

State of Oklahoma

MEMBER HANDBOOK

January 1 - December 31, 2027

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

85408OK0100001
MLGMH27-ST

WELCOME TO GLOBALHEALTH

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

As your chosen health Plan, we want to:

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

Please call our 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 [Member Portal](#) 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 to electronic delivery of documents at any time and at no cost. Contact Customer Care at 1-877-280-5600 (TTY: 711).

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 Dependents may be added to the group in accordance with the terms in this *Member Handbook*.

In the absence of Fraud, 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 Member ID card.

Amendments may be added to this Certificate of Coverage because of changes in law, changes in your coverage, or the special needs of your group. Any provision in conflict with law is automatically amended to meet the minimum requirements of the statute on the effective date of this coverage or the law, whichever is later. No person or entity has authority to waive any provision or to make changes or amendments unless approved in writing by a GlobalHealth 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 Claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

PLEASE READ THIS DOCUMENT CAREFULLY. It is important for you to know your benefits. No oral statement shall add or take away any benefits, limitations, or exclusions, under this Plan.

HELPFUL NUMBERS

Plan Issuer:

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

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)
compliance@globalhealth.com
privacy@globalhealth.com

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
10181 Scripps Gateway Ct.
San Diego, CA 92131

Prescription Drug Grievances:
1-800-424-1789 (toll-free)
GlobalHealth Pharmacy Exceptions Department
PO Box 2393
Oklahoma City, OK 73101-2393

Prescription Drug Appeals:
MedImpact
Attn: Clinical Services
10181 Scripps Gateway Ct.
San Diego, CA 92131

Mail Order Pharmacy:

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 Preventive Care in addition to treatment for illness and injury. With us, you get a wide range of services to meet your healthcare needs.

Member Materials

This *Member Handbook* applies to you if you enrolled in 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
<i>Member Handbook for State, Education, and Local Government Employees (Member Handbook)</i>	• 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.
<i>Physicians and Health Providers Directory (Provider Directory)</i>	• 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.
<i>Pharmacy Directory</i>	• Lists our <u>Network</u> of pharmacies including mail order. • Tells you if a pharmacy is a 24-hour or vaccine pharmacy.
<i>Formulary Drug List for State, Education, and Local Government Employees (Drug Formulary or Formulary)</i>	• 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 Member 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 disabilities	• We provide free aids and services if you need them to communicate 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 proficiency	• We offer over 150 languages from qualified medical interpreters. • 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 Grievance. You can file a Grievance in person or by mail or e-mail. If you need help filing a Grievance, 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 Grievances, see “Appeals and Grievances” on page 142.

Get Care

You have the right and responsibility to fully participate in all Referral requests related to your healthcare. If you are unable to fully participate in treatment Referrals, 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 PCP	See “ <u>Provider Network</u> ” starting on page 18 for more information. - 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 <u>Member ID</u> card, contact us.

Action	What To Do
See Your PCP	See your <u>PCP</u> first for all your medical care. - 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 Specialist	To see a <u>SPECIALIST</u>, you need a <u>Referral</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 PCP 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 Hospital	To go to the <u>HOSPITAL</u>, you need a <u>Referral</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 Providers</u>): - Advance care planning - After hours or out-of-area <u>Urgent Care</u> - Behavioral healthcare <u>Case Management</u> - Chiropractic care - Emergency care - Eyeglasses or contacts - Hearing aid evaluations - Nurse 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 pharmacy	See the <i>Drug Formulary</i> at www.GlobalHealth.com to check specific drug coverage information and <u>PA</u> requirements. Be sure to view the <i>Drug Formulary</i> list that matches your <u>Plan</u>. - See the <i>Pharmacy Directory</i> also on the GlobalHealth website to find a pharmacy <u>In-network</u> – www.GlobalHealth.com. - You can contact MedImpact with any questions at 1-866-909-5170 (toll-free).
Go to Urgent Care or ER	Your <u>PCP</u> is always your first contact for direction when you begin to feel you are becoming ill. \$25 <u>Copayment</u>/visit.

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

Member ID Cards

We will send a Member ID card to you at the start of your Plan Year. 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 PCP, let them know you are a GlobalHealth Member. Show your Member ID card each time you get medical care. It contains valuable information about your benefits.

Please Note:

- Services are for your personal benefit. Never lend your 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 [State of Oklahoma Member portal](#) at www.GlobalHealth.com. You should get new or additional cards within two weeks after we receive the request.
- Your Member ID card is valid only as long as you are enrolled in the Plan. Having a card does not guarantee benefits.

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

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

Information	Sample
Front of Card: - Coverage ID number - Group ID number <u>Member</u> ID number - The selected <u>PCP</u> <u>PCP</u> phone number <u>PCP</u> effective date - Relationship code to <u>Subscriber</u> <u>Copayment</u> and benefit information	 Group Number: <Group#> Member ID: <XXXXXXXXXX> <First Name> <MI> <Last Name> PCP Name: <PCP Name> PCP Phone: <XXX-XX-XXXX> RXBIN: 0009893 RXPCN: ROIRX RXGRP: 850002 Effective: [cvg_eff_dt] MOOP IND/FAM \$4000/\$12000 Copayments PCP <XX> SPEC <XX> ER <XX> (Prescription - Retail) Gen / Brand / Non-Formulary <rx_copay>
Back of Card: - What to do in case of a life-threatening emergency - Routine and <u>Urgent Care</u> information - How to reach us including phone number, office hours, and <u>Claims</u> address	BARCODE HERE IN AN EMERGENCY PROCEED TO THE NEAREST EMERGENCY ROOM OR CALL 911. Call your health plan within 48 hours. Customer Care: 1-877-280-5600 (TTY: 711) www.GlobalHealth.com Behavioral Health: 1-888-434-9204 (TTY: 1-866-835-2755) Hearing: 1-877-241-4736 (TTY: 711) Pharmacy Benefits: 1-800-424-1789 (TTY: 711) Submit Medical Claims to: GlobalHealth Claims Department P.O. Box 2718 Oklahoma City, OK 73101 EDI Payor ID: GHOKC0001 Pharmacy Claims: MedImpact, 7835 Freedom Ave NW, North Canton, OH 44720

Get Help

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

Please remember it usually takes some time to process a Referral or Claim. See “Utilization Management” on page 31 and “Claims and Payment” 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 Birdi Mail Order Pharmacy if you have questions about Prescription Drug mail order.

Steps to Improve Your Healthcare Quality and Safety

Step	What To Do
1	If you are new to GlobalHealth, visit your <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 Care</u> services. See “ <u>Preventive Care Benefits</u> ” 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 Network Providers. We have a large Network of PCPs, Specialists, and Facilities to care for you. Providers follow generally-accepted medical practices when prescribing any Course of Treatment.

<u>Provider Type</u>	<u>Examples</u>
Agencies	• Home health • Hospice
<u>Facilities</u>	• <u>Hospital</u> • Imaging center • Laboratory • <u>Outpatient Facility</u> • Pharmacy • <u>Skilled Nursing Facility</u> • <u>Urgent Care Facility</u>
<u>Physicians and Practitioners</u>	• Behavioral Health Provider (<u>BHP</u>) • Lactation counselor • Medical group • <u>PCP</u> • <u>Specialist</u> • Therapists ○ (such as physical, occupational, or speech therapist) • Other healthcare professionals ○ (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 Network Provider acting within the scope of his or her license who is accepting patients.

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

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

Network Changes

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

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

preferred.

For more information, see “[Physicians Leaving the Network](#)” on page 25.

Provider Directory

We list [Network](#) doctors, [Facilities](#), and suppliers in the *Provider Directory*. 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 *Provider Directory* concerning your [Provider](#), please have them contact GlobalHealth to have the information corrected. See “[HELPFUL NUMBERS](#)” on page 4. You may also report mistakes on our website at www.GlobalHealth.com. 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 [Providers](#) 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 [Provider type](#), [Specialty](#), 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 [Out-of-network Provider](#) contact us so we can help you find an [In-network Provider](#).

You have the right to request an [Out-of-network Provider](#). However, we may not approve coverage at an [Out-of-network Provider](#) if an [In-network Provider](#) 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 \(LCSW\)](#);
- [Licensed Marriage & Family Therapist \(LMFT\)](#);
- [Licensed Professional Counselor \(LPC\)](#);
- Opioid Treatment Program;
- [Psychiatric Clinical Nurse Specialist](#);
- [Psychiatrist](#) – Child, adolescent, adult, geriatric, addiction medicine [Specialist](#);
- [Psychologist](#);
- [Residential Treatment Center \(RTC\)](#); and
- Other mental healthcare [Facilities](#) 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, [Members](#) may seek services from any out-of-network provider. The [Member](#) 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 Providers includes doctors such as PCPs and many types of Specialists. Types of Specialists 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 Facility. Select Provider Type, then Hospital, Skilled Nursing Facility, or other Facility type.

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

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

You can find information about Hospitals such as:

- Hospital name;
- Hospital type, including, but not limited to, acute, rehabilitation, or long-term care;
- Hospital location
- Hospital 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 Hospital or the state. Not every Hospital is listed on every site.

Be sure you make an appointment with a Provider 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 Cost-share may change based on where you fill your prescription.

The *Pharmacy Directory* is updated monthly and will tell you which pharmacies are in the Network. If the pharmacy you have been using leaves the Network you will have to find a new pharmacy that is in the Network. It is a good idea to periodically check the pharmacy Network 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 <u>Cost-share</u>. If more than a 30-day supply is ordered, you will pay the 90-day supply <u>Cost-share</u>. For example, if a 45-day supply is ordered you will pay the 90-day supply <u>Cost-share</u>. • You may get a discount on your drugs, depending on the drug <u>Tier</u>, 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 <u>Network</u> 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>Cost-share</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 Birdi 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 pharmacies	• Get up to a 30-day supply. Fill once each month. • 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 www.GlobalHealth.com to use the online pharmacy search.

PCP

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

Choose a PCP

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

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

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

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

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

You can find a current list of PCPs on our website. We will assign a PCP 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 Providers before your first visit. See “Medical Records” 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 Formulary, discuss your options. See “Prescription Drug Transition of Care” on page 131.
- Discuss Preventive Care that is right for you. You may have some of the Screenings during this visit. You may need to schedule more visits for other Preventive Care.

Schedule Routine Appointments

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

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

When You Need Care Right Away

Call your PCP. If no urgent appointments are available, he or she may send you to an Urgent Care Facility. See “Urgent Care” on page 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 PCP for any reason. The change will take effect on the first of the following month. Contact us for the following:

- Change your PCP. You can make the change on [State of Oklahoma Member portal](#).
- Get help changing from a childcare doctor to an adult care doctor.
- See your PCP before you get your new Member ID card.

We recommend against changing your PCP if the change would be harmful to you. For example:

- You are an organ transplant candidate.
- You are receiving active medical care.
- You are in the third trimester of your pregnancy.

We cannot let you change if the new PCP:

- Is not taking new patients; or
- Is not in our Network.

You will need to choose another PCP.

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

Self-referral Services

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

- You do not need a Referral from your PCP before you go. You do not need PA from us.
- You pay the Cost-share, if any, for non-preventive services.
- You must go to a Network Provider for services other than emergency or out-of-area Urgent Care. You pay for care from an Out-of-network Provider.
- 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 “ <u>Chiropractic care</u> ” on page 57.
Emergency room (ER)	Do not use an <u>ER</u> in non-emergency situations. However, in an emergency, go to 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 “ <u>Vision Benefits</u> ” on page 116.
Eyewear	You may go to an eyewear <u>Provider</u> for eyeglasses or contacts following cataract surgery. See “ <u>Vision Benefits</u> ” on page 116.
Hearing aid evaluations	You may go to a hearing Specialist to have an evaluation for hearing aids. See “ <u>Hearing services –evaluation for hearing aid</u> ” on page 72.
Mammograms	You may go to an imaging center for your routine mammogram. See “ <u>Mammogram</u> ” on page 78.
Mental health/substance use disorder services	You may go to a therapist, counselor, <u>Psychologist</u> , or <u>Psychiatrist</u> for assessment, therapy, and testing. Contact your provider for telehealth services. See “ <u>Behavioral Health Benefits</u> ” on page 40.
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>. <u>Contraception Services</u>: 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. <u>Maternity</u>:

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. <u>Well-woman Exam:</u> For a list of <u>Preventive Services</u> related to your well-woman exam, see “<u>Women’s benefits</u>” on page 111. <u>Other Services:</u> You have direct access to your <u>OB/GYN</u>. He/she may perform any <u>Covered Services</u> 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 <u>PA</u> 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 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 PCP first. If your PCP believes you need to see a Specialist, he/she will send us a Referral. See “Pre-service Authorization” on page 31.

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

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

Physicians Leaving the Network

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

- He/she leaves our Provider Network.

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

We will tell you within 30 days of the date we find out that your Provider has or will be leaving our Network.

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

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

Urgent Care

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

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

- It costs you less than an ER visit.
- A doctor may see you right away in an Urgent Care Facility.
- In an ER, you may have to wait longer.
- Urgent Care Facilities usually can perform these types of services:
 - Exams
 - X-rays
 - Basic Screenings
 - Prescribe medication

Urgent Care Facilities may treat situations such as:

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

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

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

When	What To Do
Normal Office Hours	If you have an urgent medical illness or injury, call your <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 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 Prudent Layperson could expect failure to get medical help right away to result in:

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

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

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

Access

Do not use an ER visit in non-emergency situations. However, in 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-network Hospital</u>.
5	<i>All follow-up care after being treated in the <u>ER</u> must be:</i>

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

Home Healthcare

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

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

Your behavioral health Provider may also visit you at home.

Medical Records

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

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

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

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

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

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

Ask for Information

You have the right to find out your Providers' 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> <u>LPC</u> <u>LBP</u>	https://www.ok.gov/behavioralhealth/License_Verification.html
<u>Licensed Clinical Psychologists</u> <u>Psych Techs (testing only for techs)</u>	https://www.ok.gov/psychology/Public/License_Verification/index.html

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 Hospital (if the doctor is on staff).

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

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

UTILIZATION MANAGEMENT

Medical and Behavioral Health UM

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

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

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

Type	Reviewed First	Reviewed If No Policy
Medical Services	• GlobalHealth Medical Policies	• MCG™ Care Guidelines • Hayes, Inc.
Behavioral Health Services	• Caelon Behavioral Health Policies	• ASAM Criteria® • 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 Adverse Determinations. 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 PCP does not provide them. Otherwise, you will have to pay the entire cost of the services. “Services” includes any treatment, tests, procedures, supplies, or equipment.

This process ensures:

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

You may see our current PA requirements and restrictions, including written clinical criteria, at www.GlobalHealth.com. If you are receiving a Covered Service and there will be a change to PA 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 Provider 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 PA 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>PA</u> s 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 Referrals for your services. But, it is your responsibility to make sure we have authorized your services.
- You should get all care from a Network Provider including ancillary services such as:
 - x-rays
 - lab services
 - anesthesia
- Although some services do not require PA, you must use Network Providers for:
 - Hospitalization related to childbirth; or
 - Self-referral services. See “Self-referral Services” on page 24.
- You must have services while you are a Member. We will not pay for benefits, even if authorized, after your coverage ends.
- You may track your Referral through your [State of Oklahoma Member portal](#)
- 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 Hospital past the authorized period, we will conduct a review.

If we have approved a Course of Treatment:

- Any change before the end of the Course of Treatment is an Adverse Determination. A change may be either fewer treatments or ending treatments. We will tell you before we make the change. We will allow you time to Appeal before we make the change. We will cover the benefit during the Appeal process.
- You may ask us to extend the Course of Treatment beyond what we approved. We will tell you our

decision, whether or not it is in your favor. We do not cover the benefit during the Appeal process.

- We make urgent review decisions within 24 hours after we get your request. We will tell you the decision, whether or not it is in your favor.

You may not Appeal when your Plan is amended or ended. See “Appeals and Grievances” on page 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 PA to a doctor or another Facility. We work with your doctor and the Hospital case manager to have PAs in place before you leave.

We start discharge planning either:

- When you are admitted to the Hospital; or
- When we authorize the stay.

Post-service Review

After you get services, we review them to find quality or utilization issues, if any. We review Claims submitted for payment and the corresponding medical records. 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 UM 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 Prescription Drugs, special rules restrict how and when we cover them. A team of doctors and pharmacists made these rules to:

- Help you use drugs in the way that works best.
- Help control overall drug costs, which keeps your Premium lower.
- Encourage you and your Provider to use a lower-cost option when possible that:
 - Works for your condition; and
 - Is just as safe.

If there is a rule for your drug, it means that you or your Provider will have to take extra steps in order for us to cover the drug. If you want us to waive the rule for you, you will need to use the exception request process. We may or may not agree to waive the rule for you. See “Exception Requests” 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. • <u>Prescription Drugs</u> administered as part of an ER visit will not required <u>PA</u> even if the <u>Formulary</u> usually requires one. • A <u>PA</u> for medications prescribed for chronic conditions is effective for three years from the date the <u>Provider</u> receives the <u>PA</u> approval, if you remain a Member of GlobalHealth, unless: ○ The clinical criteria changes. ○ We remove the generic Prescription Drug from our <u>Formulary</u>. ○ We move the <u>Prescription Drug</u> to a higher Tier on our <u>Formulary</u>. ○ The <u>PA</u> is for an opioid or controlled substance. • A <u>PA</u> is effective for the first 60 days of enrollment when a prior Health Plan covered a <u>Prescription Drug</u> with documentation that a <u>PA</u> was in effect.
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	1-800-424-1789
Fax	1-888-586-0102
Mail	MedImpact 10181 Scripps Gateway Ct. San Diego, CA 92131

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:
 - Your parent, if you are age 18 or over.

- Your spouse.
- Your caregiver, friend, neighbor, or other.

Exception Type	Process
Standard Exception	You can ask us to waive coverage rules and limits. You may ask us by mail, e-mail, or telephone. Generally, we will only approve a request if: • The alternative drug is included on the <u>Formulary</u>; • The drug without utilization rules would not work as well for you; and • 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 <u>External Review</u>.
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 “<u>Prescription Drug Transition of Care</u>” 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 <u>External Review</u>. See “<u>External Review</u>” 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 UM Department bases its decisions on:
 - Whether the care is appropriate; and
 - Whether the care is covered.
- We do not reward anyone for denying coverage.
- We do not use financial incentives to encourage decisions that result in using fewer benefits.
- We do not use incentives to make it harder for you to get care.
- We do not make decisions regarding hiring, promoting, or terminating anyone because they are likely, or we think they are likely, to deny or support the denial of benefits.

