State of Oklahoma

MEMBER HANDBOOK

January 1 - December 31, 2026

For State, Education, and Local Government Employees 1-877-280-5600 www.GlobalHealth.com



GlobalHealth, Inc. 210 Park Avenue, Suite 2900 Oklahoma City, OK 73102-5621

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 <u>Plan</u>, we want to:

- 1. Help you <u>achieve positive health outcomes</u>. 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 dedicated, local Customer Care team if you have any questions at 1-877-280-5600 or visit www.GlobalHealth.com for more information on your Plan.

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

Notice of Electronic Delivery of Documents Consent

You have the right to receive documents electronically. If you wish to receive documents electronically, contact Customer Care at 1-877-280-5600 (TTY: 711).

You must register for the GlobalHealth <u>Member Portal</u> and consent to receiving notices and documents electronically. This consent would apply to:

Notices such as prior authorization determination notices.

Publicly available documents and notices are posted at www.GlobalHealth.com include: Member materials such as the Member Handbook, Drug Formulary, Pharmacy Directory, Provider Directory, and Summary of Benefits and Coverage.

You have the right to have any notice or document delivered in paper form at no cost.

You may update your e-mail address at any time. Contact Customer Care.

Withdrawing Consent

You have the right to withdraw your consent at any time at no cost. Contact Customer Care.

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.

GlobalHealth, Inc. will provide your employer, to deliver to you, an individual certificate that summarizes essential features of your insurance coverage and to whom benefits are payable. If your dependents or family members are included in the coverage, additional certificates may not be issued for them.

Additional employees or <u>Dependents</u> may be added to the group in accordance with the terms in this *Member Handbook*.

In the absence of <u>Fraud</u>, all statements made by your employer or you shall be deemed representations and not warranties. No statement made in obtaining your insurance will reduce your benefits unless they are made in writing and signed by your employer or you, and a copy has been furnished to you, your employer, or your beneficiary.

Beginning on your effective date, we agree to provide you the benefits described. You can find the effective date on your <u>Member</u> 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 officer. Any such amendment must be attached to this Certificate of Coverage.

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any <u>Claim</u> 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 <u>Plan</u>.

HELPFUL NUMBERS

Plan Issuer:

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

GlobalHealth Customer Care and Language Assistance:

1-877-280-5600 (toll-free) 711 (TTY) Mon – Fri, 9 a.m. – 5 p.m.

Appeals and Grievances:

GlobalHealth, Appeals and Grievances PO Box 2393 Oklahoma City, OK 73101-2393

Hearing Aid Benefits:

NationsHearing 1-877-241-4736 (toll-free)

24/7 Nurse Help Line:

CareNet 1-800-554-9371 (toll-free) 711 (TTY)

24/7 GlobalHealth Compliance Recorded Hotline:

1-877-627-0004 (toll-free) <u>compliance@globalhealth.com</u> <u>privacy@globalhealth.com</u>

Behavioral Health/Telehealth:

Carelon Behavioral Health 1-888-434-9204 (Monday – Friday, 7 am – 5 pm Central) 711 (TTY)

Behavioral Health Appeals and Grievances: Carelon Behavioral Health PO Box 1851 Hicksville, NY 11802-1851

Mail Claims to: Carelon Behavioral Health Claims Processing Center PO Box 1850 Hicksville, NY 11802-1850

Pharmacy Benefits Manager:

MedImpact Customer Service 1-800-424-1789 (toll-free) 711 (TTY)

Prior Authorizations: 1-800-424-1789 (toll-free)

Mail Claims to:
MedImpact – DMR
7835 Freedom Avenue NW
North Canton, OH 44720

Prescription Drug Grievances: 1-877-280-5600 (toll-free) GlobalHealth Pharmacy Exceptions Department PO Box 2393 Oklahoma City, OK 73101-2393

Prescription Drug Appeals: 1-866-361-4542 (toll-free) MedImpact Attn: Clinical Services 7835 Freedom Avenue NW North Canton, OH 44720

Mail Order Pharmacy:

MedImpact Birdi Patient Care 1-866-909-5170 (toll-free)

Have your Member ID card with you when you call.

Register on the at www.GlobalHealth.com to access personalized Health Insurance information.

TTY numbers require special telephone equipment and is only for people who have difficulties with hearing or speaking.

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INTRODUCTION

Important Information

GlobalHealth, Inc. (GlobalHealth) is a health maintenance organization (HMO). HMOs emphasize <u>Preventive</u> <u>Care</u> 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 State, Education, and Local Government Employees Plan.

Your comprehensive Member handbook has four 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 <u>Network</u> of doctors and <u>Facilities</u>. Tells you if a <u>Facility</u> is preferred or not for each type of service.
Pharmacy Directory	 Lists our <u>Network</u> of pharmacies including mail order. Tells you if a pharmacy is a 24-hour or vaccine pharmacy.
Formulary Drug List for State, Education, and Local Government Employees (Drug Formulary)	 Lists drugs we cover. Tells you what <u>Tier</u> a drug is in. Tells you if there are any rules to getting a drug.

How to use the Member Handbook:

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*, another document, website, or email address.

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. Printed copies are available at no cost.

The *Drug Formulary*, *Provider Directory*, and *Pharmacy Directory* are updated as needed. You will find the most recent booklets online at www.GlobalHealth.com. Printed copies are current as of the date shown on the bottom of the first page.

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

Forms, Tools, and Resources:

Besides your comprehensive <u>Member</u> handbook booklets, our website has forms and tools to help you. Call us if you would like a printed copy of any material at no cost.

- Case Management Enrollment form
- Drug Formulary
- Health information
- Member ID card request
- Member Rights and Responsibilities
- Notice of Nondiscrimination
- Notice of Privacy Practices

- Pharmacy and Provider Directories
- Quality Improvement Program (QIP) information
- Self-management tools
- Summary of Benefits and Coverage
- Transition of Care forms

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, sex, or any combination thereof. We do not exclude people or treat them differently. See the full non-disclosure information on page 169.

Need	Service
Living with	We provide free aids and services if you need them to communicate
disabilities	effectively with us, such as:
	 Qualified interpreters.
	 Written information in other formats (large print, audio, accessible
	electronic formats, other formats).
	Hearing impaired <u>Members</u> 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	We offer over 150 languages from qualified medical interpreters.
proficiency	You may ask for materials and forms written in other languages free of
	charge.

Contact us for help with any of these services.

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, sex, or any combination thereof, you can file a <u>Grievance</u>. You can file a <u>Grievance</u> in person or by mail or e-mail. If you need help filing a <u>Grievance</u>, ask us to help you.

Contact Method	Contact Information
Mail	GlobalHealth, Inc.
	ATTN: Section 1557 Coordinator
	P.O. Box 2658
	Oklahoma City, OK 73101-2658
Toll-free	1-877-280-5600 (TTY: 711)
FAX	1-405-280-5294
E-mail	section1557coordinator@globalhealth.com

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 email at:

Contact Method	Contact Information
Email	OCRComplaint@hhs.gov
Toll-free	1-800-368-1019, 1-800-537-7697 (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 Filing a Complaint | HHS.gov.

For more information, see "Section 1557 of the Affordable Care Act Grievance Procedure" on page 172.

For help with other types of complaints and <u>Grievances</u>, see "Appeals and Grievances" on page 142.

Get Care

You have the right and responsibility to fully participate in all <u>Referral</u> requests related to your healthcare. If you are unable to fully participate in treatment <u>Referrals</u>, you have the right to be represented. See "Appointment of Authorized Representation" on page 148.

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

Action	What To Do
Choose a	See "Provider Network" starting on page 18 for more information.
<u>PCP</u>	• Each family member may choose a different primary care physician (<u>PCP</u>).
	 You may choose a pediatrician for your child (up to age 18).
	 You may change your <u>PCP</u> at any time during the year. Your <u>PCP</u> change will take effect on the first of the following month. If you need to see a <u>PCP</u> before you get your new
	Member ID card, contact us.

Action	What To Do
See Your	See your <u>PCP</u> first for all your medical care.
<u>PCP</u>	Your <u>PCP</u> will coordinate and manage your medical care.
	Ask which <u>Preventive Services</u> are right for you.
	• For same-day <u>Urgent Care</u> , call your <u>PCP's</u> office for medical direction.
	After-hours, you may self-refer to an <u>Urgent Care</u> center.
	• When it's an emergency, go to the nearest <u>Hospital</u> emergency room (<u>ER</u>) or call 911.
See a	To see a <u>SPECIALIST</u> , you need a <u>Referral</u> .
<u>Specialist</u>	• If you need <u>Specialty</u> care, your <u>PCP</u> will send us a <u>Referral</u> .
	• Preauthorization (<u>PA</u>) from us is required, which is valid for a 90-day period.
	When approved, we will send you a letter in the mail.
	Make your appointment with the <u>Specialist</u> as directed in the letter.
	The <u>Specialist</u> may submit additional <u>Referrals</u> for procedures and follow-up care
	related to the initial visit. Be sure to go back to your <u>PCP</u> for all other care.
	• In most cases, you will need to go back to your <u>PCP</u> after 90 days for follow up.
	• Behavioral health <u>Specialists</u> do not require a <u>Referral</u> . See " <u>Behavioral Health Benefits</u> "
	on page 40 for <u>PA</u> requirements.
Go to the	To go to the <u>HOSPITAL</u> , you need a <u>Referral</u> .
<u>Hospital</u>	A <u>Referral</u> and <u>PA</u> are required for scheduled stays.
	 When approved, we will send you a letter of authorization.
	 Go only to the <u>Hospital</u> listed in the letter.
	You do not need <u>PA</u> for stays in connection with childbirth.
Self-refer	You may SELF-REFER for the following care (no <u>Referral</u> or <u>PA</u> needed at <u>In-network</u>
	<u>Providers</u>):
	Advance care planning
	After hours or out-of-area <u>Urgent Care</u> After hours or out-of-area <u>Urgent Care</u>
	Behavioral healthcare Gas Management
	Chiva y y a still a says
	Chiropractic care Francisco are
	Emergency care Fundamental contacts
	Eyeglasses or contacts Hooring aid evaluations
	Hearing aid evaluationsNurse line
	Physical therapy evaluations
	Routine mammograms
	 Services within an obstetrician/gynecologist's (<u>OB/GYN</u>) scope of practice
	 Vision care during an office visit
Go to the	See the <i>Drug Formulary</i> at <u>www.GlobalHealth.com</u> to check specific drug coverage
pharmacy	information and <u>PA</u> requirements. Be sure to view the <i>Drug Formulary</i> list that matches
phaniacy	your <u>Plan</u> .
	 See the <i>Pharmacy Directory</i> also on the GlobalHealth website to find a pharmacy <u>In-</u>
	network – www.GlobalHealth.com.
	You can contact MedImpact with any questions at 1-866-909-5170 (toll-free).
Go to	Your PCP is always your first contact for direction when you begin to feel you are becoming
<u>Urgent</u>	ill. \$0 Copayment/visit.
<u>Care</u> or <u>ER</u>	

Action	What To Do
	 <u>Urgent Care</u> is care for an illness, injury, or condition serious enough that you need care right away, cannot get into your <u>PCP</u> in a timely manner, and is not serious enough to go to the <u>ER</u>. \$25 <u>Copayment/</u>visit.
	• <u>ER</u> is for sudden symptoms that are life threatening, causing serious impairment/dysfunction of bodily and cognitive functions. \$400 <u>Copayment</u> /visit.

Generally, <u>Inpatient</u> and certain <u>Outpatient</u> services must be preauthorized. You do not have to get <u>PA</u> for <u>Emergency Services</u>, stays in connection with childbirth, or self-referral services. If you get other care without authorization from us, you will have to pay for it. You must go to <u>Network Providers</u> for non-emergency services.

Member ID Cards

We will send a <u>Member ID</u> card to you at the start of your <u>Plan Year</u>. Your GlobalHealth card is the key to all your medical, behavioral health, and prescription benefits. Carry it with you at all times.

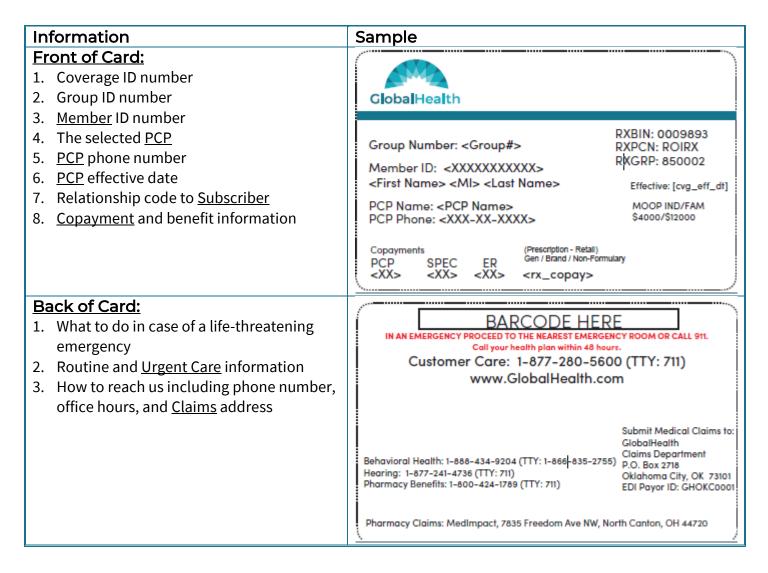
When making an appointment with your <u>PCP</u>, let them know you are a GlobalHealth <u>Member</u>. Show your <u>Member</u> ID card each time you get medical care. It contains valuable information about your benefits.

Please Note:

- Services are for your personal benefit. Never lend your card to someone else. You cannot share your benefits.
- Protect your card. If it is lost or stolen, tell us right away. We will send you a new card at no charge.
 You may also request or re-order cards on <u>State of Oklahoma Member portal</u> at
 www.GlobalHealth.com. You should get new or additional cards within two weeks after we receive
 the request.
- Your <u>Member</u> ID card is valid only as long as you are enrolled in the <u>Plan</u>. Having a card does not guarantee benefits.

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

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



Get Help

Log into your <u>Member portal</u> at <u>www.GlobalHealth.com</u> or 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? Do I need a <u>Referral</u>?
- What doctors and Hospitals can I use?
- How can I file a <u>Grievance</u> or an <u>Appeal</u>?
- Why did I get a letter or bill in the mail? What does it mean?
- How can I enroll in one of the <u>Special Programs</u>?
- How can I get access to <u>State of Oklahoma Member portal?</u>
- How can I change my <u>PCP</u>?
- What is the status of my <u>Referral</u>?
- What is the status of my <u>Claim</u>?

Please remember it usually takes some time to process a <u>Referral</u> or <u>Claim</u>. See "<u>Utilization Management</u>" on page 31 and "<u>Claims and Payment</u>" on page 136.

If you call after normal business hours, we will return your call on the next business day.

We tell you in this booklet if you need to contact someone else. For example, you will need to call MedImpact Mail Order Pharmacy if you have questions about <u>Prescription Drug</u> mail order.

Steps to Improve Your Healthcare Quality and Safety

Step	What To Do
1	If you are new to GlobalHealth, visit your <u>PCP</u> early in the year to get established. Have your
	medical records sent to your new <u>PCP</u> .
2	Visit your <u>PCP</u> at least once each year. See " <u>Routine exam - adult</u> " on page 94. Have <u>Preventive</u>
	Care services. See "Preventive Care Benefits" on page 109.
3	Write down your questions before your doctor visit.
4	Ask questions if you have any doubts or concerns about your treatment.
5	Keep and bring a list of all the drugs you take to each appointment. Include any over-the-
	counter (<u>OTC</u>) drugs and supplements. Your <u>PCP</u> 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. Ask what the results mean.
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 <u>PCP</u> gets copies of records from any other doctors or <u>Facilities</u> where you get
	care.

PROVIDER NETWORK

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

<u>Provider</u> Type	Examples
Agencies	Home health
	Hospice
<u>Facilities</u>	Hospital
	Imaging center
	Laboratory
	Outpatient Facility
	Pharmacy
	Skilled Nursing Facility
	Urgent Care Facility
Physicians and	Behavioral Health Provider (<u>BHP</u>)
<u>Practitioners</u>	Lactation counselor
	Medical group
	• <u>PCP</u>
	Specialist
	Therapists
	o (such as physical, occupational, or speech therapist)
	Other healthcare professionals
	o (such as, physician assistant, nurse practitioner, etc.)
Suppliers	Durable medical equipment (<u>DME)</u> supplier
	Vision (eye wear) <u>Providers</u>

You may choose any <u>Network Provider</u> acting within the scope of his or her license who is accepting patients.

<u>Network Providers</u> 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 <u>Network Providers</u>, and vice versa.

You could get care from <u>Providers</u> outside of our <u>Network</u> in very limited situations, usually only for emergencies or Urgent Care.

Network Changes

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

- We cannot guarantee that any one doctor, <u>Hospital</u>, or other <u>Provider</u> will stay contracted.
- We cannot guarantee that any one pharmacy will stay contracted with our pharmacy benefit manager, MedImpact.
- <u>Facilities</u> may change from preferred to non-preferred status during the year.
- You cannot change <u>Plans</u> mid-year because a <u>Provider</u> leaves our <u>Network</u> or becomes non-

preferred.

For more information, see "Physicians Leaving the Network" on page 25.

Provider Directory

We list <u>Network</u> doctors, <u>Facilities</u>, and suppliers in the <u>Provider Directory</u>. It shows which doctors are taking new patients. Contact our Customer Care if you would like a printed copy at no charge. If there are mistakes in our <u>Provider Directory</u> concerning your <u>Provider</u>, please have them contact GlobalHealth to have the information corrected. See "<u>HELPFUL NUMBERS</u>" on page 4. You may also report mistakes on our website at <u>www.GlobalHealth.com</u>. When you use the online search tool and find a provider, you can view details. Simply click on the button, Report Incorrect Data".

We update our online list of medical <u>Providers</u> at least weekly. Behavioral health and pharmacy online lists are updated monthly.

Search for doctors by first and last name, county, and zip code. You can narrow your search by <u>Provider type</u>, <u>Specialty</u>, languages spoken, or gender.

You will be able to see information about professionals include:

- Name;
- Contact information, including a website address, physical address, and phone number; and
- Specialty, if applicable.

If you have been referred to an <u>Out-of-network Provider</u> contact us so we can help you find an <u>In-network Provider</u>.

You have the right to request an <u>Out-of-network Provider</u>. However, we may not approve coverage at an <u>Out-of-network Provider</u> if an <u>In-network Provider</u> is available.

BHPs

The Network includes:

- Behavioral Health Case Manager (BHCM);
- Hospital, psychiatric Hospital;
- Licensed Alcohol & Drug Counselor (LADC);
- Licensed Behavioral Practitioner (LBP);
- Licensed Clinical Psychologist;
- Licensed Clinical Social Worker (LCSW);
- <u>Licensed Marriage & Family Therapist</u> (<u>LMFT</u>);
- <u>Licensed Professional Counselor (LPC)</u>;

- Opioid Treatment Program;
- Psychiatric Clinical Nurse Specialist;
- <u>Psychiatrist</u> Child, adolescent, adult, geriatric, addiction medicine <u>Specialist</u>;
- Psychologist;
- Residential Treatment Center (RTC); and
- Other mental healthcare <u>Facilities</u> and professionals as allowed under state law.

You can call Carelon Behavioral Health with questions about BHPs in the Network.

If coverage is not arranged within the time frame, <u>Members</u> may seek services from any out-of-network provider. The <u>Member</u> shall pay the same cost-sharing that they would pay for the same covered services received from an in-network provider. Time frames are:

- 30 days routine appointment, referral for services, start of new treatment or medication, or other maintenance services.
- 7 days residential care or hospitalization.
- 24 hours urgent, emergency, or crisis care.

Medical Service Providers

Our online list of medical <u>Providers</u> includes doctors such as <u>PCPs</u> and many types of <u>Specialists</u>. Types of <u>Specialists</u> include:

- Oncologists who care for patients with cancer.
- Cardiologists who care for patients with heart conditions.
- Orthopedists who care for patients with certain bone, joint, or muscle conditions.

Facility information includes:

- Facility name;
- Facility type;
- Types of services performed;
- Participating facility location or locations;
- Customer service telephone number; and
- Website address.

You can search by type of <u>Facility</u>. Select <u>Provider</u> Type, then <u>Hospital</u>, <u>Skilled Nursing Facility</u>, or other <u>Facility</u> type.

- Some types of <u>Facilities</u> tell you if you will pay a <u>Preferred Facility</u> or <u>Non-preferred Facility Cost-share</u>. Both types of <u>Facilities</u> are <u>In-network</u>, but you pay different <u>Cost Sharing</u>. They may or may not be part of a <u>Hospital</u>. Be sure to check for <u>Preferred Facility</u> status. The same <u>Facility</u> may offer preferred <u>Cost Sharing</u> for some services, but not others.
- Chemotherapy, radiation, and dialysis centers.
 - o Outpatient surgery centers.
 - o Imaging centers.
- Other <u>Facilities</u> are neither preferred nor non-preferred. You pay the one <u>Cost-share</u> listed in this Member Handbook. For example:
 - o ER departments.
 - o <u>Inpatient Hospitals</u>.

If you have any questions regarding a <u>Preferred Facility</u> or <u>Non-preferred Facility</u> contact our Customer Care.

You can find information about <u>Hospitals</u> such as:

- Hospital name;
- Hospital type, including, but not limited to, acute, rehabilitation, or long-term care;
- Hospital location
- <u>Hospital</u> accreditation status (when applicable);
- Customer service telephone number; and
- Website address.

For nationally recognized **Hospital** quality information, see:

- Hospital Compare at https://www.medicare.gov/hospitalcompare/search.html.
- The Leapfrog Group at http://www.leapfroggroup.org/.
- Quality Check at https://www.qualitycheck.org/.

Enter the name of the <u>Hospital</u> or the state. Not every <u>Hospital</u> is listed on every site.

Be sure you make an appointment with a <u>Provider</u> that performs the services that you are looking for.

Visit www.GlobalHealth.com to use the online provider search.

Pharmacy Directory

You have different ways to get your prescribed drugs. Your <u>Cost-share</u> may change based on where you fill your prescription.

The *Pharmacy Directory* is updated monthly and will tell you which pharmacies are in the <u>Network</u>. If the pharmacy you have been using leaves the <u>Network</u> you will have to find a new pharmacy that is in the <u>Network</u>. It is a good idea to periodically check the pharmacy <u>Network</u> on our website.

Pharmacy Type	Description
Retail pharmacies	 Get up to a 90-day supply. Please note not all drugs can be filled for 90 days. *If a 30-day supply or less is ordered, you will pay the 30-day supply Cost-share. If more than a 30-day supply is ordered, you will pay the 90-day supply Cost-share. For example, if a 45-day supply is ordered you will pay the 90-day supply Cost-share. You may get a discount on your drugs, depending on the drug Tier, when filling a 90-day supply instead of a 30-day supply. 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 <i>Pharmacy Directory</i> shows retail Network pharmacies. We tell you which pharmacies offer vaccines and which pharmacies are open 24 hours.
Mail Order	 If you choose, get a 90-day supply of maintenance drugs (drugs you take on a regular basis for a <u>Chronic Condition</u>). Fill once each three-month period. *If less than a 90-day supply is ordered, you will still pay the 90-day supply <u>Costshare</u>. MedImpact Birdie Patient Care mails your prescription(s) to your home or designated location. Allow 7 to 10 days from when your order is placed for you to receive your prescriptions. You may get a discount on your drugs, depending on the drug <u>Tier</u>, when ordering a 90-day supply through mail order instead of filling a 30-day supply at a retail store. Contact MedImpact Birdie Patient Care at 1-866-909-5170 about how to use this service. Help is available 24 hours a day, seven days a week.

Pharmacy Type	Description
Specialty	Get up to a 30-day supply. Fill once each month.
pharmacies	MedImpact will fill your <u>Specialty Drugs</u> and mail them directly to your home
	or designated location. Other specialty pharmacies are available. If you
	choose a different specialty pharmacy, call and ask to opt out of the
	MedImpact Specialty Pharmacy.
	Contact MedImpact for information about specialty medications at 1-800-
	424-1789.
	You pay the office visit <u>Cost-share</u> if given to you by your doctor.
	You pay the <u>Specialty Drugs Cost-share</u> if you take them at home.

*You pay a pro-rated amount for 30- or 90-day supplies when 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.

Visit <u>www.GlobalHealth.com</u> to use the online pharmacy search.

PCP

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

Choose a PCP

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

- Family practice or family medicine;
- General practice;

- Internal medicine; and
- Pediatrics.

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

Although you have direct access to certain doctors such as an <u>OB/GYN</u> or <u>BHP</u>, they are not your <u>PCP</u>. You will need to choose a <u>PCP</u> to coordinate medical care that they do not handle.

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

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

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 <u>Providers</u> before your first visit. See "<u>Medical Records</u>" on page 28.

- Discuss any Specialty care you are receiving. See "Continuity and/or Transition of Care" on page 130.
- 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 <u>Formulary</u>, discuss your options. See "<u>Prescription Drug Transition of Care</u>" on page 131.
- Discuss <u>Preventive Care</u> that is right for you. You may have some of the <u>Screenings</u> during this visit. You may need to schedule more visits for other <u>Preventive Care</u>.

Schedule Routine Appointments

Call your <u>PCP's</u> office when you are ready to make an appointment. Your <u>Member</u> ID card lists the number.

- Call ahead for routine, sick, or follow-up visits. This will allow you and your <u>PCP</u> 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 <u>Preventive Care</u> services.
- Make and go to follow-up visits if you have a <u>Chronic Condition</u> 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 <u>PCP</u> orders tests, show your <u>Member</u> 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 <u>PCP</u>. If no urgent appointments are available, he or she may send you to an <u>Urgent Care Facility</u>. See "<u>Urgent Care</u>" on page 26.

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, subject to state and federal privacy laws.

PCP Changes

You may change your <u>PCP</u> for any reason. The change will take effect on the first of the following month. Contact us for the following:

- Change your <u>PCP</u>. You can make the change on <u>State of Oklahoma Member portal</u>.
- Get help changing from a childcare doctor to an adult care doctor.
- See your <u>PCP</u> before you get your new <u>Member</u> ID card.

We recommend against changing your <u>PCP</u> 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.

We will let you know as soon as possible if your <u>PCP</u> is terminated from our <u>Network</u>. We will help you to transfer to another <u>PCP</u> in our <u>Network</u>.

Self-referral Services

Your <u>PCP</u> coordinates most <u>Covered Services</u> you get as a GlobalHealth <u>Member</u>, but there are a few exceptions. See the table below for a list of these services.

- You do not need a <u>Referral</u> from your <u>PCP</u> before you go. You do not need <u>PA</u> from us.
- You pay the Cost-share, if any, for non-preventive services.
- You must go to a <u>Network Provider</u> for services other than emergency or out-of-area <u>Urgent Care</u>. You pay for care from an <u>Out-of-network Provider</u>.
- See "Coverage Requirements" on page 40.

Help your PCP manage your care. Be sure your PCP:

- Gets the results of any exams or tests. See "Medical Records" on page 28; and
- Gets a list of any new prescriptions.

Service	Description
Chiropractic care	You may go to a chiropractor. See "Chiropractic care" on page 57.
Emergency room	Do not use an <u>ER</u> in non-emergency situations. However, in an emergency, go to
(<u>ER</u>)	the nearest <u>Hospital ER</u> or call 911. See " <u>Emergency Care</u> " on page 27.
Eye exams	You may go to an optometrist or ophthalmologist. See "Vision Benefits" on page
	115.
Eyewear	You may go to an eyewear <u>Provider</u> for eyeglasses or contacts following cataract
	surgery. See " <u>Vision Benefits</u> " on page 115.
Hearing aid	You may go to a hearing Specialist to have an evaluation for hearing aids. See
evaluations	"Hearing services -evaluation for hearing aid" on page 72.
Mammograms	You may go to an imaging center for your routine mammogram. See
	"Mammogram" on page 78.
Mental	You may go to a therapist, counselor, <u>Psychologist</u> , or <u>Psychiatrist</u> for
health/substance	assessment, therapy, and testing. Contact your provider for telehealth services.
use disorder	See " <u>Behavioral Health Benefits</u> " on page 40.
services	
Nurse line	You may call the nurse line. See " <u>Nurse line</u> " on page 85.
OB/GYN services	You may go to a healthcare professional who specializes in obstetrics or
	gynecology.
	The <u>Provider</u> must comply with procedures including:
	Following the process for <u>Referrals</u> ;
	Obtaining <u>PA</u> for some services, such as non-routine pap tests; and
	Following the authorized <u>Course of Treatment</u> .
	Contraception Services:
	You have direct access to either your <u>PCP</u> or <u>OB/GYN</u> for contraceptive services.
	See " <u>Contraception services</u> " on page 59.
	Makawaiku
	Maternity:

Service	Description
	You have direct access to your <u>OB/GYN</u> for all your maternity care – prenatal, delivery, and postnatal. See " <u>Maternity and newborn care</u> " on page 79.
	Well-woman Exam:
	For a list of <u>Preventive Services</u> related to your well-woman exam, see " <u>Women's</u> <u>benefits</u> " on page 111.
	Other Services:
	You have direct access to your <u>OB/GYN</u> . He/she may perform any <u>Covered</u>
	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 <u>Referrals</u>;
	 Obtaining PA for up to 30 days of therapy; and
	 Following the authorized <u>Course of Treatment</u>.
	See " <u>Physical therapy</u> " on page 89.
<u>Urgent Care</u>	First, call your <u>PCP</u> during office hours. But, you may self-refer to an <u>Urgent Care</u>
	<u>Facility</u> when your <u>PCP's</u> office is closed or when you are out of our <u>Service Area</u> .
	The care must be urgent, non-preventive, and non-routine.
	See " <u>Urgent Care</u> " on page 26.

Specialty Care

See your <u>PCP</u> first. If your <u>PCP</u> believes you need to see a <u>Specialist</u>, he/she will send us a <u>Referral</u>. See "<u>Pre-service Authorization</u>" on page 31.

- If you see a <u>Specialist</u> 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 <u>Specialist</u> visits include <u>Diagnostic Tests</u>. You do not need separate <u>PA</u> for these tests. They should be performed during the authorized visit:

X-ray

Routine lab work

UltrasoundEKG

Any other care requires specific authorization from us.

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

Physicians Leaving the **Network**

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

• He/she leaves our <u>Provider Network</u>.

- He/she is not able to be a <u>Provider</u> 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 <u>Provider</u> has or will be leaving our <u>Network</u>.

- If the <u>Provider</u> is your <u>PCP</u>, we will send you a letter with the name of your new <u>PCP</u>. You will also get a new <u>Member</u> ID card in a separate mailing. If you do not want the <u>PCP</u> we chose for you, let us know. See "<u>PCP Changes</u>" on page 23.
- If your <u>Provider</u> is a <u>Specialist</u>, the letter will tell you what the next steps are.

You may be able to keep seeing your <u>PCP</u> or <u>Specialist</u> for a short time. See "<u>Continuity and/or Transition of Care</u>" on page 130.

Urgent Care

<u>Urgent Care</u> 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 <u>ER</u>.

An <u>Urgent Care Facility</u> offers a choice when it is not an emergency and you cannot see your <u>PCP</u>.

- It costs you less than an ER visit.
- A doctor may see you right away in an <u>Urgent Care Facility</u>.
- In an <u>ER</u>, you may have to wait longer.
- <u>Urgent Care Facilities</u> usually can perform these types of services:
- Exams

Basic <u>Screenings</u>

X-rays

Prescribe medication

<u>Urgent Care Facilities</u> may treat situations such as:

- A sprained ankle
- Ear infections

- Minor burns or injuries
- Coughs, colds, sore throats

<u>Urgent Care Facilities</u> do not take the place of your <u>PCP</u>. You should see your <u>PCP</u> first when you need non-emergency medical care. If you cannot wait for an office visit, go to an <u>Urgent Care Facility</u>.

- Go to a Network Facility when you are in our Service Area.
- Have them send your records to your <u>PCP</u>. That helps maintain continuity of care.
- Have them send a list of new prescriptions. Your PCP needs to prescribe any refills.
- Go to your <u>PCP</u> for follow-up care.

When	What To Do
Normal Office Hours	If you have an urgent medical illness or injury, call your <u>PCP's</u> office. Some <u>PCPs</u>
	have extended office hours.
	Your <u>PCP</u> may arrange to see you right away or give you medical advice and
	direction.
	• If your <u>PCP</u> cannot set up an urgent appointment, you may ask to see another
	<u>Provider</u> in that office. You may see another doctor, physician's assistant, or
	nurse practitioner.
	• Your <u>PCP</u> may send you to an <u>Urgent Care Facility</u> if another <u>Provider</u> cannot
	see you. You pay the <u>Urgent Care Cost-share</u> .

When	What To Do
After Office Hours	If you need to see your <u>PCP</u> after the office has closed, you have two options:
	1. Call your <u>PCP</u> .
	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 <u>PCP's</u> after-hours voicemail instructions. It may include sending you to an <u>Urgent Care Facility</u> or <u>ER</u>.
	2. You may choose to go to an <u>Urgent Care Facility</u> if your condition cannot wait.
	You pay the <u>Urgent Care Cost-share</u> . You do not need <u>PA</u> .
Out of <u>Service Area</u>	If you are traveling and need <u>Urgent Care</u> before you come back to our <u>Service</u>
	<u>Area</u> :
	Call your <u>PCP</u> ; or
	Go to an <u>Urgent Care Facility</u> . You do not need <u>PA</u> .
	You will pay your <u>In-network Urgent Care Cost-share</u> , but the <u>Provider</u> may
	also send you a bill. See " <u>Balance Billing by an Out-of-network Provider</u> " on
	page 137.

Emergency Care

An emergency is when you have sudden symptoms (including severe pain, psychiatric disturbances, and/or substance abuse symptoms) and a <u>Prudent Layperson</u> 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 <u>Emergency Medical Condition</u> includes a pregnant woman who is having contractions when:

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

Access

Do not use an <u>ER</u> visit in non-emergency situations. However, in an emergency, follow these steps:

Step	What To Do
1	Go to the nearest <u>Hospital ER</u> or call 911. You do not need <u>PA</u> for emergency care. You will pay
	your <u>In-network ER Cost-share</u> .
2	Show your <u>Member</u> ID card.
3	Call your <u>PCP's</u> office and us within 48 hours.
4	If you:
	Are in an accident and outside the <u>Service Area;</u>
	Have no control over where you are taken; or
	Could not go to a <u>Network Hospital</u> .
	We may arrange to move you to a <u>Hospital</u> in our <u>Network</u> if you are admitted to an <u>Out-of-</u>
	<u>network Hospital</u> .
5	All follow-up care after being treated in the <u>ER</u> must be:

Step	What To Do	
	 Provided or arranged by your <u>PCP</u>. Do not go back to the <u>ER</u> for follow-up care. Preauthorized by us if required. If you need care urgently, contact the <u>UM</u> Department. See "<u>Urgent Decisions</u>" on page 33. 	

You will pay the In-network ER and ambulance Cost-share even if you utilize Out-of-network Providers.

Hospital Care

When you need to go to the <u>Hospital</u>, your doctor will arrange for you to stay at a <u>Network Hospital</u> where he/she is on staff. To get non-emergency services (other than for childbirth) you must have <u>PA</u>. Without a <u>Referral</u> and <u>PA</u>, 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 <u>Hospital</u> or <u>Skilled Nursing Facility</u>. We cover:

- Part-time or intermittent <u>Medical Services</u> 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.

Your behavioral health **Provider** may also visit you at home.

Medical Records

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

Your <u>Providers</u> are expected to share information 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 <u>PCP</u> knows about other care you get is to have copies of your medical records from other <u>Providers</u> sent to him/her as it happens.

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

- Emergency Services.
- Mental health or substance use disorder services.
- Self-referral services.
- Specialist services.
- <u>Urgent Care Facility</u> services.

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

The law requires <u>Providers</u> to protect patient medical information. You can complete an Authorization to Use or Share Protected Health Information (<u>PHI</u>) form provided by your <u>Provider's</u> office. **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 <u>Provider</u> to include in our <u>Network</u>, we conduct full credentialing and National Practitioner Database (NPDB) checks. The NPDB is a federal information repository. The Credentialing Committee reviews our <u>Providers</u> at least every 36 months. This process helps to ensure the quality of our <u>Network</u>. Providers must be competent and qualified to offer services.

Ask for Information

You have the right to find out your <u>Providers'</u> information. You can also call us if you want the following information:

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

See below for online sources.

Check Behavioral Health Providers

There are several websites to check certifications.

