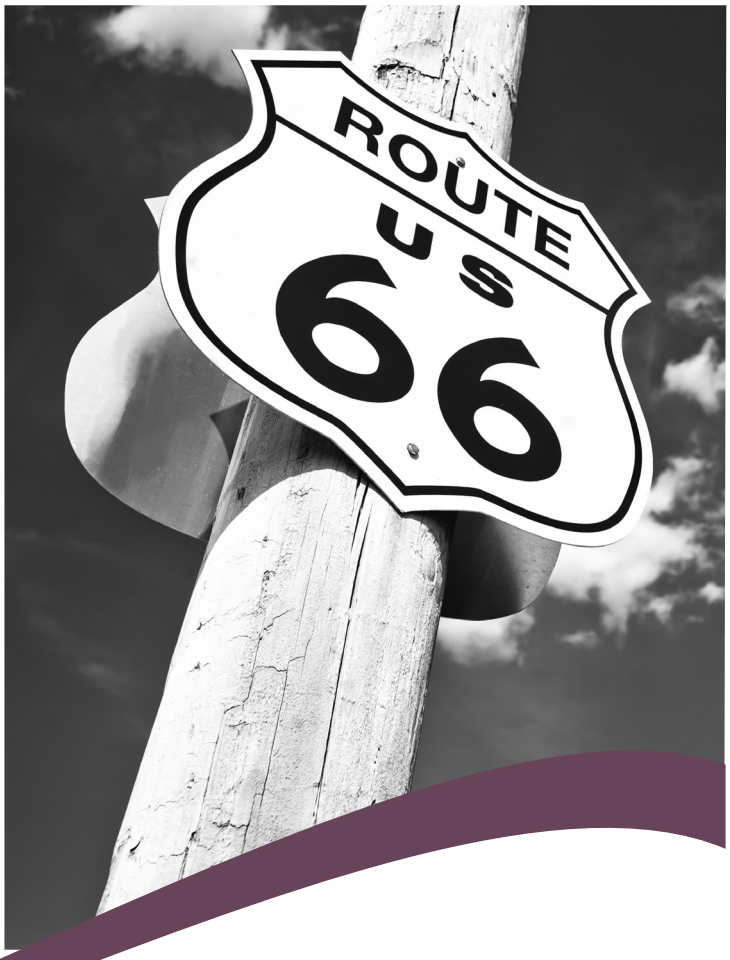
GlobalHealth

2018 Administrative Reference Manual

For Employer Group Plan Administrator



ACCREDITED NCQA HEALTH PLAN ACCREDITED

GlobalHealth, Inc.
PO Box 2393
Oklahoma City, OK 73101-2393
www.GlobalHealth.com/commercial

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SECTION 1 – Introduction

Welcome to GlobalHealth

Welcome, and thank you for choosing GlobalHealth! We look forward to being your Oklahoma-based health maintenance organization (HMO). We hope that, together, we can create a strong and long-lasting relationship.

We are committed to providing access to quality healthcare at an affordable cost. Our local customer care is fast and friendly and ready to help. Please let us know how we are doing. We appreciate any feedback that you provide.

Any questions you may have should be directed to our Customer Care department at CommercialAnswers@globalhealth.com. You can also call us at (405) 280-2964, 1-877-280-2964, or TTY 711.

Who to Call

Member Inquiries (Benefits, provider network, concerns, forms) Monday – Friday, 9 am – 5 pm	Telephone: (405) 280-2964 E-mail: GroupAnswers@globalhealth.com Toll Free: (877) 280-2964 Website: www.GlobalHealth.com/commercial TTY: 711 Mailing Address: GlobalHealth Attn: Customer Care P.O. Box 2393 Oklahoma City OK 73101-2393
MYGLOBAL™ MEMBER PORTAL	https://www.globalhealth.com/myglobal/login/
Translation Services	Telephone: (405) 280-2964 TTY: 711
24/7 Nurse Help Line	Telephone: (877) 280-2964
GlobalHealth Compliance Hotline 24/7 recorded line	Toll Free: (877) 280-5852 For reporting compliance and privacy violations
Dental Inquiries: (for plans that include pediatric dental in medical benefits package)	Careington BenefitSolutions Toll Free: (866) 636-9188 Website: www.careington.com/co/globalhealth
Pharmacy Inquiries 24 hours/7 days per week	Magellan Rx Management, LLC Toll Free: (800) 424-1789 *Drug Formulary* can be found at: www.GlobalHealth.com/commercial

	TTY: 711
Behavioral Health	Beacon Health Options Toll Free: (888)434-2903 TTY: (866) 835-2755
Utilization and Care Management Case Management and Disease Management Monday – Friday, 8:30 am – 5 pm	Telephone: (405) 280-2964 E-mail: um@globalhealth.com Toll Free: (877) 280-2964 FAX: (405) 280-5398 TTY: 711 Outside business hours: (877) 280-2964
Enrollment and Eligibility Monday - Friday, 9 am – 5 pm	Telephone: (405) 280-2964 E-mail: gheligibility@globalhealth.com Toll Free: (866) 280-2964 Website: www.GlobalHealth.com/commercial TTY: 711 Mailing Address: GlobalHealth Attn: Enrollment and Eligibility P.O. Box 2328 Oklahoma City OK 73101-2328
Billing Monday - Friday, 9 am – 5 pm	Telephone: (405) 280-5874
Appeals and Grievances Monday – Friday, 9 am – 5 pm	Telephone: (405) 280-2964 E-mail: appeals@globalhealth.com Toll Free: (877) 280-2964 TTY: 711 Mailing Address: GlobalHealth Attn: Customer Care P.O. Box 2393 Oklahoma City OK 73101-2393

Administrative Responsibilities

Employer responsibilities

- Explaining the group health plan to new employees.
- Offering new employees who are eligible for participation in the group health plan the opportunity to enroll in the program's plan within 31 days of initial eligibility.
- Verifying that all employees and dependents enrolled in the group health plan meet the eligibility rules for the plan. Failure to adhere to the eligibility rules will result in the termination of coverage for the affected enrollee(s) and reimbursement to GlobalHealth, at its sole discretion, may be required for claims paid on behalf of ineligible enrollees.

