your continuation period;
- If you become entitled to similar coverage from another source during the continuation of coverage period; or
- If you intentionally misuse your Member ID card or commit Fraud.

Conversion Privilege
If you lose your GlobalHealth group coverage, you may be eligible for COBRA continuation coverage. Ask your Insurance Coordinator or Benefits Coordinator.

If you would like to purchase Health Insurance through the ACA's Health Insurance Marketplace, visit www.healthcare.gov. This is a website the U.S. Department of Health and Human Services provides for information on the Marketplace, including how to enroll.

If You Are in the Hospital When Coverage Ends
You may continue to get benefits while you are hospitalized and under a doctor's care.

- We cover women giving birth through delivery and discharge.
- If your coverage is ending because your employer is terminating the contract, your coverage ends on the termination date of the contract.
- If your group coverage is ending because we are terminating the contract, your coverage will continue through discharge from the Hospital or expiration of benefits according to your contract.

Services must meet "Coverage Requirements" on page 36. We cover services only for the illness, injury, or condition for which you are hospitalized.

Insolvency
In the unlikely event of our insolvency, we will continue your benefits:

- For 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.

See "Notice of Protection Provided by Oklahoma Life and Health Insurance Guaranty Association" on page 129.

CLAIMS AND PAYMENT

Responsibility for Payment

When	Cost

You are responsible for:	• Your Copayments or Coinsurance for approved Covered Services until you meet the MOOP.
	• The cost of services provided by a doctor or Facility without an authorized Referral.
	• The cost of services not included in your GlobalHealth Plan benefits.
	  o The care is not covered according to this *Member Handbook*.
	  o The care is listed in the Excluded Services and Limitations section.
	• Balance Billing from an Out-of-network Provider, even if the service is at a Network Facility.
	• Full billed charges when:
	• The services were non-covered services;
	• The services were not urgent or an emergency, received Out-of-network, and not authorized by us; or
	• You obtained the services through your own Fraud.

You are not responsible for:	• Any amounts we owe a Provider for approved Medically Necessary services that are covered by your Plan.
	• Any amounts requested as Balance Billing (after we have paid the contracted Allowed Amount), provided that:
	  o The services were Covered Services;
	  o The services were approved by us;
	  o The services were provided by a Network Provider; and
	  o You have paid your required Cost-share, if any.

Balance Billing by an Out-of-network Provider

Balance Billing happens when a Provider asks you to pay the difference between its billed charge and the total amount the Provider received from your In-network Cost-share and our payment. In-network Providers may not balance bill you. Out-of-network Providers may balance bill you and you may have to pay the difference.

Special Situations

We maintain a comprehensive Network of Providers. As a general rule, you must get care from these Providers. However, there are some limited situations when you may see an Out-of-network Provider. You pay your regular Cost-share. We pay at least Usual and Customary reimbursement. But, the Provider may send you a bill if:

- You must seek Urgent Care when out of our Service Area.
- You are treated for Emergency Services while Out-of-network.
- We do not have a Provider in our Network to take care of your condition and we authorized a Referral to an Out-of-network Provider.
- We authorized medical care at an In-network Facility and you get ancillary services or

treatment from an Out-of-network Provider.
- We have approved you to see a Provider through the transition of care process.

If you believe a Provider has balance billed you in error, call us.

If You Receive a Bill

If you get a bill for services you already paid for, send an itemized bill and proof of payment. Be sure to send them to the appropriate place. You should keep copies of any documents you send to Magellan Rx Management or us for your records.

Behavioral Health and Medical
Network Providers bill us directly for services provided. However, if you get urgent or emergent care out of our Network, you might get a bill from those Providers.

If the bill is for Emergency Services you already paid for, contact us for direction within 120 days of the date of service. We will pay according to our Usual and Customary reimbursement.

Coverage Decision:
When we get your request for payment, we will let you know if we need any other information from you. We will review your request and make a coverage decision. You must follow the "Coverage Requirements" on page 36.

- If we decide that the care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail you a payment for our share of the cost. If you have not paid for the service yet, we will mail the payment directly to the Provider.
- If we decide that the care is not covered, or you did not follow all the rules, we will not pay for our share of the cost. We will send you a letter that explains the reasons why we are not sending the payment and a copy of *Appeal Rights* within 30 days after we get the Claim. See "Appeals and Grievances" on page 101.

Prescription Drugs
The pharmacy usually bills directly to Magellan Rx Management. However, if you fill a prescription without your Member ID card, the pharmacy may require you to pay. If this happens, call Magellan Rx Management. You will need to fill out a paper Claim form and send the receipts.

Contact Method	Contact Information
Toll-free	1-800-424-1789
TTY	711
Mail	Magellan Rx Management, LLC PO Box 85042 Richmond, VA 23261-5042

When You're Covered by More Than One Plan

You must tell us if you have other healthcare coverage.

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.

If you have healthcare coverage in addition to your GlobalHealth Plan, either as a Dependent or a Subscriber, we will coordinate benefits. This means that we will determine which Plan will pay as primary (first) and which Plan will pay as secondary (second). You must follow the "Coverage Requirements" on page 36, whether we pay first or second.

Behavioral Health and Medical Coverage COB

Benefits we pay are subject to COB. We apply COB rules according to the National Association of Insurance Commissioners' guidelines. Your case may be different, such as when you enroll a newborn in other coverage, but not GlobalHealth, within the first 31 days.

Provisions	COB Order of Benefit Determination Rules
Only one Plan has COB provisions	• The Plan without a COB provision pays first. • The Plan with a COB provision pays second.
Both Plans have COB provisions	• The Plan covering the Member as a Subscriber pays first. • The Plan covering the Member as a Dependent pays second.

Both Plans have COB provisions - Dependent Child - Parents not separated or divorced	• The "Birthday Rule":
	  ○ The Plan of the parent with a birthday earlier in the calendar year, regardless of the year of birth, pays first.
	  ○ If either Plan does 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 pays first.
	  ○ The Plan of the parent without custody pays second.
	• A Dependent child whose parents are divorced, and the parent with custody has remarried:
	  ○ The Plan of the parent with custody pays first.
	  ○ The Plan of the stepparent pays second.
	  ○ The Plan of the parent without custody of the Dependent pays third.
	• A Dependent child whose parents are separated or divorced and a court decree establishes responsibility for healthcare expenses – the Plan of the parent with responsibility pays first.

When we pay second:
1. The primary payer pays its part.
2. You pay your GlobalHealth Plan Cost Sharing, if any.
3. We pay the rest of the bill, up to our Allowed Amount.

Notification:
When we need verification of other coverage to process a Claim, we will ask that you complete a *Coordination of Benefits (COB) Form*. Send the completed form when requested so the Claim is not delayed or denied. We may ask you to complete a form each year.

Contact Method	Contact Information
Mail	GlobalHealth, Inc. Benefits, Enrollment, and Eligibility PO Box 2328 Oklahoma City, OK 73101-2328
E-mail	StateAnswers@globalhealth.com

Prescription Drug Coverage COB
If you are covered by more than one Plan, we will coordinate your prescription benefits. Give both Prescription Drug cards to the pharmacy staff. The pharmacy staff will enter the information. Tell them who pays first. You pay your Cost-share for that Plan. Then the secondary coverage will be billed the remaining cost.

Your GlobalHealth Plan and Medicare

If you are a Medicare recipient, either through yourself or your spouse, we will coordinate benefits with Medicare. If Medicare benefits pay first, we will pay second for benefits less the amount paid by Medicare. If you have questions about Medicare, contact your local Social Security office or visit www.medicare.gov.

You must follow the "Coverage Requirements" on page 36, whether we pay first or second.

When GlobalHealth benefits are secondary:
1. The primary payer pays its part.
2. You pay your GlobalHealth Plan Cost Sharing, if any.
3. We pay the rest of the bill, up to our Allowed Amount.

Third-Party Liability

Workers' Compensation
If you are injured on the job and need 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. Our benefits do not replace or duplicate any benefits you get under Workers' Compensation law. You must tell your employer about 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 (such as a car accident) and are entitled to healthcare coverage, you agree:
- To make a Claim.

- To pay us for the cost of medical care we paid for if you receive a monetary recovery or settlement.
- That our right to payment is the first priority Claim against any third-party. This means that we will be paid before payment of any other Claims, including any Claim by you for general damages.

We may collect from the proceeds of any settlement or judgment you get, whether or not you have been fully compensated.

If you release the responsible party for a wrongful act or negligence, we may delay or deny the Claim. We may waive our option to deny the Claim for good cause in certain specific cases.

