HealthChoice

High, High Alternative, Basic and Basic Alternative Plans and High Deductible Health Plan Handbook

Table of Contents

This health handbook replaces and supersedes any health handbook the Office of Management and Enterprise Services Employees Group Insurance Division previously issued. This health handbook will, in turn, be superseded by any subsequent health handbook OMES issues. The most current version of this health handbook can be found on the HealthChoice website at **www.healthchoiceok.com**.

Notices

PLEASE READ THIS HANDBOOK CAREFULLY

The Office of Management and Enterprise Services Employees Group Insurance Division provides health care benefits to eligible state, education and local government employees, former employees, and their dependents in accordance with the provisions of O.S. 74 (2012) §§ 1301, et seq.

The information provided in this handbook is a summary of the benefits, conditions, limitations and exclusions of the HealthChoice High, High Alternative, Basic and Basic Alternative Plans and High Deductible Health Plan (referenced herein as plan or plans). It should not be considered an all-inclusive listing. All references to you and your relate to the plan member.

- Plan benefits are subject to conditions, limitations and exclusions, which are described and located in Oklahoma statutes, handbooks and *Administrative Rules* adopted by the plan administrator. You can obtain a copy of the official *Administrative Rules* from the Office of the Oklahoma Secretary of State. An unofficial copy of the rules is available on the EGID website at **omes.ok.gov**. In the menu bar under Services, select Employees Group Insurance Division. Under Resources, select About EGID, then select Administrative Rules.
- A dispute concerning information contained within any plan handbook or any other written materials, including any letters, bulletins, notices, other written document or oral communication, regardless of the source, shall be resolved by a strict application of *Administrative Rules* or benefit administration procedures and guidelines as adopted by the plan. Erroneous, incorrect, misleading or obsolete language contained within any handbook, other written document or oral communication, regardless of the source, is of no effect under any circumstance.

INFORMATION AVAILABLE ONLINE

www.healthchoiceconnect.com

This online tool is designed to give you quick and easy access to your benefit information. HealthChoice Connect provides you with member and dependent coverage information, a link to the tobacco-free attestation during the annual Option Period, temporary member ID cards, and claim information. If you haven't already registered for HealthChoice Connect, create a unique username and password to access your information. Your covered dependents ages 18 and older must register independently for HealthChoice Connect.

omes.ok.gov

Under Services in the menu bar, select Employees Group Insurance Division. This provides information concerning all programs involved with the Oklahoma Employees Insurance and Benefits Act, including HealthChoice.

HealthChoice Plan Identification Information

Revised January 2019

Plan Names

HealthChoice High, High Alternative, Basic, Basic Alternative and High Deductible Health Plan

Customer Care

Medical Benefit Coverage, Claims, Certification Inquiries and Medical Records

HealthSCOPE Benefits
Toll-free 800-323-4314
TTY 711
www.healthchoiceconnect.com

Claims and Correspondence
P.O. Box 99011
Lubbock, TX 79490-9011

Appeals and Provider Inquiries
P.O. Box 3897
Little Rock, AR 72203-3897

Pharmacy Benefits

Pharmacy Benefit Manager
CVS/caremark
Toll-free 877-720-9375
TTY 711
Caremark.com

CVS Specialty Pharmacy
Toll-free 800-237-2767
TTY 711

Pharmacy Prior Authorization
Toll-free 800-294-5979

Subrogation Administrator

McAfee & Taft
405-235-9621 or toll-free 800-235-9621
Two Leadership Square, 10th Floor
211 N. Robinson Ave.
Oklahoma City, OK 73102

Eligibility and Enrollment

EGID Member Services
405-717-8780 or toll-free 800-752-9475
TTY 711

Plan Administrator

Office of Management and Enterprise Services
Employees Group Insurance Division
405-717-8780 or toll-free 800-752-9475
TTY 711
3545 NW 58th St., Ste. 600
Oklahoma City, OK 73112
www.healthchoiceok.com

How the HealthChoice Health Plans Work

Cost-Sharing Features

The benefits of the HealthChoice High, High Alternative, Basic and Basic Alternative Plans and High Deductible Health Plan are based on cost-sharing features that include deductibles, copays and coinsurance. Refer to Plan Definitions at the end of this handbook for an explanation of these terms.

The HealthChoice Alternative plans are designed for members and their dependents who do not or cannot complete a tobacco-free attestation when required during the annual Option Period. The alternative plans are identical to the regular plans in benefits and exclusions, but many differ in deductibles, first dollar payments and maximum out-of-pocket amounts.

HealthChoice Provider Network

You can seek care from a network provider or a non-network provider; however, the amount you are responsible for paying is greatly increased when you use a non-network provider. With a statewide and multistate network of more than 22,000 physicians, hospitals and other health care professionals and facilities, the HealthChoice Provider Network is one of the largest in Oklahoma.

Finding a HealthChoice Network Provider

You can find a HealthChoice network provider by going to **www.healthchoiceconnect.com**.

You can also contact customer care to find a network provider. A customer care member advocate can give you the names of network providers in your area. For contact information, refer to Plan Identification Information.

If you are unable to locate a HealthChoice network provider in your area, you can nominate a provider for participation by completing the online provider nomination form or contacting EGID Member Services. For contact information, refer to Plan Identification Information.

Importance of Selecting a HealthChoice Network Provider

Network providers are contracted with HealthChoice and have agreed to accept HealthChoice allowable fees for the services and equipment they provide. Network providers have agreed not to bill you for charges that are greater than allowable fees. You are still responsible for your plan's copays, deductibles, coinsurance and charges for non-covered services.

Non-network providers are **not contracted** with HealthChoice and **have not** agreed to accept allowable fees. This means you are responsible for paying the difference between the amount the provider bills and allowable fees. This process, known as balance billing, can be a large amount of money out of your own pocket. Even after you reach your plan’s out-of-pocket maximum, you are still responsible for all amounts above allowable fees when you use non-network providers.

Allowable Fees

HealthChoice pays benefits based on set fees known as allowable fees. Allowable fees represent the set dollar amounts the plans allow for covered medical services and supplies. Regardless of the amounts billed by your provider, HealthChoice always calculates benefits based on its allowable fees. Network providers have agreed to accept these allowable fees and cannot balance bill you for amounts above the allowable fees.

HealthChoice ID Cards

HealthChoice issues two ID cards for your medical benefits and one ID card for your pharmacy benefits. To request additional or replacement medical ID cards, contact customer care. To request additional or replacement pharmacy ID cards, contact the pharmacy benefit manager. For contact information, refer to Plan Identification Information.

Certification Process

The plans require providers to certify certain services before the services are performed. Refer to the Certification section.