- Offering enrollment in contributory medical plans to employees who previously declined coverage for themselves and/or their eligible dependents when they become eligible as special or late enrollees.
- Enrolling employees and submitting their enrollment forms to GlobalHealth.
- Distributing appropriate benefit materials to new participating employees.
- Maintaining copies of enrollment forms, beneficiary designation forms and other important papers relating to an employee's participation in the program.
- Verifying the monthly billing statement and remitting the monthly payments due to GlobalHealth. Non-payment could result in termination of coverage.
- Submitting changes to GlobalHealth in a timely manner.
- Instructing employees about medical and dental claim filing procedures.
- Reporting changes that affect an employee's group benefits or coverage status to GlobalHealth.
- Counseling employees who are approaching retirement concerning the effect retirement will have on their coverage.
- Registering with and reporting to government agencies, when and if required.
- Providing GlobalHealth with employee information and any statistical data needed for GlobalHealth to properly administer the plan.
- Notifying employees of their rights and obligations under the group health plan.
- Maintaining the minimum participation requirements of the group health plan. If these requirements are no longer met, it must be reported to the group health plan's account administrator. Your group may not be eligible for renewal if you do not meet the minimum participation requirement at that time.

GlobalHealth responsibilities

- Establishing and maintaining employee coverage records.
- Providing employers with technical administrative assistance and benefit plan information.
- Interpreting plan provisions.
- Preparing and distributing communication materials covering program benefits and claim procedures.
- Reviewing program renewal terms and modifying rates, when applicable.
- Controlling all accounting, statistical and costing functions as they pertain to the financial success of the program.

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

How to Get the Most Out of the GlobalHealth Plan

Members who have never had HMO coverage may have questions about how it works. Here are the basic steps to help your employees understand how to get the care they need. See the *Member Handbook* for details.

Type of Service	What Members Need to Do
Choose a Primary Care Physician (PCP) from GlobalHealth's Provider Network.	• Each family member may choose a different PCP, including a pediatrician for children. • Members may change PCP selections at any time throughout the year. The change is effective the same day.
See the PCP first for all medical care.	• The PCP coordinates and manages the member's medical care. • For same-day urgent care, call the PCP's office for medical direction. • After hours, self-refer to an in-network urgent care center. • When dealing with an emergency, go to the nearest hospital emergency room.
Seeing a specialist*	• A referral and prior authorization from GlobalHealth are required. • When approved, the member receives a letter of authorization in the mail. • Make the appointment with the specialist as directed in the letter. • The specialist may request additional referrals for procedures or follow-up care. • Be sure to go back to the PCP for all other care and after 90 days of specialist care.
Going to the hospital*	• A referral and prior authorization from GlobalHealth are required except for emergencies or childbirth. • Go to a GlobalHealth contracted hospital.
Self-refer for the following services (no preauthorization needed):	• In-network obstetrical/gynecological services; • In-network routine mammograms; • Behavioral and mental health/chemical dependency services; • In-network routine eye exams; • In-network dental care (if you chose a plan with pediatric dental); • In-network hearing and speech evaluations for children; and • In-network physical therapy evaluation.
Emergencies	• Go to the nearest hospital emergency room or call 911. • Members may be balance billed if they go to an out-of-network ER. • Call the PCP and GlobalHealth within 48 hours to let us know treatment was received. • The PCP must provide or arrange for follow-up care.
Mental health and chemical dependency care	• Call the number on the member ID card and ask to speak with a case manager. • Call 911 in an emergency situation.
Prescription drug benefits	• Ask the doctor to prescribe medications on GlobalHealth's *Drug Formulary*, and generics when possible.

Type of Service	What Members Need to Do
	• See the *Drug Formulary* for prior authorization, step therapy, and quantity limits. See the *Member Handbook* for exceptions information. • Fill prescriptions at any participating pharmacy. • Set up home delivery (at the member's option). See the Member Handbook for information.
Preventive health services	• Preventive screening, counseling, and tests are available at no cost to the member include: ➢ Prenatal and perinatal care; ➢ Well-child care for infants, children, and adolescents; ➢ Adult services; and ➢ Geriatric care. • See our website or call Customer Care for a complete list of services. • Each member should talk to the PCP about what services are appropriate, when, and how to access.

*The PCP must preauthorize all inpatient and outpatient services at a contracting facility except for an emergency, after hours urgent care, self-referral services, and childbirth services. The member is responsible for the costs of any service obtained without authorization from us.

Our Customer Care staff is trained to help guide members through the process. Simply call with any questions.

Personally Identifiable Information (PII)

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

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

When working on behalf of a member, be sure to only provide necessary information for the administration of a member's health benefits. If an e-mail containing a member's personal information needs to be sent, be sure the information is sent securely.

Protected Health Information (PHI)

Federal and state laws protect identifiable health information.

Each member has the right to access or restrict the release of his/her PHI in accordance with federal and state laws. The member may also request an accounting of disclosures of his/her PHI. These forms are available by contacting Customer Care.

The full *Notice of Privacy Practices* (NPP) is available on GlobalHealth's website or by contacting Customer Care.

Members may obtain the Oklahoma Standard *Authorization to use or Share Protected Health Information (PHI)* form on our website or at https://www.ok.gov/health/Organization/HIPAA_Privacy_Rules/Oklahoma_Standard_Authorization_Form.html.

When working on behalf of the member, be sure you only provide necessary information for the administration of the member's health benefits. If an e-mail containing a member's personal information needs to be sent, be sure the information is sent securely. We must have a signed authorization form on file from the member in order to respond to you. If we do not have a signed authorization form, we will respond directly to the member.

As the *Notice of Privacy Practices* explains, we may, under certain circumstances, disclose a Member's PHI to the plan sponsor. However, we may not disclose PHI to the plan sponsor unless:

- Your group's plan documents have been amended to comply with certain Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements; and
- Your plan sponsor has certified to us in writing that it will comply with applicable provisions of HIPAA.

If the plan sponsor satisfies these requirements, we may disclose PHI to the plan sponsor, without authorization, for purposes of treatment, payment, and healthcare operations.

If the plan sponsor elects not to receive its plan participants' PHI, we may still provide "summary health information" to the plan sponsor. Summary health information includes claims data from which certain information (e.g., the member's name, social security number, address, telephone number, account number, etc.) has been removed in order to make it more difficult for the plan sponsor to identify a particular plan participant.

In addition to summary health information, we may also provide the plan sponsor information concerning whether a particular person has enrolled in, or disenrolled from, the plan.

