GlobalHealth

2017 Member Handbook

For State, Education, and Local Government Employees

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

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WELCOME TO GLOBALHEALTH

We appreciate you choosing GlobalHealth and we look forward to serving you. Working proactively with each member, GlobalHealth engages a personalized management plan to address your specific needs and ensure the best possible health outcomes. GlobalHealth utilizes cutting edge, predictive data technology as a foundation to deliver improved healthcare as part of its commitment to making Health Insurance more affordable.

This *Member Handbook* will familiarize you with your healthcare benefits. **Please read the entire handbook**; it provides important information about your benefit coverage. To look up the definition of a capitalized word in the handbook, please refer to the glossary.

Please also review your *Schedule of Benefits, Provider Directory, and Drug Formulary*. These four documents form your Comprehensive Member Handbook.

Call our Customer Care department, located right here in Oklahoma, if you have any questions. They are ready to help, and answer calls quickly.

Visit www.globalhealth.com/state for more information on benefit coverage.

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

Sincerely,
R. Scott Vaughn, CPA
President & CEO

CERTIFICATE OF COVERAGE

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

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

- Applied for coverage under this certificate;
- Paid for the coverage;
- Satisfied the conditions specified in Eligibility and Enrollment section; and
- Been approved by GlobalHealth, Inc.

Are covered by this certificate.

Beginning on your effective date, we agree to provide you the benefits described. Your effective date is stated on your Member ID card.

No person or entity has authority to waive any provision or to make changes or amendments unless approved in writing by a GlobalHealth, Inc. officer, and the resulting waiver, change, or amendment is attached to this Certificate of Coverage.

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

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

WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any Claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

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

HELPFUL NUMBERS

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

GlobalHealth Customer Care, Language Assistance, and Disease Management:
CommercialAnswers@globalhealth.com
405.280.5600
1.877.280.5600 (toll-free)
711 (TTY)
Mon – Fri, 9 am – 5 pm

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

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

GlobalHealth Privacy Officer:
405.280.5524
privacy@globalhealth.com

Behavioral Health:
CommercialAnswers@globalhealth.com
405.280.5600
1.877.280.5600 (toll-free)
711 (TTY)
Mon – Fri, 9 am – 5 pm

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

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

Mail Claims to:
Express Scripts
Attn: Commercial Claims
PO Box 14711
Lexington, KY 40512-4711

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

***Specialty Pharmacy:**
Accredo Specialty Pharmacy
1.888.608.9010
www.accredo.com

*Accredo Specialty Pharmacy is not the exclusive Specialty Drug Pharmacy. You have the option to use other pharmacies.

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INTRODUCTION

The information in this *Member Handbook* applies to Members enrolled in the following Plan:

- State, Education, and Local Government Employees

Important Information

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

Member Materials

In order to maximize your benefits, it is very important that you familiarize yourself with our systems, policies, and benefits. Please read these materials carefully. Many of the provisions are interrelated. Reading only parts may give you a misleading impression. If you do not stay within our Network of Providers, and are unfamiliar with your benefit coverage, you might incur unnecessary costs. It is your responsibility to understand the terms and conditions.

Comprehensive Member Handbook:

- The *Member Handbook for State, Education, and Local Government Employees* ("*Member Handbook*") will help you understand your healthcare benefits – what is covered, how it is covered, and how to access it.
- The *Schedule of Benefits* states how much your Deductible, Copayment, or Coinsurance amounts are when using a Covered Service. It also states your Out-of-pocket Limit.
- The *Physicians and Health Providers Directory* ("*Provider Directory*") lists our Network of physicians, Facilities, and pharmacies.
- The *Formulary Drug List for State, Education, and Local Government Employees* ("*Drug Formulary*") lists drugs we cover. It explains what Tier a drug is in and any Utilization Management requirements for each drug.

These documents are important legal documents. Please keep them in a safe place.

When these documents say "we", "us", or "our", it means GlobalHealth, Inc. We define words or phrases that start with a capital letter in the *Member Handbook* glossary.

You can access these documents online. You will need your group ID number to see materials specific to your Plan. It is located on your Member ID card. Talk to your employer about documents related to other benefits you may have.

<u>Forms, Tools, and Resources:</u>

Get to know us better by going online! In addition to your Comprehensive Member Handbook, our website has forms and tools to help you get the most from your Plan.

- Disease and Case Management
- Member ID Card Request
- Member Rights and Responsibilities
- Notice of Privacy Practices
- PCP Select/Change Request Form
- Quality Improvement Program
- Self-Management Tools
- Summary of Benefits and Coverage
- Wellness Program

Contact Customer Care if you have questions or prefer a print version of any Member material or form at no charge. Please note that you will find the most recent *Drug Formulary* and *Provider Directory* online as we update from time to time. Printed versions are current as of the date indicated on the front cover.

Accessibility and Translation Services
You may receive information that is critical for obtaining health coverage or access to healthcare services in plain language. Information and assistance are available at no charge.

Discrimination is Against the Law
GlobalHealth, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GlobalHealth, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Need	• Service
Living with disabilities	• We provide free aids and services to people with disabilities to communicate effectively with us. Materials available on our website are accessible to Members with visual disabilities. We provide written information in other formats. • Hearing impaired Members may access the TTY number.
Limited English proficiency	• We offer over 150 languages from professionally certified medical interpreters. Interpreters adhere to generally-accepted ethics principles, including confidentiality. • Information written in other languages.

If you need these services, contact Customer Care at 1-877-280-5600 (toll-free).

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

Contact	**Contact Information**
Mail	GlobalHealth, Inc. ATTN: Compliance Attorney 701 NE 10th St, Ste 300 Oklahoma City, OK 73104-5403
Fax	(405) 280-5894
E-Mail	compliance@globalhealth.com

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

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

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

For more information, see "Section 1557 of the Affordable Care Act Grievance Procedure" on page 113.

How to Get the Most Out of Your GlobalHealth Plan

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

2. See your PCP first for all of your medical care.
   - Your PCP will coordinate and manage your medical care.
   - Ask which Preventive Services are right for you.
   - For same-day Urgent Care, call your PCP's office for medical direction.
   - After-hours, you may self-refer to a Network Urgent Care center.
   - When it's an emergency, go to the nearest Hospital emergency room. Follow these steps:
     - Show your Member ID card.
     - Call your PCP's office and us within forty-eight (48) hours. Tell us you received treatment in the ER.
     - We may arrange to transfer you to a Hospital in the Network if you are admitted to an Out-of-network Hospital.
     - Your PCP must provide or arrange for all follow-up care. You may also need Preauthorization from us.
     - Be aware, an Out-of-network Provider may balance bill you. An In-network Provider may not balance bill you.

3. To see a SPECIALIST, you need a Referral*
   - When appropriate, your PCP will submit a Referral on your behalf for specialty care.
   - Preauthorization from us is required. See "Pre-service Authorization" on page 26.
   - When approved, we will send you a letter in the mail.
   - Make your appointment with the Specialist as directed in the letter.
   - The Specialist may submit Referrals for procedures and follow-up care after the initial visit.

4. To go to the HOSPITAL, you need a Referral*
   - A Referral and Preauthorization from us are required for scheduled stays.

- You may only go to a Hospital in the Network. Follow these steps:
  - When approved, we will send you a letter of authorization.
  - Go only to the Hospital listed in the letter.
- You do not need Preauthorization for stays in connection with childbirth. However, you must go to an In-network Hospital.

5. You may SELF-REFER to an In-network Provider for the following services:
   - Services within an obstetrician/gynecologist's scope of practice
   - Routine mammograms
   - Behavioral health services
   - Routine eye exams
   - Eyeglasses or contacts
   - Physical therapy evaluations

*Generally, Inpatient and certain Outpatient services must be prior authorized. You do not have to obtain Preauthorization for Emergency Services, stays in connection with childbirth, after hours Urgent Care, or self-referral services. If you obtain other services without an authorized Referral, you will be responsible for the costs. You must go to a Network Facility for non-emergency services including childbirth. You may go to any emergency room, but you may be balance billed if you choose an ER that is not In-network. See "Balance Billing by an Out-of-network Provider" on page 81.

Member ID Cards

We will provide Member ID cards to you at the beginning of your Plan Year. Your GlobalHealth card is the key to all of your medical, behavioral health, and prescription benefits. Carry it with you at all times.

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

Please Note:

- Services are for your personal benefit. Never lend your card to someone else.
- If your card is lost or stolen, notify Customer Care immediately. We will send you a new card.
- Your membership card is valid only as long as you are enrolled in the Plan. Possession of a card does not guarantee the benefits of Plan membership.

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

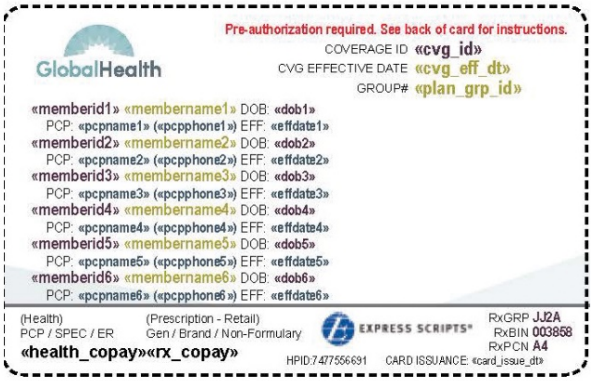
- If information on your card is not correct.
- If you need to order a new card.
- If you have questions about your card.

You should receive new or additional cards within two (2) weeks after we receive the request.

GlobalHealth Member ID Card:

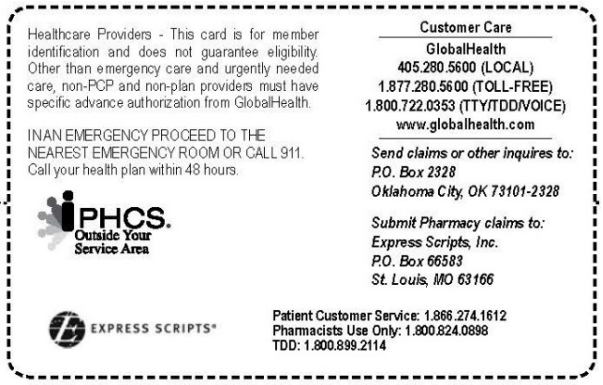
Front of Card:

1. Coverage ID number
2. Group ID number
3. Member ID number
4. The selected PCP
5. PCP phone number
6. PCP effective date
7. Relationship code to Subscriber
8. Copayment and benefit information



Back of Card:

1. What to do in case of a life-threatening emergency
2. Routine and Urgent Care information
3. How to reach GlobalHealth's Customer Care Department including phone number, office hours, and Claims address



Steps to Improve Your Healthcare Quality and Safety

1. If you are new to GlobalHealth, visit your PCP early in the year to get established. Have your medical records transferred to your new PCP.
2. Visit your PCP at least annually. Have Preventive Care services. See "Preventive Care Benefits" on page 59.
3. Write down your questions before your scheduled appointment.
4. Ask questions if you have any doubts or concerns regarding your treatment.
5. Keep and bring a list of all the drugs you take to each appointment. Include any over-the-counter drugs and supplements. Your PCP will look for drug interactions. Ask questions about new prescriptions – when and how to take them, if they have side effects, and what to avoid while taking them.
6. Get the results of any test or procedure.
7. Make sure you understand what will happen if you need surgery.
8. Talk to your doctor about all treatment options available to you. Discuss which choice your doctor recommends for your health needs and why. Make sure you understand what will happen if you choose not to treat medical conditions.
9. Make sure your PCP receives copies of records from any other physicians or Facilities where you receive care.

PROVIDER NETWORK

As a GlobalHealth Member, you must use Plan Providers for your Covered Services in almost all situations.

Network Providers are the physicians and other healthcare professionals, medical groups, Durable Medical Equipment suppliers, Hospitals, and other healthcare Facilities that have an agreement with us to accept our payment and your Plan Cost Sharing as payment in full.

HMOs emphasize Preventive Care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our Providers follow generally accepted medical practices when prescribing any course of treatment.

You should join an HMO because you prefer the Plan's benefits, not because a particular Provider is available. You cannot change Plans because a Provider leaves our Network. We cannot guarantee that any one physician, Hospital, or other Provider will be available and/or remain under contract. We cannot guarantee that any one pharmacy will remain contracted with our pharmacy benefit manager, Express Scripts Holding Company ("ESI").

You could receive care from Providers outside of our Network in very limited situations. See "Balance Billing by an Out-of-network Provider" on page 81.

Contact our Customer Care Department if you need help or if you have any questions.

Provider Directory

The *Provider Directory* has lists of Network physicians, Facilities, pharmacies, and suppliers. The printed version includes Behavioral Health Providers. It indicates which physicians are accepting new patients.

Behavioral Health Providers:
The Network includes:

- Psychiatrists – Child, adolescent, adult, geriatric, addiction medicine Specialist;
- Psychiatric Clinical Nurse Specialists;
- Licensed Clinical Psychologists;
- Licensed Clinical Social Workers ("LCSW");
- Licensed Alcohol & Drug Counselors ("LADC");
- Licensed Marriage & Family Therapists ("LMFT");
- Licensed Professional Counselors ("LPC");
- Licensed Behavioral Practitioners ("LBP");
- Psychologists;
- Hospitals, psychiatric Hospitals;
- Residential treatment centers; and
- Other mental healthcare professionals as allowed under state law.

Medical Service Providers:
We update our online list of Providers at least weekly. Visit our website to find a current *Provider Directory* and search tool for the latest information. Search by first and last name, county, and zip code. You can narrow your search by Network, specialty, clinic affiliation, or languages spoken.

Click on the Provider's name to view information such as:

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

You can also find information about Hospitals, such as their locations.

Pharmacy Networks:
You have different options to receive your prescribed drugs. Your Cost-share may change depending on where you fill your prescription. The *Provider Directory* includes the list of pharmacies in the "GlobalHealth Commercial Network". You can find the most current directory on our website.

If the pharmacy you have been using leaves the Network, you will have to find a new pharmacy that is in the Network. We will notify you in advance if this event happens.

We may restrict access to a drug when:

- The FDA has restricted distribution of the drug to certain facilities or Providers; or
- Appropriate dispensing of the drug requires special handling, Provider coordination, or patient education that a retail pharmacy cannot meet.

Pharmacy Type	**Description**
Retail pharmacies – 30-day supply	The *Provider Directory* includes location information for Network pharmacies. Check our website for 24-hour pharmacies with the following designation: OPEN 24 HOURS.
Home delivery pharmacy service – 90-day supply	ESI offers the convenience of home delivery. ESI mails maintenance medications to your home in a 90-day supply when prescribed as a 90-day supply. You may receive a discount on your drugs, depending on the drug Tier. Allow fourteen (14) days for your prescription to reach you. For more information about this optional service, contact ESI. Representatives are available twenty-four (24) hours a day, seven (7) days a week.
Extended supply retail pharmacies – 90-day supply	You may receive up to a 90-day supply of a maintenance drug at an extended supply retail Network pharmacy. Your Provider must prescribe the drug as a 90-day supply. The *Provider Directory* includes location information for Network pharmacies.

Pharmacy Type	Description
	Check our website for pharmacies with the following designation: GLOBALHEALTH EXTENDED SUPPLY NETWORK. Check our website for 24-hour pharmacies with the following designation: OPEN 24 HOURS.
Chickasaw Nation Refill Center medications by mail – 30-day or 90-day supply	Chickasaw Nation Refill Center is a Native American-owned retail pharmacy located in Oklahoma. It provides Prescription Drugs to Native Americans. Complete the *Native American Prescription Benefit Program Patient Enrollment* form available on our website and submit to Chickasaw Nation Refill Center. Proof of Native American status in one of the federally-recognized tribes is required. Once Native American heritage is established with Chickasaw Nation Refill Center, you may receive Cost-share discounts. Your non-Native American spouse is also covered. Your doctor may write a prescription for either 30-day or 90-day supplies. Chickasaw Nation Refill Center will let you know your Cost Sharing when you ask to have a prescription filled. Drugs are mailed directly to your home or designated location. Online prescription services available at cnrefillcenter.net. Call 1-855-478-8725 if you have questions.
Specialty pharmacies – 30-day supply	Contracted specialty pharmacies fill your Specialty Drugs and mail them. You pay the office visit Cost-share if sent to and administered by your doctor. You pay the Specialty Drugs Cost-share if sent to and administered by you. You can find a specialty Network pharmacy on our website.
Vaccine Network pharmacies	You may go to certain pharmacies for your covered preventive vaccinations at no cost. Check our website for pharmacies with the following designation: GLOBALHEALTH VACCINE NETWORK.

Primary Care Physician ("PCP")

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

Choose a PCP:

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

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

You have complete freedom of choice in your selection. Choose any PCP in our Network who is accepting new Members. Each member of the family may have a different PCP. You may choose a pediatrician for your children. We will automatically assign a PCP to you if you do not choose one.

For more information and for a list of PCPs, contact Customer Care. Information is also available on our website.

Although you have direct access to your obstetrician/gynecologist ("OB/GYN"), he/she is not your PCP. You will need to choose a PCP to coordinate medical care that your OB/GYN does not handle.

Your relationship with your PCP is an important one. We strongly recommend that you choose a PCP close to your home or work. Having your PCP nearby makes receiving medical care and developing a trusting and open relationship much easier.

Get Established:
Once you have chosen a PCP, it is important to make an appointment within the first thirty (30) days if possible.

- Let the office staff know that you are new to GlobalHealth or to the physician. They need to prepare paperwork for your medical records.
- Have your medical records transferred from your prior Providers before your first appointment. See "Medical Records" on page 23.
- Discuss any specialty care you are receiving. See "Continuity and/or Transition of Care" on page 73.
- Discuss your medications – what they are, what they are for, what you need to have refilled. If any of the drugs is not on our *Drug Formulary*, discuss your options.
- Discuss Preventive Care that is appropriate for you. Your PCP may perform some of the Screenings during this visit. You may need to schedule additional appointments for other Preventive Care.

Schedule Routine Appointments:
When you are ready to make an appointment to see your PCP, call his or her office. Your Member ID card lists the number.

- Call in advance for routine or health evaluation appointments. 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 keep follow-up appointments if you have a Chronic Condition such as high blood pressure or asthma.
- Prepare a list of questions before the appointment.
- Show your Member ID card and pay your Cost-share, if any, at each appointment.
- If your PCP orders tests, show your Member ID card when you arrive at your appointment.
- If you must cancel an appointment, call as far in advance as possible.

When You Need Care Right Away:
Call your PCP. If no urgent appointments are available, he or she may send you to an Urgent Care Facility. Refer to the *Provider Directory* for a list of Network Urgent Care Facilities nearest you. The most current directory is available on our website. See "Urgent Care" on page 21.

Consultations:
Your PCP may discuss special medical situations with colleagues. The team shares knowledge and experiences to recommend the best course of care for you. Everyone on the team handles your information with complete confidentiality.

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

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

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

Reasons a request to change may be denied:

- PCP is not taking new patients; or
- PCP is not in our Network.

Referrals

Your PCP will submit a Referral for any specialty care you may need. We need to approve most services in advance when your PCP does not provide them. This process is called Preauthorization. It applies to almost all services except Emergency Services, Hospitalizations related to childbirth, or services for which you may self-refer.

We will send a letter after service approval. See "Pre-service Authorization" on page 26. You must receive this authorization letter before you obtain Covered Services.

Please note:

- You may ask to use any Provider in our Network.
- A Network Provider should perform all Covered Services including ancillary services such as:
  - x-rays
  - lab services
  - anesthesia

Self-referral Services

Your PCP coordinates most Covered Services you get as a GlobalHealth Member, but there are a few exceptions. You may self-refer to a Network Provider for the services in the table below. You do not need a Referral from your PCP before you go. You will pay the applicable Cost-share for non-preventive services.

We will only cover your care when a Network Provider provides the care. You will be responsible for 100% of the cost of your care if you obtain services from an Out-of-network Provider. For a

current list of Network healthcare professionals, refer to the online *Provider Directory* or contact Customer Care. Also see "Coverage Requirements" on page 32.

It is a good idea to have the results of any exams or tests sent to your PCP, along with a list of any new prescriptions. That helps maintain continuity of care.

Service	**Description**
Eye exams (routine)	You may self-refer to an optometrist for an annual eye exam including refraction. See "Vision Benefits" on page 64.
Eyewear	You may self-refer to an eyewear Provider for eyeglasses. See "Vision Benefits" on page 64.
Mammograms (routine)	You may self-refer to an imaging center for your routine mammogram. See "Mammogram" on page 48.
Mental health/substance use services	You may self-refer to a licensed therapist or psychiatrist for assessment, therapy, and testing. See "Behavioral Health Benefits" on page 33.
Obstetrical/gynecological services	You do not need a Referral from your PCP or Preauthorization from us in order to obtain care from a healthcare professional who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures including: • Obtaining Preauthorization for certain services. You will receive a letter in the mail once your services are approved; • Following the authorized treatment plan; and • Following procedures for Referrals. <u>Contraception Services:</u> You have direct access to either your PCP or OB/GYN for contraceptive services. See "Contraception Services" on page 42. <u>Maternity:</u> You have direct access to your OB/GYN for all of your maternity care – prenatal, delivery, and postnatal. See "Maternity and Newborn Care" on page 49. <u>Well-woman Exam:</u> For a complete list of Preventive Services related to your well-woman exam, see "Services for Women" on page 61. You may be required to pay a Copayment or Coinsurance if you have other services that are not preventive. <u>Other Services:</u> You have direct access to your OB/GYN. He/she may perform any Covered Services within his/her scope of practice. You pay

Service	Description
	the Specialist Cost-share for all non-preventive office visits.
Physical therapy	You may self-refer to a healthcare professional who specializes in physical therapy for an evaluation only. The physical therapist, however, may be required to comply with certain procedures including: • Obtaining Preauthorization for up to thirty (30) days of therapy. We will send a letter once we approve your services; • Following the authorized treatment plan; and • Following procedures for Referrals. See "Physical Therapy" on page 51.
Urgent Care	You should first seek care through your PCP to maintain continuity of care. But, you may self-refer to an Urgent Care Facility when your PCP's office is closed or when you are out of our Service Area. The care must be urgent, non-preventive, and non-routine. See "Urgent Care" on page 21.

Specialty Care

See your PCP first. If your PCP believes you need to see a Specialist, he/she will submit a Referral for you.

- If you see a Specialist without an authorized Referral (other than for self-referral services), you will be responsible for the charges.
- We send you a letter when we authorize the visit. See "Pre-service Authorization" on page 26.
- Make an appointment with the Specialist as directed in the letter. You should not schedule an appointment prior to receiving authorization from us. You are only approved to have the services described in the letter. Follow-up tests, services, or procedures require additional authorization.

Certain PCPs are affiliated with integrated delivery systems or other Provider groups. These Providers will generally refer you to Specialists and Hospitals within those systems or groups. However, you may request to have services provided by any Network Provider qualified to meet your needs.

Tests:
Some Diagnostic Tests are included in the Specialist visit authorization. You do not need separate Preauthorization for these Diagnostic Tests performed in the doctor's office during the authorized visit:

- Routine lab work
- Ultrasound
- X-ray
- EKG

Any additional Diagnostic Tests, services, or procedures require specific authorization from us. If you do not obtain Preauthorization, you may be financially responsible for payment. You may ask the Provider to refer you to a Preferred Facility if you choose.

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 let you know within thirty (30) days of the date we become aware 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 newly assigned PCP. You will also get a new Member ID card in a separate mailing. If you do not want the PCP we have chosen for you, let us know. You may change at any time by contacting Customer Care.

When a Provider's contract terminates for reasons other than cause, you might be able to continue to see that Provider for up to ninety (90) days from the date of notice. See "Continuity and/or Transition of Care" on page 73.

Urgent Care

Urgent Care is defined as care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require ER Care. An Urgent Care Facility offers an alternative when there is not an emergency and you don't have access to your PCP. It is generally less expensive than an ER visit. An Urgent Care Facility usually has immediate access. In an ER, you may have to wait longer.

Urgent Care Facilities may treat simple situations such as:

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

See the list of Urgent Care Facilities in the *Provider Directory* or on our website.