Technology Assessment Process

We have a review process for new devices, medical or behavioral health procedures, or treatments including Prescription Drugs.

- 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 Specialists 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:
 - Be approved by a regulatory agency, such as the FDA;
 - Improve your net health outcome;
 - Be as beneficial as current treatments;
 - Be available outside of clinical tests;
 - Significantly improve your quality of life; and
 - Clearly show safe medical care.

BENEFITS

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

Your Share of the Cost

Benefit Charts

The benefit charts show your benefits and Cost Sharing.

- Behavioral Health Benefits on page 40.
- Medical Benefits on page 50.
- Prescription Drug Benefits on page 103.
- Preventive Care Benefits on page 109.
- Vision Benefits on page 116.

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

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

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

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 Cost-share 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 Members 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 Plan does not have a Deductible. You pay the listed Copayment or Coinsurance up to the MOOP.

MOOP

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

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

- The service you received;
- The name of the Network Provider 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 Provider 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
<u>Member MOOP</u> \$4,000 per year	• The <u>Member MOOP</u> is met when a single <u>Member</u> pays <u>Copayments</u> and/or <u>Coinsurance</u> up to this level. • If you reach the <u>Member MOOP</u>, you will not pay any more <u>Cost Sharing</u> for <u>Covered Services</u> 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>.
<u>Family MOOP</u> \$12,000 per year	• The family <u>MOOP</u> is met when any combination of family members under the 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 <u>Cost Sharing</u> until either that family member also meets the <u>Member MOOP</u> or the family <u>MOOP</u> is met. Then they will not pay any more <u>Cost Sharing</u> for <u>Covered Services</u> for the rest of the year.

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

Tracking Expenses

It is a good idea for you to keep track of your expenses. You will know when you are close to meeting your MOOP. Our records may not match due to Claims lag. Claims lag is the time between when you received services and when we process the Claim. Let us know if you think you have met your MOOP.

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 for all types of benefits	• The care is <u>Medically Necessary</u>; • Services meet generally-accepted standards of care; • 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 benefits and do not cover others	• We do not cover services: ○ When you can no longer improve from treatment; or ○ The care is either custodial or only for the convenience of others. • See "<u>Excluded Services and Limitations</u>" 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 Member and receiving care, call Carelon Behavioral Health as soon as possible. If your Provider is not contracted, Carelon Behavioral Health will help you find another Provider who is right for you. See “Behavioral Health and Medical Transition of Care” on page 131.

Covered Services

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

- Mental health; and
- Substance use disorder, including alcohol, Prescription Drug, 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:

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

Behavioral Health Benefits Chart

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

Benefit	Description	You Pay
	- 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. - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>.	
<u>Case Management</u>	<u>Covered Services:</u> - Home-based support to help you find community resources, services, and self-help. <u>PA Required:</u> - No. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>.	No <u>Copayment</u>
<u>Convulsive therapy treatment</u>	<u>Covered Services:</u> - Electroshock treatment or convulsive drug therapy. - Includes anesthesia when given with treatment. <u>PA Required:</u> - No. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>.	Included in the <u>Outpatient Copayment</u>, which is \$300 <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay

Benefit	Description	You Pay
Counseling	<u>Covered Services:</u> • Biofeedback. • Hypnotherapy. • Individual, group, marital, and/or family therapy sessions. • Transcranial magnetic stimulation. <u>PA Required:</u> • No, for behavioral health therapy office visits. • Yes, for other treatment settings. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Wilderness therapy. • Subject to General <u>Excluded Services</u>.	Behavioral health therapy office visit: No <u>Copayment</u> Included in Intensive <u>Outpatient</u> program, which is No <u>Copayment</u> Included in Partial <u>Hospitalization</u>, which is No <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment/day</u>, up to \$2,000 <u>Copayment/stay</u>
Diagnostic evaluation and assessment	<u>Covered Services:</u> • Services to diagnose a condition. • Psychological, developmental, or neuropsychological testing. • Also see “<u>Diagnostic Tests</u>” on page 66. <u>PA Required:</u> • No, for behavioral health therapy office visits. • Yes, for other treatment settings. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • 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>.	Behavioral health therapy office visit: No <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment/day</u>, up to \$2,000 <u>Copayment/stay</u>
<u>Emergency Services</u>	<u>Covered Services:</u> • Life threatening crises intervention including but not limited to: ○ Suicidal or homicidal thoughts or actions;	\$400 <u>Copayment/visit</u> and waived if admitted to <u>Inpatient</u> care within the same <u>Hospital</u> – You pay the <u>Inpatient Cost-share</u> instead

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 “<u>Emergency Care</u>” on page 27. ● Observation. <u>PA Required:</u> ● No. <u>Limitations:</u> ● Subject to General limitations. <u>Excluded Services (Not Covered):</u> ● Subject to General <u>Excluded Services</u>.	
Home Healthcare	<u>Covered Services:</u> ● See “<u>Home Healthcare</u>” on page 28. <u>PA Required:</u> ● Yes. <u>Limitations:</u> ● Subject to General limitations. <u>Excluded Services (Not Covered):</u> ● Subject to General <u>Excluded Services</u>.	No <u>Copayment</u>
<u>Inpatient Hospital Facility</u>	<u>Covered Services:</u> ● For <u>Medical Services</u> see “<u>Inpatient Hospital Facility</u>” 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 <u>Hospital</u>, psychiatric <u>Hospital</u>, or <u>RTC</u> setting. <u>PA Required:</u> ● Yes.	\$300 <u>Copayment</u> /day up to \$900 <u>Copayment</u> /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>.	
Intensive Outpatient program	<u>Covered Services:</u> • Behavior modification therapies. • Multiple times a week for a set number of hours a day. <u>PA Required:</u> • Yes. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Wilderness therapy. • Subject to General <u>Excluded Services</u>.	No <u>Copayment</u>
Medical detoxification	<u>Covered Services:</u> • Facilities that provide a detox using medical methods. • RTC that provides a chemical dependency treatment program. Please Note: Not all RTC facilities provide a medical detox prior to the program. <u>PA Required:</u> • Yes. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u> , which is \$400 <u>Copayment</u> /day, up to \$2,000 <u>Copayment</u> /stay
Medication Assisted Treatment Program	<u>Covered Services:</u> • Medication management visits. • Services to treat substance use disorder: ○ Anti-craving medications for alcohol, tobacco, opioid, and other substance use disorders. ○ <u>Case Management</u>.	<u>Case Management:</u> No <u>Copayment</u> Behavioral health therapy office visit: No <u>Copayment</u> <u>PCP:</u> Included in <u>PCP Copayment</u> , which is \$25 <u>Copayment</u> /visit

Benefit	Description	You Pay
	○ 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. <u>PA Required:</u> • No, for behavioral health therapy or PCP office visits. • Yes, for RTC or Inpatient Hospital visits. • Yes, for some medications. See the <i>Drug Formulary</i>. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General Excluded Services.	Included in RTC Copayment or Inpatient Hospital Facility Copayment, which is \$400 Copayment/day, up to \$2,000 Copayment/stay See “Prescription Drug Benefit Chart” on page 103.
Medication evaluation and management	<u>Covered Services:</u> • 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. <u>PA Required:</u> • No, for PCP or BHP office visits. • Yes, for other treatment settings. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General Excluded Services.	Behavioral health therapy office visit: No Copayment PCP: Included in PCP Copayment, which is \$25 Copayment/visit Included in RTC Copayment or Inpatient Hospital Facility Copayment, which is \$400 Copayment/day, up to \$2,000 Copayment/stay See “Prescription Drug Benefit Chart” on page 103
Partial Hospitalization	<u>Covered Services:</u>	No Copayment

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. <u>PA Required:</u> - Yes. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>.	
<u>Prescription Drugs</u>	<u>Covered Services:</u> - See “<u>Prescription Drug Benefits</u>” on page 102. <u>PA Required:</u> - See the <i>Drug Formulary</i>. <u>Limitations:</u> - See the <i>Drug Formulary</i>. - Subject to General limitations. - Subject to <u>Prescription Drug</u> limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>. - Subject to <u>Prescription Drug Excluded Services</u>.	See “ <u>Prescription Drug Benefits Chart</u> ” on page 103
Psychosocial education	<u>Covered Services:</u> - Home-based education to learn daily living and social skills. - Psychological rehabilitation. <u>PA Required:</u> - Yes. <u>Limitations:</u> - Limited to daily living and social skills education. - Subject to General limitations. <u>Excluded Services (Not Covered):</u>	No <u>Copayment</u>

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, impulse-control, or conduct disorder. - Subject to General <u>Excluded Services</u>.	
<u>RTC</u>	<u>Covered Services:</u> - Care in <u>Facilities</u> licensed as <u>RTCs</u> 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 <u>RTC Facilities</u> provide a medical detox prior to the program. <u>PA Required:</u> - Yes. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Wilderness therapy. - Subject to General <u>Excluded Services</u>.	\$300 <u>Copayment</u> /day up to \$900 <u>Copayment</u> /stay
Telehealth	<u>Covered Services:</u> - Access your certified behavioral health practitioner by secure online video or phone. <u>PA Required:</u> - No. <u>Limitations:</u> - Only available through <u>Providers</u> that offer this service. - Subject to General limitations.	No <u>Copayment</u>

Benefit	Description	You Pay
	<u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	
Testing	<u>Covered Services:</u> • Clinical evaluation using recognized assessment tools: ○ Developmental; ○ Neuropsychological; ○ Psychological; and ○ Substance abuse. <u>PA Required:</u> • No, for behavioral health therapy or well-child office visits. • Yes, for other treatment settings. <u>Limitations:</u> • Autism <u>Screening</u> and developmental <u>Screening</u> limited to well-child visits. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	Behavioral health therapy office visit: No <u>Copayment</u> <u>PCP</u> : Included in <u>PCP Copayment</u> , which is \$25 <u>Copayment</u> /visit Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u> , which is \$400 <u>Copayment</u> /day, up to \$2,000 <u>Copayment</u> /stay
Tobacco cessation	<u>Covered Services:</u> • Treatment to help you quit using tobacco products. Also see, “<u>Tobacco Cessation</u>” on page 152. <u>PA Required:</u> • No. <u>Limitations:</u> • Limited to two attempts per year. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	No <u>Copayment</u>
Urgent intervention	<u>Covered Services:</u> • Nonlife-threatening crisis assistance. • Face-to-face support at an approved behavioral health <u>Facility</u>. Call Carelon Behavioral Health for help. <u>PA Required:</u> • No.	Behavioral health therapy office visit: No <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u> , which is \$400 <u>Copayment</u> /day, up to \$2,000 <u>Copayment</u> /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 Covered Services in either a Preferred Facility or a Non-preferred Facility within our full Network. We tell you below which services have the choice. Be sure to check when you make an appointment which type of Facility it is *for the service you are having*. The Cost Sharing you pay depends on where you are having the service and what the service is. Call us if you have questions.

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

Also see “Coverage Requirements” on page 40.

Medical Benefits Chart

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

Benefit	Description	You Pay
	<u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	
Ambulance	<u>Covered Services:</u> • Transport when you must have <u>Emergency Services</u> 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. <u>PA Required:</u> • No, for emergency services. • Yes, for non-emergency services. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Commercial or public transportation. • Gurney van services. • Wheelchair van services. • Subject to General <u>Excluded Services</u>.	\$100 <u>Copayment</u> /occurrence
Anesthesia	<u>Covered Services:</u> • 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> • Subject to General <u>Excluded Services</u>.	Included in <u>Specialist Copayment</u>, which is \$50 <u>Copayment</u>/visit Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay
ASD treatment	See below.	See below
ASD – pharmacy	<u>Covered Services:</u> • See “<u>Prescription Drug Benefits</u>” on page 102.	See “ <u>Prescription Drug Benefits Chart</u> ” on page 103

Benefit	Description	You Pay
	<u>PA Required:</u> • See the <i>Drug Formulary</i>. <u>Limitations:</u> • See the <i>Drug Formulary</i>. • Subject to General limitations. • Subject to <u>Prescription Drug</u> limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>. • Subject to <u>Prescription Drug Excluded Services</u>.	
<u>ASD – Screening</u>	<u>Covered Services:</u> • Developmental delays and disabilities <u>Screening</u>. • Exam, including observations, family history, and parental perspective. <u>PA Required:</u> • No. <u>Limitations:</u> • Limited to well-child visits. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	No <u>Copayment</u>
<u>ASD – therapeutic care</u>	<u>Covered Services:</u> • <u>Habilitation Services</u> related to an <u>ASD</u> diagnosis: ○ Physical, occupational, and speech therapies. ○ Does not count toward the <u>Rehabilitation Services</u> visit limitations you may otherwise be entitled to. <u>PA Required:</u> • Yes. <u>Limitations:</u> • <u>ASD</u> treatment limited to the following diagnoses:	Office visits: \$35 <u>Copayment</u>/visit Included in rehabilitation <u>Outpatient Facility</u>, which is \$70 <u>Copayment</u>/visit Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay Included in the <u>Home Healthcare Copayment</u>, which is No <u>Copayment</u>

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. <u>Excluded Services (Not Covered):</u> ● Subject to General <u>Excluded Services</u>.	
Attention Deficit Hyperactivity Disorder (ADHD)	<u>Covered Services:</u> ● Medical management, including: ○ Diagnostic evaluation; ○ Laboratory services for monitoring prescribed drugs; and ○ Treatment. ● Counseling <u>PA Required:</u> ● No. <u>Limitations:</u> ● Subject to General limitations. <u>Excluded Services (Not Covered):</u> ● Subject to General <u>Excluded Services</u>.	Lab, x-ray, and <u>Diagnostic Tests</u>: No <u>Copayment</u> <u>PCP</u>: Included in <u>PCP Copayment</u>, which is \$25 <u>Copayment</u>/visit Counseling: See “<u>Behavioral Health Benefits Chart</u>” on page 41
Bariatric surgery	<u>Covered Services:</u> ● Lap-band surgery. <u>PA Required:</u> ● Yes. <u>Limitations:</u> ● Bariatric surgery is limited to lap-band surgery. ● Subject to General limitations. <u>Excluded Services (Not Covered):</u> ● Lap-band surgery is not covered when related to weight loss alone. Your	Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay

Benefit	Description	You Pay
	doctor must tell us the medical condition that requires surgery. • Subject to General <u>Excluded Services</u>.	
Blood and blood products	<u>Covered Services:</u> • Processing, storage, and administration, including collection and storage of autologous blood. Donated blood is a non-billable item. <u>PA Required:</u> • No, for emergencies. • Yes, for all other settings. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	Included in <u>ER Copayment</u>, which is \$400 <u>Copayment/visit</u> Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment/day</u>, up to \$2,000 <u>Copayment/stay</u>
Bone density test	<u>Covered Services:</u> • 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; ○ 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. <u>PA Required:</u> • No. <u>Limitations:</u> • DEXA scans limited to one every 24 months. • Subject to General limitations. <u>Excluded Services (Not Covered):</u>	No <u>Copayment</u>

Benefit	Description	You Pay
Breast cancer – Inpatient care	• Subject to General <u>Excluded Services</u>. <u>Covered Services:</u> • At least 48 hours after a mastectomy; • At least 24 hours after a lymph node dissection; • Reconstruction of the diseased breast; • Surgery and reconstruction of the other breast to produce symmetrical appearance when performed within 24 months of reconstruction of the diseased breast; and • Treatment of physical complications of the mastectomy, including lymphedema. <u>PA Required:</u> • Yes. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment/day</u>, up to \$2,000 <u>Copayment/stay</u>
Breast cancer – Preventive Care	<u>Covered Services:</u> • 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. <u>PA Required:</u> • Yes.	No <u>Copayment</u>

Benefit	Description	You Pay
	<u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>.	
Breast cancer – prosthetic appliance	<u>Covered Services:</u> - Surgically implanted and external appliances. <u>PA Required:</u> - Yes. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Clothing or devices available <u>OTC</u>. - Subject to General <u>Excluded Services</u>.	External appliances: 20% <u>Coinsurance</u> Internal appliances: Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u> , which is \$400 <u>Copayment/day</u> , up to \$2,000 <u>Copayment/stay</u>
Breast cancer – treatment	<u>Covered Services:</u> - All types of treatment. <u>PA Required:</u> - Yes. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>.	Radiation or chemotherapy treatment: Office or <u>Preferred Facility</u> : Included in office or <u>Facility Copayment</u> , which is \$30 <u>Copayment/treatment</u> <u>Non-preferred Facility</u> : Included in office or <u>Facility Copayment</u> , which is \$50 <u>Copayment/treatment</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/visit</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u> , which is \$400 <u>Copayment/day</u> , up to \$2,000 <u>Copayment/stay</u> Equipment, services, and supplies billed from <u>Home Healthcare</u> agency: No <u>Copayment</u> <u>Prescription Drug</u> at pharmacy: See “ <u>Prescription Drug Benefits Chart</u> ” on page 103
Cardiac	<u>Covered Services:</u>	\$20 <u>Copayment/visit</u>

Benefit	Description	You Pay
rehabilitation – Outpatient	• Counseling; • Education; and • Exercise. • Covered conditions: ○ Recovering from: ▪ Coronary bypass surgery; ▪ Heart attack; or ▪ Heart transplant. <u>PA Required:</u> • Yes. <u>Limitations:</u> • Limited to 36 visits per event. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	
Chiropractic care	<u>Covered Services:</u> • Services during an office visit. <u>PA Required:</u> • No. <u>Limitations:</u> • Limited to 15 visits per year. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	\$25 <u>Copayment</u> /visit
Cleft lip and cleft palate treatment	<u>Covered Services:</u> • <u>Inpatient</u> and <u>Outpatient</u> care for cleft lip or cleft palate or both including: ○ <u>Oral surgery</u>; ○ <u>Orthodontics</u>; and ○ Otologic, audiological, and speech/language treatment. <u>PA Required:</u> • Yes. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	Included in <u>Specialist Copayment</u>, which is \$50 <u>Copayment</u>/visit Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay

Benefit	Description	You Pay
		Otologic, audiological, and speech/language treatment office visit: \$35 <u>Copayment</u>/visit Included in rehabilitation <u>Outpatient Facility</u>, which is \$70 <u>Copayment</u>/day
Clinical trials	<u>Covered Services</u>: • <u>Routine Costs</u> only. • The clinical trial must be for cancer or another <u>Life-threatening Disease or Condition</u>. • 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, <u>Diagnostic Test</u>) and not excluded from coverage (such as, elective procedures). <u>PA Required</u>: • Yes. <u>Limitations</u>: • Subject to General limitations. <u>Excluded Services (Not Covered)</u>: • Subject to General <u>Excluded Services</u>.	Lab: No <u>Copayment</u> Included in <u>Specialist Copayment</u>, which is \$50 <u>Copayment</u>/visit 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-share</u> instead Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay
Colorectal cancer preventive Screening	<u>Covered Services</u>: • See “<u>Preventive Care Benefits</u>” on page 109. • Colonoscopy – Once every 10 years, the preventive <u>Screening</u> process includes: ○ Consultation before the <u>Screening</u> procedure if your doctor determines that it would be right for you; ○ Anesthesia services with the colonoscopy if the attending doctor determines that it would be right for you; ○ Removal of any polyps during the <u>Screening</u> procedure; and	No <u>Copayment</u> Bowel preparation medication <u>Copayment</u> dependent on <u>Tier</u>. See your <i>Drug Formulary</i>.