HealthChoice High and High Alternative Plans

Outline of Medical Benefits

The High and High Alternative plans are traditional medical plans with cost-sharing features that include copays, deductibles and coinsurance.

Note: For information about pharmacy benefits, including deductibles, copays and pharmacy out-of-pocket maximums, refer to the Pharmacy Benefits section.

Key Features

High Plan

- **Calendar Year Deductible** – You pay the calendar year deductible of $750/individual or $2,000/family of three or more for covered network and non-network medical services including, but not limited to, lab work, X-rays, surgical procedures and hospital admissions. Only allowable fees for covered medical services count toward the deductible. Copay-related services received from a network provider are not subject to the deductible. The family deductible can be met with a combination of three or more family members. No one person can meet more than $750 of the family deductible.
- **Calendar Year Out-of-Pocket Maximum** – The plan pays 100 percent of allowable fees for covered medical services for the remainder of the calendar year after you pay $3,300/individual or $8,400/family of three or more for network services or $3,800/individual or $9,900/family of three or more for non-network services. Network and non-network out-of-pocket maximums can be combined, but will not exceed the non-network out-of-pocket maximum. The out-of-pocket maximum does not include charges for non-covered services and balance billing charges from non-network providers.

High Alternative Plan

- **Calendar Year Deductible** – You pay the calendar year deductible of $1,000/individual, or $2,750/family of three or more, for covered network and non-network medical services including, but not limited to, lab work, X-rays, surgical procedures and hospital admissions. Only allowable fees for covered medical services count toward the deductible. Copay-related services received from a network provider are not subject to the deductible. The family deductible can be met with a combination of three or more family members. No one person can meet more than $1,000 of the family deductible.
- **Calendar Year Out-of-Pocket Maximum** – The plan pays 100 percent of allowable fees for covered medical services for the remainder of the calendar year after you pay $3,550/individual or $8,400/family of three or more for network services or $4,050/individual or $9,900/family of three or more for non-network services. Network and non-network out-of-pocket maximums can be combined, but will not exceed the non-network out-of-pocket maximum. The out-of-pocket maximum does not include charges for non-covered services, and balance billing charges from non-network providers

High and High Alternative Plans

- **Copays** – Copays are $30 for general physician office visits, which applies to general practitioners, internal medicine physicians, OB/GYNS, pediatricians, physician assistants and nurse practitioners who are network providers. Copays are $50 for specialist office

visits. Copays are $30 for an urgent care office visit at an urgent care facility. Plan benefits for services received from non-network providers are based on deductible and coinsurance.

Copays are $200 for each emergency room visit to a network or non-network emergency facility. The copay is waived if the patient is admitted or death occurs prior to admission.

There is a $300 non-network inpatient admission copay.

Charges for additional services such as lab work and X-rays count toward the deductible first, then coinsurance applies. Refer to Coinsurance in this section.

- **Coinsurance** – Once the deductible is met, HealthChoice pays 80 percent and you pay 20 percent of allowable fees for covered medical services received from a network provider. For services received from a non-network provider, HealthChoice pays 50 percent and you pay 50 percent of allowable fees for covered medical services, plus you pay all amounts above allowable fees. You are responsible for the cost of all non-covered services regardless of your provider's network or non-network status.
- Certain preventive services are covered at 100 percent of allowable fees when using a HealthChoice network provider. Refer to the Preventive Services section.
- **HealthChoice Provider Network** – The provider network helps limit your out-of-pocket costs. Refer to Importance of Selecting a HealthChoice Network Provider in the How the HealthChoice Health Plans Work section.

Coinsurance

	Network	Non-Network
You Pay*	20% of allowable fees	50% of allowable fees plus any amounts above allowable fees**
Plan Pays	80% of allowable fees	50% of allowable fees

*You must meet the deductible before coinsurance applies.
**This can be a substantial amount.

Calendar Year Out-of-Pocket Maximum

Network and non-network out-of-pocket maximums can be combined but will not exceed the non-network out-of-pocket maximum. The out-of-pocket maximum does not include charges for non-covered services and balance billing charges from non-network providers.

High Plan

Network

Per member $3,300
Per family of three or more $8,400

Non-Network

Per member $3,800
Per family of three or more $9,900

High Alternative Plan

Network

Per member $3,550
Per family of three or more $8,400

Non-Network

Per member $4,050
Per family of three or more $9,900

High and High Alternative Plans

After you meet the calendar year out-of-pocket maximum, the plan pays 100 percent of allowable fees for the remainder of the calendar year. You are responsible for all amounts above the allowable fees and non-network copays when you use non-network providers.

Charges That Do Not Count Toward the Out-of-Pocket Maximum

The following charges do not count toward meeting the out-of-pocket maximum and do not qualify for 100 percent payment after the out-of-pocket maximum is met:

- Amounts above HealthChoice allowable fees.
- Non-covered services or charges.
- Amounts above maximum benefit limitations.
- Non-network copays.

Lifetime Maximum

Per member ..... No Lifetime Maximum

HealthChoice Basic and Basic Alternative Plans

Outline of Medical Benefits

The medical benefits of the Basic and Basic Alternative plans are based on the costs of covered medical services you incur during the calendar year; the plans provide first dollar coverage for each covered family member.

Note: For information about pharmacy benefits, including deductibles, copays and pharmacy out-of-pocket maximums, refer to the Pharmacy Benefits section.

Key Features

Basic Plan

- **First Dollar Coverage** – The plan pays 100 percent of the first $500 of allowable fees for covered medical services for each covered family member.
- **Calendar Year Deductible** – You pay 100 percent of allowable fees for network or non-network covered medical services for the next $1,000/individual, or $1,500/family of two or more, as the deductible. Only allowable fees for covered medical services count toward meeting the deductible. The family deductible can be met with a combination of two or more family members. No one person can meet more than $1,000 of the family deductible. Covered network and non-network amounts apply.
- **Coinsurance** – Once the deductible is met, HealthChoice pays 50 percent and you pay 50 percent of allowable fees for covered medical services from a network and non-network provider until you reach the calendar year out-of-pocket maximum. For services received from a non-network provider, you are responsible for all amounts above allowable fees. You are responsible for the cost of all non-covered services regardless of your provider's network or non-network status.
- **Calendar Year Out-of-Pocket Maximum** – The plan pays 100 percent of allowable fees for covered network and non-network medical services for the remainder of the calendar year after you pay $4,000/individual or $8,000/family of two or more or $9,000/family of three or more. To minimize the member's out-of-pocket costs, network and non-network amounts cross accumulate during the year. The out-of-pocket maximum does not include charges for non-covered services and balance billing charges from non-network providers.
- Certain preventive services are covered at 100 percent of allowable fees when using a network provider. Refer to the Preventive Services section.