Normal Office Hours:

Urgent Care Facilities do not take the place of your PCP. Your PCP should be your first contact whenever you need non-emergency medical care. If you do need to go to an Urgent Care Facility, it is a good idea to have the results of any exams or Diagnostic Tests sent to your PCP, along with a list of new prescriptions. That helps maintain continuity of care.

If you have an urgent medical illness or injury that cannot wait for a regular appointment, call your PCP's office.

- Your PCP may arrange to see you right away or give you medical advice and direction.
- If your PCP is not able to set up an urgent appointment, you may ask to see another Provider in that office.
- Your PCP may direct you to an Urgent Care Facility if another physician is not available to

see you.

After Office Hours:
If you need to talk to or see your PCP after the office has closed, you have two options:

1. Call the number on your Member ID card for your PCP. When a nurse or physician is on call, he/she will return your call and advise you how to proceed. Otherwise, you should follow the PCP's after-hours voicemail instructions, which may include directing you to a Network Urgent Care Facility or emergency room.
2. You may choose to self-refer to a Network Urgent Care Facility if your condition cannot wait for your PCP. Preauthorization is not required.

Out of Service Area:
If you are traveling and require Urgent Care that you cannot delay until you return to our Service Area:

- Contact your PCP for medical advice and direction; or
- Self-refer to an Urgent Care Facility. Preauthorization is not required.

Prescriptions:
Fill your prescriptions at any Network pharmacy. See page 15. Call Express Scripts Holding Company ("ESI"), go to our website, or see our *Provider Directory* for a list of Network pharmacies including 24-hour pharmacies. Pay your Cost-share. Utilization Management rules may apply. See chart on page 29. Your regular physician should prescribe any refills, if needed.

Please Note:

- You should not use an Urgent Care Facility in place of your PCP for routine services or care that can wait for your PCP. Use of Urgent Care Facilities is only for an unforeseen illness, injury, or condition that requires immediate, Medically Necessary care when your PCP is not available.
- Your PCP must provide or arrange for all follow-up care. Preauthorization may be necessary, depending on the care needed.

Emergency Care

An emergency involves a medical condition manifesting itself by acute symptoms of severity (including severe pain) such that a Prudent Layperson, who has an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a) Placing the health of the individual in serious jeopardy;
b) Serious impairment of bodily functions; or
c) Serious dysfunction of any bodily organ or part.

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

a) That there is inadequate time to effect a transfer to another Hospital before delivery; or
b) That transfer may pose a threat to the health or safety of the mother or the unborn child.

Access:
You should not use an emergency room ("ER") visit in place of your PCP for routine services and non-emergency situations. However, in a true emergency, follow these steps:

1. Go to the nearest Hospital ER or call 911. You do not need Preauthorization for emergency care.
2. Show your Member ID card.
3. Call your PCP's office and us within forty-eight (48) hours after visiting the ER.
4. We may arrange to transfer you to a Hospital in our Network if you are admitted to an Out-of-network Hospital.
5. ***All follow-up care after being treated in the ER must be***:
    - Provided or arranged by your PCP.
    - Preauthorized by us if required. You will receive an approval letter in the mail. If you need care urgently, contact the Utilization Management Department. See "Urgent Decisions" on page 27.

Prescriptions:
Fill your prescriptions at any Network pharmacy. See page 15. Pay your Cost-share. Call ESI, go to our website, or see our *Provider Directory* for a list of Network pharmacies including 24-hour pharmacies. Utilization Management rules may apply. See chart on page 29. Your regular physician should prescribe any refills, if needed.

Accidents:
If you are in an accident and outside the Service Area, or have no control over where you are taken, you must notify your PCP and GlobalHealth within forty-eight (48) hours. We may arrange to transfer you to a Hospital in our Network.

Hospital Care

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

Home Care:
Your Provider may decide to have a nurse visit you at home rather than continue your stay in the Hospital. See "Home Healthcare" on page 47.

Medical Records

Since your PCP manages your care, it is important that he/she knows your medical history. If you are a new patient, we recommend you have your medical records transferred to your PCP's office before your first appointment. This will make him/her aware of any health conditions you may have.

Coordination of care between your physicians promotes patient safety and quality of care. The easiest way to be sure your PCP knows about other care you receive 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:

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

Your PCP will provide follow-up care if appropriate. He/she may be able to answer questions about the treatment or recommendations for treatment you received. Be sure to share a list of any new prescriptions. Your PCP will be able to check for potentially dangerous drug interactions.

Federal law requires Providers to protect patient medical information. They will handle your information with complete confidentiality.

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

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 three (3) years. This process helps to ensure the quality of our Network.

You can usually obtain information about a doctor's training and experience from:

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

A few state licensing boards issue information about disciplinary actions, but getting it may be cumbersome.

Several online organizations provide easy access to various amounts of information such as:

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

The American Medical Association's ("AMA") Doctor Find offers limited information on the certification status of all medical physicians currently licensed in the United States. It does not list disciplinary actions. You can do searches only one state at a time. This service is free of charge. For more information, visit www.ama-assn.org.

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

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

Check Specialists:
You can use the American Board of Medical Specialties ("ABMS") Certified Doctor Verification Service to check whether a doctor is certified by one of the twenty-four (24) recognized specialty boards. The searches yield no other information.

You can search all states simultaneously. This site is useful for checking the certification status of a doctor whose location is unknown. Registration at the site is required, but this service is free of charge. For more information, visit www.abms.org.

Check Behavioral Health Specialists:
There are several websites to check certifications.

Specialty	Contact Information
• Licensed Psychologists • Psych Techs (testing only for techs)	https://www.ok.gov/psychology/Public/License_Verification/index.html
• Licensed Clinical Social Workers	https://pay.apps.ok.gov/medlic/social/licensee_search.php
• Licensed Marriage and Family Therapists • Licensed Professional Counselors • Licensed Behavioral Practitioners	https://www.ok.gov/health/counselor/app/index.php
• Licensed Alcohol and Drug Counselors	http://www.okdrugcounselors.org/members.php

UTILIZATION MANAGEMENT PROGRAMS

Medical and Behavioral Health Utilization Management

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

1. The healthcare services that are covered and payable under your Plan.
   - Services must be Covered Services and meet coverage requirements. We cover services listed in limitations only as listed. We do not cover services listed in Excluded Services. See "Benefits" beginning on page 32.
   - Services must be Medically Necessary. That is, healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, disease, or its symptoms. Services must meet generally accepted standards of care.
2. The extent of such coverage and payments.
3. The appropriate level of care considered effective for your illness, injury, or disease in terms of:
   - Type;
   - Frequency;
   - Extent;
   - Site; and
   - Duration.

Our staff uses nationally recognized guidelines and resources, such as Milliman Care Guidelines®, Hayes®, and Medicare guidelines (Local Coverage Determinations and National Coverage Determinations) when conducting reviews. The criteria for medical necessity determinations are available to any current or potential Member or Network Provider upon request.

Our Medical Director makes all medical necessity determinations. The Medical Director is a licensed physician in good standing.

Pre-service Authorization

Most Covered Services, such as Specialist visits, Hospitalization, and Outpatient surgery, require Preauthorization from us. There are a few exceptions, such as Hospitalization for childbirth (at a Network Facility), emergencies, and services for which you may self-refer. Otherwise, if you do not obtain Preauthorization, you will have to pay the entire cost of the services. "Services" includes any treatment, tests, procedures, supplies, or equipment.

Your physician should submit Referrals for services on your behalf. But, ultimately it is your responsibility to make sure we have authorized your services.

We will send you a letter once we approve the services. This letter will provide you with the name and contact information for the authorized doctor or Facility and the services that we authorized. You must receive this letter before obtaining Covered Services. If your physician refers you to an Out-of-network physician or Facility, we may select a Network Provider for you. You should wait until you receive authorization before making any appointments.

Any additional treatment, Diagnostic Tests, or procedures beyond what we authorize require additional authorization from us. You may be financially responsible for payment if you do not obtain authorization before receiving services.

Non-Urgent Decisions:
We make non-urgent pre-service decisions within fifteen (15) calendar days after receiving the request. We may extend this period one time for up to fifteen (15) days if:

- It is necessary due to matters beyond our control;
- We notify you, prior to the expiration of the initial 15-day period, of why it is necessary; and,
- We notify you of the date by which we expect to render a decision.

If such an extension is necessary because we do not have the information necessary to decide the Claim:

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

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

You may contact the UM Department during regular business hours - Monday - Friday, 9 am - 5 pm Central Time.

Call	**Contact Information**
Local	(405) 280-5600
Toll-free	1-877-280-5600
TTY	711

You may contact the UM Department outside of regular business hours. Leave your name and contact information and you will receive a response on the next business day.

Call, E-mail, or FAX	**Contact Information**
E-mail	um@globalhealth.com
FAX	(405) 280-5398
Local	(405) 819-7574
Toll-free	1-877-280-5600
TTY	711

If we do not authorize a requested service, in whole or in part, we will send a letter explaining the reason. We will also send a copy of *Appeal Rights*.

Please Note:

- Although some services do not require Preauthorization, you must use In-network Providers. See "Self-referral Services" on page 18. Also see "Balance Billing by an Out-of-network Provider" on page 81 for special situations.
- You must receive authorized services while you are a current Member. You are not entitled to benefits, even if authorized, after your coverage ends.
- You may track your Referral for Medical Services through your MyGlobal account. Contact Customer Care to get your logon information.

Concurrent Review
Our concurrent review process assesses:

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

Inpatient services extending beyond the authorized period require concurrent review.

If we have approved a course of treatment (you receive over a period of time or number of treatments):

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

See "Appeals and Grievances" on page 87.

Discharge Planning
Transition of care management / discharge planning starts at the time of Hospital admission or when we authorize the admission. The plan may include benefits you will need upon discharge. Covered Services needed upon discharge may require Preauthorization to a Provider or Facility.

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

Prescription Drug Utilization Management

For certain Prescription Drugs, special rules restrict how and when we cover them. A team of physicians and pharmacists developed these Utilization Management rules to help you use drugs in the most effective ways. These rules also help control overall drug costs, which keeps your coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher cost drug, our rules are designed to encourage you and your Provider to use that lower-cost option.

If there is a restriction for your drug, it usually 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 restriction for you, you will

need to use the exception request process. We may or may not agree to waive the restriction for you. See "Exception Requests" below.

Please note that sometimes a drug may appear more than once in our drug list. This is because different restrictions or Cost Sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your healthcare Provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

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

Call (918) 878-7361 to request information on one of the following:

Type	Description
Prior Authorization	Physicians are required to obtain Preauthorization for certain drugs. This promotes appropriate, cost-effective use. Any corresponding supplies or equipment also require Preauthorization.
Quantity Limits	There are limits to the amount of certain drugs that you may receive. These drugs, if taken inappropriately for too long a time period, could be unsafe and cause adverse effects.
Step Therapy	Step therapy requires that you try one or more prerequisite, clinically equivalent drugs before we cover a step therapy drug.

Exception Requests

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

Time Frame	Process
Standard Exception	You can ask us to waive coverage restrictions and limits. You may submit your request in writing, electronically, or telephonically. Generally, we will only approve your request for an exception if: • The alternative drug is included on the Plan's Formulary; • The drug in the lower Tier or additional utilization restrictions would not be as effective in treating your condition; and • It would cause you to have adverse medical effects. In the case of a request to cover a non-formulary drug, the physician must include: • A justification supporting the need for the non-formulary drug to treat your condition; and • A statement that all covered Formulary drugs on any Tier will be or have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects. You, your designee, or your physician should contact us for instructions on obtaining a utilization restriction exception. Your physician may have to submit a prior authorization request form with supporting information. Generally, we make a decision within seventy-two (72) hours of receiving your request and sufficient information to begin the review. • If granted, the exception will be for the duration of the prescription, including

Time Frame	Process
	refills. • If we deny your exception request, you may request an External Review. See "External Review" on page 90. You will receive the determination within seventy-two (72) hours of receiving your request for review. Your drug will be covered during the time we are reviewing, and if applicable, during the External Review.
Expedited Exception	You, your designee, or your prescribing physician may request an expedited exceptions process when: • You are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function; or • You are undergoing a current course of treatment using a non-formulary drug. We will provide a decision to you, your designee, or the prescribing physician within twenty-four (24) hours after receiving the request and sufficient information to begin the review. • If granted, the exception will be for the duration of the prescription, including refills. • If we deny your exception request, you may request an External Review. See "External Review" on page 90. You will receive the determination within twenty-four (24) hours of receiving your request for review. Your drug will be covered during the time we are reviewing, and if applicable, during the External Review.

Policy on Ensuring Appropriate Utilization

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

Technology Assessment Process

We have a technology assessment and guideline review process. We review requests for coverage of newly available devices, procedures, or treatments that are not considered established benefits.

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

The committee reviews medical and behavioral healthcare procedures, drugs, and devices using scientific medical evidence. We will only consider the new procedure, drug, or device after an appropriate regulatory agency, such as the U.S. Food and Drug Administration ("FDA"), has approved it.

Before approving coverage, we require documented evidence to ensure the efficacy and safety of the new technology. The new technology must:

- Improve the net health outcome of the Member;
- Be as beneficial as established alternatives;
- Be available outside the investigational setting;
- Significantly improve the quality of life of the Member; and,
- Clearly demonstrate safe medical care to the Member.

BENEFITS

This section explains your Plan's benefits, including what is and is not covered for each type of benefit. While the following Covered Services are representative of GlobalHealth's Plans, it is not all-inclusive.

Refer to your *Schedule of Benefits* to see the specific Cost-share (Copayment and Coinsurance) you pay for the services described in this section. It will also tell you the maximum out-of-pocket ("MOOP") for your Plan. Contact our Customer Care Department if you need help determining your Cost-share.

Your Cost-share is due for each visit, treatment, admission, prescription, or occurrence, unless otherwise noted, up to your MOOP. Covered Services of all types count toward the same MOOP. See "Maximum Out-of-pocket" on page 80.

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.

Coverage Requirements

We cover the benefits described in this section only when they meet the following coverage requirements. These requirements apply to all types of benefits described in the "Benefits" section.

Requirements	Description
All requirements must be met	• Your services (including treatment, diagnostic services, supplies, drugs, and equipment) must be Medically Necessary; • Services must meet generally accepted standards of care; • You receive your care from a Network Provider acting within the scope of his/her license. Except for Emergency Services and out-of-area Urgent Care, a Network Provider must provide your services unless you obtain Preauthorization to go to an Out-of-network Provider from us. See "Balance Billing by an Out-of-network Provider" on page 81; and • Unless otherwise noted, we require Preauthorization. You will have to pay the entire cost of the service if you do not obtain Preauthorization when required.
When benefits are limited or not available	• We do not cover services once you can no longer improve from treatment; or • The care is either custodial or only for the convenience of others. • We do not cover some benefits (Excluded Services) or we cover them in only certain circumstances (limitations). See "General Excluded Services and Limitations" on page 65.

Behavioral Health Benefits

Description of Covered Services
Also see "Coverage Requirements" on page 32.

Members access Inpatient and Outpatient behavioral health services for the diagnosis and treatment of:

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

Call	Telephone Number
Toll-free	1-877-280-5600
TTY	711
Emergencies	911

If you are a new Member and receiving mental health or substance use care, please call as soon as possible. If your Provider is not contracted, we will assist you in finding the Provider who is right for you. See "Behavioral Health Transition of Care" on page 73.

Additional Services:

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

Autism Spectrum Disorder Treatment:
We cover diagnosis and psychiatric and psychological care for Members under age nine (9), or if not diagnosed or treated until after three (3) years of age, coverage for at least six (6) years. Coverage is 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.

Convulsive Therapy Treatment:
We cover electroshock treatment or convulsive drug therapy including anesthesia when given together with treatment by the same Provider.

Day/Night Psychiatric Care Services:
We cover services in a Facility on either a day-only or night-only basis in a planned treatment program.

Inpatient Medical and Psychiatric Services:
We cover the following services, provided by a Network Provider, limited to one (1) visit or service per day:

- Individual psychotherapy;
- Group psychotherapy;
- Psychological testing; and

- Medication management.

We do not cover both an Inpatient medical care visit and an individual psychotherapy visit when performed on the same day by the same physician.

Treatment must be rendered in a Hospital, psychiatric Hospital, residential treatment center, or by another approved Provider.

Outpatient Treatment of Mental Illness:
We cover standard non-emergency therapy, medication evaluation, and medication management by a physician, or other approved Provider in an Outpatient Facility setting. These services do not require Preauthorization. Applied behavioral analysis, psychological testing, home-based therapy, intensive Outpatient programs, residential treatment center programs, and partial Hospitalization programs are also covered and require Preauthorization.

Severe Mental Illness:
We cover "Severe Mental Illness", as defined by the American Psychiatric Association, as a standard medical benefit. We cover Inpatient or Outpatient services as any other illness.

These diagnoses include, but are not limited to:

- Schizophrenia
- Bipolar Disorders
- Major Depressive Disorders
- Schizo-affective Disorders
- Pervasive Developmental Disorders
- Obsessive-Compulsive Disorders

Course of Treatment:
A series of treatments is a structured, organized, and needed program which may include different Providers and Facilities. A course of treatment concludes when you are discharged on medical advice from Inpatient detoxification, Inpatient rehabilitation, partial Hospitalization, or intensive Outpatient program, or when you fail to materially comply with the treatment program.

All Providers are required to utilize evidence-based practice models to ensure you get the best treatment possible.

Treatment Settings:
You do not need to go through your PCP to receive any services for mental health or substance use. Most routine Outpatient services for behavioral healthcare do not require Preauthorization. We will provide Preauthorization when required. See the treatment setting chart below.

Treatment Setting	**Benefit Description**	***Provider Type**	**You Pay**
Outpatient therapy	Non-emergent therapy that may include medication management, therapy, and/or psychiatric testing. Preauthorization is not required.	LMFT LPC LADC LCSW LBP Psychologist	Behavioral health services office visit Cost-share
Case Management	Home-based support to assist in accessing community resources/services and self-help	BHCM LMFT	No Cost-share

Treatment Setting	Benefit Description	*Provider Type	You Pay
	support. Maximum of eight (8) sessions per month up to twenty-four (24) hours per Plan Year. Preauthorization is not required.	LPC LADC LCSW LBP Psychologist	
Psychosocial education	Home-based education on daily living and social skills development. Maximum of eight (8) sessions per month up to twenty-four (24) hours per Plan Year. Preauthorization is not required.	BHCM LMFT LPC LADC LCSW LBP Psychologist	No Cost-share
Crisis intervention	Non-life threatening crisis assistance available 24/7. Preauthorization is not required.	LMFT LPC LADC LCSW LBP Psychologist	Behavioral health services office visit Cost-share
Emergency treatment	Life threatening crisis. Contact us or have the ER Provider contact us as soon as reasonably possible. Preauthorization is not required.	ER Facility	ER Cost-share
Psychological, neurological, developmental, and substance abuse testing	Clinical evaluation performed using recognized assessment tools. Limited to eight (8) hours per Plan Year.	LMFT LPC LADC LCSW LBP Psychologist	Behavioral health services office visit Cost-share
Medication evaluation & management	Treatment provided specifically for evaluation and management of psychiatric and/or substance addiction disorder. Preauthorization is not required.	MD/DO	PCP office visit Cost-share
Intensive Outpatient program	Behavior modification or treatment multiple times a week for a predetermined number of hours a day, depending on course of treatment.	Various	Behavioral health Facility Cost-share
Partial Hospitalization (day treatment)	Treatment multiple times a week for a predetermined number of hours a day, depending on treatment plan. This treatment requires more days and/or hours per day than an intensive Outpatient program.	Various	Behavioral health Facility Cost-share
Medical detoxification	A Facility that provides a program for the treatment of chemical dependency using a treatment plan approved and monitored by a Network Provider. Any treatment Facility must	Detox Facilities	Behavioral health Facility Cost-share

Treatment Setting	Benefit Description	*Provider Type	You Pay
	be contractually affiliated with a Hospital. Treatment length depends upon related chemical used. Limited to 100 days per Plan Year.		
Residential treatment center	Non-acute Inpatient program. Limited to 100 days per Plan Year.	Various	Behavioral health Facility Cost-share
Acute Hospitalization	24-hour Inpatient program in either a Hospital or psychiatric Hospital. Emergency admissions do not require Preauthorization.	Hospital staff	Behavioral health Facility Cost-share

*See "Behavioral Health Providers" on page 14.

Prescription Drugs:
See "Prescription Drug Benefits" on page 55.

Coordination of Care
You have the right to not sign a release, but GlobalHealth encourages coordination of care between your Behavioral Health Provider and your PCP. Behavioral Health Providers are expected to coordinate on a regular basis with your PCP on your diagnosis, medication evaluation needs, and medication response in order for your treatment to be most effective. Therefore, it is important for you to consider allowing these communications to happen.

The *Oklahoma Standard Authorization to Use or Share Protected Health Information* release form is on our website. See "Medical Records" on page 23.

Healthy Living Resources
Having a plan to manage the healthcare needs of you and your family goes beyond your healthcare visits and medications. It is also about finding balance in work, family, home, and social life. Improve the quality of your life by making healthy changes for you and your family.

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

To access your GlobalHealth team and materials go to www.globalhealth.com/state:

- Free annual health risk appraisal;
- Free tools to improve and maintain your health;
- Free information on how to manage a long-term condition(s);
- Satisfaction survey;
- Fun scavenger hunt that educates you on the resources and support available;
- Health materials; and
- Powerful eLearning modules lead you towards rediscovering your inner peace and mental well-being.

Prescription Drug Abuse
Prescription pain relievers can be highly addictive and dangerous.

Prescription Drugs, especially opioid analgesics – a class of Prescription Drugs used to treat both acute and chronic pain such as hydrocodone, oxycodone, codeine, morphine, and methadone – have increasingly been implicated in drug overdose deaths over the last decade. Among drug overdose deaths in 2013, many involved prescription opioids. Deaths related to heroin have also sharply increased.

Before you allow your physician to prescribe this type of drug to you, or if you have been taking this type of drug for a period of time, have a serious discussion regarding the potential for addiction and overdose.

If you do become addicted to any drug, contact us immediately for assistance.

Your benefits cover Outpatient therapies, medication assisted treatment programs, residential substance use treatment, as well as connecting you with community resources that will support you in your recovery process.

Medical Benefits

Description of Covered Services
You may choose to receive Covered Services in either an Outpatient department of a Non-preferred Facility or in a Preferred Facility. Be sure to ask when you make an appointment which type of Facility it is. Your Cost Sharing may be different depending on where you receive services.

The Facility Copayment for Inpatient Hospital or Outpatient surgery includes:

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

The Copayment for other settings includes (as appropriate, when provided during the visit and may require Preauthorization):

- Physician and professional services;
- Laboratory/radiology/diagnostic testing;
- Specialized scans/imaging/diagnostic exams;
- Procedures;
- Treatment therapies;
- *Drugs; and
- **Medical supplies and equipment.

*Allergy serum Cost-share is in addition to the office visit Cost-share, if any.
**Durable Medical Equipment, orthotics, and prosthetics Cost-share is in addition to the Facility, or visit Cost-share, if any. Items are included in the ER Cost-Share.

Also see "Coverage Requirements" on page 32 and "Balance Billing by an Out-of-network Provider" on page 81.

1. **Allergy Care –**
   You pay the Cost-shares for the office visit and for the serum and administration. Preauthorization is not required for PCP services. We cover:

Service	Description
Serum	Allergy serum and supplies for the administration of serum. Only covered if administered during an office visit. Cost-share is in addition to office visit Cost-share, if any.
Testing	Services and supplies used in determining an appropriate plan for allergy treatment.
Treatment	Services for the treatment of allergies using an established treatment plan.

2. **Ambulance –**

Coverage	Description
Covered Services	• Ambulance transport when a medical or psychiatric condition requires Emergency Services and an ambulance is required in order to receive these services; and • Non-emergency ambulance services when preauthorized by us. • Emergency ambulance transport does not require Preauthorization.
Non-covered services	• Wheelchair van services; • Gurney van services; • Air ambulance when you do not require the assistance of medically trained personnel and can be safely transferred or transported by other means; • Non-emergent ambulance when another mode of transportation is safe and acceptable; and • Commercial or public transportation.