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. <u>PA Required:</u> • No. <u>Limitations:</u> • Limited to the <u>USPSTF Screening</u> schedule. • Subject to General limitations. • Subject to <u>Preventive Care</u> limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>. • Subject to <u>Preventive Care Excluded Services</u>.	
Contraception services	<u>Covered Services:</u> • 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. ● <u>Prescription Drug Coverage</u> 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 <u>Facility</u>. <u>PA Required:</u> ● No, for services in an office visit. ● Yes, for all other services and treatment settings. ● See the <i>Drug Formulary</i> for <u>Prescription Drug</u> information. <u>Limitations:</u> ● Subject to General limitations. ● Subject to <u>Prescription Drug</u> limitations.	

Benefit	Description	You Pay
	<u>Excluded Services (Not Covered):</u> • Hysterectomies for the purpose of contraception. • Reversal of voluntary surgical sterilization. • Subject to General <u>Excluded Services</u>. • Subject to <u>Prescription Drug Excluded Services</u>.	
<u>Cosmetic and Reconstructive Surgery</u>	<u>Covered Services:</u> • <u>Outpatient surgical services</u>. • <u>Inpatient Hospital Services</u>. <u>PA Required:</u> • Yes. <u>Limitations:</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. • <u>Reconstructive Surgery</u> 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 jaw, mouth, or face resulting from	Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment/day</u>, up to \$2,000 <u>Copayment/stay</u>

Benefit	Description	You Pay
	a birth defect. Does not include dental work. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	
Dental care – anesthesia	<u>Covered Services:</u> • Anesthesia; • Anesthesiologist; and • <u>Hospital</u> or surgical center <u>Facility</u> required for dental procedures. <u>PA Required:</u> • Yes. <u>Limitations:</u> • 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; ○ 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. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • 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.	Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay

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	<u>Covered Services:</u> - Care for accidental injury to the jaw, sound natural teeth, mouth, or face. <u>PA Required:</u> - No. <u>Limitations:</u> - Limited to <u>ER</u> services to treat accidental injury to the jaw, sound natural teeth, mouth, or face. - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Replacement, re-implantation, and follow-up care of those teeth, even if the teeth are not saved by emergency stabilization. - Subject to General <u>Excluded Services</u>.	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-share</u> instead
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	<u>Covered Services:</u> - 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 <u>Medically Necessary</u> by the Oklahoma State Board of Health, provided the <u>FDA</u> has approved such equipment and supplies. <u>PA Required:</u> - No, for monitors we provide.	20% <u>Coinsurance</u> Supplies in office or <u>Facility</u> visit: Included in <u>Specialist Copayment</u>, which is \$50 <u>Copayment</u>/visit Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay Supplies billed by a <u>Home Healthcare</u> or <u>Hospice Services</u> agency: No <u>Copayment</u>

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

Benefit	Description	You Pay
	<u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>. • Subject to <u>Prescription Drug Excluded Services</u>.	
Diabetic care – Diabetes Prevention Program	<u>Covered Services:</u> • Services for pre-diabetic <u>Members</u> (higher than normal blood sugar level, but not yet diagnosed with diabetes). • Support to learn new skills: ○ Being active; ○ Eating healthy; and ○ Losing weight. <u>PA Required:</u> • Yes. <u>Limitations:</u> • Limited to <u>Members</u> age 18 and over. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	No <u>Copayment</u>
Diabetic care – self-management training, education, and medical nutrition	<u>Covered Services:</u> • 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 <u>Referral</u> for visits to a nutritionist or dietitian. • You may pay the <u>Specialist Cost-share</u> if you have other services during the visit. <u>PA Required:</u> • No, for <u>PCP</u> or diabetic educator. • Yes, for other <u>Practitioners</u>. <u>Limitations:</u> • Subject to General limitations.	No <u>Copayment</u>

Benefit	Description	You Pay
	<u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	
<u>Diagnostic Tests</u>	<u>Covered Services:</u> • Laboratory and radiological services including, but not limited to: ○ Blood tests ○ Diagnostic mammograms ○ Diagnostic pap tests ○ Routine ultrasounds ○ Standard x-rays ○ Treadmill stress tests • We cover routine pap tests and mammograms under <u>Preventive Care</u>. We cover routine ultrasounds related to pregnancy under prenatal care. <u>PA Required:</u> • No, for routine and standard services. • Yes, for diagnostic services. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	Diagnostic mammograms: No <u>Copayment</u> Other diagnostic testing: No <u>Copayment</u>
<u>DME</u>	<u>Covered Services:</u> • Equipment and supplies your <u>Provider</u> orders for everyday or extended use. • <u>Covered Services</u> 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.	20% <u>Coinsurance</u> Equipment during office or <u>Facility</u> visit: Included in <u>Specialist Copayment</u> , which is \$50 <u>Copayment</u> /visit 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-share</u> instead Included in the <u>Outpatient Preferred Facility Copayment</u> , which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u> , which is \$800 <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u> , which is

Benefit	Description	You Pay
	<u>PA Required:</u> • Yes. <u>Limitations:</u> • Knee walker or kneeling crutch rentals limited to 4 months. • 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. <u>Excluded Services (Not Covered):</u> • 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 ○ 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>.	\$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay Equipment billed by a <u>Home Healthcare</u> or <u>Hospice Services</u> agency: No <u>Copayment</u>

Benefit	Description	You Pay
Emergency medications	<u>Covered Services:</u> - Medications prescribed during an <u>ER</u> visit. <u>PA Required:</u> - No. <u>Limitations:</u> - See the <i>Drug Formulary</i>. - Subject to General limitations. - Subject to <u>Prescription Drug</u> limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>. - Subject to <u>Prescription Drug Excluded Services</u>.	See “ <u>Prescription Drug Benefits Chart</u> ” on page 103
<u>Emergency Services</u>	<u>Covered Services:</u> - See “<u>Emergency Care</u>” 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. <u>PA Required:</u> - No. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>.	\$400 <u>Copayment</u>/visit Waived if admitted to <u>Inpatient</u> care from the <u>ER</u> department within the same <u>Hospital</u> – You pay the <u>Inpatient Cost-share</u> instead

Benefit	Description	You Pay
Eyeglasses	<u>Covered Services:</u> • Eyewear for adults and children following cataract surgery. <u>PA Required:</u> • No. <u>Limitations:</u> • 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. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>. • Subject to Vision <u>Excluded Services</u>.	See “ <u>Vision Benefits</u> ” on page 116
Foot care	<u>Covered Services:</u> • Care for injuries or conditions that affect your feet. • Routine care for <u>Members</u> with diabetes or a blood circulation disease includes: ○ Annual diabetic foot exam; ○ Nail trimming, cutting, and debridement; and ○ Hygienic and preventive foot care. <u>PA Required:</u> • No, for <u>PCP</u> visits. • Yes, for other treatment settings. <u>Limitations:</u> • Routine care is limited to <u>Members</u> with diabetes or a blood circulation disease. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	<u>PCP</u>: Included in <u>PCP Copayment</u>, which is \$25 <u>Copayment</u>/visit Included in <u>Specialist Copayment</u>, which is \$50 <u>Copayment</u>/visit
Genetic analysis, services, or testing	<u>Covered Services:</u> • 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 • <u>BRCA 1 and BRCA 2 gene testing</u>. See “<u>Breast cancer – Preventive Care</u>” on page 55. <u>PA Required:</u> • Yes. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Genetic counseling and testing for family planning. • Subject to General <u>Excluded Services</u>.	
<u>Habilitation Services</u>	<u>Covered Services:</u> • <u>Habilitation Services</u> related to an <u>ASD</u> diagnosis: ○ Physical, occupational, and speech therapies. • <u>Habilitation Services</u> related to cleft lip and cleft palate treatment: ○ Otologic, audiologic, and speech/language treatment. • Does not count toward the <u>Rehabilitation Services</u> visit limitations you may otherwise be entitled to. • See “<u>Behavioral Health Benefits</u>” on page 40. <u>PA Required:</u> • Yes. <u>Limitations:</u> • <u>ASD</u> limited to the following diagnoses:	Services in office: \$35 <u>Copayment</u>/visit Included in rehabilitation <u>Outpatient Facility</u>, which is \$70 <u>Copayment</u>/day Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay Included in <u>Home Healthcare: Copayment</u>, which is No <u>Copayment</u>

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. ● Cleft lip and cleft palate treatment limited to otologic, audiologic, and speech/language treatment. ● Subject to General limitations. <u>Excluded Services (Not Covered):</u> ● 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>.	
Hearing services – Cochlear®	<u>Covered Services:</u> ● An implantable device for bilateral, profoundly hearing-impaired <u>Members</u> that do not benefit from conventional hearing aids. ● Surgery to implant a device. <u>PA Required:</u> ● Yes. <u>Limitations:</u> ● 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. ● Subject to General limitations. <u>Excluded Services (Not Covered):</u> ● Subject to General <u>Excluded Services</u>.	Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u>

Benefit	Description	You Pay
Hearing services – evaluation for hearing aid	<u>Covered Services:</u> • 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. <u>PA Required:</u> • No. <u>Limitations:</u> • Limited to one routine hearing exam per year. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	No <u>Copayment</u>
Hearing services – hearing aids and devices	<u>Covered Services:</u> • 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: ○ 3 follow-up visits within first year of initial fitting date ○ 60-day trial period from date of fitting ○ 60 batteries per year per aid (3-year supply) ○ 3-year manufacturer repair warranty <u>PA Required:</u> • Yes. <u>Limitations:</u> • Limited to one basic hearing aid per ear every 48 months for <u>Members</u> two years of age and up, unless <u>Medically Necessary</u> to replace more often.	Entry level hearing aids: 20% <u>Coinsurance</u> 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 <u>MOOP</u> Repairs, replacement parts, adjustments, maintenance, delivery: 20% <u>Coinsurance</u> One-time coverage for lost, stolen, or damaged hearing aid: You pay the manufacturer’s <u>Deductible</u> for any warranty included with your hearing aid or for which you paid – does not count toward your <u>MOOP</u>

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. <u>Excluded Services (Not Covered):</u> - Accessories. - Additional warranties. - Subject to General <u>Excluded Services</u>.	
Hearing services – Screening	<u>Covered Services:</u> <u>Screening</u> by PCP. - Evaluation by audiologist. <u>PA Required:</u> - No. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>.	No <u>Copayment</u>
Hearing services – testing for diagnostic purposes	<u>Covered Services:</u> - Testing to diagnose medical conditions. - You must visit a GlobalHealth audiologist. <u>PA Required:</u> - Yes. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>.	Included in <u>Specialist Copayment</u> , which is \$50 <u>Copayment</u> /visit
<u>Home Healthcare</u>	<u>Covered Services:</u> - See “<u>Home Healthcare</u>” on page 73. <u>PA Required:</u> - Yes. <u>Limitations:</u> - 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
	<u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	
<u>Hospice Services</u>	<u>Covered Services:</u> • <u>Hospice Services</u> in the care plan developed by your team of <u>Providers</u> and caregivers. • Care may be in a <u>Network Hospital</u> hospice <u>Facility</u> or an in-home hospice program. • Services ○ Consultation visit ○ Skilled nursing ○ Certified home health aide, and homemaker services supervised by a qualified registered nurse ○ Bereavement services ○ Social services ○ Medical direction ○ Physical, occupational, and speech pathology services for purposes of symptom control, or to enable you to continue activities of daily living and basic functional skills ○ Drugs ▪ Pharmaceuticals billed by the hospice agency ○ Supplies and equipment ○ Medical equipment and supplies billed by the hospice agency for the palliation and management of the terminal illness and related conditions <u>PA Required:</u> • Yes. <u>Limitations:</u> • See the <i>Drug Formulary</i> for drugs not billed by the hospice agency. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	Consultation visit: No <u>Copayment</u> Services, drugs, supplies, and equipment billed by a hospice agency: No <u>Copayment</u> Equipment billed separately: 20% <u>Coinsurance</u>
<u>Immunizations</u>	<u>Covered Services:</u>	No <u>Copayment</u>

Benefit	Description	You Pay
	- See “<u>Preventive Care Benefits</u>” on page 109. <u>PA Required:</u> - No. <u>Limitations:</u> - Limited to <u>CDC</u>-recommended schedules. - Subject to General limitations. - Subject to <u>Preventive Care</u> limitations. <u>Excluded Services (Not Covered):</u> - Unless also a <u>Preventive Service</u>, shots you must have for: - Employment; - The military; - Travel; or - A vocational school or institute of higher education. - Subject to General <u>Excluded Services</u>. - Subject to <u>Preventive Care Excluded Services</u>.	
<u>Infertility services</u>	<u>Covered Services:</u> - Testing and diagnosis. - Medications. - Treatment for men and women. <u>PA Required:</u> - No, for <u>PCP</u> visits. - No, for standard fertility preservation services - Yes, for all other treatment settings. - See the <i>Drug Formulary</i> for drugs. <u>Limitations:</u> - 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.	Lab and <u>Diagnostic Tests</u>: No <u>Copayment</u> <u>PCP</u>: Included in <u>PCP Copayment</u>, which is \$25 <u>Copayment</u>/visit Included in <u>Specialist Copayment</u>, which is \$50 <u>Copayment</u>/visit Other treatment: 50% <u>Coinsurance</u> See “<u>Prescription Drug Benefits Chart</u>” on page 103.

Benefit	Description	You Pay
	<u>Excluded Services (Not Covered):</u> • Cost of donor sperm or donor egg. • Genetic counseling and genetic <u>Screening</u>. • 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 <u>Excluded Services</u>.	
Injectable drugs	• <u>Covered Services:</u> • <u>Outpatient</u> injectable drugs ○ Drugs your doctor gives you in the office. • Self-injectable drugs ○ Drugs you inject that you buy at a pharmacy. <u>PA Required:</u> • No, for <u>PCP</u> visits. • Yes, for all other treatment settings. • See the <i>Drug Formulary</i> for self-injectable drugs. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	<u>PCP</u>: Included in <u>PCP Copayment</u>, which is \$25 <u>Copayment</u>/visit Included in <u>Specialist Copayment</u>, which is \$50 <u>Copayment</u>/visit See “<u>Prescription Drug Benefits Chart</u>” on page 103.
<u>Inpatient Hospital Facility</u>	<u>Covered Services:</u> • Care in a <u>Hospital</u> 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 Copayment</u> waived – You pay the <u>Inpatient Copayment</u> instead

Benefit	Description	You Pay
	○ 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 <u>Facilities</u>; ○ Use of intensive care unit and services; and ○ X-ray services, laboratory, and other <u>Diagnostic Tests</u>. ● <u>Rehabilitation Services</u> when we expect you will have significant improvement within two months. <u>PA Required:</u> ● Yes. <u>Limitations:</u> ● <u>Hospital</u> private room limited to isolation to prevent contagion per the <u>Hospital's</u> infection control policy. ● Subject to General limitations. <u>Excluded Services (Not Covered):</u> ● Subject to General <u>Excluded Services</u>.	
Laboratory services	<u>Covered Services:</u> ● Diagnostic and therapeutic laboratory services including: ○ Blood tests; ○ Tumor markers; and ○ Urine tests. <u>PA Required:</u> ● No. <u>Limitations:</u> ● Subject to General limitations. <u>Excluded Services (Not Covered):</u> ● Subject to General <u>Excluded Services</u>.	No <u>Copayment</u>
Mammogram - diagnostic	<u>Covered Services:</u> ● <u>Testing:</u>	No <u>Copayment</u>

Benefit	Description	You Pay
	○ Breast magnetic resonance imaging (MRI) ○ Breast tomosynthesis ○ Breast ultrasound ○ Diagnostic mammogram <u>PA Required:</u> • Yes. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	
Mammogram - Screening	<u>Covered Services:</u> • <u>Screening:</u> ○ 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 mammograms ○ 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 cancer ○ 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,	No <u>Copayment</u>

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

Benefit	Description	You Pay
	<u>Limitations:</u> - 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. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>	
Maternity and newborn care – delivery and <u>Inpatient</u> services for mother	<u>Covered Services:</u> - At least 48 hours of <u>Inpatient</u> care at a <u>Hospital</u>, or a birthing center licensed as a <u>Hospital</u>, following a vaginal delivery. - At least 96 hours of <u>Inpatient</u> care at a <u>Hospital</u> following a delivery by caesarean section. - The 48/96 hour period begins at the time of delivery. If you deliver outside the <u>Hospital</u> 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; <u>Inpatient Hospital Services</u>; - 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 <u>PA</u>. <u>PA Required:</u> - No, for these services. - Yes, for other non-emergency admissions or admissions beyond the 48/96 hour routine care. <u>Limitations:</u> - Limited to costs resulting from normal, full-term delivery outside of	\$500 <u>Copayment</u>/stay