Note: See "Subrogation, Third-Party Recovery, and Reimbursement" on page 138.

Notify GlobalHealth
Tell us about potential third-party liability or Workers' Compensation situations as soon as possible so that we can coordinate benefits.

If Your Claim Is Denied

If we deny any part of a Claim submitted for payment, we will review the Claim upon written request for Appeal. See "Appeals and Grievances" on page 101.

Claims Payment Recovery

If we pay a Claim for services you received and you were not eligible for coverage at the time of the services, we may ask for a refund. You are then responsible for paying the Provider. Payment is due when we notify you. Also, we have the sole right to determine that any overpayments, wrong payments, or excess payments made for you are a debt which we may recover. We do not waive our rights, even if we accept your Premiums or pay for benefits.

We will ask for a refund from your Provider within 24 months after we made the payment, 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.

APPEALS AND GRIEVANCES

Complaints and Grievances

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

It may concern:

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

For written Grievances, please include:

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

If you wish to file a complaint or Grievance, give as much information as you can about the matter.

We will send a letter within five days after we get your request for a Grievance. This letter will let you know when you can expect a response in writing from us. You will get a final response within 30 days unless otherwise specified.

For help with Grievances related to discrimination, see "Notice of Non-discrimination" on page 127.

Behavioral Health and Medical Appeals

You have the right to Appeal any decision we make that:

- Denies payment on your Claim;
- Denies your request for medical care coverage. See "Pre-service Authorization" on page 29; or
- Changes or reduces an approved Course of Treatment. See "Concurrent Review" on page 31.

You may not Appeal if the benefit change is because your Plan changed or ended.

You may ask for more explanation when we deny your Claim or request for coverage or we did not fully cover your care.

Call us when you:

- Do not understand the reason for the denial;
- Do not understand why we did not fully cover the medical care;
- Do not understand why we denied a request for medical care coverage;
- Cannot find the applicable section in this *Member Handbook* or other Plan 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 Provider may resend the Claim to us with the needed information.

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 (such as, Claims, medical records, doctor statements, and any other relevant information).

You can get Appeal request forms on our website or by contacting us. You are not required to use the form, but you must have all of the information on the form in your letter.

Full and Fair Review

We will conduct a full and fair review of your Claim or request for coverage of medical care. The review is conducted by people associated with us, but who were not involved in making the initial denial. You may give us other information, evidence, or testimony that relates to your Claim or medical care. You may ask for copies of information that we have that pertains to your Claim(s) or medical care.

We will tell you our decision in writing within 30 days of receiving your Appeal. We will give you any new or additional evidence we used and tell you why we used it if you ask. We will give it to you free of charge. You may ask who the medical or other experts are whose advice we asked for, whether or not we used their advice in making the determination.

Initial Appeals Process

We will send a letter telling you we received your request within five business days. This letter will let you know when you can expect a determination in writing from us. We generally complete Appeals within 30 days after we get your request. If you do not get our decision within 30 days, you may ask for an External Review.

We may extend this period one time for up to 15 days, if:

- It is necessary due to matters beyond our control;
- We tell you, before the initial 30-day period ends, why it is needed; and,
- We tell you the date by which we expect to make a decision.

If extra time is needed because we do not have enough information to decide the Claim, the notice will tell you what information we need. You will have 45 days from receipt of the notice to send it.

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

1. General Review (such as, Claims processing or clerical errors).
2. Independent Internal Review (such as, adverse medical necessity or coverage determinations). This review is conducted by people not involved in the original decision.

Expedited Appeal

You may ask for a fast internal review of our denial if:

- You have a medical condition that would seriously risk your life or health or your ability to regain maximum function if you do not get care right away; and,
- It concerns:
  - Availability of care;
  - Continued stay;
  - Emergency Services and you have not been discharged from a Facility; or
  - A Hospital stay.

You, or someone authorized to act on your behalf, may ask us for a fast internal review. Send the request to the address listed on page 4. Or call us to ask for one.

If we agree to process your Appeal as an expedited internal review, we will make a determination within 72 hours after we get your request. If your Appeal does not qualify for a fast review, we will tell you and process the Appeal within the standard timeframe.

External Review

If we denied your request either to have or to pay for medical care, you have a right to have our decision reviewed by independent healthcare professionals, who have no association with us, if our decision involved:

- A determination that the service or treatment is Experimental or Investigational.
- Appropriateness.
- Healthcare setting.
- How well the healthcare service or treatment works.
- Level of care.
- Medical necessity.

You must ask in writing for an External Review **within four months** of the final Appeal determination notice.

Contact Method	Contact Information
Local	(405) 521-2828
Toll-free	1-800-522-0071
Mail	Oklahoma Insurance Department ATTN: External Review Request Five Corporate Plaza 3625 NW 56th St, Suite 100 Oklahoma City, OK 73112-4511
Website	www.ok.gov/oid/Consumers/External_Review_Process

If your request qualifies for External Review, the Insurance Department will randomly select a qualified IRO to conduct the External Review. You must authorize the release of medical records. The IRO needs to review them so it can reach a decision. The IRO will tell you its decision within **45 days** after it gets the request for review.

Expedited External Review
You may ask for a fast External Review of our denial if:

- You have a condition that would risk your life or health or your ability to get back maximum function if you do not get treatment right away;
- It concerns:
  - Availability of care;
  - Continued stay;
  - Emergency Services and you have not been discharged from a Facility;
  - A Hospital stay; or
- We determined that the medical care is Experimental or Investigational. Your doctor must certify in writing that the medical care would be significantly less effective if not started right away.

To request an expedited External Review, call the Oklahoma Insurance Department before sending your paperwork. They will give you instructions on the quickest way to send your request and supporting information.

If your request qualifies for External Review, the Insurance Commissioner will randomly select an IRO. The IRO will make a determination within 72 hours after they get your request for expedited External Review.

Note: You may not get a fast External Review when we deny payment for services you already had.

Notices

We will mail you a written Appeal determination after each level in the Appeal process. It includes other Appeal rights, when applicable.

Appointment of Authorized Representative

Someone else may ask for an Appeal for you. You can name a relative, friend, advocate, attorney, doctor, or someone else to act as your authorized representative. If you want someone to act for you, you must send us a written statement authorizing that person to do so. Both you and the person you name must sign and date this document. You can find an *Appointment of Authorized Representative* form on our website or by contacting us. We must have a signed form on file before the Appeal, Grievance, exception request, or request for continuity or transition of care can proceed if someone is working on your behalf.

Prescription Drug Appeals

Magellan Rx Management pays Claims for your Prescription Drugs. However, we handle all Prescription Drug Appeals. Follow the process for Appeals beginning on page 101.

Appeal Questions

If you have any questions or would like a copy of the benefit policy, guidelines, protocol, or other criteria used to make a determination, contact us. Your doctor may contact our Medical Director to discuss denials.

SPECIAL PROGRAMS

Care Management

We believe managing and navigating healthcare should be easier.

We have several programs that can help you get the right care for you. Each of these programs works through a team effort:

- You;
- Your caregiver, if you wish;
- Your doctors; and
- Our case manager or pharmacist.

You are the most important part of the team.

- Understand your health and help decide the best Course of Treatment.
- Go to your doctor visits and take your medicine.
- Make healthy lifestyle choices, like working toward your diet and exercise goals.

We work to support you. A case manager will:

- Get to know you and your medical needs.
- Help you set up appointments with your doctor.
- Help you get other care you need.
- Answer questions before or after your doctor visit.

We will enroll you if you meet the criteria. Or, you or your doctor can ask us to enroll you. Participation is voluntary, confidential, and available at no cost to you. You may opt out at any time.

Complex Case Management

If you have a serious condition or multiple Chronic Conditions, a case manager will help you. The goal is to promote quality, cost-effective health outcomes.

Medical and behavioral health conditions that may qualify for the program include, but are not limited to:

- Acute healthcare needs, diagnoses, or Hospitalizations;
- Complex medical issues;
- Poorly controlled disease;
- Frequent Hospital stays;
- Multiple ER visits; or
- Multiple Chronic Conditions.

Our case manager works with you, your doctors, and/or BHP to:

- Create a care plan;
- Help you navigate the healthcare system;
- Coordinate care;
- Contact you regularly and answer your questions; and
- Suggest available community resources.

Diabetes Prevention Program
Case managers work with you if you are pre-diabetic. That is, you have higher than normal blood sugar, but have not yet been diagnosed with diabetes. You will have support to:

- Eat a healthy diet;
- Have an active lifestyle; and
- Lose weight.

The goal is to keep you from becoming diabetic. By making these changes, you may cut your risk of diabetes by as much as half.