Basic Alternative Plan

- **First Dollar Coverage** – The plan pays 100 percent of the first $250 of allowable fees for covered medical services for each covered family member.
- **Calendar Year Deductible** – You pay 100 percent of allowable fees for network and non-network covered medical services for the next $1,250/individual, or $1,750/family of two or more, as the deductible. Only allowable fees for covered medical services count toward meeting the deductible. The family deductible can be met with a combination of two or more family members. No one person can meet more than $1,250 of the family deductible. Covered network and non-network amounts apply.

- **Coinsurance** – Once the deductible is met, HealthChoice pays 50 percent and you pay 50 percent of allowable fees for covered medical services from a network or non-network provider until you reach the calendar year out-of-pocket maximum. For services received from a non-network provider, you are responsible for all amounts above allowable fees. You are responsible for the cost of all non-covered services regardless of your provider's network or non-network status.
- **Calendar Year Out-of-Pocket Maximum** – The plan pays 100 percent of allowable fees for covered network and non-network medical services for the remainder of the calendar year after you pay $4,000/individual or $8,000/family of two or more or $9,000/family of three or more. To minimize the member's out-of-pocket costs, network and non-network amounts cross accumulate during the year. The out-of-pocket maximum does not include charges for non-covered services and balance billing charges from non-network providers.
- Certain preventive services are covered at 100 percent of allowable fees when using a network provider. Refer to the Preventive Services section.

Charges That Do Not Count Toward the Out-of-Pocket Maximum

The following charges do not count toward meeting the out-of-pocket maximum and do not qualify for 100 percent payment after the out-of-pocket maximum is met:

- Amounts above HealthChoice allowable fees.
- Non-covered services or charges.
- Amounts above maximum benefit limitations.
- $300 non-network hospital inpatient admission copay.

Lifetime Maximum

Per member ..... No Lifetime Maximum

HealthChoice High Deductible Health Plan

Outline of Medical Benefits

The High Deductible Health Plan is a traditional medical plan with cost-sharing features that include copays, deductibles and coinsurance that works in conjunction with a health savings account.

Note: For information about pharmacy benefits, including deductibles, copays and pharmacy out-of-pocket maximums, refer to the Pharmacy Benefits section.

Key Features

- **Calendar Year Deductible** – You pay the calendar year deductible of $1,750 for individual coverage or $3,500 for family of two or more. This is for covered network and non-network medical services including, but not limited to, lab work, X-rays, surgical procedures, hospital admissions, and covered pharmacy costs. The individual or family deductible must be met before any benefit is paid by the plan, including HealthChoice Select benefits. Allowable fees for both network and non-network medical and pharmacy services count toward the deductible. Preventive services from a network provider are not subject to the deductible.
- **Calendar Year Out-of-Pocket Maximum** – The plan pays 100 percent of allowable fees for covered network medical services for the remainder of the calendar year after you pay $6,000/individual or $12,000/family of two or more for network services. With family coverage, the out-of-pocket maximum is met by a combination of family members with $12,000 in covered services. However, the plan will pay covered services for an individual member in family coverage once that member reaches the $6,000 individual out-of-pocket maximum.

  The out-of-pocket maximum includes the calendar year deductible, allowable fees for network medical services, and allowable fees for generic and preferred medications purchased at network pharmacies.

  The out-of-pocket maximum does not include amounts above HealthChoice allowable fees (balance billing amounts), non-covered services or charges, cost differences between brand-name and generic medications, charges from non-network medical and pharmacy providers, and amounts above maximum benefit limitations. There is no out-of-pocket maximum for non-network services.
- **Copays** – After the deductible is met, copays are $30 for general physician office visits, which applies to general practitioners, internal medicine physicians, OB/GYNs, pediatricians, physician assistants and nurse practitioners who are network providers. Copays are $50 for specialist office visits. Plan benefits for services received from non-network providers are based on deductible and coinsurance.

  After the deductible is met, copays are $30 for an urgent care office visit at an urgent care facility. Additional services (such as lab work and X-rays) may be subject to coinsurance.

  Copays are $200 for each emergency room visit to a network or non-network emergency facility. The copay is waived if the patient is admitted or death occurs prior to admission.

  There is a $300 non-network hospital inpatient admission copay

  Charges for additional services such as lab work and X-rays count toward the deductible first, then coinsurance applies. Refer to Coinsurance in this section.

- **Coinsurance –** Once the deductible is met, HealthChoice pays 80 percent and you pay 20 percent of allowable fees for covered medical services received from a network provider. For services received from a non-network provider, HealthChoice pays 50 percent and you pay 50 percent of allowable fees for covered medical services, plus you are responsible for all billed amounts over allowable fees (balance billing). You are responsible for the cost of all non-covered services regardless of your provider's network or non-network status.
- Certain preventive services are covered at 100 percent of allowable fees when using a HealthChoice network provider. Refer to the Preventive Services section.
- **HealthChoice Provider Network** – The provider network helps limit your out-of-pocket costs. Refer to Importance of Selecting a HealthChoice Network Provider in the How the HealthChoice Health Plans Work section.

Lifetime Maximum

Per member ..... No Lifetime Maximum

Certification

Certification is a review process used to determine coverage criteria and/or if services are medically necessary according to HealthChoice guidelines. Certification is also referred to as prior authorization, precertification or preauthorization. All HealthChoice plans require certification for specified services. Certification approval does not guarantee benefits. Clinical editing and other plan policies, provisions and criteria apply.

Guidelines

Providers are responsible for obtaining certification. To request certification, your provider must contact customer care or go online to **www.healthchoiceconnect.com** to complete the online request form. For non-urgent services, certification requests must be initiated within three working days prior to the scheduled service. For urgent services, certification must be initiated within one day following the rendered service(s). Emergency services, as defined by HealthChoice, are not subject to certification requirements. For more information on the difference between emergency and urgent services, refer to Plan Definitions.

If certification approval is not obtained for services that require it and/or if certification is denied either before or after the services are provided, claims for those services will be denied. For certifications initiated and/or approved after services are provided, a 10 percent penalty deduction on the allowable fees may be applied. Network providers are not allowed to impose certification penalties on members or their covered dependents. If you use a non-network provider, you should ensure that the provider obtains certification prior to rendering services. Otherwise you may be held responsible for paying the full amount (if certification is denied) or the ten percent penalty (if applied because of late certification), as well as any billed amounts over allowable fees (balance billing).
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For more detailed information on certification, contact customer care. Refer to Plan Identification Information for contact information.