Benefit	Description	You Pay
	our <u>Network</u>. “Normal, full-term delivery” is defined as a delivery (vaginal or caesarean) within 30 days of your due date. See “<u>Emergency Care</u>” on page 27 for exceptions. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Alternative programs for delivery such as home delivery and use of midwives and birthing centers. • Subject to General <u>Excluded Services</u>.	
Maternity and newborn care – lactation support services	<u>Covered Services:</u> • Lactation support, education, and counseling 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. <u>PA Required:</u> • Yes. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	No <u>Copayment</u>
Maternity and newborn care – newborn services	<u>Covered Services:</u> • <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 48/96 hour approved mother’s stay require separate <u>Inpatient Hospital Cost-share</u>.	<u>Inpatient</u> services during mother’s 48/96 hour stay: Included in the mother’s delivery and <u>Inpatient</u> services <u>Copayment</u>, which is \$500 <u>Copayment/stay</u> <u>Inpatient</u> services after mother’s 48/96 hour stay: Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>,

Benefit	Description	You Pay
	• <u>Medically Necessary</u> services for up to the first 31 days of life. However, if you do not enroll your newborn in a <u>GlobalHealth Plan</u>, coverage will 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 You’re Covered by More Than One Plan</u>” 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 “<u>Well Visit Checklists</u>” on page 155. <u>PA Required:</u> • 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. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay Pediatrician office visits: No <u>Copayment</u>
Maternity and newborn care – postpartum visits	<u>Covered Services:</u> • Up to six weeks of postpartum care. We recommend at least one visit between the 3rd and 6th weeks. • If childbirth occurs at home or in a birthing center licensed as a birthing center, we cover: ○ Postpartum home care following a vaginal delivery; and ○ One home visit within 48 hours of childbirth by a <u>Provider</u> whose scope of practice includes providing postpartum care.	No <u>Copayment</u>

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

Benefit	Description	You Pay
	<u>Excluded Services (Not Covered):</u> • Home uterine monitoring. • Subject to General <u>Excluded Services</u>.	\$400 <u>Copayment</u> /day, up to \$2,000 <u>Copayment</u> /stay
Medical supplies and materials	<u>Covered Services:</u> • <u>OTC</u> items: ○ Diabetic supplies; ○ Disposable supplies needed for <u>DME</u>; and ○ Ostomy supplies. • The office visit, <u>Facility</u>, or agency <u>Cost-share</u> includes medical supplies and materials used in the course of a visit or admission such as: ○ Bandages ○ Gauze ○ Ointments ○ Slings <u>PA Required:</u> • See the <i>Drug Formulary</i>. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	<u>DME</u> and ostomy supplies: 20% <u>Coinsurance</u> Diabetic supplies: 20% <u>Coinsurance</u> Supplies during office or <u>Facility</u> visit: <u>PCP</u>: Included in <u>PCP Copayment</u>, which is \$25 <u>Copayment</u>/visit Included in <u>Specialist Copayment</u>, which is \$50 <u>Copayment</u>/visit 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-share</u> instead Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay Included in <u>Home Healthcare</u> or <u>Hospice Services Copayment</u>, which is No <u>Copayment</u>
Mental/behavioral health services	<u>Covered Services:</u> • <u>Inpatient</u> and <u>Outpatient</u> services. • Telehealth services. <u>PA Required:</u> • No, for behavioral health therapy office, telehealth services, or <u>ER</u> visits. • Yes, for other treatment settings.	See “ <u>Behavioral Health Benefits Chart</u> ” on page 41

Benefit	Description	You Pay
	<u>Limitations:</u> • Subject to General limitations. • Subject to Behavioral health services limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>. • Subject to Behavioral health services <u>Excluded Services</u>.	
Nurse line	<u>Covered Services:</u> • 24/7 access to nurse advice through CareNet at 1-800-554-9371 (TTY: 711). <u>PA Required:</u> • No. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	No <u>Copayment</u>
Obesity Screening and weight loss counseling and treatment	<u>Covered Services:</u> • <u>Screening</u> and counseling for all <u>Members</u>. See “<u>Preventive Care Benefits</u>” on page 109. • Adult benefits for weight management treatment for <u>Members</u> with BMI of 30 kg/m² or higher: ○ 12 – 26 nutritional counseling sessions in the first year; ○ Group and/or individual sessions to help <u>Members</u>; ▪ Make healthy eating choices; ▪ Address barriers to change; ▪ Monitor behavior; and ▪ Maintain physical activity. • Child benefits for age 6 and older with BMI in the 95th percentile or higher: ○ Sessions targeting both the parent and child (separately, together, or both) ○ Family and/or group sessions to help <u>Members</u> learn safe and effective ways to lose weight	No <u>Copayment</u>

Benefit	Description	You Pay
	- Services are from your <u>PCP</u>, a <u>Network</u> dietitian or nutritionist, a <u>Network</u> physical therapist, or <u>BHP</u>. <u>PA Required:</u> - No, for <u>PCP</u> or <u>BHP</u> services. - Yes, for other treatment settings. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Commercial weight loss programs or <u>OTC</u> weight loss products. - Subject to General <u>Excluded Services</u>.	
<u>Oral surgery</u>	<u>Covered Services:</u> - Surgery within or next to the oral cavity for medical purposes only. - Oral and maxillofacial surgery for: - Biopsy and excision of cysts or tumors of the jaw; - Treatment of cancer; - Tooth extraction prior to a major organ transplant; and - Radiation of the head or neck, and non-dental surgical treatment for birth defects. - Orthognathic surgery when: - The bite alignment affects your physical health, not just dental health, such as problems with: - Swallowing; - Speaking; or - Chewing. - You had trauma to the mouth that affects function. - Other forms of treatment have not worked. <u>PA Required:</u> - Yes. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u>	Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay

Benefit	Description	You Pay
Orthotic devices	• Subject to General <u>Excluded Services</u>. <u>Covered Services:</u> • Boots or other devices related to injury. • Shoes, shoe inserts, arch supports, supportive devices, braces, splints, and trusses. • Replacements, repairs, and adjustments. <u>PA Required:</u> • Yes. <u>Limitations:</u> • Footwear limited to: ○ Orthopedic or corrective shoes permanently attached to a Denis Browne splint for children. ○ Shoes, shoe inserts, arch supports, and supportive devices for <u>Members</u> diagnosed with diabetes or a blood circulation disease. • Other orthotic devices limited to: ○ Braces for the leg, arm, neck, 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. <u>Excluded Services (Not Covered):</u> • 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>.	20% <u>Coinsurance</u> Devices during your office or <u>Facility</u> visit: Included in <u>Specialist Copayment</u>, which is \$50 <u>Copayment</u>/visit 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-share</u> instead Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay

Benefit	Description	You Pay
<u>Outpatient services</u>	<u>Covered Services:</u> - Care including diagnostic, treatment, and x-ray services. You must not be bedridden. - Services may be given in a doctor's office, non-hospital based <u>Facility</u>, or a <u>Hospital</u>. <u>Rehabilitation Services</u> when we expect you will have significant improvement within two months. <u>PA Required:</u> - Yes. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>.	Lab, x-ray, and <u>Diagnostic Tests</u>: No <u>Copayment</u> <u>Imaging Facility</u> – <u>Preferred Facility</u>: \$250 <u>Copayment</u> <u>Imaging Facility</u> – <u>Non-preferred Facility</u>: \$750 <u>Copayment</u> Included in <u>Specialist Copayment</u>, which is \$50 <u>Copayment</u>/visit 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-share</u> instead Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u> <u>Rehabilitation Services</u> in office: \$35 <u>Copayment</u>/visit <u>Rehabilitation Outpatient Facility</u>: \$70 <u>Copayment</u>/day Wound therapy: \$50 <u>Copayment</u>/visit
<u>Outpatient surgery</u>	<u>Covered Services:</u> - Surgery performed in an <u>Outpatient Facility</u> instead of during an <u>Inpatient</u> stay when appropriate. <u>PA Required:</u> - Yes. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>.	Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u>

Benefit	Description	You Pay
Phenylketonuria (PKU) testing	<u>Covered Services:</u> - Newborn testing. See “<u>Preventive Care Benefits</u>” on page 109. <u>PA Required:</u> - No. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>.	No <u>Copayment</u>
Physical therapy	<u>Covered Services:</u> - Evaluation by a licensed physical therapist. - The physical therapist may send a <u>Referral</u> for up to 30 days of treatment. Services beyond the 30 days require a doctor’s <u>Referral</u> and another authorization. - All rehabilitation visits count toward the total combined physical, occupational, and speech therapy <u>Outpatient</u> visit limits for <u>Rehabilitation Services</u>. Services for 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. <u>PA Required:</u> - No, for the evaluation only. - Yes, for therapy sessions. <u>Limitations:</u> <u>Rehabilitation Services</u> limited to 60 combined <u>Outpatient</u> visits per year for: - Physical therapy; - Occupational therapy; and/or - Speech therapy. <u>ASD</u> treatment – Limited to the following diagnoses:	Office visits: \$35 <u>Copayment</u>/visit Included in rehabilitation <u>Outpatient Facility</u>, which is \$70 <u>Copayment</u>/day Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay Included in <u>Home Healthcare Copayment</u>, which is No <u>Copayment</u>

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. <u>Excluded Services (Not Covered):</u> ● 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 <u>Excluded Services</u>.	
<u>Physician Services</u>	<u>Covered 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 professionals provide are: ○ Allopathic; ○ Chiropractic; ○ Optometric; ○ Osteopathic; ○ Podiatric; ○ Psychological; and ○ Second surgical opinion. ● Locations: ○ <u>ER</u>; ○ Home; ○ <u>Inpatient</u>; ○ <u>Outpatient</u>; and ○ <u>Skilled Nursing Facility</u>. ● Telemedicine if your <u>Provider</u> offers the service and has contracted with us to provide it.	<u>PCP</u>: Included in <u>PCP Copayment</u>, which is \$25 <u>Copayment</u>/visit Chiropractor: \$25 <u>Copayment</u>/visit Optometrist: \$50 <u>Copayment</u>/visit Podiatrist: \$50 <u>Copayment</u>/visit Behavioral health: See “<u>Behavioral Health Benefits Chart</u>” on page 41. Other <u>Specialist</u>: \$50 <u>Copayment</u>/visit Included in <u>Urgent Care Copayment</u>, which is \$25 <u>Copayment</u>/visit <u>Home Healthcare</u> and <u>Hospice Services</u>: No <u>Copayment</u> 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

Benefit	Description	You Pay
	<u>PA Required:</u> - No, to see doctors in a <u>PCP</u>, <u>Urgent Care</u>, self-referral, or <u>ER</u> visit setting. - Yes, for other treatment settings. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>.	<u>Hospital</u> – You pay the <u>Inpatient Cost-share</u> instead Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment/day</u>, up to \$2,000 <u>Copayment/stay</u> Included in <u>Skilled Nursing Facility Copayment</u>, which is \$750 <u>Copayment/stay</u>
<u>Prescription Drugs</u>	<u>Covered Services:</u> - Drugs and products with a written prescription. <u>PA Required:</u> - See the <i>Drug Formulary</i>. <u>Limitations:</u> - See the <i>Drug Formulary</i>. - Subject to General limitations. - Subject to <u>Prescription Drug</u> limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>. - Subject to <u>Prescription Drug Excluded Services</u>.	See “<u>Prescription Drug Benefits Chart</u>” on page 103
<u>Preventive Care</u>	<u>Covered Services:</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. <u>PA Required:</u> - No, for most services your <u>PCP</u> or <u>OB/GYN</u> performs in his or her office.	No <u>Copayment</u>

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

Benefit	Description	You Pay
	○ Due to a significant change in your physical condition. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Bionic and myoelectric prosthetics. • Clothing or devices available <u>OTC</u>. • Subject to General <u>Excluded Services</u>.	Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay
Pulmonary rehabilitation – Outpatient	<u>Covered Services:</u> • Counseling; • Education; and • Exercise. • Covered conditions: ○ <u>COPD</u>. <u>PA Required:</u> • Yes. <u>Limitations:</u> • Limited to 36 visits per event. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	\$20 <u>Copayment</u>/visit
Rehabilitation Facility	<u>Covered Services:</u> • Care in a <u>Facility</u> that specializes in physical, speech, and/or occupational therapy. The rehabilitation <u>Outpatient</u> visits count toward the total <u>Outpatient</u> visit limitations for <u>Rehabilitation Services</u>. <u>PA Required:</u> • Yes. <u>Limitations:</u> • 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. <u>Excluded Services (Not Covered):</u>	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

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 Services</u>	<u>Covered Services:</u> • Services and devices provided by a registered physical, speech/language, or occupational therapist for the treatment of an illness or injury. <u>PA Required:</u> • Yes. <u>Limitations:</u> • 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. <u>Excluded Services (Not Covered):</u> • 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>.	Services in office: \$35 <u>Copayment</u>/visit Rehabilitation <u>Outpatient Facility</u>: \$70 <u>Copayment</u>/visit Rehabilitation <u>Inpatient Facility</u>: \$300 <u>Copayment</u>/day up to a maximum of \$900 <u>Copayment</u> Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay Included in <u>Home Healthcare Copayment</u>, which is No <u>Copayment</u>
Routine exam – adult	<u>Covered Services:</u> • 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	No <u>Copayment</u>

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

Benefit	Description	You Pay
	<u>PA Required:</u> • Yes. <u>Limitations:</u> • Limited to 100 days per year. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	
<u>Special Programs</u>	<u>Covered Services:</u> • Education services, outreach programs, and quality programs. See “<u>Special Programs</u>” on page 149. <u>PA Required:</u> • No. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	No <u>Copayment</u>
Specialized scans, imaging, and diagnostic exams	<u>Covered Services:</u> • Including, but not limited to: ○ CT scans ○ MRIs ○ Nuclear scans and stress tests with nuclear injections ○ PET scans ○ Sleep studies ○ SPECT scans • Your <u>Cost-share</u> includes interpretation. <u>PA Required:</u> • Yes. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	<u>Imaging Facility – Preferred Facility:</u> \$250 <u>Copayment</u> <u>Imaging Facility – Non-preferred Facility:</u> \$750 <u>Copayment</u> Included in <u>Specialist Copayment</u>, which is \$50 <u>Copayment</u>/visit 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-share</u> instead Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u>

Benefit	Description	You Pay
		Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay Sleep studies at home: No <u>Copayment</u>
Speech services	<u>Covered Services</u>: • <u>Screening</u> by <u>PCP</u>. • Evaluation and testing. • Speech/language therapy. • All rehabilitation visits count toward the total combined physical, occupational, and speech therapy <u>Outpatient</u> visit limits for <u>Rehabilitation Services</u>. <u>PA Required</u>: • No, for <u>PCP</u>. • Yes, for all other treatment settings. <u>Limitations</u>: • <u>Rehabilitation Services</u> limited to 60 combined <u>Outpatient</u> visits per year for: ○ Physical therapy; ○ Occupational therapy; and/or ○ Speech therapy. • Services for habilitative purposes do not count toward limitation. • <u>ASD</u> 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.	<u>PCP</u>: Included in <u>PCP Copayment</u>, which is \$25 <u>Copayment</u>/visit Included in <u>Specialist Copayment</u>, which is \$50 <u>Copayment</u>/visit Therapy in rehabilitation office: \$35 <u>Copayment</u>/visit Included in rehabilitation <u>Outpatient Facility</u>, which is \$70 <u>Copayment</u>/visit Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay Included in <u>Home Healthcare Copayment</u>, which is No <u>Copayment</u>

Benefit	Description	You Pay
	<u>Excluded Services (Not Covered):</u> • 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 <u>Excluded Services</u>.	
Substance use disorder – medical services	<u>Covered Services:</u> • Medical complications including, but not limited to: ○ Cirrhosis of the liver ○ Delirium tremens ○ Detoxification ○ Electrolyte imbalances ○ Hepatitis ○ Malnutrition • See “<u>Behavioral Health Benefits</u>” on page 40. <u>PA Required:</u> • Yes. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	Lab and <u>Diagnostic Tests</u>: No <u>Copayment</u> <u>PCP</u>: Included in <u>PCP Copayment</u>, which is \$25 <u>Copayment</u>/visit Included in <u>Specialist Copayment</u>, which is \$50 <u>Copayment</u>/visit 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-share</u> instead Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay
Temporo-mandibular joint dysfunction	<u>Covered Services:</u> • Medical professional and <u>Hospital Services</u>. <u>PA Required:</u> • No, for x-rays and laboratory services, <u>PCP</u> or chiropractic visits. • Yes, for other services. <u>Limitations:</u> • Non-surgical treatment limited to a lifetime maximum of \$1,500: ○ Professional services, physical therapy, chiropractor, physician; ○ X-rays, laboratory services; and	\$100 <u>Copayment</u>/treatment plan

Benefit	Description	You Pay
	○ <u>DME</u> appliances, orthotic devices. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Dental care. • Subject to General <u>Excluded Services</u>.	
Transplants	<u>Covered Services:</u> • Organ, tissue, bone marrow, and stem cell transplants. They must not be <u>Experimental or Investigational</u> in nature. • Office visits, lab work, tests, and <u>Inpatient Hospital Facility</u> expenses related to a transplant for the living donor and recipient. ○ When only the recipient is a GlobalHealth <u>Member</u>, donor benefits are limited to those not provided or available to the donor from any other source. <u>PA Required:</u> • No, for lab work. • Yes, for other services. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Artificial or non-human organ transplants. • Subject to General <u>Excluded Services</u>.	Lab, x-ray, and <u>Diagnostic Tests</u>: No <u>Copayment</u>/visit Preferred imaging <u>Facility</u>: \$250 <u>Copayment</u> Non-preferred imaging: \$750 <u>Copayment</u> Included in <u>Specialist Copayment</u>, which is \$50 <u>Copayment</u>/visit Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay
Treatment therapies	<u>Covered Services:</u> • Your <u>Cost-share</u> covers services and supplies. • Chemotherapy drugs and administration • Dialysis services and supplies • Growth Hormone Therapy (GHT) drugs and administration • Hyperbaric oxygen therapy. • Infusion therapy drugs and administration in: ○ The home; ○ A free-standing clinic or doctor's office;	Dialysis, radiation, or chemotherapy treatment: Office or <u>Preferred Facility</u>: \$30 <u>Copayment</u>/treatment <u>Non-preferred Facility</u>: \$50 <u>Copayment</u>/treatment Other services: Included in <u>RTC Copayment</u> or <u>Inpatient Hospital Facility Copayment</u>, which is \$400 <u>Copayment</u>/day, up to \$2,000 <u>Copayment</u>/stay

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

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

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

Prescription Drug Benefits

Covered Services

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

We also cover some OTC drugs and products. See Patient Protection and Affordable Care Act (ACA) on page 106.