Our case manager will help you find and enroll in a Diabetes Prevention Recognition Program approved by the CDC.

Disease Management
Case managers work with you and your doctor to:

- Slow disease progression and complications;
- Change behaviors and improve lifestyle choices;
- Help you follow guidelines and the care plan from your doctor and take your drugs as prescribed;
- Manage drugs and control symptoms;
- Educate about Preventive Care;
- Reduce unnecessary Hospitalizations and readmissions; and
- Prevent drug errors.

Targeted conditions are:

- CAD;
- COPD;
- CHF;
- Depression, anxiety, and severe mental illness diagnoses;
- Diabetes; and
- Substance use.

Our approach is focused on you. Efforts may include:

- Assigned care manager;
- Educational materials;
- Health risk assessment;
- Health review phone calls; and
- Assessments after you leave the Hospital or ER.

Medication Therapy Management Program
If you are taking multiple drugs for Chronic Conditions, you can get support from this program. Our pharmacists and staff give you personalized service. The goals of this program are:

- To slow disease progression by supporting drug compliance;
- To eliminate duplicate drug therapies;
- To reduce drug interactions and side effects; and
- To help you get the most out of your benefits by telling you about the lowest cost alternatives.

We review your drugs to help make sure that you are getting safe and appropriate care. These reviews are especially important if you have more than one Provider who prescribes drugs for you.

During these reviews, we look for potential problems such as:

- Drug errors;
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition;
- Drugs that may not be safe or appropriate because of your age or gender;
- Combinations of drugs that could harm you if taken at the same time; and
- Drugs that have ingredients you are allergic to.

If we see a possible problem, we will work with your Provider to correct it.

Prenatal Outreach Program
Prenatal care helps keep you and your baby healthy. Your doctor can spot and treat health problems earlier or maybe keep them from happening.

There are many things you can do to make sure you have the best pregnancy you can.

Actions	Description

What to do	• Make and keep your prenatal doctor visits. Talk to your doctor about:
	  ○ Tests, lab work, and shots.
	  ○ Childbirth classes for you and your partner.
	  ○ How much weight you should gain.
	  ○ Exercise.
	  ○ Any questions you have.
	• Get informed. Read books, watch videos, go to a childbirth class, and talk with moms you know.
	• Take your prenatal vitamins every day.
	• Get plenty of rest and sleep.
	• Eat healthy foods and drink plenty of water.
	• Find ways to control stress.

What not to do	• Don't use drugs, drink alcohol, or smoke. Stay away from second-hand smoke. • Don't start or stop taking medications (including OTC and herbal products) without talking to your doctor first. • Don't have an x-ray without telling your doctor or dentist that you are pregnant. • Don't eat uncooked or undercooked meat or fish. Don't eat fish with lots of mercury. • Don't use chemicals like insecticides, solvents, lead, mercury, and paint, even if there is no pregnancy warning on the label. • Don't be around rodents (even if pets) and cat litter.

Case Management
There is a lot to think about while you are pregnant. We want to help you along the way. You will have your own case manager. Your case manager will call you when we know you are pregnant. Or, you can call us if you don't want to wait.

Keep in mind, routine prenatal care has no cost to you.

QIP

The QIP helps us improve our functions and the services you get from Network Providers. It provides a systematic, integrated approach to measure and improve quality. The QIP:

- Meets statutory requirements.
- Follows other standards, guidelines, and contractual requirements.
- Identifies issues that we use as opportunities to improve. Work groups, made up of our employees, Members, and Network Providers:
  - Monitor performance indicators.
  - Analyze data.
  - Implement changes to improve performance and monitor progress.

The QIP goals are to:

- Improve processes, patient safety, and outcomes of care.
- Fulfill Member and Provider needs.
- Reduce the cost of healthcare.

You may ask about our QIP and work plan. Call us and ask to talk to the Quality Department or send an e-mail to quality@globalhealth.com.

NCQA

We pledge to provide the best care possible through continual improvement. To show our commitment, GlobalHealth is accredited by the NCQA. NCQA is an independent, not-for-profit organization whose mission is to improve the quality of America's healthcare. NCQA conducts audits and surveys to make sure we are working with quality of care in mind in everything we do.

You make a difference in our NCQA accreditation. We may invite you to participate in surveys. They help us understand your needs and experience with us.

Health Survey:

Each year, we may send you an HRA that asks questions about your current health. If you don't get one you may:

- Complete it online;
- Download a copy from our website to mail;
- Ask us to mail you an HRA; or
- Ask for help to complete it by phone.

Your answers help us know how to best serve you and your healthcare needs. The information you give us will remain confidential. We only disclose the HRA information to your PCP so he/she can address your health needs. It will not be used against you in any way or prevent you from getting medical care.

Satisfaction Surveys:

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

- New Member Survey;
- Customer Satisfaction Study; and/or
- CAHPS®.

Although not required, it is very important that you fill them out and send them back. Your answers will help us improve.

HEDIS® Audit:
We perform an audit approved by the NCQA called HEDIS®. It measures the Preventive Care our Network Providers give. You can help by asking for Preventive Care services.

Well Visit Checklists:
The chart shows Preventive Care services that you may discuss and/or get during routine well visits to your PCP or OB/GYN or your newborn may get in the Hospital. You can print a copy from our website to take with you.

Not every service will be right for you. Your PCP or OB/GYN will recommend services. Services may require more than one visit and/or PA. See "Preventive Care Benefits" on page 74 for additional information.

Population	Preventive Care to Discuss
Men – During routine exam (annual)	☐ Abdominal aortic aneurysm ☐ Alcohol, prescription, or illicit drug misuse ☐ Aspirin use ☐ Blood pressure ☐ Cholesterol ☐ Colorectal cancer ☐ Depression, anxiety, trauma, and domestic/interpersonal violence ☐ Diabetes ☐ Healthy diet and physical activity ☐ Falls prevention ☐ Hepatitis B ☐ Hepatitis C ☐ HIV ☐ Immunizations ☐ Lung cancer ☐ Obesity ☐ Prostate ☐ STI prevention ☐ Skin cancer ☐ Statin use ☐ Syphilis ☐ Tobacco use ☐ Tuberculosis ☐ Vision
Women – During routine exam (annual)	☐ Alcohol, prescription, or illicit drug misuse ☐ Aspirin use ☐ Blood pressure ☐ Breast cancer and mammograms

Population	Preventive Care to Discuss
	☐ Cholesterol ☐ Colorectal cancer ☐ Depression, anxiety, trauma, and domestic/interpersonal violence ☐ Diabetes ☐ Healthy diet and physical activity ☐ Falls prevention ☐ Folic acid ☐ Hepatitis B ☐ Hepatitis C ☐ HIV ☐ Immunizations ☐ Lung cancer ☐ Obesity ☐ Osteoporosis ☐ STI prevention ☐ Skin cancer ☐ Statin use ☐ Syphilis ☐ Tobacco use ☐ Tuberculosis ☐ Vision
Women – During prenatal visits (every 4 weeks – 1st 28 weeks, every 2-3 weeks – 32 – 36 weeks, every week until delivery – 37 weeks on)	☐ Alcohol, prescription, or illicit drug misuse ☐ Anemia ☐ Aspirin ☐ Blood pressure ☐ Blood tests ☐ Breastfeeding ☐ Gestational diabetes ☐ Hepatitis B ☐ HIV/STI ☐ Immunizations ☐ Rh incompatibility ☐ Safety ☐ Tobacco use ☐ Ultrasounds ☐ Urinary tract or other infection ☐ Weight
Women – During well-woman visit (annual)	☐ BRCA ☐ Breast cancer chemoprevention ☐ Breast cancer and mammograms ☐ Cervical cancer ☐ Contraception ☐ Domestic and interpersonal violence ☐ HIV/STI

Population	Preventive Care to Discuss
	☐ HPV
Children – Newborn services at birth (Inpatient)	☐ Congenital hypothyroidism ☐ Gonorrhea preventive medication for the eyes ☐ Hearing ☐ Height and weight ☐ Hemoglobinopathies or sickle cell ☐ Immunizations ☐ PKU
Children – During well-child visit (at Birth and at ages 2, 4, 6, 9, 12, 15, and 18 months, 2 – 6 years annually, 8 – 18 every other year)	☐ Alcohol, prescription, or illicit drug misuse ☐ Autism ☐ Behavioral assessments ☐ Blood pressure ☐ Cervical dysplasia ☐ Dental ☐ Depression, anxiety, trauma, and domestic/interpersonal violence ☐ Development ☐ Dyslipidemia ☐ Fluoride ☐ Health diet and physical activity ☐ Hearing ☐ Height, weight, and body mass index ☐ Hematocrit or hemoglobin ☐ HIV ☐ Immunizations ☐ Iron ☐ Lead ☐ Medical history ☐ Obesity ☐ Oral risk assessment ☐ STI prevention ☐ Skin cancer ☐ Syphilis ☐ Tobacco use interventions ☐ Tuberculin ☐ Vision

Support for Healthy Living

We are excited about our health and well-being resources. In addition to the 24/7 nurse and information line, you can see a wide variety of information and tools at www.GlobalHealth.com. We hope you use these resources to enhance your and your family's health.