Specialty	Website Address
<u>LADC</u>	http://www.okdrugcounselors.org/members.php
<u>LCSW</u>	https://osblsw.portalus.thentiacloud.net/webs/portal/register/#/
<u>LMFT</u>	https://www.ok.gov/behavioralhealth/License Verification.html
<u>LPC</u>	
<u>LBP</u>	
Licensed Clinical	https://www.ok.gov/psychology/Public/License Verification/index.html
<u>Psychologists</u>	
Psych Techs (testing	
only for techs)	

Check Medical Physicians

You can check a doctor's training, experience, qualifications, and **Board Certifications** from:

- The doctor's office;
- A local medical society (if the doctor is a member); or
- A local <u>Hospital</u> (if the doctor is on staff).

Name	Information	Website Address
American Board of	Check whether a doctor is certified by	www.abms.org
Medical Specialties	one of 24 <u>Specialty</u> boards. No other	
(ABMS) Certified	information.	
Doctor Verification		
Service		

Name	Information	Website Address
	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.	
	Free of charge.	
American Medical	Gives some information on the	www.ama-assn.org
Association's (AMA)	certification status of all medical doctors	
Doctor Find	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.	
Oklahoma Board of	Check a MD's (Medical Doctor) license	www.okmedicalboard.org
Medical Licensure	and disciplinary action.	
and Supervision	See <u>Hospital</u> privileges and languages	
(OMB)	spoken.	
	Free of charge.	
Oklahoma State	Check a DO's (Doctor of Osteopathic	www.ok.gov/osboe/
Board of	Medicine) license and disciplinary action.	
Osteopathic	See <u>Hospital</u> privileges and languages	
Examiners	spoken.	
	Free of charge.	

UTILIZATION MANAGEMENT

Medical and Behavioral Health UM

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

Rule	What It Means
Care must be	Care must be a <u>Covered Service</u> .
covered under your	Care must meet <u>Coverage Requirements</u> .
<u>Plan</u>	We cover services with limitations only as listed.
	We do not cover <u>Excluded Services</u> .
	See "Benefits" starting on page 38.
Care must be safe	Care must meet generally-accepted standards of care.
and effective	Care must be in the <u>Provider's</u> scope of practice.
Care must be right	Care must be <u>Medically Necessary</u> .
for your illness,	 Type of care;
injury, or disease	 Frequency of visits or treatments;
	Extent of care;
	 Site of care; and
	 Duration of care.

When we are reviewing your services, we use guidelines. For consistency, we determine the guideline used as follows:

Туре	Reviewed First	Reviewed If No Policy
Medical Services	GlobalHealth Medical Policies	 MCG[™] Care Guidelines
		Hayes, Inc.
Behavioral	Carelon Behavioral Health Policies	ASAM Criteria®
Health Services		InterQual®

You may ask for the criteria if you are:

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

Our Medical Directors make all medical necessity <u>Adverse Determinations</u>. A Medical Director is a licensed doctor in good standing.

Pre-service Authorization (PA)

We need to approve most services before you get them when your <u>PCP</u> 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 <u>Cost-share</u> for your benefit.
- You stay In-network.

You may see our current <u>PA</u> requirements and restrictions, including written clinical criteria, at <u>www.GlobalHealth.com</u>. If you are receiving a <u>Covered Service</u> and there will be a change to <u>PA</u> requirements and restrictions, we will notify you at least 60 days before the change takes effect.

Timeframes:

Authorizations for services other than for inpatient care, for the treatment of a chronic condition are valid for 6 months from the date your Provider receives the approval, unless clinical criteria change. If that happens, we will notify you.

Authorizations for inpatient acute care for the treatment of a chronic condition are valid for 14 days from the date your <u>Provider</u> receives approval. Authorization for continued inpatient care, if needed, is valid for an additional 14 days. A timely request for continuation of inpatient care means a request that is submitted at least 24 hours prior to the end of the previously approved <u>PA</u> and includes all necessary information to make a determination.

Behavioral Health Service Steps:

Step	Description
1	You can go to any <u>Network Provider</u> to be assessed for the services you may need. If these
	services require <u>PA</u> , the <u>Provider</u> will send Carelon Behavioral Health the request for you.
2	Carelon Behavioral Health will send a letter after the service is approved. This letter will tell you
	the name and contact information for the doctor or <u>Facility</u> . It will tell you what services are
	authorized. Any other service requires separate authorization from Carelon Behavioral Health.
3	Once Carelon Behavioral Health gives <u>PA</u> to the <u>Provider</u> , he/she may begin services right away.

Medical Service Steps:

Step	Description
1	Your <u>PCP</u> will send us a <u>Referral</u> for other care you need. After the initial visit, <u>Specialists</u> may
	send <u>Referrals</u> directly to us for services such as surgery, testing, diagnostic procedures, etc. You
	may ask to use any <u>Provider</u> in our <u>Network</u> . If your doctor refers you to an <u>Out-of-network</u> doctor
	or <u>Facility</u> , we may select one in our <u>Network</u> for you. You are responsible for knowing your
	<u>Network</u> . Your <u>Provider</u> may not be familiar with GlobalHealth's <u>Network</u> .
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 <u>Facility</u> . It will tell you what services we authorized. Any other
	service requires separate authorization from us. <u>PAs</u> are valid for 90 days. You must go back to
	your <u>PCP</u> after that.
3	Make an appointment. Wait until you get the letter before making any appointments. You must
	get this letter before you have care.

You can check the status of your medical Referral in State of Oklahoma Member portal.

Non-urgent Decisions:

We make non-urgent pre-service decisions within 7 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 7-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.

Please Note:

- Your doctor should send us <u>Referrals</u> for your services. But, it is your responsibility to make sure we have authorized your services.
- You should get all care from a <u>Network Provider</u> including ancillary services such as:
 - o x-rays
 - lab services
 - o anesthesia
- Although some services do not require PA, you must use Network Providers for:
 - o Hospitalization related to childbirth; or
 - o Self-referral services. See "Self-referral Services" on page 24.
- You must have services while you are a <u>Member</u>. We will not pay for benefits, even if authorized, after your coverage ends.
- You may track your <u>Referral</u> through your <u>State of Oklahoma Member portal</u>
- 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*. See "Appeals and Grievances" on page 142.

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 <u>Hospital</u> past the authorized period, we will conduct a review.

If we have approved a Course of Treatment:

- Any change before the end of the <u>Course of Treatment</u> is an <u>Adverse Determination</u>. 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 <u>Appeal</u> before we make the change. We will cover the benefit during the <u>Appeal</u>
 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 142.

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 <u>PA</u> to a doctor or another <u>Facility</u>. We work with your doctor and the <u>Hospital</u> case manager to have <u>PAs</u> 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 <u>Claims</u> submitted for payment and the corresponding medical records. We send notification of the decision within 30 days of the request.

Requesting a Review

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

You or your doctor may contact the <u>UM</u> Department outside of regular business hours. Leave your name and contact information and we will return your call on the next business day.

Contact Method	Contact Information
Toll-free	1-877-280-5600
TTY	711
Fax	(405) 280-5398

Prescription Drug UM

For certain <u>Prescription Drugs</u>, 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 <u>Premium</u> lower.
- Encourage you and your <u>Provider</u> to use a lower-cost option when possible that:
 - Works for your condition; and
 - o Is just as safe.

If there is a rule for your drug, it means that you or your <u>Provider</u> 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 "<u>Exception Requests</u>" below.

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:

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

Non-urgent Decisions:

We make non-urgent decisions within four business days after we get the request.

Urgent Decisions:

We make urgent pre-service decisions within 24 hours after we get the request.

Exception Requests

Contact us to ask for an exception.

Contact Method	Contact Information
Toll-free	1-877-280-5600
Fax	1-405-280-5294
Mail	GlobalHealth Pharmacy Exceptions Department
	PO Box 2393
	Oklahoma City, OK 73101-2393

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 "<u>Appointment of Authorized Representative</u>" on page 148. You will need to complete the form if you want us to share your <u>PHI</u> with anyone else, for example:
 - o Your parent, if you are age 18 or over.
 - o Your spouse.
 - o Your caregiver, friend, neighbor, or other.

Exception Type	Process
Standard	You can ask us to waive coverage rules and limits. You may ask us by mail, e-mail, or
Exception	telephone. Generally, we will only approve a request if:
	The alternative drug is included on the <u>Formulary</u> ;
	The drug without utilization rules would not work as well for you; and

Exception Type	Process
	It would cause you to have harmful side effects. We will not approve a request to lower your <u>Cost-share</u> for a drug.
	 If you ask us to cover a drug that is not on our <u>Formulary</u>, your doctor must send: The reason you need the non-formulary drug; and A statement that all <u>Formulary</u> drugs on any <u>Tier:</u> 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 ask for an exception. Your doctor will need to send us information. We make a decision within 72 hours if we have the required information.
	 If we agree, we also cover appropriate refills of the prescription. If we deny your request, you may ask for an <u>External Review</u>. See "<u>External Review</u>" on page 146. 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 131.
	 We will tell you our decision within 24 hours after you ask us for a review 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" on page 146. 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 <u>External Review</u> .

Policy on Ensuring Appropriate Utilization

- We conduct a yearly analysis to ensure the <u>UM</u> Department bases its decisions on:
 - o 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, medical or behavioral health procedures, or treatments including <u>Prescription Drugs</u>.

- A doctor-directed committee reviews requests.
- We look at both new technology and new ways to use existing technology.
- We use published scientific evidence to review technology. We seek input from relevant <u>Specialists</u> or other professionals who have expertise in the technology being evaluated. We may use information from appropriate government agencies.
- You or your doctor must send us evidence that it works and is safe. It must:
 - o Be approved by a regulatory agency, such as the FDA;
 - o Improve your net health outcome;
 - o Be as beneficial as current treatments;
 - o Be available outside of clinical tests;
 - Significantly improve your quality of life; and
 - Clearly show safe medical care.

BENEFITS

This section explains your <u>Plan's</u> 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 40.
- Medical Benefits on page 50.
- Prescription Drug Benefits on page 103.
- Preventive Care Benefits on page 109.
- Vision Benefits on page 115.

You can find more information for specific medical costs on our website, www.GlobalHealth.com. You may also request Cost Sharing information in paper form upon request or by calling Customer Care.

Copayments and Coinsurance

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

Our benefits are bundled. That means that if you have multiple services during a single office visit or <u>Facility</u> stay, you only pay the one <u>Cost-share</u> for the office visit or <u>Facility</u>.

The Facility Copayment for Inpatient Hospital or Outpatient surgery includes:

- Anesthesia;
- Diagnostic Tests;
- Doctor and OR Non-physician professional services;
- Drugs;
- General nursing care;
- Laboratory/radiology;
- Medical supplies and equipment;

- Procedures and surgeries;
- Room and board at all levels of care;
- Services by an Out-of-Network provider at an In-Network Facility;
- Specialized scans/imaging/diagnostic exams; and
- Treatment therapies.

The <u>Cost-share</u> for other settings (when provided during the visit) includes:

- Diagnostic Tests;
- Doctor and OR Non-physician 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 <u>Members</u> for whom the service would be appropriate, without regard to gender assigned at birth, gender identity, or gender of record at GlobalHealth.

"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 <u>Plan</u> does not have a <u>Deductible</u>. You pay the listed <u>Copayment</u> or <u>Coinsurance</u> up to the <u>MOOP</u>.

MOOP

A <u>MOOP</u> is a dollar amount that limits how much you have to pay for healthcare services. It includes <u>Copayments</u> and <u>Coinsurance</u> that you pay for <u>Covered Services</u>. All types of <u>Covered Services</u> count toward your <u>MOOP</u>.

You may choose to pay out-of-pocket for a healthcare service. If you obtain a <u>Medically Necessary</u> healthcare service covered by this <u>Plan</u> and negotiate for a price lower than the average <u>Allowed Amount</u> for this Plan, please send the documentation, including:

- The service you received;
- The name of the <u>Network Provider</u> and contact information;
- The Provider's order for the service;
- The final bill or statement for the service;
- The amount you paid out-of-pocket for the service; and
- A statement from the <u>Provider</u> that they are not making a claim for the same service.

Once we receive the information, we will count the full amount that you paid out-of-pocket toward the 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	• The Member MOOP is met when a single Member pays Copayments and/or
\$4,000 per year	<u>Coinsurance</u> 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 <u>Subscriber</u> .
Family <u>MOOP</u>	The family MOOP is met when any combination of family members under the
\$12,000 per year	same <u>Subscriber</u> pays <u>Copayments</u> and/or <u>Coinsurance</u> up to this level.
	• The amount paid for the <u>Member MOOP</u> contributes toward the family <u>MOOP</u> .
	• If one family member meets the <u>Member MOOP</u> , that person will not have to
	pay anything for <u>Covered Services</u> . 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.

<u>Deductibles</u>, <u>Copayments</u>, and <u>Coinsurance</u> paid before you enroll in a GlobalHealth <u>Plan</u> do not count toward your <u>MOOP</u>.

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 <u>MOOP</u>. Our records may not match due to <u>Claims</u> lag. <u>Claims</u> lag is the time between when you received services and when we process the <u>Claim</u>. Let us know if you think you have met your <u>MOOP</u>.

You can call us to confirm your expenses.

Healthcare Cost Estimator

You can get an estimate of your cost for services before you receive them. Go to www.GlobalHealth.com. Information includes:

- Whether the provider accepts your healthcare benefits plan.
- Whether the provider specializes in a particular type of care.
- The Provider's location and contact information.
- The provider's quality rating based on how other patients have rated this provider.
- The cost of the procedure when performed by a particular provider.

You will need to register at no cost.

Coverage Requirements

We cover benefits only when they meet the rules below.

Rule	Description	
All rules must be met	The care is <u>Medically Necessary</u> ;	
for all types of	Services meet generally-accepted standards of care;	
benefits	You show continual progress and improvement;	
	A <u>Network Provider</u> provides your care unless:	
	 It is for <u>Emergency Services</u> or out-of-area <u>Urgent Care</u>; or 	
	 You get <u>PA</u> to go to an <u>Out-of-network Provider</u>; 	
	 The <u>Provider</u> acts within the scope of his/her license; and 	
	• Usually, we require <u>PA</u> . We tell you which care does or does <u>not</u> need <u>PA</u> .	
We limit some	We do not cover services:	
benefits and do not	 When you can no longer improve from treatment; or 	
cover others	 The care is either custodial or only for the convenience of others. 	
	See "Excluded Services and Limitations" on page 119 for the full list.	

Behavioral Health Benefits

We cover mental health and substance use disorder conditions defined in generally recognized standards, including but not limited to:

- The most recent version of the Diagnostic and Statistical Manual of Mental Disorders
- The most recent edition of the International Classification of Disease

Examples of conditions include:

- Adjustment disorders
- Anxiety disorders
- Bipolar disorders
- Eating disorders

- Major depressive disorders
- Mood disorders
- Obsessive-compulsive disorders
- Personality disorders
- Pervasive developmental disorders
- Schizophrenia
- Schizo-affective disorders
- Substance use disorder
- Tobacco cessation

Call Carelon Behavioral Health with questions. Help is available 24/7.

If you are a new <u>Member</u> and receiving care, call Carelon Behavioral Health as soon as possible. If your <u>Provider</u> is not contracted, Carelon Behavioral Health will help you find another <u>Provider</u> who is right for you. See "<u>Behavioral Health and Medical Transition of Care</u>" on page 131.

Covered Services

We cover <u>Inpatient</u> and <u>Outpatient</u> behavioral health services for the diagnosis and treatment of:

- Mental health; and
- Substance use disorder, including alcohol, <u>Prescription Drug</u>, and illicit drug abuse.

Also see "Coverage Requirements" on page 40.

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

•	<u>Licensed Clinical Psychologist;</u>	•	LPC;
•	LCSW;	•	BHCM;
•	LADC;	•	LBP; or
•	LMFT;	•	Psychiatrist.

Behavioral Health Benefits Chart

Benefit	Description	You Pay
Autism	Covered Services:	Behavioral health therapy office visit: No
Spectrum	Behavioral health treatment includes:	<u>Copayment</u>
Disorder (<u>ASD</u>)	 Applied behavioral analysis (ABA); 	
	 Psychiatric care; and 	ABA:
	 Psychological care. 	Home: No <u>Copayment</u>
	 See <u>ASD treatment</u> on page 51 for 	
	other <u>ASD</u> care.	Natural Environment Training: \$50
		<u>Copayment</u> /day
	PA Required:	
	 No, for behavioral health therapy 	Office visit: No <u>Copayment</u>
	office visits.	
	 Yes, for other treatment settings. 	
	<u>Limitations</u> :	

Benefit	Description	You Pay
	Applied behavioral analysis limited to	
	the following diagnoses:	
	o Autistic disorder – childhood	
	autism, infantile psychosis, and	
	Kanner's syndrome;	
	Childhood disintegrative disorder	
	- Heller's syndrome;	
	Rett's syndrome; andSpecified pervasive	
	developmental disorders –	
	Asperger's disorder, atypical	
	childhood psychosis, and	
	borderline psychosis of	
	childhood.	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	Subject to General <u>Excluded Services</u> .	
<u>Case</u>	Covered Services:	No <u>Copayment</u>
<u>Management</u>	Home-based support to help you find	
	community resources, services, and self-help.	
	sett-netp.	
	PA Required:	
	• No.	
	<u>Limitations</u> :	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	Subject to General <u>Excluded Services</u> .	
Convulsive	Covered Services:	Included in the <u>Outpatient Copayment</u> ,
therapy	Electroshock treatment or convulsive drug therapy	which is \$300 <u>Copayment</u>
treatment	drug therapy.Includes anesthesia when given with	Included in <u>RTC Copayment</u> or <u>Inpatient</u>
	treatment.	Hospital Facility Copayment, which is
	treatment.	\$300 Copayment/day up to \$900
	PA Required:	Copayment/stay
	• No.	
	<u>Limitations</u> :	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	Subject to General <u>Excluded Services</u> .	

Benefit	Description	You Pay
Counseling	Covered Services:	Behavioral health therapy office visit: No
	Biofeedback.	<u>Copayment</u>
	 Hypnotherapy. 	
	 Individual, group, marital, and/or 	Included in Intensive <u>Outpatient</u>
	family therapy sessions.	program, which is No <u>Copayment</u>
	 Transcranial magnetic stimulation. 	
		Included in Partial <u>Hospitalization</u> , which
	PA Required:	is No <u>Copayment</u>
	 No, for behavioral health therapy 	
	office visits.	Included in <u>RTC Copayment</u> or <u>Inpatient</u>
	 Yes, for other treatment settings. 	<u>Hospital Facility Copayment</u> , which is
		\$300 <u>Copayment</u> /day up to \$900
	<u>Limitations</u> :	<u>Copayment</u> /stay
	 Subject to General limitations. 	
	Excluded Services (Not Covered):	
	Wilderness therapy.	
	• Subject to General <u>Excluded Services</u> .	
Diagnostic	<u>Covered Services</u> :	Behavioral health therapy office visit: No
evaluation and	Services to diagnose a condition.	Copayment
assessment	Psychological, developmental, or	
	neuropsychological testing.	Included in RTC Copayment or Inpatient
	Also see " <u>Diagnostic Tests</u> " on page	Hospital Facility Copayment, which is
	66.	\$300 <u>Copayment</u> /day up to \$900
		<u>Copayment</u> /stay
	PA Required:	
	No, for behavioral health therapy	
	office visits.	
	Yes, for other treatment settings.	
	Limitations:	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	 Education, tutoring, and services 	
	offered through a school/academic	
	institution for the purpose of	
	diagnosing or treating a learning	
	disability, disruptive, impulse-	
	control, or conduct disorder.	
	 Subject to General <u>Excluded Services</u>. 	
<u>Emergency</u>	Covered Services:	\$400 <u>Copayment</u> /visit and waived if
<u>Services</u>	 Life threatening crises intervention 	admitted to <u>Inpatient</u> care within the
<u>Jei vices</u>	including but not limited to:	same <u>Hospital</u> – You pay the <u>Inpatient</u>
	 Suicidal or homicidal thoughts or 	Cost-share instead
	actions;	
	,	

Benefit	Description	You Pay
	 Psychosis; or Mood disorder which results in the inability to take care of one's basic needs. Use the steps from "Emergency Care" on page 27. Observation. PA Required: No. 	
	 Limitations: Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. 	
Home Healthcare	Covered Services: • See "Home Healthcare" on page 28. PA Required:	No <u>Copayment</u>
	 Yes. Limitations: Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. 	6200 6
Inpatient Hospital Facility	 Covered Services: For Medical Services see "Inpatient Hospital Facility" on page 76. Behavioral health services include: Behavioral health consults; Electroconvulsive therapy; Group psychotherapy; Individual and family psychotherapy; Medication management; and Psychological and neuropsychological testing. You must have treatment in a Hospital, psychiatric Hospital, or RTC setting. PA Required: Yes. 	\$300 <u>Copayment</u> /day up to \$900 <u>Copayment</u> /stay

	<u>Limitations</u> :	
	 Subject to General limitations. 	
	Excluded Services (Not Covered):	
	• Subject to General <u>Excluded Services</u> .	
Intensive	Covered Services:	No <u>Copayment</u>
<u>Outpatient</u>	Behavior modification therapies. Multiple times a week for a set.	
program	 Multiple times a week for a set number of hours a day. 	
	number of flours a day.	
	PA Required:	
	• Yes.	
	<u>Limitations</u> :	
	• Subject to General limitations.	
	Excluded Services (Not Covered):	
	Wilderness therapy.	
	Subject to General <u>Excluded Services</u> . Covered Services.	In alluded in DTC Consumerant on Investigat
Medical	Covered Services:Facilities that provide a detox using	Included in <u>RTC Copayment</u> or <u>Inpatient</u> <u>Hospital Facility Copayment</u> , which is
detoxification	medical methods.	\$300 Copayment/day up to \$900
	RTC that provides a chemical	Copayment/stay
	dependency treatment program.	<u>copajmena</u> staj
	, , ,	
	Please Note: Not all RTC facilities	
	provide a medical detox prior to the	
	program.	
	DAD : I	
	PA Required:	
	• Yes.	
	<u>Limitations</u> :	
	 Subject to General limitations. 	
	,	
	Excluded Services (Not Covered):	
	• Subject to General <u>Excluded Services</u> .	
Medication	<u>Covered Services</u> :	<u>Case Management</u> : No <u>Copayment</u>
Assisted	Medication management visits.	B. I. II. III. III. III. III. III. III.
Treatment	Services to treat substance use	Behavioral health therapy office visit: No
Program	disorder:	Copayment
	 Anti-craving medications for alcohol, tobacco, opioid, and 	PCP: No Conayment
	· · · · · · · · · · · · · · · · · · ·	1 CI . NO COPAYMENT
		Included in RTC Copayment or Inpatient
		Hospital Facility Copayment, which is
	alcohol, tobacco, opioid, and other substance use disorders.	PCP: No Copayment Included in RTC Copayment or Inpatient Hospital Facility Copayment, which is

Benefit	Description	You Pay
Denem	 Comprehensive therapy and support to help address issues related to opioid dependence, including: Withdrawal; Cravings; and Relapse prevention. Teach and build healthy coping skills. See "Prescription Drugs Benefits" on page 102. PA Required: No, for behavioral health therapy or PCP office visits. Yes, for RTC or Inpatient Hospital visits. Yes, for some medications. See the Drug Formulary. Limitations: Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. 	\$300 Copayment/day up to \$900 Copayment/stay See "Prescription Drug Benefit Chart" on page 103.
Medication evaluation and management	 Covered Services: Services for Prescription Drug evaluation and management. Drugs may be for mental health and/or substance use disorder. Your PCP or BHP may monitor maintenance drugs. See "Prescription Drugs Benefits" on page 102. PA Required: No, for PCP or BHP office visits. Yes, for other treatment settings. Limitations: Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. 	Behavioral health therapy office visit: No Copayment PCP: No Copayment Included in RTC Copayment or Inpatient Hospital Facility Copayment, which is \$300 Copayment/day up to \$900 Copayment/stay See "Prescription Drug Benefit Chart" on page 103
Partial <u>Hospitalization</u>	<u>Covered Services</u> :	No <u>Copayment</u>

Benefit	Description	You Pay
(day treatment)	 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 <u>Outpatient</u> program. PA Required:	_
	• Yes.	
	<u>Limitations</u>:Subject to General limitations.Excluded Services (Not Covered):	
	 Subject to General <u>Excluded Services</u>. 	
<u>Prescription</u>	Covered Services:	See " <u>Prescription Drug Benefits Chart</u> " on
<u>Drugs</u>	 See "<u>Prescription Drug Benefits</u>" on page 102. 	page 103
	PA Required:See the <i>Drug Formulary</i>.	
	 Limitations: See the <i>Drug Formulary</i>. Subject to General limitations. Subject to <u>Prescription Drug</u> limitations. 	
	 Excluded Services (Not Covered): Subject to General Excluded Services. Subject to Prescription Drug Excluded Services. 	
Psychosocial education	 Covered Services: Home-based education to learn daily living and social skills. Psychological rehabilitation. 	No <u>Copayment</u>
	PA Required: • Yes.	
	 Limitations: Limited to daily living and social skills education. Subject to General limitations. 	
	Excluded Services (Not Covered):	

Benefit	Description	You Pay
	 Education, tutoring, and services offered through a school/academic institution for the purpose of diagnosing or treating a learning disability, disruptive, impulsecontrol, or conduct disorder. Subject to General Excluded Services. 	
RTC	 Covered Services: Care in Facilities licensed as RTCs including: Diagnostics, assessments, and treatment; Educational and support services; Individual, family, marital, and group counseling; Medical, nursing, and dietary services; Psychological and neuropsychological testing; and Room and board. Please Note: Not all RTC Facilities provide a medical detox prior to the program. PA Required: Yes. Limitations: Subject to General limitations. Excluded Services (Not Covered): Wilderness therapy. Subject to General Excluded Services. 	\$300 Copayment/day up to \$900 Copayment/stay
Telehealth	 Covered Services: Access your certified behavioral health practitioner by secure online video or phone. PA Required: No. Limitations: Only available through Providers that offer this service. Subject to General limitations. 	No <u>Copayment</u>

Benefit	Description	You Pay
	 Excluded Services (Not Covered): Subject to General Excluded Services. 	
Testing	 Covered Services: Clinical evaluation using recognized assessment tools: Developmental; Neuropsychological; Psychological; and Substance abuse. PA Required: No, for behavioral health therapy or well-child office visits. Yes, for other treatment settings. Limitations: Autism Screening and developmental Screening limited to well-child visits. Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. 	Behavioral health therapy office visit: No Copayment PCP: No Copayment Included in RTC Copayment or Inpatient Hospital Facility Copayment, which is \$300 Copayment/day up to \$900 Copayment/stay
Tobacco cessation	 Covered Services: Treatment to help you quit using tobacco products. Also see, "Tobacco Cessation" on page 152. PA Required: No. Limitations: Limited to two attempts per year. Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. 	No <u>Copayment</u>
Urgent intervention	 Covered Services: Nonlife-threatening crisis assistance. Face-to-face support at an approved behavioral health <u>Facility</u>. Call Carelon Behavioral Health for help. PA Required: No. 	Behavioral health therapy office visit: No Copayment Included in RTC Copayment or Inpatient Hospital Facility Copayment, which is \$300 Copayment/day up to \$900 Copayment/stay

Benefit	Description	You Pay
	<u>Limitations</u>:Subject to General limitations.	
	<u>Excluded Services (Not Covered)</u>:Subject to General <u>Excluded Services</u>.	

Medical Benefits

Covered Services

You may get some <u>Covered Services</u> in either a <u>Preferred Facility</u> or a <u>Non-preferred Facility</u> within our full <u>Network</u>. We tell you below which services have the choice. Be sure to check when you make an appointment which type of <u>Facility</u> it is *for the service you are having*. The <u>Cost Sharing</u> you pay depends on where you are having the service <u>and</u> what the service is. Call us if you have questions.

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

Also see "Coverage Requirements" on page 40.

Medical Benefits Chart

Benefit	Description	You Pay
Allergy care	• <u>Covered Services</u> :	Testing and Treatment:
_	Serum	PCP: No Copayment
	 Allergy serum and supplies for the 	
	administration of serum.	Included in <u>Specialist Copayment</u> , which
	 Not covered under <u>Prescription</u> 	is \$50 <u>Copayment</u> /visit
	<u>Drug Benefits</u> . Only covered if	
	given to you during an office visit	Serum: \$30 Copayment/ 6 week supply of
	or if the doctor prepares it for you	antigen and administration
	to give to yourself.	
	• Testing	
	Services and supplies used in	
	determining a plan for allergy	
	treatment.	
	Treatment Madical care of allergies	
	 Medical care of allergies. 	
	PA Required:	
	No, for <u>PCP</u> services.	
	 Yes, for <u>Specialist</u> services. 	
	Tes, for <u>specialist</u> services.	
	Limitations:	
	 Subject to General limitations. 	
	•	

Benefit	Description	You Pay
	Excluded Services (Not Covered):	
	• Subject to General <u>Excluded Services</u> .	
Ambulance	 Covered Services: Transport when you must have Emergency Services and an ambulance is required in order to get this care. Air ambulance when you cannot be safely moved by other means. Non-emergency ambulance services when any other mode of transportation is unsafe. PA Required: No, for emergency services. 	\$100 <u>Copayment</u> /occurrence
	 Yes, for non-emergency services. Limitations: Subject to General limitations. Excluded Services (Not Covered): Commercial or public transportation. Gurney van services. Wheelchair van services. Subject to General Excluded Services. 	
Anesthesia	Covered Services:	Included in <u>Specialist</u> <u>Copayment</u> , which
	 Services as part of a procedure or surgery. Also see "<u>Dental care – anesthesia</u>" on page 62. <u>PA Required</u>: Yes. <u>Limitations</u>: Subject to General limitations. <u>Excluded Services (Not Covered)</u>: 	is \$50 Copayment/visit Included in the Outpatient Preferred Facility Copayment, which is \$300 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is \$800 Copayment Included in the Inpatient Hospital Facility Copayment, which is \$300
	Subject to General <u>Excluded Services</u> .	Copayment/day up to \$900
	,	<u>Copayment</u> /stay
ASD treatment	See below.	See below
ASD – pharmacy	Covered Services:See "Prescription Drug Benefits" on page 102.	See " <u>Prescription Drug Benefits Chart</u> " on page 103

Benefit	Description	You Pay
	PA Required:	
	See the <i>Drug Formulary</i> .	
	<u>Limitations</u> :	
	See the Drug Formulary.	
	Subject to General limitations.	
	Subject to <u>Prescription Drug</u>	
	limitations.	
	Fushed ad Carriage (Nat Carrent)	
	Excluded Services (Not Covered):	
	Subject to General <u>Excluded Services</u> .	
	Subject to <u>Prescription Drug Excluded</u> Sanitage	
	Services.	No Consument
ASD - Screening	Covered Services:	No <u>Copayment</u>
	 Developmental delays and disabilities Screening. 	
	Exam, including observations, family	
	history, and parental perspective.	
	motory, and parental peropeetive.	
	PA Required:	
	• No.	
	<u>Limitations</u> :	
	 Limited to well-child visits. 	
	 Subject to General limitations. 	
	Excluded Services (Not Covered):	
	Subject to General <u>Excluded Services</u> .	
ASD -	<u>Covered Services</u> :	Office visits: \$35 <u>Copayment</u> /visit
therapeutic	Habilitation Services related to an	
care	ASD diagnosis:	Included in rehabilitation <u>Outpatient</u>
	 Physical, occupational, and 	Facility, which is \$70 Copayment/visit
	speech therapies. o Does not count toward the	Included in the Innational Hespital Facility
		Included in the <u>Inpatient Hospital Facility</u> <u>Copayment</u> , which is \$300
	Rehabilitation Services visit limitations you may otherwise be	
	entitled to.	Copayment/day up to \$900 Copayment/stay
	entitied to.	Copayment/stay
	PA Required:	Included in the <u>Home Healthcare</u>
	• Yes.	Copayment, which is No Copayment
	<u>Limitations</u> :	
	ASD treatment limited to the	
	following diagnoses:	

Benefit	Description	You Pay
	 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. Subject to General limitations. Excluded Services (Not Covered):	
	• Subject to General <u>Excluded Services</u> .	
Attention Deficit Hyperactivity Disorder (<u>ADHD</u>)	 Covered Services: Medical management, including: Diagnostic evaluation; Laboratory services for monitoring prescribed drugs; and Treatment. Counseling 	Lab, x-ray, and <u>Diagnostic Tests</u> : \$10 <u>Copayment</u> /visit <u>PCP</u> : No <u>Copayment</u> Counseling: See " <u>Behavioral Health</u> <u>Benefits Chart</u> " on page 41
	 PA Required: No. Limitations: Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. 	
Bariatric	Covered Services:	Included in the <u>Outpatient Preferred</u>
surgery	Lap-band surgery. PA Required:	Facility Copayment, which is \$300 Copayment
	• Yes.	Included in the <u>Outpatient Non-preferred</u>
	Limitations: • Subject to General limitations.	Facility Copayment, which is \$800 Copayment
	 Excluded Services (Not Covered): Bariatric surgery is not covered when related to weight loss alone. Your doctor must tell us the medical condition that requires surgery. Subject to General Excluded Services. 	Included in the <u>Inpatient Hospital Facility</u> <u>Copayment</u> , which is \$300 <u>Copayment</u> /day up to \$900 <u>Copayment</u> /stay

Benefit	Description	You Pay
Blood and blood	Covered Services:	Included in <u>ER Copayment</u> , which is \$400
products	 Processing, storage, and 	<u>Copayment</u> /visit
'	administration, including collection	
	and storage of autologous blood.	Included in the <u>Outpatient Preferred</u>
	Donated blood is a non-billable item.	Facility Copayment, which is \$300
		Copayment
	PA Required:	
	No, for emergencies.	Included in the <u>Outpatient Non-preferred</u>
	 Yes, for all other settings. 	Facility Copayment, which is \$800
	res, for all other settings.	<u>Copayment</u>
	Limitations:	oopayee
	 Subject to General limitations. 	Included in the <u>Inpatient Hospital Facility</u>
	Subject to defler at tillitations.	Copayment, which is \$300
	Evaluded Services (Not Covered).	Copayment/day up to \$900
	Excluded Services (Not Covered):	
	Subject to General Excluded Services. Covered Services:	Copayment/stay
Bone density	<u>Covered Services</u> :	No <u>Copayment</u>
test	Measurements used to detect low	
	bone mass and to determine risk for	
	osteoporosis in women.	
	Age 45 years and older:	
	 Have an estrogen hormone 	
	deficiency;	
	 Have vertebral abnormalities, 	
	primary hyperparathyroidism, or a	
	history of fragility bone fractures;	
	o Receive long-term glucocorticoid;	
	or	
	 Under current treatment for 	
	osteoporosis.	
	Age 60 years and older:	
	 Routine <u>Screening</u> when at higher 	
	risk for osteoporotic fractures.	
	 Age 65 years and older. 	
	PA Required:	
	• No.	
	<u>Limitations</u> :	
	DEXA scans limited to one every 24	
	months.	
	Subject to General limitations.	
	5 1 1 10 1 10 10 10 10	
	Excluded Services (Not Covered):	
	Subject to General <u>Excluded Services</u> .	
Breast cancer –	Covered Services:	Included in the <u>Inpatient Hospital Facility</u>
<u>Inpatient</u> care	• At least 48 hours after a mastectomy;	Copayment, which is \$300

Benefit	Description	You Pay
	 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. PA Required: Yes. Limitations: Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. 	Copayment/stay Copayment/stay
Breast cancer – Preventive Care	 Genetic Assessment: For women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer. For women who have an ancestry associated with breast cancer susceptibility. Genetic counseling with a positive result on the risk assessment. Genetic testing if indicated. 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. PA Required: Yes. Limitations: Subject to General limitations. 	No <u>Copayment</u>

Benefit	Description	You Pay
	Excluded Services (Not Covered):	
	• Subject to General Excluded Services.	
Breast cancer –	Covered Services:	External appliances: 20% Coinsurance
prosthetic	Surgically implanted and external	
appliance	appliances.	Internal appliances: Included in the
		Inpatient Hospital Facility Copayment,
	PA Required:	which is \$300 <u>Copayment</u> /day up to \$900
	• Yes.	<u>Copayment</u> /stay
	<u>Limitations</u> :	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	• Clothing or devices available <u>OTC</u> .	
	• Subject to General Excluded Services.	
Breast cancer –	Covered Services:	Radiation or chemotherapy
treatment	All types of treatment.	treatment:
		 Office or <u>Preferred Facility</u>:
	PA Required:	 Included in office or <u>Facility</u>
	• Yes.	Copayment, which is \$30
		<u>Copayment</u> /treatment
	Limitations:	Non-material Position to alcoholish
	Subject to General limitations.	 <u>Non-preferred Facility</u>: Included in office or <u>Facility Copayment</u>, which is
	Excluded Services (Not Covered):	\$50 Copayment/treatment
	 Subject to General <u>Excluded Services</u>. 	• Soo <u>copayment</u> , treatment
	Subject to deficial <u>Excluded Services</u> .	 Equipment, services, drugs, and
		supplies, other than radiation or
		chemotherapy, in an office: Included
		in <u>Specialist Copayment</u> , which is \$50
		<u>Copayment</u> /visit
		•
		Included in the <u>Inpatient Hospital</u> This is a second to the inpatient Hospital
		Facility Copayment, which is \$300
		Copayment/day up to \$900
		<u>Copayment</u> /stay
		 Equipment, services, and supplies
		billed from <u>Home Healthcare</u> agency:
		No <u>Copayment</u>
		•
		Prescription Drug at pharmacy: See
		" <u>Prescription Drug Benefits Chart</u> " on
		page 103
Cardiac	Covered Services:	\$20 Copayment/visit
	Counseling;	

Benefit	Description	You Pay
rehabilitation –	Education; and	
<u>Outpatient</u>	 Exercise. Covered conditions: Recovering from: Coronary bypass surgery; Heart attack; or Heart transplant. 	
	PA Required: ● Yes.	
	 Limitations: Limited to 36 visits per event. Subject to General limitations. Excluded Services (Not Covered):	
	Subject to General <u>Excluded Services</u> .	405.0
Chiropractic care	Covered Services:Services during an office visit.	\$25 <u>Copayment</u> /visit
	 PA Required: No. Limitations: Limited to 15 visits per year. Subject to General limitations. Excluded Services (Not Covered): 	
	Subject to General <u>Excluded Services.</u>	
Cleft lip and cleft palate treatment	Covered Services: Inpatient and Outpatient care for cleft lip or cleft palate or both including: Oral surgery; Orthodontics; and Otologic, audiological, and speech/language treatment.	Included in Specialist Copayment, which is \$50 Copayment/visit Included in the Outpatient Preferred Facility Copayment, which is \$300 Copayment Included in the Outpatient Non-preferred
	PA Required: • Yes.	Facility Copayment, which is \$800 Copayment
	<u>Limitations</u>:Subject to General limitations.	Included in the <u>Inpatient Hospital Facility</u> <u>Copayment</u> , which is \$300 <u>Copayment</u> /day up to \$900
	<u>Excluded Services (Not Covered)</u>:Subject to General <u>Excluded Services</u>.	<u>Copayment</u> /stay

Benefit	Description	You Pay
		Otologic, audiological, and speech/language treatment office visit: \$35 Copayment/visit
		Included in rehabilitation <u>Outpatient</u> <u>Facility</u> , which is \$70 <u>Copayment</u> /day
Clinical trials	 Covered Services: 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). PA Required: Yes. Limitations: Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. 	Lab: \$10 Copayment/visit Included in Specialist Copayment, which is \$50 Copayment/visit Included in ER Copayment, which is \$400 Copayment/visit and waived if admitted to Inpatient care within the same Hospital – You pay the Inpatient Costshare instead Included in the Outpatient Preferred Facility Copayment, which is \$300 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is \$800 Copayment Included in the Inpatient Hospital Facility Copayment, which is \$300 Copayment, which is \$300 Copayment/day up to \$900
Colorectal cancer preventive Screening	 Covered Services: See "Preventive Care Benefits" on page 109. Colonoscopy – Once every 10 years, the preventive Screening process includes:	No Copayment Bowel preparation medication Copayment dependent on Tier. See your Drug Formulary.

