



GlobalHealth

State of Oklahoma

Member
Orientation 2018



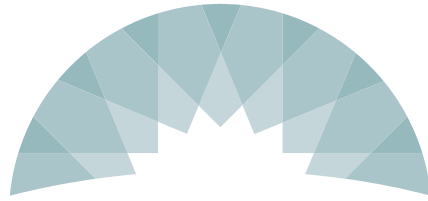
Welcome to GlobalHealth



GlobalHealth, Inc.
P.O. Box 2393
Oklahoma City, OK 73101-2393
www.GlobalHealth.com/state

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WELCOME TO THE GLOBALHEALTH FAMILY!



GlobalHealth



MEMBER MATERIALS

Make the most of your benefits by going to www.GlobalHealth.com/state to download information including:

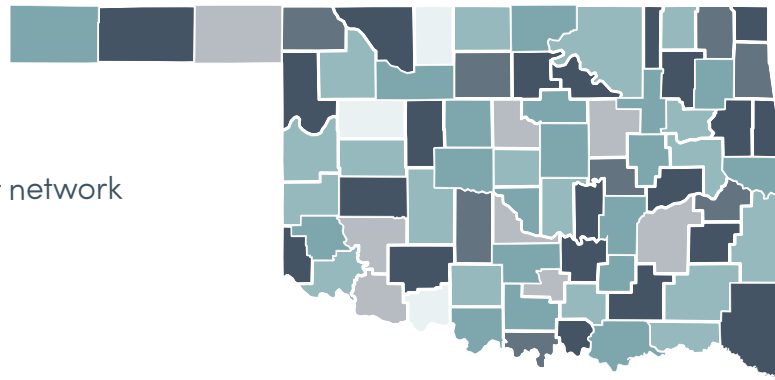
- ▶ **Member Handbook**
(includes Member Rights and Responsibilities & Notice of Privacy Practices)
- ▶ **Drug Formulary**
- ▶ **Physician and Health Providers Directory**
- ▶ **Summary of Benefits and Coverage**

Printed copies are available upon request by calling Customer Care.

NETWORK PROVIDERS

Our provider network includes top-quality providers, hospitals, and pharmacies throughout Oklahoma. It is important to stay in network in order to keep out-of-pocket costs low and avoid being balance billed.

- + All 77 counties
- + Strong provider network



Search Our Provider Network



Visit www.GlobalHealth.com/search to find out which physicians and facilities are in our network. Your network name is the **GlobalHealth State & Education Employee Network**.



Visit www.GlobalHealth.com/provider-directory to download a PDF version of the provider directory. Select the **Commercial Network** when downloading.



Download Our Mobile App

Visit www.GlobalHealth.com/mobileapp to easily access our provider search and to access benefits, wellness topics and GlobalHealth contact information.

CHOOSE A PRIMARY CARE PHYSICIAN (PCP)

When you enroll, you choose a PCP from the GlobalHealth provider network. Each member of the family may choose a different PCP, including a pediatrician for children. You may change your PCP selection at any time throughout the year. Your PCP change will be effective the same day.



Always start with your PCP. \$0 copay.

Your PCP will coordinate and manage your medical care including preventive care & referral requests if specialty care is necessary. Do not make your appointment with the specialist until you receive the authorization letter. The specialist may request referrals for procedures and follow up care after the initial visit. For same-day urgent care needs, call your PCP if during normal office hours. A referral is not required for specific self-referral services.



Hospital visits require referrals.

A referral and preauthorization from GlobalHealth are required for scheduled stays. You may only go to a hospital in the network except in an emergency. You do not have to obtain preauthorization for emergency services or stays in connection with childbirth. 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.



Emergency Care.

Let your PCP & GlobalHealth know within 48 hours of being seen. We may arrange to transfer you to an in-network hospital if you are admitted to an out-of-network hospital from ER. You may go to any emergency room, but you may be balance billed if you choose an ER that is not in-network.