24/7 Nurse Help Line

Only your doctor can diagnose, prescribe, or give medical advice. But, our nurse can help you make confident decisions. It's not always easy to decide when to seek emergency care, treat

symptoms yourself, or see a PCP. Call 1-877-280-2993 anytime at no cost. If you believe it is an emergency, call 911.

The nurse help line gives you:

- Nurses using clinically-proven guidelines to help you decide what to do next.
- 24/7 access.

GlobalHealth.com

Our website has links to health interactive tools and information. Many topics are available in English and Spanish.

Category	Information Available

MyGlobal® - Call us for login set-up	• Contact us via secure messaging:
	  ○ Request/re-order Member ID cards; and
	  ○ Change your PCP.
	• View Plan details (benefits, MOOP, Cost-share).
	• View Claims for Medical Services.
	• View Referrals.

Maintain Your Health	• Read about:
	  ○ Healthy eating;
	  ○ The importance of exercise; and
	  ○ Health Screenings for Preventive Care. View prevention checklists for all age groups.
	• Use tips and interactive tools to incorporate healthy diet and exercise into daily life.
	• Find links to clinical guidelines.
	• Take quizzes to see if you are on the right track.

Improve Your Health	• Read educational material and use interactive tools.
	• Find links about topics such as:
	  ○ Alcohol/drug abuse
	  ○ Quitting tobacco use
	  ○ Sticking to your care plan
	  ○ Stress and depression

Manage Long-Term Conditions	• Read about Chronic Conditions and how to manage them. Learn about treatment options to talk about with your doctor.
	• Enroll in a GlobalHealth-sponsored program.
	  ○ Complex Case Management
	  ○ Diabetes Prevention Program
	  ○ Disease Management
	  ○ Medication Therapy Management
	  ○ Prenatal Outreach

Tools/Calculators	• Includes:
	  ○ The annual HRA.
	  ○ Body Mass Index (“BMI”) calculator.
	  ○ Drug guide.

Clinical Practice Guidelines

We use clinical practice guidelines from AHRQ. Guidelines include, but are not limited to:

Clinical Practice Guidelines	Disease
Preventive	• Breast cancer • Colorectal cancer • Hypertension • Obesity assessment
Medical conditions	• COPD • CHF diagnosis, evaluation, and management • CAD clinical practice guidelines • Diabetes mellitus
Behavioral health	• ADHD assessment and management • Treatment of ASD • Treatment and management of depression in adults

We have evidence-based preventive health guidelines for all ages:

- Perinatal;
- Children up to 24 months old;
- Children 2-19 years old;
- Adults 20-64 years old; and
- Adults 65 years and older.

You can find clinical practice guidelines and preventive health guidelines on our website.

Tobacco Cessation

You or your Dependent age 18 or older is eligible for help with quitting tobacco use. Tobacco use is defined as:

- Using any tobacco product other than for religious or ceremonial use; and
- Using on average, four or more times per week within the past six months.

Tobacco products include:

- Candy-like products that contain tobacco
- Cigarettes
- Cigars
- Smokeless tobacco
- Smoking tobacco
- Snuff

Benefit	Description
Promoting health	Tobacco use is one of the most preventable causes of death and disease in the U.S. Our tobacco cessation goals are to: • Reduce the number of Members who use tobacco products; • Increase awareness of tobacco cessation programs; and • Improve the overall health of Members.
Steps to quit	1. Find *your* motivation. 2. Call your PCP, BHP, or the Oklahoma Tobacco Helpline for support

Benefit	Description
	and to set up your quit plan. 3. Talk with your doctor about medicines to help you quit. 4. Set a quit date within the next two weeks. 5. Make small changes. For example: Throw away ashtrays in your home, car, and office so you aren't tempted to smoke. 6. Make your home and car smoke-free. 7. If you have friends who smoke, ask them not to smoke around you. 8. Plan for how you will handle challenges like cravings. The most important thing to remember is to keep trying. Our website has more helpful hints.
Cessation attempts	Studies show that the most effective way to stop smoking involves: • Counseling; • Social support; and • The use of cessation medication. Counseling and drugs both work for treating tobacco dependence. Using them together works better than using either alone. We cover two tobacco cessation attempts per year. One attempt is considered: • Four tobacco cessation counseling sessions; and • FDA-approved tobacco cessation drugs (including both prescription and OTC). You do not need PA. You pay for other treatment or non-generic drugs.
Counseling	You may attend individual, group, or telephone counseling sessions for at least 10 minutes each through your PCP or BHP. You may also call the Oklahoma Tobacco Helpline at 1-800-QUIT-NOW (1-800-784-8669). You will talk to a trained cessation expert. He or she will tailor a plan for you.
Prescriptions	Smoking cessation products are limited to two full 90-day courses of any FDA-approved tobacco cessation products per year. Your PCP or BHP will write a prescription. This benefit is available to you and your enrolled Dependents who are at least 18 years old. The covered drugs are listed in the Formulary and include: • Bupropion SR 150 mg (generic for Zyban®). • Chantix™ (varenicline); • Nicotrol® Inhaler (nicotine); and • Nicotrol® Nasal Spray (nicotine). We also cover FDA-approved OTC products with a prescription written by your physician: • Gum;

Benefit	Description
	• Inhalers; • Lozenges; • Nasal sprays; and • Nicotine patches. Your *Drug Formulary* will tell you if the drug is part of Preventive Services at no cost. However, if your Provider tells us you need a non-preventive drug as part of your quit attempts, we will cover that drug at no cost. See "Exception Requests" on page 33. Not all products that may be used for tobacco cessation are included. For example, we do not cover electronic cigarettes (e-cigarettes).
Enroll	You can enroll by contacting us or going on our website.

DISCLOSURES AND LEGAL NOTICES

Many of these documents are on our website.

Advance Directives

An Advance Directive is a document to tell doctors and others of your wishes to receive, decline, or stop life-sustaining medical care. It may include a living will, appointment of a health proxy, or both.

Who can have an Advance Directive?
Any person of sound mind and at least 18 years of age can have an Advance Directive. It starts when your doctor is told and you can no longer make decisions about getting life-sustaining treatment.

You may cancel your Advance Directive in whole or in part at any time:

- When you tell your doctor or other Provider; or
- By a witness to the revocation.

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

Helpful Information

- If you are admitted to a Hospital, give the Hospital a copy.
- Ask your doctor to make it part of your medical record.
- Keep a second copy in a safe place where it can be easily found.
- If you have appointed a healthcare proxy, give them a copy.
- 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, ask your PCP or contact us.

Continuation Coverage Rights Under COBRA

This provision may not apply to your Plan's coverage. Check with your employer to find out if your Plan is subject to COBRA regulations.

Section	Description
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

Section	Description
	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."

Section	Description
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 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 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 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 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 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.

Section	Description
	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.

Creditable Coverage Disclosure Notices

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-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 not 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 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 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 19 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 us 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).

ERISA Rights

You may be entitled to certain rights and protections under ERISA. These rights only apply to Members enrolled through a group health Plan governed by ERISA. Check with your Plan Administrator (your employer) to see if your group health Plan is governed by ERISA.

ERISA provides that all Plan participants shall be entitled to:

Right	Description
Receive Information About Your Plan and Benefits	Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements. Obtain, upon request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and updated Plan materials. The Plan Administrator may make a reasonable charge for the copies. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report. 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 117.
Prudent Actions by Plan Fiduciaries	In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate

Right	Description
	against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
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 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 EBSA, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, 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 EBSA.

Fraud and Abuse

"Fraud" is:

- *Knowingly and willfully* carrying out, or attempting to carry out, a plan to defraud a healthcare benefit program; or
- To obtain, by means of a lie or false pretenses, a benefit when you are not entitled.

"Abuse" is:

- Asking us to pay for items and services when you are not entitled to them.
- You or your Provider has *unknowingly or unintentionally* misrepresented facts to get payment.