Benefit	Description	You Pay
	 Pathology to determine whether the polyp is malignant. For bowel preparation medication, some are available at no cost. See your <i>Drug Formulary</i>. CT Colonoscopy – Every five years. Fecal immunochemical test (FIT) – Every 12 months. Fecal occult blood testing (FOBT) – Every 12 months. FIT-DNA – Every three years. Doctor's prescription required. Follow-up colonoscopy after a positive sigmoidoscopy or CT colonography. Sigmoidoscopy Once every three years. Once every five years with FOBT every 12 months. Once every 10 years with FIT every 12 months. PA Required: No. 	
	 Limitations: Limited to the <u>USPSTF Screening</u> schedule. Subject to General limitations. Subject to <u>Preventive Care</u> limitations. Excluded Services (Not Covered): Subject to General <u>Excluded Services</u>. Subject to <u>Preventive Care Excluded</u> 	
	Services.	
Contraception services	 Covered Services: Counseling, contraceptive use, and follow-up care (such as, management, evaluation, changes, and removal or discontinuation). Office visits include one more of each type at no cost: Diaphragm; IUD copper; IUD with progestin; and 	No <u>Copayment</u>

Benefit	Description	You Pay
	 Shot/injection. Surgical coverage includes one or more of each type at no cost: Cervical cap; Implantable rod; Sterilization surgery; and Surgical sterilization implant for women. Prescription Drug Coverage includes 	
	 one or more of each type at no cost: Oral contraceptives (combined pill); Oral contraceptives (progestin only); Oral contraceptives (extended/continuous use); Patch; Sponge; Condom; Spermicide; Shot/injection; Vaginal contraceptive ring; Emergency contraception (Plan B/Plan B One Step/Next Choice); and Emergency contraception (Ella). Additional contraceptives approved, granted, or cleared by the FDA. Services and items at no cost include all items and services integral to furnishing contraceptives such as anesthesia, the device, and the office visit or Facility. 	
	 PA Required: No, for services in an office visit. Yes, for all other services and treatment settings. See the <i>Drug Formulary</i> for Prescription Drug information. 	
	 Limitations: Subject to General limitations. Subject to <u>Prescription Drug</u> limitations. 	

Benefit	Description	You Pay
	 Excluded Services (Not Covered): Hysterectomies for the purpose of contraception. Reversal of voluntary surgical sterilization. Subject to General Excluded Services. Subject to Prescription Drug Excluded Services. 	
Cosmetic and	<u>Covered Services</u> :	Included in the <u>Outpatient Preferred</u>
<u>Reconstructive</u>	Outpatient surgical services.	Facility Copayment, which is \$300
<u>Surgery</u>	 Inpatient Hospital Services. 	<u>Copayment</u>
	PA Required: • Yes. Limitations:	Included in the <u>Outpatient Non-preferred</u> <u>Facility Copayment</u> , which is \$800 <u>Copayment</u>
	 Cosmetic surgery limited to: Breast reconstruction after a mastectomy; Improvement of the functioning of a malformed part of the body; and Repair due to an accidental injury. Reconstructive Surgery limited to: Breast reduction; 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; 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; and Trauma, infection, tumors, or disease. Dentistry or dental processes to the teeth and surrounding tissue limited to: Surgery to improve function of the 	Included in the Inpatient Hospital Facility Copayment, which is \$300 Copayment/day up to \$900 Copayment/stay

Benefit	Description	You Pay
	a birth defect. Does not include	
	dental work.	
	 Subject to General limitations. 	
	Excluded Services (Not Covered):	
	• Subject to General <u>Excluded Services</u> .	
Dental care –	<u>Covered Services</u> :	Included in the <u>Outpatient Preferred</u>
anesthesia	Anesthesia;	Facility Copayment, which is \$300
	Anesthesiologist; and	Copayment
	Hospital or surgical center <u>Facility</u>	
	required for dental procedures.	Included in the <u>Outpatient Non-preferred</u>
		Facility Copayment, which is \$800
	PA Required:	Copayment
	• Yes.	
		Included in the <u>Inpatient Hospital Facility</u>
	<u>Limitations</u> :	Copayment, which is \$300
	General anesthesia/IV sedation for	Copayment/day up to \$900
	dental services limited to a <u>Member</u>	<u>Copayment</u> /stay
	who:	
	Has a medical or emotional	
	condition that requires	
	Hospitalization or general	
	anesthesia for dental care;	
	o Is severely disabled;	
	 In the judgment of the treating 	
	Practitioner, is not of sufficient	
	emotional development to	
	undergo a <u>Medically Necessary</u>	
	dental procedure without the use	
	of anesthesia; and	
	Requires <u>Inpatient</u> or <u>Outpatient</u>	
	services because of an underlying medical condition and clinical	
	status or because of the severity of	
	the dental procedure.	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	 Correction of occlusive jaw defects, 	
	dental implants, or grafting of	
	alveolar ridges.	
	General or preventive dentistry. Non amorgansy procedures that	
	Non-emergency procedures that involve the teeth or their supporting	
	involve the teeth or their supporting	
	structures.	

Benefit	Description	You Pay
	 Treatment of soft tissue to prepare for dental procedures or dentures. Subject to General <u>Excluded Services</u>. 	
Dental care – emergencies	 Covered Services: Care for accidental injury to the jaw, sound natural teeth, mouth, or face. PA Required: No. 	Included in <u>ER Copayment</u> , which is \$400 <u>Copayment</u> /visit and waived if admitted to <u>Inpatient</u> care within the same <u>Hospital</u> – You pay the <u>Inpatient Costshare</u> instead
	 Limitations: Limited to <u>ER</u> services to treat accidental injury to the jaw, sound natural teeth, mouth, or face. Subject to General limitations. 	
	 Excluded Services (Not Covered): Replacement, re-implantation, and follow-up care of those teeth, even if the teeth are not saved by emergency stabilization. Subject to General Excluded Services. 	
Diabetic care	 Medical care for: Pre-diabetes; Insulin dependent (type I); Non-insulin dependent (type II); and Elevated blood glucose levels during pregnancy. See below. 	See below
Diabetic care – diabetic supplies	 Covered Services: Cartridges for the legally blind; Injection aids; Syringes; Test strips for glucose monitors; Visual reading and urine testing strips; and Other diabetes equipment and related services that are determined Medically Necessary by the Oklahoma State Board of Health, provided the FDA has approved such equipment and supplies. 	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 \$300 Copayment/day up to \$900 Copayment/stay Supplies billed by a Home Healthcare or Hospice Services agency: No Copayment
	PA Required:No, for monitors we provide.	

Benefit	Description	You Pay
	See the Drug Formulary.	-
	-	
	<u>Limitations</u> :	
	See the Drug Formulary.	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	• Subject to General <u>Excluded Services</u> .	
Diabetic care –	<u>Covered Services</u> :	20% <u>Coinsurance</u>
<u>DME</u> , orthotics,	Appliances for feet to prevent	
and supplies	complications from diabetes;	Equipment during office or <u>Facility</u> visit:
	Blood glucose monitors;	Included in <u>Specialist Copayment</u> , which
	Blood glucose monitors for the legally	is \$50 <u>Copayment</u> /visit
	blind;	
	Insulin pumps and needed	Included in the <u>Outpatient Preferred</u>
	accessories; and	Facility Copayment, which is \$300
	Insulin infusion devices.	Copayment
	B4 B	Included in the Outpatient New professed
	PA Required:	Included in the <u>Outpatient Non-preferred</u>
	• Yes.	Facility Copayment, which is \$800
	Limitations	Copayment
	Limitations:	Equipment billed by a <u>Home Healthcare</u>
	Footwear limited to shoes, shoe inserts, arch supports, and supportive	or <u>Hospice Services</u> agency: No
	inserts, arch supports, and supportive devices for <u>Members</u> diagnosed with	Copayment
	diabetes or a blood circulation	Сораутель
	disease.	
	Glucometers limited to two per year.	
	 Subject to General limitations. 	
	Subject to deficial limitations.	
	Excluded Services (Not Covered):	
	 Subject to General <u>Excluded Services</u>. 	
Diabetic care –	Covered Services:	See "Prescription Drug Benefits Chart" on
medications	• Insulin; and	page 103
Inedications	Oral agents for controlling blood	h 200 - 200
	sugar.	
	PA Required:	
	See the Drug Formulary.	
	<u>Limitations</u> :	
	See the <i>Drug Formulary</i> .	
	Subject to General limitations.	
	Subject to <u>Prescription Drug</u>	
	limitations.	

Benefit	Description	You Pay
	 Excluded Services (Not Covered): Subject to General Excluded Services. Subject to Prescription Drug Excluded Services. 	
Diabetic care – <u>Diabetes</u> <u>Prevention</u> <u>Program</u>	 Covered Services: Services for pre-diabetic Members (higher than normal blood sugar level, but not yet diagnosed with diabetes). Support to learn new skills: Being active; Eating healthy; and Losing weight. PA Required: 	No <u>Copayment</u>
	 Yes. Limitations: Limited to Members age 18 and over. Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. 	
Diabetic care - self- management training, education, and medical nutrition	Covered Services: Services at no cost include: Visits at the diagnosis of diabetes; Visits your doctor recommends due to a change in your symptoms or condition that mean you need changes in self-management; and Visits for re-education or refresher training. Training may be from your doctor or a diabetic educator. Or, your doctor may send us a Referral for visits to a nutritionist or dietitian. You may pay the Specialist Cost-share if you have other services during the visit. PA Required: No, for PCP or diabetic educator. Yes, for other Practitioners. Limitations: Subject to General limitations.	No Copayment

Benefit	Description	You Pay
	Excluded Services (Not Covered):	
	• Subject to General <u>Excluded Services</u> .	
Diagnostic Tests	 Covered Services: Laboratory and radiological services including, but not limited to:	\$10 Copayment/visit
	 Limitations: Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. 	
DME	Covered Services:	20% Coinsurance
	 Equipment and supplies your Provider orders for everyday or extended use. Covered Services examples include: CPAP and supplies Crutches Oxygen and oxygen equipment Some equipment and supplies for diabetes self-management Wheelchairs 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. Replacement, repairs, adjustments, maintenance, and delivery costs. 	Equipment during office or Facility visit: Included in Specialist Copayment, which is \$50 Copayment/visit Included in ER Copayment, which is \$400 Copayment/visit and waived if admitted to Inpatient care within the same Hospital – You pay the Inpatient Costshare instead Included in the Outpatient Preferred Facility Copayment, which is \$300 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is \$800 Copayment Included in the Inpatient Hospital Facility Copayment, which is \$300

Benefit	Description	You Pay
	PA Required:	Copayment/day up to \$900
	• Yes.	<u>Copayment</u> /stay
	<u>Limitations</u> :	Equipment billed by a <u>Home Healthcare</u>
	 Knee walker or kneeling crutch 	or <u>Hospice Services</u> agency: No
	rentals limited to 4 months.	<u>Copayment</u>
	Oxygen and oxygen equipment	
	rentals limited to 36 months and	
	remaining <u>Medically Necessary</u> .	
	Other <u>DME</u> rentals limited to 13	
	months.	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	 Changes to your home or vehicle. 	
	 Continuous passive motion devices. 	
	Devices available OTC.	
	Equipment that serves as comfort or	
	convenience.	
	 For example, portable oxygen 	
	concentrators.	
	Jacuzzi/whirlpools.	
	Mattresses and other bedding or bed	
	wetting alarms.	
	Multiple <u>DME</u> items for the same or	
	like purposes.	
	 Power-operated vehicles that may be used as wheelchairs. 	
	 Purchase or rental of equipment or 	
	supplies for common household use	
	such as:	
	 Air-cleaning machines or filtration 	
	devices	
	 Air conditioners 	
	 Beds and chairs 	
	 Cervical or lumbar pillows 	
	o Grab bars	
	 Physical fitness equipment 	
	 Raised toilet seats 	
	 Shower benches 	
	 Traction tables 	
	Water purifiers	
	Upgrade features to enhance basic	
	equipment.	
	• Subject to General <u>Excluded Services</u> .	

Benefit	Description	You Pay
Emergency	Covered Services:	See "Prescription Drug Benefits Chart" on
medications	 Medications prescribed during an <u>ER</u> visit. 	page 103
	PA Required:See the <i>Drug Formulary</i>.	
	 Limitations: See the <i>Drug Formulary</i>. Subject to General limitations. Subject to <u>Prescription Drug</u> limitations. 	
	 Excluded Services (Not Covered): Subject to General Excluded Services. Subject to Prescription Drug Excluded Services. 	
Emergency Services	Covered Services: See "Emergency Care" on page 27. 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: Your health would be put in serious danger; or You would have serious problems with your bodily functions; or You would have serious damage to any part or organ of your body. Services provided by an Out-of- Network Provider. Includes observation services. PA Required: No.	\$400 Copayment/visit Waived if admitted to Inpatient care from the ER department within the same Hospital – You pay the Inpatient Costshare instead
	<u>Limitations</u>:Subject to General limitations.<u>Excluded Services (Not Covered)</u>:	
	 Subject to General <u>Excluded Services</u>. 	

Benefit	Description	You Pay
Eyeglasses	 Covered Services: Eyewear for adults and children following cataract surgery. 	See " <u>Vision Benefits</u> " on page 115
	PA Required: ■ No.	
	 Limitations: Limited to pair of basic non-designer frames and single vision lenses or contact lenses following cataract surgery. Subject to General limitations. Subject to vision limitations. 	
	 Excluded Services (Not Covered): Subject to General Excluded Services. Subject to Vision Excluded Services. 	
Foot care	 Covered Services: Care for injuries or conditions that affect your feet. Routine care for Members with diabetes or a blood circulation disease includes: Annual diabetic foot exam; Nail trimming, cutting, and debridement; and Hygienic and preventive foot care. 	PCP: No Copayment Included in Specialist Copayment, which is \$50 Copayment/visit
	 No, for <u>PCP</u> visits. Yes, for other treatment settings. Limitations: Routine care is limited to <u>Members</u> with diabetes or a blood circulation disease. Subject to General limitations. Excluded Services (Not Covered): 	
Genetic analysis, services, or testing	 Subject to General Excluded Services. Covered Services: Biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition when the 	No <u>Copayment</u>

Benefit	Description	You Pay
	test is supported by medical and scientific evidence. Clinical genetic testing for an inherited gene mutation for individuals with a personal or family history of cancer Evidence-based cancer imaging for individuals with an increased risk of cancer BRCA 1 and BRCA 2 gene testing. See "Breast cancer – Preventive Care" on page 55.	·
	PA Required: • Yes.	
	<u>Limitations</u> : • Subject to General limitations.	
	 Excluded Services (Not Covered): Genetic counseling and testing for family planning. Subject to General Excluded Services. 	
<u>Habilitation</u>	Covered Services:	Services in office: \$35 <u>Copayment</u> /visit
<u>Services</u>	 Habilitation Services related to an ASD diagnosis: Physical, occupational, and speech therapies. Habilitation Services related to cleft lip and cleft palate treatment: Otologic, audiologic, and speech/language treatment. Does not count toward the Rehabilitation Services visit limitations you may otherwise be entitled to. See "Behavioral Health Benefits" on page 40. 	Included in rehabilitation <u>Outpatient</u> <u>Facility</u> , which is \$70 <u>Copayment</u> /day Included in the <u>Inpatient Hospital Facility</u> <u>Copayment</u> , which is \$300 <u>Copayment</u> /day up to \$900 <u>Copayment</u> /stay Included in <u>Home Healthcare</u> : <u>Copayment</u> , which is No <u>Copayment</u>
	PA Required: • Yes.	
	<u>Limitations</u>:<u>ASD</u> limited to the following diagnoses:	

Benefit	Description	You Pay
Hearing services – Cochlear°	 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. Cleft lip and cleft palate treatment limited to otologic, audiologic, and speech/language treatment. Subject to General limitations. Excluded Services (Not Covered): Acupuncture/acupressure. Kinesiology or movement therapy. Private duty nursing. Recreational therapy including, but not limited to:	Included in the Outpatient Preferred Facility Copayment, which is \$300 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is \$800 Copayment
	<u>Excluded Services (Not Covered)</u>:Subject to General <u>Excluded Services</u>.	

Benefit	Description	You Pay
Hearing services - evaluation for hearing aid	 Covered Services: Testing to determine need for hearing aid. Related services needed to access, select, and fit or adjust a hearing aid. You must visit a NationsHearing audiologist. Call 1-800-921-4559 for help. PA Required: No. Limitations: Limited to one routine hearing exam per year. Subject to General limitations. 	No Copayment
Hearing services - hearing aids and devices	 Subject to General Excluded Services. Covered Services: Repairs and replacement parts (except when lost, sold, damaged, or destroyed due to improper use or abuse), adjustments, maintenance, and delivery costs. You must get your hearing aids through NationsHearing providers. Hearing aid purchases include: 	Entry level hearing aids: 20% Coinsurance Upgraded technology: You pay the charge above the cost of an entry level hearing aid in addition to your coinsurance for the entry level hearing aid – the extra amount does not count toward your MOOP Repairs, replacement parts, adjustments, maintenance, delivery: 20% Coinsurance One-time coverage for lost, stolen, or damaged hearing aid: You pay the manufacturer's Deductible for any warranty included with your hearing aid or for which you paid – does not count toward your MOOP

Benefit	Description	You Pay
	 Limited to four additional ear molds per year (two molds for each ear) for children less than two years of age. Subject to General limitations. Excluded Services (Not Covered): Accessories. Additional warranties. Subject to General Excluded Services. 	
Hearing services - <u>Screening</u>	Covered Services: Screening by PCP. Evaluation by audiologist. PA Required: No.	No <u>Copayment</u>
	 Limitations: Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. 	
Hearing services - testing for diagnostic purposes	 Covered Services: Testing to diagnose medical conditions. You must visit a GlobalHealth audiologist. 	Included in <u>Specialist Copayment</u> , which is \$50 <u>Copayment</u> /visit
	 PA Required: Yes. Limitations: Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. 	
<u>Home</u> <u>Healthcare</u>	Covered Services: See "Home Healthcare" on page 73. PA Required: Yes. Limitations: Limited to a total of 100 visits per year. Subject to General limitations.	Services, drugs, supplies, and equipment billed by a <u>Home Healthcare</u> agency: No <u>Copayment</u> Equipment billed separately: 20% <u>Coinsurance</u>

Benefit	Description	You Pay
	Excluded Services (Not Covered):	
	• Subject to General Excluded Services.	
<u>Hospice</u>	Covered Services:	Consultation visit: No Copayment
Hospice Services	 Covered Services: 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	Consultation visit: No Copayment Services, drugs, supplies, and equipment billed by a hospice agency: No Copayment Equipment billed separately: 20% Coinsurance
	Excluded Services (Not Covered):	
	Subject to General <u>Excluded Services</u> .	 N
Immunizations	Covered Services:	No <u>Copayment</u>

Benefit	Description	You Pay
	See " <u>Preventive Care Benefits</u> " on page 109.	
	PA Required: ■ No.	
	 Limitations: Limited to <u>CDC</u>-recommended schedules. Subject to General limitations. Subject to <u>Preventive Care</u> limitations. 	
	 Excluded Services (Not Covered): Unless also a Preventive Service, shots you must have for: Employment; The military; Travel; or A vocational school or institute of higher education. Subject to General Excluded Services. Subject to Preventive Care Excluded 	
	Services.	
Infertility services	 Covered Services: Testing and diagnosis. Medications. Treatment for men and women. 	Lab and <u>Diagnostic Tests</u> : \$10 <u>Copayment</u> /visit <u>PCP</u> : No <u>Copayment</u>
	PA Required:No, for PCP visits.No, for standard fertility preservation	Included in <u>Specialist Copayment</u> , which is \$50 <u>Copayment</u> /visit
	 services Yes, for all other treatment settings. See the <i>Drug Formulary</i> for drugs. 	Other treatment: 50% <u>Coinsurance</u> See " <u>Prescription Drug Benefits Chart</u> " on page 103.
	 Limitations: Limited to Cryopreservation or storage of sperm (sperm banking), eggs, or embryos for individuals diagnosed with cancer and who are within reproductive age when a treatment may directly or indirectly cause iatrogenic infertility. See the <i>Drug Formulary</i> for drugs. Subject to General limitations. 	

Benefit	Description	You Pay
Benefit	 Excluded Services (Not Covered): Cost of donor sperm or donor egg. Genetic counseling and genetic Screening. Insemination procedures and all services related to insemination. Gamete Intrafallopian Transfer (GIFT) Intracervical Insemination (ICI) In Vitro Fertilization (IVF) 	
	 Zygote Intrafallopian Transfer (ZIFT) Reversal of a sterilization procedure. Services associated with these procedures Surrogate parenting. Subject to General Excluded Services. 	
Injectable drugs	 Subject to General Excluded Services. Covered Services: Outpatient injectable drugs Drugs your doctor gives you in the office. Self-injectable drugs Drugs you inject that you buy at a pharmacy. 	PCP: No Copayment Included in Specialist Copayment, which is \$50 Copayment/visit See "Prescription Drug Benefits Chart" on page 103.
	 PA Required: No, for PCP visits. Yes, for all other treatment settings. See the Drug Formulary for self-injectable drugs. Limitations: Subject to General limitations. Excluded Services (Not Covered): 	
Inpatient Hospital Facility	 Subject to General Excluded Services. Covered Services: 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; 	\$300 <u>Copayment</u> /day up to \$900 <u>Copayment</u> /stay <u>ER</u> transfers within the same <u>Hospital</u> : <u>ER</u> <u>Copayment</u> waived – You pay the <u>Inpatient Copayment</u> instead

Benefit	Description	You Pay
Laboratory services	 General nursing care; Meals and special diets; Physician and professional services; 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. Rehabilitation Services when we expect you will have significant improvement within two months. PA Required: Yes. Limitations: Hospital private room limited to isolation to prevent contagion per the Hospital's infection control policy. Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. Covered Services: Diagnostic and therapeutic laboratory services including:	\$10 Copayment/visit
Mammogram - diagnostic	 Limitations: Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. Covered Services: Testing: 	No <u>Copayment</u>

Benefit	Description	You Pay
	 Breast magnetic resonance imaging (MRI) Breast tomosynthesis Breast ultrasound 	
	o Diagnostic mammogram	
	PA Required:	
	• Yes.	
	<u>Limitations</u>:Subject to General limitations.	
	Excluded Services (Not Covered):	
	• Subject to General <u>Excluded Services</u> .	
Mammogram -	Covered Services:Screening:	No <u>Copayment</u>
Screening	 Between the ages of 35 and 39 One routine mammogram during this 5-year span 	
	Age 40 and over	
	One routine mammogram	
	every 12 months	
	2D and 3D mammogramsIf additional imaging (e.g.,	
	o if additional imaging (e.g., contrast-enhanced	
	mammography, magnetic	
	resonance imaging (MRI), breast	
	ultrasound, or molecular breast	
	imaging) is indicated, these	
	services are covered to complete	
	the screening process for	
	malignancies based on personal	
	or family history or additional	
	factors that increase the risk of	
	breast cancerPatient navigation services involve	
	o Patient navigation services involve person-to-person (e.g., in-person,	
	virtual, hybrid models) contact	
	with the patient. Services include,	
	but are not limited to, person-	
	centered assessment and	
	planning, health care access and	
	health system navigation, referrals	
	to appropriate support services	
	(e.g., language translation,	

Benefit	Description	You Pay
	transportation, and social services), and patient education PA Required: No.	
	<u>Limitations</u>:Subject to General limitations.	
	<u>Excluded Services (Not Covered)</u>:Subject to General <u>Excluded Services</u>.	
Maternity and newborn care	 Covered Services: Pregnancy, labor, and delivery. It includes Complications of Pregnancy, medical care for abortion when the mother's life is endangered, or miscarriage. Morning sickness is not a Complication of Pregnancy. PA Required: No, for emergencies, office visits to your OB/GYN, and delivery Yes, for all other services. Limitations: Subject to General limitations. Excluded Services (Not Covered): Elective abortions. 	Included in the delivery and Inpatient services for mother's Copayment, which is \$500 Copayment/stay Included in ER Copayment, which is \$400 Copayment/visit and waived if admitted to Inpatient care within the same Hospital – You pay the Inpatient Costshare instead Included in the Outpatient Preferred Facility Copayment, which is \$300 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is \$800 Copayment
	 Expenses related to surrogate parenthood. Subject to General <u>Excluded Services</u>. 	
Maternity and newborn care – breastfeeding supplies	 Covered Services: Breastfeeding supplies. Rental or purchase of breastfeeding equipment is for the duration of breastfeeding. Please Note: Breast pumps become 	No <u>Copayment</u>
	available in your third trimester. Contact Customer Care if you need a breast pump earlier. PA Required: Yes.	

Benefit	Description	You Pay
	 Limitations: 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. Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services 	
Maternity and	Covered Services:	\$500 <u>Copayment</u> /stay
newborn care – delivery and Inpatient services for mother	 At least 48 hours of Inpatient care at a Hospital, or a birthing center licensed as a Hospital, following a vaginal delivery. 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; Physical assessment; and Training or assistance with breast or bottle feeding. Other non-emergency admissions or admissions beyond the 48/96 hour routine care require PA. PA Required: No, for these services. Yes, for other non-emergency admissions beyond the 48/96 hour routine care. 	\$300 <u>Copayment</u> stay
	<u>Limitations</u>:Limited to costs resulting from normal, full-term delivery outside of	

Benefit	Description	You Pay
Maternity and newborn care - lactation support services	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 27 for exceptions. Subject to General limitations. Excluded Services (Not Covered): Alternative programs for delivery such as home delivery and use of midwives and birthing centers. Subject to General Excluded Services. Covered Services: Antenatal (before or during childbirth); Perinatal (period around childbirth); and Postpartum (after childbirth) period. One-on-one or group session includes: In-person conversations; Online support; Phone calls; Print materials; and Videos.	No <u>Copayment</u>
	Yes.<u>Limitations</u>:Subject to General limitations.	
	Excluded Services (Not Covered): • Subject to General Excluded Services.	
Maternity and newborn care – newborn services	 <u>Medically Necessary</u> care during the 48/96 hour mother's stay, including Routine <u>Screenings</u>, newborn tests, and immunizations required by law. Newborns hospitalized beyond the 	Inpatient services during mother's 48/96 hour stay: Included in the mother's delivery and Inpatient services Copayment, which is \$500 Copayment/stay
	48/96 hour approved mother's stay require separate <u>Inpatient Hospital Cost-share</u> .	Inpatient services after mother's 48/96 hour stay: Included in the Inpatient Hospital Facility Copayment, which is

Benefit	Description	You Pay
	Medically Necessary services for up to	\$300 Copayment/day up to \$900
	the first 31 days of life. However, if	<u>Copayment</u> /stay
	you do not enroll your newborn in a	
	GlobalHealth <u>Plan</u> , coverage will	Pediatrician office visits: No Copayment
	automatically end after the 31 days.	
	We will coordinate benefits for these	
	31 days if you enroll your newborn in	
	another <u>Plan</u> and the effective date is	
	between birth and day 31. See " <u>When</u>	
	You're Covered by More Than One	
	Plan" on page 139.	
	When the maternity care is for a	
	<u>Dependent</u> child, the newborn (a	
	<u>Dependent</u> of a <u>Dependent</u>) does not	
	have coverage beyond the 48/96 hour	
	approved mother's stay.	
	We cover circumcision for newborns.	
	Also see "Well Visit Checklists" on	
	page 155.	
	PA Required:	
	 No, for the 48/96 hour mother's stay 	
	or pediatrician visits.	
	Yes, for admission past the 48/96 hour	
	mother's stay.	
	,	
	<u>Limitations</u> :	
	Mother must remain enrolled in	
	GlobalHealth.	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	Subject to General <u>Excluded Services.</u>	
Maternity and	Covered Services:	No <u>Copayment</u>
newborn care -	Up to six weeks of postpartum care.	
postpartum	We recommend at least one visit	
visits	between the 3 rd and 6 th weeks.	
	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 <u>Provider</u> whose	
	scope of practice includes	
	providing postpartum care.	

Benefit	Description	You Pay
	 Visits include: Appropriate clinical tests; Depression Screening; Diabetic Screening; Parent education; Physical assessment of the mother and newborn; and Training or assistance with breast or bottle feeding. Counseling interventions for depression. 	
	PA Required:No.Limitations:	
	 Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. 	
Maternity and newborn care – prenatal care	 Covered Services: Case Management services. See "Prenatal Outreach Program" on page 150. Your doctor decides how many visits 	Case Management: No Copayment Routine care: No Copayment Non-routine, non-preventive, or high-risk
	 Your doctor decides now many visits are right for you and what care you get in each visit. Routine services include, but are not limited to: Immunizations Lab work Obstetrical care Screenings Ultrasounds Counseling interventions for 	prenatal services: Included in Specialist Copayment, which is \$50 Copayment/visit Included in ER Copayment, which is \$400 Copayment/visit and waived if admitted to Inpatient care within the same Hospital – You pay the Inpatient Cost-share instead
	depression.See "Well Visit Checklists" on page 155.	Included in the <u>Outpatient Preferred</u> Facility Copayment, which is \$300 Copayment
	 PA Required: No, for Case Management, routine care, or ER visits. Yes, for non-routine, non-preventive, or high-risk prenatal services. 	Included in the <u>Outpatient Non-preferred</u> <u>Facility Copayment</u> , which is \$800 <u>Copayment</u>
	Limitations: • Subject to General limitations.	Included in the <u>Inpatient Hospital Facility</u> <u>Copayment</u> , which is \$300

Benefit	Description	You Pay
	 Excluded Services (Not Covered): Home uterine monitoring. Subject to General Excluded Services. 	Copayment/day up to \$900 Copayment/stay
Medical supplies and materials	Covered Services: OTC items: Diabetic supplies; Disposable supplies needed for DME; and Ostomy supplies. The office visit, Facility, or agency Cost-share includes medical supplies and materials used in the course of a visit or admission such as: Bandages Gauze Ointments Slings PA Required: See the Drug Formulary. Limitations: Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services.	DME and ostomy supplies: 20% Coinsurance Diabetic supplies: 20% Coinsurance Supplies during office or Facility visit: PCP: No Copayment Included in Specialist Copayment, which is \$50 Copayment/visit Included in ER Copayment, which is \$400 Copayment/visit and waived if admitted to Inpatient care within the same Hospital – You pay the Inpatient Costshare instead Included in the Outpatient Preferred Facility Copayment, which is \$300 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is \$800 Copayment Included in the Inpatient Hospital Facility Copayment, which is \$300 Copayment/day up to \$900 Copayment/stay Included in Home Healthcare or Hospice Services Copayment, which is No
Mental/ behavioral health services	 <u>Covered Services</u>: <u>Inpatient</u> and <u>Outpatient</u> services. Telehealth services. 	Copayment See "Behavioral Health Benefits Chart" on page 41
	 PA Required: No, for behavioral health therapy office, telehealth services, or <u>ER</u> visits. Yes, for other treatment settings. 	

Benefit	Description	You Pay
	Services are from your <u>PCP</u> , a	
	Network dietitian or nutritionist, a	
	<u>Network</u> physical therapist, or <u>BHP</u> .	
	PA Required:	
	No, for <u>PCP</u> or <u>BHP</u> services.	
	 Yes, for other treatment settings. 	
	res, for other treatment settings.	
	<u>Limitations</u> :	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	Commercial weight loss programs or	
	OTC weight loss products.	
	Subject to General <u>Excluded Services</u> .	
<u>Oral surgery</u>	Covered Services:	Included in the <u>Outpatient Preferred</u>
	Surgery within or next to the oral	Facility Copayment, which is \$300
	cavity for medical purposes only.	Copayment
	 Oral and maxillofacial surgery for: Biopsy and excision of cysts or 	Included in the <u>Outpatient Non-preferred</u>
	tumors of the jaw;	Facility Copayment, which is \$800
	Treatment of cancer;	Copayment
	 Tooth extraction prior to a major 	
	organ transplant; and	Included in the <u>Inpatient Hospital Facility</u>
	 Radiation of the head or neck, and 	Copayment, which is \$300
	non-dental surgical treatment for	Copayment/day up to \$900
	birth defects.	<u>Copayment</u> /stay
	 Orthognathic surgery when: 	
	 The bite alignment affects your 	
	physical health, not just dental	
	health, such as problems with:	
	 Swallowing; 	
	Speaking; orChaving	
	Chewing.You had trauma to the mouth that	
	affects function.	
	 Other forms of treatment have not 	
	worked.	
	PA Required:	
	• Yes.	
	<u>Limitations</u> :	
	Subject to General limitations.	
	Evaluded Consists (Not Coursed)	
	Excluded Services (Not Covered):	

Benefit	Description	You Pay
	• Subject to General <u>Excluded Services</u> .	
Orthotic	Covered Services:	20% <u>Coinsurance</u>
devices	Boots or other devices related to	
	injury.	Devices during your office or <u>Facility</u> visit:
	 Shoes, shoe inserts, arch supports, 	Included in <u>Specialist</u> <u>Copayment</u> , which
	supportive devices, braces, splints,	is \$50 <u>Copayment</u> /visit
	and trusses.	
	 Replacements, repairs, and 	Included in <u>ER Copayment</u> , which is \$400
	adjustments.	Copayment/visit and waived if admitted
		to <u>Inpatient</u> care within the same
	PA Required:	Hospital – You pay the Inpatient Cost-
	• Yes.	<u>share</u> instead
	<u>Limitations</u> :	Included in the <u>Outpatient Preferred</u>
	Footwear limited to:	Facility Copayment, which is \$300
	 Orthopedic or corrective shoes 	<u>Copayment</u>
	permanently attached to a Denis	
	Browne splint for children.	Included in the <u>Outpatient Non-preferred</u>
	 Shoes, shoe inserts, arch 	Facility Copayment, which is \$800
	supports, and supportive devices	<u>Copayment</u>
	for <u>Members</u> diagnosed with	
	diabetes or a blood circulation	Included in the <u>Inpatient Hospital Facility</u>
	disease.	Copayment, which is \$300
	 Other orthotic devices limited to: 	Copayment/day up to \$900
	 Braces for the leg, arm, neck, 	<u>Copayment</u> /stay
	back, or shoulder;	
	 Back and special surgical corsets; 	
	 Splints for the extremities; and 	
	 Hernia trusses. 	
	 Replacements, repairs, and 	
	adjustments limited to:	
	 Normal wear and tear; or 	
	Due to a significant change in your	
	physical condition.	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	 Devices available <u>OTC</u>. 	
	Equipment or devices not medical in	
	nature such as:	
	 Braces worn for athletic or 	
	recreational use	
	Ear plugs	
	 Elastic stockings and supports 	
	 Garter belts 	
	• Subject to General <u>Excluded Services</u> .	