Medical Services that Require Certification

- Ambulance: air and ground (non-emergent).
- Bariatric surgery (eligibility criteria also required).
- Blood transfusion (home setting).
- Chemotherapy (home setting).
- Chiropractic therapy (after initial 20 visits per calendar year).
- Diagnostic imaging services: CT scans.
- Drugs and medical injectables (some exceptions apply).
  - Separate pharmacy requirements are maintained by the HealthChoice pharmacy benefit manager.
- Durable medical equipment.
- Enteral feeding.
- Exhaustion of Medicare lifetime reserve days (required for the additional 365 lifetime reserve days for hospitalization).
- Foot orthotics.
- Genetic testing.
- Glucose monitors: continuous.
- HealthChoice is second or third payer (required only after Medicare benefits are exhausted).
- Hearing aids.

- Home health care.
- Home intravenous (IV) therapy.
- Hyperbaric oxygen therapy (outpatient).
- Inpatient admissions.
- Maternity care (if patient and baby are not discharged from the hospital within 48 hours of vaginal delivery or within 96 hours of cesarean section delivery).
- Mental health treatment.
  - Inpatient, residential and partial hospitalization.
  - Outpatient services after initial 20 visits per calendar year.
  - Intensive outpatient therapy services.
  - Transcranial magnetic stimulation treatment.
- Observation stays 48 hours or longer.
- Occupational therapy (after initial 20 outpatient visits per calendar year).
- Oral splints and appliances (some exceptions apply).
- Oral surgery (inpatient/outpatient).
- Outpatient surgical procedures:
  - Blepharoplasty.
  - Mammoplasty (including reduction, removal of implants and symmetry).
  - Correction of lid retraction.
  - Panniculectomy.
  - Rhinoplasty.
  - Septoplasty.
  - Varicose vein surgeries and procedures, including sclerotherapy.
  - Sleep apnea related surgeries, limited to:
    - Radiofrequency ablation (coblation, somnoplasty).
    - Uvulopalatopharyngoplasty, including laser-assisted procedure.
- Oxygen.
- Physical medicine/physical therapy (after initial 20 outpatient visits per calendar year).
- Prophylactic and gynocomastia mastectomies.
- Prostheses and orthopedic appliances (some exceptions apply).
- Proton beam radiation therapy.
- Skilled nursing facility.
- Spinal surgical procedures:
  - Cervical.
  - Lumbar.
  - Thoracic.
- Speech therapy (age 17 and younger).
- Spinal cord stimulator placement and revision.
- Substance use disorder treatment.
  - Inpatient, residential and partial hospitalization.
  - Outpatient services after initial 20 visits per calendar year.
  - Intensive outpatient treatment.
- Transplants.
- Unlisted and not otherwise specified – required for specific codes.

For authorization guidelines related to pharmacy benefits, refer to the Pharmacy Benefits section.

Covered Services, Supplies and Equipment

Benefits for covered services, supplies and equipment are based on the use of network or non-network providers and the provisions of your plan. Refer to the HealthChoice High and High Alternative Plans, HealthChoice Basic and Basic Alternative Plans, and HealthChoice High Deductible Health Plan sections for more information. Certification is required for certain services and in certain situations as determined by the plan. For more information on services that require certification, refer to the Certification section of this handbook.

Acupuncture

- Covered only as anesthesia for surgery.

Allergy Serum

- Subject to deductible and coinsurance.

Allergy Treatment and Testing

- Benefits for testing are limited to one battery of 60 tests every 24 months; excludes testing of the home environment.
- Administration of allergy serum is subject to deductible and coinsurance.

Ambulance

- Medically necessary ground or air services.

Ancillary Services

- Additional services such as radiology, laboratory, administration of injections, collection of specimens, manipulative therapy, surgical procedures, etc.
- Services referred to a provider for interpretation.

Anesthesia

- Eligible services for covered illness or surgery.
- Includes services provided by a certified registered nurse anesthetist (CRNA).

Autism Spectrum Disorders

- Eligible services include the screening and diagnosis of autism spectrum disorders by a licensed physician or a licensed doctoral-level psychologist.
- Eligible services include the treatment of autism spectrum disorders for up to eight years.
- Maximum benefit for applied behavior analysis is 25 hours per week and no more than $25,000 per calendar year.
- Proposed treatment plan with script is required upon receipt of the first claim each rolling year from a medical doctor or clinical psychologist.
- Services subject to plan deductibles, copays and coinsurance.

Bariatric Surgery

- Must be age 18 or older.
- Procedures available: sleeve; bypass; duodenal switch; and revision and conversions of sleeve, bypass and duodenal switch.
- Must meet specific criteria which includes, but is not limited to, severity of obesity, reliable participation in preoperative weight-loss program that is multidisciplinary, and expectation of adherence to postoperative care.

- Must be covered by HealthChoice 12 consecutive months before the surgery (all testing, lab work and consultations can be completed prior to the 12 months).
- Procedures must be obtained from a Metabolic Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) Comprehensive Center of Excellence contracted with HealthChoice.
- Services subject to plan deductibles, copays, coinsurance and the out-of-pocket maximum.
- The following are **not** covered: band and band revisions, non-network services, and revisions or complications from any covered procedure originally obtained from a facility that was not a HealthChoice bariatric network provider or when the individual was not covered by HealthChoice.

Birthing Center

- Must be associated with a full health-treatment hospital.

Blood and Blood Products

- Processing, storage and administration of blood and blood products in inpatient and outpatient settings, including collection and storage of autologous blood.

Chelation Therapy

- Covered only for heavy metal poisoning.

Chiropractic Therapy

- Limited to 60 visits per calendar year.
- High and High Alternative network benefits: you pay an office visit copay per visit and all additional ancillary services and treatments are subject to the deductible and coinsurance.
- HDHP network benefits (after deductible is met): you pay an office visit copay per visit and all additional ancillary services and treatments are subject to coinsurance.

Christian Science Nurse

- Limited to 15 visits per calendar year.

Christian Science Practitioner

- For High and High Alternative network benefits, you pay an office visit copay per visit.
- For HDHP network benefits, after the combined medical and pharmacy deductible is met, you pay an office visit copay per visit.

Clinical Trials

- Routine patient costs associated with approved clinical trials based on the following guidelines:
  a. All applicable plan limitations for non-network care apply to routine patient care costs.
  b. For covered clinical trials that involve non-investigational drugs, prior authorization by the pharmacy benefit manager is required.
- Specific experimental aspects (medication, test or procedure) of the trial are not covered.

Contraceptive Services

- Family services provided in a physician's office, including surgical procedures for sterilization, injections, IUDs and internally time-released implants.

Corrective Lenses

- Covered (eyeglasses) only one time following cataract surgery.