3. **Anesthesia –**
   We cover eligible services in conjunction with a procedure or surgery. Your Facility Cost-share includes anesthesia services.

4. **Attention Deficit/Hyperactivity Disorder ("ADHD") –**
   We cover medical management, including diagnostic evaluation, treatment, and laboratory services associated with monitoring prescribed drugs. You pay the office visit Cost-share. See "Behavioral Health Benefits" on page 33 for neurological testing or behavior modification programs.

5. **Autism Spectrum Disorder –**
   Services and supplies for the treatment of autism spectrum disorder. We cover:
   - Behavioral health treatment;
   - Pharmacy care;
   - Psychiatric care;
   - Psychological care: and
   - Therapeutic care.

Benefit	Description
Applied behavioral analysis ("ABA") up to a	• Members under age nine (9), or if not diagnosed or treated until after three (3) years of age, coverage for at least six (6)

Benefit	Description
maximum of twenty-five (25) hours per week and no more than $25,000 per Plan Year	years limited to the following diagnoses: o Autistic disorder – childhood autism, infantile psychosis, and Kanner's syndrome; o Childhood disintegrative disorder – Heller's syndrome; o Rett's syndrome; and o Specified pervasive developmental disorders – Asperger's disorder, atypical childhood psychosis, and borderline psychosis of childhood. • Member must continually and consistently show progress and improvement. • You pay the ABA Cost-share.
Physical, occupational, and speech therapies – does not count toward the Rehabilitation Services visit limitations your child may otherwise be entitled to	• Members under age nine (9), or if not diagnosed or treated until after three (3) years of age, coverage for at least six (6) years limited to the following diagnoses: o Autistic disorder – childhood autism, infantile psychosis, and Kanner's syndrome; o Childhood disintegrative disorder – Heller's syndrome; o Rett's syndrome; and o Specified pervasive developmental disorders – Asperger's disorder, atypical childhood psychosis, and borderline psychosis of childhood. • You pay physical, occupational, and/or speech therapy Cost-share.
Autism Screening	• Members at age eighteen (18) months and twenty-four (24) months. • Provided during well-child visits at no Cost-share. • Preauthorization is not required.

6. **Blood and Blood Products –**
   We cover processing, storage, and administration, including collection and storage of autologous blood. Included in Facility Cost-share. Donated blood is a non-billable item.

7. **Bone Density Test –**

Age	Benefit
Age forty-five (45) years and older	• When a PCP or Referral physician has requested testing, subject to Diagnostic Test Cost-share • Reimbursement is limited to $150.00
Age sixty (60) years and older	• Routine osteoporosis Screening when at increased risk for osteoporotic fractures for no Cost-share
Age sixty-five (65) years and older	• No Cost-share – Preauthorization is not required

8. **Breast Cancer (and other breast conditions) –**
   In addition to treating the condition, we provide coverage for:

Benefit	Description

Benefit	Description
Inpatient care	• Not less than forty-eight (48) hours of Inpatient care following a mastectomy; • Not less than twenty-four (24) hours of Inpatient care following a lymph node dissection for the treatment of breast cancer; • Surgery and reconstruction of the other breast to produce symmetrical appearance; and • Treatment of physical complications of the mastectomy, including lymphedema. • You pay the Cost-share for the Inpatient Hospital Facility.
Prosthetic appliance	• Prostheses such as bras following a mastectomy at the prosthetic appliances Cost-share.
BRCA Preventive Care	• Genetic counseling, and, if indicated, testing for harmful BRCA mutations for women with a family history that may be associated with an increased risk of having a potentially harmful gene mutation. • Coverage is available at no cost regardless of whether you have previously been diagnosed with cancer, as long as you are not currently symptomatic of or receiving active treatment for breast, ovarian, tubal, or peritoneal cancer.

9. Cardiac and Pulmonary Rehabilitation –

Benefit	Description
Rehabilitation specific to patients with one of these conditions:	• Recovering from heart transplant; • Recovering from bypass surgery; • Recovering from heart attack; or • Chronic obstructive pulmonary disease.
Covered Services	• Exercise; • Education; and • Counseling.

10. Chemical Dependency –
See "Behavioral Health Benefits" on page 33.

11. Chiropractic Care –
We cover manipulative therapy or other services within a chiropractor's scope of practice. Limited to fifteen (15) visits per Plan Year. You pay the chiropractic care Cost-share.

12. Cleft Lip and Cleft Palate –
We cover Inpatient and Outpatient care for treatment of cleft lip or cleft palate or both including oral surgery, orthodontics, and otologic, audiological, and speech/language treatment.

13. Clinical Trials –
Routine Costs associated with an Approved Clinical Trial are covered under your Plan's regular Cost Sharing. The clinical trial must be for cancer or another Life-threatening Disease or Condition.

In order to be approved, the subject or purpose of the clinical trial must be the evaluation of an item or service that falls within a benefit category (e.g., Physician Services, Diagnostic Test) and not excluded from coverage (e.g., cosmetic surgery). The trial must have therapeutic intent and not designed solely to test disease pathophysiology. An approved organization must sponsor the trial and must be in compliance with federal regulations relating to the protection of human subjects.

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

14. Colorectal Cancer Preventive Screening –

We cover examination and laboratory tests for any non-symptomatic Members at least fifty (50) years of age. We cover Members less than fifty (50) years of age if at high risk for colorectal cancer as determined by your physician. We cover preventive Screenings at no Cost-share. See "Preventive Care Benefits" on page 59. You pay regular Cost-share for non-preventive testing.

Benefit	Description
Fecal occult blood testing ("FOBT")	• Once per year
Sigmoidoscopy	• Once every three (3) years • Once every five (5) years with FOBT
Colonoscopy	• Once every ten (10) years , the preventive Screening process includes: o The required consultation prior to the Screening procedure if the attending Provider determines that the pre-procedure consultation would be medically appropriate for you; o The anesthesia services performed in connection with the preventive colonoscopy if the attending Provider determines that anesthesia would be medically appropriate for you; o The removal of polyps during the Screening procedure when necessary; and o The pathology exam to determine whether the polyp is malignant.

15. Complications of Pregnancy –

We cover conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. You pay the Cost-share for the service or treatment received. Emergencies and office visits to your OB/GYN do not require Preauthorization. Morning sickness and a non-emergency caesarean section are not Complications of Pregnancy.

16. Contraception Services –

Population	Benefit
Women – Includes at least	• Surgical coverage includes:

Population	Benefit
one (1) type within every FDA-approved method at no Cost-share	○ Sterilization surgery for women; ○ Surgical sterilization implant for women; ○ Implantable rod; and ○ Cervical cap. • Office visit coverage without a Preauthorization includes: ○ Shot/injection; ○ IUD copper; ○ IUD with progestin; and ○ Diaphragm. • Prescription Drug Coverage includes: ○ Oral contraceptives (combined pill); ○ Oral contraceptives (progestin only); ○ Oral contraceptives extended / continuous use; ○ Patch; ○ Sponge; ○ Female condom; ○ Spermicide; ○ Shot/injection; ○ Vaginal contraceptive ring; ○ Emergency contraception (Plan B/Plan B One Step/Next Choice); and ○ Emergency contraception (Ella). • Prescription Drug benefits require a written prescription from your Provider, even if you purchase the item over-the-counter. See your *Drug Formulary* for any restrictions. • If multiple services and FDA-approved items within a contraceptive method are medically appropriate, we will determine which specific products to cover without Cost Sharing. However, if your attending Provider recommends a particular service or FDA-approved item based on a determination of medical necessity for you, that service or item will be covered without Cost Sharing. We defer to your Provider. ○ See "Exception Requests" on page 29 to get coverage for Prescription Drugs. ○ See "Pre-service Authorization" on page 26 to get coverage for surgical services. • Services and items provided at no cost include the office visit or Facility at no Cost-share.
Men	• Procedures covered under office visit or surgical benefit with applicable Cost-share.

We do not cover reversal of voluntary surgical sterilization or genetic counseling.

17. Cosmetic and Reconstructive Surgery –

You pay the Cost-share for either the Inpatient Hospital or Outpatient Facility.

Surgery	Benefit

Surgery	Benefit
Cosmetic surgery	Limited to: • Repair conditions resulting from an accidental injury; • Breast reconstruction following a mastectomy; and • Improvement of the physiological functioning of a malformed part of the body not related to dentistry or dental processes to the teeth and surrounding tissue.
Reconstructive Surgery	Limited to: • Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions; • Post-mastectomy Reconstructive Surgery to restore or achieve symmetry, including treatment of physical complications; • Cranial facial abnormalities to improve function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects or developmental abnormalities; • Trauma, infection, tumors, or disease, and • Reduction mammoplasty.

18. Dental Care –

Medical Benefit	Description
General dental coverage	• Not covered.
Dental emergencies	• Services to treat accidental injury to the jaw, sound natural teeth, mouth, or face. • Replacement, re-implantation, and follow-up care of those teeth are not covered, even if the teeth are not saved by emergency stabilization. • You pay the ER Cost-share if you go to the ER. • Preauthorization is not required.
Dental treatment anesthesia	• Members who are: o Under the age of nine (9) when he or she has a medical or emotional condition that requires Hospitalization or general anesthesia for dental care; o Severely disabled; o A minor four (4) years of age or under who, in the judgment of the Practitioner treating the child, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia; and o Require Inpatient and Outpatient services because of an underlying medical condition and clinical status or because of the severity of the dental procedure. • Only anesthesia services are covered under Facility Cost-share if you receive services in an Inpatient or Outpatient Facility.

19. Diabetic Self-Management, Equipment, and Supplies –

Preauthorization not required for monitors we provide. See your *Drug Formulary* for what, if any, restrictions apply to specific supplies and drugs.

Service	Description
Outpatient self-management training, education, and medical nutrition therapy services at no cost	Limited to: • Visits upon the diagnosis of diabetes; • A physician diagnosis which represents a significant change in your symptoms or condition make changes in your self-management; and • Visits for re-education or refresher training.
Equipment and supplies covered under diabetic supplies Cost-share	Including, but not limited to: • Blood glucose monitors; • Blood glucose monitors for the legally blind; • Test strips for glucose monitors; • Visual reading and urine testing strips; • Injection aids; • Cartridges for the legally blind; • Syringes; • Insulin pumps and appurtenances thereto; • Insulin infusion devices; • Podiatric appliances for prevention of complications associated with diabetes; and • Other diabetes equipment and related services that are determined Medically Necessary by the Oklahoma State Board of Health, provided the federal Food and Drug Administration ("FDA") has approved such equipment and supplies.
Medications covered under Prescription Drug Cost-share	Including, but not limited to: • Insulin; and • Oral agents for controlling blood sugar.

20. Diagnostic Tests –

We cover diagnostic laboratory and diagnostic and therapeutic radiological services in support of basic healthcare services including, but not limited to:

- Blood tests
- Non-routine pap tests
- Standard x-rays
- Routine ultrasounds
- Non-routine mammograms

Routine services do not require Preauthorization. We cover routine pap tests and mammograms under Preventive Care at no Cost-share. We cover routine ultrasounds related to pregnancy under prenatal care at no Cost-share. Pathology and/or interpretation included in Diagnostic Tests Cost-share.

21. Durable Medical Equipment ("DME") –

We cover equipment and supplies ordered by a healthcare Provider for everyday or extended use. We determine whether to rent or purchase an item. You must return rental equipment when medical necessity ends.

Coverage	Description

Coverage	Description
Covered Services examples	• Examples include: o Oxygen and oxygen equipment o Wheelchairs o Crutches o Equipment and supplies for diabetes self-management • Replacement, repairs, adjustments, maintenance, and delivery costs of equipment. • You pay the DME Cost-share, except for during an ER visit.
Non-covered services	• Equipment, or electrical or mechanical features to enhance basic equipment, that serves as comfort or convenience. • Equipment used for environmental setting or surroundings of an individual. • Repair and replacement if the equipment is lost, sold, damaged, or destroyed due to improper use or abuse.

22. **Emergency Medications –**
We cover drugs prescribed by an ER Provider when filled at a Network pharmacy. Your regular physician should prescribe refills.

23. **Emergency Services –**
The ER Cost-share includes all services provided during your emergency room visit to evaluate the Emergency Medical Condition and treatment to keep the condition from getting worse. Emergency Services do not require Preauthorization.

If you are admitted to the Hospital from the ER department:
- We waive your ER Cost-share.
- You pay the Cost-share for Inpatient Hospital Facility.

24. **Eyeglasses –**
First set of basic frames and lenses following cataract surgery up to the maximum allowance of $100. Also see "General Excluded Services and Limitations" on page 65.

25. **Foot Care (Routine) –**
Limited to Members with a diagnosis of diabetes or peripheral vascular disease. You pay the office visit Cost-share.

26. **Hearing Services –**
Benefits for children are available through the end of the month in which they turn eighteen (18). When child benefits end, benefits for adults start the following month.

Benefit	Child Benefit Description	Adult Benefit Description
Hearing Screening and testing	• Screening by PCP – Preauthorization is not required. • Evaluation and testing. • You pay the office visit Cost-share for Specialist services.	• Not covered.
Speech exams	• Screening by PCP –	• Not covered.

Benefit	Child Benefit Description	Adult Benefit Description
	Preauthorization is not required. • Evaluation and testing. • You pay the office visit Cost-share for Specialist services.	
Hearing aids and devices	• Limited to one (1) aid per ear every forty-eight (48) months unless Medically Necessary to replace more often. • For Members under the age of two (2), four (4) additional ear molds may be obtained per year (two molds for each ear). • You pay the DME Cost-share.	• Not covered.
Cochlear device	• An implantable cochlear device for bilateral, profoundly hearing-impaired Members that do not benefit from conventional hearing aids. • Coverage is for Members at least eighteen (18) months of age or for pre-lingual Members with minimal speech perception using hearing aids. • Covered under the Facility Cost-share.	• An implantable cochlear device for bilateral, profoundly hearing-impaired Members that do not benefit from conventional hearing aids. • Covered under the Facility Cost-share.
Cochlear services	• Implantation of, and services related to, a cochlear device that meets the coverage guidelines to receive the device. • You pay the Cost-share for either the Inpatient or Outpatient Facility.	• Implantation of, and services related to, a cochlear device that meets the coverage guidelines to receive the device. • You pay the Cost-share for either the Inpatient or Outpatient Facility.

You pay the DME Cost-share for replacement parts and repairs. You will be responsible for any charge above the cost of a standard hearing aid. Hearing aid accessories or supplies (including remote controls and warranty packages) are not covered.

27. Home Healthcare –

We cover part-time or intermittent Medical Services provided in your home. A licensed nurse, or licensed speech, occupational, or physical therapist must provide medical Home Healthcare services.

Diabetes self-management training and training related to medical nutrition therapy, when provided by a registered, certified, or licensed healthcare professional. Includes instruction in medical nutrition therapy only by a licensed registered dietician or licensed certified nutritionist.

Limited to a total of 100 visits per Plan Year.

Your Home Healthcare Cost-share covers services, drugs, supplies, and equipment billed by the home health agency. You pay DME Cost-share for equipment billed separately.

28. Hospice Services –

We cover Hospice Services for Members in a Network Hospital hospice Facility or in-home hospice program.

We provide Hospice Services in accordance with the care plan developed by your team of Providers and caregivers. Your Hospice Services Cost-share covers services, drugs, supplies, and equipment billed by the hospice agency.

Hospice Care	Description
Services	• Skilled nursing • Certified home health aide, and homemaker services under the supervision of a qualified registered nurse • Bereavement services • Social services • Medical direction • Pharmaceuticals • Medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions • Physical, occupational, and speech pathology services for purposes of symptom control, or to enable you to continue activities of daily living and basic functional skills

29. Hospitalization –

We cover care in a Hospital that requires admission as an Inpatient and usually requires an overnight stay. If you transfer from ER, we waive the ER Cost-share and you only pay the Inpatient Hospital Facility Cost-share.

30. Immunizations –

See "Preventive Care Benefits" on page 59.

31. Infertility Services –

Coverage	Description
Covered Services	• You pay the office visit Cost-share for diagnosis, testing, and medication dispensed by a physician • You pay the Prescription Drug Cost-share for oral and self-

Coverage	Description
	injectable fertility drugs dispensed by a pharmacy • Treatment for men and women
Non-covered services	• In Vitro Fertilization ("IVF") • Intracervical Insemination ("ICI") • Gamete Intrafallopian Transfer ("GIFT") • Zygote Intrafallopian Transfer ("ZIFT") • Services associated with these procedures • Genetic counseling and genetic Screening • Insemination procedures and all services related to insemination • Reversal of a sterilization procedure • Cost of donor sperm or donor egg • Cryopreservation or storage of sperm (sperm banking), eggs, or embryos

32. Injectable Drugs –

Benefit	Description
Outpatient injectable drugs	• We cover injectable drugs given in the physician's office as part of the medical office visit.
Self-injectable drugs	• We cover self-injectable drugs at the applicable pharmacy Cost-share.

33. Inpatient Hospital Services –

We cover services including room and board, general nursing care, meals and special diets when medically necessary, use of operating room and related facilities, use of intensive care unit and services, x-ray services, laboratory, and other Diagnostic Tests, drugs, medications, biologicals, anesthesia and oxygen services, special duty nursing when medically necessary, radiation therapy, inhalation therapy, perfusion, and administration of whole blood and blood plasma. We cover short-term Rehabilitation Services and physical therapy when we expect it can result in significant improvement of your condition within two (2) months.

34. Laboratory Services –

We cover diagnostic and therapeutic laboratory services. You pay the Diagnostic Tests Cost-share. Preauthorization is not required.

35. Mammogram –

Routine mammograms are not subject to Preauthorization or Cost-share. See "Preventive Care Benefits" on page 59. You pay the Diagnostic Tests Cost-share for non-routine mammograms. 3D mammograms are not covered.

Age Range	Frequency
Between the ages of 35 and 40	One (1) routine mammogram during this 5-year span
Over the age of forty (40)	One (1) routine mammogram annually (every 12 months)

36. Maternity and Newborn Care –

If your PCP or OB/GYN refers you to another Provider or Facility for additional services, you are responsible for the applicable Cost-share. The 48/96 hour period begins at the time of

delivery. However, if you deliver outside the Hospital and you are later admitted in connection with childbirth (as determined by your Provider), the period begins at the time of admission.

Service	Description
Prenatal care	• Your physician will decide how many visits are right for you and what care you receive in each visit. Services include, but are not limited to: o Routine obstetrical care; o Routine Screenings; o Routine lab work; and o Routine ultrasounds. • Routine services have no Cost Sharing and Preauthorization is not required. See "Well Visit Checklists" on page 96. • You pay the applicable Cost-share for non-routine, non-preventive, or high-risk prenatal services.
Delivery and Inpatient services	• A minimum of forty-eight (48) hours of Inpatient care is allowed at a Hospital, or a birthing center licensed as a Hospital, following a vaginal delivery, for the mother and newborn infant after childbirth. • A minimum of ninety-six (96) hours of Inpatient care at a Hospital following a delivery by caesarean section is covered. • Care includes: o Delivery; o Physical assessment of the mother and the newborn infant; o Parent education; o Training or assistance with breast or bottle feeding; and o Performance of any appropriate clinical tests. • Preauthorization is not required for these specified services. • Normal, full-term delivery is defined as a delivery (vaginal or caesarean) within thirty (30) days of your due date. • The maternity delivery and Inpatient Hospital Cost-share covers both mother and baby. It includes delivery, Inpatient services, and newborn services. • Other non-emergency admissions or admissions beyond the 48/96 hour routine care require Preauthorization.
Inpatient newborn services	• We cover routine newborn care in the Hospital under the mother's maternity benefit. Preauthorization is not required for the 48/96 hour mother's stay. Also see "Well Visit Checklists" on page 96. • Newborns hospitalized beyond the 48/96 hour approved mother's stay require separate Inpatient Hospital Cost-share. • Your newborn will have coverage for Medically Necessary services for up to the first thirty-one (31) days of life. However, if you do not enroll your newborn in the Plan, coverage will automatically end after the thirty-one (31) days. • When the maternity care is for a Dependent child, the newborn (a Dependent of a Dependent) does not have

Service	Description
	coverage beyond the 48/96 hour approved mother's stay.
Postpartum care	• Up to six (6) weeks of postpartum care for a one-time Outpatient postnatal office visit Cost-share. • Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. One home visit within forty-eight (48) hours of childbirth by a licensed healthcare Provider whose scope of practice includes providing postpartum care is also covered. • Preauthorization is not required.
Breastfeeding supplies	• Breastfeeding supplies limited to purchase or rental of breast pump and related supplies. • Limited to one pump per Plan Year for women who are pregnant and/or nursing. • Rental or purchase of breastfeeding equipment is for the duration of breastfeeding. • No Cost-share.
Lactation support services	• Lactation support and counseling services extends for the duration of the breastfeeding. • No Cost-share.

37. Medical Supplies and Materials –

The office visit or Facility Cost-share includes medical supplies and materials used in the course of a visit or admission such as:

- Gauze
- Ointments
- Bandages
- Slings

We generally do not cover these items for any other purpose. Over-the-counter items are not covered.

38. Mental/Behavioral Health Services –

Includes both Inpatient and Outpatient care. See "Behavioral Health Benefits" on page 33.

39. Obesity Screening, Weight Loss Counseling, and Treatment –

We cover screening, counseling, and services for all Members at no Cost-share.

Weight management services at no Cost-share for Members at nineteen (19) and over with BMI of 30 kg/m^2 or higher:

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

See "Preventive Care Benefits" on page 59. Preauthorization is not required when services are performed by your PCP. We do not cover commercial weight loss programs.

40. Oral Surgery –

We cover surgical procedures occurring within or adjacent to the oral cavity for medical purposes only. You pay the Cost-share for either the Inpatient or Outpatient Facility.

Medical Benefits	Description
Oral and maxillofacial surgery	• Biopsy and excision of cysts or tumors of the jaw; • Treatment of malignant neoplastic disease; • Tooth extraction prior to a major organ transplant; and • Radiation of the head or neck, and non-dental surgical treatment procedures for congenital defects.
Orthognathic surgery - sufficient clinical documentation to support	• The malocclusion is affecting the patient's physical health, not just dental health; • The malocclusion has not been amenable to other standard and less invasive forms of treatment; and • Other medical problems such as difficulty swallowing, speech abnormalities, malnutrition related to inability to chew, and/or significant intraoral trauma that produce significant inability to function.

41. Orthotic Devices –

Limited to:

- Members with diagnoses pertaining to peripheral vascular disease or diabetes.

We cover replacements, repairs, and adjustments. Coverage is limited to normal wear and tear or because of a significant change in your physical condition.

You pay the orthotic devices Cost-share, except for during an ER visit.

42. Outpatient Services –

We cover services including diagnostic services, treatment services, and x-ray services, for patients who are ambulatory and may be provided in a non-hospital based healthcare Facility or at a Hospital. We cover short-term Rehabilitation Services and physical therapy when we expect it can result in significant improvement of your condition within two (2) months.

43. Outpatient Surgery –

We cover same-day surgical procedures performed in an Outpatient surgical Facility as a substitute for Inpatient care. Your Cost-share may be different depending on where you receive services. You pay the Outpatient Facility Cost-share.

44. Phenylketonuria ("PKU") Testing –

We cover newborn testing at no Cost-share. See "Preventive Care Benefits" on page 59.

45. Physical Therapy –

We cover evaluation by a licensed physical therapist without a Referral or Preauthorization. The physical therapist may submit a Referral request for up to thirty (30) days of treatment. You pay the physical, occupational, and/or speech therapy Cost-share for the evaluation and each therapy session. Services beyond the thirty (30) days require a physician's Referral and our authorization.

All physical therapy visits count toward the total combined physical, occupational, and speech therapy Outpatient visit limits for Rehabilitation Services or autism spectrum disorder services.

We cover massage therapy if provided during physical therapy. We do not cover massage therapy if that is the purpose of the visit or it is billed separately.