Benefit	Description	You Pay
Outpatient	<u>Covered Services</u> :	Lab, x-ray, and <u>Diagnostic Tests</u> : \$10
services	• Care including diagnostic, treatment,	<u>Copayment</u> /visit
	and x-ray services. You must not be	
	bedridden.	Imaging <u>Facility</u> – <u>Preferred Facility</u> : \$250
	Services may be given in a doctor's	Copayment
	office, non-hospital based <u>Facility</u> , or	
	a <u>Hospital</u> .	Imaging <u>Facility</u> – <u>Non-preferred Facility</u> :
	Rehabilitation Services when we	\$750 Copayment
	expect you will have significant	Included in <u>Specialist Copayment</u> , which
	improvement within two months.	is \$50 <u>Copayment</u> /visit
	PA Required:	is \$50 <u>copayment</u> , visit
	• Yes.	Included in <u>ER Copayment</u> , which is \$400
	163.	Copayment/visit and waived if admitted
	Limitations:	to <u>Inpatient</u> care within the same
	Subject to General limitations.	Hospital – You pay the Inpatient Cost-
		share instead
	Excluded Services (Not Covered):	
	• Subject to General Excluded Services.	Included in the <u>Outpatient Preferred</u>
		Facility Copayment, which is \$300
		Copayment
		Included in the Outpatient New preferred
		Included in the <u>Outpatient Non-preferred</u> <u>Facility Copayment</u> , which is \$800
		Copayment
		<u>copayment</u>
		Rehabilitation Services in office: \$35
		<u>Copayment</u> /visit
		Rehabilitation <u>Outpatient Facility</u> : \$70
		<u>Copayment</u> /day
		Wound therapy: \$50 <u>Copayment</u> /visit
<u>Outpatient</u>	<u>Covered Services</u> :	Included in the <u>Outpatient Preferred</u>
surgery	Surgery performed in an <u>Outpatient</u> Surgery performed in a <u>Outpatient</u> Surgery p	Facility Copayment, which is \$300
	Facility instead of during an Inpatient	Copayment
	stay when appropriate.	Included in the <u>Outpatient Non-preferred</u>
	PA Required:	Facility Copayment, which is \$800
	• Yes.	Copayment
	. 55.	
	<u>Limitations</u> :	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	Subject to General <u>Excluded Services</u> .	

Benefit	Description	You Pay
Phenylketonuri	Covered Services:	No <u>Copayment</u>
a (PKU) testing	 Newborn testing. See "<u>Preventive</u> 	
	Care Benefits" on page 109.	
	PA Required:	
	• No.	
	<u>Limitations</u> :	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	Subject to General <u>Excluded Services</u> .	
Physical	Covered Services:	Office visits: \$35 <u>Copayment</u> /visit
therapy	Evaluation by a licensed physical	
	therapist.	Included in rehabilitation <u>Outpatient</u>
	The physical therapist may send a Performal forces to 20 days of	<u>Facility</u> , which is \$70 <u>Copayment</u> /day
	Referral for up to 30 days of	Services as <u>Inpatient</u> : Included in the
	treatment. Services beyond the 30 days require a doctor's <u>Referral</u> and	Inpatient Hospital Facility Copayment,
	another authorization.	which is \$300 Copayment/day up to \$900
	All rehabilitation visits count toward	Copayment/stay
	the total combined physical,	сораутеть/зкау
	occupational, and speech therapy	Included in <u>Home Healthcare</u>
	Outpatient visit limits for	Copayment, which is No Copayment
	Rehabilitation Services. Services for	оорајшена , ишен о по оорајшене
	habilitative purposes do not count	
	toward limitation.	
	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.	
	PA Required:	
	 No, for the evaluation only. 	
	 Yes, for therapy sessions. 	
	<u>Limitations</u> :	
	Rehabilitation Services limited to 60	
	combined <u>Outpatient</u> visits per year	
	for:	
	o Physical therapy;	
	Occupational therapy; and/or	
	Speech therapy. ASD treatment. Limited to the	
	ASD treatment – Limited to the following diagnoses:	
	following diagnoses:	

Benefit	Description	You Pay
Benefit	 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. Subject to General limitations. Excluded Services (Not Covered): Acupuncture/acupressure. 	You Pay
	 Kinesiology or movement therapy. Massage therapy. Recreational therapy including, but not limited to: Animal-facilitated therapy Music therapy Rolf technique. Subject to General Excluded Services. 	
<u>Physician</u>	Covered Services:	PCP: No Copayment
<u>Services</u>	 Diagnostic, treatment, consultant, and <u>Referral</u> services provided by your <u>PCP</u> or a <u>Specialist</u>. Services doctors and other health 	Chiropractor: \$25 <u>Copayment</u> /visit Optometrist: \$50 <u>Copayment</u> /visit
	professionals provide are: Allopathic; Chiropractic; Optometric; Podiatric; Psychological; and Second surgical opinion. Locations: ER; Home; Unpatient; Outpatient; and Skilled Nursing Facility. Telemedicine if your Provider offers the service and has contracted with us to provide it.	Podiatrist: \$50 Copayment/visit Behavioral health: See "Behavioral Health Benefits Chart" on page 41. Other Specialist: \$50 Copayment/visit Included in Urgent Care Copayment, which is \$25 Copayment/visit Home Healthcare and Hospice Services: No Copayment Included in ER Copayment, which is \$400 Copayment/visit and waived if admitted to Inpatient care within the same

Benefit	Description	You Pay
	PA Required:	<u>Hospital</u> – You pay the <u>Inpatient Cost-</u>
	No, to see doctors in a <u>PCP</u> , <u>Urgent</u>	<u>share</u> instead
	<u>Care</u> , self-referral, or <u>ER</u> visit setting.	
	Yes, for other treatment settings.	Included in the <u>Outpatient Preferred</u>
	Limitations	Facility Copayment, which is \$300 Copayment
	<u>Limitations</u> : • Subject to General limitations.	<u>Copayment</u>
	Subject to defler at tillitations.	Included in the <u>Outpatient Non-preferred</u>
	Excluded Services (Not Covered):	Facility Copayment, which is \$800
	 Subject to General <u>Excluded Services</u>. 	Copayment
		Included in the <u>Inpatient Hospital Facility</u>
		Copayment, which is \$300
		Copayment/day up to \$900
		<u>Copayment</u> /stay
		Included in Chill IN 1 5 200
		Included in Skilled Nursing Facility
		Copayment, which is \$750 Copayment/stay
<u>Prescription</u>	Covered Services:	See " <u>Prescription Drug Benefits Chart</u> " on
<u>Drugs</u>	 Drugs and products with a written 	page 103
Diugs	prescription.	hage 100
	p and pass	
	PA Required:	
	See the <i>Drug Formulary</i> .	
	<u>Limitations</u> :	
	See the Drug Formulary.	
	Subject to General limitations.	
	Subject to <u>Prescription Drug</u> Continue Conti	
	limitations.	
	Excluded Services (Not Covered):	
	 Subject to General Excluded Services. 	
	Subject to <u>Prescription Drug Excluded</u>	
	Services.	
Preventive Care	Covered Services:	No <u>Copayment</u>
_	We update the list of <u>Covered Services</u>	
	each year or as required by law. See	
	" <u>Preventive Care Benefits</u> " on page	
	109.	
	DA Doguizado	
	PA Required:	
	 No, for most services your <u>PCP</u> or <u>OB/GYN</u> performs in his or her office. 	
	OD/OTN PERIORIIS III IIIS OF HER OFFICE.	

Benefit	Description	You Pay
	Yes, for "Adult benefits that require	
	<u>PA</u> ".	
	Limitations:	
	 Subject to General limitations. 	
	Subject to <u>Preventive Care</u>	
	limitations.	
	Fuelvided Continue (Net Coursed)	
	Excluded Services (Not Covered): Subject to General Excluded Services	
	 Subject to General <u>Excluded Services</u>. Subject to <u>Preventive Care Excluded</u> 	
	Services.	
Prostate cancer	Covered Services:	No <u>Copayment</u>
<u>Screening</u>	One <u>Screening</u> 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.	
	PA Required:	
	• No.	
	<u>Limitations</u> :	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	 Subject to General <u>Excluded Services</u>. 	
Prosthetic	Covered Services:	External appliances: 20% Coinsurance
appliances	Appliance examples include:	
	 Artificial leg 	External appliances during office visit:
	 Artificial eye 	Included in <u>Specialist Copayment</u> , which
	Joint replacementPacemaker	is \$50 <u>Copayment</u> /visit
	 Pacemaker Implantation or removal of breast 	External appliances billed by a <u>Home</u>
	prostheses and bras after a	Healthcare or Hospice Services agency:
	mastectomy.	No <u>Copayment</u>
	Replacements, repairs, and	
	adjustments.	Internal appliances:
		Included in the <u>Outpatient Preferred</u>
	PA Required:	Facility Copayment, which is \$300
	• Yes.	<u>Copayment</u>
	Limitations:	Included in the <u>Outpatient Non-preferred</u>
	 Replacements, repairs, and 	Facility Copayment, which is \$800
	adjustments limited to:	<u>Copayment</u>
	 Normal wear and tear; or 	

Benefit	Description	You Pay
	 Due to a significant change in your physical condition. Subject to General limitations. Excluded Services (Not Covered): Bionic and myoelectric prosthetics. Clothing or devices available OTC. Subject to General Excluded Services. 	Included in the <u>Inpatient Hospital Facility</u> <u>Copayment</u> , which is \$300 <u>Copayment</u> /day up to \$900 <u>Copayment</u> /stay
Pulmonary	Covered Services:	\$20 <u>Copayment</u> /visit
rehabilitation – Outpatient	 Counseling; Education; and Exercise. Covered conditions: COPD. 	
	 PA Required: Yes. Limitations: Limited to 36 visits per event. Subject to General limitations. Excluded Services (Not Covered): 	
	 Subject to General <u>Excluded Services</u>. 	
Rehabilitation <u>Facility</u>	 Covered Services: Care in a Facility that specializes in physical, speech, and/or occupational therapy. The rehabilitation Outpatient visits count toward the total Outpatient visit limitations for Rehabilitation Services. 	Rehabilitation <u>Outpatient Facility</u> : \$70 <u>Copayment</u> /visit Rehabilitation <u>Inpatient Facility</u> : \$300 <u>Copayment</u> /day up to \$900 <u>Copayment</u> /stay
	 PA Required: Yes. Limitations: Limited to 60 <u>Outpatient</u> visits, combination of therapies. <u>Outpatient</u> visits include office visits and/or rehabilitation <u>Outpatient Facility</u> visits. Services for habilitative purposes do not count toward limitation. 	
	 Subject to General limitations. Excluded Services (Not Covered): 	

Benefit	Description	You Pay
	Acupuncture/acupressure.	
	 Kinesiology or movement therapy. 	
	 Massage therapy. 	
	 Private duty nursing. 	
	 Recreational therapy including, but 	
	not limited to:	
	 Animal-facilitated therapy 	
	 Music therapy 	
	Rolf technique.	
	• Subject to General <u>Excluded Services</u> .	
<u>Rehabilitation</u>	<u>Covered Services</u> :	Services in office: \$35 <u>Copayment</u> /visit
<u>Services</u>	 Services and devices provided by a 	
	registered physical, speech/language,	Rehabilitation <u>Outpatient Facility</u> : \$70
	or occupational therapist for the	<u>Copayment</u> /visit
	treatment of an illness or injury.	
		Rehabilitation <u>Inpatient Facility</u> : \$300
	PA Required:	Copayment/day up to a maximum of
	• Yes.	\$900 <u>Copayment</u>
	Limitations:	Included in the <u>Inpatient Hospital Facility</u>
		Copayment, which is \$300
	 Limited to 60 <u>Outpatient</u> visits, combination of therapies. <u>Outpatient</u> 	Copayment/day up to \$900
	visits include office visits and/or	Copayment/stay
	rehabilitation <u>Outpatient Facility</u>	Сораўтеть зау
	visits. Services for habilitative	Included in Home Healthcare
	purposes do not count toward	Copayment, which is No Copayment
	limitation.	сораутиеть, минет 13 по сораутиеть
	 Subject to General limitations. 	
	Subject to deficial initiations.	
	Excluded Services (Not Covered):	
	Acupuncture/acupressure.	
	 Kinesiology or movement therapy. 	
	Massage therapy.	
	 Private duty nursing. 	
	 Recreational therapy including, but 	
	not limited to:	
	 Animal-facilitated therapy 	
	Music therapy	
	Rolf technique.	
	• Subject to General <u>Excluded Services</u> .	
Routine exam -	Covered Services:	No <u>Copayment</u>
adult	A general checkup when the <u>PCP</u>	
	discusses <u>Preventive Care</u> . You may	
	have some <u>Preventive Care</u> services	
	during the visit. You may need to	

Benefit	Description	You Pay
	schedule other services. See " <u>Well</u>	
	<u>Visit Checklists</u> " on page 155.	
	PA Required:	
	• No.	
	<u>Limitations</u> :	
	Limited to one per year.	
	Subject to General limitations.	
	 Subject to <u>Preventive Care</u> limitations. 	
	timitations.	
	Excluded Services (Not Covered):	
	 Subject to General <u>Excluded Services</u>. Subject to <u>Preventive Care Excluded</u> 	
	Services.	
Routine exam –	Covered Services:	No <u>Copayment</u>
child	Child benefits include well-child visits.	
	PA Required:	
	• No.	
	<u>Limitations</u> :	
	Limited to the American Academy of	
	Pediatrics schedule.	
	Subject to General limitations. Subject to Properties Care	
	 Subject to <u>Preventive Care</u> limitations. 	
	Excluded Services (Not Covered):	
	 Subject to General <u>Excluded Services</u>. Subject to <u>Preventive Care Excluded</u> 	
	<u>Services</u> .	
Skilled Nursing	Covered Services:	\$750 <u>Copayment</u> /stay
<u>Facility</u> care	 A <u>Plan</u> doctor must prescribe treatment. 	
	Care includes:	
	Drugs, medications, biologicals; Congress agrees.	
	General nursing care;Meals and special diets;	
	Medical care;	
	 Physician and professional 	
	services; o Room and board; and	
	Special-duty nursing.	

Benefit	Description	You Pay
	PA Required:	
	• Yes.	
	<u>Limitations</u> :	
	 Limited to 100 days per year. 	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	• Subject to General <u>Excluded Services</u> .	
<u>Special</u>	<u>Covered Services</u> :	No <u>Copayment</u>
<u>Programs</u>	•	
	, , , , ,	
	" <u>Special Programs</u> " on page 149.	
	1	
	• No.	
	Limitations	
	• Subject to General limitations.	
	Excluded Services (Not Covered):	
Specialized	-	Imaging Facility – Preferred Facility: \$250
•		
		oopaye
J	o MRIs	Imaging Facility – Non-preferred Facility:
CAGIIII	 Nuclear scans 	
	o PET scans	
	 Sleep studies 	Included in <u>Specialist Copayment</u> , which
	 SPECT scans 	is \$50 <u>Copayment</u> /visit
	 Your <u>Cost-share</u> includes 	
	interpretation.	Included in <u>ER Copayment</u> , which is \$400
		Copayment/visit and waived if admitted
	PA Required:	
	Yes.	
		share instead
	Subject to General limitations.	·
	Fuelvided Const. (N. 1.C	
	· · · · · · · · · · · · · · · · · · ·	<u>Copayment</u>
	• Subject to General <u>Excluded Services</u> .	Included in the Outpatient New professed
		·
		Copayment
-	 Education services, outreach programs, and quality programs. See "Special Programs" on page 149. PA Required: No. Limitations: Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. Covered Services: Including, but not limited to:	Imaging Facility – Preferred Facility: \$250 Copayment Imaging Facility – Non-preferred Facility: \$750 Copayment Included in Specialist Copayment, which is \$50 Copayment/visit Included in ER Copayment, which is \$400

Benefit	Description	You Pay
		Included in the <u>Inpatient Hospital Facility</u>
		Copayment, which is \$300
		Copayment/day up to \$900
		<u>Copayment</u> /stay
		Sleep studies at home: No <u>Copayment</u>
Speech services	Covered Services:	PCP: No Copayment
Speech services	 Screening by PCP. 	<u>rer</u> . No <u>copayment</u>
	 Evaluation and testing. 	Included in <u>Specialist</u> <u>Copayment</u> , which
	 Speech/language therapy. 	is \$50 <u>Copayment</u> /visit
	 All rehabilitation visits count toward 	10 400 <u>10 p.m</u>
	the total combined physical,	Therapy in rehabilitation office: \$35
	occupational, and speech therapy	<u>Copayment</u> /visit
	Outpatient visit limits for	<u></u>
	Rehabilitation Services.	Included in rehabilitation <u>Outpatient</u>
	<u></u>	Facility, which is \$70 Copayment/visit
	PA Required:	
	No, for <u>PCP</u> .	Services as <u>Inpatient</u> : Included in the
	 Yes, for all other treatment settings. 	Inpatient Hospital Facility Copayment,
		which is \$300 Copayment/day up to \$900
	Limitations:	Copayment/stay
	Rehabilitation Services limited to 60	
	combined <u>Outpatient</u> visits per year	Included in <u>Home Healthcare</u>
	for:	Copayment, which is No Copayment
	Physical therapy;	
	 Occupational therapy; and/or 	
	Speech therapy.	
	Services for habilitative purposes do	
	not count toward limitation.	
	ASD treatment 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.	
	Cleft lip and cleft palate treatment	
	limited to otologic, audiologic, and	
	speech/language treatment.	
	Subject to General limitations.	

Benefit	Description	You Pay
	 Excluded Services (Not Covered): Acupuncture/acupressure. Kinesiology or movement therapy. Massage therapy. Recreational therapy including, but not limited to: Animal-facilitated therapy Music therapy Rolf technique. Subject to General Excluded Services. 	
Substance use disorder - medical services	 Covered Services: Medical complications including, but not limited to: Cirrhosis of the liver 	Lab and <u>Diagnostic Tests</u> : \$10 <u>Copayment</u> /visit <u>PCP</u> : No <u>Copayment</u>
	 Delirium tremens Detoxification Electrolyte imbalances Hepatitis 	Included in <u>Specialist Copayment</u> , which is \$50 <u>Copayment</u> /visit
	 Malnutrition See "<u>Behavioral Health Benefits</u>" on page 40. 	Included in <u>ER Copayment</u> , which is \$400 <u>Copayment</u> /visit and waived if admitted to <u>Inpatient</u> care within the same <u>Hospital</u> – You pay the <u>Inpatient Cost-</u>
	PA Required:	<u>share</u> instead
	 Yes. <u>Limitations</u>: Subject to General limitations. <u>Excluded Services (Not Covered)</u>: 	Included in the <u>Inpatient Hospital Facility</u> <u>Copayment</u> , which is \$300 <u>Copayment</u> /day up to \$900 <u>Copayment</u> /stay
	 Subject to General <u>Excluded Services</u>. 	
Temporo- mandibular joint dysfunction	<u>Covered Services</u>:Medical professional and <u>Hospital</u> <u>Services</u>.	\$100 <u>Copayment</u> /treatment plan
dysidifiction	 PA Required: No, for x-rays and laboratory services, PCP or chiropractic visits. Yes, for other services. 	
	 Limitations: Non-surgical treatment limited to a lifetime maximum of \$1,500: Professional services, physical therapy, chiropractor, physician; X-rays, laboratory services; and 	

Benefit	Description	You Pay
	 DME appliances, orthotic devices. 	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	Dental care.	
	Subject to General <u>Excluded Services</u> .	
Transplants	<u>Covered Services</u> :	Lab, x-ray, and <u>Diagnostic Tests</u> : \$10
	Organ, tissue, bone marrow, and stem	<u>Copayment</u> /visit
	cell transplants. They must not be	Droforred imaging Facility \$250
	Experimental or Investigational in nature.	Preferred imaging <u>Facility</u> : \$250
	000	Copayment
	Office visits, lab work, tests, and Inpatient Hospital Facility expenses	Non-preferred imaging: \$750 <u>Copayment</u>
	related to a transplant for the living	Non preferred imaging. \$750 <u>copayment</u>
	donor and recipient.	Included in <u>Specialist Copayment</u> , which
	 When only the recipient is a 	is \$50 <u>Copayment</u> /visit
	GlobalHealth <u>Member</u> , donor	
	benefits are limited to those not	Included in the <u>Inpatient Hospital Facility</u>
	provided or available to the donor	Copayment, which is \$300
	from any other source.	Copayment/day up to \$900
		<u>Copayment</u> /stay
	PA Required:	
	No, for lab work.	
	Yes, for other services.	
	Limitations:	
	 Subject to General limitations. 	
	Excluded Services (Not Covered):	
	Artificial or non-human organ	
	transplants.	
	• Subject to General <u>Excluded Services</u> .	
Treatment	Covered Services:	Dialysis, radiation, or chemotherapy
therapies	Your <u>Cost-share</u> covers services and	treatment:
	supplies.	Office or <u>Preferred Facility</u> : \$30
	Chemotherapy drugs and	<u>Copayment</u> /treatment
	administration	6 1 1
	Dialysis services and supplies	Non-preferred Facility: \$50
	Growth Hormone Therapy (GHT)	<u>Copayment</u> /treatment
	drugs and administration	Other services:
	Hyperbaric oxygen therapy. Infusion therapy drugs and	
	Infusion therapy drugs and administration in:	Included in the <u>Inpatient Hospital Facility</u> <u>Copayment</u> , which is \$300
	administration in:	Copayment/day up to \$900
	The home;A free-standing clinic or doctor's	Copayment/stay
	o A free-standing clinic or doctor's office;	copayment , stay
	UIIICE,	

Benefit	Description	You Pay
	 A <u>Hospital</u>; A <u>Skilled Nursing Facility</u>; or A rehabilitation <u>Facility</u>. 	Included in <u>Skilled Nursing Facility</u> <u>Copayment</u> , \$750 <u>Copayment</u> /stay
	Radiation therapyRespiratory/inhalation therapy	Equipment, services, and supplies billed from <u>Home Healthcare</u> agency: No <u>Copayment</u>
	PA Required:	
	• Yes.	Pharmacy: See " <u>Prescription Drug</u> <u>Benefits Chart</u> " on page 103
	<u>Limitations</u>:Subject to General limitations.	
	Excluded Services (Not Covered):Subject to General Excluded Services.	
<u>Urgent Care</u>	 Covered Services: Care in an <u>Urgent Care Facility</u>. See "<u>Urgent Care</u>" on page 26. 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 <u>Emergency Room Care</u>. 	\$25 <u>Copayment</u> /visit
	 No. <u>Limitations</u>: Subject to General limitations. <u>Excluded Services (Not Covered)</u>: Subject to General <u>Excluded Services</u>. 	
Vision	 Covered Services: Services for adults and children. PA Required: No. 	See " <u>Vision Benefits Chart</u> " on page 116 for benefits
	<u>Limitations</u>:Subject to General limitations.Subject to Vision limitations.	
	 Excluded Services (Not Covered): Subject to General Excluded Services. Subject to Vision Excluded Services. 	

Benefit	Description	You Pay
Well-child care	<u>Covered Services</u> :	No <u>Copayment</u>
	Routine childcare. See " <u>Well Visit</u>	
	<u>Checklists</u> " on page 155.	
	DA Poquirod	
	PA Required: No.	
	TWO.	
	Limitations:	
	Limited to the American Academy of	
	Pediatrics schedule.	
	Subject to General limitations.	
	Subject to <u>Preventive Care</u>	
	limitations.	
	Evaluded Consider (Not Covered):	
	<u>Excluded Services (Not Covered)</u>:Subject to General <u>Excluded Services</u>.	
	 Subject to General <u>Excluded Services</u>. Subject to <u>Preventive Care Excluded</u> 	
	Services.	
Well-woman	Covered Services:	No Copayment
exam	Preventive Care services. See "Well	
	<u>Visit Checklists</u> " on page 155.	
	PA Required:	
	No, for routine tests and counseling	
	when provided by your <u>PCP</u> or	
	OB/GYN.	
	<u>Limitations</u> :	
	 Limited to the <u>HRSA</u> guidelines. 	
	 Subject to General limitations. 	
	Subject to <u>Preventive Care</u>	
	limitations.	
	Excluded Services (Not Covered):	
	Subject to General <u>Excluded Services</u> . Subject to Researching Comp Finducted.	
	 Subject to <u>Preventive Care Excluded</u> <u>Services</u>. 	
Wigs	Covered Services:	20% <u>Coinsurance</u>
VVIES	 Wigs or other scalp prostheses. 	2070 Sombarance
	0	
	PA Required:	
	• Yes.	
	<u>Limitations</u> :	
	Limited to one synthetic wig or scalp	
	prosthesis per year when required	

Benefit	Description	You Pay
	due to loss of hair resulting from chemotherapy or radiation therapy.Subject to General limitations.	
	Excluded Services (Not Covered):	
	 Subject to General <u>Excluded Services</u>. 	

Prescription Drug Benefits

Covered Services

Your <u>Prescription Drug</u> benefit covers <u>Outpatient</u> 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 <u>OTC</u> drugs and products. See Patient Protection and Affordable Care Act (<u>ACA</u>) on page 106.

We encourage you to use the <u>Prescription Drug</u> cost calculator available at <u>www.GlobalHealth.com</u>. You can:

- Determine your financial responsibility for a drug, based on your pharmacy benefit.
- Find the location and contact information of a <u>Network</u> pharmacy.
- Conduct a pharmacy proximity search based on zip code.
- Determine the availability of generic substitutes.

You can get more help on our website:

- Initiate the exceptions process.
- Order a refill for an existing, unexpired mail-order prescription.

You can also call us for this information.

Please note:

- All drugs and products must be <u>FDA</u>-approved.
- Quantity limits, prior authorization criteria, and step therapies may apply. See your *Drug Formulary* for any restrictions.
- A <u>Network Provider</u> must write the prescription. We cover prescriptions by <u>Out-of-network Providers</u> in these situations:
 - ER or Urgent Care Providers; and
 - o Dentists.
- Your regular doctor should handle all follow-up care, including writing or refilling your prescriptions. See "Provider Directory" on page 19.
- A Network pharmacy must fill the prescription.
- You will pay your <u>Cost-share</u> or the cost of the drug, whichever is less.
- A generic equivalent will be dispensed when available, unless your doctor specifically requests the brand name drug and specifies Dispense as Written. If your doctor requests a brand name drug, your

doctor must complete a <u>PA</u> form. The <u>PA</u> form must include documentation explaining why the generic equivalent cannot be used.

- o If the <u>PA</u> request is approved, you will pay the <u>Cost-share</u> of the <u>Tier</u> that the brand name drug is in.
- o If the <u>PA</u> request is not approved and you choose to fill a brand name drug when a generic equivalent is available, your <u>Cost-share</u> will be:
- o The Cost-share of the Tier the brand name drug is in; plus
- o The cost difference between the brand name drug and the generic equivalent.

Also see "Coverage Requirements" on page 40.

Prescription Drug Benefits Chart

You can find more information for specific drug costs on our website, www.GlobalHealth.com.

<u>Tier</u>	Description	You Pay 30-day Supply	You Pay 90-day Supply
ACA - Tier Zero	 Preventive Care Prescription Drugs and OTC drugs with a prescription (Noted in the Drug Formulary with (HCR). 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. See "ACA" on page 106. The list is subject to change as ACA guidelines are updated or modified. 	• No <u>Copayment</u>	• No <u>Copayment</u>
<u>Tier</u> One	This <u>Tier</u> includes generic drugs on the <u>Formulary</u> .	 \$20 <u>Copayment</u>/prescription fill or refill 	• \$40 <u>Copayment</u> /prescription fill or refill
<u>Tier</u> Two	 This <u>Tier</u> has preferred brand name drugs on the <u>Formulary</u>. 	 \$65 <u>Copayment</u>/prescription fill or refill 	• \$130 <u>Copayment/prescription</u> fill or refill
<u>Tier</u> Three	 This <u>Tier</u> includes non-preferred brand name and high-cost generic drugs. If we allow coverage of non-formulary drugs, you will pay the <u>Cost-share</u> for this <u>Tier</u>. See "<u>Exception</u> 	 \$90 <u>Copayment</u>/prescription fill or refill Diabetic insulin: Maximum of \$30 <u>Copayment</u>/prescription 	 \$180 <u>Copayment</u>/prescription fill or refill Diabetic insulin: Maximum of \$90 <u>Copayment</u>/prescription
	Requests" on page 35.	fill or refill	fill or refill

<u>Tier</u>	Description	You Pay 30-day Supply	You Pay 90-day Supply
<u>Tier</u> Four	 This <u>Tier</u> has three <u>Cost</u> Sharing levels: Preferred <u>Specialty</u>	 Preferred: \$200 <u>Copayment</u>/prescription fill or refill Non-preferred: \$400 <u>Copayment</u>/prescription fill or refill Chemotherapy drugs: <u>Maximum of \$100</u> <u>Copayment</u>/prescription fill or refill 	Limited to a one-month supply per fill.

Prescription Drug Limitations:

- Contraceptive drugs limited to:
 - o A three-month supply the first time you obtain the drug.
 - A six-month supply at each subsequent time you obtain the same drug, regardless of whether you
 were enrolled in this <u>Plan</u> at the first time the drug was obtained.
 - o One six-month supply of a covered <u>Prescription Drug</u> during each six-month period.
- Epinephrine autoinjectors limited to four per year.
- Inhaler extender devices and peak flow meters 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 <u>FDA</u>-approved tobacco cessation products per year, if prescribed by your PCP.
 - o Members who are at least 18 years old.
- Drugs prescribed or given to you by <u>Out-of-network</u> doctors in non-emergencies limited to those prescribed by dentists.
- Non-prescription contraceptive jellies, ointments, foams, or devices limited to those that are <u>FDA</u>-approved and prescribed by a <u>Network</u> doctor for a woman.
- <u>Prescription Drugs</u> for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy, hyporgasmy, or decreased libido limited to post-prostate surgery indications.
 We may cover certain investigational uses of chemotherapy for cancer treatment.
- Also see "General limitations" on page 119.

Prescription Drug Excluded Services (Not Covered):

- Products available without a prescription (OTC). Including but not limited to:
 - Dietary supplements
 - o Foods
 - o Formulas
 - Medications for irrigation

- Non-preventive care drugs
- Saline
- Drugs prescribed for a non-<u>FDA</u> approved indication, dosage, or length of therapy.
- Compounded drugs
- Also see "General Excluded Services" on page 122.

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 brand name drugs as well as generics and biosimilars that may save your money. It also shows any <u>UM</u> needed for each drug.

Sometimes a drug may appear more than once in our drug list. This is because different rules or <u>Cost Sharing</u> may apply for the drug prescribed by your <u>Provider</u> based on:

- Strength (for example, 10 mg versus 100 mg); or
- Form (for example, tablet versus liquid).

P&T Committee:

The Pharmacy & Therapeutics (P&T) Committee oversees the Formulary drug list.

The committee meets at least every three months. The committee reviews the list of drugs and <u>UM</u> rules at least once each year. The list of drugs and UM rules are updated as appropriate.

All new <u>FDA</u>-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 <u>Formulary</u>.

Committee members include:

- Practicing doctors;
- Practicing pharmacists; and
- Other practicing professionals licensed to prescribe drugs.

Drug Tiers:

The *Drug Formulary* will tell you which <u>Tier</u> a drug is in and the <u>UM</u> rules that apply. The <u>Cost-share</u> and description for each <u>Tier</u> remains the same for the entire year. During the year, individual drugs may move between <u>Tiers</u>. If your <u>Cost-share</u> will go up, you will pay the new <u>Tier Cost-share</u> after we give you 60 days' notice. The *Drug Formulary* is reviewed at least monthly. The most current list is available on our website. It is current as of the date on the bottom of the first page.

The <u>Prescription Drug Cost-share</u> 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 GlobalHealth phone number printed on your <u>Member</u> 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 <u>FDA</u> releases:

- o A new or lower cost drug that has the same purpose and effect; or
- o 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:
 - o Removing a drug from our Formulary;
 - Adding new rules to getting a drug; or
 - o Moving a drug to a higher <u>Tier</u>.
- If the <u>FDA</u> decides a drug on our <u>Formulary</u> is unsafe or the drug's manufacturer removes the drug from the market, we will remove the drug from our <u>Formulary</u> right away and tell you within 30 days.

Exclusions:

We don't cover some <u>Prescription Drugs</u> because we have formulary drugs for the same purpose and effect that:

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

ACA

Some products are available at no cost. Others have some <u>Cost Sharing</u>. This happens when there are multiple <u>FDA</u>-approved items that are for the same purpose. See the <u>Drug Formulary</u> for a list of drugs covered with and without <u>Cost Sharing</u>. Those without <u>Cost Sharing</u> are noted with "<u>HCR</u>" in <u>Tier</u> "0".

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 cardiovascular disease (CVD).

Colonoscopy Preparation:

Bowel preparation medications, when medically appropriate and prescribed by a healthcare <u>Provider</u>, are an integral part of the preventive screening colonoscopy.

Contraception Drugs and Devices for Women:

We cover at least one <u>FDA</u>-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 "<u>Contraception services</u>" on page 59.

- Products from a pharmacy require a written prescription from your doctor, even if it is available <u>OTC</u>.
 See your *Drug Formulary* for any rules for getting the item.
- If the <u>FDA</u> has approved multiple services and items within a method, we will decide which items to cover without <u>Cost Sharing</u>. However, if your doctor recommends a particular service or <u>FDA</u>-approved

item for you, we will cover it without <u>Cost Sharing</u>. We defer to your doctor. See "<u>Exception Requests</u>" on page 35 to get coverage.

If you have concerns about GlobalHealth's compliance with federal coverage requirements, you may contact CMS at <u>contraception complaints@cms.hhs.gov</u> or by calling toll free at 1-888-393-2789.

OTC:

We cover some <u>FDA</u>-approved <u>OTC</u> 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	For women planning a pregnancy or capable of becoming pregnant
supplements	
Iron supplements	For children from birth – 12 months
Oral fluoride	For children from birth – 5 years
supplements	
Tobacco cessation products	For adults age 18 and older

To get benefits, you must:

- Use a Network pharmacy; and
- Have a prescription from your doctor.

Pre-exposure Prophylaxis:

Doctors may prescribe pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy for adults who are at high risk of getting HIV.

Vaccines:

We cover immunizations listed in "<u>Preventive Care Benefits Chart</u>" on page 109 at no cost. Shots required for work, school, or travel are not covered unless also a <u>Preventive Care</u> immunization. Check with your <u>PCP</u> first.

<u>Network Providers</u>, 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 <u>FDA</u>. To be covered, the drug must be for the <u>FDA</u>-approved:

- Disease or medical condition;
- Dosage; and
- Length of therapy.

Also, the drug must be prescribed within <u>FDA</u> 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 is one exception:

1. We cover off-label uses of drug(s) used in the study or treatment of cancer when recommended by the National Comprehensive Cancer Network® guidelines.

Compounded Drugs

We do not cover compounded drugs.

Prescriptions Received in an ER or Urgent Care Facility

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

Managing Your Pain

Opioid abuse is a serious public health issue. Drugs may be:

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

Our *Drug Formulary* includes many pain management drugs that are not opioids. Work with your doctor to choose these drugs when appropriate.

We cover <u>Prescription Drugs</u> within medication-assisted treatment programs. See page 45. Also see "<u>Substance Use Disorder</u>" on page 98. Call Carelon Behavioral Health for help with these services. You can view the resources Carelon has available to members at www.achievesolutions.net/achievesolutions/en/Topic.do?topicId=855¢erId=3.

We also cover medical and other behavioral health benefits for pain management:

- See "Counseling" on page 43.
- See "<u>Telehealth</u>" on page 48.
- See "Chiropractic care" on page 57.
- See "Physical therapy" on page 89.

Visit with your doctor about these services and if they would be appropriate for you.

Overdose:

Call 911. We cover some naloxone-based products at no cost as a <u>Preventive Care</u> product.

Drug Disposal:

Be sure to dispose of drugs in a safe manner.