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.

- 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.

In these situations, we will pay in accordance with our usual and customary reimbursement and you could be balance billed by the provider. If you believe a provider has balance billed you in error, call Customer Care.

YOU MAY SELF REFER FOR THE FOLLOWING SERVICES

You do not need preauthorization from GlobalHealth or from your PCP in order to obtain in-network care for the following services:



Obstetrical/Gynecological Services and Well-Woman Exams

From a healthcare professional who specializes in obstetrics or gynecology.



Routine Mammogram

From an imaging center.



Physical Therapy

For an evaluation only from a healthcare professional who specializes in physical therapy. You will need preauthorization for any additional treatment.



Routine Eye Exams & Eyewear

From a network optometrist & eyewear providers.



Behavioral & Mental Health/Chemical Dependency Services

Medication management, therapy, and/or psychiatric testing from a healthcare professional who specializes in behavioral health.



After-Hours Urgent Care Visits

URGENT CARE VS. EMERGENCY ROOM

It is important to choose the appropriate place of care when it comes to injuries and illnesses. More than 50% of ER visits could be handled more efficiently in an urgent care*. Urgent care does not take the place of your Primary Care Physician (PCP). If possible, always visit your PCP first for non-life threatening injuries or illnesses.

URGENT CARE \$25 copay		EMERGENCY ROOM \$300 copay	
Minor Injuries	Minor Illnesses	Life-Threatening Injuries	Life-Threatening Illnesses
<ul style="list-style-type: none"> • Stitches • X-rays • Sprains • Fractures • Minor cuts and burns 	<ul style="list-style-type: none"> • Cold • Flu • Sore throat • Low-grade fever 	<ul style="list-style-type: none"> • Severe cuts • Severe burns • Broken bones • Head trauma 	<ul style="list-style-type: none"> • Chest pain • Stroke • Trouble breathing • Severe abdominal pain • High-grade fever

OR

Still unsure? Call your in-network urgent care center and ask if they treat your symptoms. The above scenarios do not outweigh your personal judgment.

When it's an emergency, go to the nearest hospital emergency room and follow these steps:

- Show your member ID card.
- Call GlobalHealth's Customer Care within 48 hours, ask for Case Management and inform them you were treated in the ER.
- Call your PCP's office within 48 hours. Tell them you were treated in the ER.
- If you are admitted to an out-of-network hospital, GlobalHealth may arrange to transfer you to a hospital in the network.
- All follow-up care must be provided or arranged by your PCP. Preauthorization by GlobalHealth may also be needed.
- Be aware, an out-of-network provider may balance bill you. An in-network provider may not balance bill you.

*Source: Tulsa People Magazine, December 2015 Edition

BENEFITS AT A GLANCE

The following is intended to be only a summary of benefits offered by GlobalHealth, plan MLGMH18-ST for State, Education and Local Government Employees. For more information, go to www.GlobalHealth.com/state.

BENEFIT	YOU PAY
ANNUAL DEDUCTIBLE	This plan doesn't have an annual deductible.
ANNUAL OUT-OF-POCKET MAXIMUM	Member – \$3,500 Family – \$10,500
PRIMARY CARE VISITS	\$0 copay per visit
SPECIALIST VISITS	\$50 copay per visit
PREVENTIVE CARE	\$0 copay
X-RAYS & LABS	\$0 copay
SPECIALIZED SCANS, IMAGING, & DIAGNOSTIC EXAMS	\$250 copay per scan in preferred facility; \$750 copay per scan in non-preferred facility
INPATIENT HOSPITAL STAY	\$250 copay per day with \$750 maximum per admission
OUTPATIENT SURGERY	\$250 copay in preferred facility; \$750 copay in non-preferred facility
EMERGENCY ROOM SERVICE	\$300 copay, waived if admitted to hospital inpatient
URGENT CARE	\$25 copay in urgent care facility
MATERNITY CARE	\$0 copay for prenatal care; \$25 one-time copay for delivery and all post-natal care; \$500 copay per admission for delivery
FAMILY PLANNING	No copay on FDA-approved services \$0 copay for men if services performed in an office setting
ALLERGY CARE	\$0 copay per PCP visit; \$50 copay per specialist visit \$30 copay/6-week supply of antigen and administration
PHYSICAL, OCCUPATIONAL, SPEECH THERAPY (limited to 60 combined visits per course of therapy)	No copay for inpatient Outpatient: \$50 copay per visit Rehabilitation Facility: \$250 copay per day with \$750 copay per admission
CHIROPRACTIC CARE (15 visits per year)	\$25 copay per visit
MENTAL HEALTH SERVICES CHEMICAL DEPENDENCY & SUBSTANCE ABUSE	\$0 copay per outpatient office visit \$250 copay per day with \$750 per admission