46. **Physician Services –**
We cover diagnostic, treatment, consultant, and Referral services provided by your PCP or a Specialist. We cover services provided by physicians and other health professionals as necessary to provide allopathic, osteopathic, chiropractic, podiatric, optometric, and psychological services in Inpatient, Outpatient, ER, Skilled Nursing Facility, and home settings. We cover services for the purpose of a second surgical opinion. Seeing physicians in a PCP, self-referral, or ER visit setting does not require Preauthorization.

47. **Prescription Drugs –**
We cover drugs that by law require a prescription. See "Prescription Drug Benefits" on page 55.

48. **Preventive Care –**
We update the list of Covered Services annually or as required by law. Most services your PCP or OB/GYN perform in his or her office do not require a Preauthorization. See "Preventive Care Benefits" on page 59 for services available at no Cost-share.

49. **Prostate Cancer –**
We cover Screening for men over the age of forty (40) at no cost. We cover treatment of the condition at regular Cost Sharing for the applicable Covered Services.

50. **Prosthetic Appliances –**
Implantation or removal of breast prostheses and bras are Covered Services only in connection with reconstructive breast surgery performed due to a mastectomy. Bionic and myoelectric prosthetics are not covered. Your Inpatient or Outpatient Facility Cost-share covers internal appliances. You pay the prosthetic appliances Cost-share for external appliances.

We cover replacements, repairs, and adjustments. Coverage is limited to normal wear and tear or because of a significant change in your physical condition. You pay the prosthetic appliances Cost-share, except for during an ER visit.

51. **Rehabilitation Facility –**
We cover services received in a Facility that specializes in physical, speech, and/or occupational therapy. The Outpatient visits count toward the total Outpatient visit limitations for Rehabilitation Services or autism spectrum disorder treatment for Members age six (6) and under.

52. **Rehabilitation Services –**
We cover services and devices provided by a registered physical, speech, or occupational therapist for the treatment of an illness or injury. Limited to sixty (60) Outpatient visits, combination of therapies. Outpatient visits include office visits and/or Rehabilitation Outpatient Facility visits. You pay the physical, occupational, and/or speech therapy Cost-share based on the setting.

53. **Routine Exam (Adult) –**
We cover one (1) routine exam per Plan Year for adults age nineteen (19) and over at no Cost-share. It includes a general checkup when the PCP discusses Preventive Care. You may receive some Preventive Care services during the visit. You may schedule other services. Preauthorization is not required. See "Well Visit Checklists" on page 96.

54. **Severe Mental Illness –**
See "Behavioral Health Benefits" on page 33.

55. **Skilled Nursing Facility Care –**
We cover care prescribed by a Plan doctor and performed in a Skilled Nursing Facility. Limited to 100 days per Plan Year.

56. **Sleep Studies –**
We cover tests that measure how well you sleep and how your body responds to sleep problems. These tests can help your doctor find out whether you have a sleep disorder and how severe it is. You pay the specialized scans, imaging, and diagnostic exams Cost-share.

57. **Special Programs –**
We cover education services and disease and Case Management programs at no Cost-share. No Preauthorization required. See "Special Programs" on page 92.

Service	Condition
Complex Case Management	• Specific conditions; and/or • Multiple Chronic Conditions.
Disease management programs	• Chronic heart failure; • Chronic obstructive pulmonary disease; • Coronary artery disease; • Diabetes; • Depression, anxiety, and other severe mental illness diagnoses; and • Substance use.
Health education services	• Asthma; • Behavioral health; and • Obesity.
Medication therapy management program	• Multiple drugs for Chronic Conditions.
Wellness program	• Smoking cessation.

58. **Specialized Scans, Imaging, and Diagnostic Exams –**
We cover specialized scans, imaging, and diagnostic exams including, but not limited to: CT scans, PET scans, SPECT scans, MRIs, nuclear scans, and sleep studies. You pay the specialized scans, imaging, and diagnostic exams Cost-share per scan. It includes interpretation. Your Cost-share may be different depending on where you receive services. Scans are included in the Facility Cost-share if received during an Inpatient admission, ER visit, or Outpatient surgery visit. Scans are included in the office visit Cost-share if received during a PCP, Specialist office, or Urgent care office visit.

59. **Substance Use Services –**
See "Behavioral Health Benefits" on page 33.

60. **Transplants –**
We cover organ, tissue, bone marrow, and stem cell transplants which are not Experimental or Investigational in nature. We cover office visits, lab work, tests, and Inpatient Hospital Facility expenses related to a transplant for the living donor and recipient. When only the recipient is a

GlobalHealth Member, donor benefits are limited to those not provided or available to the donor from any other source. You pay the applicable Cost-share for each visit.

We do not cover donor search. You must use a plan-designated center of excellence.

61. Treatment Therapies –

Your Cost-share is based on the setting where you receive treatment. It covers services and supplies. Your Facility Cost-share covers services and supplies while Inpatient.

Treatment	Description
Chemotherapy	• You pay the Prescription Drug Cost-share for oral and self-injectable/self-administered chemotherapy. • Treatment administered by clinical staff covered under treatment Cost-share.
Dialysis	• Acute and chronic hemodialysis services and supplies covered under treatment Cost-share. • Peritoneal dialysis services and supplies covered under Home Healthcare Cost-share.
Growth Hormone Therapy ("GHT")	• You pay the Prescription Drug Cost-share for oral and self-injectable/self-administered GHT. • Treatment administered by clinical staff covered under treatment Cost-share.
Radiation therapy	• You pay the treatment Cost-share for standard and complex radiation.
Respiratory/inhalation therapy	• You pay the treatment Cost-share for treatments. • You pay the DME Cost-share for home equipment.
Infusion therapy	• The therapeutic use of drugs or other substances a Network Provider prepares and administers through a needle or catheter. • Infusion services must be provided in: o The home; o A free standing clinic or doctor's office; o A Hospital; o A Skilled Nursing Facility; or o A Rehabilitation Facility.

62. Urgent Care –

We cover services received in an Urgent Care Facility. Preauthorization is not required. See "Urgent Care" on page 21.

63. Vision –

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

64. Well-child Care –

Routine child health services are covered for no Cost-share at specific ages. Preauthorization is not required. See "Well Visit Checklists" on page 96.

65. Well-woman Exam –

We cover each Preventive Care service once per Plan Year for no Cost-share. Multiple visits may be required to obtain all recommended services as determined by your physician. Routine tests and counseling are not subject to Preauthorization when provided by your PCP or OB/GYN. See "Well Visit Checklists" on page 96.

66. Wigs –

We cover wigs or other scalp prostheses necessary for your comfort and dignity when required due to loss of hair resulting from chemotherapy or radiation therapy. Benefits limited to $150 per Plan Year. You pay the prosthetic appliances Cost-share.

Prescription Drug Benefits

Description of Covered Services

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

We also cover some over-the-counter drugs and products. Please see "Affordable Care Act" on page 57.

Please note:

- All covered drugs and products must be FDA-approved.
- Quantity limits, prior authorization criteria, and step therapies may apply. See your *Drug Formulary* for any restrictions to a specific drug.
- A Network physician must write the prescription. Exceptions are limited to:
  - ER or Urgent Care physicians; and
  - Dentists.
- If an Out-of-network physician in either an ER or Urgent Care Facility writes a prescription, you will receive a letter that other prescriptions written by the same Out-of-network physician are not covered. Your regular physician should handle all follow-up care, including writing or refilling your prescriptions.
- A Network pharmacy must fill the prescription.
- You pay the applicable Cost-share each time you fill or refill a prescription. You will pay your Cost-share or the cost of the Prescription Drug, whichever is less.

Also see "Coverage Requirements" on page 32.

P&T Committee

The Pharmacy and Therapeutics ("P&T") Committee establishes and maintains the Formulary drug list. Formulary management decisions are based on:

- Scientific evidence; and
- Considerations that achieve appropriate, safe, and cost-effective drug therapy.

The committee meets at least quarterly. The committee reviews Utilization Management protocols and restrictions at least annually.

All new Food and Drug Administration ("FDA") approved drugs are reviewed within ninety (90) days. The committee makes a decision within 180 days of its release onto the market.

Committee membership includes a diverse set, a majority of whom are:

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

Preferred Formulary Drug List

We list preferred drugs in the *Drug Formulary*. Drugs on the list are selected based on quality (effectiveness and safety) as well as cost-effectiveness. It includes FDA-approved generic and brand name drugs.

Changes:

The list of drugs can change during the year.

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

Exclusions:

The P&T Committee excludes some Prescription Drugs from coverage because other therapeutic equivalents are considered:

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

We post a 60-day notice of exclusion on our website prior to the exclusion becoming effective.

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

Drug Tiers:

The *Drug Formulary* will tell you which Tier a drug is in and any Utilization Management that applies. The Cost-share and description for each Tier remains the same for the entire Plan Year. During the Plan Year, individual drugs may move to a different Tier. The new Tier Cost-share will apply after the 60-day Member notice. The *Drug Formulary* is available on our website. Please contact Customer Care for a printed copy.

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

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

Tier Level	Benefit Description
ACA	Preventive Care Prescription Drugs and over-the-counter drugs with a prescription. You pay no Cost-share. The list is subject to change as ACA guidelines are updated or modified.
Tier One	This Tier has two Cost Sharing levels. • You will pay the lower Cost-share for select, low-cost generics ("LCG"). • All other generics have a higher Cost-share.
Tier Two	Preferred brand name drugs on the Formulary have the next highest cost.
Tier Three	Non-preferred medications have the highest cost of these three (3) generic and brand name Tiers. This Tier contains both non-preferred name brand and specified high-cost generic drugs.
Tier Four	A specialty pharmacy fills Specialty Drugs. Specialty Drugs are limited to no more than a one-month supply per fill. • You will pay the lower Cost-share for preferred Specialty Drugs. • You will pay the higher Cost-share for non-preferred Specialty Drugs.

Affordable Care Act
Some products are available at no Cost-share, subject to reasonable medical management. Others are available with some Cost Sharing when there are multiple FDA-approved items that are medically appropriate. See the *Drug Formulary* for a list of drugs covered with and without Cost Sharing.

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

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

Contraception Drugs and Devices for Women:
The full range of FDA-approved prescription contraceptive methods are included. This means women can access oral contraception, 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 42.

Over-the-Counter:

We cover some FDA-approved over-the-counter ("OTC") drugs and products at no Cost-share. Not all tobacco cessation products are included.

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

Vaccines:
Immunizations listed in the "Preventive Care Benefits" on pages 61 and 63 are covered at no Cost-share. Immunizations required for work or travel are not covered.

Network Providers, including pharmacies, must provide the immunizations. See our website for a list of pharmacies that provide immunizations.

Generally, pharmacies only administer limited immunizations. You should go to your PCP for most immunizations.

Compounded Drugs
We do not cover compounded drugs.

Off-label Uses
Our Plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the FDA.

- We cover off-label uses of drug(s) used in the treatment of cancer or the study of oncology.
- We may cover certain investigational uses of chemotherapy for cancer treatment if administered as part of an Approved Clinical Trial.

We do not cover any other non-FDA approved off-label utilization of drugs or medical devices. This exclusion is for non-FDA approved:

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

Prescriptions Received in an Emergency Room or Urgent Care Facility
You may fill drugs prescribed by ER or Urgent Care physicians at a Network pharmacy. You will pay your pharmacy Cost-share. Utilization Management rules may apply. Your regular physician should prescribe refills, if needed.

Prescription Drug Abuse and Heroin Use
Opioid abuse is a serious public health issue whether drugs are prescribed, such as OxyContin® or hydrocodone, or drugs are illegal, such as heroin.

Be sure to dispose of drugs in a safe manner.

- Follow any specific disposal instructions on the Prescription Drug labeling or patient information that accompanies the drug. Do not flush drugs down the sink or toilet unless the patient information specifically instructs you to do so.
- Take advantage of programs that allow the public to 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 in your community. Contact your city's or county government's household trash and recycling service to learn about drug disposal options and guidelines for your area.
- Transfer unused medicines 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 receptacles ("drop-boxes"). Visit the DEA's website or call 1-800-882-9539 for more information and to find an authorized collector in your community.

See "Medication Therapy Management Program" on page 93.

Preventive Care Benefits

Description of Covered Services

Guidelines	Description
USPSTF	• Evidence-based items or services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force
HRSA	• Evidence-informed exams, Screenings, immunizations, and counseling in the comprehensive guidelines by the Health Resources and Services Administration, including such additional Preventive Care and Screenings with respect to women
CDC	• Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved

Service Types:
We cover the following types of Preventive Services as recommended by USPSTF, HRSA, and CDC. You do not have to pay a Copayment or Coinsurance or meet the Deductible, if any.

Benefit	Description

Benefit	Description
Types	• Counseling; • Exams; • Evaluations; • Immunizations; • Screenings; and • Tests
Ages	• Prenatal and perinatal care; • Care for infants, children, and adolescents; • Care for adults; and • Geriatric care.

You may be required to pay your normal Cost-share if the primary purpose of the service is for treatment rather than preventive Screenings. Services are preventive when there are no prior symptoms. Services are for treatment purposes when you are having symptoms or you have been diagnosed with a particular condition. There are two (2) exceptions. You may have these services with no Cost Sharing even with prior symptoms:

1. You may go to your PCP for one annual routine physical regardless of prior diagnoses; and
2. BRCA testing for women in certain situations. See "Breast Cancer (and other breast conditions)" on page 39.

Where an attending physician determines that a recommended Preventive Service is medically appropriate for an individual – such as, for example, providing a mammogram or pap smear for a transgender man who has residual breast tissue or an intact cervix – and the individual otherwise satisfies the criteria in the recommendation or guideline as well as all other coverage requirements, we will provide coverage for the recommended Preventive Service, without Cost Sharing, regardless of sex assigned at birth, gender identity, or gender of record at GlobalHealth.

Accessing the 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 determine which services are right for you and perform some services at that time. You can discuss which other services you need and set up additional Preventive Care appointments. He/she will submit any Referrals you need. There are two (2) exceptions:

1. You have direct access to your OB/GYN for services he/she handles; and
2. You have direct access to an imaging center for your mammogram.

Not everyone needs every Preventive Service. Each service has limits on when or how often it is covered. For more detailed information on each service below, see the USPSTF website, http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. Also see "Coverage Requirements" on page 32. Contact Customer Care if you have questions.

Services for Adults

These services do not require Preauthorization.

- Alcohol misuse Screening and counseling;
- Aspirin use for men and women of certain ages;

- Blood pressure Screening for all adults;
- Cholesterol Screening for adults of certain ages or at higher risk;
- Depression Screening for adults;
- Diabetes Screening for adults as part of cardiovascular risk assessment in adults age 40 – 70 who are overweight or obese;
- Diet counseling for adults at higher risk for chronic disease;
- Falls prevention counseling and preventive medication for adults age sixty-five (65) and older;
- Healthy diet and physical activity counseling for adults with high risk of CVD;
- Hepatitis B Screening for adults at high risk for infection;
- Hepatitis C virus infection Screening for adults at high risk and one-time Screening for adults born between 1945 and 1965;
- HIV Screening (testing) for all adults to age sixty-five (65);
- Immunization vaccines for adults – doses, recommended ages, and recommended populations vary:

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

- Obesity Screening and counseling for all adults;
- Sexually transmitted infection ("STI") prevention counseling for adults at higher risk;
- Syphilis Screening for all adults at higher risk; and
- Tobacco use Screening for all adults and cessation interventions for tobacco users.

Services for Women

These services do not require Preauthorization.

- Anemia Screening on a routine basis for pregnant women;
- Aspirin as preventive medication after twelve (12) weeks of gestation in women who are at high risk for pre-eclampsia;
- Breast cancer mammography Screenings every 1 - 2 years for women over age forty (40);
- Cervical cancer Screening for sexually active women;
- Chlamydia infection Screening for younger women and other women at higher risk;
- Contraception: FDA-approved contraceptive methods and patient education and counseling, not including abortifacient drugs;
- Depression Screening for pregnant and postpartum women;
- Domestic and interpersonal violence Screening and counseling for all women;
- Folic acid supplements for women who may become pregnant;
- Gestational diabetes Screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes;

- Gonorrhea Screening for all women at higher risk;
- Hepatitis B Screening for pregnant women at their first prenatal visit;
- HIV Screening (testing) and counseling for sexually active women;
- HPV DNA test every three (3) years for women with normal cytology results who are age thirty (30) or older;
- Osteoporosis Screening for women over age sixty (60) depending on risk factors;
- Rh incompatibility Screening for all pregnant women and follow-up testing for women at higher risk;
- STI counseling for sexually active women;
- Syphilis Screening for all pregnant women or other women at increased risk;
- Tobacco use Screening and interventions for all women, and expanded counseling for pregnant tobacco users;
- Urinary tract or other infection Screening for pregnant women; and
- Well-woman visits to obtain recommended Preventive Services for women under age sixty-five (65). Multiple visits may be required to perform all services.
    - Routine pap test
    - Human papillomavirus ("HPV") testing
    - Counseling for sexually transmitted infections
    - Counseling/Screening for HIV
    - Contraceptive methods and counseling
    - Counseling/Screening for interpersonal and domestic violence

Adult Services that require Preauthorization

- Abdominal aortic aneurysm one-time Screening for men of specified ages who have ever smoked;
- BRCA counseling about genetic testing and testing for women at higher risk;
- Breast cancer chemoprevention counseling for women at higher risk;
- Breastfeeding comprehensive support and counseling from trained Providers, as well as access to breastfeeding supplies, for pregnant and nursing women;
- Colorectal cancer Screening for adults ages 50 – 75;
- Contraception sterilization procedures; and
- Lung cancer Screening for adults ages 55 - 80 years who have a thirty (30) pack-year smoking history.

Services for Children

These services are performed as part of the newborn services at birth or during a well-child visit. Preauthorization is not required.

- Alcohol and drug use assessments for adolescents;
- Autism Screening for children at ages 18 and 24 months;
- Behavioral assessments for children at ages 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years;
- Blood pressure Screening for children at ages 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years;
- Cervical dysplasia Screening for sexually active females;
- Congenital hypothyroidism Screening for newborns;
- Dental caries Screening for children from birth through age five (5);

- Depression Screening for adolescents;
- Developmental Screening for children under age three (3), and surveillance throughout childhood;
- Dyslipidemia Screening for children at higher risk of lipid disorders at ages 1-4 years, 5-10 years, 11-14 years, 15-17 years;
- Fluoride chemoprevention supplements for children without fluoride in their water source;
- Gonorrhea preventive medication for the eyes of all newborns;
- Hearing Screening for all newborns;
- Height, weight and body mass index measurements for children at ages 0-11 months, 1-4 years, 5-10 years, 11-14 years, 15-17 years;
- Hematocrit or hemoglobin Screening for children;
- Hemoglobinopathies or sickle cell Screening for newborns;
- Hepatitis B Screening for adolescents at high risk, at ages 11-17 years;
- HIV Screening (testing) for children age fifteen (15) and older and adolescents at higher risk;
- Immunization vaccines for children from birth to age eighteen (18) – doses, recommended ages, and recommended populations vary:

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

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

Follow-up Care:
We cover follow-up care for conditions discovered during Preventive Care services through our regular care processes. Your physician will schedule an appointment, or submit a Referral request if needed, for treatment. There is no Cost Sharing for the Preventive Care service that led to the diagnosis, but you must pay the applicable Cost-share for treatment of the new diagnosis provided on a different date.

Vision Benefits

Description of Covered Services
We cover eye care services for the detection and treatment of diseases or injury to the eye.

Self-refer to a Network optometrist for your eye exam. Self-refer to a Network eyewear Provider for eyeglasses or contacts. Preauthorization is not required for vision benefits.

You may receive your eye examination and eyeglasses/contacts on different dates or through different Provider locations, if desired. However, you must obtain complete eyeglasses at one time, from one Provider.

Also see "Coverage Requirements" on page 32.

Benefit	Child Benefit Description	Adult Benefit Description
Exam	• Routine eye exam • Refraction exam • Dilatation as necessary	• Routine eye exam • Refraction exam • Dilatation as necessary
Frames	• Basic, after cataract surgery	• Basic, after cataract surgery
Frequency	• Once every Plan Year: o Examination • Once after cataract surgery o Single vision lenses o Basic frames o Contact lenses	• Once every Plan Year: o Examination • Once after cataract surgery o Single vision lenses o Basic frames o Contact lenses
Standard plastic, glass, or poly spectacle lenses – include scratch resistant coating	• Single vision, after cataract surgery • You pay all charges after we pay the maximum benefit of $100	• Single vision, after cataract surgery • You pay all charges after we pay the maximum benefit of $100
Lens options	• Not covered	• Not covered
Contact lenses	• Not covered	• Not covered

General Excluded Services and Limitations

All benefits described below are excluded or limited under this Plan for all types of services.

General Limitations

We cover certain benefits only as follows:

Benefit	Limitation Description
Ancillary services and supplies	• Hearing aids are limited to coverage for: o Children through the month in which he or she turns eighteen (18) years of age, one (1) aid per ear every forty-eight (48) months unless Medically Necessary to replace more often. o Children less than two (2) years of age, four (4) additional ear molds per Plan Year. • Corrective lenses and fittings limited to first set of basic frames and lenses (up to $100.00) following cataract surgery. • Routine foot care, shoes, shoe inserts, arch supports, and supportive devices limited to foot care for Members diagnosed with diabetes or peripheral vascular disease. • Orthopedic or corrective shoes limited to those permanently attached to a Denis Browne splint for children. • Wigs and scalp prostheses limited to $150 reimbursement per Plan Year when required due to loss of hair resulting from chemotherapy or radiation therapy. • Breast pumps limited to one (1) per Plan Year for women who are pregnant or nursing. • Orthotic devices limited to: o Members with diagnoses pertaining to peripheral vascular disease or diabetes.
Behavioral health services	• Autism Screening is limited to children at ages eighteen (18) months and twenty-four (24) months. • Developmental Screening is limited to children up to the age of three (3) years. • Compulsive disorders treatment is limited to programs for feeding and eating disorders. • Residential treatment center care limited to 100 days per Plan Year. • Medical detoxification limited to 100 days per Plan Year. • Behavioral health Case Management limited to eight (8) hours per month and twenty-four (24) hours per Plan Year. • Psychosocial rehabilitation limited to eight (8) hours per month and twenty-four (24) hours per Plan Year. • Psychological testing limited to eight (8) hours per Plan Year. • Psychiatric or psychological treatment for developmental disorders, limited to mental retardation, pervasive developmental disorder and other specific developmental disorders, such as autism, Rett's, or Asperger's. • Applied behavioral analysis limited to: o Members under age nine (9), or if not diagnosed or treated until after age three (3), for at least six (6) years;

Benefit	Limitation Description
	○ A maximum of twenty-five (25) hours per week; and ○ A maximum of $25,000 per Plan Year.
Chiropractic care	• Limited to fifteen (15) visits per Plan Year.
Cosmetic services	• Treatment, item, supply, drug, procedure, or any portion of a procedure performed primarily to improve physical appearance limited to: ○ Repairing conditions resulting from an accidental injury; ○ Improvement of the physiological functioning of a malformed part of the body not related to dentistry or dental processes to the teeth and surrounding tissue; and ○ Breast reconstruction following a mastectomy.
Dental services – medical coverage	• Dentistry or dental processes to the teeth and surrounding tissue limited to: ○ Emergency room services to treat accidental injury to the jaw, sound natural teeth, mouth, or face. ○ Improvement of the physiological functioning of a malformed part of the body resulting from a congenital defect. • General anesthesia/IV sedation for dental services limited to Members who are: ○ Under the age of nine (9) when he or she has a medical or emotional condition that requires Hospitalization or general anesthesia for dental care; ○ Severely disabled; ○ A minor four (4) years of age or under who, in the judgment of the Practitioner treating the child, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia; and ○ Require Inpatient or Outpatient services because of an underlying medical condition and clinical status or because of the severity of the dental procedure.
Experimental or Investigational therapies	• Drugs, items, devices, and procedures limited to: ○ Off-label uses of certain drugs used in the treatment of cancer or the study of oncology; and ○ Certain investigational uses of drugs, including chemotherapy for cancer treatment, if administered as part of an Approved Clinical Trial.
General care or Hospital Services	• Hospital private room limited to when the Member is required under the infection control policy of the Hospital to be in isolation to prevent contagion. • Treatment of injuries or illnesses sustained or contracted as the result of being under the influence of any narcotic, unless prescribed by a physician, limited to injury as a result of a medical condition (including both physical and mental health conditions).
Genetic analysis, services, or testing	• Genetic counseling and testing is limited to women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 and BRCA 2 genes.