SECTION 2 - Enrollment

Open Enrollment

Open enrollment is the time when eligible employees may choose to enroll in GlobalHealth. All employees and dependents enrolling must be eligible according to your *Group Agreement*. The employer group sets eligibility guidelines.

If an employee did not elect coverage in the current plan year, he / she may do so for the next plan year. Employees currently enrolled in GlobalHealth may add eligible family members to their coverage if they qualify for a special enrollment period. See "Qualifying Life Events" below. Normally, these types of changes can only be made during the open enrollment period. It is very important that employees are notified of these options each year.

We suggest that you hold your open enrollment at least one month before the plan's effective date. GlobalHealth representatives are available to assist you. We can conduct presentations for your employees or just be available for a question and answer session. Materials can also be provided upon request.

Regardless of how your company decides to communicate open enrollment information, GlobalHealth is available to help you and your employees. It is important that your employees have the opportunity to make an informed decision.

Minimum Participation

At least 70% of employees eligible to participate through a small group must choose to participate. GlobalHealth uses the Small Business Health Options Program (SHOP) Marketplace calculator to determine minimum participation. It is available on the HealthCare.gov website - https://www.healthcare.gov/shop-calculators-fte/

The requirement is waived each year from November 15 through December 15.

Large groups must have at least 80% of employees eligible to participate choose to do so unless the employee is enrolled in minimum essential coverage through another source.

New Hires

Eligible new hires may enroll themselves and their eligible dependents within thirty (30) days of the hire date according to the provisions of your *Group Agreement*. Coverage begins on the first day of the month following any waiting period your plan may have. The waiting period should be no longer than 60 days. If participating, the employee's and dependent's coverage must begin within 90 days.

Qualifying Life Events

Employees and their eligible dependents may enroll outside of the open enrollment period under special circumstances. These situations are called "Qualifying Life Events". Enrollment

is effective the first day of the calendar month after GlobalHealth receives a completed *Membership Enrollment Form*.

Qualifying Life Events	Member Requirements
• Legal Marital Status Changes: ➢ Marriage ➢ Divorce, legal separation or annulment ➢ Death of spouse • Number of Eligible Children Changes: ➢ Birth or adoption of a child ➢ Child gains or loses eligibility • Death • Court order to provide coverage • Other Coverage No Longer Available: ➢ A person through whom the employee or eligible dependent was covered loses coverage. ➢ The employer stopped contributing toward the employee or eligible dependent's coverage. ➢ COBRA is exhausted under another group health plan.	The subscriber should complete and submit the *Membership Enrollment Form* to GlobalHealth within thirty-one (31) days of the event. To elect coverage due to loss of other coverage, the eligible employee must: • Have declined coverage in writing when first eligible because you had other coverage; • Provide proof of loss of the other coverage; and • Request enrollment with GlobalHealth no later than thirty-one (31) days following the termination of the other group health plan coverage.

Changes to Enrollment

It is the member's responsibility to notify GlobalHealth of any changes that affect eligibility for services and benefits, as defined by your *Group Agreement*. The subscriber will need to complete a new *Membership Enrollment Form*, and submit it to Enrollment and Eligibility. Any changes that need to be made to the member's information should be made as soon as possible.

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

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

Note that the subscriber's signature is required for changes to be made. Your employee, as the subscriber, should complete the *Membership Enrollment Form*.

Enrollment Forms

Form	Reason to Use	When to Use
Membership Enrollment Form	• New enrollment • Making changes to enrollment	• Open enrollment period • New hire enrollment period • Change to enrollment
Declining Insurance Form	• When eligible employee currently has other health coverage and chooses to decline GlobalHealth coverage.*	• Open enrollment period • New hire enrollment period
Transition of Care Form	• Current health condition • Continuation of care from previous coverage	• Open enrollment period • New hire enrollment period • Change to enrollment
Rx Transition of Care Form	• Current prescribed medication • Continuation of care from previous coverage	• Open enrollment period • New hire enrollment period • Change to enrollment
Common Law Affidavit	• Common law marriage	• Open enrollment period • New hire enrollment period • Change to enrollment
Ethnicity & National Heritage Form	• Optional form	• Open enrollment period • New hire enrollment period

*Eligible employees must submit *Declining Insurance Form* in order to enroll later due to loss of other coverage.

Send them to:
GlobalHealth
Attn: Enrollment and Eligibility
PO Box 2328
Oklahoma City, OK 73101-2328

The employee must complete the enrollment forms. GlobalHealth cannot accept enrollment forms that are altered in any way. Please do not erase, cross out, white out, or write over on the form(s). Supplies can be requested by calling Customer Care.

Please review all forms for accuracy and verify that they are filled out completely before submitting to Enrollment and Eligibility.

Keep copies for your records. Members may also use a copy of the *Membership Enrollment Form* as a temporary ID card until they receive a permanent one. Member ID cards are usually mailed within 7 – 10 calendar days of the date we receive the enrollment form.

SECTION 3 – Eligibility

Group Agreement

Upon enrollment, we will forward the *Group Agreement* to you for signature.

The *Group Agreement* specifies your:

- Coverage effective date;
- Benefit package;
- Eligibility;
- Premium payment; and
- Agreement termination.

At your annual renewal time, we will send you a new agreement containing renewal rates. Please file it with your original *Group Agreement*.

Changes in Ownership

You must notify us in writing about any changes in the company's ownership within (thirty) 30 days.

Coverage Eligibility

GlobalHealth is available for selection during annual open enrollment and following specific qualifying life events listed in Section 2.

Your employees are eligible to enroll with GlobalHealth if he/she lives or works in the GlobalHealth service area. A person cannot be covered both as an employee and as a dependent. In addition, no person shall be covered as a dependent of more than one employee. GlobalHealth allows the following dependents:

- Lawful spouse
- Natural, step, legally adopted, foster child(ren) to age 26
- Disabled dependent child(ren) past the age of 26

As the plan administrator, you may define other eligibility requirements as long as they comply with state and federal law. For example, you determine the waiting period and minimum hours worked per week.

Your employees' spouses and children are eligible to enroll with GlobalHealth as dependents if they meet your eligibility requirements.

Service Area

GlobalHealth provides a service area that includes all counties in Oklahoma.