PRESCRIPTION DRUG BENEFITS

Get details on preferred drugs and pharmaceutical management procedures at www.GlobalHealth.com/state. We offer a four-tier system for generics, preferred brand-name medications, non-preferred medications and specialty medications. You may choose to obtain your prescriptions through retail or home delivery.



Visit www.GlobalHealth.com/search to find out which pharmacies are in our network.

PHARMACY TYPE	DESCRIPTION
RETAIL NETWORK PHARMACIES	Up to a 30-day supply that you pick up at your local network pharmacy.
HOME DELIVERY PHARMACY SERVICE	Maintenance medications are mailed to your home in a 90-day supply when prescribed as a 90-day supply by a network Provider.
EXTENDED SUPPLY RETAIL PHARMACY NETWORK	You may receive up to a 90-day supply of a maintenance drug at an extended supply retail pharmacy for the applicable home delivery copay. Medication must be prescribed as 90-day.
CHICKASAW NATION REFILL CENTER MEDICATIONS BY MAIL	Native American-owned retail pharmacy that provides prescription medications to Native Americans. Proof of Native American status in one of the federally recognized tribes is required to receive discounts. Medications are mailed directly to your home or designated location.
SPECIALTY PHARMACIES	Contracted specialty pharmacies fill your specialty medications and mail them to your home. You pay the prescription drug copay when specialty medications are sent to and administered by you.

GlobalHealth's Preferred Formulary Drug List

Preferred drugs are listed in the Drug Formulary. It includes generic and brand name medications that are approved by the FDA.

The list of drugs is subject to change.

- New medications 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 medication 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 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, the drug will be removed immediately from our formulary and you will be notified.

PRESCRIPTION DRUG BENEFITS

See the Drug Formulary to see what tier your medications are in and what, if any, utilization management restrictions they have.

TIER LEVEL	YOU PAY	BENEFIT DESCRIPTION
ACA	You pay no Cost-share	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	Network Retail Pharmacy Low-Cost Generic: \$5 copay Preferred Generic: \$10 copay Home Delivery or Extended Supply Retail Low-Cost Generic: \$10 copay Preferred Generic: \$20 copay	You will pay the lowest cost-share for select, low-cost generics. All other generics in this tier have the higher cost-share.
TIER TWO	Network Retail Pharmacy \$50 copay Home Delivery or Extended Supply Retail \$100 copay	Preferred brand name medications on the formulary
TIER THREE	Network Retail Pharmacy \$75 copay Home Delivery or Extended Supply Retail \$150 copay	Non-preferred name brand and specified high-cost generic drugs
TIER FOUR	Network Specialty Pharmacy Preferred Specialty: \$100 copay *Non-preferred Specialty: \$200 copay Home Delivery or Extended Supply Retail Not covered	Preferred and non-preferred specialty medications are filled through a specialty pharmacy. Specialty drugs are limited to no more than a one-month supply per fill.

Use our Prescription Drug Cost Calculator at www.GlobalHealth.com/prescription_pricing

*Oral cancer medications have a maximum copay of \$100 per 30-day fill.