- Follow the instructions on the <u>Prescription Drug</u> 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 Drug Enforcement Administration (<u>DEA</u>). Authorized sites may be retail, <u>Hospital</u> or clinic pharmacies, and law enforcement locations. Some

- offer mail-back programs or collection drop-boxes. Visit the <u>DEA's</u> website at <u>www.deadiversion.usdoj.gov</u> or call 1-800-882-9539 for more information and to find an authorized collector in your area.
- Participate in "National Take Back Day". It is a program through the <u>DEA</u> to provide a safe, convenient, and responsible means of disposing <u>Prescription Drugs</u>. For more information visit their website at <u>www.deadiversion.usdoj.gov</u>.

Preventive Care Benefits

Covered Services

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

Agency	Guidelines Description
United States	Evidence-based items or services
Preventative	Have a rating of "A" or "B"
Services Task Force	• For more detailed information on each service, see the <u>USPSTF</u> website,
(<u>USPSTF</u>)	<u>United States Preventive Services Taskforce</u>
	(uspreventiveservicestaskforce.org).
Health Resources	Evidence-informed exams, <u>Screenings</u> , shots, and counseling
and Services	Including <u>Preventive Care</u> and <u>Screenings</u> with respect to women
Administration	
(<u>HRSA</u>)	
Centers for Disease	Immunizations recommended by the Advisory Committee on Immunization
Control (<u>CDC</u>)	Practices
	Prevention with respect to the individual involved

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

• Frequency;

• Treatment; or

Method;

• Setting.

Also see "Coverage Requirements" on page 40. For full details about the covered benefit and who qualifies for each, see Healthy Living Tips on our website, www.GlobalHealth.com.

Preventive Care Benefits Chart

Population	Benefits Description	You pay
Adult benefits	You do not need <u>PA</u> .	No <u>Copayment</u>
	 Alcohol misuse <u>Screening</u> and counseling; 	
	Anxiety <u>Screening</u> ;	
	Aspirin use to prevent cardiovascular disease and colorectal	
	cancer in adults aged 50 to 59 years at increased risk. See	
	" <u>ACA</u> " on page 106;	
	Blood pressure <u>Screening</u> for all adults, including obtaining	
	measurements outside of the clinical setting for diagnostic	
	confirmation;	
	• Colorectal cancer <u>Screening</u> for adults ages 45 – 75. See	
	"Colorectal cancer prevention Screening" on page 58;	

Population	Benefits Description	You pay
	Depression <u>Screening</u> for adults;	
	Diabetes <u>Screening</u> for prediabetes and type 2 diabetes in	
	adults age 35 – 70 who are overweight or obese;	
	 Drug use disorder or unhealthy drug use <u>Screening</u>; 	
	Falls prevention counseling and exercise interventions for	
	adults age 65 and older at higher risk for falls;	
	Healthy diet and physical activity counseling for adults with	
	high risk of <u>CVD</u> ;	
	Hepatitis B <u>Screening</u> for adults at high risk for infection;	
	Hepatitis C virus infection <u>Screening</u> for adults at high risk and	
	one-time Screening for adults age 18 to 79 years;	
	HIV <u>Screening</u> (testing) for all adults to age 65 or older adults thicker risks.	
	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 <u>CDC</u>	
	website – Vaccines & Immunizations Vaccines &	
	Immunizations CDC. See "ACA" on page 106.	
	 COVID-19 	
	Hepatitis A	
	Hepatitis B	
	 Human Papillomavirus (HPV) 	
	o Influenza (Flu Shot)	
	 Measles, Mumps, Rubella (MMR) 	
	 Meningococcal (Meningitis) 	
	 Pneumococcal (Pneumonia) 	
	 Tetanus, Diphtheria, Pertussis (TDaP) 	
	o Varicella (Chicken Pox)	
	o Zostavax (Shingles)	
	Obesity <u>Screening</u> for all adults with intensive behavioral interventions for adults who screen positive. See "Obesity"	
	interventions for adults who screen positive. See "Obesity Screening, weight loss counseling, and treatment" on page	
	<u>Screening, weight loss counseling, and treatment</u> " on page 85;	
	 Pre-exposure prophylaxis to prevent HIV and essential 	
	support services (including medication self-	
	management/adherence counseling, risk reduction strategies,	
	and mental health counseling, ongoing follow-up, and	
	monitoring, etc.). See " <u>ACA</u> " on page 106;	
	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 <u>CVD</u> for adults age 40	
	– 75 at higher risk. See " <u>ACA</u> " on page 106;	
	Syphilis <u>Screening</u> for asymptomatic, non-pregnant adults at high as violation.	
	higher risk;	

and Cess ■ Tub Women's You do benefits 79 for so	acco use <u>Screening</u> for all adults and <u>Prescription Drug</u> behavioral interventions for tobacco users. See " <u>Tobacco</u> <u>sation</u> " on page 152; and erculosis infection <u>Screening</u> for all adults at higher risk. not need <u>PA</u> . See " <u>Maternity and newborn care</u> " on page ervices related to pregnancy and postpartum. iety <u>Screening</u> ;	No <u>Copayment</u>
Women's You do 79 for se	not need <u>PA</u> . See " <u>Maternity and newborn care</u> " on page ervices related to pregnancy and postpartum. iety <u>Screening</u> ;	No <u>Copayment</u>
	iety <u>Screening</u> ;	
 Aspin won person on patch words. Cervyeal Chlayou Conpating drug Dep Diable afte gest Diable preg Gon Heatop Hepp preg Gon Hepp preg HIV word HPV 65; Hypp blood Intiring age ong Obe 	irin as preventive medication after 12 weeks of gestation romen who are at high risk for pre-eclampsia. See "ACA" page 106; teriuria Screening in pregnant persons; ast cancer mammography Screenings every 1 – 2 years for men over age 40. See "Mammogram" on page 78; vical cancer Screening every 3 years for women aged 21-29 as and every 3-5 years for women aged 30-65 years; amydia infection Screening for women age 24 years or mager and women age 25 or older at higher risk; traception: FDA-approved contraceptive methods and ent education and counseling, not including abortifacient ags. See "Contraception services" on page 59; ression Screening for pregnant and postpartum women; potes Screening for women after 24 weeks of gestation or r, and Screening for those at high risk of developing that interpersonal violence Screening for all women 14 – 46 with intervention services for women who screen dive; acid supplements for women who may become gnant. See "ACA" on page 106; orrhea Screening for all women at higher risk; lthy weight gain, behavioral counseling, and interventions revent excess gestational weight gain; attits B Screening for pregnant women at their first matal visit; Screening (testing) and counseling for sexually active men and all pregnant women; I DNA test every three years for women who are age 30 to ertensive disorders Screening in pregnant persons with od pressure measurements throughout pregnancy; mate partner violence Screening in women of reproductive and provide or refer women who screen positive to oing support services; sity prevention in midlife women who are age 40 to 60 as with normal to overweight BMI;	

Population	Benefits Description	You pay
	 Osteoporosis Screening for women over age 60 depending on risk factors. See "Bone Density Test" on page 54; Patient navigation services for breast and cervical cancer Screening Pre-eclampsia Screening for pregnant women with high blood pressure measurement. 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 152; Urinary incontinence Screening. 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. Routine Pap test Human papillomavirus (HPV) testing Counseling for sexually transmitted infections Counseling/Screening for HIV Contraceptive methods and counseling Counseling/Screening for intimate partner and domestic violence Screening for urinary incontinence 	
Adult benefits that require <u>PA</u>	 Screening for anxiety 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 55; Breast cancer chemoprevention counseling for women at higher risk. See "ACA" on page 106; Breastfeeding comprehensive support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women; Contraception surgical procedures. See "Contraception services" on page 59; and Lung cancer Screening (low-dose computed tomography) for adults ages 50 – 80 years who have a smoking history within the past 15 years. 	No <u>Copayment</u>
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 <u>PA</u> . • Alcohol and drug use assessments for adolescents;	No <u>Copayment</u>

Population	Benefits Description	You pay
	Anemia <u>Screening</u> ;	
	 Anxiety <u>Screening</u> for adolescent girls; anxiety <u>Screening</u> for 	
	children and adolescents age 8 – 18 years;	
	Autism <u>Screening</u> for children;	
	Behavioral/Social/Emotional <u>Screening</u> for children;	
	Blood pressure <u>Screening</u> for;	
	Cervical dysplasia <u>Screening</u> for sexually active females;	
	Chlamydia testing;	
	Congenital heart defect <u>Screening;</u>	
	 Dental cavities <u>Screening</u> for children from birth through age five; 	
	• Depression <u>Screening</u> for adolescents age 12 – 18 years;	
	Developmental <u>Screening</u> for children;	
	Dyslipidemia <u>Screening</u> for children;	
	Fluoride chemoprevention supplements for children starting	
	as age 6 months without fluoride in their water source;	
	Gonorrhea preventive medication for the eyes of all	
	newborns;	
	Hearing <u>Screening</u> ;	
	Height, weight, and body mass index measurements;	
	Hepatitis B assessment;	
	Hepatitis C <u>Screening</u> ;	
	HIV risk assessment and prevention education beginning at	
	age 11 and continuing as determined by risk;	
	 HIV <u>Screening</u> (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 <u>CDC</u> website - <u>https://www.cdc.gov/vaccines-</u>	
	children/index.html.	
	o COVID-19	
	 Diphtheria, Tetanus, Pertussis (DTaP) 	
	 Haemophilus influenzae type b (Hib) 	
	 Hepatitis A 	
	 Hepatitis B 	
	 Human Papillomavirus (HPV) 	
	o Inactivated Poliovirus (Polio)	
	o Influenza (Flu Shot)	
	o Measles, Mumps, Rubella (MMR)	
	o Meningococcal (Meningitis)	
	Pneumococcal (Pneumonia) Potovirus (PV)	
	O Rotavirus (RV) O Varicella (Chicken Boy)	
	 Varicella (Chicken Pox) Iron supplements for children agos 6 12 months at risk for 	
	 Iron supplements for children ages 6 – 12 months at risk for anemia; 	
	ancina,	

Population	Benefits Description	You pay
	 Lead <u>Screening</u> for children at risk of exposure; 	
	 Medical history for all children throughout development; 	
	Obesity <u>Screening</u> , counseling, and comprehensive intensive	
	behavioral interventions for children age 6years and older;	
	Oral health risk assessment;	
	Pre-exposure prophylaxis (PrEP) using effective antiretroviral	
	therapy for adolescents at increased risk of HIV acquisition to	
	decrease the risk of acquiring HIV;	
	STI prevention counseling and <u>Screening</u> ;	
	 Skin cancer behavioral counseling for children, adolescents, and young adults; 	
	• Sudden cardiac arrest and sudden cardiac death assessment;	
	 Syphilis infection <u>Screening</u> for asymptomatic, nonpregnant adolescents at higher risk; 	
	Tobacco use interventions, including education or brief	
	counseling, for school-aged children and adolescents age 10 –	
	17 years;	
	Tuberculin risk assessment;	
	Uniform <u>Screening</u> panel for newborns; and	
	Vision <u>Screening</u> for all children.	

Preventive Care Limitations:

• Limited to <u>USPSTF</u>, <u>HRSA</u>, and <u>CDC</u> guidelines.

Preventive Care Excluded Services (Not Covered):

• Screening services requested solely by you, such as commercially advertised heart scans.

Get Services

Make an appointment with your <u>PCP</u> early in the year for your routine adult exam or your child's well-child exam. Your <u>PCP</u> 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 <u>Preventive Care</u> visits including evidence-based cancer imaging.

Your <u>PCP</u> will send us any <u>Referrals</u> 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 <u>Preventive Services</u> at on-site contracted employer-sponsored health fairs.

You do not have a copayment if the primary purpose of the visit is for preventive services. You have to pay your normal <u>Cost-share</u> if the primary purpose of the service is for treatment rather than <u>Preventive Care</u>. 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 <u>Screening</u>.

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 adult routine physical or scheduled well-child visits; and
- 2. BRCA testing for women in certain situations. See "Breast cancer Preventive Care" on page 55.

You will not need every <u>Preventive Service</u>. 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 <u>Screenings</u> earlier or more often.

When a doctor determines that a <u>Preventive Service</u> is right for an individual, we cover it without <u>Cost Sharing</u> 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 <u>Preventive Care</u> services through our regular care processes. Your doctor will schedule an appointment, or send us a <u>Referral</u> if needed, for treatment. There is no cost for any part of the <u>Preventive Care</u> service that led to the diagnosis, but you must pay your regular <u>Cost-share</u> for follow-up care should your doctor find something suspicious through the <u>Screening</u> process. Follow-up care begins when the doctor either tells you that you need to have more testing or start treatment.

Service Type	Description	
<u>Preventive Care</u> - no	Pre-service consultation for services;	
cost	• Listed <u>Preventive Care</u> service or procedure, including removing tissue;	
	 Ancillary services (anesthesiology, pathology, etc.); and 	
	Office visit or <u>Facility</u> .	
Follow-up care –	<u>Diagnostic Tests</u> for positive <u>Screening</u> result (except follow-up colonoscopy	
with regular <u>Cost</u>	after a positive sigmoidoscopy or CT colonography);	
<u>Sharing</u>	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 <u>Network</u> optometrist or ophthalmologist for office visits. Go to a <u>Network</u> eyewear <u>Provider</u> for eyeglasses or contacts after cataract surgery. We cover cataract surgery under <u>Outpatient</u> surgery benefits and <u>Coverage Requirements</u>.

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 <u>Provider</u>. You may choose either eyeglasses or contact lenses, but not both.

Also see "Coverage Requirements" on page 40.

Vision Benefits Chart

Benefit	Description	You Pay
Routine exam	<u>Covered Services</u> :	\$50 <u>Copayment</u> /visit
	Routine comprehensive eye exam	
	includes:	
	 Dilatation as necessary; 	
	 Evaluation of depth perception, 	
	color vision, eye muscle	
	movements, peripheral vision, and	
	pupil response to light;	
	 Evaluation of focus, movements, 	
	and how well eyes work together;	
	 Eye health evaluation; and 	
	Refraction exam.	
	May be combined with diabetic eye	
	exam and/or glaucoma test in one	
	visit with one <u>Copayment</u> .	
	PA Required:	
	• No.	
	Limitations:	
	Limited to one per year.	
	Subject to General limitations.	
	,	
	Excluded Services (Not Covered):	
	• Subject to General <u>Excluded Services</u> .	
Diabetic eye	Covered Services:	\$50 <u>Copayment</u> /visit
exam	 Dilatation with <u>Diagnostic Tests</u>. 	
	 May be combined with routine exam 	
	and/or glaucoma test in one visit with	
	one <u>Copayment</u> .	
	PA Required:	
	• No.	
	Limitations	
	<u>Limitations</u> : • Limited to one per year.	
	 Subject to General limitations. 	
	- Subject to Scherat mintations.	
	Excluded Services (Not Covered):	
	 Subject to General <u>Excluded Services</u>. 	
Glaucoma test	Covered Services:	\$50 Copayment/visit
	Exams for <u>Members</u> at high risk may	
	include:	
	 Angle in the eye where the iris 	
	meets the cornea;	

Benefit	Description	You Pay
Supplemental diagnostic testing and treatment	 Description Complete field of vision; Inner eye pressure; Shape and color of the optic nerve; and Thickness of the cornea. May be combined with routine and/or diabetic eye exam in one visit with one Copayment. PA Required: No. Limitations: Limited to one per year. Subject to General limitations. Excluded Services (Not Covered): Subject to General Excluded Services. Covered Services: Tests as follow-up to eye exams. Treatment for diseases or injury. Cataract surgery. PA Required: No, for Diagnostic Tests. Yes, for other services. Limitations: Treatment for orthoptics or visual training limited to a diagnosis of mild strabismus. Subject to General limitations. Excluded Services (Not Covered): 	Diagnostic Tests: \$10 Copayment/visit Imaging Facility - Preferred Facility: \$250 Copayment Imaging Facility - Non-preferred Facility: \$750 Copayment Surgery: Included in the Outpatient Preferred Facility Copayment, which is \$300 Copayment Included in the Outpatient Non-preferred Facility Copayment, which is \$800 Copayment
	 Computer programs of any type, including, but not limited to, those to assist with vision therapy. 	Copayment
	 LASIK, INTACS, radial keratotomy, and other refractive surgery. Special multifocal ocular implant lenses. Subject to General <u>Excluded Services</u>. 	
Frames	 Covered Services: Basic non-designer frames after cataract surgery. 	No <u>Copayment</u>

Benefit	Description	You Pay
	PA Required:	
	• No.	
	<u>Limitations</u> :	
	Limited to first set of basic frames and	
	lenses or contact lenses following	
	cataract surgery.Subject to General limitations.	
	Subject to defler at tillitations.	
	Excluded Services (Not Covered):	
	• Subject to General <u>Excluded Services.</u>	
Prescription	Covered Services:	No <u>Copayment</u>
spectacle	Single vision lenses after cataract	
lenses	surgery.	
	Standard plastic, glass, or	
	polycarbonate lenses.	
	DA Doguirod	
	PA Required: No.	
	No.	
	Limitations:	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	 Lens upgrades. 	
	Non-prescription lenses.	
	Subject to General <u>Excluded Services.</u>	-
Prescription	Covered Services:	No <u>Copayment</u>
contact lenses	Soft lens and contact lens to treat	•
	post-cataract surgery: o One set or one annual supply of	
	 One set or one annual supply of disposable lenses instead of 	
	eyeglasses.	
	.,	
	PA Required:	
	• No.	
	<u>Limitations</u> :	
	Subject to General limitations.	
	Excluded Services (Not Covered):	
	 Insurance for contact lenses. 	
	• Subject to General <u>Excluded Services.</u>	

Vision Limitations:

- Diabetic eye exam limited to one per year.
- Glaucoma test limited to one per year.
- 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.

Vision Excluded Services:

- 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.
- Lens upgrades.
- Non-prescription lenses.
- Special multifocal ocular implant lenses.

Excluded Services and Limitations

All benefits described below are excluded or limited under this <u>Plan</u> 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 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. Autism <u>Screening</u> and Developmental <u>Screening</u> limited to well-child visits. Psychosocial education limited to daily living and social skills education.
Cardiac rehabilitation services	Limited to 36 visits per event.
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: Breast reconstruction after a mastectomy; Improve function of a malformed part of the body; and Repair due to an accidental injury.
Dental services	 Dentistry or dental processes to the teeth and surrounding tissue limited to: <u>ER</u> services to treat accidental injury to the jaw, sound natural teeth, mouth, or face. Surgery to improve function of the jaw, mouth, or face resulting from a birth defect. Does not include dental work. General anesthesia/IV sedation for dental services limited to a <u>Member</u> who: Has a medical or emotional condition that requires <u>Hospitalization</u> or general anesthesia for dental care;

Benefit	Limitation				
	 Is severely disabled; In the judgment of the treating <u>Practitioner</u>, is not of sufficient emotional development to undergo a <u>Medically Necessary</u> dental procedure without the use of anesthesia; and Requires <u>Inpatient</u> or <u>Outpatient</u> services because of an underlying medical condition and clinical status or because of the severity of the dental procedure. 				
DME, orthotic	Breast pumps limited to:				
devices, and	 One per year for women who are pregnant or nursing. 				
prosthetic appliances	 Purchase or rental of breast pump and related supplies. 				
	Corrective lenses and fittings limited to pair of basic non-designer frames				
	and single vision lenses or contact lenses following cataract surgery.				
	Footwear limited to: Shape shape incomes and supporting devices for Marchard				
	 Shoes, shoe inserts, arch supports, and supportive devices for <u>Members</u> diagnosed with diabetes or a blood circulation disease. 				
	 Orthopedic or corrective shoes permanently attached to a Denis Browne 				
	splint for children.				
	DME rentals:				
	 Knee walker or kneeling crutch rentals limited to 4 months. 				
	 Oxygen and oxygen equipment rentals limited to 36 months and 				
	remaining Medically Necessary.				
	 Other <u>DME</u> rentals limited to 13 months. 				
	Hearing aids limited to:				
	One basic hearing aid per ear every 48 months unless <u>Medically</u> Necessary to replace more of the periods.				
	Necessary to replace more often. o Four additional ear molds per year (two molds for each ear) for children				
	less than two years of age.				
	Orthotic devices limited to:				
	Braces for the leg, arm, neck, back, or shoulder;				
	 Back and special surgical corsets; 				
	 Splints for the extremities; and 				
	o Hernia trusses.				
	Replacements, repairs, and adjustments for orthotics and prosthetics				
	limited to:				
	 Normal wear and tear; and 				
	Due to a significant change in your physical condition.				
	Wigs and scalp prostheses limited to one synthetic wig or scalp prosthesis per year when required due to less of hair resulting from shamethers by or				
	per year when required due to loss of hair resulting from chemotherapy or radiation therapy.				
Foot care	Routine care limited to <u>Members</u> with diabetes or a blood circulation				
1 JUL Cale	disease.				
General care or	Hospital private room limited to isolation to prevent contagion per the				
Hospital Services	Hospital's infection control policy.				
General limitations	Sexual dysfunction services limited to drugs and supplies for post-prostate				
	surgery indications.				

Benefit	Limitation					
Genetic analysis, services, or testing	Limited to counseling and testing for women whose personal or family history or ancestry is associated with a higher risk for deleterious mutations in <u>BRCA</u> 1 and <u>BRCA</u> 2 genes. Limited to biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition when the test is supported by medical and scientific evidence.					
Hearing services	 Cochlear® surgery and basic devices limited to <u>Members</u> at least 18 months of age or for pre-lingual <u>Members</u> with minimal speech perception using hearing aids. 					
Home Healthcare	Limited to 100 visits per year.					
Obstetrical care	 Costs resulting from normal, full-term delivery out of our <u>Network</u> limited to emergencies. Cryopreservation or storage of sperm (sperm banking), eggs, or embryos limited to individuals diagnosed with cancer and who are within reproductive age when a treatment may directly or indirectly cause introductive. 					
Physical, occupational, and speech therapy	 Rehabilitation Services limited to 60 Outpatient visits, combination of therapies. Outpatient visits include office visits and/or rehabilitation Outpatient Facility visits. Habilitation Services limited to: ASD treatment – Physical, occupational, and/or speech therapy services for 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. Cleft lip and cleft palate treatment – Otologic, audiologic, and speech 					
Prescription Drugs	 Contraceptive drugs limited to: A three-month supply the first time you obtain the drug. A six-month supply at each subsequent time you obtain the same drug, regardless of whether you were enrolled in this Plan at the first time the drug was obtained. One six-month supply of a covered Prescription Drug during each sixmonth period. Drugs prescribed or given to you by Out-of-network doctors in non-emergencies limited to those prescribed by dentists. Epinephrine autoinjectors limited to four per year. Glucometers limited to two per year. Inhaler extender devices and peak flow meters limited to three per year. 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. 					

Benefit	Limitation				
	 Non-prescription contraceptive jellies, ointments, foams, or devices limit to those that are <u>FDA</u>-approved and prescribed by a <u>Network</u> doctor for a woman. <u>Prescription Drugs</u> for the treatment of sexual dysfunction, including ered dysfunction, impotence, and anorgasmy, hyporgasmy, or decreased libid limited to post-prostate surgery indications. Prescription diaphragms limited to two per year. The Pharmacy and Therapeutics Committee's standard quantity limits, pauthorization criteria, and step therapies apply. Smoking cessation products limited to: Two full 90-day courses of <u>FDA</u>-approved tobacco cessation products year, if prescribed by your <u>PCP</u>. <u>Members</u> who are at least 18 years old. <u>Specialty Drugs</u> limited to a one-month supply. 				
Preventive care	 DEXA scans for bone density screening limited to one every 24 months. Limited to <u>USPSTF</u>, <u>HRSA</u>, and <u>CDC</u> guidelines. Routine exam for adults limited to one per year. Routine exam for children and well-child care limited to the American Academy of Pediatrics (AAP) schedule. Tobacco cessation limited to two attempts per year. 				
Pulmonary rehabilitation services	Limited to 36 visits per event.				
Skilled Nursing Facility care	• Limited to 100 days per year.				
Temporomandibular joint dysfunction	Non-surgical treatment limited to a lifetime maximum of \$1,500.				
Vision	 Diabetic eye exam limited to one per year. Glaucoma test limited to one per year. 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 <u>Excluded Services</u> 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	 Education, tutoring, and services offered through a school/academic 					
services	institution for the purpose of diagnosing or treating a learning disability,					
	disruptive, impulse-control, or conduct disorder.					
	Wilderness therapy.					

Benefit	Excluded Service					
Dental services	 Correction of occlusive jaw defects, dental implants, or grafting of alveolar ridges. 					
	General or preventive dentistry.					
	Non-emergency procedures that involve the teeth or their supporting					
	structures.					
	Replacement, re-implantation, and follow-up care of teeth, even if the teeth					
	are not saved by emergency stabilization.					
	Treatment of soft tissue to prepare for dental procedures or dentures.					
DME , orthotic	• Accessories.					
devices, and	Additional warranties.					
prosthetic	Bandages, pads, or diapers.					
appliances	Bionic and myoelectric prosthetics.					
	Changes to your home or vehicle.					
	Clothing and devices available <u>OTC.</u>					
	Continuous passive motion devices.					
	Equipment that serves as comfort or convenience.					
	 For example, portable oxygen concentrators. 					
	Equipment or devices not medical in nature such as:					
	 Braces worn for athletic or recreational use 					
	o Ear plugs					
	 Elastic stockings and supports 					
	o Garter belts					
	Jacuzzi/whirlpools.					
	Mattresses and other bedding or bed-wetting alarms.					
	Multiple <u>DME</u> items for the same or like purposes.					
	 Power-operated vehicles that may be used as wheelchairs. 					
	Purchase or rental of equipment or supplies for common household use such					
	as:					
	 Air-cleaning machines or filtration devices 					
	 Air conditioners 					
	Beds and chairs					
	 Cervical or lumbar pillows 					
	o Grab bars					
	 Physical fitness equipment 					
	 Raised toilet seats 					
	 Shower benches 					
	 Traction tables 					
	 Water purifiers 					
	Upgrade features to enhance basic equipment.					
General Excluded	Care or services provided outside the GlobalHealth <u>Service Area</u> if the need for					
Services	such care or services could have been foreseen before leaving the <u>Service</u>					
	<u>Area</u> .					
	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.					

Benefit	nefit <u>Excluded Service</u>					
	Custodial care, respite care, homemaker services, or domiciliary care.					
	Drugs, therapies, and technologies:					
	 Before the long-term effect is known or proven; or 					
	 That are not more effective than standard treatment. 					
	 Drugs, eyewear, devices, appliances, equipment, dental work, or other items that are lost, missing, sold, or stolen. 					
	Drugs or other items that have been damaged or rendered unusable due to					
	improper handling or abuse.					
	Elective enhancement procedures, services, supplies, or medications,					
	including but not limited to:					
	Anti-aging					
	 Athletic performance 					
	 Cosmetic purposes 					
	 Hair growth 					
	 Sexual performance 					
	Lodging and meals.					
	 New procedures, services, supplies, and drugs that have not been reviewed 					
	and approved by GlobalHealth.					
	Personal or comfort items.					
	Private duty nursing.					
	Screening services requested solely by you, such as commercially advertised					
	heart or lung scans.					
	Separate charges for missed or canceled appointments, penalty or finance					
	charges, maintenance and/or record-keeping, record copying, or <u>Case</u>					
	<u>Management</u> services.					
	Services for travel, insurance, licensing, employment, school, camp, sports,					
	premarital, or pre-adoption purposes.					
	Services, other than <u>Hospital Services</u> for behavioral health, for which you do					
	not allow the release of information to GlobalHealth.					
	 Services received while outside of the U.S. (50 states and territories). 					
	 Services received without an authorization when one is required. 					
	Complications arising from those services.					
	Services resulting in whole or in part from an excluded condition, item, or					
	service.					
	 Services that are provided as a result of Workers' Compensation laws or 					
	similar laws.					
	 Treatment of any kind which is excessive or not <u>Medically Necessary</u>. 					
	 Treatment of any kind which is excessive of not inedicatly recessary. Treatment of any kind received before your start date of coverage or after the 					
	time coverage ends, even if authorized.					
	 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.					
	 Treatment for injury resulting from extreme activities including, but not 					
	limited to:					
	 Bungee jumping 					

Benefit	Excluded Service						
	o Bull riding						
	 Car racing 						
	 Skydiving 						
	 Motorcycle/BMX racing and/or stunts 						
	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).						
	Treatment for which the cost is recoverable under any other coverage,						
	including Workers' Compensation, Occupational Disease law, school/academic institution, or any state or government agency						
	school/academic institution, or any state or government agency.						
Genetic analysis,	Genetic counseling and testing for family planning or disease identification						
services, or testing	purposes.						
Immunizations	 Unless also a <u>Preventive Service</u>, shots you must have for: 						
	o Employment;						
	o The military;						
	o Travel; or						
	A vocational school or institute of higher education.						
Obstetrical and	Alternative programs for delivery such as home delivery and use of midwives.						
<u>Infertility</u> services	Cost of donor sperm or donor egg.						
	Elective abortions. Expanses related to surrogate parenthood.						
	 Expenses related to surrogate parenthood. Genetic counseling and genetic <u>Screening</u>. 						
	_						
	Hysterectomies for the purpose of contraception.						
	 Insemination procedures and all services related to insemination. Gamete Intrafallopian Transfer (GIFT) 						
	Gamete intrafallopian Transfer (GIFT) In Vitro Fertilization (IVF)						
	o In vitro Fertilization (IVF) o Intracervical Insemination (ICI)						
	Zygote Intrafallopian Transfer (ZIFT)						
	 Reversal of a sterilization procedure. 						
	 Services associated with these procedures. 						
Physical,	Acupuncture/acupressure.						
occupational, and	 Kinesiology or movement therapy. 						
speech therapy	Massage therapy.						
	 Recreational therapy including, but not limited to: 						
	 Animal-facilitated therapy 						
	Music therapy						
	Rolf technique.						
Prescription Drugs	Drugs prescribed for a non- <u>FDA</u> approved indication, dosage, or length of						
<u></u>	therapy.						
	• Products available without a prescription (<u>OTC</u>). Including but not limited to:						
	 Dietary supplements 						
	o Foods						
	o Formulas						
	 Medications for irrigation 						

Benefit	Excluded Service					
	 Non-preventive care drugs 					
	o Saline					
	Compounded drugs					
Transplants	Artificial or non-human organ transplants.					
Transportation	Commercial or public transportation.					
	Gurney van services.					
	Wheelchair van services.					
Vision	 Computer programs of any type, including, but not limited to, those to as 					
	with vision therapy.					
	Insurance for contact lenses.					
	LASIK, INTACS, radial keratotomy, and other refractive surgery.					
	Lens upgrades.					
	Non-prescription lenses.					
	Special multifocal ocular implant lenses.					
Weight loss	Commercial weight loss programs or <u>OTC</u> weight loss products.					
_	Bariatric surgery when related to weight loss alone.					

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 <u>Service Area</u> (<u>Subscriber</u> or spouse).
- You are a U.S. citizen or national or are a non-citizen who is lawfully present in the U.S. and
 - You reasonably expect to be a citizen or national.
 - 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 <u>Subscriber</u> to the <u>Plan</u>. The spouse and children are <u>Dependents</u>.

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 Consolidated Omnibus Budget Reconciliation Act (<u>COBRA</u>)-eligible, an employee's <u>Dependents</u> 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 <u>Dependents</u> 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 133.

Disabled Dependents

Enrolled <u>Dependents</u> who reach the age of 26 may stay enrolled in the <u>Plan</u> 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 <u>Dependents</u> of your <u>Dependents</u> are not covered. We do not cover your <u>Dependent</u> child's spouse or children, including newborns beyond the 48/96 hour routine <u>Hospital</u> admission.

Service Area

Our <u>Service Area</u> includes the following Oklahoma counties in their entirety:

Caddo, Canadian, Carter, Cleveland, Creek, Garfield, Garvin, Grady, Hughes, Lincoln, Logan, Mayes, McClain, McIntosh, Muskogee, Okfuskee, Oklahoma, Okmulgee, Pawnee, Pittsburg, Pontotoc, Pottawatomie, Rogers, Seminole, Tulsa, and Wagoner.

<u>Subscribers</u> and spouses must live or work in our <u>Service Area</u> in order to enroll. If you are away from our <u>Service Area</u> for more than six months, contact your Insurance Coordinator or Benefits Coordinator. There is a mid-year change when you may enroll with another <u>Plan</u> that includes your new location in its <u>Service Area</u>. You should be close to your <u>Plan</u>'s <u>Provider Network</u> to make it easy to get the care you need.

Dependents Living Out-of-Area

<u>Dependents</u> under the age of 26 who live outside of our <u>Service Area</u> may enroll. He/she must have an assigned <u>Network PCP</u> to manage routine or chronic care. <u>Out-of-network</u> coverage is for <u>Emergency Services</u> and <u>Urgent Care</u> only unless we authorize specific <u>Out-of-network</u> coverage.

Enrollment Periods

In order to get coverage, an eligible person must enroll in the <u>Plan</u>. You should submit your <u>Enrollment</u> through your Insurance Coordinator or Benefits Coordinator. Make your <u>Premium</u> contribution through your employer. We must receive your <u>Enrollment</u> 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 <u>Plans</u> or drop coverage; and/or
- Add or drop <u>Dependents</u> from coverage.

Mid-year Change

You may be able to enroll outside of Option Period in limited circumstances. You must have one of the <u>Qualifying Life Events</u> 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 <u>CHIP</u> eligibility. See "<u>Medicaid and CHIP Notice</u>" on page 166.

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

Change in family status:

Your <u>Premium</u> 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 <u>Plan</u> options are.

<u>Dependent</u> Type	Description						
Adopted children	We cover adopted children from the date placed in the home.						
	• Subject to the "Excluded Services and Limitations" on page 119, we cover the						
	medical costs related to the birth of the child who is 18 months or younger.						
	 Send us copies of the medical bills and records related to the birth of the 						
	child.						
	 Send us proof that you have paid or are responsible to pay those bills and 						
	that the cost was not covered by another <u>Plan</u> , 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 <u>Dependent</u> during the first 31 days,						
	the newborn's coverage ends on day 31.						
	We cover newborns of <u>Dependent</u> children for the approved mother's (your						
	<u>Dependent</u>) stay of 48/96 hours.						
New <u>Dependents</u> as	If you marry, we cover new family members from the first day of the month						
a result of marriage	after your marriage.						
Qualified Medical	We cover children to comply with a Qualified Medical Child Support Order. If						
Child Support Order	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						
	<u>Plan Member</u> or you send us written evidence that:						
	 The court or administrative order has ended; or 						
	 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 <u>Plan</u> . There						
	cannot be a gap in coverage.						
Death, divorce, or	We cover new <u>Subscribers</u> and <u>Dependents</u> from the first day of the month						
legal separation	 after enrollment if they qualify through <u>COBRA</u> or GlobalHealth <u>Plan</u>. You must enroll within 30 days after you lose coverage as a Dependent 						
	You must enroll within 30 days after you lose coverage as a <u>Dependent</u>						
	through a spouse or parent.						

Change in coverage:

You may enroll when:

- You move from your Plan's Service Area.
- You lose Medicaid coverage or premium-free Medicare Part A eligibility.
- You gain lawful presence in the U.S. See "<u>Eligibility</u>" on page 127.
- You are enrolled in a <u>Plan</u> for which you don't qualify due to <u>Enrollment</u> 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:
 - o You or your eligible family member has exhausted **COBRA** under another group health **Plan**;
 - Work hours of the <u>Subscriber</u> end or are reduced;
 - o Any other health <u>Plan</u> coverage ends;
 - o The employer stopped paying part of your <u>Premium</u>; or
 - o Death, divorce, or legal separation of the Subscriber.
- You are no longer incarcerated.

- You have exceptional circumstances such as in the case of a child of an incarcerated parent.
- You are a <u>Dependent</u> that becomes disabled and financially dependent on the <u>Subscriber</u>.
- Change in employment:
- You may enroll when:
- You are hired.
- You become eligible because of hours worked.

When Coverage Begins

Coverage for you and your eligible <u>Dependents</u> begins as of 12:01 a.m. on the effective date of your <u>Enrollment</u>. 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 <u>Plan</u> 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 care through an <u>Out-of-network Provider</u> while we are transferring your care to an <u>Innetwork Provider</u>, we will pay at least <u>Usual and Customary</u> amounts for your services. You pay your <u>Innetwork Cost-share</u>.

Examples of conditions that may require continuity or <u>Transition of Care</u>:

- Behavioral health conditions during active treatment
- Currently hospitalized
- Currently taking drugs for which we require <u>UM</u> review
- Currently on a transplant list
- Impending Hospitalization

- Currently pregnant and undergoing a course of treatment for the pregnancy from the <u>Provider</u> or <u>Facility</u>
- Terminal illness
- Undergoing chemotherapy or radiation therapy

The approved <u>Out-of-network</u> care ends when:

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

The approval applies only to the condition and the <u>Provider</u> shown in the approval letter for a limited time. An <u>In-network Provider</u> must treat all other conditions. If you need <u>Referral</u> services, we may authorize for <u>In-network Providers</u> 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 148. You will need to complete the form if you want us to share your PHI with anyone else, for example:
 - o Your parent, if you are age 18 or over.
 - o Your spouse.
 - o Your caregiver, friend, neighbor, or other.