Adair	**Cotton**	**Jackson**	**McCurtain**	**Roger Mills**
Alfalfa	**Craig**	**Jefferson**	**Murray**	**Rogers**
Atoka	**Creek**	**Johnston**	**Muskogee**	**Seminole**
Beaver	**Custer**	**Kay**	**Noble**	**Sequoyah**
Beckham	**Delaware**	**Kingfisher**	**Nowata**	**Stephens**
Blaine	**Dewey**	**Kiowa**	**Okfuskee**	**Texas**
Bryan	**Ellis**	**Latimer**	**Oklahoma**	**Tillman**
Caddo	**Garfield**	**Le Flore**	**Okmulgee**	**Tulsa**
Canadian	**Garvin**	**Lincoln**	**Osage**	**Wagoner**
Carter	**Grady**	**Logan**	**Ottawa**	**Washita**
Cherokee	**Grant**	**Love**	**Pawnee**	**Washington**
Choctaw	**Greer**	**Major**	**Payne**	**Woods**
Cimarron	**Harmon**	**Marshall**	**Pittsburg**	**Woodward**
Cleveland	**Harper**	**Mayes**	**Pontotoc**	
Coal	**Haskell**	**McClain**	**Pottawatomie**	
Comanche	**Hughes**	**McIntosh**	**Pushmataha**	

Employees and spouses must reside in or work at a location in the GlobalHealth service area in order to select GlobalHealth. Members permanently moving out of the service area should notify you, the plan administrator. It is important that the member understand that it is in their best interest to enroll in a plan that has a network of facilities and providers in his/her new area.

You should respond to any specific questions concerning eligibility for your group.

When Coverage Begins

When Enrolled	Effective Date
Open enrollment period	Employees and their enrolled dependents are covered as of 12:01 am on the effective date of your *Group Agreement*.
New hire	New hires and their enrolled dependents are covered as of 12:01 am on the first day of the month following the waiting period. You determine the length of the waiting period, subject to state and federal law.
Qualifying life event	Employees and their enrolled dependents are covered as of 12:01 am on the first day of the month following submission of the completed enrollment forms.

When Coverage Ends

Event	Expiration Date
Your *Group Agreement* terminates.	Ends on the expiration date stated in the *Group Agreement*, unless otherwise provided.
You fail to pay premium.	Ends on the last day of the month of your grace period.

Event	Expiration Date
A dependent becomes ineligible.	Ends on the last day of the month.
An employee is terminated.	Ends on the last day of the month for which payment was made.
An employee is no longer eligible through your group plan.	Ends on the last day of the month for which payment was made.
Fraud is committed, such as presenting false information or permitting another person to use a GlobalHealth member ID card.	Ends immediately.
A member receives notice of disenrollment.	Ends on the first day of the month. The member first receives a notice of violation.
A Member permanently moves outside GlobalHealth's service area.	Ends on the last day of the month in which the member enrolls in another plan in his/her new service area.
The employee's death.	Subscriber coverage ends on the date of death. Dependent coverage ends on the last day of the month in which the subscriber's death occurred.

Coverage stops automatically when a member is no longer eligible.

A member is not eligible for continuation of coverage if coverage is terminated because of nonpayment, intentional misuse of a member ID card, or detrimental conduct. (See COBRA in Section 9.)

In all cases, if a dependent's coverage is terminated, it does not affect the coverage of other family members. If the employee's coverage stops, the membership of all dependents stops as well.

If you are not subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), a member may continue coverage for 63 days beyond these timeframes if coverage is ending due to a reason other than group health plan termination or termination due to gross misconduct. Premium payments must still be paid.

Member is in the Hospital When Coverage Ends

Coverage ends on the termination date of the *Group Agreement*. This applies whether termination of the *Group Agreement* is by you or by GlobalHealth.

If coverage is ending due to termination of the *Group Agreement* by GlobalHealth, coverage will continue through discharge from the hospital or expiration of benefits according to your *Group Agreement*. Women giving birth will be covered through delivery and discharge.

If coverage is ending due to nonpayment, intentional misuse of the member ID card, or gross misconduct, continuation of coverage is not available.

GlobalHealth Member ID Card

Each subscriber receives a member ID card at the beginning of the plan year. This card is key to receiving healthcare benefits. It is important that members carry it with them at all times.

A member should always identify him/herself as a GlobalHealth member when making an appointment, and show the member ID card whenever receiving medical care.

Members should review their member ID cards to make sure all of the information is correct, including the name of the selected PCP. Call GlobalHealth's Customer Care if a correction is needed or to request a new card.

Contract Renewal

Each year, GlobalHealth will send you, the plan administrator, a letter illustrating the changes to your current Plan(s) along with renewal premium rates for other eligible GlobalHealth Plans(s). New premium rates are based on your group's current enrollment with GlobalHealth. You should receive the packet about sixty (60) days prior to the policy anniversary.

Small groups will automatically be quoted plans with embedded pediatric dental. If you have dental coverage available to all of your employees and their dependents through another source, please provide a statement including the name of the carrier and policy number.

This is the time to review your current plan. You may request to:

- Change waiting periods and eligibility requirements (subject to federal and state laws);
- Change benefit designs, including copayments; or
- Increase or decrease deductibles.

A sales representative will help you get the plan design that works for you and your employees. He/she will communicate your changes to GlobalHealth. Please note that these changes may increase or decrease your premium.

GlobalHealth will mail you a new *Group Agreement* when the renewal plan design is received. Your current plan stays in effect until the renewal date. All changes will become effective as of the renewal date.

No revisions will be processed after the renewal date. We will renew the current or most similar plan design if we do not hear from you by the deadline stated in the renewal letter. Your first bill for the renewal period will reflect the new rates as indicated in the renewal letter.

All premiums due for the period before the renewal date must be paid in full to renew with GlobalHealth.

Employees will need to complete a new form. Those wishing to participate will complete the *Membership Enrollment Form*. Those who do not wish to participate will complete the *Declining Coverage Form*.

SECTION 4 – Member Materials

Comprehensive Member Handbook

GlobalHealth's Comprehensive *Member Handbook* includes the *Member Handbook, Physician & Health Providers Directory,* and *Drug Formulary for Small Groups and Large Groups*. Together, these publications help familiarize you and your employees with your healthcare benefits.

Booklet	Purpose
Member Handbook	Explains what is covered or not covered and how much each service costs the member. It also explains how to access benefits for medical, preventive care, prescription, mental health, and chemical dependency.
Physician & Health Providers Directory ("Provider Directory")	Network provider lists include: • Hospitals • Behavioral health providers • PCPs • Pharmacies • Specialists • Urgent care facilities
Drug Formulary for Small Groups and Large Groups ("Drug Formulary")	Provides drug lists, alphabetically and by use.