Source	Examples
Healthcare Providers	• Billing or charging you for services that we cover (other than your Cost-share). • Offering you gifts or money to get medical care that you do not need. • Offering you free services, equipment, or supplies in exchange for using your GlobalHealth Member ID number. • Giving you medical care that you do not need. • Billing us for services that were not actually provided.
Members	• Selling or lending your Member ID card to someone else. • Lying to a Provider in order to get items or services that are not Medically Necessary.

Reporting Fraud and Abuse
We are committed to finding and preventing Fraud and Abuse. You can help by telling us if you suspect Fraud and/or Abuse. Call and leave a message on our 24-hour hotline. Provide as much detail as you can. You may remain anonymous if you choose.

Contact Method	Contact Information
Toll-free	1-877-280-5852
E-mail	compliance@globalhealth.com

Guaranteed Renewability

Your employer can choose to keep the same group health Plan from year to year, except when:

- Premium is not paid;
- Your employer commits Fraud;
- Your group does not follow participation and/or contribution rules;
- GlobalHealth no longer offers large group Plans;
- All participating employees move outside the Service Area; or
- Association membership ends, if you enrolled through an association.

In addition, you may choose to re-enroll each year if your employer chooses to keep the same Plan, except when:

- You commit Fraud; or
- You move outside the Service Area.

Medicaid and CHIP Notice

Premium assistance under Medicaid and CHIP.

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a Premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to Health Insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these Premium assistance programs. But, you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in Oklahoma, you can contact your State Medicaid or CHIP office to find out if Premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, you can contact the State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the Premiums for an employer-sponsored Plan.

Once it is determined that you or your Dependents are eligible for Premium assistance under Medicaid or CHIP, as well as eligible under your employer Plan, your employer must permit you to enroll in your employer Plan if you are not already enrolled. This is called a "special Enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for Premium assistance. If you have questions about enrolling in your employer Plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in Oklahoma, you may be eligible for assistance paying your employer health Plan Premiums. You should contact Oklahoma Health Care Authority for further information on eligibility.

Contact Method	Contact Information
Website	http://www.insureoklahoma.org
Toll-free	1-888-365-3742

To see if other States have a Premium assistance program, or for more information on special Enrollment rights, you can contact either:

Department	Contact Information
U.S. Department of Labor	U.S. Department of Labor Employee Benefits Security Administration www.dol.gov/ebsa 1-866-444-EBSA (3272)
U.S. Department of Health and Human Services	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565

Member Rights and Responsibilities

Your Rights

As a partner with us, your doctor, and other Providers, you or your legal designee have the right to:

- Get information about us, our services, your Providers, and your rights and responsibilities as a Member.
- Be treated with dignity and respect.
- Privacy and confidential treatment of all personal information.
- Participate with Providers in making decisions about your care.
- An open discussion of all treatment options for your condition, regardless of the cost of care or benefit coverage.

- Voice complaints about us or your care. Appeal any unfavorable decisions by following the Appeal and Grievance process.
- Make recommendations regarding our Member rights and responsibilities policy.
- Ask about any healthcare concerns, request medical advice or get more information about treatment in order to make an informed decision or refuse a Course of Treatment.
- Understand your condition, health status, and the drugs prescribed for you – what they are, what they are for, how to take them properly, and possible side effects.
- Know how your Plan operates. Get Plan materials.
- See your PCP and get 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.
- Information about Provider payment agreements, as well as explanations of benefits or Claims processing determinations.
- Expect problems to be fairly examined and 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:

- Give information, to the extent possible, that:
  - Your Providers need in order to provide care; and
  - We need in order to determine payment for that care.
- Follow care plans that you and your Providers have agreed to.
- Understand your health problems and help create treatment goals, as much as possible.
- Show your Member ID card when getting Medical Services.
- Be on time for all appointments. Tell your doctor's office as soon as possible if you need to cancel or reschedule.
- Tell your PCP and us within 48 hours, or as soon as possible, if you:
  - Are hospitalized;
  - Get emergency care; or
  - Get out-of-area Urgent Care.
- Pay your Cost-share when you have services.
- Understand Covered Services, policies and procedures. Read your Plan materials.
- Ask questions if you do not understand your benefits or care options.

MHPAEA

MHPAEA requires employment-based group health Plans and Health Insurance issuers provide increased parity between mental health and substance use disorder benefits and medical/surgical benefits. The Departments of Labor, Treasury, and Health and Human Services (collectively, the Departments), administer MHPAEA together with the States.

MHPAEA and its implementing regulations:

- Provide that financial requirements (such as Copayments), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits can generally be no more restrictive than the requirements or limitations applied to

medical/surgical benefits.

- Include requirements to provide for parity for non-quantitative ("NQTL") treatment limitations (such as medical management standards).
  - The Departments' regulations provide that under the terms of the Plan as written and in practice, any processes, strategies, evidentiary standards, or other factors used by a Plan or issuer in applying an NQTL to mental health or substance use disorder benefits must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitations to medical/surgical benefits.
  - Specifically, the review and authorization of services to treat mental health and substance use disorder will be handled in a way that is comparable to the review and authorization of medical/surgical services.
  - If we make a decision to deny or reduce authorization of a service, you will receive a letter explaining the reason for the denial or reduction.
  - We will send you or your Provider a copy of the criteria used to make this decision within 30 days of your request.

GlobalHealth Plans meet the requirements of MHPAEA. If you have concerns about our compliance with MHPAEA, you can contact the Department of Labor at 1-866-444-3272 or on the web at http://www.dol.gov/ebsa/contactEBSA/consumerassistance.html.

Minimum Essential Coverage and Minimum Value Standard

Minimum Essential Coverage

This Plan qualifies as Minimum Essential Coverage ("MEC"). It satisfies the ACA Individual Responsibility Requirement. For more information, visit the Internal Revenue Service ("IRS") website at www.irs.gov/affordable-care-act/individuals-and-families/individual-shared-responsibility-provision.

We send Form 1095-B to Subscribers. This form has information you need when you file your tax return. It shows which family members were covered and when. We also send these forms to the IRS. Call the telephone number on the form if you have any questions.

Minimum Value Standard

The ACA sets a minimum value for health Plans. The Minimum Value Standard is 60% (actuarial value). This Plan's coverage does meet this standard.

A metallic name, such as Platinum, Gold, Silver, or Bronze, is not the value of the actual amount of expenses that you will pay. Your cost will vary depending on the services you use, and Plan you chose. Metallic names reflect only an estimate of the actuarial value of a Plan.

Notice of Non-discrimination

We comply with state and federal civil rights laws. We do not treat people differently because of:

- Race;
- Ethnicity;
- National origin;
- Religion;
- Gender or gender identity;
- Sexual orientation;
- Age;
- Mental or physical disability;
- Health status;
- Medical condition (including both

physical and mental illnesses);
- Claims experience;
- Healthcare received;
- Medical history;
- Genetic information;
- Evidence of insurability (including conditions due to acts of domestic violence);
- Source of payment; or
- Geographic location within the Service Area.

All Members have the same eligibility rules and base Premium rates. We may have variations in the administration, processes, or benefits. They must be:

- Based on reasonable medical management; or
- Part of a wellness program.

Section 1557 of the Affordable Care Act Grievance Procedure

It is the policy of GlobalHealth not to discriminate on the basis of race, color, national origin, sex, age, or disability. We have adopted an internal Grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the Section 1557 Coordinator who has been designated to coordinate the efforts of GlobalHealth to comply with Section 1557.

Contact Method	Contact Information
Mail	Compliance Attorney 210 Park Avenue, Ste. 2800 Oklahoma City, OK 73102-5621
E-mail	compliance@globalhealth.com
Fax	(405) 280-5894

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a Grievance under this procedure. It is against the law for us to retaliate against anyone who opposes discrimination, files a Grievance, or participates in the investigation of a Grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date the person filing the Grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain our files and records relating to such Grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to Grievances and will share them only with those who have a need to know.

- The Section 1557 Coordinator will issue a written decision on the Grievance, based on a preponderance of the evidence, no later than 3 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the Grievance may Appeal the decision of the Section 1557 Coordinator by writing to the Compliance Officer or designee within 15 days of receiving the Section 1557 Coordinator's decision. The Compliance Officer or designee shall issue a written decision in response to the Appeal no later than 30 days after its filing.

The availability and use of this Grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age, or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

Contact Method	Contact Information
Call	1-800-368-1019 (toll-free) 800-537-7697 (TDD)
Mail	U.S. Department of Health and Human Services 200 Independence Avenue SW Room 509F, HHH Building Washington, DC 20201

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

We will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this Grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with Low Vision, or assuring a barrier-free location for the proceedings. Contact us for help with such arrangements.