If we do not approve ongoing care through the <u>Out-of-network Provider</u>, you may <u>Appeal</u> the decision. See "<u>Appeals and Grievances</u>" on page 142.

Behavioral Health and Medical Transition of Care

If you are a current GlobalHealth <u>Member</u> and your <u>Provider</u> leaves the <u>Network</u>, you may keep getting care from that <u>Provider</u> in certain cases while we are transferring your care to an <u>In-network Provider</u>.

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

- Ongoing treatment for a <u>serious and complex condition from the Provider</u> or <u>Facility</u>;
 - o In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
 - o In the case of a chronic illness or condition, a condition that is:
- Life-threatening, degenerative, potentially disabling, or congenital; and
- Requires specialized medical care over a prolonged period of time.
- Ongoing course of institutional or <u>Inpatient</u> care from the <u>Provider</u> or <u>Facility</u>;
- Ongoing course of treatment for a pregnancy from the <u>Provider</u> or <u>Facility</u>;
- Scheduled to undergo non-elective surgery from the <u>Provider</u>, including receipt of postoperative care from such <u>Provider</u> or <u>Facility</u> with respect to such a surgery;
- Ongoing treatment for an individual determined to be terminally ill and is receiving treatment for such illness from such <u>Provider</u> or <u>Facility</u>; or
- Ongoing treatment for which a treating doctor or other <u>Provider</u> attests that changing care to another doctor or <u>Provider</u> would make the condition or expected outcome worse

If approved for transition care, we cover care until the earlier of 90 days or the date on which you are no longer a continuing care patient with respect to such <u>Provider</u> or <u>Facility</u>. If you are pregnant, we cover transition care through six weeks postpartum, even if it is more than 90 days. If you remain enrolled in the same <u>Plan</u> 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 <u>Provider's</u> contract ended due to quality of care issues.
- The <u>Provider</u> did not comply with regulatory or other contract requirements.

If you are a new <u>Member</u> to GlobalHealth, we will honor a <u>PA</u> from your previous <u>Health Insurance</u> carrier for 60 days. During that time, we will perform our own <u>PA</u> review and either issue a new <u>PA</u> or make an <u>Adverse</u> Determination.

Prescription Drug Transition of Care

If you are new to GlobalHealth, you may ask us to:

- Cover non-formulary drugs; or
- Waive restrictions on Formulary drugs.

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. If not approved, you may ask for an <u>External Review</u>.

For more information, see "Exception Requests" on page 35.

Behavioral Health and Medical Continuity of Care

If you are a current GlobalHealth <u>Member</u> and your <u>Provider</u> leaves the <u>Network</u>, you may keep getting care from that <u>Provider</u> in certain cases while we are transferring your care to an <u>In-network Provider</u>.

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

- Ongoing treatment for a <u>serious and complex condition from the Provider</u> or <u>Facility</u>;
 - o In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
 - o In the case of a chronic illness or condition, a condition that is:
- Life-threatening, degenerative, potentially disabling, or congenital; and
- Requires specialized medical care over a prolonged period of time.
- Ongoing course of institutional or Inpatient care from the Provider or Facility;
- Ongoing course of treatment for a pregnancy from the **Provider** or **Facility**;
- Scheduled to undergo non-elective surgery from the <u>Provider</u>, including receipt of postoperative care from such <u>Provider</u> or <u>Facility</u> with respect to such a surgery;
- Ongoing treatment for an individual determined to be terminally ill and is receiving treatment for such illness from such <u>Provider</u> or <u>Facility</u>; or
- Ongoing treatment for which a treating doctor or other <u>Provider</u> attests that changing care to another doctor or <u>Provider</u> would make the condition or expected outcome worse.

If approved for continuity care, we cover care for up to 90 days while we are working to transfer your care. 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 <u>Plan</u> 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 <u>Provider's</u> contract ended due to quality of care issues.
- The <u>Provider</u> 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 <u>Dependents</u>;
- If you gain, lose, or make policy changes to any other group health coverage;
- Moving out of our Service Area; or
- Change in:
 - o Name

0	Mailing address	0	<u>PCP</u>	0	Family status
	and zip code	0	Disability status	0	Retirement
0	Telephone number	0	Medicare status	0	Death
	(home and work)	0	COBRA	0	Divorce

You should make any change as soon as possible, but always within 30 days. See "Enrollment Periods" on page 128 for deadlines for mid-year changes. Call your Insurance Coordinator or Benefits Coordinator.

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

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

Or, if you have a life changing event such as:

- Death of a spouse
- Divorce

 Your <u>Dependent</u> child is no longer eligible because of age

See "Continuation Coverage Rights Under COBRA" on page 160.

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 and OHCA 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 <u>Plan</u>.

Coverage Terminations

A termination is when your coverage ends. Coverage ends at 12:00 midnight on the day of your termination. If a <u>Dependent's</u> coverage ends, it does not affect the coverage of other family members. If the <u>Subscriber's</u> coverage ends, the membership of all <u>Dependents</u> stops as well. See "<u>Continuation Coverage Rights Under COBRA</u>" on page 160.

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

Reason	Description	When Coverage Stops
Aging-off	 Children are eligible for <u>Dependent</u> 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 <u>Plan</u>. You should get the notice before the month you are to be disenrolled. 	The last day of the month turning 26

Reason	Description	When Coverage Stops
	 You may ask for continued coverage for disabled <u>Dependents</u>. 	
Death	 If the <u>Subscriber</u> dies, coverage for the Subscriber and for all <u>Dependents</u> end. If a <u>Dependent</u> dies, only that Dependent's coverage ends. 	 Subscriber dies: Subscriber - The date of death Dependent: The last day of the month of the Subscriber's death Dependent dies: The date of death
Eligibility	 Your employer defines eligibility for employees and <u>Dependents</u>. 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
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 166. We can take actions that have serious effects on your coverage. These include, but are not limited to: Retroactive loss of coverage. Loss of coverage going forward. Denial of benefits. Recovery of amounts we already paid. 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. 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/ <u>CHIP</u>	Oklahoma Health Care Authority defines eligibility.	The day before the new coverage starts with Medicaid/ <u>CHIP</u>

Reason	Description	When Coverage Stops
Moving from Service Area	You should enroll in a <u>Plan</u> that has a <u>Network</u> of <u>Providers</u> in your new <u>Service Area</u> .	The last day of the month for which Premium was paid
Non-payment of <u>Premium</u>	 You are not eligible for a mid-year change: If your coverage or your <u>Dependents</u>' coverage ends for failure to pay <u>COBRA Premium</u>; or If your coverage or your <u>Dependents</u>' coverage ends for failure to enroll in <u>COBRA</u> within the timeframe to elect <u>COBRA</u>. 	The last day of the month for which Premium was paid
<u>Plan</u> error	We may discover that we have enrolled you when you were not eligible.	The same day as the original effective date

If you have any of these situations, you may be eligible for a mid-year change to enroll with another <u>Health</u> <u>Insurance</u> company. Or you may choose continuation of coverage or <u>COBRA</u> if you qualify.

Continuation of Coverage

You may be able to keep coverage in the same <u>Plan</u> for 63 days beyond these timeframes. You must keep paying your <u>Premium</u>.

Continuation of coverage <u>may not</u> be available:

- If you fail to make timely <u>Premium</u> 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 <u>COBRA</u> continuation coverage. Ask your Insurance Coordinator or Benefits Coordinator.

If you would like to purchase <u>Health Insurance</u> through the <u>ACA's Health Insurance Marketplace</u>, visit <u>HealthCare.gov</u>. This is a website the U.S. Department of Health and Human Services provides for <u>Marketplace</u> information, 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 <u>Hospital</u> or expiration of benefits according to your contract.

Services must meet "Coverage Requirements" on page 40. 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 <u>Premiums</u> have been paid.
- If you are confined in a <u>Hospital</u> 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 173.

CLAIMS AND PAYMENT

Responsibility for Payment

When	Cost
You are responsible for:	Your Copayments or Coinsurance for approved <u>Covered Services</u> until you meet the MOOP.
	 The cost of services provided by a doctor or <u>Facility</u> without an authorized <u>Referral</u>. The cost of services not included in your GlobalHealth <u>Plan</u> benefits. The care is not covered according to this <u>Member Handbook</u>. The care is listed in the <u>Excluded Services</u> and Limitations section. Full billed charges when: The services were non-covered services; The services were not urgent or an emergency, received <u>Out-of-network</u>, and not authorized by us; or You obtained the services through your own <u>Fraud</u>.
You are not responsible for:	 Any amounts we owe a <u>Provider</u> for approved <u>Medically Necessary</u> services that are covered by this <u>Plan</u>. Any amounts requested as <u>Balance Billing</u> (after we have paid the contracted <u>Allowed Amount</u>), provided that: The services were <u>Covered Services</u>; The services were approved by us; The services were provided by a <u>Network Provider</u>; and You have paid your required <u>Cost-share</u>, if any.

Balance Billing by an Out-of-network Provider

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

There are exceptions when <u>Out-of-network Providers</u> may not send you a bill for the difference:

- You are treated for **Emergency Services** while **Out-of-network**.
- You receive air and ground ambulance services.
- You seek non-emergent care at certain <u>Network Facilities</u>, follow the coverage rules, and receive care from an <u>Out-of-network Provider</u> at that <u>Facility</u>.

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 in an emergency or urgent situation, 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 MedImpact, Carelon Behavioral Health, or us for your records.

Behavioral Health

Network behavioral health Providers will bill Carelon Behavioral Health directly for services.

If you need to file a <u>Claim</u> for emergency <u>Out-of-network</u> services, mail the <u>Claim</u> to Carelon Behavioral Health.

Contact Method	Contact Information
Toll-free	1-888-434-9204
Mail	Carelon Behavioral Health
	PO Box 1850
	Hicksville, NY 11802-1850

Medical

<u>Network Providers</u> bill us directly for services provided. However, if you get urgent or emergent care out of our <u>Network</u>, you might get a bill from those <u>Providers</u>.

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

Contact Method	Contact Information
Toll-free	1-877-280-5600
Mail	GlobalHealth, Inc.
	Claims
	PO Box 2328
	Oklahoma City, OK 73101-2328

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 40.

- 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 <u>Appeal Rights</u> within 30 days after we get the <u>Claim</u>. See "<u>Appeals and Grievances</u>" on page 142.

Prescription Drugs

The pharmacy usually bills directly to MedImpact. However, if you fill a prescription without your <u>Member</u> ID card, the pharmacy may require you to pay. If this happens, call MedImpact. You will need to fill out a paper <u>Claim</u> form and send the receipts. If this happens, call MedImpact or access the form from our website <u>www.globalhealth.com/oklahoma/state/member-materials-search/</u>.

Contact Method	Contact Information
Toll-free	1-800-424-1789
TTY	711
Mail	MedImpact
	7835 Freedom Avenue NW
	North Canton, OH 44720

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 <u>Plans</u> no longer accepting new <u>Members</u>;
- Group-type coverage;
- The medical care benefits of long-term care coverage, such as <u>Skilled Nursing Care</u>;
- 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 <u>Plan</u> under Medicaid. That type of <u>Plan</u> may be limited to <u>Hospital</u>, medical, and surgical benefits of the governmental program; and
- Group and individual insurance coverage and <u>Subscriber</u> coverage that pay or reimburse for the cost of dental care.

If you have healthcare coverage in addition to your GlobalHealth <u>Plan</u>, either as a <u>Dependent</u> or a <u>Subscriber</u>, we will coordinate benefits. This means that we will determine which <u>Plan</u> will pay as primary (first) and which <u>Plan</u> will pay as secondary (second). You must follow the "<u>Coverage Requirements</u>" on page 40, whether we pay first or second.

Behavioral Health and Medical Coverage COB

Benefits we pay are subject to Coordination of Benefits (<u>COB</u>). We apply <u>COB</u> rules according to the National Association of Insurance Commissioners' guidelines and applicable state laws. 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 <u>Plan</u> has	Generally, the <u>Plan</u> without a <u>COB</u> provision pays first.
COB provisions	The <u>Plan</u> with a <u>COB</u> provision pays second.
Both <u>Plans</u> have COB	The <u>Plan</u> covering the <u>Member</u> as a <u>Subscriber</u> pays first.
provisions	• The <u>Plan</u> covering the <u>Member</u> as a <u>Dependent</u> pays second.
Both <u>Plans</u> have <u>COB</u>	The "Birthday Rule":
provisions -	 The <u>Plan</u> of the parent with a birthday earlier in the calendar year,
<u>Dependent</u> Child -	regardless of the year of birth, pays first.
Parents not	o If either <u>Plan</u> does not follow the Birthday Rule, then the rules of the <u>Plan</u>
separated or	that does <u>not</u> have the Birthday Rule provision apply.
divorced	

Provisions	COB Order of Benefit Determination Rules
Both <u>Plans</u> have <u>COB</u>	A <u>Dependent</u> child whose parents are separated or divorced, and the parent
provisions -	with custody has not remarried:
<u>Dependent</u> Child -	 The <u>Plan</u> of the parent with custody pays first.
Parents separated or	 The <u>Plan</u> of the parent without custody pays second.
divorced	A <u>Dependent</u> child whose parents are divorced, and the parent with custody
	has remarried:
	 The <u>Plan</u> of the parent with custody pays first.
	 The <u>Plan</u> of the stepparent pays second.
	 The <u>Plan</u> of the parent without custody of the <u>Dependent</u> pays third.
	A <u>Dependent</u> child whose parents are separated or divorced and a court
	decree establishes responsibility for healthcare expenses – the <u>Plan</u> 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 <u>Claim</u>, we will ask that you complete a <u>Coordination of Benefits (COB) Form</u>. Send the completed form when requested so the <u>Claim</u> is not delayed or denied. We may ask you to complete a form each year.

Contact Method	Contact Information
Mail	GlobalHealth, Inc.
	Enrollment & Eligibility
	PO Box 2328
	Oklahoma City, OK 73101-2328

Prescription Drug Coverage COB

If you are covered by more than one <u>Plan</u>, we will coordinate your prescription benefits. Give both <u>Prescription Drug</u> cards to the pharmacy staff. Tell them who pays first. The pharmacy staff will enter the information. You pay your <u>Cost-share</u> for that <u>Plan</u>. 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 Welcome to Medicare Medicare.

You must follow the "Coverage Requirements" on page 40, 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

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 <u>Claim</u> against any third-party. This means that we will be paid before payment of any other <u>Claims</u>, including any <u>Claim</u> 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 <u>Claim</u>. We may waive our option to deny the <u>Claim</u> for good cause in certain specific cases.

Note: See "Subrogation, Third-Party Recovery, and Reimbursement" on page 183.

Notify GlobalHealth

Tell us about potential third-party liability or Workers' Compensation situations as soon as possible. When another third-party liability payer is primary, GlobalHealth <u>Network</u> and authorization rules still apply.

If Your Claim Is Denied

If we deny any part of a <u>Claim</u> submitted for payment, we will review the <u>Claim</u> upon written request for <u>Appeal</u>. See "<u>Appeals and Grievances</u>" on page 142.

Claims Payment Recovery

If we pay a <u>Claim</u> 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 <u>Provider</u>. 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 <u>Premiums</u> or pay for benefits.

- We may ask for a refund from you within 6 months after we made the payment. We will ask for a refund from your <u>Provider</u> within 12 months after we made the payment, unless:
- The payment was made because of <u>Fraud</u> committed by you or the healthcare <u>Provider</u>; or
- You or the healthcare <u>Provider</u> has otherwise agreed to make a refund to us for overpayment of a <u>Claim</u>.

APPEALS AND GRIEVANCES

Complaints and <u>Grievances</u>

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

It may concern:

- Access
- Any aspect of the <u>Plan</u> operations
- Attitude/Service
- Billing/Financial
- Policies

- Procedures
- Quality of care
- Quality of <u>Provider</u> office site
- Other issue

Send written <u>Grievances</u> to the <u>Appeals</u> and <u>Grievances</u> addresses on page 4. Please include:

- Member's name and address;
- GlobalHealth Member ID#;
- <u>Provider</u> of services, if applicable;

- A description of the complaint and resolution desired; and
- Copies of <u>Claims</u>, records, or other relevant information.

If you wish to file a complaint or <u>Grievance</u>, 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 <u>Grievance</u>. 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.

You, or someone on your behalf, may ask the Insurance Commissioner for help at any time whether or not you submit a written <u>Grievance</u> to us.

For help with Grievances related to discrimination, see "Notice of Non-discrimination" on page 169.

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 31; or
- Changes or reduces an approved Course of Treatment. See "Concurrent Review" on page 33.

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

You may ask for more explanation when we deny your <u>Claim</u> or request for coverage or we did not fully cover your care. There is no cost to you for requesting either an initial <u>Appeal</u> or an <u>External Review</u>.

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 <u>Plan</u> documents;
- Want a copy (free of charge) of documents, records, and other information relevant to your <u>Claim</u>;
- 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 <u>Claim</u> was denied due to missing or incomplete information, you or your <u>Provider</u> may resend the <u>Claim</u> to us with the needed information.

Your <u>Appeal</u> request must be submitted in writing to the GlobalHealth, <u>Appeals</u> and <u>Grievances</u> address on page 4 **within 180 days** of receiving the <u>Adverse Determination</u> notice. Include the following:

- Member's name and address;
- GlobalHealth Member ID#;
- <u>Provider</u> of services;
- Date of service if appealing a denied <u>Claim</u>;
- Description of the denied service and why the Appeal is being requested; and
- Copies of documentation to support the <u>Appeal</u> request (such as, <u>Claims</u>, medical records, doctor statements, and any other relevant information).

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

Full and Fair Review

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

Behavioral Health Appeals

Carelon Behavioral Health administers your behavioral health benefits on our behalf. They also handle all behavioral health <u>Appeals</u>. Follow the same process for medical <u>Appeals</u> but send the information to this address:

Contact Method	Contact Information
Toll-free	1-888-434-9204
	Monday – Friday, 7 am – 5 pm
TTY	711
Fax	1-855-378-8309
Mail	Carelon Behavioral Health
	PO Box 1851
	Hicksville, NY 11802-1851

We will tell you our decision in writing within 30 days of receiving your <u>Appeal</u>. 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. If you do not get our decision within 30 days, you may ask for an <u>External Review</u>. See "<u>External Review</u>" on page 146.

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 <u>Claim</u>, 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 <u>Adverse Determination</u>, there are two different types of internal review:

- 1. <u>General Review</u> (such as, <u>Claims</u> processing or clerical errors).
- 2. <u>Independent Internal Review</u> (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;
 - o Emergency Services and you have not been discharged from a Facility; or
 - A <u>Hospital</u> 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 <u>Appeal</u> as an expedited internal review, we will make a determination within 72 hours after we get your request. If your <u>Appeal</u> does not qualify for a fast review, we will tell you and process the <u>Appeal</u> within the standard timeframe.

Medical Appeals

For medical <u>Appeals</u>, follow the <u>Appeals</u> process on page 143. We will tell you our decision in writing within 30 days of receiving your <u>Appeal</u>. 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. If you do not get our decision within 30 days, you may ask for an <u>External Review</u>. See "<u>External Review</u>" on page 146.

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 <u>Claim</u>, 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 <u>Adverse Determination</u>, there are two different types of internal review:

- 1. General Review (such as, Claims processing or clerical errors).
- 2. <u>Independent Internal Review</u> (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;
 - o Emergency Services and you have not been discharged from a Facility; or
 - o 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 <u>Appeal</u> as an expedited internal review, we will make a determination within 72 hours after we get your request. If your <u>Appeal</u> does not qualify for a fast review, we will tell you and process the Appeal within the standard timeframe.

Prescription Drug Appeals

Contact Method	Contact Information
Fax	1-888-586-1118
Toll-free	1-800-424-1789
Mail	MedImpact
	Attn: Clinical Services
	7835 Freedom Avenue NW
	North Canton, OH 44720

For <u>Prescription Drug</u> exceptions, we will tell you our decision within 72 hours of receiving your exception request. We will give you any new or additional evidence we used and tell you why we used it if you ask. We

will give you this information free of charge. You may ask who the medical or other experts are whose advice we asked for, and whether or not we used their advice in making the determination. We use a pharmacist to review pharmacy denials based on medical necessity.

Prescription Drug Expedited Exception Request

If your situation is critical your doctor may request a fast internal review. In that case, we will make a determination within 24 hours after we get the request.

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 <u>Experimental or</u> <u>Investigational</u>.
- Appropriateness.
- Healthcare setting.

- How well the healthcare service or treatment works.
- Level of care.
- Medical necessity.

There are no filing fees or other cost for this review. If you would like additional information regarding independent <u>Appeal</u> rights, contact us.

Behavioral Health and Medical Reviews

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
	400 N.E. 50 th Street
	Oklahoma City, OK 73105
Website	https://www.oid.ok.gov/consumers/external-review-process/

If your request qualifies for <u>External Review</u>, the Insurance Department will randomly select a qualified Independent Review Organization (<u>IRO</u>) to conduct the <u>External Review</u>. You must authorize the release of medical records. The <u>IRO</u> needs to review them so it can reach a decision. The <u>IRO</u> 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;
 - o Emergency Services and you have not been discharged from a Facility;
 - o A Hospital stay; or

• We determined that the medical care is <u>Experimental or Investigational</u>. Your doctor must certify in writing that the medical care would be significantly less effective if not started right away.

You can request an expedited External Review at the same time as an expedited internal Appeal process.

To request an expedited <u>External Review</u>, 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 <u>External Review</u>, the Insurance Commissioner will randomly select an <u>IRO</u>. The <u>IRO</u> will make a determination within 72 hours after they get your request for expedited <u>External Review</u>.

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

Prescription Drug Reviews

You must ask for an External Review within 72 hours of the exception request determination notice.

Contact Method	Contact Information
Local	(405) 521-2828
Toll-free	1-800-522-0071
Mail	Oklahoma Insurance Department
	400 N.E. 50th Street
	Oklahoma City, OK 73105
Website	https://www.oid.ok.gov/consumers/external-review-process/

If your request qualifies for <u>External Review</u>, the Insurance Department will randomly select a qualified Independent Review Organization (<u>IRO</u>) to conduct the <u>External Review</u>. You must authorize the release of medical records. The <u>IRO</u> needs to review them so it can reach a decision. The <u>IRO</u> will tell you its decision within **72 hours** after it gets the request for review.

Expedited External Review

To request an expedited <u>External Review</u>, 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 <u>External Review</u>, the Insurance Commissioner will randomly select an <u>IRO</u>. The <u>IRO</u> will make a determination within 24 hours after they get your request for expedited <u>External Review</u>.

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

Notices

We will mail you a written Appeal determination after each level in the Appeal process. It includes:

- Specific reason(s) for the denial;
- A reference to the benefit provision, guideline, protocol, or other similar criterion on which a denial is based;
- The credentials of the person, or persons, involved in reviewing your Appeal; and

• Other Appeal rights, when applicable.

Appointment of Authorized Representative

Someone else may ask for an <u>Appeal</u>, exception request, or continuity or <u>Transition of Care</u> 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 <u>Appointment of Authorized Representative</u> form on our website or by contacting us. We must have a signed form on file before the <u>Appeal</u>, <u>Grievance</u>, exception request, or continuity or <u>Transition of Care</u> can proceed if someone is working on your behalf.

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. Our main areas of focus are:

- Keeping Members healthy;
- Managing Members with emerging risk;
- Member safety or outcomes across settings; and
- Managing multiple chronic illnesses.

You are the most important part of managing your health.

- Understand your health and 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 and can even provide a case manager who will focus on:

- Getting to know you and your medical needs.
- Helping you set up appointments with your doctor.
- Helping you get other care you need.
- Answering questions before or after your doctor visit.
- Helping you in a way that meets your cultural needs and preferences.

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

- Advance Care Planning Services
- Diabetes Prevention Program
- Medication Therapy Management Program
- Prenatal Outreach Program
- Proactive Outreach Program
- Site of Care Program
- Tobacco Cessation Program

You can find out more about each program below.

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. Your doctor or our case manager can help you find and enroll in a <u>Network</u> diabetes prevention program.

Medication Therapy Management Program

If you are taking multiple drugs for <u>Chronic Conditions</u>, 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 <u>Provider</u> who prescribes drugs for you.

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

- 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 <u>Provider</u> to correct it.

Ultimately, 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.

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. See "Maternity and newborn care" on page 79.

Actions	Description
What to do	 Make and keep your prenatal doctor visits. Schedule your first visit within the first trimester. 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. Be aware of your blood pressure and blood sugar measurements. 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. Talk about and prepare for postnatal visits and well-child visits.

Actions	Description
What <u>not</u> to do	 Don't use drugs, drink alcohol, or smoke. Stay away from second-hand smoke.
•	 Don't start or stop taking medications (including <u>OTC</u> 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.

Proactive Outreach Program

We help you manage your healthcare through our GlobalHealth Proactive Outreach Program. The goal is to decrease inpatient admissions, readmissions, and unnecessary <u>ER</u> visits by working with you and your doctor to:

- Evaluate health risks;
- Verify or create a workable care plan;
- Help you follow guidelines and the care plan from your doctor and take your drugs as prescribed;
 and
- Coordinate care.

The Proactive Outreach Program offers you two types of support:

1. Discharge Outreach

Provides support if you have recently experienced a <u>Transition of Care</u>. The Discharge team works with you to support and reinforce treatment plans to prevent readmission and unnecessary <u>ER</u> visits.

2. Case Management

Consists of what is traditionally known as complex <u>Case Management</u> and disease management. The goal is to promote quality, cost-effective health outcomes. Our case manager works with you, your doctors, and/or <u>BHP</u> 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.

Site of Care Program

If you take certain <u>Specialty Drugs</u> through infusion, there are different locations to get them. Each setting has a different <u>Cost-share</u>.

- Preferred settings:
- In your home.
- In your doctor's office.
- In an infusion suite/center.
- Non-preferred setting:
- Outpatient Hospital Facility.

Our Site of Care program directs you to the most cost-effective, clinically appropriate location to have your infusions. It saves you money and is more convenient.

First Dose

Your first dose of medication may be given in an <u>Outpatient Hospital Facility</u> when:

- A preferred place of service cannot meet the requirements for first dose administration.
- You have specific factors preventing administration in a preferred setting.

After First Dose

You may continue to get your infusions in an <u>Outpatient Hospital Facility</u> if your doctor sends us information that it is <u>Medically Necessary</u>. Without the information, you will be directed to a preferred site of care.

Tobacco Cessation Program

Smoking and tobacco use can lead to disease and disability and harm nearly every organ in your body. Tobacco use can cause cancer, heart disease, stroke, lung diseases, diabetes, nicotine poisoning, and <u>COPD</u>, which includes emphysema and chronic bronchitis. Smoking also increases the risk for tuberculosis, certain eye diseases, and problems of the immune system, such as rheumatoid arthritis.

<u>Tobacco products include:</u>

- Candy-like products that contain tobacco
- Cigarettes
- Cigars

- Smokeless tobacco
- Smoking tobacco
- Snuff

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.

E-cigarettes:

Using E-cigarettes could be just as dangerous. E-cigarettes are not safe for youth, young adults, pregnant women, or adults who do not currently use tobacco products. E-cigarettes produce an aerosol that users inhale into their lungs. The aerosol can contain harmful and potentially harmful substances including:

- Nicotine
- Ultrafine particles that can be inhaled deep into the lungs
- Flavoring such as diacetyl, a chemical linked to a serious lung disease
- Volatile organic compounds
- Cancer-causing chemicals
- Heavy metals such as nickel, tin, and lead

For more information on how to prevent and detect E-cigarette use visit https://www.cdc.gov/tobacco/e-cigarettes/about.html?CDC AAref Val=https://www.cdc.gov/tobacco/basic information/e-cigarettes/about-e-cigarettes.html.

Quitting:

- If you are looking to quit smoking, tobacco use, or the use of E-cigarettes we can help. Our tobacco cessation goals are to:
 - o Reduce the number of <u>Members</u> who use tobacco products;

- Increase awareness of tobacco cessation programs; and
- o Improve the overall health of Members.

Steps to quit:

- 1. Find *your* motivation.
- 2. Call your <u>PCP</u>, <u>BHP</u>, or the Oklahoma Tobacco Helpline for support and to set up your quit plan.
- 3. Talk with your doctor about medicines to help you quit.
- 4. Set a guit 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.
 - Make your home and car smoke-free.
 - If you have friends who smoke, ask them not to smoke around you.
- 6. Plan for how you will handle challenges like cravings.

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. The most important thing to remember is to keep trying.

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 <u>PA</u>. You pay for other treatment or non-generic drugs.

For those under age 18 visit Smoke Free Teen at https://teen.smokefree.gov/ for quit methods and tools.

Counseling

You or your <u>Dependent</u> age 13 or older may attend individual, group, or telephone counseling sessions for at least 10 minutes each through your <u>PCP</u> or <u>BHP</u>.

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 <u>FDA</u>-approved tobacco cessation products per year. Your <u>PCP</u> or <u>BHP</u> will write a prescription. This benefit is available to you and your enrolled <u>Dependents</u> who are at least 18 years old.

The covered drugs include:

• Bupropion SR 150 mg (generic for Zyban*).

- Varenicline (generic for Chantix™);
- Nicotrol® Inhaler (nicotine); and
- Nicotrol® Nasal Spray (nicotine).

We also cover <u>FDA</u>-approved <u>OTC</u> products with a prescription written by your physician:

- Gum;
- Lozenges; and
- Nicotine patches.

Not all products that may be used for tobacco cessation are included. For example, we do not cover electronic cigarettes (e-cigarettes) or vaporizers.

How to enroll

Each of these programs is a team effort and that team includes you, your caregiver (if you wish), your doctors, and our GlobalHealth team members.

We will automatically enroll you in these programs, except the Medication Therapy Management and Tobacco Cessation Programs, if you meet the criteria. You, your caregiver, discharge planner, or doctor can ask us to enroll you in any of these programs. Participation is voluntary, confidential, and available at no cost to you. You may opt out at any time.

Call us if you have any questions.

Quality of Care Procedures

GlobalHealth has procedures that ensure that healthcare services provided are rendered under reasonable standards of quality of care. Procedures are consistent with professionally recognized standards of medical practice. The procedures include processes to assure availability, accessibility, and continuity of care.

Quality Improvement Program (QIP)

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

- 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:
 - o Monitor performance indicators.
 - Analyze data.
 - Identify practices that result in positive health outcomes.
 - o Implement changes to improve performance.
 - o 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 <u>QIP</u> and work plan. Call us and ask to talk to the Quality Department or send an e-mail to <u>quality@globalhealth.com</u>.

Health Survey

We ask that you complete an HRA each year. It has questions about your current health. 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.

Well Visit Checklists

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

Not every service will be right for you. Your <u>PCP</u> or <u>OB/GYN</u> will recommend services. Services may require more than one visit and/or <u>PA</u>. See "<u>Preventive Care Benefits</u>" on page 109 for additional information.

Population	Preventive Care to Discuss
Men - During routine	☐ Abdominal aortic aneurysm
exam (annual)	☐ 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

Population	Preventive Care to Discuss
-	□ Vision
Women - During	□ Alcohol, prescription, or illicit drug misuse
routine exam	☐ Aspirin use
(annual)	☐ Blood pressure
	☐ Breast cancer and mammograms
	□ 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	□ Alcohol, prescription, or illicit drug misuse
prenatal visits	□ Anemia
(every 4 weeks – 1st	□ Aspirin
28 weeks, every 2-3	□ Blood pressure
weeks - 32 - 36	□ Blood tests
weeks, every week	□ Breastfeeding
until delivery – 37	☐ Gestational diabetes
weeks on)	□ Hepatitis B
	□ HIV/STI
	□ Immunizations
	□ Rh incompatibility
	□ Safety
	□ Tobacco use
	□ Ultrasounds
	□ Urinary tract or other infection
	□ Weight □
Women - During	□ <u>BRCA</u>
well-woman visit	☐ Breast cancer chemoprevention
(annual)	☐ Breast cancer and mammograms
•	

Population	Preventive Care to Discuss
	□ Cervical cancer
	□ Contraception
	□ Intimate partner and domestic violence
	□ HIV/STI
	□ HPV
Children – Newborn	□ Congenital hypothyroidism
services at birth	☐ Gonorrhea preventive medication for the eyes
(<u>Inpatient</u>)	□ Hearing
	☐ Height and weight
	□ Hemoglobinopathies or sickle cell
	□ Immunizations
	□ PKU
	□ State-required testing
Children – During	□ Alcohol, prescription, or illicit drug misuse
well-child visit	□ Autism
(at Birth and at ages	☐ Behavioral/Social/Emotional assessments
2, 4, 6, 9, 12, 15, and	☐ Blood pressure
18 months, 2 - 6	☐ Cervical dysplasia
years annually, 8 –	□ Dental
18 every other year)	□ 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
	□ 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 should diagnose, prescribe, or give medical advice. But, our 24/7 nurse advice line can help you make confident decisions. It's not always easy to decide when to seek emergency care, treat symptoms yourself, or see a <u>PCP</u>. Call CareNet at 1-800-554-9371 (TTY: 711) 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

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 materials at no cost go to www.GlobalHealth.com:

- Tools to improve and maintain your health;
- Information on how to manage long-term conditions;
- Health materials; and
- Powerful eLearning modules lead you towards rediscovering your inner peace and mental wellbeing.

Our website has links to interactive health tools, calculators, and information. Many topics are available in English and Spanish. Call us if you would like a printed copy of any material at no cost.

Category	Information Available
State of Oklahoma	Contact us via secure messaging:
<u>Member portal</u> - Call	 Request/re-order <u>Member</u> ID cards; and
us for login set-up	 Change your <u>PCP</u>.
	• View <u>Plan</u> details (benefits, <u>Cost-share</u>).
	View <u>Claims</u> for <u>Medical Services</u> .
	View <u>Referrals</u> .
Maintain Your Health	Read evidence-based information about:
	 Healthy weight (BMI) maintenance;
	 Healthy eating;
	 The importance of exercise; and
	 Health <u>Screenings</u> for <u>Preventive Care</u>. View prevention checklists for all
	age groups.
	Use tips and interactive tools to incorporate healthy diet and exercise into
	daily life.
Improve Your Health	Read educational material and use interactive self-management tools.
	Find links about topics such as:
	 Alcohol/drug abuse or at-risk drinking;

Category	Information Available
	 Quitting tobacco use, including teen tobacco use and e-cigarettes; and
	 Managing stress and identifying depressive symptoms.
Manage Long-Term	Read evidence-based information about <u>Chronic Conditions</u> and how to
Conditions	manage them. Learn about treatment options to talk about with your doctor.
	Enroll in a GlobalHealth-sponsored program.

Clinical Practice Guidelines

We use clinical practice guidelines from the National Center for Complementary and Integrative Health. Guidelines include, but are not limited to:

Clinical Practice Guidelines	Disease
Preventive	Breast cancer
	Colorectal cancer
	Hypertension
	Obesity assessment
Medical conditions	• COPD
	Chronic Kidney Disease (<u>CKD</u>)
	<u>CAD</u> clinical practice guidelines
	Diabetes mellitus
Behavioral health	ADHD assessment and management
	Autism
	Treatment and management of depression in adults

We have evidence-based 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 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 <u>Provider</u>; 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 <u>Hospital</u>, give the <u>Hospital</u> 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.

Continuation Coverage Rights Under COBRA

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

Section	Description
Introduction	The right to <u>COBRA</u> continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (<u>COBRA</u>). <u>COBRA</u> continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the <u>Plan</u> and under federal law, you should review the <u>Plan</u> 's Summary <u>Plan</u> Description or contact the <u>Plan</u> Administrator.
	You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual <u>Plan</u> 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

Section	Description
Section	·
	enrollment period for another group health <u>Plan</u> for which you are eligible (such
What's CORRA	as a spouse's <u>Plan</u>), even if that <u>Plan</u> generally doesn't accept late enrollees.
What is <u>COBRA</u>	COBRA continuation coverage is a continuation of <u>Plan</u> coverage when it would
Continuation	otherwise end because of a life event. This is also called a "qualifying event."
Coverage?	Specific qualifying events are listed later in this notice. 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're an employee, you'll become a qualified beneficiary if you lose your
	coverage under the <u>Plan</u> because of the following qualifying events: • Your hours of employment are reduced, or
	Your employment ends for any reason other than your gross misconduct.
	If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the <u>Plan</u> because of the following qualifying events: • 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 <u>Dependent</u> children will become qualified beneficiaries if they lose coverage under the <u>Plan</u> because the following qualifying events: • 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 <u>Plan</u> as a "<u>Dependent</u> child."
	If your <u>Plan</u> provides retiree health coverage sometimes, sometimes filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the <u>Plan</u> , the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the <u>Plan</u> .