You and your employees can access electronic versions of these materials at www.GlobalHealth.com/commercial. You will need your group number to access. You or your employees may request printed copies by contacting Customer Care.

After reading these documents, assistance may still be needed. Please contact our Customer Care Department.

You may also logon to www.GlobalHealth.com/commercial for additional information on healthcare topics or benefit coverage.

SECTION 5 – Physician Access

Helping Your Employees Choose a Primary Care Physician (PCP)

GlobalHealth members must use network providers to access covered services. This starts with members choosing a PCP from the list of physicians in the *Physician & Health Providers Directory*. A complete and current list is available on our website. At GlobalHealth, PCPs are made up of network physicians, including:

- Family practitioners;
- General practitioners;
- Internal medicine physicians; and
- Pediatricians.

To select a PCP, members complete the primary care physician section of the *Membership Enrollment Form*. Each family member may choose the same PCP, or may have different PCPs. Members may designate a pediatrician for children. We will assign a PCP for any member who does not choose one.

Changing PCPs

Members can change PCPs at any time. A member may make a change request by calling Customer Care, submitting a written request to Customer Care, or online at www.GlobalHealth.com/pcp_change.aspx. The change will be effective immediately. Call Customer Care if the member needs to be seen before the new member ID card arrives in the mail.

We recommend not changing PCPs if the change could have an adverse effect on the quality of healthcare. For example, members who are:

- Organ transplant candidates;
- Receiving active medical care for an unstable, acute condition; or
- In the third trimester of pregnancy.

If a PCP leaves GlobalHealth's Provider Network

We will let members know within thirty (30) days when a PCP leaves our network. Each member may choose a different PCP. Follow the steps outlined in "Changing PCPs" above.

We will mail a new member ID card with the new PCP's information.

Nominating a Physician

You may nominate a physician/specialist to add to GlobalHealth's network by completing the *Provider Nomination Form* on GlobalHealth's website. This is not a guarantee that they will be contracted.

Referrals

GlobalHealth must preauthorize almost all inpatient and outpatient services at a network facility or with a network physician. Preauthorizations are not needed for:

- Primary care physician visits;

- Emergency room care;
- After-hours urgent care;
- Services from in-network obstetricians and gynecologists;
- In-network optometrists and eye wear providers;
- In-network audiologists;
- In-network routine mammograms;
- In-network physical therapy evaluations;
- Dental care (if you chose a plan with pediatric dental); and
- Behavioral and mental health/chemical dependency services.

For more information about these services, see the *Member Handbook*.

Only the member's PCP of record can request a referral to a participating specialist, hospital, or ancillary provider. Also, participating specialists can request referrals for services and procedures. All services must be medically necessary.

Members must receive authorization from GlobalHealth to receive services or supplies from an out-of-network provider before going.

GlobalHealth mails a letter of authorization to the member when approved. Members may only go to the specialist or facility listed in the letter. Members are responsible for services obtained without an authorized referral.

GlobalHealth must give prior authorization for a member to receive services or supplies that are not covered benefits listed in the *Member Handbook*. Even if services are for covered benefits, GlobalHealth must give authorization for a member to receive services or supplies from an out-of-network provider before scheduling an appointment.

Be sure to make an appointment after receiving authorization.

Call Customer Care with any questions. Access MYGLOBAL™ MEMBER PORTAL at https://www.globalhealth.com/myglobal/login/ to check the status of any outstanding referrals.

SECTION 6 – Quality and Health Programs

Quality Improvement Program

GlobalHealth's priority is to provide quality healthcare for the preservation of good health. We expect to meet or exceed national and community standards in providing plan benefit coverage.

GlobalHealth develops and implements an annual Quality Improvement Program (QIP) to ensure we meet these expectations. The QIP includes procedures to objectively monitor and evaluate healthcare delivery systems. The QIP also assesses group health plan management activities.

A statement of *Member Rights and Responsibilities* is available to Members and Providers. The current *Member Rights and Responsibilities* can be found in the *Member Handbook* or on the GlobalHealth website. You can also contact Customer Care for a copy.

GlobalHealth conducts the Consumer Assessment of Healthcare Providers and Systems ([1]CAHPS) survey each year. The survey is sent to Members' homes with instructions to complete and return. The survey responses identify areas that need improvement. It also determines our ranking among regional and national healthcare plans.

Members may request information about the QIP by calling Customer Care.

[1]CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Special Programs

GlobalHealth offers several programs to address rising healthcare costs and promote a healthy lifestyle to keep your employees healthy. More information, including how to enroll, can be found in the *Member Handbook*.

We have several programs that can help you get the right care for you including:

- **Proactive Outreach**
  The Proactive Outreach Program offers you two types of support:
  1. **Discharge Outreach**
     Provides support if you have recently experienced a transition of care. The Discharge team works with you to support and reinforce treatment plans to prevent readmission and unnecessary ER visits.
  2. **Case Management**
     Consists of what is traditionally known as Complex Case Management and Disease Management. The goal is to promote quality, cost-effective health outcomes. Our case manager works with you, your doctors, and/or BHP to:
     - Remove social, cultural and economic barriers;
     - Create a health management plan;
     - Coordinate care;
     - Help you understand disease risk factors, signs and symptoms, and treatment options; and
     - Contact you regularly to monitor, follow-up and answer your questions.

- **National 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.

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.

- **Medication Therapy Management Program**

If you are taking multiple drugs, our pharmacists and staff can support you with personalized service. Our team will review your drugs to help make sure that you are getting safe and appropriate care, and these reviews are especially important if you have more than one Provider who prescribes drugs for you.

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 possible, and we want to help you along the way. You will have your own case manager who 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.

Health & Wellness Resources

GlobalHealth has several self-management tools, calculators, and information on our website. They are designed to enhance the quality of life and health. Sections include:

- Maintain Your Health – contains information about healthy eating, exercise, and preventive care;
- Improve Your Health – contains tools to quit smoking or drinking, managing stress, and medication/treatment adherence information;
- Managing Long-Term Conditions – contains medical management information; and
- Tools/Calculators – contains links to body mass index and other health calculators.

GlobalHealth sends members an annual health appraisal requesting information on their current health status. The information submitted on the health appraisal will not be used against the member in any way or prevent him/her from obtaining services and treatment. This information allows us to determine how to best serve a member's specific healthcare needs. The more information provided, the better we can tailor our services.