Benefit	Limitation Description
Home Healthcare	• Limited to 100 visits per Plan Year.
Physical, occupational, and speech therapy	• Physical, occupational, and/or speech therapy services limited to sixty (60) combined visits per Plan Year for you to regain, maintain, or prevent deterioration of a skill or function that has been acquired, but then lost or impaired due to illness, injury, or disabling condition.
Prescription Drugs	• Inhaler extender devices, peak flow meters, Ana-Kits, and EpiPens are limited to three (3) per Plan Year. • Prescription diaphragms are limited to two (2) per Plan Year. • The Pharmacy and Therapeutics Committee's standard quantity limits, prior authorization criteria, and step therapies apply. • Specialty Drugs are limited to a one-month supply. • Smoking cessation products are limited to two (2) full 90-day courses of any FDA-approved tobacco cessation product per Plan Year, if prescribed by your PCP. Limited to Members who are at least eighteen (18) years old. • Drugs prescribed or administered by Out-of-network physicians in non-emergencies is 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 physician for a woman. • Biological sera, medication prescribed for parenteral use or administration, allergy sera, immunizing agents, and immunizing injectable drugs limited to immunizations covered under Preventive Care guidelines and administered at a Network pharmacy. • Prescription Drugs for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy, hyporgasmy, or decreased libido limited to post-prostate surgery indications.
Sexual dysfunction	• Services related to sexual dysfunction limited to drugs and supplies for post-prostate surgery indications.
Skilled Nursing Facility care	• Limited to 100 days per Plan Year.
Transgender services	• Limited to individually appropriate Preventive Care services.
Vision	• Routine services limited to one (1) check-up, including eye refraction, per Plan Year. • Treatment for orthoptics or visual training limited to a diagnosis of mild strabismus.

General Excluded Services

The following benefits are not covered:

Benefit	Excluded Service Description
Ancillary services and supplies	• Mattresses and other bedding or bed-wetting alarms. • Equipment or devices not medical in nature such as braces worn for athletic or recreational use, ear plugs, elastic stockings and supports, or garter belts.

Benefit	Excluded Service Description
	• Jacuzzi/whirlpools. • Power-operated vehicles that may be used as wheelchairs. • Purchase or rental of equipment or supplies for common household use including, but not limited to: Physical fitness equipment, traction tables, air conditioners, water purifiers, air-cleaning machines or filtration devices, cervical or lumbar pillows, grab bars, raised toilet seats, shower benches, beds, or chairs. • Bandages, pads, or diapers.
Behavioral health services	• Education, tutoring, and services for the purpose of diagnosing or treating a learning disability, disruptive, impulse-control, or conduct disorder. • Marital counseling.
Dental services – medical coverage	• General dental services. • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and the alveolar bones). • Correction of occlusive jaw defects, dental implants, or grafting of alveolar ridges. • Treatment of soft tissue for the purpose of facilitating dental procedures or dentures.
Experimental or Investigational therapies	• Drugs, therapies, and technologies whose long-term efficacy or effect is undetermined or unproven or whose efficacy is no greater than that of traditionally accepted standard treatment. • New procedures, services, supplies, and drugs until they are reviewed for safety, efficacy, and cost-effectiveness and approved by GlobalHealth.
General care or Hospital Services	• Treatment of any kind which is excessive or not Medically Necessary. • Services received without an authorization when one is required, and complications arising from those services. • Treatment of any kind received before your start date of coverage or after the time coverage ends, even if authorized. • Care or services provided outside the GlobalHealth Service Area if the need for such care or services could have been foreseen before leaving the Service Area. • Services, other than Hospital Services for behavioral health, for which you do not allow the release of information to GlobalHealth. • Services for travel, insurance, licensing, employment, school, camp, sports, premarital, or pre-adoption purposes. • Personal or comfort items. • Services received while outside of the United States (50 states and District of Columbia). • Charges for injuries resulting from war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer. • Treatment of injuries or illnesses resulting from an attempt or commission of a felony, or as a result of being engaged in an illegal occupation.

Benefit	Excluded Service Description
	• Services as a result of recreational drug or alcohol use. • Elective or voluntary enhancement procedures, services, supplies, or medications, including but not limited to: o Hair growth o Sexual performance o Athletic performance o Cosmetic purposes o Anti-aging • Separate charges for missed or canceled appointments, penalty or finance charges, maintenance and/or record-keeping, record copying, or Case Management services. • Treatment, supplies, drugs, and devices for which no charge was made. Treatment, supplies, drugs, and devices for which no payment would be requested if you did not have this coverage. • Custodial care, respite care, homemaker services, or domiciliary care. • Treatment for injury resulting from extreme activities including, but not limited to: o Base jumping o Bungee jumping o Bull riding o Car racing o Skydiving o Motorcycle stunts • Alternative drugs and/or treatments used in the place of standard therapy, to treat any condition or illness. • Screening services requested solely by you, such as commercially advertised heart scans.
Obstetrical and Infertility services	• Elective abortions. • Home uterine monitoring. • Expenses related to surrogate parenthood. • Alternative programs for delivery such as home delivery and use of midwives and birthing centers. • In vitro fertilization, artificial insemination, embryo transfers, reversal of voluntary sterilization, ovum transplant, gamete intrafallopian transfer (“GIFT”), zygote intrafallopian transfer (“ZIFT”), surrogate parenting, and donor semen expenses.
Other coverage	• Treatment for disabilities connected to military service for which you are legally entitled and to which you have reasonable accessibility (i.e., services through a federal governmental agency). • Services that are provided as a result of Workers’ Compensation laws or similar laws. • Treatment for which the cost is recoverable under any other coverage, including Workers’ Compensation, Occupational Disease law, or any state or government agency.
Other Excluded Services	• Services resulting in whole or in part from an excluded condition, item, or service.

Benefit	Excluded Service Description
Physical, occupational, and speech therapy	• Kinesiology, movement therapy, or biofeedback. • Rolf technique. • Massage therapy. • Acupuncture/acupressure. • Recreational therapy including, but not limited to: o Animal-facilitated therapy o Music therapy
Prescription Drugs	• Drugs and dietary supplements available without a prescription (over-the-counter) or for which there is a non-prescription therapeutic equivalent available, even if ordered by a physician. • Saline and medications for irrigation. • Topical testosterone products (e.g., AndroGel®, Fortesta®, etc.). • Drugs prescribed for a non-FDA approved indication, dosage, or length of therapy.
Repair and replacement	• Drugs, eyewear, devices, appliances, equipment, dental work, or other items that are lost, missing, sold, or stolen. • Items that have been damaged or destroyed due to improper use or abuse.
Transplants	• Artificial or non-human organ transplants or transplants considered experimental, investigative, or unproven. • Donor Screening tests and donor search expenses.
Transportation/lodging	• Routine, non-emergent ambulance transport unless preauthorized by GlobalHealth. • Lodging, meals, and transportation costs.
Vision	• Non-prescription lenses. • LASIK, INTACS, radial keratotomy, and other refractive surgery. • Computer programs of any type, including, but not limited to, those to assist with vision therapy. • Special multifocal ocular implant lenses.
Weight Reduction Programs	• Gastric stapling, gastric balloon services, or any surgical treatment for obesity or weight-loss purposes.

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

You are the Subscriber to the Plan. Your 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.

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

Children:
Your children, including foster children or adopted children from the date placed in the home, may continue as eligible Dependents through the end of the month in which they turn twenty-six (26) years of age. Also see "Aging-off Terminations" on page 77.

The Dependents of your Dependents are not covered.

Disabled Dependents:
Enrolled Dependents who attain the age of twenty-six (26) may continue Enrollment in the Plan beyond the limiting age if:

- The Dependent lives with you or your separated or divorced spouse;
- The Dependent is incapable of self-sustaining employment by reason of mental or physical handicap;
- The Dependent is chiefly dependent upon you for support and maintenance; *and*
- The mental or physical condition existed continuously prior to reaching the limiting age.

Service Area

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

Subscribers and spouses must live or work in our Service Area in order to obtain coverage. If you are away from our Service Area for more than six (6) months, contact your Insurance Coordinator or Benefits Coordinator. You should enroll with a different carrier that has a Network of Providers in your new area. There is a Special Enrollment Period during which you may enroll with another carrier that includes your new location in its Service Area.

Dependents Living Out-of-Area:
Child Dependents under the age of twenty-six (26) who live outside of our Service Area may enroll. He/she must have an assigned Network PCP to manage routine or chronic care. Out-of-network coverage is for Emergency Services and Urgent Care only unless we authorize specific Out-of-Network Coverage. See "Balance Billing by an Out-of-network Provider" on page 81.

Enrollment Periods

You should submit your Enrollment through your employer. Make your Premium contribution through your employer. We must receive your Enrollment during Option Period or within the time periods below.

Open Enrollment Period
You may enroll in GlobalHealth during your group's annual 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 eligible 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 ("QLE") below to be eligible for a mid-year change. If you have a change in circumstances, see your Insurance Coordinator or Benefits Coordinator to find out if you are eligible.

- You will have thirty (30) days in most cases to enroll if you have a change in family status or coverage.
- You will have sixty (60) days to enroll if you have a change in Medicaid or Children's Health Insurance Program ("CHIP") eligibility. See "Medicaid and CHIP Notice" on page 109

Change in family status:
Your rates may change if your coverage type changes. Your Insurance Coordinator or Benefits Coordinator will let you know what your Plan options are.

- Newborns. We cover your newborn from the date of birth. We automatically cover newborns that are born to a covered Subscriber (or covered spouse) for the first thirty-one (31) days of life for all Medically Necessary services. If you do not add a newborn as a Dependent during the first thirty-one (31) days, the newborn's coverage ends on day thirty-one (31).
- Adopted Children and Foster Children. We cover adopted and foster children from the date placed in the home.
- New Dependents as a Result of Marriage. If you marry, we cover new family members from the first day of the month following your marriage.
- Qualified Medical Child Support Order. We cover children for whom you or your spouse are required to provide health coverage to comply with a Qualified Medical Child Support

Order.

Change in coverage:
If you declined Enrollment for yourself or your Dependents (including your spouse) because of other Health Insurance or group health Plan coverage, you are eligible for a mid-year change if you lose coverage.

- You move from your carrier's Service Area.
- You lose Medicaid coverage.
- You lose limited Medicaid coverage not recognized as Minimum Essential Coverage.
- You gain lawful presence in the United States. See "Eligibility" on page 71.
- 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 the other coverage is no longer available due to:
  - You or your eligible family member has exhausted COBRA under another group health Plan;
  - Termination or reduction of hours of the person through whom you or your eligible family member were covered;
  - Termination of any other health Plan coverage;
  - The employer ceased to contribute toward you or your eligible family member's coverage; or
  - Death, divorce, or legal separation of the person through whom you or your eligible family member was covered.
- You are no longer incarcerated.
- You lose Minimum Essential Coverage.
- You have exceptional circumstances such as in the case of a child of an incarcerated parent.

To request special Enrollment or obtain more information, contact your Insurance Coordinator or Benefits Coordinator.

When Coverage Begins

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

The group Plan Year is effective January 1st through December 31st.

If you join a group Plan after the group effective date because you qualify for a mid-year change due to a family status or coverage change or you are a new hire, your Plan Year begins when you enroll and ends December 31st. Your next Plan Year will coincide with the group's Plan Year.

Continuity and/or Transition of Care

If we authorize you to continue care through an Out-of-network Provider, we will pay at least Usual and Customary amounts for your services. You could be balance billed. See "Balance Billing by an Out-of-network Provider" on page 81.

Referrals submitted by the authorized Provider must be for In-network Covered Services.

Examples of conditions that may require continuity or transition of care

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

If approved for ongoing care, we cover care through six (6) weeks postpartum care if you are in the second or third trimester, even if it is more than ninety (90) days. If you remain enrolled in the same Plan across Plan Years, these timeframes apply across Plan Years.

These approved provisions end:

- If you successfully transfer to a Network Provider;
- If you meet or exceed benefit limitations; or
- If care is excessive or not Medically Necessary.

If we do not approve ongoing care through the Out-of-network Provider, you may Appeal the decision. See "Appeals and Grievances" on page 87.

Behavioral Health Transition of Care
If you are undergoing treatment for mental health or substance use, contact us as soon as possible for transition instructions to our Network. See "Behavioral Health Benefits" on page 33.

Medical Transition of Care
If you are enrolling in GlobalHealth and changing from another health carrier, you may be eligible for care with your present Provider.

You will need to complete the *GlobalHealth Transition of Care Request Form*. This is necessary, even if your current PCP is also a GlobalHealth Provider. Some Specialists and Facilities currently scheduled for your care may differ from our Network. You can find the form on our website or contact Customer Care for a printed version.

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

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

We will notify you and your healthcare Provider if we authorize continued services or if we are going to transition your care to one of our Network Providers. If approved, you may receive up to thirty (30) days of ongoing course of treatment. If we do not approve continued care, you and your

healthcare Provider will receive a letter that includes our decision. We will provide information about your right to Appeal the decision.

Prescription Drug Transition of Care
If you are new to GlobalHealth, you may request coverage for:

- Non-formulary drugs; or
- Drugs on the Formulary that require prior authorization or step therapy.

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

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

Behavioral Health Continuity of Care
If a Behavioral Health Provider leaves the Network, we will notify you. Contact us for instructions to request continuity of care for mental health or substance use services. See "Behavioral Health Benefits" on page 33.

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

You must be in an active course of treatment to continue treatment until complete or for ninety (90) days, whichever is shorter, at In-network Cost Sharing. "Active treatment" means:

1. An ongoing course of treatment for a Life-threatening Disease or Condition;
2. An ongoing course of treatment for a Serious Acute Condition;
3. The second or third trimester of pregnancy through the postpartum period; or
4. An ongoing course of treatment for a health condition for which a treating physician or other healthcare Provider attests that discontinuing care by that physician or healthcare Provider would worsen the condition or interfere with anticipated outcomes.

Treatment for a medical condition must have been within the previous thirty (30) days.

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

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

Changes to Enrollment

It is your responsibility to notify us of any changes that affect eligibility for services and benefits. Changes that you must report include, but are not limited to:

- Social Security numbers for newborn children;
- Termination or addition of any other group health coverage;
- Permanently moving out of our Service Area; or
- Change in:
  - Name

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

You should make any change as soon as possible, but always within thirty (30) days. Please see "Enrollment Periods" on page 72 for mid-year change deadlines for changes. Call your Insurance Coordinator or Benefits Coordinator.

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

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

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

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

- Divorce
- Death of a spouse
- Your Dependent child is no longer eligible because of age

See "Continuation Coverage Rights Under COBRA" on page 103.

Changes to Your GlobalHealth Plan

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

The Office of Management and Enterprise Services ("OMES") may cancel the contract. Your employer should notify you in writing of the cancellation at least sixty (60) days before the contract expires.

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

Coverage Terminations

A termination is either a voluntary or involuntary cessation of coverage that occurs after the effective date. You will receive proper notice of termination if it is involuntary. We will mail your

notification within five (5) business days. The employer makes termination decisions for employer groups.

Employer Requested Terminations:
Your employer may ask us to end your group's coverage. It is your employer's responsibility to notify you when that happens.

Terminations for Fraud:
We may stop your coverage if you commit Fraud. For example, if you willingly gave your Member ID card to another person so that person could obtain services. See "Fraud and Abuse" on page 109.

The effective date of the termination may be retroactive. That means that the effective date is before the date we actually notify you. We will provide written notice at least thirty (30) days before we terminate your coverage. That will allow you time to contest.

If we decide that the termination stands, we may deny Claims for services you received after the effective date of termination, even if we received the Claims before we notify you. We will return your Premium for that period, if we received any.

Retroactive terminations may be made for up to thirty (30) days plus the current month. This means that a termination cannot be made for more than sixty (60) days before you are notified.

Terminations for Non-Payment of Premium:
You are not eligible for a mid-year change for loss of Minimum Essential Coverage.

- If your group's coverage terminates for failure to pay Premium;
- If your coverage or your Dependents' coverage terminates for failure to pay COBRA Premium; or
- If your coverage or your Dependents' coverage terminates for failure to enroll in COBRA after group eligibility ends within the specified timeframe to elect COBRA.

You may qualify for a mid-year change for other reasons. If you do qualify for a mid-year change for other reasons and you re-enroll, your previous MOOP does not carry into your new Plan. You may enroll during the next annual Option Period.

Aging-off Terminations:
Your children are eligible for Dependent coverage until the end of the month they turn twenty-six (26) years of age. We will send a termination notice including information about how to select a new Plan. You should receive the notice before the month you are to be disenrolled.

Reasons for Retroactive Terminations:

- Death – effective date of death;
- Fraud – effective date is variable;
- Exhausted Grace Period – effective the last day of the Grace Period;
- Medicaid/CHIP – effective the day before the new coverage starts with Medicaid/CHIP; or
- Plan error – effective the same day as the original effective date.

When Coverage Stops

Coverage stops automatically on the earliest of the following:

- The effective date is variable if Enrollment was based on Fraud.
- The last day of the month in which you or a Dependent were enrolled in a GlobalHealth Plan and you are enrolled into another carrier's Plan through a mid-year change because you permanently moved outside our Service Area.
- You are no longer eligible as defined by your employer.
- The date the group's coverage terminates. Unless otherwise provided, your coverage will expire at 12:01 am on the stated expiration date.
- You or your employer fails to make a Premium payment by the last day of the Grace Period.
- The last day of the month a Dependent becomes ineligible.
- If your employment is terminated or you are no longer eligible through your employer, the last day of the month for which the last Premium was paid.
- If the Subscriber of employer group coverage dies, coverage for Dependents ends on the last day of the month of the Subscriber's death. Contact the employer for the Dependents' continuation rights.

If a Dependent's coverage terminates, it does not affect the coverage of other family members. If the Subscriber's coverage ends, the membership of all Dependents stops as well. Coverage ends at 12:01 am on the day that the termination is effective. See "Continuation Coverage Rights Under COBRA" on page 103.

Continuation of Coverage

You may be able to continue coverage in the same Plan for sixty-three (63) days beyond these timeframes. You will be required to continue paying your Premium.

Continuation of coverage may not be available:

- If you fail to make timely Premium payments;
- If the group coverage terminates in its entirety during your continuation period;
- If you become entitled to similar coverage from another source during the continuation of coverage period; 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. Check with your Insurance Coordinator or Benefits Coordinator.

If you would like to purchase Health Insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.healthcare.gov. This is a website provided by the U.S. Department of

Health and Human Services that provides up-to-date information on the Marketplace, including how to enroll.

If You Are in the Hospital When Coverage Ends
You may continue to receive benefits for treatment of the illness or injury for which you are hospitalized while you are hospitalized and under a doctor's care.

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

Services must meet "Coverage Requirements" on page 32. We do not provide benefits for services treating any other illness, injury, or condition.

Insolvency
In the unlikely event of plan insolvency, we will continue your benefits as follows:

- For the duration of the period for which Premiums have been paid.
- If you are confined in a Hospital on the date of insolvency, until you are discharged or your benefits end.
- If you are pregnant, through delivery and discharge.

See "Notice of Protection Provided by Oklahoma Life and Health Insurance Guaranty Association" on page 115.

CLAIMS AND PAYMENT

Maximum Out-of-pocket

A maximum out-of-pocket ("MOOP") is a dollar amount that limits how much you have to pay for healthcare services. A MOOP is sometimes called an Out-of-pocket Limit. It includes Copayments and Coinsurance that you pay for Covered Services. See your *Schedule of Benefits* for your MOOP.

Count Toward MOOP?	Service
Covered Services that may count toward your MOOP - see "Benefits" on page 32	• Behavioral health services and treatment; • Medical Services and treatment; • Prescription Drugs; and • Vision services and eyewear.
Some expenses do not count toward your MOOP	• Premium payments; • Non-covered services; and • Balance Billing from an Out-of-network Provider.

If you reach your MOOP for the Plan Year, we will cover any Covered Services you need for the rest of the Plan Year without a Copayment or Coinsurance.

The per Member MOOP is met when a single Member pays Copayments and/or Coinsurance up to the level of his or her Plan. If you reach the per Member MOOP, you will not pay any more Cost Sharing for the Plan Year. This applies even if you have other family members also enrolled under the same Subscriber.

The family MOOP is met when any combination of family members under the same Subscriber pays Copayments and/or Coinsurance up to that level of his or her Plan. The amount paid for the per Member MOOP contributes toward the family MOOP. If one family member meets the per Member MOOP, the other family members will continue to pay applicable Cost Sharing until the family MOOP is met.

The MOOP of the most current benefit Plan applies if you change GlobalHealth benefit Plans during the Plan Year. We will apply Copayments and Coinsurance paid under the previous GlobalHealth benefit Plan within the same Plan Year to the current benefit Plan MOOP. You are not entitled to a refund if the current MOOP is less than the previous MOOP. If your coverage terminates due to nonpayment of Premium, and you later enroll through a mid-year change, your previous expenses do not count toward your new Plan Year MOOP.

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

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

Responsibility for Payment

Responsibility	Service
You are responsible	• Your Copayments or Coinsurance for approved Covered Services until the MOOP is met. • The charges for services provided by a physician or medical Facility without an authorized Referral from your PCP. • The cost of services not included in your GlobalHealth Plan benefits. • Balance Billing from an Out-of-network Provider rendering service at an In-network Facility. • Full billed charges when: o The services were non-covered services; o The services were received Out-of-network and were not authorized by us; or o You obtained the services through your own Fraud.
You are not responsible	• Any amounts owed by us to a Provider for approved Medically Necessary services that are covered by your Plan benefits. • Any amounts requested as Balance Billing (after we have paid the contracted Allowed Amount), provided that: o The services were Covered Services; o The services were approved by us; o The services were provided by a Network Provider; and o You have paid your required Cost-share, if any.

Balance Billing by an Out-of-network Provider

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

Special Situations

We maintain a comprehensive Network of Providers. As a general rule, you must receive care from Providers within our Network. However, there are some limited situations in which you may see an Out-of-network Provider. We pay Usual and Customary reimbursement. You could be balance billed:

- If you must seek Urgent Care when out of our Service Area.
- If you are treated for Emergency Services while Out-of-network.
- If we do not have a Provider in our Network to take care of your condition and we authorized a Referral to an Out-of-network Provider.
- If we have authorized services or treatment at an In-network Facility and you receive ancillary services or treatment from an Out-of-network Provider.
- If we have approved you to see a Provider through the continuity of care or transition of care process.

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

If You Receive a Bill

If you receive a bill for services you received and already paid for, send an itemized bill and proof of payment to the appropriate address below. You should keep copies of any documents you send to us for your records.

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

If you receive a bill for care that is covered under your benefit Plan, immediately contact us.

Call	Contact Information
Toll-free	1-877-280-5600
TTY	711
Mail	GlobalHealth, Inc. Attn: Claims PO Box 2328 Oklahoma City, OK 73101-2328

Medical:
Network Providers will bill services directly to us. However, if you receive urgent or emergent care out of our Network, you might receive a bill from those Providers.

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

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

Call or Mail	Contact Information
Toll-free	1-877-280-5600
TTY	711
Mail	GlobalHealth, Inc. Attn: Claims PO Box 2328 Oklahoma City, OK 73101-2328

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

Call or Mail	Contact Information
Toll-free	1-866-274-1612

Call or Mail	Contact Information
TTY	1-800-899-2114
Mail	Express Scripts Attn: Commercial Claims PO Box 14711 Lexington, KY 40512-4711

Coverage Decision
When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision. You must follow the "Coverage Requirements" on page 32.

- 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 your reimbursement of our share of the cost to you. 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. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to Appeal the decision. See "Appeals and Grievances" on page 87.

When GlobalHealth May Deny Coverage

- The services are not covered according to your *Schedule of Benefits;*
- The services are Excluded Services or are not covered as explained in limitations; or
- You received services or treatment before your coverage began or after your coverage ended.

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 87.