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

- Determine your financial responsibility for a drug, based on your pharmacy benefit.
- Find the location and contact information of a Network 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 FDA-approved.
- Quantity limits, prior authorization criteria, and step therapies may apply. See your *Drug Formulary* for any restrictions.
- A Network Provider must write the prescription. We cover prescriptions by Out-of-network Providers in these situations:
 - ER or Urgent Care Providers; and
 - 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 Cost-share 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 PA form. The PA form must include documentation explaining why the generic equivalent cannot be used.

- If the PA request is approved, you will pay the Cost-share of the Tier that the brand name drug is in.
- If the PA request is not approved and you choose to fill a brand name drug when a generic equivalent is available, your Cost-share will be:
- The Cost-share of the Tier the brand name drug is in; **plus**
- 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
<u>ACA – Tier Zero</u>	• <u>Preventive Care Prescription Drugs</u> and <u>OTC</u> drugs with a prescription (Noted in the <i>Drug Formulary</i> with (<u>HCR</u>). • Each drug has rules for when it is prescribed for <u>Preventive Care</u>. You pay the <u>Tier Cost-share</u> shown in the <i>Drug Formulary</i> if you do not meet the criteria for <u>Preventive Care</u> coverage. See “<u>ACA</u>” on page 106. • The list is subject to change as <u>ACA</u> guidelines are updated or modified.	• No <u>Copayment</u>	• No <u>Copayment</u>
<u>Tier One</u>	• 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 Two</u>	• This <u>Tier</u> has preferred brand name drugs on the <u>Formulary</u>.	• \$65 <u>Copayment</u>/prescription fill or refill • Diabetic insulin: Maximum of \$30 <u>Copayment</u>/prescription fill or refill	• \$130 <u>Copayment</u>/prescription fill or refill • Diabetic insulin: Maximum of \$90 <u>Copayment</u>/prescription fill or refill
<u>Tier Three</u>	• This <u>Tier</u> includes non-preferred brand name and high-cost generic drugs.	• \$90 <u>Copayment</u>/prescription fill or refill	• \$180 <u>Copayment</u>/prescription fill or refill

<u>Tier</u>	Description	You Pay 30-day Supply	You Pay 90-day Supply
	If we allow coverage of non-formulary drugs, you will pay the <u>Cost-share</u> for this <u>Tier</u>. See “<u>Exception Requests</u>” on page 35.	Diabetic insulin: Maximum of \$30 <u>Copayment</u>/prescription fill or refill	Diabetic insulin: Maximum of \$90 <u>Copayment</u>/prescription fill or refill
<u>Tier Four</u>	- This <u>Tier</u> has three <u>Cost Sharing</u> levels: - Preferred <u>Specialty Drugs</u> (Noted in the <i>Drug Formulary</i> with “<u>PS</u>”). - Non-preferred <u>Specialty Drugs</u> (Noted in the <i>Drug Formulary</i> with “<u>NPS</u>”). - Chemotherapy drugs in the <i>Drug Formulary</i> have a maximum <u>Copayment</u> of \$100.	- Preferred: \$200 <u>Copayment</u>/prescription fill or refill - Non-preferred: \$400 <u>Copayment</u>/prescription fill or refill - Chemotherapy drugs: Maximum of \$100 <u>Copayment</u>/prescription fill or refill	Limited to a one-month supply per fill.

Prescription Drug Limitations:

- 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 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 FDA-approved tobacco cessation products per year, if prescribed by your PCP.
 - Members who are at least 18 years old.
- Drugs prescribed or given to you by Out-of-network doctors in non-emergencies limited to those prescribed by dentists.
- Non-prescription contraceptive jellies, ointments, foams, or devices limited to those that are FDA-approved and prescribed by a Network doctor for a woman.
- Prescription Drugs for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasm, hyporgasm, 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
 - Foods
 - Formulas
 - Medications for irrigation
 - Non-preventive care drugs
 - Saline
- Drugs prescribed for a non-FDA approved indication, dosage, or length of therapy.
- Compounded drugs
- Also see “General Excluded Services” on page 123.

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 UM needed for each drug.

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

- Strength (for example, 10 mg versus 100 mg); 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 UM rules at least once each year. The list of drugs and UM rules are updated as appropriate.

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

Committee members include:

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

Drug Tiers:

The *Drug Formulary* will tell you which Tier a drug is in and the UM rules that apply. The Cost-share and description for each Tier remains the same for the entire year. During the year, individual drugs may move between Tiers. If your Cost-share will go up, you will pay the new Tier Cost-share 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 Prescription Drug Cost-share for anticancer drugs you take by mouth is no greater than for drugs you take by IV or injection.

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

Changes:

The list of drugs can change during the year.

- The FDA may release new brand name drugs or generic drugs.
- We will only stop or lower coverage for a drug when the FDA releases:
 - A new or lower cost drug that has the same purpose and effect; or
 - Information that the drug is not safe or does not work.
- If we make changes to a drug that you take, we will tell you at least 60 days before the changes take effect. Changes may be:
 - Removing a drug from our Formulary;
 - Adding new rules to getting a drug; or
 - Moving a drug to a higher Tier.
- If the FDA decides a drug on our Formulary is unsafe or the drug's manufacturer removes the drug from the market, we will remove the drug from our Formulary right away and tell you within 30 days.

Exclusions:

We don't cover some Prescription Drugs 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 Cost Sharing. This happens when there are multiple FDA-approved items that are for the same purpose. See the *Drug Formulary* for a list of drugs covered with and without Cost Sharing. Those without Cost Sharing are noted with "HCR" in Tier "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 Provider, are an integral part of the preventive screening colonoscopy.

Contraception Drugs and Devices for Women:

We cover at least one FDA-approved item or product in every contraceptive method. This means women can get the pill, the shot, the ring, contraceptive implants, diaphragms, cervical caps, and permanent

contraceptive methods like tubal ligation. We cover some of these methods under your medical benefits. See “[Contraception services](#)” on page 59.

- Products from a pharmacy require a written prescription from your doctor, even if it is available [OTC](#). See your *Drug Formulary* for any rules for getting the item.
- If the [FDA](#) has approved multiple services and items within a method, we will decide which items to cover without [Cost Sharing](#). However, if your doctor recommends a particular service or [FDA](#)-approved item for you, we will cover it without [Cost Sharing](#). We defer to your doctor. See “[Exception Requests](#)” on page 35 to get coverage.

If you have concerns about GlobalHealth’s compliance with federal coverage requirements, you may contact CMS at contraception_complaints@cms.hhs.gov or by calling toll free at 1-888-393-2789.

OTC:

We cover some [FDA](#)-approved [OTC](#) drugs and products at no cost. Not all products of each type are included.

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

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 “[Preventive Care Benefits Chart](#)” on page 109 at no cost. Shots required for work, school, or travel are not covered unless also a [Preventive Care](#) immunization. Check with your [PCP](#) first.

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

Off-label Uses

“Off-label use” is any use of the drug other than those on a drug’s label as approved by the FDA. To be covered, the drug must be for the FDA-approved:

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

Also, the drug must be prescribed within FDA safety guidelines:

- Standards for safety and effectiveness in clinical studies; and
- Warnings, precautions, and potential drug interactions.

Generally, we do not cover off-label use. There 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 ER or Urgent Care doctors at any Network pharmacy. You will pay your Prescription Drug Cost-share. UM rules may apply. Your regular doctor should prescribe refills, if needed.

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 Prescription Drugs within medication-assisted treatment programs. See page 45. Also see “Substance Use Disorder” 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 “Telehealth” 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 Preventive Care product.

Drug Disposal:

Be sure to dispose of drugs in a safe manner.

- Follow the instructions on the Prescription Drug labeling or patient information that comes with the drug. Do not flush drugs down the sink or toilet unless the instructions tell you to do so.
- Use programs that let you take unused drugs to a central location for proper disposal. Call your local law enforcement agencies to see if they sponsor drug take-back programs. Contact your local household trash and recycling service to learn about drug disposal options and guidelines for your area.
- Take unused drugs to collectors registered with the Drug Enforcement Administration (DEA). Authorized sites may be retail, Hospital or clinic pharmacies, and law enforcement locations. Some offer mail-back programs or collection drop-boxes. Visit the DEA's website at www.deadiversion.usdoj.gov 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 DEA to provide a safe, convenient, and responsible means of disposing Prescription Drugs. For more information visit their website at www.deadiversion.usdoj.gov.

Preventive Care Benefits

Covered Services

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

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

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

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

Also see “Coverage Requirements” on page 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>

Population	Benefits Description	You pay
	• 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 “<u>Colorectal cancer prevention Screening</u>” on page 58; • 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 <u>Screening</u> for adults age 18 to 79 years; • HIV <u>Screening</u> (testing) for all adults to age 65 or older adults at higher risk; • Immunization vaccines for adults – doses, recommended ages, and recommended populations vary. This list is representative and may not be all-inclusive. See the <u>CDC</u> website – Vaccines & Immunizations Vaccines & Immunizations CDC. See “<u>ACA</u>” on page 106. ○ COVID-19 ○ Hepatitis A ○ Hepatitis B ○ Human Papillomavirus (HPV) ○ Influenza (Flu Shot) ○ Measles, Mumps, Rubella (MMR) ○ Meningococcal (Meningitis) ○ Pneumococcal (Pneumonia) ○ Tetanus, Diphtheria, Pertussis (TDaP) ○ Varicella (Chicken Pox) ○ Zostavax (Shingles) • Obesity <u>Screening</u> for all adults with intensive behavioral interventions for adults who screen positive. See “<u>Obesity 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,	

Population	Benefits Description	You pay
	and mental health counseling, ongoing follow-up, and monitoring, etc.). See “ACA” 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 CVD for adults age 40 – 75 at higher risk. See “ACA” on page 106; • Syphilis Screening for asymptomatic, non-pregnant adults at higher risk; • Tobacco use Screening for all adults and Prescription Drug and behavioral interventions for tobacco users. See “Tobacco Cessation” on page 152; and • Tuberculosis infection Screening for all adults at higher risk.	
Women’s benefits	You do not need PA. See “Maternity and newborn care” on page 79 for services related to pregnancy and postpartum. • Anxiety Screening; • Aspirin as preventive medication after 12 weeks of gestation in women who are at high risk for pre-eclampsia. See “ACA” on page 106; • Bacteriuria Screening in pregnant persons; • Breast cancer Screenings every 1 – 2 years for women over age 40, including mammography and additional imaging to complete the screening process (e.g., MRI, ultrasound, and additional mammography). See “Mammogram” on page 78; • Cervical cancer Screening every 3 years for women aged 21-29 years and every 3-5 years for women aged 30-65 years; • Chlamydia infection Screening for women age 24 years or younger and women age 25 or older at higher risk; • Contraception: FDA-approved contraceptive methods and patient education and counseling, not including abortifacient drugs. See “Contraception services” on page 59; • Depression Screening for pregnant and postpartum women; • Diabetes Screening for women after 24 weeks of gestation or after, and Screening for those at high risk of developing gestational diabetes before 24 weeks of gestation; • Diabetes Screening after pregnancy; • Domestic and interpersonal violence Screening for all women age 14 – 46 with intervention services for women who screen positive; • Folic acid supplements for women who may become pregnant. See “ACA” on page 106; • Gonorrhea Screening for all women at higher risk; • Healthy weight gain, behavioral counseling, and interventions to prevent excess gestational weight gain;	No Copayment

Population	Benefits Description	You pay
	• Hepatitis B <u>Screening</u> for pregnant women at their first prenatal visit; • HIV <u>Screening</u> (testing) and counseling for sexually active women and all pregnant women; • HPV DNA test every three years for women who are age 30 to 65; • Hypertensive disorders <u>Screening</u> in pregnant persons with blood pressure measurements throughout pregnancy; • Intimate partner violence <u>Screening</u> in women of reproductive age and provide or refer women who screen positive to ongoing support services; • Obesity prevention in midlife women who are age 40 to 60 years with normal to overweight BMI; • Osteoporosis <u>Screening</u> for women over age 60 depending on risk factors. See “<u>Bone Density Test</u>” on page 54; • Patient navigation services for breast and cervical cancer <u>Screening</u>. Person-to-person (e.g., in-person, virtual, or hybrid) visits include, but are not limited to: ○ Person-centered assessment and planning ○ Healthcare access and health system navigation ○ Referrals to appropriate support services (e.g., language translation, transportation, and social services) ○ Patient education • Pre-eclampsia <u>Screening</u> for pregnant women with high blood pressure measurement. • Rh incompatibility <u>Screening</u> for all pregnant women and follow-up testing for women at higher risk. • STI counseling for sexually active women; • Syphilis <u>Screening</u> for all pregnant women or other women at higher risk; • Tobacco use <u>Screening</u> and interventions for all women, and expanded counseling for pregnant tobacco users. See “<u>Tobacco Cessation</u>” on page 152; • Urinary incontinence <u>Screening</u>. • Well-woman visits to have recommended <u>Preventive Services</u> 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 <u>PCP</u> visits. ○ Routine Pap test ○ Human papillomavirus (HPV) testing ○ Counseling for sexually transmitted infections ○ Counseling/<u>Screening</u> for HIV ○ Contraceptive methods and counseling ○ Counseling/<u>Screening</u> for intimate partner and domestic violence ○ <u>Screening</u> for urinary incontinence	

Population	Benefits Description	You pay
Adult benefits that require PA	○ <u>Screening</u> for anxiety • Abdominal aortic aneurysm one-time <u>Screening</u> for men of specified ages who have ever smoked; • <u>BRCA</u> counseling about genetic testing and testing for women at higher risk. See “<u>Breast cancer – Preventive Care</u>” on page 55; • Breast cancer chemoprevention counseling for women at higher risk. See “<u>ACA</u>” on page 106; • Breastfeeding comprehensive support and counseling from trained <u>Providers</u>, as well as access to breastfeeding supplies, for pregnant and nursing women; • Contraception surgical procedures. See “<u>Contraception services</u>” on page 59; and • Lung cancer <u>Screening</u> (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; • 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;	No <u>Copayment</u>

Population	Benefits Description	You pay
	• 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 - https://www.cdc.gov/vaccines-children/index.html. ○ COVID-19 ○ Diphtheria, Tetanus, Pertussis (DTaP) ○ Haemophilus influenzae type b (Hib) ○ Hepatitis A ○ Hepatitis B ○ Human Papillomavirus (HPV) ○ Inactivated Poliovirus (Polio) ○ Influenza (Flu Shot) ○ Measles, Mumps, Rubella (MMR) ○ Meningococcal (Meningitis) ○ Pneumococcal (Pneumonia) ○ Rotavirus (RV) ○ Varicella (Chicken Pox) • Iron supplements for children ages 6 – 12 months at risk for anemia; • Lead <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 USPSTF, HRSA, and CDC 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 PCP early in the year for your routine adult exam or your child's well-child exam. Your PCP will decide which services are right for you and perform some services at that time. You can talk about which other services you need and set up more Preventive Care visits including evidence-based cancer imaging.

Your PCP will send us any Referrals you need. There are four exceptions:

1. You have direct access to your OB/GYN for services he/she handles;
2. You have direct access to an imaging center for your mammogram;
3. You have direct access to your BHP for services he/she handles. and
4. You may get shots and Preventive Services at on-site contracted employer-sponsored health fairs.

You do not have a copayment if the primary purpose of the visit is for preventive services. You have to pay your normal Cost-share if the primary purpose of the service is for treatment rather than Preventive Care. Services are preventive when there are no prior symptoms for that condition. Services are for treatment purposes when you are having symptoms, have been diagnosed with a condition, or need more tests after a positive preventive Screening.

There are two exceptions. You may have these services at no cost even with prior symptoms:

1. You may go to your PCP for one annual 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 Preventive Service. Each service has limits on when or how often it is covered if you have average risk factors. Talk to your doctor about any risk factors that mean you need Screenings earlier or more often.

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

Follow-up Care

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

Service Type	Description
<u>Preventive Care</u> – no cost	• Pre-service consultation for services; • Listed <u>Preventive Care</u> service or procedure, including removing tissue; • Ancillary services (anesthesiology, pathology, etc.); and • Office visit or <u>Facility</u>.

Service Type	Description
Follow-up care – with regular <u>Cost Sharing</u>	• <u>Diagnostic Tests</u> for positive <u>Screening</u> result (except follow-up colonoscopy after a positive sigmoidoscopy or CT colonography); • Care for newly discovered disease; and/or • Care for existing symptoms or disease.

Vision Benefits

Covered Services

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

You may go to a Network optometrist or ophthalmologist for office visits. Go to a Network eyewear Provider for eyeglasses or contacts after cataract surgery. We cover cataract surgery under Outpatient surgery benefits and Coverage Requirements.

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

Also see “Coverage Requirements” on page 40.