Notice of Protection Provided by Oklahoma Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that your life, annuity, or Health Insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay Claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits

    - $100,000 in cash surrender or withdrawal values
- Health Insurance
    - $500,000 in Hospital, medical, and surgical insurance benefits
    - $300,000 in disability income insurance benefits
    - $300,000 in long-term care insurance benefits
    - $100,000 in other types of Health Insurance benefits
- Annuities
    - $300,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except that with regard to Hospital, medical, and surgical insurance benefits, the maximum amount that will be paid is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Oklahoma law.

To learn more about the above protections, please visit the Association's website at www.oklifega.org, or contact:

Department	Contact Information
Oklahoma Life & Health Insurance Guaranty Association	Oklahoma Life & Health Insurance Guaranty Association 201 Robert S. Kerr, Ste 600 Oklahoma City, OK 73102 (405) 272-9221
Oklahoma Department of Insurance	Oklahoma Department of Insurance 3625 NW 56th St, Ste 100 Oklahoma City, OK 73112 1-800-522-0071 or (405) 521-2828

Insurance companies and agents are not allowed by Oklahoma law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Oklahoma law, then Oklahoma law will control.

PII

PII is information that can be used to distinguish or trace a person's identity. It may be used alone or combined with other information that may be linked to a specific person. 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. We may receive the information directly, from another person, or from a government agency.

We will not share PII with anyone else except to carry out the functions of providing your health coverage, for which you have provided consent for your information to be used or disclosed, and as permitted by law.

Gramm-Leach-Bliley Act ("GLBA") Notice
Read this privacy notice carefully. It explains the rules we follow when we collect non-public personal information. Financial companies, including insurers, choose how they share your information. Federal and state laws say that we must tell you how we collect, share, and protect your information.

Section	Description
What Personal Information We May Collect	• Name • Telephone number • Occupation • Social Security Number • Address • Date of birth • Financial and health history • Insurance Claim information
When We Collect It	We collect your personal information when you: • Enroll in insurance • File a Claim • Get care that we pay for • Pay Premiums • Give us your contact information
Other Sources We May Use	We collect personal information about you from others such as: • Other insurers • Service providers • Healthcare professionals • Insurance support organizations • Consumer reporting agencies
What Personal Information We Use and Share	For everyday business purposes, we may share all of the personal information about you that we collect with affiliates and nonaffiliated companies (companies that are not under common ownership with us, such as our service providers), for any purpose the law allows. For example, we may use your personal information and share it with others to: • Help us run our business; • Process your transactions; • Maintain your account(s); • Administer your benefit Plan; • Respond to court orders and legal or regulatory investigations or exams; • Report to credit bureaus; • Support or improve our programs or services, including our care management and wellness programs; • Offer you our other products and services;

Section	Description
	• Do research for us; • Audit our business; • Help us prevent Fraud, money laundering, terrorism, and other crimes by verifying what we know about you; and • Sell all or any part of our business or merge with another company. We may also share your personal information with: • Medical healthcare professionals; • Insurers, including reinsurers; • Successor insurers or Claim administrators who administer your benefit Plan; and • Companies that help us recover overpayments, pay Claims, or do coverage reviews.
For Our Marketing Purposes	We may share information with our agents and service providers to offer our products and services to you.
For Joint Marketing with Other Financial Companies	We may share your personal information with other financial companies for the purpose of joint marketing. Joint marketing is when there is a formal agreement between nonaffiliated financial companies that jointly endorse, sponsor, or market financial products or services to you.
How Do We Protect Your Personal Information?	To protect personal information from unauthorized access and use, we: • Use reasonable security measures, including secured files, user authentication, encryption, firewall technology, and detection software; • Review the data security practices of companies we share your personal information with; and • Grant access to personal information to people who must use it to do their jobs.
How Can You See and Correct Your Personal Information?	Generally, you have the right to review the personal information we collect to provide you with insurance products and services if you: • Ask us in writing; and • Send the letter to the address below. When you write to us, please include your full name, address, telephone number, and Member ID number in your letter. If the information you ask for includes health information, we may provide the information to you through your healthcare Provider. Due to its legal sensitivity, we won't send you anything that we've collected in connection with a Claim or legal proceedings. If you believe the personal information we have is incorrect, please write to us and explain why you believe it is incorrect. If we agree with you, we will correct our records. If we disagree with you, you may send us a statement and we will include it when we give your personal information to anyone outside of GlobalHealth.
Additional Rights Under Other	You may have additional rights under state or other applicable laws.

Section	Description
Privacy Laws	
Questions or Concerns about this GLBA Notice	Write to us at: GlobalHealth, Inc. Attn: Privacy Officer 210 Park Avenue, Ste 2800 Oklahoma City, OK 73102-5621

We may also share personal information about former Members in the way described above. Federal laws don't allow you to limit the sharing of personal information as described above.

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. Contact us for forms.

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 can also find 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.

Section	Description
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

Section	Description
	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

Section	Description
	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 disclose 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, e-mail, 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.

Section	Description
	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 years prior to the date of your request (three years if PHI is an electronic health record). If you request more than one 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.

Section	Description
	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.** **210 Park Avenue** **Suite 2800** **Oklahoma City, OK 73102-5621** **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.

PHI Disclosure to Plan Sponsors
We may disclose your PHI to your group health Plan sponsor (that is, the Subscriber's employer). However, we will not disclose your PHI to the Plan sponsor unless:

- Your group's Plan documents have been amended to comply with HIPAA requirements; and
- Your Plan sponsor has certified to us in writing that it will comply with HIPAA.

If these requirements are met, we may disclose your PHI to the Plan sponsor, without your authorization, when needed for treatment, payment, and healthcare.

If your Plan sponsor elects not to get PHI, we may still give "summary health information". This includes Claims data from which we removed certain information so the Plan sponsor cannot identify a particular Plan participant. For example, your:

- Name;
- Social security number;
- Address;
- Telephone number; and
- Member ID number.

We may also give the Plan sponsor information about whether a person has enrolled in, or disenrolled from, the Plan.

If you have questions, contact your Plan Administrator.

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 48 hours following a vaginal delivery, or less than 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-pocket 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 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, contact us.

Subrogation, Third-Party Recovery, and Reimbursement

Section	Description
Benefits Subject to This Provision	This provision applies to all benefits provided under any section of this Plan to: • 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 • All other agents, attorneys, representatives, and persons acting for, on

Section	Description
	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" shall mean 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

Section	Description
	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

Section	Description
	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

Section	Description
	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

Section	Description
	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. iii. 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	The provisions of this section apply to the parents, trustee, guardian, or

Section	Description
Person is a Minor or is Deceased	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) (i) 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 *Member Handbook* is ambiguous or unclear, or if any questions arise concerning the meaning or intent of any of its terms, the

Section	Description
	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.

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. See "Benefits" on page 35 for your Deductible and your Cost Sharing for applicable services. If you would like more information on WHCRA benefits, contact your Plan Administrator.

FAQS

These FAQs are subject to "Coverage Requirements" on page 36 and "Excluded Services and Limitations" on page 81.

Topic	Q&A
Chiropractic	Q. Does the Plan cover chiropractor visits? A. Yes.
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. Yes, Dependents must establish a relationship with a PCP in our Network. We cover Out-of-network emergencies and Urgent Care. We do not cover Out-of-network routine care. Any Out-of-network services, other than Emergency Services or Urgent Care must be preauthorized by GlobalHealth. Q. What about Dependents over 18 years of age? A. We cover eligible children through the end of the month in which they turn 26 years of age.
Emergencies and Urgent Care	Q. When I go to the ER, is my copay waived if I am then admitted to the Hospital? A. Yes. 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 48 hours of receiving the care. When same-day Urgent Care is needed and you cannot see your PCP, 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 if you cannot wait for your PCP's office hours.
Hearing	Q. Does the Plan cover hearing aids? A. Yes. See Hearing services – hearing aids and devices on page 54.
Hospital Admission	Q. Does my Hospital copay cover doctor visits to the Hospital? A. Yes. Q. Does the Plan cover private rooms in the Hospital? A. When Medically Necessary. Q. What Hospitals are in your Network?