Dental Accident

- Medically necessary treatment for the repair of injury to sound natural teeth or gums, provided the accident and treatment occur while the individual is a member under the health plan and the treatment is performed within 12 months following the date of the accident.

Diabetic Testing Supplies

- Continuous glucose monitoring.*
- Insulin pumps and related supplies.**

*Covered as durable medical equipment.

**Refer to the Pharmacy Benefits section for coverage of other supplies.

Diagnostic X-Ray, Including Ultrasound

- Refer to Ancillary Services in this section.

Durable Medical Equipment and Supplies

Emergency Room Treatment

- Medically necessary services and supplies for treatment of an emergency illness or injury.
- High and High Alternative: $200 emergency room copay for network and non-network facilities.
- HDHP (after deductible is met): $200 emergency room copay for network and non-network facilities.
- Copay waived if admitted or death occurs prior to admission.
- Non-network emergency medical conditions and benefits for services received on the same day of emergency visit are covered as network. You are responsible for non-covered services and amounts above allowable fees for non-network visits.
- Refer to the Emergency Care Coverage section.

Foot Orthotics

- Covered only for diabetes.
- Covered under durable medical equipment.

Fundus Photography

Gynecological Examinations

- Subject to calendar year limits for routine examinations.
- One annual screening Pap test is covered at 100 percent of allowable fees when using a network provider.
- Office visit copay does not apply to preventive services visit within the calendar year limit.
- Other lab work or office visits and services beyond annual limits are subject to plan provisions.
- Refer to the Preventive Services section.

Hearing Exams and Tests

- Limited to one screening exam and one test per calendar year.
- Does not include a comprehensive hearing exam.
- High and High Alternative network benefits: you pay an office visit copay per visit; not subject to the deductible.
- HDHP network benefits (after deductible is met, unless preventive care): you pay an office visit copay per visit; not subject to the deductible.

Hearing Aids

- Covered only for participating dependent children up to age 18.
- Must be prescribed, filled and dispensed by a licensed audiologist.
- Limited to one every 48 months per impaired ear.
- Up to four additional ear molds per year for children up to age two.

Home Health Care

- Limited to 100 visits per calendar year.

Home Health Care Medications

- Eligible home health care prescription medications are covered under the medical benefit.
- Certain home health care medications such as Pulmozyme and Tobramycin are covered under the pharmacy benefit; for information, contact the pharmacy benefit manager. For contact information, refer to Plan Identification Information.

Home Hospice

- Requires a physician's statement of life expectancy of six months or less.

Home Intravenous (IV) Therapy

Hospital

- Refer to Inpatient Hospital Services or Outpatient Hospital/Facility Services in this section.

Infertility Services

- Covered services related to the diagnosis and treatment of infertility.
- Certain prescription drugs for the treatment of infertility.
- Refer to the Plan Exclusions and Limitations section for services that are not covered.

Inpatient Hospital Services

- Semi-private room — subject to medical necessity.
- Includes intensive care, coronary care and all other covered hospital services, such as physician hospital visits, anesthesia, radiology and laboratory.
- High, High Alternative, Basic and Basic Alternative plans and HDHP: An additional $300 hospital copay applies for each non-network, non-emergent hospital stay.
- Facility must have a national certification (CARF/JCAHO) or a Medicare certification.

Laboratory

- Includes laboratory work related to physical examinations.
- Refer to Ancillary Services in this section.

Mammogram

- Refer to the Preventive Services section.

Manipulative Therapy

- Refer to Physical Therapy/Physical Medicine in this section.

Maternity Care

- Includes hospital and delivery with prenatal and postnatal care.
- Includes one skilled nurse home health visit if the delivery is at home or in a birthing center.

- Includes laboratory work associated with prenatal visits.
- A separate calendar year deductible and coinsurance apply to the newborn. Refer to Eligible Dependents in the Eligibility and Effective Dates section for more information.

Mental Health Treatment

Inpatient

- Facility must have a national certification (CARF/JCAHO) or a Medicare certification.

Outpatient

Nurse Midwife Services

- Provider must be a Certified Nurse Midwife and licensed by the state in which services are provided.

Occupational Therapy

- Limited to 60 visits per calendar year.

Office Visits

- Medically necessary services for evaluation and medical management of an illness or injury.
- Routine, age-based preventive services visits are covered at 100 percent of allowable fees when using a network provider.
- High and High Alternative network benefits: you pay an office visit copay for each non-preventive services visit.
- HDHP network benefits (after deductible is met): you pay an office visit copay for each non-preventive services visit.
- Refer to Ancillary Services in this section.
- Refer to the Preventive Services section.

Oral Surgery

- Includes the removal of tumors or cysts.
- Does not include removal of wisdom teeth.
- For emergency oral surgery, refer to Emergency Room Treatment in this section.

Organ Transplants

- Medically necessary treatment for the non-experimental transplant of bone marrow, peripheral stem cells, cornea and the following solid organs: kidney, liver, pancreas, kidney/pancreas, heart, lung, heart/lung, and intestine.
- The organ or tissue must be of human origin.
- The donor does not have to be a member of the plan.
- Procurement and harvesting are eligible for coverage.
- Non-member donor medical expenses are limited to 90 days following the transplant.
- Review follows United Network for Organ Sharing guidelines.

Ostomy Supplies

- Wafers and bags are covered under both medical and pharmacy benefits; other ostomy supplies are covered under medical benefits.

Outpatient Chemotherapy

Outpatient Hospital/Facility Services

- Includes hospital, surgery facility, and all other covered outpatient services, including diagnostic services in conjunction with a surgical procedure or non-emergency care.

Oxygen

Pharmacy

- Refer to the Pharmacy Benefits section.

Physical Therapy/Physical Medicine

- Limited to 60 visits per calendar year.
- High and High Alternative network benefits for physical examinations: you pay an office visit copay, and all additional ancillary services and treatments are subject to the deductible and coinsurance.
- HDHP network benefits for physical examinations (after deductible is met): you pay an office visit copay, and all additional ancillary services and treatments are subject to the deductible and coinsurance.

Preventive Services

- For members who meet the clinical criteria, certain preventive services based on government recommendations are covered at 100 percent of allowable fees when using a HealthChoice network provider. The list of preventive services is available at **www.healthchoiceconnect.com**.
- Refer to the Preventive Services section.

Prostheses/Orthopedic Appliances

- Covered as durable medical equipment.

Rehabilitation (Inpatient)

- Facility must have a national certification (CARF/JCAHO) or a Medicare certification.

Skilled Nursing Facility

- Services prescribed by a physician and provided in a licensed, skilled nursing facility when medically necessary.
- Limited to a maximum of 100 days per calendar year.