Utilization Management

GlobalHealth has a Utilization Management (UM) team to assist members in receiving the appropriate healthcare and maximizing coverage for those healthcare services. Utilization decisions are based on sound clinical evidence, taking into account individual circumstances. Members or their doctors may call the UM staff to discuss specific cases and decisions.

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

Members should contact their primary care physician to discuss these and other enhanced programs.

Pharmacy Management
Staff pharmacists are available to help members with:

- Finding less expensive alternatives to discuss with the physician;
- Ensuring the member understands potential drug interactions; and
- Compliance to the prescribed regimen.

SECTION 7 – Claims Payment

Claims

Medical Services

Services provided by the PCP are billed directly to GlobalHealth. However, a member might receive a bill if urgent or emergency care is received outside of GlobalHealth's service area.

Call Customer Care for directions on how to handle bills sent directly to the member. Send any bill for services already paid for and proof of payment for reimbursement to GlobalHealth within 120 days from the date of service. Balance billing may occur when the member visits an out-of-network provider. However, balance billing the member may not occur when seeing an in-network provider.

The service must be covered under your *Group Agreement* and authorized by GlobalHealth to be paid.

Contact Customer Care or access MYGLOBAL™ MEMBER PORTAL at https://www.globalhealth.com/myglobal/login/ to check a claim's status. If a claim is denied, GlobalHealth will reconsider the claim upon written request for appeal. See Grievance and Appeal Process in Section 10.

Mental/Behavioral Health/Substance Abuse

Services provided by network providers will be billed directly to us. However, if a member receives urgent or emergent care out of our service area, he/she might receive a bill from those providers.

If a member receives a bill for care that is covered under the benefit plan, he/she should send the bill to:

Beacon Health Options
PO Box 1850
Hicksville, NY 11802-1850

Prescription Drugs

Medications filled at a network pharmacy will usually be billed directly to Magellan Rx Management. However, if a prescription is filled without a member ID card, he/she may be required to pay the pharmacy. If this happens, call Magellan Rx Management, LLC at 1-800-424-1789 (toll-free) or 711 (TTY).

Dental (If you chose a Plan with pediatric dental)

Services provided by network providers will be billed directly to Careington. However, if treatment is received from a dentist who has not entered into an agreement with Careington, the member is responsible for paying the dentist.

Coordination of Benefits

The member is responsible for notifying GlobalHealth of any other health coverage. The member must fill out the Coordination of Benefits form and send back to Customer Care.

Health benefits provided by GlobalHealth are subject to the Coordination of Benefits (COB) provision. We apply COB rules in accordance with the National Association of Insurance Commissioners' (NAIC) guidelines and applicable state laws.

COB Order of Benefit (Primary/Secondary)	Determination Rules
Only one plan has COB provisions	• Generally, the plan without a COB provision is primary over the plan with a COB provision.
Both plans have COB provisions	• If both plans have a COB provision, the plan covering the member as a subscriber is primary over the plan covering the member as a dependent.
Both plans have COB provisions - dependent child - parents not separated or divorced	• The plan of the parent with a birthday earlier in the calendar year, regardless of the year of birth, is primary. This is referred to as the "Birthday Rule". • If one 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 is primary over the plan of the parent without custody. • A dependent child whose parents are divorced, and the parent with custody has remarried - the plan of the parent with custody is primary over the plan of the stepparent. The plan of the stepparent (in this case, secondary) assumes responsibility before the plan of the parent without custody of the dependent (in this case, tertiary). • A dependent child whose parents are separated or divorced and a court decree establishes financial responsibility for healthcare expenses - the plan of the parent with such financial responsibility is primary.

Effective Date Active/Retiree Status

There may be times when the above rules do not establish an order of benefit determination.

- The plan covering the member for the longer period of time is primary over the plan with the shorter period of coverage.
- A plan covering an active employee or his/her dependents is primary over a laid-off or retired employee or his/her dependent's plan.

Medicare Eligibility
Medicare always makes the final determination as to whether they are primary payor. It is critical that we are notified if an employee or dependent has Medicare coverage so we can administer these requirements correctly.

Even when GlobalHealth is the secondary payer, GlobalHealth must authorize services in order for the claim to be paid. Some cost-sharing may still apply.

Pharmacy Coordination of Benefits
If an employee is covered by more than one healthcare Plan, we will coordinate his/her prescription benefits. He/she will need to give both Prescription Drug cards to the pharmacy staff and tell them which is primary. The pharmacy staff will enter the information for both the primary and secondary coverage. The primary coverage will apply to his/her Cost-Share. Then the secondary coverage will be billed the remaining Cost-Share.

Third Party Liability

If an Employee is Injured on the Job
GlobalHealth benefits are not designed to duplicate any benefits received under Workers' Compensation law.

Subrogation, Third-Party Recovery, and Reimbursement
In some instances, a Member may incur medical or other charges related to injuries or illnesses caused by the act or omission of another person. The other person may be liable or legally responsible for payment of charges incurred in connection with such injuries or illnesses.

You may print additional copies of the *Subrogation, Third-Party Recovery, and Reimbursement* document from the GlobalHealth website, www.GlobalHealth.com/commercial, or you may request a copy from Customer Care.

Claim Payment
In any case, the Member must notify GlobalHealth. When another third party liability payer is primary, GlobalHealth network and authorization rules still apply.

GlobalHealth may deny coverage:

- 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.
  - The care is not covered according to this *Member Handbook*.
  - 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.

SECTION 8 – Premium Billing

Monthly Billing

You will receive a monthly premium bill from GlobalHealth on or around the 20th of the month. This bill is for the following month's coverage. Payment is due by the date indicated on the statement. GlobalHealth may terminate coverage for any group that does not remit full payment by the last day of the month on which payment is due. Please see your *Group Agreement* for your group's specific grace period.

GlobalHealth makes adjustments to each month's bill based on the eligibility information you have forwarded to the Enrollment and Eligibility department. It is not necessary for you to make manual adjustments to the bill if GlobalHealth receives all information prior to the monthly billing cutoff.