We will notify you of the Adverse Determination within thirty (30) days after receipt of the Claim. We may extend this period one (1) time for up to fifteen (15) days, provided that we determine:

- An extension is necessary due to matters beyond our control;
- We notify you, prior to the end of the initial 30-day period, of why the extension is needed; and
- The date by which we expect to render a decision.

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

When You're Covered by More Than One Plan

You must notify 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 group Plan, either as a Dependent or a Subscriber, we will coordinate benefits in accordance with applicable law. This means that we will determine which Plan will pay as primary (first) and which Plan will pay as secondary (second). You must follow the "Coverage Requirements" on page 32, whether we pay as primary or secondary.

When GlobalHealth benefits are secondary:
1. The primary payer pays its portion.
2. You pay your GlobalHealth Plan Cost Sharing.
3. We pay the remaining balance, up to our Allowed Amount.

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

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

Provisions	*COB Order of Benefit (Primary/Secondary) Determination Rules
	• A Dependent child whose parents are separated or divorced and a court decree establishes financial responsibility for healthcare expenses - the Plan of the parent with such financial responsibility is primary.

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

Notification:
When we need verification of other coverage for processing a Claim, we will request that you complete a *Coordination of Benefits (COB) Form*. Your failure to provide the completed form when requested will cause the Claim to be delayed or denied. We may ask you to complete a form annually.

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

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

For information about coordination of benefits, contact Customer Care.

Your GlobalHealth Plan and Medicare

If you are a Medicare recipient, either through yourself or your spouse, we will coordinate benefits with Medicare and determine which payer is primary. If Medicare benefits are primary, we will pay secondary for approved benefits less the amount paid by Medicare. If you have questions about Medicare, contact your local Social Security office or visit www.medicare.gov.

You must follow the "Coverage Requirements" on page 32, whether we pay as primary or secondary.

When GlobalHealth benefits are secondary:
1. The primary payer pays its portion.
2. You pay your GlobalHealth Plan Cost Sharing.
3. We pay the remaining balance, up to our Allowed Amount.

Third-Party Liability

Workers' Compensation:
If you are injured on the job and require healthcare services, you will need to sign an assignment of benefits form at your Provider's office. It allows the Provider to bill Workers' Compensation. Our

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

Third-Party

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

- To make a Claim for such expenses.
- To reimburse us for the cost of all such services if you receive a monetary recovery or settlement.
- That our right to reimbursement is the first priority Claim against any third-party. This means that we will be reimbursed from any recovery before payment of any other existing Claims, including any Claim by you for general damages.

We may collect from the proceeds of any settlement or judgment you receive, regardless of whether you have been fully compensated.

When you have released 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: Please see Subrogation, Third-Party Recovery, and Reimbursement on page 122.

Notify GlobalHealth

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

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 request a refund. You are then responsible for paying the Provider.

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

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

We may take longer than twenty-four (24) months to seek a refund in those cases.

APPEALS AND GRIEVANCES

Complaints and Grievances

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

It may concern:

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

Call or E-mail	Contact Information
Local	(405) 280-5600
Toll-free	1-877-280-5600
TTY	711
E-mail	appeals@globalhealth.com

For written Grievances, please include:

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

Mail or E-mail	Contact Information
Mail	GlobalHealth, Inc. ATTN: Grievances PO Box 2393 Oklahoma City, OK 73101-2393
E-mail	appeals@globalhealth.com

If you wish to file a complaint or Grievance, you should provide as much information as possible to describe the nature and substance of the matter.

You will receive an acknowledgement letter within five (5) days of GlobalHealth's receipt of your written correspondence. This letter will let you know when you can expect a response or resolution in writing from us. You will generally receive a final response within thirty (30) days unless otherwise specified.

Appeals

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

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

Contact us when you:

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

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

Your Appeal request must be submitted in writing **within 180 days** of the Adverse Determination notice and include the following:

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

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

Mail or E-mail	**Contact Information**
Mail	GlobalHealth, Inc. ATTN: Appeals PO Box 2393 Oklahoma City, OK 73101-2393
E-mail	appeals@globalhealth.com

Full and Fair Review

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

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

Initial Appeals Process
You will receive an acknowledgement letter within five (5) business days of our receipt of your Appeal request. This letter will let you know when you can expect a determination in writing from us. Appeals are generally completed within thirty (30) days of receipt of the request. If you do not receive our decision within thirty (30) days, you may be entitled to request an External Review as described below.

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

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

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

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

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

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

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

You, or someone authorized to act on your behalf, may submit a request for an expedited internal review to the address listed on page 87. Or a request may be made by telephone to Customer Care.

Call	**Contact Information**
Local	(405) 280-5600
Toll-free	1-877-280-5600
TTY	711

If we agree to process your Appeal as an expedited internal review, a determination will be made within seventy-two (72) hours of receipt of your request. If your Appeal does not qualify for an expedited review, we will process the Appeal under the standard timeframe of thirty (30) days.

External Review

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

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

Your request for an External Review must be made in writing **within four (4) months** of the final Appeal determination notice.

Note: You will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision.

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

The Insurance Department will randomly select a qualified Independent Review Organization ("IRO") to conduct the External Review. The IRO will notify you of its determination within **forty-five (45) days** of the receipt of the request for review.

Expedited External Review

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

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

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

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

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

Notices

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

Appointment of Representative

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

Behavioral Health Appeals

We handle all behavioral health Appeals. Follow the process for Appeals beginning on page 87.

Prescription Drug Appeals

ESI pays Claims for your Prescription Drugs. However, we handle all Prescription Drug Appeals. Follow the process for Appeals beginning on page 87.

Appeal Questions

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

SPECIAL PROGRAMS

Complex Case Management

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

Conditions that may qualify for the program include, but are not limited to:

- Acute healthcare needs, diagnoses, or Hospitalizations;
- Complex medical issues and/or comorbidities;
- Poorly controlled disease states;
- Frequent Hospital admissions;
- Multiple emergency room visits; or
- Multiple Chronic Conditions.

Case Management is a collaborative process. A case manager works with you and your physician and/or Behavioral Health Provider to assess, plan, and facilitate treatment options.

Your case manager will:

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

You may self-refer or your physician may refer you for complex Case Management. Participation is voluntary, confidential, and available at no cost to you. You may opt out at any time.

Call or go to Website	Contact Information
Local	(405) 280-5600
Toll-free	1-877-280-5600
TTY	711
Go to our website	www.globalhealth.com/state

Disease Management

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

The goal of the program is to help participants manage their conditions through program participation, education, and clinical staff relationships. Case managers work with program participants and treating physicians to:

- Slow disease progression and complications;
- Change behaviors and improve lifestyle choices;
- Improve compliance with guidelines, drugs, and physician care plans;

- Manage drugs and control symptoms;
- Educate about recommended Preventive Care;
- Reduce unnecessary Hospitalizations and readmissions; and
- Prevent drug errors.

Targeted diseases are:

- Chronic obstructive pulmonary disease;
- Congestive heart failure;
- Coronary artery disease;
- Diabetes;
- Depression, anxiety, and other severe mental illness diagnoses; and
- Substance use.

We use a patient-centered approach. Interventions may include:

- Assigned care manager;
- Educational materials;
- Health risk assessment;
- Health review phone calls; and
- Post-hospitalization and ER assessments.

If you are interested in learning more about the program or would like to see if the program is right for you, contact Customer Care. You may self-refer. You may choose to opt out at any time.

Self-refer for disease management, enroll, or disenroll.

Call or go to Website	Contact Information
Go to our website	www.globalhealth.com/state
Local	(405) 280-5600
Toll-free	1-877-280-5600
TTY	711

Medication Therapy Management Program

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

- To slow disease progression by supporting drug compliance;
- To eliminate duplicate drug therapies;
- To reduce drug interactions and side effects; and
- To optimize your benefits by advising of the lowest cost alternatives.

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

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

- Possible drug errors;
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition;
- Drugs that may not be safe or appropriate because of your age or gender;
- Certain combinations of drugs that could harm you if taken at the same time;

- Prescriptions written for drugs that have ingredients you are allergic to; and
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of drugs, we will work with your Provider to correct the problem.

This program is voluntary and at no cost to you. We will automatically enroll you and send you information. You can also contact Customer Care if you would like to participate in the program. If you decide to opt out at any time, please contact Customer Care and we will withdraw you from the program.

Quality Improvement Program ("QIP")

We are committed to supporting quality healthcare and the preservation of good health. The QIP helps us improve our functions and services from Network Providers.

The QIP provides the framework to assess and improve the quality of care and services. It is based on a model that stresses a systematic, integrated approach to quality. The QIP is designed to meet statutory requirements. It adheres to standards, guidelines, and contractual requirements for health plans.

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

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

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

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

Quality Improvement Work Plan:
We develop and implement a Quality Improvement Work Plan each year. The Work Plan monitors and evaluates healthcare delivery systems and Plan management activities. Its purpose is to ensure quality care and service.

We evaluate the Quality Improvement activities annually. We identify opportunities and implement changes to the QIP to address identified issues. We implement corrective action plans as necessary and the Quality Improvement Committee monitors progress.

You may request information on our Quality Improvement Program and Work Plan by contacting Customer Care. Ask to be connected to the Quality Department.

National Committee for Quality Assurance ("NCQA")
To show our commitment to quality, GlobalHealth is accredited by the NCQA. The information gathered through audits and surveys provides quality indicators that affirm our pledge to always strive to provide the best care possible through continual improvement.

You make a difference in our NCQA accreditation. Each year we may invite you to participate in surveys. They help us understand your needs and experience with us. We hope to exceed all your expectations and look forward to helping you reach your health goals!

Health Survey:
Each year, we may send you a health risk appraisal ("HRA") that asks questions about your current health. If you don't receive one, you may download a copy from our website. You may also request an HRA by contacting Customer Care.

Your answers help us know how to best serve you and your healthcare needs. The information you give us will remain confidential as required by law. We only disclose the information submitted in the HRA to your PCP so he/she can address needs identified in the HRA. It will not be used against you in any way or prevent you from obtaining services and treatment.

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

- New Member Survey;
- Customer Satisfaction Study; and/or
- Consumer Assessment of Healthcare Providers and Systems ("[1]CAHPS®").

It is very important that you participate. Your answers will help us improve the quality of care our Network of Providers gives.

[2]HEDIS® Audit:
We perform an audit approved by the National Committee for Quality Assurance ("NCQA") called HEDIS® (Healthcare Effectiveness Data Information Systems). It measures the quality of Preventive Care our Network Providers deliver. You can help by asking for Preventive Care services.

Well Visit Checklists:
The chart shows Preventive Care services that you may discuss and/or receive during routine well visits to your PCP or OB/GYN or your newborn may receive in the Hospital. Not every service will be right for you. Your PCP or OB/GYN will recommend appropriate services. Services may require multiple visits and/or Preauthorization. See "Preventive Care Benefits" on page 59 for additional information.

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

Population	Preventive Care to Discuss
Men – During routine	☐ Abdominal aortic aneurysm

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

Population	Preventive Care to Discuss
prenatal visits (every 4 week – 1st 28 weeks, every 2-3 weeks – 32 – 36 weeks, every week until delivery – 37 weeks on)	☐ Anemia ☐ Aspirin ☐ Blood pressure ☐ Blood tests ☐ Breastfeeding ☐ Gestational diabetes ☐ Hepatitis B ☐ HIV/STI ☐ Immunizations ☐ Rh incompatibility ☐ Safety ☐ Tobacco use ☐ Ultrasounds ☐ Urinary tract or other infection ☐ Weight
Women – During well-woman visit (annual)	☐ BRCA ☐ Breast cancer chemoprevention ☐ Cervical cancer ☐ Contraception ☐ Domestic and interpersonal 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
Children – During well-child visit (at Birth and at ages 2, 4, 6, 9, 12, 15, and 18 months, 2 – 6 years annually, 8 – 18 every other year)	☐ Alcohol, prescription, or illicit drug misuse ☐ Autism ☐ Behavioral assessments ☐ Blood pressure ☐ Cervical dysplasia ☐ Dental ☐ Depression, anxiety, trauma, and domestic/interpersonal violence ☐ Development ☐ Dyslipidemia ☐ Fluoride ☐ Health diet and physical activity ☐ Hearing ☐ Height, weight, and body mass index ☐ Hematocrit or hemoglobin ☐ HIV

Population	Preventive Care to Discuss
	☐ Immunizations ☐ Iron ☐ Lead ☐ Medical history ☐ Obesity ☐ Oral risk assessment ☐ STI prevention ☐ Skin cancer ☐ Tobacco use interventions ☐ Tuberculin ☐ Vision

Support for Healthy Living

We are excited to provide you with Internet-based health and well-being resources. In addition to the 24/7 nurse and information line, a wide variety of information is available at www.globalhealth.com/state. Contact Customer Care to request printed materials.

We encourage you to use these resources to enhance the health of you and your family.

24/7 Nurse Help Line:
Life happens, and our nurse help and information line is available 24/7 each day of the year. It's not always easy to determine when to seek emergency care, treat symptoms yourself, or see a PCP. The nurse helps you make confident decisions. Call 1-877-280-2993 anytime for access to the care advice you are seeking at no cost.

The 24/7 Nurse Help Line gives access to:

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

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

Category	Information Available
MyGlobal® - Call Customer Care for logon set-up	• Contact Customer Care via messaging: o Request/re-order Member ID cards; and o Change your PCP. • View Plan details (benefits, MOOP, Cost-share). • View Claims for Medical Services. • View Referrals.
Maintain Your Health	• Read about: o Healthy eating; o The importance of exercise; and o Health Screenings for Preventive Care. • Access tips and interactive tools to incorporate healthy diet and

Category	Information Available
	exercise into daily life. • View prevention checklists for all age groups. • Access links to clinical guidelines. • Take surveys to help you decide if you are on the right track.
Improve Your Health	• Education material and interactive tools. • Resource links about: o Medication and treatment adherence; o Stress; o Smoking cessation; and o Alcohol/drug abuse.
Manage Long-Term Conditions	• Find information on many health conditions and other medical management information. Use the interactive tools that encourage compliance. Learn about treatment options to discuss with your doctor. • Enroll in a GlobalHealth-sponsored program if you or a family member has one of the targeted diseases. See "Disease Management" on page 92. • Members taking multiple drugs for Chronic Conditions can receive support. See "Medication Therapy Management Program" on page 93.
Tools/Calculators	• Includes: o The Annual Health Appraisal. o Body Mass Index ("BMI") calculator. o Drug guide. o Information about our health information line.

Clinical Practice Guidelines:

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

Clinical Practice Guidelines	Disease
Preventive	• Obesity assessment • Breast cancer • Colorectal cancer • Hypertension

Clinical Practice Guidelines	Disease
Medical conditions	• Chronic obstructive pulmonary disease ("COPD") o Diagnosis and management of acute exacerbations o Diagnosis and management of stable COPD o Pulmonary rehabilitation • Congestive heart failure ("CHF") o Diagnosis and evaluation o Management of chronic heart failure in adults in primary and secondary care • Coronary artery disease ("CAD") o CAD clinical practice guidelines • Diabetes mellitus ("DM") o Management of micro vascular complications o Nutritional management
Behavioral health	• Attention deficit hyperactive disorder ("ADHD") o ADHD assessment and management • Depression o Treatment and management of depression in adults

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

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

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

Tobacco Cessation:

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

- Using any tobacco product other than for religious or ceremonial use; and
- On average, four (4) or more times per week within the past six (6) months.

Benefit	Description
Promoting Health	Tobacco use is the most preventable cause of death and disease in the United States. Our tobacco cessation goals are to: • Reduce the number of GlobalHealth Members who use tobacco products; • Increase awareness of tobacco cessation programs; and • Improve the overall health of Member population.

Benefit	Description
Steps to quit	1. Call your PCP, Behavioral Health Provider, or the Oklahoma Tobacco Helpline for support and to set up your quit plan. 2. Talk with your doctor about medicines to help you quit. 3. Set a quit date within the next two (2) weeks. 4. Make small changes. For example: Throw away ashtrays in your home, car, and office so you aren't tempted to smoke. 5. Make your home and car smoke-free. 6. If you have friends who smoke, ask them not to smoke around you. 7. Plan for how you will handle challenges like cravings. The most important thing to remember is don't give up trying. You can refer to our website to get more helpful hints to quit smoking.
Cessation Attempts	We cover two (2) tobacco cessation attempts per Plan Year. One attempt is considered: • Four (4) tobacco cessation counseling sessions; and • All FDA-approved tobacco cessation drugs (including both prescription and OTC). Preauthorization is not required. You pay more for additional treatment or non-generic drugs. Studies show that the most effective method to stop smoking involves: • Counseling; • Social support; and, • The use of cessation medication. Counseling and medication are both effective for treating tobacco dependence, and using them together is more effective than using either one alone.
Counseling	You may attend individual, group, or telephone counseling sessions for at least ten (10) minutes each through your PCP or Behavioral Health Provider. 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 your specific needs.

Benefit	Description
Prescriptions	Smoking cessation products are limited to two (2) full 90-day courses of any FDA-approved tobacco cessation product per Plan Year, if prescribed by your PCP or Behavioral Health Provider. This benefit is available to you as well as your enrolled Dependents who are at least eighteen (18) years old. The covered drugs are listed in the Formulary and include: Chantix™ (varenicline), Nicotrol® Inhaler (nicotine), Nicotrol® Nasal Spray (nicotine), and bupropion SR 150 mg (generic for Zyban®). We also cover FDA-approved over-the-counter products (such as nicotine patches, gum, and lozenges) with a prescription written by your physician. Your *Drug Formulary* will indicate if the prescription is available without a Cost-share as part of Preventive Services. However, if your Provider recommends a particular drug based on determination of medical necessity for you, we will cover that drug at no Cost-share. See "Exception Requests" on page 29. Not all products that may be used for tobacco cessation are included. For example, we do not cover electronic cigarettes available over-the-counter (e-cigarettes).
Enroll	You can enroll by contacting Customer Care or on our website.

DISCLOSURES AND NOTICES

Advance Directives

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

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

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

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

Helpful Information:

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

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

Continuation Coverage Rights Under COBRA

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

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

Section	Description
	through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly Premiums and lower Out-of-pocket costs. Additionally, you may qualify for a 30-day Special Enrollment Period for another group health Plan for which you are eligible (such as a spouse's Plan), even if that Plan generally doesn't accept late enrollees.
What is COBRA Continuation Coverage?	COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event. This is also called a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens: • Your hours of employment are reduced, or • Your employment ends for any reason other than your gross misconduct. If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events happens: • Your spouse dies; • Your spouse's hours of employment are reduced; • Your spouse's employment ends for any reason other than his or her gross misconduct; • Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or • You become divorced or legally separated from your spouse. Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens: • The parent-employee dies; • The parent-employee's hours of employment are reduced; • The parent-employee's employment ends for any reason other than his or her gross misconduct; • The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both); • The parents become divorced or legally separated; or • The child stops being eligible for coverage under the Plan as a "Dependent child."
When is COBRA	The Plan will offer COBRA continuation coverage to qualified beneficiaries

Section	Description
Continuation Coverage Available?	only after the employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (Part A, Part B, or both), the Plan Administrator must be notified of the qualifying event.
You Must Give Notice of Some Qualifying Events	**For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the employer within 60 days after the qualifying event occurs.**
How is COBRA Continuation Coverage Provided?	Once the employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for eighteen (18) months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of thirty-six (36) months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended. <u>Disability extension of 18-month period of continuation coverage:</u> If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify your employer in a timely fashion, you and your entire family may be entitled to get up to an additional eleven (11) months of COBRA continuation coverage, for a maximum of twenty-nine (29) months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. <u>Second qualifying event extension of 18-month period of continuation coverage:</u> If your family experiences another qualifying event during the eighteen (18) months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any Dependent children getting continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (Part A, Part B, or both); gets divorced or legally separated; or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second

Section	Description
	qualifying event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.
Are There Other Options Besides COBRA Continuation Coverage?	Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health Plan coverage options (such as a spouse's Plan) through what is called a "Special Enrollment Period". Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.
If You Have Questions	Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your employer. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health Plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.
Keep Your Plan Informed of Address Changes	To protect your family's rights, let both your employer and GlobalHealth know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer.
Plan Contact Information	You can obtain information about the Plan and COBRA continuation coverage by sending a request to your employer.

Creditable Coverage Disclosure Notices

Creditable Coverage Disclosure Notice for Medicare Eligible Members
This notice applies to Members enrolled in the State, Education, and Local Government Employees group.

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

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

1. Medicare Prescription Drug Coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug Coverage. All Medicare drug plans

provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly Premium.

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

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

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

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

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

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

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

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

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

For more information about Medicare Prescription Drug Coverage:

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

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

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

ERISA Rights

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

Continue Group Health Plan Coverage

Continue healthcare coverage for yourself, spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. See "Continuation Coverage Rights Under COBRA" on page 103.

Enforce Your Rights

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact your Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from your Plan Administrator, you should contact the nearest office of the

Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Fraud and Abuse

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

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

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

Reporting Fraud and Abuse:
We are committed to detecting and preventing healthcare Fraud and Abuse. You can help in this effort by reporting suspected Fraud and/or Abuse. Call and leave a message on our 24-hour hotline. If you call this number, please provide as much detailed information as possible. You may remain anonymous if you choose.

Call or E-mail	Contact Information
Local	(405) 280-5852
Toll-free	1-877-280-5852
E-mail	compliance@globalhealth.com

Medicaid and CHIP Notice

Premium assistance under Medicaid and the 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. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to Health Insurance through their employer. If you

or your children are not eligible for Medicaid or CHIP, you will not be eligible for these Premium assistance programs.

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

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

Once it is determined that you or your Dependents are eligible for Premium assistance under Medicaid or CHIP, as well as eligible under your employer Plan, your employer must permit you to enroll in your employer Plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within sixty (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 one of the following States, you may be eligible for assistance paying your employer health Plan Premiums. The following list of States is current as of July 31, 2013. You should contact your State for further information on eligibility –

Call or E-mail	Contact Information
Website	http://www.insureoklahoma.org
Toll-free	1-888-365-3742

To see if any more States have added a Premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

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

A stand-alone printable version of this notice is available on our website.

Member Rights and Responsibilities

Your Rights:

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

- Receive information about our organization, services, and Practitioners and Providers.

- Be treated with dignity and respect.
- Participate with Practitioners in making decisions about your healthcare.
- A candid discussion of all appropriate, Medically Necessary treatment options for your condition, regardless of the cost of care or benefit coverage.
- Voice complaints or Appeals about us or the care provided.
- Make recommendations regarding GlobalHealth's Member Rights and Responsibilities policy.
- Freely communicate with your Practitioner about treatment options, regardless of benefit coverage limitations.
- A right to ask about any healthcare concerns, request medical advice or obtain additional information about a prescribed treatment in order to make an informed decision or refuse a course of treatment.
- Completely understand your medical condition, health status, and the medications prescribed for you - what they are, what they are for, how to take them properly, and possible side effects.
- Appeal any unfavorable medical or administrative decisions by following the established Appeal and Grievance procedures of your Plan. You have the right to an external or expedited review of an Adverse Determination when applicable.
- Know how your Plan operates – as stated in your *Member Handbook* and *Schedule of Benefits*.
- Have access to your PCP and Referrals to Specialists when Medically Necessary or urgent.
- Use Emergency Services when you, as a Prudent Layperson acting reasonably, believe that an Emergency Medical Condition exists.
- Confidential treatment of all protected or individually identifiable health information as required by federal and state law.
- Information about contracted physician payment agreements, as well as explanations of benefits or Claims processing determinations.
- Expect problems to be fairly examined and appropriately addressed.

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

<u>Your Responsibilities:</u>
You or your legal designee has the responsibility to:

- Supply information, to the extent possible, that GlobalHealth and its Practitioners and Providers need in order to provide care.
- Follow plans and instructions for care that you have agreed to with your Practitioner.
- Understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
- Identify yourself by presenting your Member ID card (to physician, laboratory, Hospital, etc.) when receiving Medical Services.
- Be on time for all appointments and to notify your physician's office as far in advance as possible if you need to cancel or reschedule an appointment.
- Notify your PCP within forty-eight (48) hours, or as soon as possible, if you are hospitalized or receive emergency or out-of-area Urgent Care.
- Pay all required Cost Sharing at the time you receive healthcare services.
- Review information regarding Covered Services, policies and procedures as stated in your *Member Handbook* or *Schedule of Benefits* booklet.
- Ask questions if you do not understand your health benefits or treatment recommendations.