Speech Therapy

- Covered for restoring existing speech lost due to disease or injury. Therapy must be expected to restore the level of speech the participant had before the disease or injury.
- Not covered for learning disabilities or birth defects.
- Limited to 60 visits per calendar year.

Standby Services

- Surgeon, assistant surgeon, perfusionist and anesthesiologist, when medically necessary and in attendance during the surgery.
- Standby services must be documented in the patient's medical record and include time in attendance.

Substance Use Disorder

Inpatient

- Facility must have a national certification (CARF/JCAHO) or a Medicare certification.

Outpatient

Surgeon, Assistant Surgeon, Perfusionist and Anesthesiologist

- Covered if medically necessary and the provider is in attendance during the surgery.

Surgical Benefits

- Inpatient or outpatient facility for covered illness or injury.
- Refer to Outpatient Hospital/Facility Services in this section.
- Facility must have a national certification (CARF/JCAHO) or a Medicare certification.

Thermograms

- Covered only for whiplash.

Transplants

- Refer to Organ Transplants in this section.

Ultrasound

- Refer to Ancillary Services in this section.

Ultraviolet Treatment – Actinotherapy

- Covered only for psoriasis.

Vaccinations for Adults and Children

- Covered in accordance with the current Centers for Disease Control and Prevention guidelines.
- Refer to the Preventive Services section.

Wigs and Scalp Prostheses

- One wig or one scalp prosthesis per calendar year is covered for individuals who experience hair loss due to radiation or chemotherapy treatment resulting from a covered medical condition.
- Coverage is subject to calendar year deductibles and coinsurance.
- Must be obtained from a licensed cosmetologist or durable medical equipment provider.

Emergency Care Coverage

The term emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. This is in accordance with section 1867(e)(1)(A) of the *Social Security Act* (42 U.S.C. 1395dd(e)(1)(A)).

In addition to the deductible and the coinsurance required under each plan, there is a $200 emergency room copay for each emergency room visit under the High, High Alternative plans and HDHP. This copay is your responsibility regardless of the facility's network or non-network status. This copay is waived if the

patient is admitted or death occurs prior to admission. If emergency treatment cannot be provided and the patient is referred to another emergency room for treatment, the emergency room copay is waived on the emergency room that could not provide treatment.

The benefits of the Basic and Basic Alternative plans do not require you to pay the $200 emergency room copay.

If an inpatient admission occurs as a result of an emergency, you or the facility must notify customer care within one working day of the admission. For contact information, refer to Plan Identification Information.

Non-Network Services

Emergency medical conditions treated in a non-network emergency room setting are reimbursed at and subject to network provider rates and benefits. All non-network services provided in the emergency room setting on the same day as the emergency room hospital services are covered at the network rate and benefits. You are still responsible for non-covered services and amounts over allowable fees. For Emergency Services, refer to Plan Definitions.

You may qualify for additional benefits when, as the result of an emergency, you have no option but to seek care at a non-network emergency room or facility. To qualify, you must notify customer care. For contact information, refer to Plan Identification Information.

Preventive Services

These are covered services provided for overall health maintenance — such as routine health/wellness exams and tests, vaccinations, well-baby care and well-child care. Health screenings and wellness exams can discover problems you may not know you have. The earlier problems are found, the greater the opportunity for treatment.

HealthChoice covers qualifying preventive care services at 100 percent of allowable fees when rendered by a participating network provider. You will not have to worry about copays, deductibles or coinsurance. Qualifying coverage may be determined by age, gender or other factors. Limitations may apply. If you receive services during a preventive care visit other than for qualifying preventive care, you may have to pay.

In addition to Affordable Care Act specific requirements, HealthChoice follows the recommendations of the United States Preventive Services Task Force and The American Academy of Pediatrics Bright Futures recommendations for the basis of coverage and criteria. For more details on qualifying preventive care services, contact customer care, and a member advocate will be happy to assist you. Refer to Plan Identification Information for contact information.

Preventive Services

This is not an all-inclusive list. Qualifying coverage criteria may apply.

- Abdominal aortic aneurysm screening.
- Blood pressure screenings.
- Breast cancer screening.
- Alcohol misuse: screening and counseling.
- BRCA screening/assessment
- Breastfeeding supply and services.

- Cervical cancer screening.
- Depression screening.
- Gonorrhea screening.
- Hepatitis B screening.
- HIV screening.
- Lung cancer screening.
- Osteoporosis screening.
- Tobacco use counseling.
- Sexually transmitted infection screening.
- Colorectal cancer screening.
- Diabetes screening.
- Newborn screening and medication.
- Hepatitis C screening.
- Intimate partner violence screening.
- Obesity screening.
- Prenatal screenings, services and tests.
- Tuberculosis screening.
- Vision screening (children).

Vaccinations for Adults and Children

Vaccinations, including the vaccine and its administration, are covered under both medical and pharmacy benefits.

CDC-recommended vaccinations, such as for shingles, are covered at 100 percent when using a network pharmacy. These can also be covered under the health benefit if provided by a recognized network health provider, such as a physician or health department.

Vaccine administration fees are also covered at 100 percent if the services are provided by a network provider.

When using a non-network provider, you are subject to non-network benefits and can be balance billed for amounts above the allowable fees.

Please note that free-standing ambulatory care clinics located inside pharmacies, grocery stores or supercenters may not be participating providers, and your services may not be covered at these locations. Always verify network provider status by visiting the HealthChoice website or calling customer care. For contact information, refer to Plan Identification Information.

The following vaccinations are covered under medical or pharmacy benefits:

- Anthrax
- Hepatitis A
- Influenza A
- Measles
- Pneumococcal
- Rabies, PF Chick-EMB Cell
- Shingrix (Shingles)
- Tetanus, Diphtheria, Pertussis
- Varicella
- Flu
- Hepatitis B
- Influenza HD
- Meningococcal
- Poliomyelitis
- Rotavirus
- Smallpox (Vaccinia) Vaccine
- Yellow Fever
- Haemophilus Influenzae
- Human Papillomavirus
- Japanese Encephalitis
- Mumps
- Rabies, Human Diploid
- Rubella
- Tetanus Booster
- Typhoid
- Zoster (Shingles)

This list is not all-inclusive.

Pharmacy Benefits

The pharmacy benefits of the HealthChoice High, High Alternative, Basic and Basic Alternative Plans and High Deductible Health Plan include the following features:

- Electronic point-of-sale claims processing.
- An extensive pharmacy network.
- Coverage of up to a 90-day supply of medication at mail and retail for the applicable copay.
- Coverage of certain tobacco cessation medications for $0 copay.

Note: Specific therapeutic categories, medications and/or dosage forms may have more restrictive quantity and/or duration of therapy limitations. Pharmacy benefits are subject to and limited by your physician's orders. Refer to Medications Limited in Quantity in this section.