PRESCRIPTION DRUG BENEFITS

Formulary Terms and Definitions

TERM	DEFINITIONS
PRIOR AUTHORIZATION (PA)	On certain medications physicians are required to get approval from GlobalHealth before you fill your prescriptions. If you do not get approval, GlobalHealth may not cover the drug.
STEP THERAPY (ST)	In some cases, GlobalHealth requires you to try one or more prerequisite, clinically equivalent drugs to treat your medical condition before we will cover another drug for that condition.
QUANTITY LIMITS (QL)	There are limits to the amount of certain medications that you may receive. These drugs, if taken inappropriately for too long a period of time, could be unsafe and cause adverse effects.



Prescription Drug Resources and Links

Prior Authorization form for physicians: www.GlobalHealth.com/pharm_priorauth

Sign up for mail order: www.GlobalhHealth.com/pharmacy/mail-order-drugs/

Sign up for Chickasaw Nation Refill Center:

www.GlobalHealth.com/pharmacy/chickasaw-nation-refill-center/

Other forms and resources: www.GlobalHealth.com/prescriptions

GLOBALFIT® GYM MEMBERSHIP DISCOUNTS

Through our partnership with GlobalFit®, you can register for our wellness benefit giving you access to discounts on gym memberships at thousands of fitness clubs nationwide.



Members can register at: www.globalfit.com/globalhealth

2018 EXCLUSIONS AND LIMITATIONS

All benefits described below are excluded or limited under this Plan for all types of services. We cover some benefits only as follows. You pay for additional services. We do not cover the following benefits. We may pay for care while deciding whether or not the care falls within the Excluded Services listed below. If it is later determined that the care is excluded from your coverage, we will recover the amount we have allowed for benefits. You must give us all documents needed to enforce our rights.

General Limitations

We cover certain benefits only as follows:

Behavioral health services

- Applied behavioral analysis 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.
- Autism Screening limited to well-child visits.
- Compulsive disorders treatment limited to programs for feeding and eating disorders.
- Developmental Screening limited to well-child visits.
- Psychiatric or psychological treatment for developmental disorders, limited to mental retardation, pervasive developmental disorder and other specific developmental disorders, such as autism, Rett's, or Asperger's.

Chiropractic care

- Limited to 15 visits per year.

Cosmetic services

- Treatment, item, supply, drug, procedure, or any portion of a procedure performed primarily to improve physical appearance limited to:
 - o Repair due to an accidental injury;
 - o Improve function of a malformed part of the body. Does not include dentistry or dental processes; and
 - o Breast reconstruction after a mastectomy.

Dental services

- Dentistry or dental processes to the teeth and surrounding tissue limited to:
 - o ER services to treat accidental injury to the jaw, sound natural teeth, mouth, or face.
 - o Improve function of a malformed part of the body resulting from a birth defect.
- General anesthesia/IV sedation for dental services limited to a Member who:
 - o Has a medical or emotional condition that requires Hospitalization or general anesthesia for dental care;
 - o Is severely disabled;
 - o In the judgment of the treating Practitioner, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia; and
 - o Requires Inpatient or Outpatient services because of an underlying medical condition and clinical status or because of the severity of the dental procedure.

DME, orthotic devices, and prosthetic appliances

- Breast pumps limited to one per year for women who are pregnant or nursing.
- Corrective lenses and fittings following cataract surgery limited to:
 - o First set of basic frames and lenses; or
 - o One set of contact lenses.
- Foot care limited to:
 - o Routine foot care, shoes, shoe inserts, arch supports, and supportive devices for Members diagnosed with diabetes or a blood circulation disease.
 - o Orthopedic or corrective shoes permanently attached to a Denis Browne splint for children.
- Hearing aids limited to:
 - o One aid per ear every 48 months unless Medically Necessary to replace more often.
 - o Four additional ear molds per year for children less than two years of age.
- Orthotic devices limited to:
 - o Members with diagnoses pertaining to peripheral vascular disease or diabetes.
- Wigs and scalp prostheses limited to one synthetic wig or scalp prosthesis per year when required due to loss of hair resulting from chemotherapy or radiation therapy.