Topic	Q&A
	A. They are listed in the *Provider Directory*. You can do a search on our website.
Mental Health	Q. Does the Plan cover mental health services? A. Yes. You do not have to go through your PCP. See "Behavioral Health Benefits" on page 37. Q. How can I find out who the mental health Providers are? A. There is a listing in the *Provider Directory*.
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. 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 starts right away. You can make changes on our website. If you need to see a PCP before you receive your new Member ID card, contact us.
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 us. 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 Magellan Rx Management. Home delivery prescriptions are filled with a 90-day supply. A discount may be available. Q. Where can I get my prescriptions filled? A. We have over 800 participating pharmacies across the state of Oklahoma. Magellan Rx Management, our pharmacy benefit manager, has a nation-wide Network that you can access.
Preventive Care	Q. Is Preventive Care covered? A. We cover all Preventive Services covered under the ACA at no cost to you when delivered by a Network Provider. See "Preventive Care Benefits" on page 74 for a current list of services. Q. How do I get Preventive Services? A. Start with your PCP. He/she will provide most services or send us a Referral if needed. However, you have direct access to your OB/GYN for

Topic	Q&A
	services he/she handles and to a Network imaging center for your mammogram.
Referrals	Q. Do I need a Referral to see a Specialist? A. Yes. Except for services you get from your OB/GYN, your PCP is responsible to manage all of your care. He or she sends us a Referral when needed. Procedures must also have PA.
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 49.
Worldwide Coverage	Q. Am I covered worldwide? A. No.

ACRONYMS

Acronym	Phrase
ACA	Patient Protection and Affordable Care Act of 2010 as amended by The Health Care and Education Reconciliation Act of 2010
ADHD	Attention deficit hyperactivity disorder
AHRQ	Agency for Healthcare Research and Quality
ASD	Autism spectrum disorder
BHCM	Certified Behavioral Health Case Manager
BHP	Behavioral Health Provider
CAD	Coronary artery disease
CAHPS®[1]	Consumer Assessment of Healthcare Providers and Systems
CDC	Centers for Disease Control
CHF	Congestive heart failure or chronic heart failure
CHIP	Children's Health Insurance Program
COB	Coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
DEA	Drug Enforcement Administration
DME	Durable Medical Equipment
EBSA	Employee Benefits Security Administration
ER	Emergency room
ERISA	Employee Retirement Income Security Act of 1974
FDA	U.S. Food and Drug Administration
HEDIS®[2]	Healthcare Effectiveness Data Information Systems
HIPAA	Health Insurance Portability and Accountability Act of 1996
HRA	Health risk appraisal
HRSA	Health Resources and Services Administration
IRO	Independent Review Organization
LADC	Licensed Alcohol & Drug Counselor
LBP	Licensed Behavioral Practitioner
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage & Family Therapist
LPC	Licensed Professional Counselor
MHPAEA	The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008
MOOP	Maximum out-of-pocket or Out-of-pocket Limit
NCQA	National Committee for Quality Assurance
OB/GYN	Obstetrician/gynecologist

Acronym	Phrase
OTC	Over-the-counter
PA	Preauthorization or prior authorization
PCP	Primary Care Physician
PHI	Protected health information
PII	Personally identifiable information
P&T	Pharmacy and Therapeutics
QIP	Quality improvement program
RTC	Residential treatment center
SEP	Special Enrollment Period
UM	Utilization Management
USPSTF	United States Preventive Services Task Force

[1]CAHPS® is a registered trademark of AHRQ.
[2]HEDIS® is a registered trademark of NCQA.

GLOSSARY

Term	Definition
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	This is the maximum payment GlobalHealth will pay for covered healthcare services. May be called "eligible expense," "payment allowance," or "negotiated rate."
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.
Appeal	A request for GlobalHealth to review a decision that denies a benefit or payment (either in whole or in part).
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 balance remaining on the bill your Plan doesn't cover. This amount is the difference between the actual billed amount and the GlobalHealth Allowed Amount. For example, if the Provider's charge is $200 and the GlobalHealth Allowed Amount is $110, the Provider may bill you for the remaining $90. This happens most often when you see an Out-of-network Provider. A Network Provider may *not* bill you for Covered Services.
Behavioral Health Provider ("BHP")	A behavioral healthcare professional (psychiatrist, psychologist, clinical social worker, marriage and family therapist, behavioral professional, behavioral Practitioner, and/or alcohol and drug counselor) that is licensed, certified, or accredited by State law.
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.

Term	Definition
Claim	A request for a benefit (including reimbursement of a healthcare expense) made by you or your healthcare Provider to GlobalHealth for items or services you think are covered.
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 generally 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 generally aren't Complications of Pregnancy.
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.
Cost Sharing	Your share of costs for services that your Plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of Cost Sharing are Copayments, Deductibles, and Coinsurance. Family Cost Sharing is the share of cost for Deductibles, and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your Premiums, penalties you may have to pay, or the cost of care your Plan doesn't cover usually are not considered Cost Sharing.
Course of Treatment	A series of treatments (you get over a period of time or number of treatments) in a structured program. It may include multiple Providers and Facilities. You should be an active participant of the planning team.
Covered Services	Medically Necessary services or supplies provided under the terms of this *Member Handbook*, your *Drug Formulary,* and your *Provider Directory*.
Deductible	The amount you could owe during a coverage period (usually one year) for covered healthcare services before GlobalHealth begins to pay. An overall Deductible applies to all or almost all covered items and services. A Plan with an overall Deductible may also have separate Deductibles that apply to specific services or groups of services. A Plan may also have only separate Deductibles. (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.

Term	Definition
Dependent	Any spouse or child up to the age of 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.
Diagnostic Test	Tests to figure out what your health problem is. For example, an x-ray can be a Diagnostic Test to see if you have a broken bone.
Durable Medical Equipment ("DME")	Equipment and supplies ordered by a healthcare Provider for everyday or extended use. DME may include: Oxygen equipment, wheelchairs, and crutches.
Emergency Medical Condition	An illness, injury, symptom (including severe pain), or condition that is severe enough to risk serious danger to your health if you didn't get medical attention right away. If you did not get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.
Emergency Medical Transportation	Ambulance services for an Emergency Medical Condition. Types of Emergency Medical Transportation may include transportation by air, land, or sea. Your Plan may not cover all types of Emergency Medical Transportation, or may pay less for certain types.
Emergency Room Care / Emergency Services	Services to check for an Emergency Medical Condition and treat you to keep an Emergency Medical Condition from getting worse. These services may be provided in a licensed Hospital's emergency room or other place that provides care for Emergency Medical Conditions.
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 Plan Member. A Member is enrolled when GlobalHealth accepts the Enrollment form submitted by the Subscriber. GlobalHealth and the employer group must abide by the contract and the employer group must pay Premiums on time.
Excluded Services	Healthcare services that your Plan 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.
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.
Formulary	A list of drugs your Plan covers. A Formulary may include how much your share of the cost is for each drug. Your Plan may put drugs in different Cost Sharing levels or Tiers. For example, a Formulary may include generic drug and brand name drug Tiers and different Cost Sharing amounts will apply to each Tier. Your *Drug Formulary* uses Tiers.

Term	Definition
Fraud	The intentional deception by you or a Provider to provide false information to GlobalHealth, or the intentional misuse of your Member ID Card.
Grace Period	The time between your last Premium payment and when your coverage is terminated due to lack of payment.
Grievance	A complaint that you communicate to GlobalHealth in writing.
Habilitation Services	Healthcare services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.
Health Insurance	A contract that requires GlobalHealth to pay some or all of your healthcare costs in exchange for a Premium. A Health Insurance contract may also be referred to as a "policy" or "Plan."
Home Healthcare	Healthcare services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed healthcare Providers. Home Healthcare usually does not include help with non-medical tasks, such as cooking, cleaning, or driving.
Hospice Services	Services to provide comfort and support for persons in the last stages of a terminal illness and their families.
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.
Hospitalization	Care in a Hospital that requires admission as an Inpatient and usually requires an overnight stay. Some Plans may consider an overnight stay for observation as Outpatient care instead of Inpatient care.
Hospital Outpatient Care	Care in a Hospital that usually doesn't require an overnight stay.
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.
Individual Responsibility Requirement	Sometimes called the "individual mandate," the duty you may have to be enrolled in health coverage that provides Minimum Essential Coverage. If you do not have Minimum Essential Coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.
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.