Vision Benefits Chart

Benefit	Description	You Pay
Routine exam	<u>Covered Services:</u> • 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>. <u>PA Required:</u> • No. <u>Limitations:</u> • Limited to one per year. • Subject to General limitations. <u>Excluded Services (Not Covered):</u>	\$50 <u>Copayment</u> /visit

Benefit	Description	You Pay
	Subject to General <u>Excluded Services</u>.	
Diabetic eye exam	<u>Covered Services:</u> - Dilatation with <u>Diagnostic Tests</u>. - May be combined with routine exam and/or glaucoma test in one visit with one <u>Copayment</u>. <u>PA Required:</u> - No. <u>Limitations:</u> - Limited to one per year. - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>.	\$50 <u>Copayment</u> /visit
Glaucoma test	<u>Covered Services:</u> - Exams for <u>Members</u> at high risk may include: - Angle in the eye where the iris meets the cornea; - 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 <u>Copayment</u>. <u>PA Required:</u> - No. <u>Limitations:</u> - Limited to one per year. - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Subject to General <u>Excluded Services</u>.	\$50 <u>Copayment</u> /visit
Supplemental diagnostic testing and treatment	<u>Covered Services:</u> - Tests as follow-up to eye exams. - Treatment for diseases or injury. - Cataract surgery. <u>PA Required:</u> - No, for <u>Diagnostic Tests</u>.	<u>Diagnostic Tests:</u> No <u>Copayment</u>/visit <u>Imaging Facility – Preferred Facility:</u> \$250 <u>Copayment</u> <u>Imaging Facility – Non-preferred Facility:</u> \$750 <u>Copayment</u>

Benefit	Description	You Pay
	• Yes, for other services. <u>Limitations:</u> • Treatment for orthoptics or visual training limited to a diagnosis of mild strabismus. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Computer programs of any type, including, but not limited to, those to assist with vision therapy. • LASIK, INTACS, radial keratotomy, and other refractive surgery. • Special multifocal ocular implant lenses. • Subject to General <u>Excluded Services</u>.	Surgery: Included in the <u>Outpatient Preferred Facility Copayment</u>, which is \$300 <u>Copayment</u> Included in the <u>Outpatient Non-preferred Facility Copayment</u>, which is \$800 <u>Copayment</u>
Frames	<u>Covered Services:</u> • Basic non-designer frames after cataract surgery. <u>PA Required:</u> • No. <u>Limitations:</u> • Limited to first set of basic frames and lenses or contact lenses following cataract surgery. • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Subject to General <u>Excluded Services</u>.	No <u>Copayment</u>
Prescription spectacle lenses	<u>Covered Services:</u> • Single vision lenses after cataract surgery. • Standard plastic, glass, or polycarbonate lenses. <u>PA Required:</u> • No. <u>Limitations:</u> • Subject to General limitations. <u>Excluded Services (Not Covered):</u> • Lens upgrades.	No <u>Copayment</u>

Benefit	Description	You Pay
	- Non-prescription lenses. - Subject to General <u>Excluded Services</u>.	
Prescription contact lenses	<u>Covered Services:</u> - Soft lens and contact lens to treat post-cataract surgery: - One set or one annual supply of disposable lenses instead of eyeglasses. <u>PA Required:</u> - No. <u>Limitations:</u> - Subject to General limitations. <u>Excluded Services (Not Covered):</u> - Insurance for contact lenses. - Subject to General <u>Excluded Services</u>.	No <u>Copayment</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 Plan for all types of services. We cover some benefits only as follows. You pay for additional services.

Limitations

Benefit	Limitation
Bariatric surgery	Bariatric surgery is limited to lap-band surgery.
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;

Benefit	Limitation
	○ 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; ○ 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.
<u>DME</u>, orthotic devices, and prosthetic appliances	• Breast pumps limited to: ○ One per year for women who are pregnant or nursing. ○ 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: ○ 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. • <u>DME</u> rentals: ○ Knee walker or kneeling crutch rentals limited to 4 months. ○ Oxygen and oxygen equipment rentals limited to 36 months and remaining <u>Medically Necessary</u>. ○ Other <u>DME</u> rentals limited to 13 months. • Hearing aids limited to:

Benefit	Limitation
	○ One basic hearing aid per ear every 48 months unless <u>Medically Necessary</u> to replace more often. ○ 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 ○ 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 loss of hair resulting from chemotherapy or radiation therapy.
Foot care	• Routine care limited to <u>Members</u> with diabetes or a blood circulation disease.
General care or Hospital Services	• <u>Hospital</u> private room limited to isolation to prevent contagion per the <u>Hospital's</u> infection control policy.
General limitations	• Sexual dysfunction services limited to drugs and supplies for post-prostate surgery indications.
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 1</u> and <u>BRCA 2</u> 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 iatrogenic infertility
Physical, occupational, and speech therapy	• <u>Rehabilitation Services</u> 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. • <u>Habilitation Services</u> limited to: ○ <u>ASD</u> treatment – Physical, occupational, and/or speech therapy services for the following diagnoses:

Benefit	Limitation
	▪ 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 therapy.
<u>Prescription Drugs</u>	• 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 <u>Plan</u> at the first time the drug was obtained. ○ One six-month supply of a covered <u>Prescription Drug</u> during each six-month period. • Drugs prescribed or given to you by <u>Out-of-network</u> 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 <u>Preventive Care</u> guidelines and given to you at a <u>Network</u> pharmacy. • 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 anorgasm, hyporgasm, or decreased libido limited to post-prostate surgery indications. • Prescription diaphragms limited to two per year. • The Pharmacy and Therapeutics Committee’s standard quantity limits, prior authorization criteria, and step therapies apply. • Smoking cessation products limited to: ○ Two full 90-day courses of <u>FDA</u>-approved tobacco cessation products per 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.
<u>Preventive care</u>	• DEXA scans for bone density screening limited to one every 24 months. • Limited to <u>USPST</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.
<u>Pulmonary</u>	• Limited to 36 visits per event.

Benefit	Limitation
rehabilitation services	
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 Excluded Services listed below. If it is later determined that the care is excluded from your coverage, we will recover the amount we have allowed for benefits. You must give us all documents needed to enforce our rights.

Benefit	<u>Excluded Service</u>
Behavioral health services	- 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. - Wilderness therapy.
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 devices, and prosthetic appliances	- Accessories. - Additional warranties. - Bandages, pads, or diapers. - 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 - Ear plugs - Elastic stockings and supports - Garter belts

Benefit	<u>Excluded Service</u>
	• 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 ○ Grab bars ○ Physical fitness equipment ○ Raised toilet seats ○ Shower benches ○ Traction tables ○ Water purifiers • Upgrade features to enhance basic equipment.
<u>General Excluded Services</u>	• Care or services provided outside the GlobalHealth <u>Service Area</u> if the need for such care or services could have been foreseen before leaving the <u>Service 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. • 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. • <u>Screening</u> services requested solely by you, such as commercially advertised heart or lung scans.

Benefit	<u>Excluded Service</u>
	• Separate charges for missed or canceled appointments, penalty or finance charges, maintenance and/or record-keeping, record copying, or <u>Case 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 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: ○ Base jumping ○ Bungee jumping ○ 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.
Genetic analysis, services, or testing	• Genetic counseling and testing for family planning or disease identification purposes.
Immunizations	• Unless also a <u>Preventive Service</u>, shots you must have for: ○ Employment; ○ The military; ○ Travel; or ○ A vocational school or institute of higher education.
<u>Obstetrical and Infertility services</u>	• Alternative programs for delivery such as home delivery and use of midwives. • Cost of donor sperm or donor egg. • Elective abortions. • Expenses related to surrogate parenthood.

Benefit	<u>Excluded Service</u>
	• Genetic counseling and genetic <u>Screening</u>. • Home uterine monitoring. • Hysterectomies for the purpose of contraception. • Insemination procedures and all services related to insemination. ○ Gamete Intrafallopian Transfer (GIFT) ○ In Vitro Fertilization (IVF) ○ Intracervical Insemination (ICI) ○ Zygote Intrafallopian Transfer (ZIFT) • Reversal of a sterilization procedure. • Services associated with these procedures.
Physical, occupational, and speech therapy	• Acupuncture/acupressure. • Kinesiology or movement therapy. • Massage therapy. • Recreational therapy including, but not limited to: ○ Animal-facilitated therapy ○ Music therapy • Rolf technique.
<u>Prescription Drugs</u>	• Drugs prescribed for a non-<u>FDA</u> approved indication, dosage, or length of therapy. • Products available without a prescription (<u>OTC</u>). Including but not limited to: ○ Dietary supplements ○ Foods ○ Formulas ○ Medications for irrigation ○ Non-preventive care drugs ○ 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 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.
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 Service Area (Subscriber or spouse).
- You are a U.S. citizen or national or are a non-citizen who is lawfully present in the U.S. 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 Subscriber to the Plan. The spouse and children are Dependents.

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

Unless Consolidated Omnibus Budget Reconciliation Act (COBRA)-eligible, an employee's Dependents may only enroll if:

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

Spouses

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

Children

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

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

Also see Aging-off terminations under "Coverage Terminations" on page 133.

Disabled Dependents

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

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

Dependents of Dependents

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

Service Area

Our Service Area includes 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.

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

Dependents Living Out-of-Area

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

Enrollment Periods

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

Open Enrollment Period

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

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

Mid-year Change

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

- You will have 30 days to enroll if you have a change in family status or coverage.
- You will have 60 days to enroll if you have a change in Medicaid or CHIP eligibility. See "Medicaid and CHIP Notice" on page 166.

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

Change in family status:

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

Dependent Type	Description
Adopted children	- We cover adopted children from the date placed in the home. - Subject to the “Excluded Services and Limitations” on page 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 Plan, including Medicaid.
Foster children	We cover foster children from the date placed in the home.
Newborns	- We cover your newborn from the date of birth. - We cover newborns for the first 31 days of life for all Medically Necessary services. If you do not add a newborn as a Dependent during the first 31 days, the newborn’s coverage ends on day 31. - We cover newborns of Dependent children for the approved mother’s (your Dependent) stay of 48/96 hours.
New Dependents as a result of marriage	If you marry, we cover new family members from the first day of the month after your marriage.
Qualified Medical Child Support Order	- We cover children to comply with a Qualified Medical Child Support Order. If an order is issued concerning your child, contact us. We have to follow certain procedures. - You must keep your child enrolled unless you are no longer eligible to be a Plan Member or you send us written evidence that: - 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 Plan. There cannot be a gap in coverage.
Death, divorce, or legal separation	- We cover new Subscribers and Dependents from the first day of the month after enrollment if they qualify through COBRA or GlobalHealth Plan. - You must enroll within 30 days after you lose coverage as a Dependent 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 “[Eligibility](#)” on page 127.
- You are enrolled in a [Plan](#) for which you don’t qualify due to [Enrollment](#) errors.
- You declined coverage in writing when you were first eligible because you had other coverage and you no longer have the other coverage due to:
 - You or your eligible family member has exhausted [COBRA](#) under another group health [Plan](#);
 - Work hours of the [Subscriber](#) end or are reduced;
 - Any other health [Plan](#) coverage ends;
 - The employer stopped paying part of your [Premium](#); or
 - Death, divorce, or legal separation of the [Subscriber](#).
- You are no longer incarcerated.

- You have exceptional circumstances such as in the case of a child of an incarcerated parent.
- You are a Dependent that becomes disabled and financially dependent on the Subscriber.
- 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 Dependents begins as of 12:01 a.m. on the effective date of your Enrollment. Your employer must certify your eligibility.

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

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

Continuity and/or Transition of Care

If we authorize you for care through an Out-of-network Provider while we are transferring your care to an In-network Provider, we will pay at least Usual and Customary amounts for your services. You pay your In-network Cost-share.

Examples of conditions that may require continuity or Transition of Care:

- Behavioral health conditions during active treatment
- Currently hospitalized
- Currently taking drugs for which we require UM review
- Currently on a transplant list
- Impending Hospitalization
- Currently pregnant and undergoing a course of treatment for the pregnancy from the Provider or Facility
- Terminal illness
- Undergoing chemotherapy or radiation therapy

The approved Out-of-network care ends when:

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

The approval applies only to the condition and the Provider shown in the approval letter for a limited time. An In-network Provider must treat all other conditions. If you need Referral services, we may authorize for In-network Providers only.

Others that may help with this process include.

- Your doctor or pharmacist.
- The parent of a child under 18 years of age.
- Your power of attorney with medical decision authority. We must have a copy of the signed power of attorney form on file.

- Your authorized representative. See “Appointment of Authorized Representative” on page 148. You will need to complete the form if you want us to share your PHI with anyone else, for example:
 - Your parent, if you are age 18 or over.
 - Your spouse.
 - Your caregiver, friend, neighbor, or other.

If we do not approve ongoing care through the Out-of-network Provider, you may Appeal the decision. See “Appeals and Grievances” on page 142.

Behavioral Health and Medical Transition of Care

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

You must be in active treatment. “Active treatment” means:

- Ongoing treatment for a serious and complex condition from the Provider or Facility;
 - 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
 - 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 Provider, including receipt of postoperative care from such Provider or Facility 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 Provider or Facility; or
- Ongoing treatment for which a treating doctor or other Provider attests that changing care to another doctor or Provider would make the condition or expected outcome worse

If approved for 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 Provider or Facility. 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 Plan across calendar years, these timeframes apply across calendar years.

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

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

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

For more information, see “Exception Requests” on page 35.

Behavioral Health and Medical Continuity of Care

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

You must be in active treatment. “Active treatment” means:

- Ongoing treatment for a serious and complex condition from the Provider or Facility;
 - 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
 - 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 Provider, including receipt of postoperative care from such Provider or Facility 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 Provider or Facility; or
- Ongoing treatment for which a treating doctor or other Provider attests that changing care to another doctor or Provider would make the condition or expected outcome worse.

If approved for continuity care, we cover care for up to 90 days 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 Plan across calendar years, these timeframes apply across calendar years.

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

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

Changes to Enrollment

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

- Social Security numbers for new Dependents;
- If you gain, lose, or make policy changes to any other group health coverage;
- Moving out of our Service Area; or
- Change in:
 - Name

- Mailing address and zip code
- Telephone number (home and work)
- PCP
- Disability status
- Medicare status
- COBRA
- Family status
- Retirement
- Death
- Divorce

You should make any change as soon as possible, but always within 30 days. See “Enrollment Periods” on page 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
- Leave of absence
- Retirement
- Temporary layoff
- Termination of employment

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

- Death of a spouse
- Divorce
- Your Dependent 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 Plan.

Coverage Terminations

A termination is when your coverage ends. Coverage ends at 12:00 midnight on the day of your termination. If a Dependent’s coverage ends, it does not affect the coverage of other family members. If the Subscriber’s coverage ends, the membership of all Dependents stops as well. See “Continuation Coverage Rights Under COBRA” on page 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.	<u>Subscriber dies</u> : - Subscriber - The date of death <u>Dependent</u>: The last day of the month of the <u>Subscriber's</u> death <u>Dependent dies</u>: 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 <u>Premium</u> 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 <u>Premium</u> was paid
<u>Fraud</u>	- We may stop your coverage if you commit <u>Fraud</u>. For example, it is Fraud if you willingly gave your <u>Member</u> ID card to another person so that person could get services. See "<u>Fraud and Abuse</u>" 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 <u>Fraud</u> to criminal authorities. - We will provide written notice at least 30 days before we end your coverage. That will allow you time to <u>Appeal</u>. - If we decide that the termination stands, we will return your <u>Premium</u> for that period, if we received any. You may ask for an <u>External Review</u>. - 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
<u>Moving from Service Area</u>	You should enroll in a <u>Plan</u> that has a <u>Network of Providers</u> in your new <u>Service Area</u>.	The last day of the month for which <u>Premium</u> was paid
<u>Non-payment of 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 <u>Premium</u> was paid
<u>Plan error</u>	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 Health Insurance company. Or you may choose continuation of coverage or COBRA if you qualify.

Continuation of Coverage

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

Continuation of coverage may not be available:

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

Conversion Privilege

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

If you would like to purchase Health Insurance through the ACA's Health Insurance Marketplace, visit HealthCare.gov. This is a website the U.S. Department of Health and Human Services provides for Marketplace 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 Hospital 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 Premiums have been paid.
- If you are confined in a Hospital on the date of insolvency, until you are discharged or your benefits end.
- If you are pregnant, through delivery and discharge.

See “Notice of Protection Provided by Oklahoma Life and Health Insurance Guaranty Association” on page 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 <u>MOOP</u>. • 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 <i>Member Handbook</i>. ◦ 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

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

There are exceptions when Out-of-network Providers *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 Network Facilities, follow the coverage rules, and receive care from an Out-of-network Provider at that Facility.

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 Claim for emergency Out-of-network services, mail the Claim 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

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

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

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 Appeal Rights within 30 days after we get the Claim. See “Appeals and Grievances” on page 142.

Prescription Drugs

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

Contact Method	Contact Information
Toll-free	1-800-424-1789
TTY	711
Mail	MedImpact - DMR 10181 Scripps Gateway Ct. San Diego, CA 92131

When You're Covered by More Than One Plan

You must tell us if you have other healthcare coverage.

Other healthcare coverage includes:

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

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

Behavioral Health and Medical Coverage COB

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

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

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

Prescription Drug Coverage COB

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

Your GlobalHealth Plan and Medicare

If you are a Medicare recipient, either through yourself or your spouse, we will coordinate benefits with Medicare. If Medicare benefits pay first, we will pay second for benefits less the amount paid by Medicare. If you have questions about Medicare, contact your local Social Security office or visit [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 Claim against any third-party. This means that we will be paid before payment of any other Claims, including any Claim by you for general damages.

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

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

Note: See "Subrogation, Third-Party Recovery, and Reimbursement" on page 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 Network and authorization rules still apply.

If Your Claim Is Denied

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

Claims Payment Recovery

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

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

APPEALS AND GRIEVANCES

Complaints and Grievances

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

It may concern:

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

Send written Grievances to the Appeals and Grievances addresses on page 4. Please include:

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

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

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

You, or someone on your behalf, may ask the Insurance Commissioner for help at any time whether or not you submit a written Grievance 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 Appeal if the benefit change is because your Plan changed or ended.

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

Call us when you:

- Do not understand the reason for the denial;
- Do not understand why we did not fully cover the medical care;
- Do not understand why we denied a request for medical care coverage;

- Cannot find the applicable section in this *Member Handbook* or other Plan documents;
- Want a copy (free of charge) of documents, records, and other information relevant to your Claim;
- Want a copy (free of charge) of the guideline, criteria, or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to Appeal.

If your Claim was denied due to missing or incomplete information, you or your Provider may resend the Claim to us with the needed information.

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

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

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

Full and Fair Review

We will conduct a full and fair review of your Claim or request for coverage of 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 Claim or care. You may ask for copies of information that we have that pertains to your Claim(s) or care.

Behavioral Health Appeals

Carelon Behavioral Health administers your behavioral health benefits on our behalf. They also handle all behavioral health Appeals. Follow the same process for medical Appeals 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 Appeal. We will give you any new or additional evidence we used and tell you why we used it if you ask. We will give it to you free of charge. You may ask who the medical or other experts are whose advice we asked for, whether or not we used their advice in making the determination.