To ensure that your monthly bill is accurate and simple to reconcile, please follow these guidelines:

- Immediately forward all completed forms to the GlobalHealth Enrollment and Eligibility department. Please keep a copy of all forms for your files.
- Each month, compare the current activity and retroactivity appearing on the bill with copies of the forms you sent to GlobalHealth. Changes received prior to the cutoff date appear as appropriate credits or retroactive charges. Changes received after the billing cycle has closed appear on the following month's premium bill.
- Each month's payment should include:
  - A copy of your billing statement for each premium bill; and
  - A check, made payable to GlobalHealth, Inc. for the total amount due for each premium bill payable.
- Contact Enrollment and Eligibility:
  - If a change you forwarded to GlobalHealth does not appear on the premium billing for two consecutive billing cycles.
  - You will be responsible for premium payments for any employees or dependents when you do not notify us in writing before the third consecutive billing cycle.
- Contact Billing:
  - If you have any questions regarding your premium bill.

Billing Address

GlobalHealth, Inc.
Section 4140
P.O. Box 26706
Oklahoma City, OK 73126-0706

Returned Check Fee

If the group's premium payments are returned for insufficient funds, you will pay GlobalHealth a returned check fee of fifty dollars ($50) for each returned check. GlobalHealth will include any return check fees on the next regular invoice.

SECTION 9 – Law

Federal Law

GlobalHealth complies with all federal and state laws. Following are a few of the laws that could apply to your group and GlobalHealth. Some of these regulations may not apply to your employer group. Please check with your Human Resources Department or Legal Counsel to determine whether or not you are subject to any of the regulations below. Refer to your Legal Counsel for specific guidance for carrying out your responsibilities.

Law	What it is	GlobalHealth Responsibilities	Employer Responsibilities
Employee Retirement Income Security Act of 1974 (ERISA)	ERISA applies to your group coverage unless it is specifically exempt by law from the provisions of ERISA.	We distribute notices to members: • Special enrollment notice • Newborns' Act disclosure • Women's Health & Cancer Rights Act notice	You are responsible for ensuring that the plan complies with provisions of ERISA. You are also responsible for informing employees of their respective ERISA rights and protections under the plan. ERISA provides that all plan participants are entitled to: • Receive information about the plan • Continue group health plan coverage • Prudent actions by plan fiduciaries • Enforce their rights • Assistance with questions
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	COBRA requires employers, with 20 full time employees or more, to allow employees and their eligible dependents to continue enrollment in	We do not administer COBRA on behalf of the employer group.	We reinstate the member on your monthly premium billing statement once we are notified. You are responsible for notifying members of

Law	What it is	GlobalHealth Responsibilities	Employer Responsibilities
	their employer-sponsored health plan past the date they would normally have terminated coverage in certain circumstances.		their COBRA rights and the collection of monthly premiums. You are required to notify GlobalHealth of COBRA elections by: • Completing and forwarding the Request for Continuation of Coverage form if a qualified employee elects coverage within the specified time frame and has paid the required premium. • Notify GlobalHealth immediately if a member ceases to be eligible for COBRA continuation coverage.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	HIPAA is legislation enacted by the federal government to streamline the healthcare industry. It provides additional rights and protections to health plan participants.	Please refer to our *Notice of Privacy Practices* (Privacy Notice).	There are two employer components – the group health plan and the plan sponsor. HIPAA regulations may vary for your company depending on which component wishes to receive PHI, and how much information each component needs.
Family Medical Leave Act of 1993 (FMLA)	FMLA entitles eligible employees to 12 weeks of job-protected, unpaid leave during any 12-month period for specific reasons.	We do not administer FMLA on behalf of the employer group.	You are required to maintain coverage under a group health plan for the duration of the leave as if the employee were continuously employed.

Law	What it is	GlobalHealth Responsibilities	Employer Responsibilities
	It also requires that employee's group health benefits be maintained during the leave.		Coverage is paid for just as it was when the employee was active. This also includes coverage for the employee's eligible dependents. You should consult legal counsel to determine any reimbursement rights that you may have.
Gramm-Leach-Bliley Act of 1999 (GLBA)	The GLBA is a law affecting institutions that deal with financial information which includes nonpublic personal information. This may include: • Addresses • Phone numbers • Bank and credit card account numbers • Income and credit histories • Social Security numbers The GLBA includes requirements to protect the security, integrity, and confidentiality of this consumer information.	We develop, implement, and enforce an information security program. It includes administrative, technical, and physical safeguards. We are responsible for taking steps to ensure that our affiliates and service providers safeguard member information in their care.	

SECTION 10 – Grievances and Appeals

Grievance and Appeal Process

Complaints and Grievances

Members may file a complaint by calling Customer Care.

A Grievance is a formal complaint made in writing. It may concern any aspect of the Plan operations, policies, procedures, quality of care, level of service, or other issue.

Appeals

Any member dissatisfied with an adverse determination (or denial) has the right to request an appeal of that determination. The appeal must be submitted in writing and within 180 days of the adverse determination.

Expedited Appeal

Members may request an expedited review if an emergency exists and the normal time frame would jeopardize his/her life or health.

Call Customer Care:
(405) 280-2964 (local)
1-877-280-2964 (toll-free)
711 (TTY)

Submit written grievances or appeals to:
GlobalHealth, Inc.
ATTN: Appeals and Grievances
PO Box 2393
Oklahoma City, OK 73101-2393

E-mail:
appeals@globalhealth.com

External Review

To request an external review, call the Oklahoma Insurance Department or visit the website at https://www.ok.gov/oid/Consumers/External_Review_Process/ before sending any paperwork to receive instructions on the quickest way to submit the request and supporting information.

The request for external review must be submitted in writing within four (4) months of the final adverse determination to:

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

Website: www.ok.gov/oid
Telephone: 1-800-522-0071
405-521-2828

Expedited External Review
Requests for expedited external review are submitted to the Oklahoma Insurance Department. (See external review above.)

Forms
Appeal forms are available by contacting Customer Care.

Form	What it is	When to use it	Required?
Member's Appeals Rights	Notifies member of appeals rights and the steps to filing an appeal or grievance.	When a member is considering or initiating an appeal or grievance.	Yes, if requesting an appeal or grievance.*
Appeal Request Form	Requests adverse determination review.	Used when GlobalHealth is to re-evaluate a claim or grievance decision.	No, as long as all information is provided in a written request.
Appointment of Authorized Representative	Authorizes another person to act on behalf of the member in the appeal process.	Used when someone else is representing the member in the appeal.	Yes, when another person will be representing the member in the appeal process.
Certification of Treating Healthcare Provider for Expedited Consideration of a Patient's External Review Appeal	Indicates the requested healthcare service or treatment would be significantly less effective if delayed.	Used when the Oklahoma Insurance Commissioner reviews the appeal and an emergency exists where the regular appeal time frame would jeopardize life or health.	Yes, if requesting an external review and a health emergency exists.
What to Send and Where to Send it	Tells the member what information is required for external review.	Used when the Oklahoma Insurance Commissioner reviews the appeal.	Yes, if requesting an external review.