HealthChoice pharmacy benefits include the following provisions:

- Generic medications are preferred medications.
- If no generic exists, then a preferred brand-name medication is usually the next least expensive choice.
- If you choose a non-preferred medication instead of a preferred medication, you are responsible for the higher non-preferred copay.
- If you choose a brand-name medication when a generic is available, you are responsible for the difference in cost, plus the copay.
- **The cost difference between generic and brand-name medications, non-preferred copays, medications purchased at non-network pharmacies and excluded medications do not count toward your pharmacy out-of-pocket maximum.**
- Certain medications require prior authorization for coverage. Refer to Pharmacy Prior Authorization in this section.
- Ostomy bags and wafers are covered under both medical and pharmacy benefits.
- Diabetic supplies, including insulin syringes with needles, testing strips, lancet devices and glucometers are covered under pharmacy benefits; quantity limitations apply.

HealthChoice Pharmacy Network

In Oklahoma, there are more than 930 pharmacies that participate in the HealthChoice pharmacy network. Nationwide, there are nearly 68,000 participating pharmacies. To locate a HealthChoice network pharmacy, select Find a Provider under Resources on our website at **www.healthchoiceok.com** or contact the pharmacy benefit manager. For contact information, refer to Plan Identification Information.

Network Pharmacy Benefits

Pharmacy deductible – Before benefits are available** for HealthChoice High, High Alternative, Basic and Basic Alternative plan members, the pharmacy deductible of $100 per individual/$300 maximum per family must be met. For HDHP members, the combined medical and pharmacy deductible must be met.

**Medications on the HealthChoice Preventive Medication List are not subject to the deductible. Copays apply to the pharmacy out-of-pocket maximum, but not the deductible.

Medication Type	Up to a 30-Day Supply of a Medication	31- to 90-Day Supply of a Medication
Generic	Up to $10 copay	Up to $25 copay
Preferred	Up to $45 copay	Up to $90 copay
Non-Preferred	Up to $75 copay	Up to $150 copay
Specialty	Generic – $10 copay* Preferred – $100 copay* Non-preferred – $200 copay*	Specialty medications are covered only for up to a 30-day supply
*Specialty medications are covered only when ordered through the CVS/caremark specialty pharmacy.		
All plan provisions apply. Only copays for preferred medications purchased at network pharmacies apply to the annual $2,500 individual/$4,000 family pharmacy out-of-pocket maximum family. Some medications are subject to prior authorization and/or quantity limitations. When a generic is available, and you choose a brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the brand-name copay.		

Non-Network Pharmacy Benefits

Preferred Medication	Non-Preferred Medication
50% of the cost of the medication, plus the dispensing fee.	75% of the cost of the medication, plus the dispensing fee.
All plan provisions apply. Only copays for preferred medications purchased at network pharmacies apply to the annual $2,500 individual/$4,000 family pharmacy out-of-pocket maximum.	

When you use a non-network pharmacy, you pay the full amount and submit your claim to the pharmacy benefit manager for reimbursement. Refer to Claims Procedures for more information.

Calendar Year Out-of-Pocket Maximum

Network Pharmacy ..... $2,500 individual/$4,000 family
Non-Network Pharmacy .....No out-of-pocket maximum
HDHP (Combined Medical and Pharmacy) ..... $6,000 individual/$12,000 family

After meeting the out-of-pocket maximum, the plan pays 100 percent of the cost of preferred medications purchased at network pharmacies for the remainder of the calendar year.

Note: When a generic is available and you choose a brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the brand-name copay. The brand-generic cost difference does not count toward your pharmacy out-of-pocket maximum and is always your responsibility even after your out-of-pocket maximum is met.

The following charges **do not count** toward your pharmacy out-of-pocket maximum and do not qualify for 100 percent payment after your out-of-pocket maximum is met:

- Non-network pharmacy purchases.
- Non-preferred medications.

- Cost differences between generic and brand-name medications.
- Non-covered medications.
- Amounts paid by copay assistance programs, manufacturer copay cards, or other third parties do not apply toward deductibles or out-of-pocket maximums.

Generics are Preferred Medications

If your medication is not a generic and does not appear on the HealthChoice Comprehensive Formulary, your options are to:

- Ask your physician to prescribe a preferred medication you can receive at the preferred pharmacy copay.
- Continue with your current non-preferred medication and pay the non-preferred copay.
- Obtain a medical necessity exception if you have specific health problems that require a non-preferred medication. To be considered for this exception, specific criteria must be met and detailed documentation from your physician must justify your request for an exception. The steps to request a medical necessity exception are the same as the steps to request a prior authorization. Refer to Pharmacy Prior Authorization in this section.

HealthChoice Comprehensive Formulary

The HealthChoice Comprehensive Formulary is a list of medications covered by the plan. To find out how your medications are covered, contact the pharmacy benefit manager. For contact information, refer to Plan Identification Information. You can also visit our website at **www.healthchoiceok.com**. Select the Member tab in the top menu bar and then select Pharmacy Benefits Information. Here you can also find lists of commonly prescribed medications, excluded medications with preferred alternatives, and specialty medications.

Your share of the cost of a medication is subject to:

- The cost of the medication.
- Network copays.
- Pharmacy deductible.
- Non-network coinsurance.
- The cost difference between a brand-name and generic medication if a brand-name is purchased when a generic is available.
- Medication quantity limits per copay.

Pharmacy Prior Authorization

Pharmacy Prior Authorization is a medical review that is required for coverage of certain medications such as those that:

- Are high cost.
- Have specific prescribing guidelines.
- Are generally used for cosmetic purposes.
- Are limited in quantity.
- Have lower cost preferred alternatives.

Follow the steps below to request a prior authorization:

1. Have your physician's office call the pharmacy benefit manager. For contact information, refer to Plan Identification Information.
2. The pharmacy benefit manager will assist your physician's office with completing a prior authorization form.
3. If your prior authorization is approved, your physician's office is notified of the approval within 24 to 48 hours. You are also notified in writing.
4. If your prior authorization is denied, your physician's office is notified of the denial within 24 to 48 hours. You are also notified in writing.

Types of Prior Authorizations

- **Traditional Prior Authorization Medications**
  Traditional prior authorization reviews typically require that specific medical criteria be met before the medication is covered.
- **Step Therapy Medications**
  A step therapy prior authorization requires you to first try a designated preferred drug to treat your medical condition before the plan covers another drug for that same condition. Some step therapy medications may also be limited in quantity.
- **Brand-Name Exceptions and Non-Preferred Medications**
  A prior authorization for a brand-name or non-preferred drug may be approved when you are unable to tolerate the generic or preferred drug.