Experimental or Investigational therapies

- Drugs, items, devices, and procedures limited to:
 - o Off-label uses of certain drugs used in the study or treatment of cancer; and
 - o Certain investigational uses of drugs, including chemotherapy for cancer treatment, if given to you as part of an Approved Clinical Trial.

General care or Hospital Services

- Hospital private room limited to isolation to prevent contagion per the Hospital's infection control policy.

Genetic analysis, services, or testing

- Limited to counseling and testing for women whose family history is associated with a higher risk for deleterious mutations in BRCA 1 and BRCA 2 genes.

Home Healthcare

- Limited to 100 visits per year.

Physical, occupational, and speech therapy

- Rehabilitation Services limited to 60 combined Outpatient visits per year for:
 - o Physical therapy;
 - o Occupational therapy; and/or
 - o Speech therapy.

ASD Treatment – Physical, occupational, and/or speech therapy services 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.

Prescription Drugs

- Inhaler extender devices, peak flow meters, Ana-Kits, and EpiPens limited to three per year.
- The Pharmacy and Therapeutics Committee's standard quantity limits, prior authorization criteria, and step therapies apply.
- Specialty Drugs limited to a one-month supply.
- Smoking cessation products limited to:
 - o Two full 90-day courses of FDA-approved tobacco cessation products per year, if prescribed by your PCP.
 - o Members who are at least 18 years old.
- Drugs prescribed or given to you by Out-of-network doctors in non-emergencies limited to those prescribed by dentists.
- Non-prescription contraceptive jellies, ointments, foams, or devices limited to those that are FDA-approved and prescribed by a Network doctor for a woman.
- Prescription diaphragms limited to two per year.
- Biological sera, medication prescribed for parenteral use or administration, allergy sera, immunizing agents, and immunizing injectable drugs limited to immunizations covered under Preventive Care guidelines and given to you at a Network pharmacy.
- Prescription Drugs for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasm, hypogasm, or decreased libido limited to post-prostate surgery indications.

Sexual dysfunction

- Limited to drugs and supplies for post-prostate surgery indications.

Skilled Nursing Facility care

- Limited to 100 days per year.

Vision

- Routine services limited to one check-up, including eye refraction, per year.
- Treatment for orthoptics or visual training limited to a diagnosis of mild strabismus.

EXCLUDED SERVICES

Behavioral health services

- Education, tutoring, and services for the purpose of diagnosing or treating a learning disability, disruptive, impulse-control, or conduct disorder.

Dental services

- General dental services.
- Procedures that involve the teeth or their supporting structures.
- Correction of occlusive jaw defects, dental implants, or grafting of alveolar ridges.
- Treatment of soft tissue to prepare for dental procedures or dentures.

DME, orthotic devices, and prosthetic appliances

- Bandages, pads, or diapers.
- Equipment or devices not medical in nature such as:
 - o Braces worn for athletic or recreational use
 - o Ear plugs
 - o Elastic stockings and supports
 - o Garter belts
- Jacuzzi/whirlpools.
- Mattresses and other bedding or bed-wetting alarms.
- Power-operated vehicles that may be used as wheelchairs.
- Purchase or rental of equipment or supplies for common household use such as:
 - o Air-cleaning machines or filtration devices
 - o Air conditioners
 - o Beds and chairs
 - o Cervical or lumbar pillows
 - o Grab bars
 - o Physical fitness equipment
 - o Raised toilet seats
 - o Shower benches
 - o Traction tables
 - o Water purifiers

Experimental or Investigational therapies

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

General care or Hospital Services

- Treatment of any kind which is excessive or not Medically Necessary.
- Services received without an authorization when one is required. Complications arising from those services.
- Treatment of any kind received before your start date of coverage or after the time coverage ends, even if authorized.
- Care or services provided outside the GlobalHealth Service Area if the need for such care or services could have been foreseen before leaving the Service Area.
- Services, other than Hospital Services for behavioral health, for which you do not allow the release of information to GlobalHealth.
- Services for travel, insurance, licensing, employment, school, camp, sports, premarital, or pre-adoption purposes.
- Personal or comfort items.