Term	Definition
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 *Provider Directory* or on our website Provider Search. Also see Network.
In-network Coinsurance	Your share (for example, 20%) of the Allowed Amount for covered healthcare services. Your share is usually lower for In-network Covered Services. 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 for which likelihood of death is probable unless the course of the disease or condition is interrupted.
Local Coverage Determination ("LCD")	A document published by Medicare Contractors that details which conditions or diagnosis codes support medical necessity for a service or procedure. They specify under what clinical circumstances a service is considered to be reasonable and necessary.
Low Vision	Low Vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in Low Vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision.
Marketplace	A Marketplace for Health Insurance where individuals, families, and small businesses can learn about their Plan options; compare Plans based on costs, benefits, and other important features; apply for and receive financial help with Premiums and Cost Sharing based on income; choose a Plan; and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the Federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program ("CHIP"). Available online, by phone, and in-person.
Maximum Out-of-pocket Limit	Yearly amount the federal government sets as the most each individual or family can be required to pay in Cost Sharing during the Plan Year for covered, In-network services. Applies to most types of health Plans and insurance. This amount may be higher than the Out-of-pocket Limits stated for your Plan. This may be called "MOOP".
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.

Term	Definition
Medically Necessary	Healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.
Member	Any eligible Subscriber or Dependent of Subscriber.
Minimum Essential Coverage	Health coverage that will meet the Individual Responsibility Requirement. Minimum Essential Coverage generally includes Plans, Health Insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. All GlobalHealth Plans provide Minimum Essential Coverage.
Minimum Value Standard	A basic standard to measure the percent of permitted costs the Plan covers. If you are offered an employer Plan that pays for at least 60% of the total allowed costs of benefits, the Plan offers minimum value and you may not qualify for Premium tax credits and Cost Sharing reductions to buy a Plan from the Marketplace. All GlobalHealth Plans meet the Minimum Value Standard.
National Coverage Determination ("NCD")	Developed by CMS to describe the circumstances for which Medicare will cover specific services, procedures, or technologies on a national basis. Often, NCD's are clarified by the creation of an LCD (at the local contractor level).
Network	The Facilities, Providers, and suppliers that GlobalHealth has contracted with to provide healthcare services. These Facilities and Providers are also referred to as "In-network".
Network Provider	A Provider who has a contract with GlobalHealth who has agreed to provide services to Members of a Plan. You will pay less if you see a Provider in the Network.
Non-preferred Facility	A Facility which has a contract with GlobalHealth to provide services to you at a discount. You will pay the higher Cost-share when you choose these Facilities instead of a Preferred Facility.
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.
Orthotics and Prosthetics	Leg, arm, back and neck braces, artificial legs, arms and eyes, and external breast prostheses after a mastectomy. These services include: Adjustment, repairs, and replacements required because of breakage, wear, or a change in the patient's physical condition.
Out-of-network	A healthcare Provider does not have a contract with GlobalHealth to provide services to Members.
Out-of-network Coinsurance	Your share (for example, 40%) 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.

Term	Definition
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-network Provider	A Provider who does not have a contract with GlobalHealth to provide services. GlobalHealth only covers Out-of-network services in limited situations.
Out-of-pocket Limit	The most you could pay during a coverage period (usually a year) for your share of the costs of Covered Services. After you meet this limit, GlobalHealth begins to pay 100% of the Allowed Amount. This limit helps you plan for healthcare costs. This limit never includes your Premium, balance-billed charges, or healthcare costs that your Plan doesn't cover. This may be called "maximum out-of-pocket" or "MOOP".
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, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine) provides or coordinates.
Plan	Health coverage issued to you directly (individual Plan) or through an employer, union, or other group sponsor (employer group Plan) that provides coverage for certain healthcare costs. Also called "Health Insurance Plan", "policy", "Health Insurance policy", or "Health Insurance".
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.
Plan Year	The 12 months your contract covers, or the timeframe from your effective date to the end of your group's Plan Year if you are a late enrollee.
Practitioner	A professional who provides healthcare services. Practitioners are licensed as required by law.
Preauthorization ("PA")	A decision by GlobalHealth that a healthcare service, treatment plan, Prescription Drug, or Durable Medical Equipment ("DME") is Medically Necessary. 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 Facility	A Facility which has a contract with GlobalHealth to provide services to you at a discount. You will pay the lowest Cost-share when you choose these Facilities. It may also be called, "Ambulatory Surgical Center".

Term	Definition
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. You will pay the Cost-share listed in your *Schedule of Benefits*.
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	Coverage under a Plan that helps pay for Prescription Drugs. If the Plan's Formulary uses "Tiers" (levels), Prescription Drugs are grouped together by type or cost. The amount you will pay in Cost Sharing will be different for each "Tier" of covered Prescription Drugs.
Prescription Drugs	Drugs and medications that by law require a prescription.
Preventive Care (Preventive Service)	Routine health care, including Screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.
Primary Care Physician ("PCP")	A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine) who provides or coordinates a range of healthcare services for you.
Primary Care Provider	A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the Plan, who provides, coordinates, or helps you access a range of healthcare services.
Provider	An individual or Facility that provides healthcare services. Some examples of a Provider include a doctor, nurse, chiropractor, physician assistant, Hospital, surgical center, Skilled Nursing Facility, and rehabilitation center. GlobalHealth may require the Provider to be licensed, certified, or accredited as required by state law.
Prudent Layperson	A person without medical training who reasonably draws on practical experience when making a decision regarding whether Emergency Services are needed. 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.
Qualifying Life Event	A change in your situation – like getting married, having a baby, or losing health coverage – that can make you eligible for a Special Enrollment Period, allowing you to enroll in Health Insurance outside the yearly Open Enrollment period.

Term	Definition
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	A written order from your Primary Care Provider for you to see a Specialist or get certain healthcare services. In many health maintenance organizations ("HMOs"), you need to get a Referral before you can get healthcare services from anyone except your Primary Care Provider. If you don't get a Referral first, GlobalHealth may not pay for the services. GlobalHealth allows limited access to services in addition to your PCP without a Referral.
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.
Screening	A type of Preventive Care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.
Serious Acute Condition	A disease or condition requiring complex ongoing care which you are currently receiving, such as chemotherapy, radiation therapy, or post-operative visits.
Service Area	A geographical area, as approved by the Oklahoma Insurance Department, within which GlobalHealth arranges for basic medical, Hospital, and supplemental healthcare services.
Skilled Nursing Care	Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled Nursing Care is not the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.
Skilled Rehabilitation Services	Services provided in the home by licensed therapists (e.g., physical, occupational, speech).
Skilled Nursing Facility	A Facility or Hospital unit primarily engaged in providing, in addition to room and board accommodations, 24 hour Skilled Nursing Care under the supervision of a licensed physician. GlobalHealth contracts with Skilled Facilities that are certified under Title XVIII of the Social Security Act (Medicare certified).
Special Enrollment Period ("SEP")	The period of time, outside of Open Enrollment, when a person may enroll in a health Plan.

Term	Definition
Specialist	A Provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.
Specialty Drug	A type of Prescription Drug that, in general, requires special handling or ongoing monitoring and assessment by a healthcare professional, or is relatively difficult to dispense. Generally, Specialty Drugs are the most expensive drugs on a Formulary.
Subscriber	A person meeting the eligibility requirements of the contract based on employment or association rules of the group, and for whom the appropriate health Plan Premium has been received by GlobalHealth. Usually, the Subscriber is the employee.
Tier	Groups of drugs that fall within description and pricing levels. Drugs are assigned based on drug usage, cost, and clinical effectiveness. The higher the Tier, the more you pay through higher Cost Sharing.
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 Usual, Customary, and Reasonable ("UCR") amount sometimes is used to determine the Allowed Amount.
Utilization Management ("UM")	A process for monitoring the use, delivery, and cost-effectiveness of services.

Language	Translation
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-280-5600 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-280-5600 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-280-5600 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-280-5600 OR (TTY: 711)번으로 전화해 주십시오.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-280-5600 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل 1-877-280-5600 (هاتف الصم والبكم برقم 711)
Burmese	သတိပြုရန် - အကယ့်၍ သင့်သည့်ျမန်မာစကား ကို ဖျတပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတက္ြ စီစဉ်ဆောင်ရက္ြပေးပါမည်။ ဖုန်းနံပါတ် 1-877-280-5600 (TTY: 711) သို ခေါ်ဆိုပါ။
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-280-5600 (TTY: 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-280-5600 (TTY: 711).
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-280-5600 (ATS: 711).
Laotian	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-280-5600 (TTY: 711).
Thai	**เรียน:** ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-280-5600 (TTY: 711).
Urdu	خبردار: اگر آپ اردو بولتے ہیں، مفت خدمات کی مدد کی زبان کو آپ تو ہیں دستیاب میں ۔ کریں کال 1-877-280-5600 (TTY: 711).
Cherokee	Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 1-877-280-5600 (TTY: 711).
Persian	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید 1-877-280-5600 (TTY: 711)

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