Form	What it is	When to use it	Required?
Healthcare Service or Treatment Decision in Dispute	Allows the member to explain why he/she is requesting an external review.	Used when the Oklahoma Insurance Commissioner reviews the appeal.	Yes, if requesting an external review.
External Review Request Form	Supplies information to the Oklahoma Insurance Department.	Used when the Oklahoma Insurance Commissioner reviews the appeal.	Yes, if requesting an external review.
Physician Certification – Experimental/Investigational Denials	Certifies that the member needs treatment previously denied due to experimental or investigational status.	Used when the denial was due to experimental or investigational treatment.	Yes, if requesting an external review and the treatment was denied due to being experimental or investigational.

* For appeals or grievances in regards to dental services contact Careington BenefitSolutions.

Questions
Questions concerning appeal rights or requests for more information concerning a denied item or service should be directed to Customer Care. If a member or his/her physician would like to speak with our Medical Director or a healthcare professional from our Utilization Management Department, he/she may call GlobalHealth Customer Care at 1-877-280-2964 or (405) 280-2964 and request a call back. TTY users should call 711.

For more details on the appeals and grievances process, see your *Member Handbook*.

SECTION 11 – FAQs

FAQs Your Employees May Ask

Your employees may ask you questions regarding GlobalHealth's plan. Here are some common questions and answers.

Topic	Question	Answer
Chiropractic	Does the plan cover chiropractor visits?	Yes, to in-network chiropractors. Referrals are required by member's PCP.
Diabetic Supplies	Are my diabetic supplies covered?	Yes.
Dependent Coverage	If I enroll in GlobalHealth, is my child who lives in another state covered?	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.
	What about dependents over 18 years of age?	We cover eligible children up to the age 26.
Emergencies and Urgent Care	When I go to the emergency room, is my copay waived if I am then admitted to the hospital?	Yes, if you chose a copayment plan. Coinsurance is not waived.
	What if I get sick when I am out of the service area? Am I still covered?	Yes, an emergency and urgent care are covered. In a true medical emergency, go immediately to the nearest hospital for care. Call the PCP within 48 hours of receiving the care. When same-day urgent care is needed, self-refer to an urgent care facility.
	What if I need to see a doctor on the weekend/I become sick after hours?	Call the PCP who gives direction. Or self-refer to an in-network urgent care center.
Hearing	Does the plan cover hearing aids?	Yes.
Hospital Admission	Does my hospital copay cover doctor visits to the hospital?	Yes.
	Does the plan cover private	Only when medically necessary.

Topic	Question	Answer
	rooms in the hospital?	
	What hospitals are in your network?	They are listed in the *Provider Directory* and on the website: www.GlobalHealth.com/commercial.
Mental Health	Does the plan cover mental health services?	Yes. Members do not have to go through their PCPs. Please be sure to ask for and sign a release with the mental health provider or facility to ensure coordination of care between behavioral health services and PCP. It is important that the PCP is aware of services that have been received and medication prescribed.
	How can I find out who the providers are?	There is a listing in the *Provider Directory* and on our website.
Minimum Essential Coverage	Does this coverage provide minimum essential coverage?	The Affordable Care Act requires most people to have health coverage that qualifies as "minimum essential coverage". This plan does provide minimum essential coverage.
Minimum Value Standard	Does this coverage meet the minimum value standard?	The Affordable Care Act establishes a minimum value standard of benefits of a group health plan. The minimum value standard is 60% (actuarial value). This group health plan does meet the minimum value standard for the benefits it provides.
Network	How can I find out if my specialist is in the network?	Refer to the *Provider Directory* or visit our website www.GlobalHealth.com/commercial.
PCP	Do I have to choose one of the network doctors?	Yes. Members choose a PCP at Enrollment. Each family member may choose a different PCP, including a pediatrician for children. *Provider Directories* are available and you may also go to our website, www.GlobalHealth.com/commercial, Provider Search.
	Can I change my PCP or am I stuck with them all year?	Yes, members may change PCPs at any time throughout the year, and the change is effective immediately. Changes may be made on our website or by calling Customer Care.
Pre-existing	Does the plan accept pre-	Yes, HMO's do not discriminate

Topic	Question	Answer
	existing conditions?	against pre-existing conditions.
Prescriptions	Are dental prescriptions covered?	Yes.
	What is a Drug Formulary?	The *Drug Formulary* is a list of drugs most commonly prescribed and approved by GlobalHealth. It is a preferred list. Due to the development of the *Drug Formulary* being an ongoing process, this list is subject to change.
	Does the plan have mail order?	Yes, through Magellan Rx Management. A discount may be available for using home delivery rather than a retail pharmacy.
	Where can I get my prescriptions filled?	We have over 800 participating pharmacies across the state of Oklahoma. Magellan Rx Management has a nation-wide network that you can access.
Preventive Care	Is preventive care covered?	GlobalHealth covers all preventive services covered under the Affordable Care Act at no cost-sharing for the member when delivered by a network provider. Call Customer Care for a current list of services.
Referrals	Do I need a referral to see a specialist?	Yes. The member's PCP is responsible to manage all care. He/she processes a referral on the member's behalf to a specialist within our network when needed. All procedures must also receive prior authorization.
Weight Loss and Cosmetic Surgery	Does the plan cover gastric bypass or surgery for obesity?	Yes, subject to prerequisites outlined in the *Member Handbook*.
	Does the plan cover cosmetic surgery?	Only in specific limited circumstances.
Worldwide Coverage	Am I covered worldwide?	No.

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	Director of Compliance and Legal Services 701 NE 10th St, Ste. 300 Oklahoma City, OK 73104-5403
Toll Free	1-877-280-5852
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.

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 1-877-280-5600 (هاتف الصم والبكم برقم 711). اتصل.
Burmese	သတိပြုရန် - အကယ့်၍ သင့်သည်ျမန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-877-280-5600 (TTY: 711) သို့ ခေၚဆိုပါ။
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, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. 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 1-877-280-5600 (TTY: 711) کریں کال ۔
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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