- Services received while outside of the U.S. (50 states and District of Columbia).
- Charges for injuries resulting from war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.
- Treatment of injuries or illnesses resulting from an attempt or commission of a felony, or as a result of being engaged in an illegal occupation.
- Elective enhancement procedures, services, supplies, or medications, including but not limited to:
 - o Anti-aging
 - o Athletic performance
 - o Cosmetic purposes
 - o Hair growth
 - o Sexual performance
- Separate charges for missed or canceled appointments, penalty or finance charges, maintenance and/or record-keeping, record copying, or Case Management services.
- Treatment, supplies, drugs, and devices for which no charge was made. Treatment, supplies, drugs, and devices for which no payment would be requested if you did not have this coverage.
- Custodial care, respite care, homemaker services, or domiciliary care.
- Treatment for injury resulting from extreme activities including, but not limited to:
 - 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

- Alternative programs for delivery such as home delivery and use of midwives and birthing centers.
- Elective abortions.
- Expenses related to surrogate parenthood.
- Home uterine monitoring.
- In vitro fertilization, artificial insemination, embryo transfers, reversal of voluntary sterilization, ovum transplant, gamete intrafallopian transfer ("GIFT"), zygote intrafallopian transfer ("ZIFT"), surrogate parenting, and donor semen expenses.

Other coverage

- Treatment for disabilities connected to military service for which you are legally entitled and to which you have reasonable accessibility (that is, services through a federal governmental agency).
- Services that are provided as a result of Workers' Compensation laws or similar laws.
- Treatment for which the cost is recoverable under any other coverage, including Workers' Compensation, Occupational Disease law, or any state or government agency.

Other Excluded Services

- Services resulting in whole or in part from an excluded condition, item, or service.

Physical, occupational, and speech therapy

- Kinesiology, movement therapy, or biofeedback.
- Rolf technique.
- Massage therapy.
- Acupuncture/acupressure.
- Recreational therapy including, but not limited to:
 - o Animal-facilitated therapy
 - o Music therapy

Prescription Drugs

- Non-preventive care drugs, dietary, formulas, foods, and products supplements available without a prescription (OTC).
- OTC drugs that are for the same purpose and have the same effect as Prescription Drugs, even if ordered by a doctor.
- Saline and medications for irrigation.
- Drugs prescribed for a non-FDA approved indication, dosage, or length of therapy.

Repair and replacement

- Drugs, eyewear, devices, appliances, equipment, or other items that are lost, missing, sold, or stolen.
- Items that have been damaged or destroyed due to improper use or abuse.

Transplants

- Artificial or non-human organ transplants.
- Transplants considered experimental, investigative, or unproven.

Transportation/ lodging

- Routine, non-emergent ambulance transport unless preauthorized by GlobalHealth.
- Lodging, meals, and transportation costs.

Vision

- Computer programs of any type, including, but not limited to, those to assist with vision therapy.
- Insurance for contact lenses.
- LASIK, INTACS, radial keratotomy, and other refractive surgery.
- Multiple pairs of glasses in lieu of bifocals or trifocals.

Weight Reduction Programs

- Gastric stapling, gastric balloon services, or any surgical treatment for obesity or weight-loss purposes.
- Commercial weight loss programs.



Have Questions? Contact Customer Care
(405) 280-5600 (local) 1-877-280-5600 (toll-free)
(TTY: 711)
www.GlobalHealth.com/state

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