Section	Description
When is COBRA	The <u>Plan</u> will offer <u>COBRA</u> continuation coverage to qualified beneficiaries only
continuation	after the Plan Administrator has been notified that a qualifying event has
coverage available?	occurred. The employer must notify the <u>Plan</u> Administrator of the following
	qualifying events:
	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).
	•
	For all other qualifying events (divorce or legal separation of the employee
	and spouse or a <u>Dependent</u> child's losing eligibility for coverage as a
	<u>Dependent</u> child), you must notify the <u>Plan</u> Administrator within 60 days
	after the qualifying event occurs. You must provide notice to: your <u>Plan</u>
	Administrator.
How is <u>COBRA</u>	Once the <u>Plan</u> Administrator receives notice that a qualifying event has occurred,
continuation	COBRA continuation coverage will be offered to each of the qualified
coverage provided?	beneficiaries. Each qualified beneficiary will have an independent right to elect
	<u>COBRA</u> continuation coverage. Covered employees may elect <u>COBRA</u>
	continuation coverage on behalf of their spouses, and parents may elect <u>COBRA</u>
	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 <u>COBRA</u> continuation
	coverage can be extended.
	Disability extension of 18-month period of continuation coverage
	If you or anyone in your family covered under the <u>Plan</u> is determined by Social
	Security to be disabled and you notify your <u>Plan</u> Administrator in a timely
	fashion, you and your entire family may be entitled to get up to an additional 11
	months of <u>COBRA</u> continuation coverage, for a maximum of 29 months. The
	disability would have to have started at some time before the 60th day of <u>COBRA</u>
	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 <u>COBRA</u> continuation coverage, for a

Section	Description
	maximum of 36 months, if the <u>Plan</u> is properly notified about the second
	qualifying event. This extension may be available to the spouse and any
	<u>Dependent</u> children getting <u>COBRA</u> continuation coverage employee or former
	employee dies; becomes entitled to Medicare benefits (Part A, Part B, or both);
	gets divorced or legally separated; or if the <u>Dependent</u> child stops being eligible
	under the <u>Plan</u> as a <u>Dependent</u> child. This extension is only available if the
	second qualifying event would have caused the spouse or <u>Dependent</u> child to
	lose coverage under the <u>Plan</u> had the first qualifying event not occurred.
Are there other	Yes. Instead of enrolling in <u>COBRA</u> continuation coverage, there may be other
coverage options	coverage options for you and your family through the <u>Health Insurance</u>
besides <u>COBRA</u>	Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or
Continuation	other group health <u>Plan</u> coverage options (such as a spouse's <u>Plan</u>) through what
Coverage?	is called a "Special Enrollment Period". Some of these options may cost less than
	<u>COBRA</u> continuation coverage. You can learn more about many of these options at <u>www.healthcare.gov</u> .
Can I enroll in	In general, if you don't enroll in Medicare Part A or B when you are first eligible
Medicare instead of	because you are still employed, after the Medicare initial enrollment period, you
COBRA continuation	have an 8-month special enrollment period to sign up for Medicare Part A or B,
coverage after my	beginning on the earlier of
group health <u>Plan</u>	The month after your employment ends; or
coverage ends?	The month after group health <u>Plan</u> coverage based on current employment
	ends.
	If you don't enroll in Medicare and elect <u>COBRA</u> continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect <u>COBRA</u> continuation coverage and later enroll in Medicare Part A or B before the <u>COBRA</u> continuation coverage ends, the <u>Plan</u> may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the <u>COBRA</u> election, <u>COBRA</u> coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. If you are enrolled in both <u>COBRA</u> continuation coverage and Medicare, Medicare will generally pay first (primary payer) and <u>COBRA</u> continuation coverage will pay second. Certain <u>Plans</u> may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
	For more information visit https://www.medicare.gov/medicare-and-you .
If you have questions	Questions concerning your <u>Plan</u> or your <u>COBRA</u> continuation coverage rights should be addressed to the contact or contacts identified below. For more
questions	information about your rights under Employee Retirement Income Security Act
	(ERISA), including COBRA, the Patient Protection and Affordable Care Act, and
	other laws affecting group health <u>Plans</u> , 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

Section	Description
	numbers of Regional and District <u>EBSA</u> Offices are available through <u>EBSA's</u>
	website.) For more information about the Marketplace, visit
	<u>www.healthcare.gov</u> .
Keep your <u>Plan</u>	To protect your family's rights, let the <u>Plan</u> Administrator know about any
informed of address	changes in the addresses of family members. You should also keep a copy, for
changes	your records, of any notices you send to the <u>Plan</u> Administrator.
<u>Plan</u> contact	You can obtain information about the <u>Plan</u> and <u>COBRA</u> continuation coverage by
information	sending a request to your employer.

Creditable Coverage Disclosure Notices

Creditable Coverage Disclosure Notice for Medicare Eligible Members

Important Notice from GlobalHealth 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 <u>Prescription Drug Coverage</u> with GlobalHealth and about your options under Medicare's <u>Prescription Drug Coverage</u>. This information can help you decide whether or not you want to join a Medicare drug <u>Plan</u>. 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 <u>Plans</u> offering Medicare <u>Prescription Drug Coverage</u> in your area. Information about where you can get help to make decisions about your <u>Prescription Drug Coverage</u> is at the end of this notice.

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

- 7. Medicare <u>Prescription Drug Coverage</u> became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare <u>Prescription Drug Plan</u> or join a Medicare Advantage <u>Plan</u> (like an HMO or PPO) that offers <u>Prescription Drug Coverage</u>. All Medicare drug <u>Plan</u>s provide at least a standard level of coverage set by Medicare. Some <u>Plans</u> may also offer more coverage for a higher monthly Premium.
- 9. GlobalHealth has determined that this <u>Prescription Drug Coverage</u> is, on average for all <u>Plan</u> participants, expected to pay out as much as standard Medicare <u>Prescription Drug Coverage</u> pays and is therefore considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher <u>Premium</u> (a penalty) if you later decide to join a Medicare drug <u>Plan</u>.

When Can You Join A Medicare Drug Plan?

8.

You can join a Medicare drug <u>Plan</u> when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable <u>Prescription Drug Coverage</u>, through no fault of your own, you will also be eligible for a two-month <u>Special Enrollment Period</u> (<u>SEP</u>) to join a Medicare drug <u>Plan</u>.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug <u>Plan</u>, your current GlobalHealth coverage will not be affected. **You can keep this coverage if you elect part D and this <u>Plan</u> will coordinate with Part D coverage.** See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug <u>Plan</u> provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug <u>Plan</u> and drop your current GlobalHealth coverage, be aware that you and your <u>Dependents</u> will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with GlobalHealth and don't join a Medicare drug <u>Plan</u> within 63 continuous days after your current coverage ends, you may pay a higher <u>Premium</u> (a penalty) to join a Medicare drug <u>Plan</u> later.

If you go 63 continuous days or longer without creditable <u>Prescription Drug Coverage</u>, your monthly <u>Premium</u> may go up by at least 1% of the Medicare base beneficiary <u>Premium</u> per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your <u>Premium</u> may consistently be at least 19% higher than the Medicare base beneficiary <u>Premium</u>. You may have to pay this higher <u>Premium</u> (a penalty) as long as you have Medicare <u>Prescription Drug Coverage</u>. 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. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug <u>Plan</u>, and if this coverage through GlobalHealth 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 <u>Plans</u> that offer <u>Prescription Drug Coverage</u> 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 <u>Plans</u>.

For more information about Medicare Prescription Drug Coverage:

- Visit www.medicare.gov
- Call your State <u>Health Insurance</u> 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 <u>Prescription Drug Coverage</u> is available. For information about this extra help, visit Social Security on the web at <u>www.socialsecurity.gov</u>, 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 <u>Plans</u>, 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 <u>Premium</u> (a penalty).

Fraud, Waste, 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.

"Waste" is:

- Overuse of services, or other methods that, directly or indirectly, result in unnecessary costs.
- Misuse of resources.

"Abuse" is:

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

•

Source	Examples
Healthcare	Billing or charging you for services that we cover (other than your <u>Cost-</u>
<u>Providers</u>	<u>share</u>).
	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 <u>Member</u> ID number.
	Giving you medical care that you do not need.
	Billing us for services that were not actually provided.
<u>Members</u>	Selling or lending your <u>Member</u> ID card to someone else.
	• Lying to a <u>Provider</u> in order to get items or services that are not <u>Medically</u>
	Necessary.

Reporting Fraud, Waste, and Abuse

We are committed to finding and preventing <u>Fraud</u>, Waste, and <u>Abuse</u>. You can help by telling us if you suspect <u>Fraud</u>, Waste, and/or <u>Abuse</u>. 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	1-877-627-0004
E-mail	compliance@globalhealth.com

Guaranteed Renewability

Your employer can choose to keep the same group health <u>Plan</u> 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 <u>Plan</u>, except when:

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

Medicaid and CHIP Notice

Premium assistance under Medicaid and Children's Health Insurance Program (CHIP).

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

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

If you or your <u>Dependents</u> are NOT currently enrolled in Medicaid or <u>CHIP</u>, and you think you or any of your <u>Dependents</u> might be eligible for either of these programs, you can contact the State Medicaid or <u>CHIP</u> office or dial 1-877-KIDS NOW or <u>www.insurekidsnow.gov</u> 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.

If you or your <u>Dependents</u> are eligible for <u>Premium</u> assistance under Medicaid or <u>CHIP</u>, as well as eligible under your employer <u>Plan</u>, your employer must allow you to enroll in your employer <u>Plan</u> if you are not already enrolled. This is called a "special <u>Enrollment</u>" opportunity, and **you must request coverage within 60 days of being determined eligible for <u>Premium</u> assistance. If you have questions about enrolling in your employer <u>Plan</u>, you can contact the Department of Labor electronically at <u>www.askebsa.dol.gov</u> 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 <u>Plan Premiums</u>. Contact your State for more information on eligibility.

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

To see if other States have added a <u>Premium</u> assistance program since January 31, 2023, or for more information on special <u>Enrollment</u> rights, you can contact either:

Department	Contact Information
U.S. Department of	U.S. Department of Labor
Labor	Employee Benefits Security Administration
	www.dol.gov/agencies/ebsa
	1-866-444-EBSA (3272)

Department	Contact Information
U.S. Department of	U.S. Department of Health and Human Services
Health and Human	Centers for Medicare & Medicaid Services
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 <u>Providers</u>, you or your legal designee have the right to:

- Get information about us, our services, your <u>Providers</u>, and your rights and responsibilities as a <u>Member</u>.
- Be treated with dignity and respect.
- Privacy and confidential treatment of all personal information.
- Participate with <u>Providers</u> 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. <u>Appeal</u> any unfavorable decisions by following the <u>Appeal</u> and <u>Grievance</u> process.
- Make recommendations regarding our <u>Member</u> 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 <u>Plan</u> operates. Get <u>Plan</u> materials.
- See your PCP and get Referrals to Specialists when Medically Necessary or urgent.
- Use <u>Emergency Services</u> when you, as a <u>Prudent Layperson</u> acting reasonably, believe that an <u>Emergency Medical Condition</u> exists.
- Information about <u>Provider</u> payment agreements, as well as explanations of benefits or <u>Claims</u> 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:
 - o 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 <u>Providers</u> have agreed to.
- Understand your health problems and help create treatment goals, as much as possible.
- Show your <u>Member</u> ID card when getting <u>Medical Services</u>.
- 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;
- o Get emergency care; or
- o Get out-of-area Urgent Care.
- Pay your <u>Cost-share</u> 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

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 (<u>MHPAEA</u>) requires employment-based group health <u>Plans</u> and <u>Health Insurance</u> 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 <u>MHPAEA</u> together with the States.

MHPAEA and its implementing regulations:

- Provide that financial requirements (such as <u>Copayments</u> and <u>Deductible</u>), 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 <u>Plan</u> as written and in practice, any processes, strategies, evidentiary standards, or other factors used by a <u>Plan</u> 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 <u>Provider</u> a copy of the criteria used to make this decision within 30 days of your request.

GlobalHealth <u>Plans</u> meet the requirements of <u>MHPAEA</u>. If you have concerns about our compliance with <u>MHPAEA</u>, you can contact the Department of Labor at 1-866-444-3272 or on the web at <u>www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity</u>.

Minimum Value Standard

The <u>ACA</u> sets a minimum value for health <u>Plans</u>. The <u>Minimum Value Standard</u> is 60% (actuarial value). This <u>Plan's</u> 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 <u>Plan</u> you chose. Metallic names reflect only an estimate of the actuarial value of a Plan.

Notice of Availability

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-280-5600 (TTY: 711).

You may opt out of receipt of this notice in your primary language and through any appropriate auxiliary aids and services. Please note:

Your decision to opt out does not affect your benefits in any way.

You have the right to receive this notice upon request in your primary language and through the appropriate auxiliary aids and services.

Opting out of receiving this notice is not a waiver of your right to receive language assistance services and/or any appropriate auxiliary aids and services.

We will document, on an annual basis, that you have opted out of receiving this notice.

If you do not respond to a request to opt out is not treated as a decision to opt out.

Language	Translation
Spanish	Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se encuentran disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-877- 280-5600 (TTY: 711).
Chinese	如果您會說中文,我們可以為您提供免費語言幫助服務。也免費提供適當的輔助工具和服務,以無障礙格式提供資訊。請撥打 1-877-280-5600 (TTY 711)。
Tagalog	Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo sa tulong sa wika. Ang naaangkop na mga pantulong na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay makukuha rin nang walang bayad. Tumawag sa 1-877-280-5600 (TTY: 711).
French	Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-280-5600 (TTY: 711).
Vietnamese	Nếu bạn nói tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Các hỗ trợ và dịch vụ phù trợ phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng được cung cấp miễn phí. Gọi 1-877-280-5600 (TTY: 711).
German	Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Auch entsprechende Hilfsmittel und Services zur Bereitstellung von Informationen in barrierefreien Formaten stehen kostenlos kostenlos zur Verfügung. Rufen Sie: 1-877-280-5600 (TTY: 711) an.
Korean	한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하는 적절한 보조 지원 및 서비스도 무료로 제공됩니다. 1-877-280-5600 (TTY 711) 로 전화하세요.
Russian	Если вы говорите по-русски, вам доступны бесплатные услуги языковой помощи. Соответствующие вспомогательные средства и услуги по

	предоставлению информации в доступных форматах также
	предоставляются бесплатно. Позвоните по номеру 1-877-280-5600 (ТТҮ
	711).
Arabic	تتوفر المساعدات والخدمات إذا كنت تتحدث العربية ، فإن خدمات المساعدة اللغوية المجانية متاحة لك
	5600-587-1 اتصل بالرقم المساعدات المناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا
	(TTY 711).
Italian	Se parli italiano, sono a tua disposizione servizi di assistenza linguistica gratuiti.
	Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire
	informazioni in formati accessibili. Chiama il numero 1-877-280-5600 (TTY 711).
Portuguese	Se você fala português, serviços gratuitos de assistência linguística estão
	disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços
	auxiliares adequados para fornecer informações em formatos acessíveis. Ligue
	para 1-877-280-5600 (TTY 711).
French	Si w pale kreyòl franse, sèvis asistans lang gratis disponib pou ou. Èd ak sèvis
Creole	oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib tou gratis.
	Rele 1-877-280-5600 (TTY 711).
Polish	Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.
	Odpowiednie pomoce pomocnicze i usługi umożliwiające dostarczanie informacji
	w przystępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer
	1-877-280-5600 (TTY 711).
Hindi	यदि आप हिंदी बोलते हैं, तो मुफ्त भाषा सहायता सेवाएं आपके लिए उपलब्ध ैं। सुलभ प्रारूपों
	में जानकारी प्रदान करने के लिए उपयुक्त सहायक एड्स और सेवाएं भी नि: शुल्क उपलब्ध ैं।
	कॉल 1-877-280-5600 (TTY 711).
Japanese	日本語を話せる場合は、無料の言語支援サービスをご利用いただけます。ア
_	クセシブルな形式で情報を提供するための適切な補助援助やサービスも無料
	で利用できます。 1-877-280-5600 (TTY 711) に電話します。
	,

Notice of Non-discrimination

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

- Race;
- Color
- Ethnicity;
- National origin;
- Religion;
- Sex (sex stereotypes, sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, and gender identity);
- Age;
- Mental or physical disability;
- Blindness or partial blindness;
- Health status;
- Medical condition (including both physical and mental illnesses);

- Vaccination or immunity status;
- <u>Claims</u> experience;
- Healthcare received;
- Medical history;
- Genetic information;
- Evidence of insurability (including conditions due to acts of domestic violence);
- Source of payment;
- Geographic location within the <u>Service</u> <u>Area;</u>
- Association with a person in a protected class; or
- Any combination thereof.

All <u>Members</u> have the same eligibility rules, benefit coverage, and base <u>Premium</u> 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 <u>Grievance</u> 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	GlobalHealth, Inc.
	Attn: Section 1557 Coordinator
	P.O. Box 2658
	Oklahoma City, OK 73101-2658
Toll-free	1-877-280-5600 (TTY: 711)
FAX	1-405-280-5294
E-mail	section1557coordinator@globalhealth.com

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 <u>Grievance</u> under this procedure. It is against the law for us to retaliate against anyone who opposes discrimination, files a <u>Grievance</u>, or participates in the investigation of a <u>Grievance</u>.

Procedure:

- <u>Grievances</u> must be submitted to the Section 1557 Coordinator within 60 days of the date the person filing the <u>Grievance</u> 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 <u>Grievances</u>. 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 <u>Grievances</u> and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the <u>Grievance</u>, 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 <u>Grievance</u> 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 <u>Grievance</u> 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 email at:

Contact Method	Contact Information
Email	OCRComplaint@hhs.gov
Toll-free	1-800-368-1019, 1-800-537-7697 (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 <u>Grievance</u> process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with <u>Low Vision</u>, or assuring a barrier-free location for the proceedings. Contact us for help with such arrangements.

Notice of Protection Provided by Oklahoma Life and <u>Health</u> <u>Insurance</u> Guaranty Association

This notice provides a **brief summary** of the Oklahoma Life and <u>Health Insurance</u> 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 <u>Health Insurance</u> 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 <u>Claims</u>, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

- Life Insurance
 - o \$300,000 in death benefits
 - o \$100,000 in cash surrender or withdrawal values
- Health Insurance
 - \$500,000 for health benefit plans (see definition below)

- \$300,000 in disability income insurance benefits
- o \$300,000 in long-term care insurance benefits
- o \$100,000 in other types of Health Insurance benefits

Annuities

 \$300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal 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 health benefit plans for which the maximum amount of protection is \$500,000 for each individual.

"Health benefit plan" is defined in 36 O.S. §2024(7) and generally includes <u>Hospital</u> or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

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 &	Oklahoma Life & Health Insurance Guaranty Association
<u>Health Insurance</u>	201 Robert S. Kerr, Ste 600
Guaranty Association	Oklahoma City, OK 73102
	(405) 272-9221
Oklahoma	Oklahoma Insurance Department
Department of	400 N.E. 50 th Street
Insurance	Oklahoma City, OK 73105
	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.

Personally Identifiable Information

Personally identifiable information (<u>PII</u>) 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 <u>PII</u> 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	Name
Information We May	Telephone number
Collect	Occupation
	Social Security Number
	• Address
	Date of birth
	Financial and health history
	Insurance <u>Claim</u> information
When We Collect It	We collect your personal information when you:
	Enroll in insurance
	File a <u>Claim</u>
	Get care that we pay for
	Pay <u>Premiums</u>
	Give us your contact information
Other Sources We	We collect personal information about you from others such as:
May Use	Other insurers
	Service providers
	Healthcare professionals
	Insurance support organizations
	Consumer reporting agencies
What Personal	For everyday business purposes, we may share all of the personal information
Information We Use	about you that we collect with affiliates and nonaffiliated companies (companies
and Share	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; Processor and the second s
	Process your transactions; Maintain and the second (a)
	Maintain your account(s); Administrative when efit Plans
	Administer your benefit <u>Plan;</u> Respond to court orders and logal or regulatory investigations or exams:
	Respond to court orders and legal or regulatory investigations or exams;
	Report to credit bureaus; Support or improve our programs or sorvices, including our care.
	Support or improve our programs or services, including our care management and wellness programs:
	management and wellness programs;

Section	Description
	Offer you our other products and services;
	Do research for us;
	Audit our business;
	Help us prevent <u>Fraud</u> , 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 <u>Claim</u> administrators who administer your benefit <u>Plan</u> ;
	and
	o Companies that help us recover overpayments, pay <u>Claims</u> , or do
	coverage reviews.
For Our Marketing	We may share information with our agents and service providers to offer our
Purposes	products and services to you.
For Joint Marketing	We may share your personal information with other financial companies for the
with Other Financial	purpose of joint marketing. Joint marketing is when there is a formal agreement
Companies	between nonaffiliated financial companies that jointly endorse, sponsor, or
Have Da Wa Breatast	market financial products or services to you.
How Do We Protect Your Personal	To protect personal information from unauthorized access and use, we:
Information?	Use reasonable security measures, including secured files, user authoritistics, encryption, firewall technology, and detection software.
imormation:	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	Generally, you have the right to review the personal information we collect to
and Correct Your	provide you with insurance products and services if you:
Personal	Ask us in writing; and
Information?	 Send the letter to the address below.
	When you write to us, please include your full name, address, telephone number,
	and <u>Member</u> ID number in your letter.
	If the information you ask for includes health information, we may provide the
	information to you through your healthcare <u>Provider</u> . Due to its legal sensitivity,
	we won't send you anything that we've collected in connection with a <u>Claim</u> 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.

Section	Description
Additional Rights	You may have additional rights under state or other applicable laws.
Under Other Privacy	
Laws	
Questions or	Write to us at:
Concerns about this	GlobalHealth, Inc.
GLBA Notice	Attn: Legal Services
	210 Park Avenue, Suite 2900
	Oklahoma City, OK 73102-5621

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

Protected Health Information (PHI)

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

You have the right to access or restrict the release of your <u>PHI</u> in accordance with federal and state laws. You may also request an accounting of disclosures of your <u>PHI</u>. Contact us for forms.

When changing <u>PCPs</u>, a signed authorization for release of information is required to transfer your medical records. Your current <u>PCP's</u> office can provide you with the form. You can also find the Authorization to Use or Disclose Protected Health Information (<u>PHI</u>) form on our website under Member Materials.

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

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

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

GlobalHealth is committed and required to protect 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. This HIPAA Notice of Privacy Practices (the "Notice") contains important information regarding your PHI. Our current Notice is posted at www.GlobalHealth.com.

Section	Description
How	For Treatment. We may use and/or disclose your PHI to a healthcare provider,
GlobalHealth	hospital, or other healthcare facility in order to arrange for or facilitate treatment
May Use or	for you.
Disclose Your	
Health	For Payment. We may use and/or disclose your PHI for purposes of paying
Information	claims from physicians, hospitals, and other healthcare providers for services
	delivered to you that are covered by your health plan; to determine your

Section	Description
	eligibility for benefits; to coordinate benefits; to review for medical necessity; to obtain premiums; to issue explanations of benefits to the individual who subscribes to the health plan in which you participate; and other payment related functions.
	For Health Plan 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. We will not use or disclose your genetic information for underwriting purposes.
	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.

Section	Description
	Business Associates. We may use and/or disclose your PHI to business
	associates that we contract with to provide services on our behalf. Examples
	include consultants, accountants, lawyers, auditors, health
	information organizations, data storage and electronic health record vendors,
	etc. We will only make these disclosures if we have received satisfactory
	assurance that the business associate will properly safeguard your PHI.
	Personal/Authorized Representatives. 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 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, email, or telephone call. If you are not home, we may leave a message on an answering machine or with the person answering the telephone.
	Medication and Refill Reminders. We may use and/or disclose your PHI to
	remind you to refill your prescriptions, to communicate about the generic equivalent of a drug, or to encourage you to take your prescribed medications.
	Limited Data Set. If we use your PHI to make a "limited data set," we may give
	that information to others for purposes of research, public health action or health
	care operations. The individuals/entities that receive the limited data set are
	required to take reasonable steps to protect the privacy of your information.
	Other Uses. If you are an organ donor, we may release your medical information to
	organizations that handle organ procurement or organ, eye, or tissue transplantation
	or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation. We may release your medical information to a coroner or medical
	examiner.

Section	Description
Section	Description
	NOTE: 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. The information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease required to be reported pursuant to State law.
Your Health	Right to Inspect and Copy
Information Rights	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.
	Dight to Association of Displacemen
	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 health care or health plan operations and disclosures made to you, authorized by you, or pursuant to this Notice. To receive an accounting, you must submit your request in writing and provide the specific time period requested. You may request an accounting for up to six (6) years prior to the date of your request (three years if PHI is an electronic health record). If you request more than one (1) accounting in a 12-month period, we may charge you for the costs of providing the list. We will notify you of the cost and you may withdraw your request before any costs are incurred.
	Right to Request Restrictions on Uses or Disclosures You have the right to request restrictions or limitations on certain uses and
	disclosures of your PHI to third parties unless the disclosure is required or permitted by law. Your request must be made in writing and specify (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want the limits to apply. We are not required to honor your request. If do we 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.

Section	Description
	Any agreement to restrictions must be signed by a person authorized to make
	such an agreement on our behalf.
	Right to Request Amendment of PHI
	You have the right to request an amendment of your PHI if you believe the record
	is incorrect or incomplete. You must submit your request in writing and state the
	reason(s) for the amendment. We will deny your request if: (1) it is not in writing or
	does not include a reason to support the request; (2) the information was not
	created by us or is not part of the medical record that we maintain; (3) the information is not a part of the record that you would be permitted to inspect and
	copy, or (4) the information in the record is accurate and complete. If we deny
	your amendment request, you have a right to file a statement of disagreement
	with our Privacy Officer.
	Right to Be Notified of a Breach
	You have the right to receive notification of any breaches of your unsecured PHI.
	Right to Revoke Authorization
	You may revoke an authorization at any time, in writing, but only as to future
	uses or disclosures and not disclosures that we have made already, acting on
	reliance on the authorization you have given us or where authorization was not required.
	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 is required to comply with the requirements of this Notice
	currently in effect. We reserve the right to change this Notice and make the new
	provisions effective for all PHI that we maintain. The revised Notice will be
To Donort -	made available to you on our website at www.globalHealth.com . If you have a question concerning your privacy rights or believe your rights have
To Report a Privacy	If you have a question concerning your privacy rights or believe your rights have been violated, you may contact our Privacy Officer at:
Violation	been violated, you may contact out I fivacy officer at.
2.5.0.0	ATTN: Privacy Officer
	210 Park Avenue
	Suite 2900
	Oklahoma City, OK 73102
	Toll-free 1-877-627-0004
	Email privacy@globalhealth.com
Non-	GlobalHealth, Inc. complies with applicable Federal civil rights laws and does
discrimination	not discriminate on the basis of race, color, national origin, age, disability, or
	sex. Global Health does not exclude people or treat them differently because of
	race, color, national origin, age, disability, or sex. We will not penalize nor retaliate against you for filing a complaint with the Secretary of DHHS, or
	with GlobalHealth.
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Section	Description
	GlobalHealth provides free aids and services to people with disabilities to communicate effectively with us, such as (a) qualified sign language interpreters; (b) written information in other formats (large print, audio, accessible electronic formats, other formats), (c) qualified interpreters; (d) information written in other languages. If you need these services, contact GlobalHealth's Customer Care at 1 (844) 280-5555 (toll-free) (TTY:711).
	If you believe that GlobalHealth has 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 with:
	ATTN: Medicare Compliance Officer
	210 Park Ave Suite 2900
	Oklahoma City, OK 73102-5621
	Email: compliance@globalhealth.com
	You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Customer Care is available 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 for Civil Rights Complaint Portal, available
	at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at: U.S. Department of Health and Human Services
	200 Independence Avenue SW
	Room 509F, HHH Building
	Washington, DC 20201 1-800-368-1019, 800-537-7697 (TDD)
	Complaint forms are available
	at https://www.hhs.gov/ocr/complaints/index.html .
	Please be advised that most Third-Party App's will not be covered by HIPAA. Most apps will instead fall under the jurisdiction of the Federal Trade Commission (FTC) and the protections provided by the FTC Act. The FTC Act, among other things, protects against deceptive acts (e.g., if an app shares personal data without permission, despite having a privacy policy that says it will not do so). If you have any concerns regarding the use of Third-Party App's and your information you may contact the Federal Trade Commission (FTC) and file a complaint at https://reportfraud.ftc.gov/#/ .
Effective Date	Effective Date: 10/01/2023
	Original Notice: 04/01/2003 Revised: 04/01/2011 04/01/2013

Section	Description
	08/01/2021
	10/01/2023
	07/2025

Sponsors

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

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

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

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

- Name;
- Social security number;
- Address;

- Telephone number; and
- Member ID number.

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

If you have questions, contact your <u>Plan Administrator</u>.

Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health <u>Plans</u> and <u>Health Insurance</u> issuers offering group <u>Health Insurance</u> coverage generally may not restrict benefits for any <u>Hospital</u> 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 <u>Plan</u> or issuer may pay for a shorter stay if the attending <u>Provider</u> (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also under federal law, <u>Plans</u> 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 <u>Plan</u> or issuer may not, under federal law, require that a physician or other healthcare <u>Provider</u> obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain <u>Providers</u> or <u>Facilities</u>, 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 <u>Plan</u> to: Covered Persons (or <u>Members</u>) and <u>Dependents</u>, <u>COBRA</u> 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 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 <u>Provider</u> 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 <u>Claim</u> against Another Party for payment of the medical or other charges.
Defined Terms	"Another Party" means any individual or entity, other than the <u>Plan</u> , 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 <u>Plan</u> 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 <u>Plan</u> 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 <u>Plan</u> . The Covered Person

Section	Description
	agrees that acceptance of benefits is constructive notice of this section. As a
	condition to receiving benefits under this <u>Plan</u> , a Covered Person and each other
	obligated party agree(s):
	d) That in the event a Covered Person under this <u>Plan</u> , and/or the Covered
	Person's Representatives receives any Recovery or other benefits arising
	out of any injury, accident, event, or incident for which the Covered
	Person has, may have, or asserts any <u>Claim</u> 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 <u>Plan</u> to Covered Person for such
	benefits shall be made on the condition and with the agreement and
	understanding that the <u>Plan</u> 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;
	e) That the <u>Plan</u> 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 <u>Plan</u> to Covered Person or on Covered Person's
	behalf with respect to that illness, injury, damage, or loss immediately
	upon the <u>Plan's</u> payment or provision of any benefits to Covered Person
	or on Covered Person's behalf. The <u>Plan's</u> 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;
	f) To notify GlobalHealth's <u>Plan Administrator</u> if a Covered Person has a
	potential right to receive payment from someone else; to promptly
	execute and deliver to the <u>Plan Administrator</u> , if requested by the <u>Plan</u>
	Administrator or its representatives, a Subrogation and Reimbursement
	agreement; and, to supply other reasonable information and assistance
	as requested by the <u>Plan Administrator</u> regarding the <u>Claim</u> or potential
	<u>Claim</u> . The <u>Plan Administrator</u> may determine, in its sole discretion, that it
	is in the <u>Plan's</u> 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 <u>Plan</u> will still be entitled to Subrogation and Reimbursement
	according to the terms of this Section;

Section	Description
	g) To serve as a constructive trustee, and to hold in constructive trust for the
	benefit of the <u>Plan</u> any Recovery from Another Party, and agrees not to
	dissipate any such Recovery without prior written consent of the <u>Plan</u> , 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 <u>Plan</u> all Recovery and funds Covered
	Person receives in payment of or as compensation for any injury, illness,
	damage, and loss Covered Person sustained resulting from any such
	event, incident, accident, injury, illness, and occurrence. Any such
	Recovery or funds received by, on behalf of, with the consent of, or at the
	direction of Covered Person, or to which Covered Person is entitled to
	receive or direct payment, or over which Covered Person (or a Covered
	Person's Representatives) has, or exercises, any control, are deemed and
	shall be considered and treated as assets of the <u>Plan</u> . Failure to hold
	Recovery and such funds in trust or to abide by these <u>Plan</u> terms will be
	deemed a breach of Covered Person's (or the Covered Person's
	Representative's) fiduciary duty to the <u>Plan</u> . The <u>Plan</u> 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 <u>Plan</u> may, at its option
	and sole discretion, exercise either its subrogation and/or its repayment
	rights. The <u>Plan</u> 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 <u>Plan</u> 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 <u>Plan's</u>
	rights herein. The <u>Plan</u> shall be entitled to an accounting from the
	Covered Person of all Recovery, funds, and activities described herein;
	h) To restore to the <u>Plan</u> any such benefit paid or payable to, or on behalf of,
	the Covered Person when said benefits are paid or established by Another
	Party;
	i) To transfer title to the <u>Plan</u> for all benefits paid or payable as a result of
	said illness or injury. The Covered Person acknowledges that the <u>Plan</u> has
	a property interest in the Covered Person's Recovery, and that the <u>Plan's</u>
	Subrogation rights shall be considered a first priority <u>Claim</u> 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;
	j) That the <u>Plan</u> 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 <u>Plan</u> in enforcing this provision; and such
	lien is an asset of the <u>Plan</u> . The <u>Plan's</u> 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

Section	Description
	Covered Person is made whole or has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs; k) That the Covered Person also agrees to notify the <u>Plan</u> of Covered Person's intention to pursue or investigate a <u>Claim</u> to recover damages or obtain compensation with respect to any matter for which Covered Person has obtained or will obtain any benefits from the <u>Plan</u> . Covered Person will be required to provide all information requested by the <u>Plan</u> or its representative regarding any such <u>Claim</u> . Covered Person also agrees to keep the <u>Plan</u> informed as to all facts and communications that
	might affect the <u>Plan's</u> rights; l) 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 <u>Plan's</u> written approval;
	m) To notify the <u>Plan</u> in writing of any proposed settlement and obtain the <u>Plan's</u> written consent before signing a settlement agreement;
	n) Without limiting the preceding, the <u>Plan</u> shall be subrogated to any and all <u>Claims</u> , causes, action, or rights that the Covered Person has or that may arise against Another Party for which the Covered Person <u>Claims</u> an entitlement to benefits under this <u>Plan</u> , regardless of how classified or characterized;
	o) If the Covered Person (or guardian or estate) decides to pursue Another Party, the Covered Person agrees to include the <u>Plan's</u> Subrogation <u>Claim</u> in that action and if there is failure to do so, the <u>Plan</u> will be legally presumed to be included in such action or Recovery;
	p) In the event the Covered Person decides not to pursue Another Party, the Covered Person authorizes the <u>Plan</u> to pursue, sue, compromise, or settle any such <u>Claim</u> in their name, to execute any and all documents necessary to pursue said <u>Claims</u> in their name, and agrees to fully cooperate with the <u>Plan</u> in the prosecution of any such <u>Claims</u> . Such cooperation shall include a duty to provide information and execute and deliver any acknowledgement or other legal instrument documenting the <u>Plan's</u> Subrogation rights. The Covered Person (or guardian or estate) agrees to take no prejudicial actions against the Subrogation rights of the <u>Plan</u> or to in any way impede the action taken by the <u>Plan</u> to recover its Subrogation <u>Claim</u> . 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).
	q) The <u>Plan</u> will not pay, offset any Reimbursement, or in any way be responsible for any fees or costs associated with pursuing a <u>Claim</u> unless the <u>Plan</u> agrees to do so in writing. The <u>Plan</u> '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;

Section	Description
Jecuon	r) The <u>Plan Administrator</u> retains sole and final discretion for interpreting the terms and conditions of the <u>Plan</u> document. The <u>Plan Administrator</u>
	may amend the <u>Plan</u> 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.
	s) That the <u>Plan Administrator</u> may, in its sole discretion, require the
	Covered Person or his or her attorney to sign a subrogation/recovery
	agreement acknowledging and agreeing to the <u>Plan's</u> rights herein as a
	condition to any payment of benefits and as a condition to any payment
Miles e Comment	of future benefits for other illnesses or injuries.
When a Covered Person Retains an	If the Covered Person retains an attorney, the <u>Plan Administrator</u> may, in its sole
Attorney	discretion, require that the attorney sign a subrogation/recovery agreement acknowledging and agreeing to the <u>Plan's</u> rights herein as a condition to any
Attorney	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 <u>Plan</u> 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 <u>Plan</u> 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 <u>Plan</u> has received full Reimbursement. An attorney who
	receives any Recovery has an absolute obligation to immediately tender the
	Recovery to the <u>Plan</u> 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 <u>Plan</u> will be deemed to hold the Recovery in constructive trust
	for the <u>Plan</u> , 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
	<u>Plan</u> has been fully Reimbursed.
	In addition, the <u>Plan</u> 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 <u>Plan</u> in connection with that matter.
	iii. The <u>Plan</u> is also entitled to receive and has priority to receive the first
	funds from payments received by Covered Person until the <u>Plan</u> has
	been repaid for all sums expended. Covered Person shall execute and
	deliver any instruments and documents reasonably requested by the
	<u>Plan</u> and shall do whatever is necessary to fully protect all the <u>Plan's</u>
	rights. Covered Person shall do nothing to prejudice the rights of the
	<u>Plan</u> 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

Section	Description
	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 other
Person is a Minor or	representative of a minor Covered Person and to the heir or personal
is Deceased	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	a) (i) If the Subrogation agreement is not properly executed and returned as
Person Does Not	provided for in this provision; (ii) information and assistance is not
Comply	provided to the <u>Plan Administrator</u> upon request; or, (iii) any other
. ,	provision or obligation of this Section is not timely complied with, no
	benefits will be payable under the <u>Plan</u> with respect to costs Incurred in
	connection with such illness or injury.
	b) If a Covered Person fails to Reimburse the <u>Plan</u> 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 <u>Plan</u> , 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 <u>Plan's</u>
	attempt to recover such money or property from the Covered Person;
	and, the <u>Plan</u> 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
	<u>Plan's</u> rights or interests against such reimbursements that should have
	been made to the <u>Plan</u> , as well as to suspend or terminate further
	coverage until such reimbursements are recovered by the <u>Plan</u> . 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 <u>Plan</u> 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 <u>Plan</u> all attorney's fees
	and costs incurred by or on behalf of the <u>Plan</u> in connection with such
	efforts.
	d) Additionally, the <u>Plan</u> may, in the discretion of its final decision maker,
	terminate Covered Person's participation in the <u>Plan</u> or the participation
	of any other person who directly or indirectly acted or cooperated to

Section	Description
	interfere with, impair, or defeat the <u>Plan's</u> rights or interest. In the event
	that any <u>Claim</u> 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 <u>Plan</u> 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 <u>Plan's</u> Subrogation and Reimbursement rights described herein are
	essential to ensure the equitable character of the <u>Plan</u> and its financial
	soundness, and to ensure that funds are recouped and made available for
	the benefit of all Covered Persons under the <u>Plan</u> 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 <u>Copayments</u> and <u>Coinsurance</u> applicable to other medical and surgical benefits provided under this <u>Plan</u>. See "<u>Benefits</u>" on page 38 for your <u>Cost Sharing</u> for applicable services. If you would like more information on WHCRA benefits, contact your <u>Plan</u> <u>Administrator</u>.