Initial Appeals Process

We will send a letter telling you we received your request within five business days. This letter will let you know when you can expect a determination in writing from us. If you do not get our decision within 30 days, you may ask for an External Review. See “External Review” 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 Claim, the notice will tell you what information we need. You will have 45 days from receipt of the notice to send it.

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

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

Expedited Appeal

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

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

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

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

Medical Appeals

For medical Appeals, follow the Appeals process on page 143. We will tell you our decision in writing within 30 days of receiving your Appeal. We will give you any new or additional evidence we used and tell you why we used it if you ask. We will give it to you free of charge. You may ask who the medical or other experts are whose advice we asked for, whether or not we used their advice in making the determination.

Initial Appeals Process

We will send a letter telling you we received your request within five business days. This letter will let you know when you can expect a determination in writing from us. If you do not get our decision within 30 days, you may ask for an External Review. See “External Review” 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 Claim, the notice will tell you what information we need. You will have 45 days from receipt of the notice to send it.

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

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

Expedited Appeal

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

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

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

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

Prescription Drug Appeals

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

For Prescription Drug 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 Experimental or Investigational.
- 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 Appeal 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 External Review, the Insurance Department will randomly select a qualified Independent Review Organization (IRO) to conduct the External Review. You must authorize the release of medical records. The IRO needs to review them so it can reach a decision. The IRO will tell you its decision within **45 days** after it gets the request for review.

Expedited External Review

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

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

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

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

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

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

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

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

Expedited External Review

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

If your request qualifies for External Review, the Insurance Commissioner will randomly select an IRO. The IRO will make a determination within 24 hours after they get your request for expedited External Review.

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 Appeal, exception request, or continuity or Transition of Care for you. You can name a relative, friend, advocate, attorney, doctor, or someone else to act as your authorized representative. If you want someone to act for you, you must send us a written statement authorizing that person to do so. Both you and the person you name must sign and date this document. You can find an Appointment of Authorized Representative form on our website or by contacting us. We must have a signed form on file before the Appeal, Grievance, exception request, or continuity or Transition of Care 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 Network diabetes prevention program.

Medication Therapy Management Program

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

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 Provider 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 ER 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 Transition of Care. The Discharge team works with you to support and reinforce treatment plans to prevent readmission and unnecessary ER visits.

2. Case Management

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

- Remove social, cultural, and economic barriers;
- Create a health management plan;
- Coordinate care;
- Help you understand disease risk factors, signs and symptoms, and treatment options; and
- Contact you regularly to monitor, follow-up and answer your questions.

Site of Care Program

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

- 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 Outpatient Hospital Facility 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 Outpatient Hospital Facility if your doctor sends us information that it is Medically Necessary. 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 COPD, 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.

Tobacco products include:

- 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:
 - Reduce the number of Members who use tobacco products;

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

Steps to quit:

1. Find your motivation.
2. Call your PCP, BHP, or the Oklahoma Tobacco Helpline for support and to set up your quit plan.
3. Talk with your doctor about medicines to help you quit.
4. Set a quit date within the next two weeks.
5. Make small changes. For example:
 - Throw away ashtrays in your home, car, and office so you aren't tempted to smoke.
 - 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 PA. 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 Dependent age 13 or older may attend individual, group, or telephone counseling sessions for at least 10 minutes each through your PCP or BHP.

You may also call the Oklahoma Tobacco Helpline at 1-800-QUIT-NOW (1-800-784-8669). You will talk to a trained cessation expert. He or she will tailor a plan for you.

Prescriptions

Smoking cessation products are limited to two full 90-day courses of FDA-approved tobacco cessation products per year. Your PCP or BHP will write a prescription. This benefit is available to you and your enrolled Dependents who are at least 18 years old.

The covered drugs include:

- Bupropion SR 150 mg (generic for Zyban®).

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

We also cover FDA-approved OTC 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 QIP helps us improve our functions and the services you get from Network Providers. It provides a systematic, integrated approach to measure and improve quality. The QIP:

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

The QIP goals are to:

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

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

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 [Preventive Care](#) services that you may discuss and/or get during routine well visits to your [PCP](#) or [OB/GYN](#) or your newborn may get in the [Hospital](#). You can print a copy from our website to take with you.

Not every service will be right for you. Your [PCP](#) or [OB/GYN](#) will recommend services. Services may require more than one visit and/or [PA](#). See “[Preventive Care Benefits](#)” on page 109 for additional information.

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

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

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

Support for Healthy Living

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

24/7 Nurse Help Line

Only your doctor 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 PCP. 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 well-being.

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 Member portal - Call us for login set-up	• Contact us via secure messaging: ○ Request/re-order <u>Member</u> ID cards; and ○ 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 Conditions	• Read evidence-based information about <u>Chronic Conditions</u> and how to 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	• <u>COPD</u> • Chronic Kidney Disease (<u>CKD</u>) • <u>CAD</u> clinical practice guidelines • Diabetes mellitus
Behavioral health	• <u>ADHD</u> 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 available on our website. Visit <https://www.globalhealth.com/oklahoma/mystateplan/member-materials-search/> to view them online.

Advance Directives

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

Who can have an Advance Directive?

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

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

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

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

Helpful Information

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

Continuation Coverage Rights Under COBRA

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

Section	Description
Introduction	The right to <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's</u> 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
	enrollment period for another group health <u>Plan</u> for which you are eligible (such as a spouse's <u>Plan</u>), even if that <u>Plan</u> generally doesn't accept late enrollees.
What is <u>COBRA</u> Continuation Coverage?	<u>COBRA</u> continuation coverage is a continuation of <u>Plan</u> coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, <u>COBRA</u> continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your <u>Dependent</u> children could become qualified beneficiaries if coverage under the <u>Plan</u> is lost because of the qualifying event. Under the <u>Plan</u>, qualified beneficiaries who elect <u>COBRA</u> continuation coverage must pay for <u>COBRA</u> 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 <u>COBRA</u> continuation coverage available?	The <u>Plan</u> will offer <u>COBRA</u> continuation coverage to qualified beneficiaries only after the <u>Plan</u> Administrator has been notified that a qualifying event has 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> continuation coverage provided?	Once the <u>Plan</u> Administrator receives notice that a qualifying event has occurred, <u>COBRA</u> continuation coverage will be offered to each of the qualified 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. <u>COBRA</u> 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. <i>Disability extension of 18-month period of continuation coverage</i> 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. <i>Second qualifying event extension of 18-month period of continuation coverage</i> If your family experiences another qualifying event during the 18 months of <u>COBRA</u> continuation coverage, the spouse and <u>Dependent</u> 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 coverage options besides <u>COBRA</u> Continuation Coverage?	Yes. Instead of enrolling in <u>COBRA</u> continuation coverage, there may be other coverage options for you and your family through the <u>Health Insurance Marketplace</u>, Medicare, Medicaid, Children’s Health Insurance Program (<u>CHIP</u>), or other group health <u>Plan</u> coverage options (such as a spouse’s <u>Plan</u>) through what is called a “<u>Special Enrollment Period</u>”. Some of these options may cost less than <u>COBRA</u> continuation coverage. You can learn more about many of these options at www.healthcare.gov.
Can I enroll in Medicare instead of <u>COBRA</u> continuation coverage after my group health <u>Plan</u> coverage ends?	In general, if you don’t enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of • The month after your employment ends; or • 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 <u>COBRA</u> 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 information about your rights under Employee Retirement Income Security Act (<u>ERISA</u>), including <u>COBRA</u>, 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 (<u>EBSA</u>) 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 <u>Marketplace</u> , visit www.healthcare.gov .
Keep your <u>Plan</u> informed of address changes	To protect your family's rights, let the <u>Plan</u> Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the <u>Plan</u> Administrator.
<u>Plan</u> contact information	You can obtain information about the <u>Plan</u> and <u>COBRA</u> continuation coverage by 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 Prescription Drug Coverage with GlobalHealth and about your options under Medicare's Prescription Drug Coverage. This information can help you decide whether or not you want to join a Medicare drug Plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the Plans offering Medicare Prescription Drug Coverage in your area. Information about where you can get help to make decisions about your Prescription Drug Coverage is at the end of this notice.

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

7. Medicare Prescription Drug Coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug Coverage. All Medicare drug Plans provide at least a standard level of coverage set by Medicare. Some Plans may also offer more coverage for a higher monthly Premium.
- 8.
9. GlobalHealth has determined that this Prescription Drug Coverage is, on average for all Plan participants, expected to pay out as much as standard Medicare Prescription Drug Coverage pays and is therefore considered creditable coverage. Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher Premium (a penalty) if you later decide to join a Medicare drug Plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug Plan, your current GlobalHealth coverage will not be affected. **You can keep this coverage if you elect part D and this Plan 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 Plan 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 Plan and drop your current GlobalHealth coverage, be aware that you and your Dependents will be able to get this coverage back.

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

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact us for further information. NOTE: You'll get this notice each year. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug Plan, and if this coverage 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 Plans that offer Prescription Drug Coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug Plans.

For more information about Medicare Prescription Drug Coverage:

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

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

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

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 Provider has *unknowingly or unintentionally* misrepresented facts to get payment.
-

Source	Examples
<u>Healthcare Providers</u>	• Billing or charging you for services that we cover (other than your <u>Cost-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 ID</u> 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 ID</u> card to someone else. • Lying to a <u>Provider</u> in order to get items or services that are not <u>Medically Necessary</u>.

Reporting Fraud, Waste, and Abuse

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

Contact Method	Contact Information
Toll-free	1-877-627-0004
E-mail	compliance@globalhealth.com

Guaranteed Renewability

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

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

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

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

Medicaid and CHIP Notice

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

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

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

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

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

If you live in Oklahoma, you may be eligible for assistance paying your employer health Plan Premiums. 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 Premium assistance program since January 31, 2023, or for more information on special Enrollment rights, you can contact either:

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

Department	Contact Information
U.S. Department of Health and Human Services	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov 1-877-267-2323, Menu Option 4, Ext. 61565

Member Rights and Responsibilities

Your Rights

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

- Get information about us, our services, your Providers, and your rights and responsibilities as a Member.
- Be treated with dignity and respect.
- Privacy and confidential treatment of all personal information.
- Participate with Providers in making decisions about your care.
- An open discussion of all treatment options for your condition, regardless of the cost of care or benefit coverage.
- Voice complaints about us or your care. Appeal any unfavorable decisions by following the Appeal and Grievance process.
- Make recommendations regarding our Member rights and responsibilities policy.
- Ask about any healthcare concerns, request medical advice or get more information about treatment in order to make an informed decision or refuse a Course of Treatment.
- Understand your condition, health status, and the drugs prescribed for you – what they are, what they are for, how to take them properly, and possible side effects.
- Know how your Plan operates. Get Plan materials.
- See your PCP and get Referrals to Specialists when Medically Necessary or urgent.
- Use Emergency Services when you, as a Prudent Layperson acting reasonably, believe that an Emergency Medical Condition exists.
- Information about Provider payment agreements, as well as explanations of benefits or Claims processing determinations.
- Expect problems to be fairly examined and addressed.

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

Your Responsibilities

You or your legal designee has the responsibility to:

- Give information, to the extent possible, that:
 - Your Providers need in order to provide care; and
 - We need in order to determine payment for that care.
- Follow care plans that you and your Providers have agreed to.
- Understand your health problems and help create treatment goals, as much as possible.
- Show your Member ID card when getting Medical Services.
- Be on time for all appointments. Tell your doctor's office as soon as possible if you need to cancel or reschedule.
- Tell your PCP and us within 48 hours, or as soon as possible, if you:

- Are hospitalized;
- Get emergency care; or
- Get out-of-area Urgent Care.
- Pay your Cost-share when you have services.
- Understand Covered Services, policies and procedures. Read your Plan materials.
- Ask questions if you do not understand your benefits or care options.

MHPAEA

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 (MHPAEA) requires employment-based group health Plans and Health Insurance issuers provide increased parity between mental health and substance use disorder benefits and medical/surgical benefits. The Departments of Labor, Treasury, and Health and Human Services (collectively, the Departments), administer MHPAEA together with the States.

MHPAEA and its implementing regulations:

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

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

Minimum Value Standard

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

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

Notice of 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 Sprachassistentendienste 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 (TTY 711).
Arabic	تتوفر المساعدات والخدمات. إذا كنت تتحدث العربية ، فإن خدمات المساعدة اللغوية المجانية متاحة لك 1-877-280-5600 اتصل بالرقم. المساعدات المناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجاناً (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 Creole	Si w pale kreyòl franse, sèvis asistans lang gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòm 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 हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक एड्स और सेवाएं भी निः शुल्क उपलब्ध हैं। 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;
- Claims 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 Service Area;
- Association with a person in a protected class; or
- Any combination thereof.

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

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

Section 1557 of the Affordable Care Act Grievance Procedure

It is the policy of GlobalHealth not to discriminate on the basis of race, color, national origin, sex, age, or disability.

We have adopted an internal Grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the Section 1557 Coordinator who has been designated to coordinate the efforts of GlobalHealth to comply with Section 1557.

Contact Method	Contact Information
Mail	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 Grievance under this procedure. It is against the law for us to retaliate against anyone who opposes discrimination, files a Grievance, or participates in the investigation of a Grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within 60 days of the date the person filing the Grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain our files and records relating to such Grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to Grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the Grievance, based on a preponderance of the evidence, no later than 3 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the Grievance may appeal the decision of the Section 1557 Coordinator by writing to the Compliance Officer or designee within 15 days of receiving the Section 1557 Coordinator's

decision. The Compliance Officer or designee shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this Grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age, or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or 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 Grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with Low Vision, or assuring a barrier-free location for the proceedings. Contact us for help with such arrangements.

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

This notice provides a **brief summary** of the Oklahoma Life and Health Insurance Guaranty Association (the Association) and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or Health Insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay Claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies. (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
 - \$300,000 in death benefits
 - \$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
- \$300,000 in long-term care insurance benefits
- \$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 Hospital 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 & Health Insurance Guaranty Association	Oklahoma Life & Health Insurance Guaranty Association 201 Robert S. Kerr, Ste 600 Oklahoma City, OK 73102 (405) 272-9221
Oklahoma Department of Insurance	Oklahoma Insurance Department 400 N.E. 50 th Street 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 (PII) is information that can be used to distinguish or trace a person's identity. It may be used alone or combined with other information that may be linked to a specific person. It is protected by federal and state laws.

Anyone who receives information that you are required to provide may use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of your health coverage. We may receive the information directly, from another person, or from a government agency.

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

Gramm-Leach-Bliley Act (GLBA) Notice

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

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

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 ○ Companies that help us recover overpayments, pay <u>Claims</u>, or do coverage reviews.
For Our Marketing Purposes	We may share information with our agents and service providers to offer our products and services to you.
For Joint Marketing with Other Financial Companies	We may share your personal information with other financial companies for the purpose of joint marketing. Joint marketing is when there is a formal agreement between nonaffiliated financial companies that jointly endorse, sponsor, or market financial products or services to you.
How Do We Protect Your Personal Information?	To protect personal information from unauthorized access and use, we: • Use reasonable security measures, including secured files, user authentication, encryption, firewall technology, and detection software; • Review the data security practices of companies we share your personal information with; and • Grant access to personal information to people who must use it to do their jobs.
How Can You See and Correct Your Personal Information?	Generally, you have the right to review the personal information we collect to provide you with insurance products and services if you: • Ask us in writing; and • Send the letter to the address below. When you write to us, please include your full name, address, telephone number, and <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 Under Other Privacy Laws	You may have additional rights under state or other applicable laws.
Questions or Concerns about this GLBA Notice	Write to us at: GlobalHealth, Inc. Attn: Legal Services 210 Park Avenue, Suite 2900 Oklahoma City, OK 73102-5621

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

Protected Health Information (PHI)

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

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

When changing PCPs, a signed authorization for release of information is required to transfer your medical records. Your current PCP's office can provide you with the form. You can also find the Authorization to Use or Disclose Protected Health Information (PHI) 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 Appeal investigation.
- Fraud 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.

GlobalHealth is required by law to provide you with this Notice of our legal duties and privacy practices, to notify you following a breach of unsecured PHI, and to abide by the terms of this Notice currently in effect. We reserve the right to change the terms of this Notice and our privacy practices. Any revised Notice will apply to all PHI we maintain, including PHI we created or received before the change, as allowed by 45 C.F.R. §164.530(i)(2)(ii). If material changes are made to this Notice, GlobalHealth will (a) prominently post the revised Notice on our website by the effective date of the change, and (b) provide the revised Notice, or

information about the material change and how to obtain the revised Notice, in our next annual mailing to individuals then covered by the plan, as required under 45 C.F.R. §164.520(c)(1)(v)(A).

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

Section	Description
	• In order to comply with laws and regulations related to Workers' Compensation; • For coordination of insurance or Medicare benefits, if applicable; • When necessary to prevent or lessen a serious and imminent threat to a person or the public and such disclosure is made to someone that can prevent or lessen the threat (including the target of the threat); and • In the course of any administrative or judicial proceeding, where required by law. Business Associates. We may use and/or disclose your PHI to business associates that we contract with to provide services on our behalf. Examples include consultants, accountants, lawyers, auditors, health information organizations, data storage and electronic health record vendors, etc. We will only make these disclosures if we have received satisfactory assurance that the business associate will properly safeguard your PHI. Personal/Authorized 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 officer, we may disclose your PHI to the correctional institute or law enforcement official, as necessary for: (a) the institution or official to provide you with health care; (b) your health and safety or the health and safety of other inmates; (c) the health and safety of correctional staff or others responsible for transporting or supervising you; (d) the administration and maintenance of the safety, security, and good order of the correctional institution. These uses and disclosures are permitted under the HIPAA Privacy Rule and other applicable law, including situations governed by 45 C.F.R. §164.512(k)(5) and, where applicable, 42 CFR part 2. 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. Other forms of outreach, including, but not limited to, text messages, emails, and telephone

Section	Description
	calls, will be used only if you have provided us with written consent to receive such communications. 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. Other forms of outreach, including, but not limited to, text messages, emails, and telephone calls, will be used only if you have provided us with written consent to receive such communications. Limited Data Set. A “limited data set” is health information from which certain direct identifiers (such as your name, address, Social Security number, telephone number, email address, and other information that can directly identify you) have been removed, as permitted under HIPAA. A limited data set may still include information such as dates of service, city, state, ZIP code, and other non-direct identifiers needed for analysis or operational purposes. 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 must enter into a Data Use Agreement which require them to take reasonable steps to protect the privacy of your information. Substance Use Disorder Patient Records. To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena. 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. 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 non-communicable disease required to be reported pursuant to State law.
Your Health Information Rights	Right to Inspect and Copy You have the right to inspect and copy your PHI as provided by law. This right does not apply to psychotherapy notes. Your request must be made in writing. We have the right to charge you the amounts allowed by State and Federal law for such copies. We may deny your request to inspect and copy your records in

Section	Description
	certain circumstances. If you are denied access, you may appeal to our Privacy Officer. Right to Confidential Communication You have the right to receive confidential communication of your PHI by alternate means or at alternative locations. For example, you may request to receive communication from us at an alternate address or telephone number. Your request must be in writing and identify how or where you wish to be contacted. We reserve the right to refuse to honor your request if it is unreasonable or not possible to comply with. Right to Accounting of Disclosures You have the right to request an accounting of certain disclosures of your PHI to third parties, except those disclosures made for treatment, payment, or 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. 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.