You can find GlobalHealth's *Member Rights and Responsibilities* on our website. You can print a copy from our website or you may request a copy from Customer Care.

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

The Mental Health Parity and Addiction Equity Act of 2008

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity 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, the 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 nonquantitative ("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 limitation 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 thirty (30) days of your request.

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

Minimum Essential Coverage and Minimum Value Standard

Minimum Essential Coverage:

Coverage under this Plan qualifies as Minimum Essential Coverage ("MEC") and satisfies the Patient Protection and Affordable Care Act's ("ACA") Individual Responsibility Requirement. Please visit the Internal Revenue Service ("IRS") website at www.irs.gov/affordable-care-act/individuals-and-families/individual-shared-responsibility-provision for more information on the individual requirement for MEC.

You may receive one or more forms providing information about the healthcare coverage that you had or were offered during the previous year. Much like Form W-2 and Form 1099, which include

information about the income you received, these new healthcare forms provide information that you may need when you file your individual income tax return.

We will send Form 1095-B to Subscribers covered through employer-sponsored GlobalHealth Plans, with information about which family members were covered and when. Also like Forms W-2 and 1099, these forms will be provided to the IRS. Call the telephone number on the form if you have any questions.

Minimum Value Standard:
The ACA establishes a minimum value for the standard of benefits of a health Plan. The Minimum Value Standard is 60% (actuarial value). The health coverage of this Plan does meet the Minimum Value Standard for the benefits the Plan provides.

The use of a metallic name in your *Schedule of Benefits*, such as Platinum, Gold, Silver, or Bronze, or other statements with respect to a Plan's actuarial value, is not an indicator of the actual amount of expenses that you will be responsible to pay out of your own pocket. Your out-of-pocket expenses will vary depending on many factors, such as the particular healthcare services, healthcare Providers, and particular Plan chosen. Please note that metallic names reflect only an approximation of the actuarial value of a particular Plan.

Notice of Non-discrimination

GlobalHealth, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, ethnicity, national origin, religion, gender or gender identity, sexual orientation, age, mental or physical disability, health status, Claims experience, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), source of payment, or geographic location within the Service Area.

We will not impose eligibility rules or variations in Premium. We will not discriminate against you for coverage under your Plan. Variations in the administration, processes, or benefits that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives, and/or other programs do not constitute discrimination.

Section 1557 of the Affordable Care Act Grievance Procedure
It is the policy of GlobalHealth, Inc. not to discriminate on the basis of race, color, national origin, sex, age, or disability. GlobalHealth, Inc. has 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

Contact	Contact Information
Mail	Compliance Attorney 701 NE 10th St, Ste. 300 Oklahoma City, OK 73104-5403
E-mail	compliance@globalhealth.com

Contact	Contact Information
Fax	(405) 280-5894

who has been designated to coordinate the efforts of GlobalHealth, Inc. to comply with Section 1557.

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 GlobalHealth, Inc. 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 sixty (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 the files and records of GlobalHealth, Inc. 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 thirty (30) 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 fifteen (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 thirty (30) days after its filing.

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

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

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

GlobalHealth, Inc. 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. Customer Care can assist you with such arrangements.

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

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

The basic protections provided by the Association are:

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

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

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

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

Department	Contact Information

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

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

A stand-alone printable version of this notice is available on our website.

Personally Identifiable Information ("PII")

PII is information that can be used to distinguish or trace an individual's identity. It may be information used alone or combined with other information that may be linked to a specific individual. 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 Federal agency. We will not share PII with anyone else except to carry out the functions of providing your health coverage and for which you have provided consent for your information to be used or disclosed.

Protected Health Information ("PHI")

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

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

When changing PCPs, a signed authorization for release of information is required to transfer your medical records. Your current PCP's office can provide you with the form. You may also obtain the *Oklahoma Standard Authorization to Use or Share Protected Health Information* release form on our website.

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

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

Notice of Privacy Practices ("NPP")
THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION ("PHI") MAY BE USED AND/OR DISCLOSED. PLEASE REVIEW IT CAREFULLY.

GlobalHealth, Inc. ("GlobalHealth") is committed to protecting the privacy and confidentiality of our Members' Protected Health Information ("PHI") in compliance with applicable federal and state laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act.

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 Healthcare Operations. We may use and/or disclose PHI about you for health plan operational purposes. Some examples include: risk management, patient safety, quality improvement, internal auditing, utilization review, medical or peer review, certification, regulatory compliance, internal training, accreditation, licensing, credentialing, investigation of complaints, performance improvement, etc. Health-Related Business and Services. We may use and disclose your PHI to tell you of health-related products, benefits, or services related to your treatment, care management, or alternate treatments, therapies, Providers, or care settings. Where Permitted or Required by Law. We may use and/or disclose information about you as permitted or required by law. For example, we may disclose information: • To a regulatory agency for activities including, but not limited to, licensure, certification, accreditation, audits, investigations, inspections, and medical device reporting; • To law enforcement upon receipt of a court order, warrant, summons, or other similar process; • In response to a valid court order, subpoena, discovery request, or administrative order related to a lawsuit, dispute or other lawful process; • To public health agencies or legal authorities charged with preventing or controlling disease, injury or disability; • For health oversight activities conducted by agencies such as the Centers

Section	Description
	for Medicare and Medicaid Services ("CMS"), State Department of Health, Insurance Department, etc.; • For national security purposes, such as protecting the President of the United States or the conducting of intelligence operations; • In order to comply with laws and regulations related to Workers' Compensation; • For coordination of insurance or Medicare benefits, if applicable; • When necessary to prevent or lessen a serious and imminent threat to a person or the public and such disclosure is made to someone that can prevent or lessen the threat (including the target of the threat); and • In the course of any administrative or judicial proceeding, where required by law. Business Associates. We may use and/or disclose your PHI to business associates that we contract with to provide services on our behalf. Examples include consultants, accountants, lawyers, auditors, health information organizations, data storage and electronic health record vendors, etc. We will only make these disclosures if we have received satisfactory assurance that the business associate will properly safeguard your PHI. Personal/Authorized Representative. We may use and/or disclose PHI to your authorized representative. Family, Friends, Caregivers. We may disclose your PHI to a family member, caregiver, or friend who accompanies you or is involved in your medical care or treatment, or who helps pay for your medical care or treatment. If you are unable or unavailable to agree or object, we will use our best judgment in communicating with your family and others. Emergencies. We may use and/or disclose your PHI if necessary in an emergency if the use or disclosure is necessary for your emergency treatment. Military / Veterans. If you are a member or veteran of the armed forces, we may disclose your PHI as required by military command authorities. Inmates. If you are an inmate of a correctional institute or under the custody of law enforcement officer, we may disclose your PHI to the correctional institute or law enforcement official. Appointment Reminders. We may use and/or disclose your PHI to contact you as a reminder that you have an appointment for treatment or medical care. This may be done through direct mail, e-mail, or telephone call. If you are not home, we may leave a message on an answering machine or with the person answering the telephone.

Section	Description
	Medication and Refill Reminders. We may use and/or disclose your PHI to remind you to refill your prescriptions, to communicate about the generic equivalent of a drug, or to encourage you to take your prescribed medications. Limited Data Set. If we use your PHI to make a "limited data set," we may give that information to others for purposes of research, public health action, or healthcare operations. The individuals/entities that receive the limited data set are required to take reasonable steps to protect the privacy of your information. Any Other Uses. We will disclose your PHI for purposes not described in this notice only with your written authorization. Most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing or fundraising purposes, and disclosures that constitute a sale of PHI require your written authorization. NOTE: The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease required to be reported pursuant to state law.
Your Health Information Rights	Right to Inspect and Copy You have the right to inspect and copy your PHI as provided by law. This right does not apply to psychotherapy notes. Your request must be made in writing. We have the right to charge you the amounts allowed by state and federal law for such copies. We may deny your request to inspect and copy your records in certain circumstances. If you are denied access, you may Appeal to our Privacy Officer. Right to Confidential Communication You have the right to receive confidential communication of your PHI by alternate means or at alternative locations. For example, you may request to receive communication from us at an alternate address or telephone number. Your request must be in writing and identify how or where you wish to be contacted. We reserve the right to refuse to honor your request if it is unreasonable or not possible to comply with. Right to Accounting of Disclosures You have the right to request an accounting of certain disclosures of your PHI to third parties, except those disclosures made for treatment, payment, or healthcare or health plan operations and disclosures made to you, authorized by you, or pursuant to this Notice. To receive an accounting, you must submit your request in writing and provide the specific time period requested. You may request an accounting for up to six (6) years prior to the date of your request (three years if PHI is an electronic health record). If you request more than one (1) accounting in a 12-month period, we may charge you for the costs of providing the list. We will notify you of the cost

Section	Description
	and you may withdraw your request before any costs are incurred. Right to Request Restrictions on Uses or Disclosures You have the right to request restrictions or limitations on certain uses and disclosures of your PHI to third parties unless the disclosure is required or permitted by law. Your request must be made in writing and specify (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want the limits to apply. We are not required to honor your request. If we do agree, we will make all reasonable efforts to comply with your request unless the information is needed to provide emergency treatment to you or the disclosure has already occurred or the disclosure is required by law. Any agreement to restrictions must be signed by a person authorized to make such an agreement on our behalf. Right to Request Amendment of PHI You have the right to request an amendment of your PHI if you believe the record is incorrect or incomplete. You must submit your request in writing and state the reason(s) for the amendment. We will deny your request if: (1) it is not in writing or does not include a reason to support the request; (2) the information was not created by us or is not part of the medical record that we maintain; (3) the information is not a part of the record that you would be permitted to inspect and copy, or (4) the information in the record is accurate and complete. If we deny your amendment request, you have a right to file a statement of disagreement with our Privacy Officer. Right to Be Notified of a Breach You have the right to receive notification of any breaches of your unsecured PHI. Right to Revoke Authorization You may revoke an authorization at any time, in writing, but only as to future uses or disclosures and not disclosures that we have made already, acting on reliance on the authorization you have given us or where authorization was not required. Right to Receive a Copy of this Notice You have the right to receive a paper copy of this Notice upon request. Changes to this Notice GlobalHealth reserves the right to change this notice and make the new provisions effective for all PHI that we maintain.
To Report a Privacy Violation	If you have a question concerning your privacy rights or believe your rights have been violated, you may contact our Privacy Officer at: **ATTN: Privacy Officer** **GlobalHealth, Inc.** **701 NE 10th**

Section	Description
	Suite 300 **Oklahoma City, OK 73104-5403** **Toll-free 1-877-280-5852** You may also report a violation to the Region VI U.S. Department of Health and Human Services Office for Civil Rights, 1301 Young ST, Suite 1169, Dallas, TX 75202. You will not be penalized or retaliated against for filing a complaint.

Effective Date 4/1/2013.

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

PHI Disclosure to Plan Sponsors
We may, under certain circumstances, disclose your PHI to your group health Plan sponsor (i.e., the Subscriber's employer). However, we may not disclose your PHI to the Plan sponsor unless:

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

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

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

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

If you have questions regarding whether your Plan sponsor has elected to receive Plan participants' PHI, please 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 forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending Provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also under federal law, Plans and issuers may not set the level of benefits or out-of-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 forty-eight (48) hours (or 96 hours). However, to use certain Providers or Facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact Customer Care.

Subrogation, Third-Party Recovery, and Reimbursement

Section	Description
Benefits Subject to This Provision	This provision applies to all benefits provided under any section of this Plan to: • Covered Persons (or Members) and Dependents, COBRA beneficiaries, family members, and any other person who may recover on behalf of a Covered Person or beneficiary including, but not limited to, the estate of a deceased Covered Person or beneficiary, (collectively referred to as "Covered Person"); and • All other agents, attorneys, representatives, and persons acting for, on behalf of, in concert with, or at the direction of a Covered Person (sometimes referred to as "Covered Person's Representatives") with respect to such benefits.
When this Provision Applies	A Covered Person may incur medical or other charges related to injuries or illnesses caused by the act or omission of Another Party including a physician or other Provider for acts or omissions including but not limited to malpractice. Another Party may be liable or legally responsible for payment of charges incurred in connection with such Injuries or Illnesses. If so, the Covered Person may have a Claim against Another Party for payment of the medical or other charges.
Defined Terms	"Another Party" means any individual or entity, other than the plan, that is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's injuries or illnesses. Another Party shall include the party or parties who caused the injuries or illness (first or third parties); the insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's, or any other liability insurer; a workers' compensation insurer; a medical malpractice or similar fund; and any other person, corporation, or entity that is liable or legally responsible for payment in connection with the injuries or illness. "Recovery" shall mean any and all money, fund, property, compensation, as well as all rights thereto, or damages paid or available to the Covered Person by Another Party through insurance payments, settlement proceeds, first or

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	third party payments or settlement proceeds, judgments, reimbursements or otherwise (no matter how those monies may be characterized, designated, or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. "Reimbursement" or "Reimburse" means repayment to the plan for medical or other benefits paid or payable toward care and treatment of the illness or injury and for any other expenses incurred by the plan in connection with benefits paid or payable. "Subrogation" or "Subrogate" shall mean the plan's right to pursue the Covered Person's Claims against Another Party for medical or other charges paid by the plan.
Conditions and Agreements	Benefits are payable only upon the Covered Person's acceptance of, and compliance with, the terms and conditions of this Plan. The Covered Person agrees that acceptance of benefits is constructive notice of this section. As a condition to receiving benefits under this Plan, a Covered Person and each other obligated party agree(s): a) That in the event a Covered Person under this Plan, and/or the Covered Person's Representatives receives any Recovery or other benefits arising out of any injury, accident, event, or incident for which the Covered Person has, may have, or asserts any Claim or right to recovery under any theory of law or equity, tort, contract, statute, regulation, ordinance, or otherwise against any other person, entity, or source including, without limitation, any third party, insurer, insurance, and/or insurance coverage (e.g., uninsured and underinsured motorist coverage, personal injury coverage, medical payments coverage, workers' compensation, etc.), any payment or payments made by the plan to Covered Person for such benefits shall be made on the condition and with the agreement and understanding that the plan will be reimbursed by Covered Person and Covered Person's Representatives to the extent of, but not to exceed the Recovery amount or amounts received by Covered Person from such Another Party or source by way of any agreement, settlement judgment or otherwise; b) That the plan shall be subrogated to all rights of Recovery the Covered Person has against Another Party potentially responsible for making any payment to Covered Person as a result of any injury, damage, loss, or illness Covered Person sustains to the full extent of benefits provided or to be provided by the plan to Covered Person or on Covered Person's behalf with respect to that illness, injury, damage, or loss immediately upon the plan's payment or provision of any benefits to Covered Person or on Covered Person's behalf. The plan's recovery, subrogation, and reimbursement rights provided herein exist even where a party allegedly at-fault or responsible for any loss, injury, damage, or illness Covered Person sustains does not admit responsibility and regardless of the designation or characterization given to the funds Covered Person

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	receives or agrees to be disbursed from that party or that party's representative; c) To notify GlobalHealth's Plan Administrator if a Covered Person has a potential right to receive payment from someone else; to promptly execute and deliver to the Plan Administrator, if requested by the Plan Administrator or its representatives, a Subrogation and Reimbursement agreement; and, to supply other reasonable information and assistance as requested by the Plan Administrator regarding the Claim or potential Claim. The Plan Administrator may determine, in its sole discretion, that it is in the plan's best interests either to pay, or to not pay, medical or other benefits for the injuries or illness before the Subrogation and Reimbursement agreement has been signed. However, in either event, the plan will still be entitled to Subrogation and Reimbursement according to the terms of this Section; d) To serve as a constructive trustee, and to hold in constructive trust for the benefit of the plan any Recovery from Another Party, and agrees not to dissipate any such Recovery without prior written consent of the plan, or to otherwise prejudice or impair the plan's first rights to any such Recovery, regardless of how such Recovery may be characterized, designated, or allocated. Covered Person agrees to hold, as trustee (or co-trustee) in trust for the benefit of the plan all Recovery and funds Covered Person receives in payment of or as compensation for any injury, illness, damage, and loss Covered Person sustained resulting from any such event, incident, accident, injury, illness, and occurrence. Any such Recovery or funds received by, on behalf of, with the consent of, or at the direction of Covered Person, or to which Covered Person is entitled to receive or direct payment, or over which Covered Person (or a Covered Person's Representatives) has, or exercises, any control, are deemed and shall be considered and treated as assets of the plan. Failure to hold Recovery and such funds in trust or to abide by these plan terms will be deemed a breach of Covered Person's (or the Covered Person's Representative's) fiduciary duty to the plan. The plan has a right of subrogation or reimbursement before any Recovery and funds are paid to Covered Person from the responsible source and no attorneys' fees or costs may be subtracted from such amount. The plan may, at its option and sole discretion, exercise either its subrogation and/or its repayment rights. The plan is also entitled to any Recovery and funds Covered Person receives or is entitled to receive regardless of whether or not the payment represents full compensation to Covered Person. The plan expressly disclaims all make whole and common fund rules and doctrines and/or any other rule or doctrine that would impair or interfere with the plan's rights herein. The plan shall be entitled to an accounting from the Covered Person of all Recovery, funds, and activities described herein; e) To restore to the plan any such benefit paid or payable to, or on behalf of, the Covered Person when said benefits are paid or established by Another Party;

Section	Description
	f) To transfer title to the plan for all benefits paid or payable as a result of said illness or injury. The Covered Person acknowledges that the plan has a property interest in the Covered Person's Recovery, and that the plan's Subrogation rights shall be considered a first priority Claim to any Recovery, and shall be paid from any such Recovery before any other Claims for the Covered Person as the result of the illness or injury, regardless of whether the Covered Person is made whole; g) That the plan is granted a first right and priority to, as well as a first lien against, 100% of any Recovery to the extent of benefits paid or to be paid and expenses incurred by the plan in enforcing this provision; and such lien is an asset of the plan. The plan's first lien fully supersedes any right of first payment, or Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person is made whole or has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs; h) That the Covered Person also agrees to notify the plan of Covered Person's intention to pursue or investigate a Claim to recover damages or obtain compensation with respect to any matter for which Covered Person has obtained or will obtain any benefits from the plan. Covered Person will be required to provide all information requested by the plan or its representative regarding any such Claim. Covered Person also agrees to keep the plan informed as to all facts and communications that might affect the plan's rights; i) To refrain from releasing Another Party that may be liable for or obligated to the Covered Person for the injury or condition without obtaining the plan's written approval; j) To notify the plan in writing of any proposed settlement and obtain the plan's written consent before signing a settlement agreement; k) Without limiting the preceding, the plan shall be subrogated to any and all Claims, causes, action, or rights that the Covered Person has or that may arise against Another Party for which the Covered Person Claims an entitlement to benefits under this plan, regardless of how classified or characterized; l) If the Covered Person (or guardian or estate) decides to pursue Another Party, the Covered Person agrees to include the plan's Subrogation Claim in that action and if there is failure to do so, the plan will be legally presumed to be included in such action or Recovery; m) In the event the Covered Person decides not to pursue Another Party, the Covered Person authorizes the plan to pursue, sue, compromise, or settle any such Claim in their name, to execute any and all documents necessary to pursue said Claims in their name, and agrees to fully cooperate with the plan in the prosecution of any such Claims. Such cooperation shall include a duty to provide information and execute and deliver any acknowledgement or other legal instrument documenting the plan's Subrogation rights. The Covered Person (or guardian or estate) agrees to take no prejudicial actions against the Subrogation rights of the

Section	Description
	plan or to in any way impede the action taken by the plan to recover its Subrogation Claim. This includes attempts by the Covered Person, (or by his or her attorney or other agent) to have payments characterized as non-medical in nature, or to direct or consent to have payments made to others (e.g., to or on behalf of relatives, attorneys, agents, representatives, or friends). n) The plan will not pay, offset any Reimbursement, or in any way be responsible for any fees or costs associated with pursuing a Claim unless the plan agrees to do so in writing. The plan's right of first Reimbursement will not be reduced for any reason including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise; o) The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of the plan document. The Plan Administrator may amend the plan in its sole discretion at any time without notice. This right of Subrogation shall bind the Covered Person's guardian(s), estate, executor, personal representatives, and heirs. p) That the Plan Administrator may, in its sole discretion, require the Covered Person or his or her attorney to sign a subrogation/recovery agreement acknowledging and agreeing to the plan's rights herein as a condition to any payment of benefits and as a condition to any payment of future benefits for other illnesses or injuries.
When a Covered Person Retains an Attorney	If the Covered Person retains an attorney, the Plan Administrator may, in its sole discretion, require that the attorney sign a subrogation/recovery agreement acknowledging and agreeing to the plan's rights herein as a condition to any payment of benefits and as a condition to any payment of future benefits for other illnesses or injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The plan will not pay the Covered Person's attorney's fees and costs associated with the recovery of funds, nor will it reduce its Reimbursement pro rata for the payment of the Covered Person's attorney's fees and costs. Attorneys' fees will be payable from the Recovery only after the plan has received full Reimbursement. An attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery to the plan under the terms of this provision. A Covered Person's attorney who receives any such Recovery and does not immediately tender the Recovery to the plan will be deemed to hold the Recovery in constructive trust for the plan, because neither the Covered Person nor his attorney is the rightful owner of the Recovery and should not be in possession of the Recovery until the plan has been fully Reimbursed. In addition, the plan may further require that: a) Covered Person utilizes the services of attorneys, representatives, or agents who will execute a Reimbursement Agreement and who will not

Section	Description
	assert the make whole and common fund rule or doctrines, and b) Covered Person agrees to terminate any relationship with anyone who refuses to do so, or benefits will not be payable under the plan in connection with that matter. c) The plan is also entitled to receive and has priority to receive the first funds from payments received by Covered Person until the Plan has been repaid for all sums expended. Covered Person shall execute and deliver any instruments and documents reasonably requested by the plan and shall do whatever is necessary to fully protect all the plan's rights. Covered Person shall do nothing to prejudice the rights of the plan to such reimbursement and Subrogation, including, without limitation, any attempt by Covered Person or others to have payments characterized as non-medical in nature (e.g., for emotional distress, pain and suffering, embarrassment, mental anguish, loss of consortium, etc.) or to direct or consent to have payments made to others (e.g., to or on behalf of relatives, attorneys, agents, representatives, or friends).
When the Covered Person is a Minor or is Deceased	The provisions of this section apply to the parents, trustee, guardian, or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the representative has access or control of the Recovery.
When a Covered Person Does Not Comply	a) If the Subrogation agreement is not properly executed and returned as provided for in this provision; (ii) information and assistance is not provided to the Plan Administrator upon request; or, (iii) any other provision or obligation of this Section is not timely complied with, no benefits will be payable under the plan with respect to costs Incurred in connection with such illness or injury. b) If a Covered Person fails to Reimburse the plan for all benefits paid or to be paid, as a result of their illness or injury, out of any Recovery received as provided in this Plan, or otherwise fails to comply with any other provision or obligation of this Section, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the plan's attempt to recover such money or property from the Covered Person; and, the plan shall be entitled to offset and apply any future benefits that might otherwise be due, for the benefit of the Covered Person, the Covered Person's family members, or any other person who directly or indirectly acted or cooperated to interfere with, impair, or defeat the plan's rights or interests against such reimbursements that should have been made to the plan, as well as to suspend or terminate further coverage until such reimbursements are recovered by the plan. This right of Reimbursement shall bind the Covered Person's guardian(s), estate, executor, personal representative, and heir(s). c) Additionally, Covered Person shall be fully responsible for the actions of Covered Person's Representatives, attorneys, agents, family members, and all persons acting for, on behalf of, in concert with, or at the direction of Covered Person regarding the plan or Covered Person's

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	obligations described herein. Covered Person shall be responsible to ensure that such persons cooperate and comply with Covered Person's obligations herein. If Covered Person or Covered Person's agents, attorneys, or any other representative fails to fully cooperate with any Subrogation, reimbursement, or repayment efforts, or directly or indirectly defeats, hinders, impedes, or interferes with any such efforts, Covered Person shall be responsible to account for and pay to the plan all attorney's fees and costs incurred by or on behalf of the plan in connection with such efforts. d) Additionally, the plan may, in the discretion of its final decision maker, terminate Covered Person's participation in the plan or the participation of any other person who directly or indirectly acted or cooperated to interfere with, impair, or defeat the plan's rights or interest. In the event that any Claim is made that any wording, term, or provision set forth in this Subrogation and Right of Reimbursement portion of the Member Handbook is ambiguous or unclear, or if any questions arise concerning the meaning or intent of any of its terms, the plan through its final decision maker, shall have the sole authority and discretion to construe, interpret, and resolve all disputes regarding the interpretation of any such wording, term, or provision. e) The plan's Subrogation and Reimbursement rights described herein are essential to ensure the equitable character of the plan and its financial soundness, and to ensure that funds are recouped and made available for the benefit of all Covered Persons under the plan collectively.