FAQS

These FAQs are subject to "Coverage Requirements" on page 40 and "Excluded Services and Limitations" on page 119.

Topic	Q&A
Chiropractic care	Q. Does the <u>Plan</u> cover chiropractor visits?
	A. Yes.
Diabetic supplies	Q. Are my diabetic supplies covered?
	A. Yes, only certain brands. See the <i>Drug Formulary</i> at
	www.GlobalHealth.com.
Dependent coverage	Q. If I enroll in GlobalHealth, is my child who lives in another state covered?
	A. Yes, <u>Dependents</u> must establish a relationship with a <u>PCP</u> in our <u>Network</u> .
	We cover <u>Out-of-network</u> emergencies and <u>Urgent Care</u> . We do not cover <u>Out-of-</u>
	<u>network</u> routine care. Any <u>Out-of-network</u> services, other than <u>Emergency</u>
	Services or Urgent Care, must be preauthorized by GlobalHealth.
	<u></u> ,,
	Q. What about <u>Dependents</u> 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	Q. When I go to the <u>ER</u> , is my copay waived if I am then admitted to the
Urgent Care	Hospital?
	A. Yes, if it is within the same <u>Hospital</u> . You then pay the <u>Inpatient Hospital</u>
	Facility Cost-share.
	· ·
	Q. What if I get sick when I am out of the <u>Service Area?</u> Am I still covered?
	A. Emergency and <u>Urgent Care</u> is covered. In a true emergency, go
	immediately to the nearest medical <u>Facility</u> for care. Call the <u>PCP</u> and
	GlobalHealth within 48 hours of receiving the care. When same-day <u>Urgent Care</u>
	is needed and you cannot see your <u>PCP</u> , self-refer to an <u>Urgent Care</u> center.
	Q. What if I need to see a doctor on the weekend? Or I become sick after
	hours?
	A. Call your <u>PCP</u> for direction. Or self-refer to a <u>Network Urgent Care</u> center if
	you cannot wait for your <u>PCP's</u> office hours.
Hearing	Q. Does the <u>Plan</u> cover hearing aids?
	A. Yes. We cover basic hearing aids. See " <u>Hearing services – hearing aids and</u>
	devices" on page 72.
Hospital admission	Q. Does my <u>Hospital</u> copay cover doctor visits to the <u>Hospital</u> ?
	A. Yes.
	Q. Does the <u>Plan</u> cover private rooms in the <u>Hospital</u> ?
	A. When <u>Medically Necessary</u> .
	Q. What <u>Hospitals</u> are in your <u>Network</u> ?

Topic	Q&A
	A. They are listed in the <i>Provider Directory</i> . You can do a search on our website.
Mental health	Q. Does the <u>Plan</u> cover mental health services? A. Yes. You do not have to go through your <u>PCP</u> . See " <u>Behavioral Health</u> <u>Benefits</u> " on page 40.
	Q. How can I find out who the mental health <u>Providers</u> are?A. There is a listing in the <i>Provider Directory</i>.
<u>Network</u>	Q. What is a " <u>Network</u> "? A. We require, except in specific circumstances, that you get your care through doctors, suppliers, and <u>Facilities</u> contracted with GlobalHealth. All of those together make up our <u>Network</u> of <u>Providers</u> .
	Q. What do "Preferred" and "Non-preferred" mean? A. Within in that <u>Network</u> , you may get some <u>Outpatient</u> services at either preferred or non-preferred locations. "Preferred" means that you will pay the lower amount listed in the " <u>Benefits</u> " section of this <u>Member Handbook</u> when more than one amount is shown. "Non-preferred" means that you will pay the higher amount listed in the " <u>Benefits</u> " section of this <u>Member Handbook</u> . Just being in the <u>Network</u> does not make a <u>Facility</u> "preferred".
	 Q. How can I tell the status of a <u>Facility</u>? A. The <i>Provider Directory</i> tells you the preferred/non-preferred status of a <u>Facility</u>.
	Q. How can I find out if my <u>Specialist</u> is in the <u>Network</u>?A. Refer to the <i>Provider Directory</i> or visit our website.
<u>PCP</u>	Q. Do I have to choose one of the <u>Network</u> doctors? A. Yes. You choose a <u>PCP</u> at <u>Enrollment</u> . Each family member may choose a different <u>PCP</u> , including a pediatrician for children. <i>Provider Directories</i> are available and you may also go to our website.
	Q. Can I change my <u>PCP</u> or am I stuck with them all year? A. Yes, you may change <u>PCPs</u> at any time during the year. The change will take effect on the first of the following month You can make changes on our website. If you need to see a <u>PCP</u> before you receive your new <u>Member</u> ID card, contact us.
Pre-existing	 Q. Does the <u>Plan</u> accept pre-existing conditions? A. Yes. GlobalHealth does not deny, exclude, or limit coverage due to pre-existing conditions.
Prescriptions	Q. Where can I get my prescriptions filled? A. We have over 900 participating pharmacies across the state of Oklahoma. MedImpact, our pharmacy benefit manager, has a nation-wide Network that you can access. Search for pharmacies on our website – Find a Pharmacy.
	Q. Are dental prescriptions covered?

Topic	Q&A
	A. Yes.
	Q. What is a <i>Drug Formulary</i> ?
	A. The <i>Drug Formulary</i> is a list of drugs most commonly prescribed and
	approved by us. It is a preferred list. Because the development of the <i>Drug</i>
	Formulary is an ongoing process, this list is subject to change.
	Q. Does the <u>Plan</u> have mail order?
	A. Yes, through Bindi Mail Order Pharmacy. Mail order prescriptions are filled
	with a 90-day supply. You may get a discount on your drugs, depending on the
	drug <u>Tier</u> , when ordering a 90-day supply from mail order instead of a 30-day
	supply from a retail store.
Preventive Care	Q. Is <u>Preventive Care</u> covered?
	A. We cover all <u>Preventive Services</u> covered under the <u>ACA</u> at no cost to you
	when delivered by a <u>Network Provider</u> . See " <u>Preventive Care Benefits</u> " on page
	109 for a current list of services.
	Q. How do I get <u>Preventive Services</u> ?
	A. Start with your <u>PCP</u> . He/she will provide most services or send us a
	Referral if needed. However, you have direct access to your OB/GYN for services
	he/she handles and to a <u>Network</u> imaging center for your mammogram.
<u>Referrals</u>	Q. Do I need a <u>Referral</u> to see a <u>Specialist</u> ?
	A. Yes. Except for services you get that are listed in "Self-referral Services"
	on page 24, your <u>PCP</u> is responsible to manage all of your care. He or she sends
	us a <u>Referral</u> when needed. Procedures must also have <u>PA</u> .
Weight loss and	Q. Does the <u>Plan</u> cover weight loss surgery?
cosmetic surgery	A. Yes. See page 53. We also cover other weight loss counseling and
	treatment at no cost. See page 85.
	Q. Does the <u>Plan</u> cover cosmetic surgery?
	Q. Does the <u>Plan</u> cover cosmetic surgery?A. Only in specific limited circumstances. See page 61.
Worldwide coverses	
Worldwide coverage	
	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
ASD	Autism spectrum disorder
ВНСМ	Certified Behavioral Health Case Manager
ВНР	Behavioral Health Provider
BRCA	BReast CAncer susceptibility gene 1 and 2
CAD	Coronary artery disease
CDC	Centers for Disease Control
CHIP	Children's <u>Health Insurance</u> Program
CKD	Chronic kidney disease
СОВ	Coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
DEA	Drug Enforcement Administration
DME	<u>Durable Medical Equipment</u>
EBSA	Employee Benefits Security Administration
ER	Emergency room
FDA	U.S. Food and Drug Administration
HIPAA	<u>Health Insurance</u> 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 <u>Practitioner</u>
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage & Family Therapist
LPC	Licensed Professional Counselor
МНРАЕА	The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008
МООР	Maximum out-of-pocket or <u>Out-of-pocket Limit</u>
OB/GYN	Obstetrician/gynecologist
ОТС	Over-the-counter
PA	Preauthorization or prior authorization
РВМ	Pharmacy benefit manager
PCP	Primary Care Physician

Acronym	Phrase
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	<u>Utilization Management</u>
USPSTF	United States Preventive Services Task Force

GLOSSARY

Term	Definition
Abuse	Includes requesting payment for items and services when there is no entitlement
	for payment of those items or services. Unlike <u>Fraud</u> , the individual or entity has
	not knowingly or intentionally misrepresented facts to obtain payment.
Accepting New	Indicates whether the <u>Practitioner</u> is <u>Accepting New Patients</u> into their practice,
Patients	or if any special conditions apply. A special condition could be, for example, a
	pediatrician who only treats children or a geriatric physician who only treats
	older patients. A physician's ability to accept new patients is provided by the
	<u>Practitioner's</u> application at credentialing and re-credentialing (every three
	years). GlobalHealth contacts <u>Network</u> (contracted) <u>Providers</u> every three months
	to update if the physician is <u>Accepting New Patients</u> . When GlobalHealth receives
	updated information, it is verified and the website updated within 30 days.
Adverse	A determination that an admission, availability of care, continued stay or other
Determination	healthcare service that is a covered benefit has been reviewed, and based upon
	the information provided, does not meet the <u>Plan's</u> 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	A licensed public or private establishment with an organized medical staff of
Center	physicians with permanent <u>Facilities</u> that are equipped and operated primarily
	for the purpose of performing surgical procedures and continuous <u>Physician</u>
	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	A clinical trial that is sponsored by a credible organization and conducted in compliance with federal regulations including those relating to the protection of
Trial	human subjects. The trial must have a therapeutic intent and not designed solely
	to identify or test disease pathophysiology.
Ralance Billing	When a <u>Provider</u> bills you for the balance remaining on the bill your <u>Plan</u> doesn't
Balance Billing	cover. This amount is the difference between the actual billed amount and the
	GlobalHealth <u>Allowed Amount</u> . For example, if the <u>Provider's</u> charge is \$200 and
	the GlobalHealth <u>Allowed Amount</u> is \$110, the <u>Provider</u> may bill you for the
	remaining \$90. This happens most often when you see an <u>Out-of-network</u>
	Provider. A Network Provider may not bill you for Covered Services.
Behavioral Health	A behavioral healthcare professional (<u>Psychiatrist</u> , <u>Psychologist</u> , clinical social
Provider (BHP)	worker, marriage and family therapist, behavioral professional, behavioral
. 1011401 (5111 /	<u>Practitioner</u> , and/or alcohol and drug counselor) that is licensed, certified, or
	accredited by State law.
	,

Term	Definition
Board Certification	The healthcare professional who has advanced education and training in one clinical area of practice (a "Specialist") must be certified by a medical
	organization devoted to that <u>Specialty</u> . This medical organization is referred to as a "Board" and the healthcare professional that has been certified by this
	organization is said to be "Board Certified". The physician must pass an
	examination given by the board for their <u>Specialty</u> as part of their requirements
	for "Board Certification". Board Certification is provided on the healthcare professional's application and must be verified by GlobalHealth directly with the
	stated Board upon credentialing and re-credentialing (every three years). When
	GlobalHealth receives updated information, it is verified and the website updated within 30 days.
Case Management	A process to assess, plan, implement, coordinate, monitor, and evaluate options
Case Management	to meet your healthcare needs based on the benefits and resources needed in
	order to promote a quality outcome for you.
Certified Behavioral	A State certified <u>Practitioner</u> specializing in providing resource linkage, patient
Health Case	advocacy, <u>Provider</u> /resources <u>Referral</u> and coordination, and care plan
Manager (BHCM)	monitoring for those with mental illness and/or substance use disorders.
Chronic Condition	A continuous or persistent condition over an extended amount of time which requires ongoing treatment.
Claim	A request for a benefit (including reimbursement of a healthcare expense) made by you or your healthcare <u>Provider</u> 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 <u>Plans</u> 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 <u>Allowed Amount</u> for the service. You generally pay the <u>Coinsurance plus</u> any <u>Deductibles</u> you owe. (For example, if GlobalHealth's <u>Allowed Amount</u> for an office visit is \$100 and you've met your <u>Deductible</u> , your <u>Coinsurance</u> 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 <u>Complications of Pregnancy</u> .
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 <u>Deductibles</u> , <u>Copayments</u> , and <u>Coinsurance</u> .
Cost Sharing	Your share of costs for services that your <u>Plan</u> covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of
	<u>Cost Sharing</u> are <u>Copayments</u> , <u>Deductibles</u> , and <u>Coinsurance</u> . Family <u>Cost Sharing</u> is the share of cost for <u>Deductibles</u> , and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your

Term	Definition
	<u>Premiums</u> , penalties you may have to pay, or the cost of care your <u>Plan</u> doesn't
	cover usually are not considered <u>Cost Sharing</u> .
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 <u>Providers</u> and <u>Facilities</u> . 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, your Pharmacy Directory, 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
Donandont	
Dependent	
Diagnostic Test	'
2 14 3 11 2 2 1 2 2 2	<u>Diagnostic Test</u> to see if you have a broken bone.
Durable Medical	Equipment and supplies ordered by a healthcare <u>Provider</u> for everyday or
Equipment (DME)	extended use. <u>DME</u> may include: Oxygen equipment, wheelchairs, and crutches.
Emergency Medical	An illness, injury, symptom (including severe pain), or condition that is severe
Condition	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
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Transportation	
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Enrolled Family	
_	
···Cilioci	
	member who meets all of the eligibility requirements of the <u>Subscriber's</u>
	employer group and GlobalHealth.
Emergency Medical	Equipment and supplies ordered by a healthcare <u>Provider</u> for everyday or extended use. <u>DME</u> may include: Oxygen equipment, wheelchairs, and crutches. 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. Ambulance services for an <u>Emergency Medical Condition</u> . Types of <u>Emergency Medical Transportation</u> may include transportation by air, land, or sea. Your <u>Pla</u> may not cover all types of <u>Emergency Medical Transportation</u> , or may pay less for certain types. Services to check for an <u>Emergency Medical Condition</u> and treat you to keep an <u>Emergency Medical Condition</u> from getting worse. These services may be provided in a licensed <u>Hospital's</u> emergency room or other place that provides care for <u>Emergency Medical Conditions</u> . A family member that is enrolled with GlobalHealth meets all eligibility requirements of the <u>Subscriber's</u> employer group and GlobalHealth, and for which GlobalHealth has received <u>Premiums</u> . An eligible family member is a famil member who meets all of the eligibility requirements of the <u>Subscriber's</u>

Term	Definition
Enrollment	The event when a person becomes a <u>Plan Member</u> . A <u>Member</u> is enrolled when GlobalHealth accepts the <u>Enrollment</u> form submitted by the <u>Subscriber</u> . GlobalHealth and the employer group must abide by the contract and the employer group must pay <u>Premiums</u> on time.
Excluded Services	Healthcare services that your <u>Plan</u> doesn't pay for or cover.
Experimental or Investigational	Procedures and/or items determined by GlobalHealth as not <u>FDA</u> -approved and/or not generally accepted by the medical community.
External Review	An <u>Appeal</u> process through which you may have a denied <u>Claim</u> 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 <u>Plan</u> covers. A <u>Formulary</u> may include how much your share of the cost is for each drug. Your <u>Plan</u> may put drugs in different <u>Cost Sharing</u> levels or <u>Tiers</u> . For example, a <u>Formulary</u> may include generic drug and brand name drug <u>Tiers</u> and different <u>Cost Sharing</u> amounts will apply to each <u>Tier</u> . Your <u>Drug Formulary</u> uses <u>Tiers</u> .
Fraud	The intentional deception by you or a <u>Provider</u> to provide false information to GlobalHealth, or the intentional misuse of your <u>Member</u> ID Card.
Grievance	A complaint that you communicate to GlobalHealth in writing except for complaints related to discrimination which may be submitted by telephone.
Habilitation	Healthcare services that help a person keep, learn, or improve skills and
Services	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 Care Reform Products (HCR)	The Affordable Care Act (ACA) requires certain preventive generic products to be covered at zero dollar <u>Copayment</u> .
Health Insurance	A contract that requires GlobalHealth to pay some or all of your healthcare costs in exchange for a <u>Premium</u> . A <u>Health Insurance</u> contract may also be referred to as a "policy" or " <u>Plan</u> ."
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 <u>Providers</u> . <u>Home Healthcare</u> 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 <u>Facility</u> primarily and continuously engaged in providing and operating for the medical care and treatment of sick or injured persons on an <u>Inpatient</u> basis for which a charge is made. GlobalHealth contracts with <u>Hospitals</u> licensed by the State of Oklahoma.
Hospitalization	Care in a <u>Hospital</u> that requires admission as an <u>Inpatient</u> and usually requires an overnight stay. Some <u>Plans</u> may consider an overnight stay for observation as <u>Outpatient</u> care instead of <u>Inpatient</u> care.
Hospital Affiliation	Most of the time, <u>Hospital Affiliation</u> means the <u>Hospital(s)</u> where a physician may admit patients. A <u>Member</u> may hear a phrase such as, "Dr. Smith is affiliated with a certain <u>Hospital</u> ." Sometimes a physician who is affiliated with a <u>Hospital</u> may

Term	Definition
	not admit patients but have some other role at the <u>Hospital</u> . For example, the
	physician may only do consulting at the <u>Hospital</u> rather than admitting. If
	uncertain, ask the physician or call GlobalHealth Customer Care. Hospital
	Affiliation is verified directly through the Hospital(s) at credentialing and at re-
	credentialing (every three years). When GlobalHealth receives updated
	information, it is verified and the website updated within 30 days.
Hospital Outpatient	Care in a <u>Hospital</u> that usually doesn't require an overnight stay.
Care	
Hospital Services	Medically Necessary services provided by a Hospital. The services may be
	provided on an <u>Inpatient</u> or <u>Outpatient</u> basis. They are prescribed, directed, or
	authorized by your <u>PCP</u> .
Independent	An entity that conducts independent <u>External Reviews</u> of <u>Adverse Determinations</u>
Review	and final <u>Adverse Determinations</u> .
Organization (IRO)	
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
	<u>Network Provider</u> , as a cause of <u>Infertility</u> .
In-network	A healthcare <u>Provider</u> or <u>Facility</u> that has a contract with GlobalHealth to provide
	services at a discounted rate for <u>Members</u> . <u>In-network Providers</u> can be found in
	the <i>Provider Directory</i> or on our website Provider Search. Also see <u>Network</u> .
In-network	Your share (for example, 20%) of the <u>Allowed Amount</u> for covered healthcare
Coinsurance	services. Your share is usually lower for <u>In-network Covered Services</u> .
	GlobalHealth does not have different <u>Cost-share</u> based on <u>Network</u> . You only
	have coverage for services in our <u>Network</u> , except for urgent or emergent care.
In-network	A fixed amount (for example, \$15) you pay for covered healthcare services to
Copayment	Providers who contract with GlobalHealth. <u>In-network Copayments</u> 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
1	Network, except for urgent or emergent care. Patient who is admitted to and is assigned a health care Facility while
Inpatient	Patient who is admitted to and is assigned a bed in a healthcare <u>Facility</u> while undergoing diagnosis and receiving treatment and care.
Languages Cuelles	Refers to language(s), other than English, that a healthcare professional or their
Languages Spoken	clinical office staff speaks fluently. Language(s), other than English, that are
by the Physician or Clinical Staff	spoken fluently is/are provided by the healthcare professional's application at
Cumcat Staff	credentialing and re-credentialing (every three years). When GlobalHealth
	receives updated information, it is verified and the website updated within 30
	days.
Late Enrollment	Enrolling in the plan outside of the first period in which you are eligible to enroll
Eace Em oument	or a special enrollment period.
Licensed Alcohol &	A master's or doctoral level, licensed <u>Practitioner</u> specializing in the diagnosis
Drug Counselor	and treatment of substance use disorders.
(LADC)	
Licensed Behavioral	A master's or doctoral level, licensed <u>Practitioner</u> specializing in the diagnosis
Practitioner (LBP)	and treatment of mental illness and/or substance use disorders.
. ractitioner (LDF)	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -

Term	Definition
Licensed Clinical Social Worker (LCSW)	A master's or doctoral level, licensed <u>Practitioner</u> specializing in the diagnosis and treatment of mental illness and/or substance use disorders.
Licensed Clinical Psychologist	A doctoral level, licensed <u>Practitioner</u> specializing in the diagnosis and treatment of mental illness and/or substance use disorders.
Licensed Marriage & Family Therapist (LMFT)	A master's or doctoral level, licensed <u>Practitioner</u> specializing in the diagnosis and treatment of relationship dynamics and dysfunction, mental illness and/or substance use disorders.
Licensed Professional Counselor (LPC)	A master's or doctoral level, licensed <u>Practitioner</u> specializing in the diagnosis and treatment of mental illness and/or substance use disorders.
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	<u>Low Vision</u> is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in <u>Low Vision</u> care can evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision.
Marketplace	A <u>Marketplace</u> for <u>Health Insurance</u> where individuals, families, and small businesses can learn about their <u>Plan</u> options; compare <u>Plans</u> based on costs, benefits, and other important features; apply for and receive financial help with <u>Premiums</u> and <u>Cost Sharing</u> based on income; choose a <u>Plan</u> ; and enroll in coverage. Also known as an "Exchange". The <u>Marketplace</u> is run by the state in some states and by the Federal government in others. In some states, the <u>Marketplace</u> also helps eligible consumers enroll in other programs, including Medicaid and the Children's <u>Health Insurance</u> Program (<u>CHIP</u>). 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 <u>Cost Sharing</u> during the <u>Plan Year</u> for covered, <u>Innetwork</u> services. Applies to most types of health <u>Plans</u> and insurance. This amount may be higher than the <u>Out-of-pocket Limits</u> stated for your <u>Plan</u> . This may be called " <u>MOOP</u> ".
Medical Group Affiliation	This means a physician is associated with a specific "medical group" where he practices medicine. For example, this could be where two or more physicians and perhaps other healthcare professionals work together and share the same building or office space. The healthcare professionals do not need to practice the same Specialty to have the same Medical Group Affiliation . Medical Group Affiliation is provided by the Practitioner's application at credentialing and recredentialing (every three years). When GlobalHealth receives updated information, it is verified and the website updated within 30 days.

Term	Definition
Medical Services	The Medically Necessary professional services delivered by a physician, surgeon,
	or paramedical personnel. <u>Medical Services</u> must be directed by your <u>PCP</u> or
	<u>Specialty</u> physician and authorized by your <u>PCP</u> unless specified otherwise.
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 <u>Subscriber</u> or <u>Dependent</u> of <u>Subscriber</u> .
Minimum Essential	Minimum essential coverage generally includes plans, health insurance available
Coverage	through the Marketplace or other individual market policies, Medicare, Medicaid,
	CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of
	minimum essential coverage, you may not be eligible for the premium tax credit.
Minimum Value	A basic standard to measure the percent of permitted costs the <u>Plan</u> covers. If you
Standard	are offered an employer <u>Plan</u> that pays for at least 60% of the total allowed costs
	of benefits, the <u>Plan</u> offers minimum value and you may not qualify for <u>Premium</u>
	tax credits and <u>Cost Sharing</u> reductions to buy a <u>Plan</u> from the <u>Marketplace</u> . All
	GlobalHealth <u>Plans</u> meet the <u>Minimum Value Standard</u> .
National Coverage	Developed by CMS to describe the circumstances for which Medicare will cover
Determination	specific services, procedures, or technologies on a national basis. Often, NCD's
(NCD)	are clarified by the creation of an LCD (at the local contractor level).
Natural	Instructions that are both driven by the individual's motivation and carried out in
Environment	the environments that closely resemble natural environments, (the "real world")
Training	while being highly structured with regard to the individual's access to
_	reinforcement. Also called natural environment teaching.
Network	
Naturalis Dravidas	
Network Provider	·
Non-preferred	
-	
	share than preferred Specialty Drugs.
Non-preferred	High-cost drugs used to treat complex or rare conditions, such as multiple
Specialty Drug	sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia.
(NPS)	
Open Enrollment	The time period determined by GlobalHealth and the <u>Subscriber's</u> employer
•	group when all eligible employees and their eligible family members may enroll
	in GlobalHealth.
Oral Surgery	Surgery of the mouth including removal of teeth, particularly wisdom teeth.
Orthodontics	A dental <u>Specialty</u> concerned with straightening or moving misaligned teeth or
	jaws.
Orthotics and	Leg, arm, back and neck braces, artificial legs, arms and eyes, and external breast
Prosthetics	prostheses after a mastectomy. These services include: Adjustment, repairs, and
(NPS) Open Enrollment Oral Surgery Orthodontics Orthotics and	High-cost drugs used to treat complex or rare conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia. The time period determined by GlobalHealth and the <u>Subscriber's</u> employer group when all eligible employees and their eligible family members may enroll in GlobalHealth. Surgery of the mouth including removal of teeth, particularly wisdom teeth. A dental <u>Specialty</u> concerned with straightening or moving misaligned teeth or jaws. Leg, arm, back and neck braces, artificial legs, arms and eyes, and external breast

Term	Definition
	replacements required because of breakage, wear, or a change in the patient's
	physical condition.
Out-of-network	A healthcare <u>Provider</u> does not have a contract with GlobalHealth to provide
	services to <u>Members</u> .
Out-of-network	Your share (for example, 40%) of the <u>Allowed Amount</u> for covered healthcare
Coinsurance	services to <u>Providers</u> who do <i>not</i> contract with GlobalHealth. <u>Out-of-network</u>
	<u>Coinsurance</u> usually costs you more than <u>In-network Coinsurance</u> . GlobalHealth
	does not have different <u>Cost-share</u> based on <u>Network</u> . You only have coverage for
	services in our <u>Network</u> , except for urgent or emergent care.
Out-of-network	A fixed amount (for example, \$30) you pay for covered healthcare services from
Copayment	<u>Providers</u> who do <i>not</i> contract with GlobalHealth. <u>Out-of-network Copayments</u>
	usually are more than <u>In-network Copayments</u> . GlobalHealth does not have
	different <u>Cost-share</u> based on <u>Network</u> . You only have coverage for services in our
	Network, except for urgent or emergent care.
Out-of-network	A <u>Provider</u> who does not have a contract with GlobalHealth to provide services.
Provider	GlobalHealth only covers <u>Out-of-network</u> 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 <u>Covered Services</u> .
	Afternoon manatable limit Clabell solth beginn to man 1000/ of the Allenand
	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 <u>Premium</u> , balance-billed charges, or healthcare costs that your <u>Plan</u> doesn't cover. This may be called "maximum out-of-pocket" or " <u>MOOP</u> ".
Outnotions	Patient who is undergoing diagnosis and receiving treatment and care, but is not
Outpatient	admitted to or assigned a bed in a healthcare <u>Facility</u> .
Physician Services	Healthcare services a licensed medical physician, including an M.D. (Medical
r Hysician Services	Doctor) or D.O. (Doctor of Osteopathic Medicine) provides or coordinates.
Plan	Health coverage issued to you directly (individual <u>Plan</u>) or through an employer,
1 (41)	union, or other group sponsor (employer group <u>Plan</u>) that provides coverage for
	certain healthcare costs. Also called " <u>Health Insurance Plan</u> ", "policy", " <u>Health</u>
	<u>Insurance</u> policy", or " <u>Health Insurance</u> ".
Plan Administrator	The person who is identified as having responsibility for administering the <u>Plan</u> . 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 <u>Plan Year</u> if you are a late enrollee.
Practitioner	A professional who provides healthcare services. <u>Practitioners</u> are licensed as
	required by law.
Preauthorization	A decision by GlobalHealth that a healthcare service, treatment plan, <u>Prescription</u>
(PA)	<u>Drug</u> , or <u>Durable Medical Equipment</u> (<u>DME</u>) is <u>Medically Necessary</u> . Sometimes
	called prior authorization, prior approval, or precertification. GlobalHealth may
	require <u>Preauthorization</u> for certain services before you receive them, except in
	an emergency. <u>Preauthorization</u> isn't a promise that GlobalHealth will cover the
	cost.

Term	Definition
Pre-existing Condition	A health problem, like asthma, diabetes, or cancer, you had before the date that new health coverage starts. GlobalHealth can't refuse to cover treatment for your pre-existing condition or charge you more. Pregnancy and genetic information are not considered pre-existing conditions.
Preferred Facility	A <u>Facility</u> which has a contract with GlobalHealth to provide services to you at a discount. You will pay the lowest <u>Cost-share</u> when you choose these <u>Facilities</u> . It may also be called, " <u>Ambulatory Surgical Center</u> ".
Preferred Provider	A <u>Provider</u> who has a contract with GlobalHealth to provide services to you at a discount. GlobalHealth may have <u>Preferred Providers</u> who are also "participating" <u>Providers</u> . Participating <u>Providers</u> also contract with GlobalHealth, but the discount may not be as great, and you may have to pay more. You will pay the <u>Cost-share</u> listed in this <u>Member Handbook</u> .
Preferred Specialty (PS)	Preferred <u>Specialty Drugs</u> in the <i>Drug Formulary</i> have a lower <u>Cost-share</u> than Non-preferred <u>Specialty Drugs</u> .
Premium	The amount that must be paid for your GlobalHealth <u>Plan</u> . You and/or your employer usually pay it monthly, quarterly, or yearly.
Prescription Drug Coverage	Coverage under a <u>Plan</u> that helps pay for <u>Prescription Drugs</u> . If the <u>Plan's Formulary</u> uses " <u>Tiers</u> " (levels), <u>Prescription Drugs</u> are grouped together by type or cost. The amount you will pay in <u>Cost Sharing</u> will be different for each " <u>Tier</u> " of covered <u>Prescription Drugs</u> .
Prescription Drugs	Drugs and medications that by law require a prescription.
Preventive Care (Preventive Service)	Routine health care, including <u>Screenings</u> , 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 <u>Plan</u> , who provides, coordinates, or helps you access a range of healthcare services.
Provider	An individual or <u>Facility</u> that provides healthcare services. Some examples of a <u>Provider</u> include a doctor, nurse, chiropractor, physician assistant, <u>Hospital</u> , surgical center, <u>Skilled Nursing Facility</u> , and rehabilitation center. GlobalHealth may require the <u>Provider</u> 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 <u>Emergency Services</u> 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.
Psychiatric Clinical Nurse Specialist/Physician Assistant	A licensed medical <u>Practitioner</u> specializing in the diagnosis and pharmaceutical/medication treatment of mental illness disorders.

Term	Definition
Psychiatrist	A licensed medical <u>Practitioner</u> specializing in the diagnosis and
	pharmaceutical/medication treatment of mental illness disorders.
Psychologist	A licensed medical <u>Practitioner</u> specializing in diagnosing and treating diseases of
	the brain, emotional disturbance, and behavior problems.
Qualified Member	You are qualified to participate in an <u>Approved Clinical Trial</u> if (1) You are eligible to participate in the trial according to its protocol; and (2) either a <u>Network Provider</u> 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 mid-year change, allowing you to enroll in <u>Health Insurance</u> outside the yearly <u>Open Enrollment</u> period.
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 <u>Primary Care Provider</u> for you to see a <u>Specialist</u> or get certain healthcare services. In many health maintenance organizations (HMOs), you need to get a <u>Referral</u> before you can get healthcare services from anyone except your <u>Primary Care Provider</u> . If you don't get a <u>Referral</u> first, GlobalHealth may not pay for the services. GlobalHealth allows limited access to services in addition to your <u>PCP</u> without a <u>Referral</u> .
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 <u>Rehabilitation Services</u> in a variety of <u>Inpatient</u> and/or <u>Outpatient</u> settings.
Residential Treatment Center (RTC)	24/7 healthcare (<u>Hospital</u> and non-hospital based) <u>Facility</u> that specializes in the diagnosis and treatment of mental illness, behavioral problems, and/or substance use disorder.
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 <u>Preventive Care</u> 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	A disease or condition requiring complex ongoing care which you are currently
Condition	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, <u>Hospital</u> , 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

Term	Definition
	services performed by therapists or technicians (rather than licensed nurses) in
	your home or in a nursing home.
Skilled	Services provided in the home by licensed therapists (e.g., physical, occupational,
Rehabilitation	speech).
Services	
Skilled Nursing	A <u>Facility</u> or <u>Hospital</u> unit primarily engaged in providing, in addition to room and
Facility	board accommodations, 24 hour <u>Skilled Nursing Care</u> under the supervision of a
	licensed physician. GlobalHealth contracts with skilled <u>Facilities</u> that are certified
	under Title XVIII of the Social Security Act (Medicare certified).
Special Enrollment	The period of time, outside of <u>Open Enrollment</u> , when a person may enroll in a
Period (SEP)	health Plan.
Specialist	A <u>Provider</u> 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	A healthcare professional who has advanced education and training in one
	clinical area of practice is said to have a " <u>Specialty</u> ". This individual is called a " <u>Specialist</u> ". Surgeons, urologists, radiologists, cardiologists, and dermatologists
	are examples of <u>Specialists</u> . <u>Specialists</u> treat particular medical conditions or
	health problems. GlobalHealth is responsible for ensuring that healthcare
	professionals who claim to be <u>Specialists</u> are properly licensed and credentialed.
	Area of <u>Specialty</u> is provided on each physician's application and is verified at
	time of credentialing by GlobalHealth and at re-credentialing (every three years).
	When GlobalHealth receives updated information, it is verified and the website
	updated within 30 days.
Specialty Drug	A type of <u>Prescription Drug</u> that, in general, requires special handling or ongoing
_	monitoring and assessment by a healthcare professional, or is relatively difficult
	to dispense Generally, <u>Specialty Drugs</u> 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 <u>Plan Premium</u> has been received by GlobalHealth. Usually, the <u>Subscriber</u> is the employee.
Tier	Groups of drugs that fall within description and pricing levels. Drugs are assigned
Her	based on drug usage, cost, and clinical effectiveness. The higher the <u>Tier</u> , the
	more you pay through higher <u>Cost Sharing</u> .
Transition of Care	The process of moving care from physician to physician or from one level of care
Transition of darc	to another. It includes transferring care of new GlobalHealth <u>Members</u> to
	<u>Providers</u> in the GlobalHealth <u>Network</u> or helping new <u>Members</u> move to using
	<u>Prescription Drugs</u> covered on the GlobalHealth <i>Drug Formulary</i> .
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 <u>Emergency Room</u>
	<u>Care</u> .
Usual and	The amount paid for a <u>Medical Service</u> in a geographic area based on what
Customary	<u>Providers</u> in the area usually charge for the same or similar <u>Medical Service</u> . The
	Usual, Customary, and Reasonable (UCR) amount sometimes is used to
	determine the <u>Allowed Amount</u> .

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



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