Section	Description
	Right to Be Notified of a Breach You have the right to receive notification of any breaches of your unsecured PHI. Right to Revoke Authorization You may revoke an authorization at any time, in writing, but only as to future uses or disclosures and not disclosures that we have made already, acting on reliance on the authorization you have given us or where authorization was not required. Right to Receive a Copy of this Notice You have the right to receive a paper copy of this Notice upon request.
To Report a Privacy Violation	If you have a question concerning your privacy rights or believe your rights have been violated, you may contact our Privacy Officer at: ATTN: Privacy Officer 210 Park Avenue Suite 2900 Oklahoma City, OK 73102 Toll-free 1-877-280-5600 (TTY: 711) (operational hours: Monday – Friday 8:00 am – 5:00 pm local time) Email privacy@globalhealth.com You may file a complaint in writing by mail or email. You will not be penalized or retaliated against for filing a privacy complaint. You also have the right to file a privacy complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, if you believe your privacy rights under HIPAA have been violated. You may file electronically through the OCR Complaint Portal at https://ocrportal.hhs.gov, 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://ocrportal.hhs.gov/ocr/portal/lobby.jsf. GlobalHealth will not retaliate against you for filing a complaint with us or with the Secretary.
Third-Party apps and the FTC	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

Section	Description
	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 08/01/2021 10/01/2023 07/2025 02/2026

Sponsors

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

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

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

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

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

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

If you have questions, contact your Plan Administrator.

Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health Plans and Health Insurance issuers offering group Health Insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending Provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

Subrogation, Third-Party Recovery, and Reimbursement

Section	Description
Benefits Subject to This Provision	This provision applies to all benefits provided under any section of this <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	“<u>Another Party</u>” 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. “<u>Recovery</u>” 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. “<u>Reimbursement</u>” or “<u>Reimburse</u>” means repayment to the <u>Plan</u> for medical or other benefits paid or payable toward care and treatment of the illness or injury

Section	Description
	and for any other expenses incurred by the <u>Plan</u> in connection with benefits paid or payable. “<u>Subrogation</u>” or “<u>Subrogate</u>” shall mean the <u>Plan’s</u> right to pursue the Covered Person’s <u>Claims</u> against Another Party for medical or other charges paid by the <u>Plan</u>.
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 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 Administrator</u> or its representatives, a Subrogation and Reimbursement agreement; and, to supply other reasonable information and assistance

Section	Description
	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; 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 <u>Plan's</u> 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 <u>Claims</u> for the Covered Person as the result of the illness or injury, regardless of whether the Covered Person is made whole;

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	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 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).

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	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's</u> right of first Reimbursement will not be reduced for any reason including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise; 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 of future benefits for other illnesses or injuries.
When a Covered Person Retains an Attorney	If the Covered Person retains an attorney, the <u>Plan Administrator</u> may, in its sole 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 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

Section	Description
	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 distress, pain and suffering, embarrassment, mental anguish, loss of consortium, etc.) or to direct or consent to have payments made to others (e.g., to or on behalf of relatives, attorneys, agents, representatives, or friends).
When the Covered Person is a Minor or is Deceased	The provisions of this section apply to the parents, trustee, guardian, or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the representative has access or control of the Recovery.
When a Covered Person Does Not Comply	a) (i) If the Subrogation agreement is not properly executed and returned as provided for in this provision; (ii) information and assistance is not provided to the <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

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	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 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 <i>Member Handbook</i> 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 Copayments and Coinsurance applicable to other medical and surgical benefits provided under this Plan. See "Benefits" on page 38 for your Cost Sharing for applicable services. If you would like more information on WHCRA benefits, contact your Plan Administrator.

FAQS

These FAQs are subject to “[Coverage Requirements](#)” on page 40 and “[Excluded Services and Limitations](#)” on page 119.

Topic	Q&A
Chiropractic care	Q. Does the Plan 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.
<u>Dependent coverage</u>	Q. If I enroll in GlobalHealth, is my child who lives in another state covered? A. Yes, Dependents must establish a relationship with a PCP in our Network. We cover Out-of-network emergencies and Urgent Care. We do not cover Out-of-network routine care. Any Out-of-network services, other than Emergency Services or Urgent Care, must be preauthorized by GlobalHealth. Q. What about Dependents over 18 years of age? A. We cover eligible children through the end of the month in which they turn 26 years of age.
<u>Emergencies and Urgent Care</u>	Q. When I go to the ER, is my copay waived if I am then admitted to the Hospital? A. Yes, if it is within the same Hospital. You then pay the Inpatient Hospital Facility Cost-share. Q. What if I get sick when I am out of the Service Area? Am I still covered? A. Emergency and Urgent Care is covered. In a true emergency, go immediately to the nearest medical Facility for care. Call the PCP and GlobalHealth within 48 hours of receiving the care. When same-day Urgent Care is needed and you cannot see your PCP, self-refer to an Urgent Care center. Q. What if I need to see a doctor on the weekend? Or I become sick after hours? A. Call your PCP for direction. Or self-refer to a Network Urgent Care center if you cannot wait for your PCP's office hours.
Hearing	Q. Does the Plan cover hearing aids? A. Yes. We cover basic hearing aids. See “Hearing services – hearing aids and devices” on page 72.
<u>Hospital admission</u>	Q. Does my Hospital copay cover doctor visits to the Hospital? A. Yes. Q. Does the Plan cover private rooms in the Hospital? A. When Medically Necessary. Q. What Hospitals are in your Network? A. They are listed in the <i>Provider Directory</i>. You can do a search on our website.

Topic	Q&A
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 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 <i>Member Handbook</i> 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 <i>Member Handbook</i>. 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 ID</u> 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 <u>Network</u> that you can access. Search for pharmacies on our website – Find a Pharmacy. Q. Are dental prescriptions covered? A. Yes.

Topic	Q&A
	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 Formulary</i> is an ongoing process, this list is subject to change. Q. Does the <u>Plan</u> have mail order? A. Yes, through Birdi 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.
<u>Preventive Care</u>	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 <u>Referral</u> if needed. However, you have direct access to your <u>OB/GYN</u> 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>.
<u>Weight loss and cosmetic surgery</u>	Q. Does the <u>Plan</u> cover weight loss 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? A. Only in specific limited circumstances. See page 61.
<u>Worldwide coverage</u>	Q. Am I covered worldwide? A. No.

ACRONYMS

Acronym	Phrase
ACA	Patient Protection and Affordable Care Act of 2010 as amended by The Health Care and Education Reconciliation Act of 2010
ADHD	Attention deficit hyperactivity disorder
ASD	Autism spectrum disorder
BHCM	Certified Behavioral Health Case Manager
BHP	<u>Behavioral Health Provider</u>
BRCA	BRest 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
COB	Coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
DEA	Drug Enforcement Administration
DME	<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	<u>Independent Review Organization</u>
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
MHPAEA	The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008
MOOP	Maximum out-of-pocket or <u>Out-of-pocket Limit</u>
OB/GYN	Obstetrician/gynecologist
OTC	Over-the-counter
PA	<u>Preauthorization</u> or prior authorization
PBM	<u>Pharmacy benefit manager</u>
PCP	<u>Primary Care Physician</u>

Acronym	Phrase
PHI	Protected health information
PII	Personally identifiable information
P&T	Pharmacy and Therapeutics
QIP	Quality improvement program
RTC	<u>Residential Treatment Center</u>
SEP	<u>Special Enrollment Period</u>
UM	<u>Utilization Management</u>
USPSTF	United States <u>Preventive Services</u> 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 Patients	Indicates whether the <u>Practitioner</u> is <u>Accepting New Patients</u> into their practice, 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 Determination	A determination that an admission, availability of care, continued stay or other healthcare service that is a covered benefit has been reviewed, and based upon the information provided, does not meet the <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 Center	A licensed public or private establishment with an organized medical staff of physicians with permanent <u>Facilities</u> that are equipped and operated primarily for the purpose of performing surgical procedures and continuous <u>Physician Services</u> and registered professional nursing services whenever a patient is in the <u>Facility</u> and which does not provide services or other accommodations for patients to stay overnight.
Appeal	A request for GlobalHealth to review a decision that denies a benefit or payment (either in whole or in part).
Approved Clinical Trial	A clinical trial that is sponsored by a credible organization and conducted in compliance with federal regulations including those relating to the protection of human subjects. The trial must have a therapeutic intent and not designed solely to identify or test disease pathophysiology.
Balance Billing	When a <u>Provider</u> bills you for the balance remaining on the bill your <u>Plan</u> doesn't 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 Provider</u> . A <u>Network Provider</u> may <i>not</i> bill you for <u>Covered Services</u> .
Behavioral Health Provider (BHP)	A behavioral healthcare professional (<u>Psychiatrist</u> , <u>Psychologist</u> , clinical social worker, marriage and family therapist, behavioral professional, behavioral <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 “ <u>Specialist</u> ”) 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”. <u>Board Certification</u> 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 to meet your healthcare needs based on the benefits and resources needed in order to promote a quality outcome for you.
Certified Behavioral Health Case Manager (BHCM)	A State certified <u>Practitioner</u> specializing in providing resource linkage, patient advocacy, <u>Provider</u> /resources <u>Referral</u> and coordination, and care plan 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</u> <i>plus</i> 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 <u>Allowed Amount</u> .
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	<u>Medically Necessary</u> services or supplies provided under the terms of this <i>Member Handbook</i> , your <i>Drug Formulary</i> , your <i>Pharmacy Directory</i> , and your <i>Provider Directory</i> .
Deductible	The amount you could owe during a coverage period (usually one year) for covered healthcare services before GlobalHealth begins to pay. An overall <u>Deductible</u> applies to all or almost all covered items and services. A <u>Plan</u> with an overall <u>Deductible</u> may also have separate <u>Deductibles</u> that apply to specific services or groups of services. A <u>Plan</u> may also have only separate <u>Deductibles</u> . (For example, if your <u>Deductible</u> is \$1,000, GlobalHealth won't pay anything until you've met your \$1,000 <u>Deductible</u> for covered healthcare services subject to the <u>Deductible</u> .) The <u>Deductible</u> may not apply to all services. Not all GlobalHealth <u>Plans</u> have a <u>Deductible</u> .
Dependent	Any spouse or child up to the age of 26 (including stepchildren, foster children, and adopted children from the date placed in the home) of the <u>Subscriber</u> . GlobalHealth covers <u>Dependents</u> when they meet eligibility and <u>Premium</u> requirements.
Diagnostic Test	Tests to figure out what your health problem is. For example, an x-ray can be a <u>Diagnostic Test</u> to see if you have a broken bone.
Durable Medical Equipment (DME)	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.
Emergency Medical Condition	An illness, injury, symptom (including severe pain), or condition that is severe enough to risk serious danger to your health if you didn't get medical attention right away. If you did not get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.
Emergency Medical Transportation	Ambulance services for an <u>Emergency Medical Condition</u> . Types of <u>Emergency Medical Transportation</u> may include transportation by air, land, or sea. Your <u>Plan</u> may not cover all types of <u>Emergency Medical Transportation</u> , or may pay less for certain types.
Emergency Room Care / Emergency Services	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> .
Enrolled Family Member	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 family member who meets all of the eligibility requirements of the <u>Subscriber's</u> employer group and GlobalHealth.

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 <i>Drug Formulary</i> 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 ID Card</u> .
Grievance	A complaint that you communicate to GlobalHealth in writing except for complaints related to discrimination which may be submitted by telephone.
Habilitation Services	Healthcare services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of <u>Inpatient</u> and/or <u>Outpatient</u> 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. <u>Hospital Affiliation</u> is verified directly through the <u>Hospital(s)</u> 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	Care in a <u>Hospital</u> that usually doesn't require an overnight stay.
Hospital Services	<u>Medically Necessary</u> services provided by a <u>Hospital</u> . 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 Review Organization (IRO)	An entity that conducts independent <u>External Reviews</u> of <u>Adverse Determinations</u> and final <u>Adverse Determinations</u> .
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 Coinsurance	Your share (for example, 20%) of the <u>Allowed Amount</u> for covered healthcare 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 Copayment	A fixed amount (for example, \$15) you pay for covered healthcare services to <u>Providers</u> who contract with GlobalHealth. <u>In-network Copayments</u> usually are less than <u>Out-of-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 <u>Network</u> , except for urgent or emergent care.
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 Spoken by the Physician or Clinical Staff	Refers to language(s), other than English, that a healthcare professional or their clinical office staff speaks fluently. Language(s), other than English, that are spoken fluently is/are provided by the healthcare professional's application at 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 or a special enrollment period.
Licensed Alcohol & Drug Counselor (LADC)	A master's or doctoral level, licensed <u>Practitioner</u> specializing in the diagnosis and treatment of substance use disorders.
Licensed Behavioral Practitioner (LBP)	A master's or doctoral level, licensed <u>Practitioner</u> specializing in the diagnosis and treatment of mental illness and/or substance use disorders.

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>In-network</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 <u>Specialty</u> to have the same <u>Medical Group Affiliation</u> . <u>Medical Group Affiliation</u> is provided by the <u>Practitioner's</u> application at credentialing and re-credentialing (every three years). When GlobalHealth receives updated information, it is verified and the website updated within 30 days.

Term	Definition
Medical Services	The <u>Medically Necessary</u> 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 Coverage	Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.
Minimum Value Standard	A basic standard to measure the percent of permitted costs the <u>Plan</u> covers. If you 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 Determination (NCD)	Developed by CMS to describe the circumstances for which Medicare will cover specific services, procedures, or technologies on a national basis. Often, NCD's are clarified by the creation of an LCD (at the local contractor level).
Natural Environment Training	Instructions that are both driven by the individual's motivation and carried out in the environments that closely resemble natural environments, (the "real world") while being highly structured with regard to the individual's access to reinforcement. Also called natural environment teaching.
Network	The <u>Facilities</u> , <u>Providers</u> , and suppliers that GlobalHealth has contracted with to provide healthcare services. These <u>Facilities</u> and <u>Providers</u> are also referred to as "In-network".
Network Provider	A <u>Provider</u> who has a contract with GlobalHealth who has agreed to provide services to <u>Members</u> of a <u>Plan</u> . You will pay less if you see a <u>Provider</u> in the <u>Network</u> .
Non-preferred Facility	A <u>Facility</u> which has a contract with GlobalHealth to provide services to you at a discount. You will pay the higher <u>Cost-share</u> when you choose these <u>Facilities</u> instead of a <u>Preferred Facility</u> . Non-preferred <u>Specialty Drugs</u> have a higher <u>Cost-share</u> than preferred <u>Specialty Drugs</u> .
Non-preferred Specialty Drug (NPS)	High-cost drugs used to treat complex or rare conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia.
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 Prosthetics	Leg, arm, back and neck braces, artificial legs, arms and eyes, and external breast prostheses after a mastectomy. These services include: Adjustment, repairs, and

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 Coinsurance	Your share (for example, 40%) of the <u>Allowed Amount</u> for covered healthcare services to <u>Providers</u> who do <i>not</i> contract with GlobalHealth. <u>Out-of-network 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 Copayment	A fixed amount (for example, \$30) you pay for covered healthcare services from <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 <u>Network</u> , except for urgent or emergent care.
Out-of-network Provider	A <u>Provider</u> who does not have a contract with GlobalHealth to provide services. 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>. After you meet this limit, GlobalHealth begins to pay 100% of the <u>Allowed Amount</u>. 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>".
Outpatient	Patient who is undergoing diagnosis and receiving treatment and care, but is not 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 Doctor) or D.O. (Doctor of Osteopathic Medicine) provides or coordinates.
<u>Plan</u>	Health coverage issued to you directly (individual <u>Plan</u>) or through an employer, 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 Insurance policy</u> ", 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 (PA)	A decision by GlobalHealth that a healthcare service, treatment plan, <u>Prescription Drug</u> , or <u>Durable Medical Equipment (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 <i>Member Handbook</i> .
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	<u>Routine Costs</u> associated with an <u>Approved Clinical Trial</u> 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. <u>Routine Costs</u> 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 Condition	A disease or condition requiring complex ongoing care which you are currently receiving, such as chemotherapy, radiation therapy, or post-operative visits.
Service Area	A geographical area, as approved by the Oklahoma Insurance Department, within which GlobalHealth arranges for basic medical, <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. <u>Skilled Nursing Care</u> 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 Rehabilitation Services	Services provided in the home by licensed therapists (e.g., physical, occupational, speech).
Skilled Nursing Facility	A <u>Facility</u> or <u>Hospital</u> unit primarily engaged in providing, in addition to room and 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 Period (SEP)	The period of time, outside of <u>Open Enrollment</u> , when a person may enroll in a health <u>Plan</u> .
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 <u>Formulary</u> .
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 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 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 <u>Drug Formulary</u> .
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 Care</u> .
Usual and Customary	The amount paid for a <u>Medical Service</u> in a geographic area based on what <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 Management (UM)	A process for monitoring the use, delivery, and cost-effectiveness of services.



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