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

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 Deductibles, Copayments, and Coinsurance applicable to other medical and surgical benefits provided under this Plan. See your *Schedule of Benefits* for your Deductible, if any, and your Cost Sharing for applicable services. If you would like more information on WHCRA benefits, contact your Plan Administrator.

FAQS

These FAQs are subject to "Coverage Requirements" on page 32 and "General Excluded Services and Limitations" on page 65.

Topic	Q&A
Chiropractic	Q. Does the Plan cover chiropractor visits? A. Yes.
Diabetic Supplies	Q. Are my diabetic supplies covered? A. Yes.
Dependent Coverage	Q. If I enroll in GlobalHealth, is my child who lives in another state covered? A. Yes, Dependents must establish a relationship with a PCP in our Network. We cover Out-of-network emergencies and urgent care. We do not cover Out-of-network routine care. Any Out-of-network services, other than Emergency Services or Urgent Care must be preauthorized by GlobalHealth. Q. What about Dependents over eighteen (18) years of age? A. We cover eligible children through the end of the month in which they turn twenty-six (26) years of age.
Emergencies and Urgent Care	Q. When I go to the emergency room, is my copay waived if I am then admitted to the Hospital? A. Yes. Q. What if I get sick when I am out of the Service Area? Am I still covered? A. Emergency and Urgent Care is covered. In a true emergency, go immediately to the nearest medical Facility for care. Call the PCP and GlobalHealth within forty-eight (48) hours of receiving the care. When same-day Urgent Care is needed, self-refer to an Urgent Care center. An Out-of-network Provider may balance bill you. An In-network Provider may not balance bill you. Q. What if I need to see a doctor on the weekend? Or I become sick after hours? A. Call your PCP for direction. Or self-refer to a Network Urgent Care center if you cannot wait for your PCP's office hours.
Hearing	Q. Does the Plan cover hearing aids? A. Yes. See "Hearing Services" on page 45.
Hospital Admission	Q. Does my Hospital copay cover doctor visits to the Hospital? A. Yes. Q. Does the Plan cover private rooms in the Hospital? A. When Medically Necessary. Q. What Hospitals are in your Network?

Topic	Q&A
	A. They are listed in the *Provider Directory* and on our website.
Mental Health	Q. Does the Plan cover mental health services? A. Yes. You do not have to go through your PCP. See "Behavioral Health Benefits" on page 33. Q. How can I find out who the mental health Providers are? A. There is a listing in the *Provider Directory*.
Network	Q. How can I find out if my Specialist is in the Network? A. Refer to the *Provider Directory* or visit our website.
PCP	Q. Do I have to choose one of the Network doctors? A. Yes. You choose a PCP at Enrollment. Each family member may choose a different PCP, including a pediatrician for children. *Provider Directories* are available and you may also go to our website. Q. Can I change my PCP or am I stuck with them all year? A. Yes, you may change PCPs at any time during the year, and the change is effective right away. You can make changes on our website. If you need to see a PCP before you receive your new Member ID card, contact Customer Care.
Pre-existing	Q. Does the Plan accept pre-existing conditions? A. Yes.
Prescriptions	Q. Are dental prescriptions covered? A. Yes. Q. What is a *Drug Formulary*? A. The *Drug Formulary* is a list of drugs most commonly prescribed and approved by us. It is a preferred list. Because the development of the *Drug Formulary* is an ongoing process, this list is subject to change. Q. Does the Plan have mail order? A. Yes, through ESI. Home delivery prescriptions are filled with a 90-day supply. A discount may be available. Q. Where can I get my prescriptions filled? A. We have over 800 participating pharmacies across the state of Oklahoma. ESI, our pharmacy benefit manager, has a nation-wide Network that you can access.
Preventive Care	Q. Is Preventive Care covered? A. We cover all Preventive Services covered under the Affordable Care Act for no Cost-share to you when delivered by a Network Provider. See "Preventive Care Benefits" on page 59 for a current list of services. Q. How do I get Preventive Services? A. Start with your PCP. He/she will provide most services or submit a Referral on your behalf to a Network Provider if needed. However, you

Topic	Q&A
	have direct access to your OB/GYN for services he/she handles and to a Network imaging center for your mammogram.
Referrals	Q. Do I need a Referral to see a Specialist? A. Yes. Except for services you receive from your OB/GYN, your PCP is responsible to manage all of your care. He or she submits a Referral on your behalf to a Specialist within our Network when needed. Procedures must also receive Preauthorization.
Weight Loss and Cosmetic Surgery	Q. Does the Plan cover gastric bypass or surgery for obesity? A. No. Q. Does the Plan cover cosmetic surgery? A. Only in specific limited circumstances. See page 43.
Worldwide Coverage	Q. Am I covered worldwide? A. No.

GLOSSARY

Term	Definition
Abuse	Includes requesting payment for items and services when there is no entitlement for payment of those items or services. Unlike Fraud, the individual or entity has not knowingly or intentionally misrepresented facts to obtain payment.
Adverse Determination	A determination that an admission, availability of care, continued stay or other healthcare service that is a covered benefit has been reviewed, and based upon the information provided, does not meet the plan's requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness, and the requested services or payment for the service is therefore denied, reduced, or terminated.
Allowed Amount	This is the maximum payment GlobalHealth will pay for covered healthcare services. May be called "eligible expense," "payment allowance," or "negotiated rate."
Ambulatory Surgical Center	A licensed public or private establishment with an organized medical staff of physicians with permanent Facilities that are equipped and operated primarily for the purpose of performing surgical procedures and continuous Physician Services and registered professional nursing services whenever a patient is in the Facility and which does not provide services or other accommodations for patients to stay overnight.
Appeal	A request for GlobalHealth to review a decision that denies a benefit or payment (either in whole or in part).
Approved Clinical Trial	A clinical trial that is sponsored by a credible organization and conducted in compliance with federal regulations including those relating to the protection of human subjects. The trial must have a therapeutic intent and not designed solely to identify or test disease pathophysiology.
Balance Billing	When a Provider bills you for the balance remaining on the bill your Plan doesn't cover. This amount is the difference between the actual billed amount and the GlobalHealth Allowed Amount. For example, if the Provider's charge is $200 and the GlobalHealth Allowed Amount is $110, the Provider may bill you for the remaining $90. This happens most often when you see an Out-of-network Provider. A Network Provider may *not* bill you for Covered Services.
Behavioral Health Provider	A behavioral healthcare professional (psychiatrist, psychologist, clinical social worker, marriage and family therapist, behavioral professional, behavioral Practitioner, and/or alcohol and drug counselor) that is licensed, certified, or accredited by State law.
Case Management	A process to assess, plan, implement, coordinate, monitor, and evaluate options to meet your healthcare needs based on the benefits and resources needed in order to promote a quality outcome for you.
Chronic Condition	A continuous or persistent condition over an extended amount of time which requires ongoing treatment.

Term	Definition
Claim	A request for a benefit (including reimbursement of a healthcare expense) made by you or your healthcare Provider to GlobalHealth for items or services you think are covered.
COBRA	Consolidated Omnibus Budget Reconciliation Act. This is the federal law requiring certain group health plans to give employees and certain family members the opportunity to continue their healthcare coverage at group rates in specific instances where coverage would otherwise end.
Coinsurance	Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the Allowed Amount for the service. You generally pay the Coinsurance *plus* any Deductibles you owe. (For example, if GlobalHealth's Allowed Amount for an office visit is $100 and you've met your Deductible, your Coinsurance payment of 20% would be $20.) GlobalHealth pays the rest of the Allowed Amount.
Complications of Pregnancy	Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't Complications of Pregnancy.
Copayment	A fixed amount (for example, $15) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.
Cost-share	The portion of the cost for services, treatment, and supplies that you pay. This includes Deductibles, if any, Copayments, and Coinsurance.
Cost Sharing	Your share of costs for services that your Plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of Cost Sharing are Copayments, Deductibles, and Coinsurance. Family Cost Sharing is the share of cost for Deductibles, if any, and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your Premiums, penalties you may have to pay, or the cost of care your Plan doesn't cover usually are not considered Cost Sharing.
Covered Services	Medically Necessary services or supplies provided under the terms of this *Member Handbook*, your *Schedule of Benefits,* your *Drug Formulary,* and your Provider Directory.
Deductible	The amount you could owe during a coverage period (usually one year) for covered healthcare services before GlobalHealth begins to pay. An overall Deductible applies to all or almost all covered items and services. A Plan with an overall Deductible may also have separate Deductibles that apply to specific services or groups of services. A Plan may also have only separate Deductibles. (For example, if your Deductible is $1,000, GlobalHealth won't pay anything until you've met your $1,000 Deductible for covered healthcare services subject to the Deductible.) The Deductible may not apply to all services. Not all GlobalHealth Plans have a Deductible.
Dependent	Any spouse or child up to the age of twenty-six (26) (including stepchildren, foster children, and adopted children from the date placed in the home) of

Term	Definition
	the Subscriber. GlobalHealth covers Dependents when they meet eligibility and Premium requirements.
Diagnostic Test	Tests to figure out what your health problem is. For example, an x-ray can be a Diagnostic Test to see if you have a broken bone.
Durable Medical Equipment ("DME")	Equipment and supplies ordered by a healthcare Provider for everyday or extended use. DME may include: Oxygen equipment, wheelchairs, and crutches.
Emergency Medical Condition	An illness, injury, symptom (including severe pain), or condition that is severe enough to risk serious danger to your health if you didn't get medical attention right away. If you did not get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.
Emergency Medical Transportation	Ambulance services for an Emergency Medical Condition. Types of Emergency Medical Transportation may include transportation by air, land, or sea. Your Plan may not cover all types of Emergency Medical Transportation, or may pay less for certain types.
Emergency Room Care / Emergency Services	Services to check for an Emergency Medical Condition and treat you to keep an Emergency Medical Condition from getting worse. These services may be provided in a licensed Hospital's emergency room or other place that provides care for Emergency Medical Conditions.
Enrolled Family Member	A family member that is enrolled with GlobalHealth meets all eligibility requirements of the Subscriber's employer group and GlobalHealth, and for which GlobalHealth has received Premiums. An eligible family member is a family member who meets all of the eligibility requirements of the Subscriber's employer group and GlobalHealth.
Enrollment	The event when a person becomes a Plan Member. A Member is enrolled when GlobalHealth accepts the Enrollment form submitted by the Subscriber. GlobalHealth and the employer group must abide by the contract and the employer group must pay Premiums on time.
Excluded Services	Healthcare services that your Plan doesn't pay for or cover.
Experimental or Investigational	Procedures and/or items determined by GlobalHealth as not FDA-approved and/or not generally accepted by the medical community.
External Review	An Appeal process through which you may have a denied Claim reviewed by an external, independent reviewer.
Facility	Any building, or area in a building, in which healthcare services are delivered.
Formulary	A list of drugs your Plan covers. A Formulary may include how much your share of the cost is for each drug. Your Plan may put drugs in different Cost Sharing levels or Tiers. For example, a Formulary may include generic drug and brand name drug Tiers and different Cost Sharing amounts will apply to each Tier. GlobalHealth's *Schedule of Benefits* includes how much

Term	Definition
	you pay. GlobalHealth's *Drug Formulary* uses Tiers.
Fraud	The intentional deception by you or a Provider to provide false information to GlobalHealth, or the intentional misuse of your Member ID Card.
Grace Period	The time between your last Premium payment and when your coverage is terminated due to lack of payment.
Grievance	A complaint that you communicate to GlobalHealth in writing.
Group Agreement	The contract between GlobalHealth and your employer that requires GlobalHealth to pay some or all of your healthcare costs in exchange for a Premium. This contract will prevail over any conflicting information.
Habilitation Services	Healthcare services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.
Health Insurance	A contract that requires GlobalHealth to pay some or all of your healthcare costs in exchange for a Premium. A Health Insurance contract may also be referred to as a "policy" or "Plan."
Home Healthcare	Healthcare services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed healthcare Providers. Home Healthcare usually does not include help with non-medical tasks, such as cooking, cleaning, or driving.
Hospice Services	Services to provide comfort and support for persons in the last stages of a terminal illness and their families.
Hospital	A medical Facility primarily and continuously engaged in providing and operating for the medical care and treatment of sick or injured persons on an Inpatient basis for which a charge is made. GlobalHealth contracts with Hospitals licensed by the State of Oklahoma.
Hospitalization	Care in a Hospital that requires admission as an Inpatient and usually requires an overnight stay. Some Plans may consider an overnight stay for observation as Outpatient care instead of Inpatient care.
Hospital Outpatient Care	Care in a Hospital that usually doesn't require an overnight stay.
Hospital Services	Medically Necessary services provided by a Hospital. The services may be provided on an Inpatient or Outpatient basis. They are prescribed, directed, or authorized by your PCP.
Independent Review Organization ("IRO")	An entity that conducts independent External Reviews of Adverse Determinations and final Adverse Determinations.
Individual Responsibility Requirement	Sometimes called the "individual mandate," the duty you may have to be enrolled in health coverage that provides Minimum Essential Coverage. If you do not have Minimum Essential Coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a

Term	Definition
	health coverage exemption.
Infertility	The inability to conceive a pregnancy or to carry a pregnancy to live birth after a year or more of regular sexual relations without contraception and the presence of a demonstrated condition recognized by a licensed physician, who is a Network Provider, as a cause of Infertility.
In-network	A healthcare Provider or Facility that has a contract with GlobalHealth to provide services at a discounted rate for Members. In-network Providers can be found in the *Provider Directory* or on our website Provider Search. Also see Network.
In-network Coinsurance	Your share (for example, 20%) of the Allowed Amount for covered healthcare services. Your share is usually lower for In-network Covered Services. GlobalHealth does not have different Cost-share based on Network. You only have coverage for services in our Network, except for urgent or emergent care.
In-network Copayment	A fixed amount (for example, $15) you pay for covered healthcare services to Providers who contract with GlobalHealth. In-network Copayments usually are less than Out-of-network Copayments. GlobalHealth does not have different Cost-share based on Network. You only have coverage for services in our Network, except for urgent or emergent care.
Inpatient	Patient who is admitted to and is assigned a bed in a healthcare Facility while undergoing diagnosis and receiving treatment and care.
Life-threatening Disease or Condition	Any disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted.
Local Coverage Determination ("LCD")	A document published by Medicare Contractors that details which conditions or diagnosis codes support medical necessity for a service or procedure. They specify under what clinical circumstances a service is considered to be reasonable and necessary.
Low Vision	Low Vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in Low Vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision.
Marketplace	A Marketplace for Health Insurance where individuals, families, and small businesses can learn about their Plan options; compare Plans based on costs, benefits, and other important features; apply for and receive financial help with Premiums and Cost Sharing based on income; choose a Plan; and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the Federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program ("CHIP"). Available online, by phone, and in-person.
Maximum Out-of-pocket Limit	Yearly amount the federal government sets as the most each individual or family can be required to pay in Cost Sharing during the Plan Year for covered, In-network services. Applies to most types of health Plans and

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

Term	Definition
Out-of-network Coinsurance	Your share (for example, 40%) of the Allowed Amount for covered healthcare services to Providers who do *not* contract with GlobalHealth. Out-of-network Coinsurance usually costs you more than In-network Coinsurance. GlobalHealth does not have different Cost-share based on Network. You only have coverage for services in our Network, except for urgent or emergent care.
Out-of-network Copayment	A fixed amount (for example, $30) you pay for covered healthcare services from Providers who do *not* contract with GlobalHealth. Out-of-network Copayments usually are more than In-network Copayments. GlobalHealth does not have different Cost-share based on Network. You only have coverage for services in our Network, except for urgent or emergent care.
Out-of-network Provider	A Provider who does not have a contract with GlobalHealth to provide services. GlobalHealth only covers Out-of-network services in limited situations.
Out-of-pocket Limit	The most you could pay during a coverage period (usually a year) for your share of the costs of Covered Services. After you meet this limit, GlobalHealth begins to pay 100% of the Allowed Amount. This limit helps you plan for healthcare costs. This limit never includes your Premium, balance-billed charges, or healthcare costs that your Plan doesn't cover. This may be called "maximum out-of-pocket or "MOOP".
Outpatient	Patient who is undergoing diagnosis and receiving treatment and care, but is not admitted to or assigned a bed in a healthcare Facility.
Physician Services	Healthcare services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine) provides or coordinates.
Plan	Health coverage issued to you directly (individual Plan) or through an employer, union, or other group sponsor (employer group Plan) that provides coverage for certain healthcare costs. Also called "Health Insurance Plan", "policy", "Health Insurance policy", or "Health Insurance".
Plan Administrator	The person who is identified as having responsibility for administering the Plan. It could be the employer, a committee of employees, a company executive, or someone hired for that purpose. It does not refer to GlobalHealth.
Plan Year	The twelve (12) months your *Group Agreement* covers, or the timeframe from your effective date to the end of your group's Plan Year if you are a late enrollee.
Practitioner	A professional who provides healthcare services. Practitioners are licensed as required by law.
Preauthorization	A decision by GlobalHealth that a healthcare service, treatment plan, Prescription Drug, or Durable Medical Equipment ("DME") is Medically Necessary. Sometimes called prior authorization, prior approval, or precertification. GlobalHealth may require Preauthorization for certain

Term	Definition
	services before you receive them, except in an emergency. Preauthorization isn't a promise that GlobalHealth will cover the cost.
Preferred Facility	A Facility which has a contract with GlobalHealth to provide services to you at a discount. You will pay the lowest Cost-share when you choose these Facilities. It may also be called, "Ambulatory Surgical Center".
Preferred Provider	A Provider who has a contract with GlobalHealth to provide services to you at a discount. GlobalHealth may have Preferred Providers who are also "participating" Providers. Participating Providers also contract with GlobalHealth, but the discount may not be as great, and you may have to pay more. You will pay the Cost-share listed in your *Schedule of Benefits*.
Premium	The amount that must be paid for your GlobalHealth Plan. You and/or your employer usually pay it monthly, quarterly, or yearly.
Prescription Drug Coverage	Coverage under a Plan that helps pay for Prescription Drugs. If the Plan's Formulary uses "Tiers" (levels), Prescription Drugs are grouped together by type or cost. The amount you will pay in Cost Sharing will be different for each "Tier" of covered Prescription Drugs.
Prescription Drugs	Drugs and medications that by law require a prescription.
Preventive Care (Preventive Service)	Routine health care, including Screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.
Primary Care Physician ("PCP")	A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine) who provides or coordinates a range of healthcare services for you.
Primary Care Provider	A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse Practitioner, clinical nurse Specialist, or physician assistant, as allowed under state law and the terms of the Plan, who provides, coordinates, or helps you access a range of healthcare services.
Provider	An individual or Facility that provides healthcare services. Some examples of a Provider include a doctor, nurse, chiropractor, physician assistant, Hospital, surgical center, Skilled Nursing Facility, and rehabilitation center. GlobalHealth may require the Provider to be licensed, certified, or accredited as required by state law.
Prudent Layperson	A person without medical training who reasonably draws on practical experience when making a decision regarding whether Emergency Services are needed. A person, who has an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual in serious jeopardy; (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part.
Qualified Member	You are qualified to participate in an Approved Clinical Trial if (1) You are eligible to participate in the trial according to its protocol; and (2) either a Network Provider who has referred you to the trial concludes that participation would be appropriate, or you provide medical and scientific information that establishes that your participation is appropriate.

Term	Definition
Qualifying Life Event ("QLE")	A change in your situation – like getting married, having a baby, or losing health coverage – that can make you eligible for a Special Enrollment Period, allowing you to enroll in Health Insurance outside the yearly Open Enrollment period.
Reconstructive Surgery	Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.
Referral	A written order from your Primary Care Provider for you to see a Specialist or get certain healthcare services. In many health maintenance organizations ("HMOs"), you need to get a Referral before you can get healthcare services from anyone except your Primary Care Provider. If you don't get a Referral first, GlobalHealth may not pay for the services. GlobalHealth allows limited access to services in addition to your PCP without a Referral.
Rehabilitation Services	Healthcare services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric Rehabilitation Services in a variety of Inpatient and/or Outpatient settings.
Routine Costs	Routine Costs associated with an Approved Clinical Trial are costs that are associated with reasonable and necessary medical care that is typically provided absent a clinical trial, including costs associated with diagnosis and treatment of complications arising from participation in the clinical trial. Routine Costs do not include the cost of an investigational drug or item itself, or costs for items and services provided solely for data collection and analysis.
Schedule of Benefits	Used in conjunction with your *Member Handbook*, providing benefit information specific to your Plan, including Copayment/Coinsurance, Deductible, and MOOP information.
Screening	A type of Preventive Care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.
Serious Acute Condition	A disease or condition requiring complex ongoing care which you are currently receiving, such as chemotherapy, radiation therapy, or post-operative visits.
Service Area	A geographical area, as approved by the Oklahoma Insurance Department, within which GlobalHealth arranges for basic medical, Hospital, and supplemental healthcare services.
Skilled Nursing Care	Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled Nursing Care is not the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.
Skilled Rehabilitation Services	Services provided in the home by licensed therapists (e.g., physical, occupational, speech).

Term	Definition
Skilled Nursing Facility	A Facility or Hospital unit primarily engaged in providing, in addition to room and board accommodations, twenty-four (24) hour Skilled Nursing Care under the supervision of a licensed physician. GlobalHealth contracts with Skilled Facilities that are certified under Title XVIII of the Social Security Act (Medicare certified).
Special Enrollment Period ("SEP")	The period of time, outside of Open Enrollment, when a person may enroll in a health Plan.
Specialist	A Provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.
Specialty Drug	A type of Prescription Drug that, in general, requires special handling or ongoing monitoring and assessment by a healthcare professional, or is relatively difficult to dispense. Generally, Specialty Drugs are the most expensive drugs on a Formulary.
Subscriber	A person meeting the eligibility requirements of the *Group Agreement* based on employment or association rules of the group, and for whom the appropriate health Plan Premium has been received by GlobalHealth. Usually, the Subscriber is the employee.
Tier	Groups of drugs that fall within description and pricing levels. Drugs are assigned based on drug usage, cost, and clinical effectiveness. The higher the Tier, the more you pay through higher Cost Sharing.
Urgent Care	Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Room Care.
Usual and Customary	The amount paid for a Medical Service in a geographic area based on what Providers in the area usually charge for the same or similar Medical Service. The Usual, Customary, and Reasonable ("UCR") amount sometimes is used to determine the Allowed Amount.
Utilization Management ("UM")	A process for monitoring the use, delivery, and cost-effectiveness of services.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-280-5600 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-280-5600 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877-280-5600 (TTY: 711)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-280-5600 (TTY: 711)번으로 전화해 주십시오.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-280-5600 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل بـ 1-877-280-5600 (TTY: 711). رقم هاتف الصم والبكم 1-800-227-3530

သတိျပဳရန္ - အကယ္၍ သင့္သည္ျမန္မာစကား ကို ျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့္အတြက္ စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ 1-877-280-5600 (TTY: 711) သို႔ ေခၚဆိုပါ။

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-280-5600 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-280-5600 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-280-5600 (ATS: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-280-5600 (TTY: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-280-5600 (TTY: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-280-5600 (TTY: 711).

Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 1-877-280-5600 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید 1-877-280-5600 (TTY: 711).

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