All of these reviews follow the same process as described in the Pharmacy Prior Authorization section.

Medications Limited in Quantity

Certain medications are limited in the quantity you can receive per copay based on their recommended duration of therapy and routine use.

If generics are available or become available for brand-name drugs that are limited in quantity, the generics are also limited in quantity. When new medications become available in drug categories that have quantity limits, they will automatically have quantity limits per copay. New drug categories also can become subject to quantity limits throughout the year.

Specialty Medications

Specialty medications are covered only if ordered through the CVS/caremark specialty pharmacy. Specialty medications are usually high-cost medications that require special handling and extensive monitoring. You must pay a copay for each 30-day fill of a specialty medication. Copays are $10 for generic medications, $100 for preferred medications and $200 for non-preferred medications.

The CVS/caremark specialty pharmacy also provides:

- Free supplies, such as needles and syringes.
- Free shipping.
- Refill reminder calls.
- A personal counseling team of registered nurses and pharmacists.

Be aware, if you don't order your specialty medications through the specialty pharmacy, you are responsible for the full cost of your medications.

For more information, contact the specialty pharmacy. Refer to Plan Identification Information.

Tobacco Cessation Products

HealthChoice covers the following tobacco cessation medications at 100 percent when purchased at a network pharmacy:

- Buproban 150mg SA Tabs
- Bupropion HCL SR 150mg Tabs
- Chantix 0.5mg and 1mg Tabs
- Nicotrol 10mg Cartridge
- Nicotrol NS 20mg/m Nasal Spray

HealthChoice covers up to 168 days supply of a prescription product each calendar year.

Additionally, HealthChoice provides members with over-the-counter nicotine replacement therapy products (patches, gum and lozenges) and telephone coaching at no charge to HealthChoice health plan members. To take advantage of these benefits, call toll-free 800-QUIT-NOW (800-784-8669) and identify yourself as a HealthChoice member. The hours of operation are 7 a.m. to 2 a.m., seven days a week. Members living outside of Oklahoma call toll-free 866-QUIT-4-LIFE (866-784-8454).

HealthChoice Medication Lists

Following are the medication lists of covered medications. The lists are by therapeutic category and are not all-inclusive. (Generics should be considered the first line of prescribing.) Generic medications are listed in lowercase, branded generics are in upper- and lowercase, and brand-name products are in all uppercase.

These lists are on the HealthChoice website at **www.healthchoiceok.com**. Under Resources, select Members, then Member Home, then Pharmacy Benefits Information. Select each current list under Resources on that page.

Preventive Medication List

The HealthChoice Preventive Medication List is a list of generic preventive medications that are not subject to a pharmacy deductible on the HealthChoice plans. Medications on this list will pay at the normal pharmacy copay.

Standard Medication List

The HealthChoice Standard Medication List is a list of commonly prescribed non-specialty medications that are preferred on the HealthChoice plans. This list also contains a summary of preferred alternatives to the non-specialty medications that are excluded from coverage.

Advanced Control Specialty Formulary

The Advanced Control Specialty Formulary is a list of commonly prescribed specialty medications that are preferred on the HealthChoice plans. This list also contains a summary of preferred alternatives to the specialty medications that are excluded from coverage.

Excluded Medication List

The drug removal list is a list of specialty and non-specialty medications that have been removed from coverage under the HealthChoice plans. For each excluded medication, preferred alternatives are listed next to the excluded medication.

Plan Exclusions and Limitations

There is no coverage for expenses incurred for or in connection with any of the items listed below.
This list is not all-inclusive.

1. Services supplied by a provider who is a relative by blood or marriage of the patient or one who normally lives with the patient.
2. Services provided in a school or daycare setting.
3. Any confinement, medical care or treatment not recommended by a duly qualified practitioner.
4. Room humidifiers, air purifiers, pulse oximeters, blood pressure cuffs, exercise clubs, classes and equipment, swimming pools, Jacuzzi pumps, saunas, hot tubs, automobiles or adaptive equipment for automobiles, sun lamps, augmentative communication devices, patient lifts, adaptive bathroom and self-care equipment, assistive devices, cold/cryotherapy devices, items not used exclusively by you or your dependent, any equipment that exceeds lifetime maximum benefits (e.g., one walker per lifetime, one air flotation mattress per lifetime), mattresses not specifically designed for the prevention or treatment of skin breakdown or healing, or any other bedding purchased for any other reason.
5. Devices that attach to a building (walls, ceilings, floors, etc.).
6. Manipulative and physical therapy for palliative care (treatment for only the relief of pain), elective care (care designed to relieve recurring subjective symptoms), or prolonged care (treatment that does not move toward resolution as documented in the evaluation or re-evaluation goals).
7. Charges for missed or canceled appointments, mileage, penalties, finance charges, separate charges for maintenance, record keeping or case management services.
8. Claims submitted later than 365 days from the date of service.
9. Convenience items, such as telephones, tablets, computers, watches, apps for tablets, computers and watches, or televisions and personal comfort items, such as cervical pillows, protective clothing or shoes.
10. Medical care and supplies for which no charge is made or no payment would be requested if the insured individual did not have this coverage.
11. Complications from any non-covered or excluded treatments, items or procedures.
12. Any treatment, device or medication that is an exclusion of the plan, whether or not medical necessity is established.
13. Medical and/or mental health treatment of any kind, including hospital care, medications and medical care or medical equipment which is excessive or where medical necessity has not been proven.
14. Any medication, device or procedure not FDA approved for general use or sale in the United States.
15. Illness, injury or death as a result of committing or attempting to commit an assault or felony, including participation in a riot or insurrection as an aggressor.
16. Any treatment or procedure considered experimental or investigational. This restriction also applies to any facility, appliance, device, equipment or medication. Clinical trials are an exception as listed in Covered Services, Supplies and Equipment section.
17. Medications in approved clinical trials not prior authorized for use by the pharmacy benefit manager.
18. Medical services or treatments not generally accepted as the standard of care by the medical community.

19. Expenses incurred prior to the effective date of an individual's coverage, or for expenses incurred during a period of confinement which had its inception prior to the effective date of an individual's coverage.
20. Injury or sickness which is covered under an Extended Benefits provision of previous health coverage, until such time as such individual has exhausted all extended benefits available thereunder.
21. Hospitalization or other medical treatment furnished to the insured or dependent after coverage has terminated.
22. Medical and surgical services and supplies in excess of the fee schedule for such services and supplies.
23. Expenses to the extent the insured person is reimbursed or is entitled to reimbursement, or is in any way indemnified for such expenses by or through any public program, state or federal, or any such program of medical benefits sponsored and paid for by the federal government or any agency or subdivision thereof.
24. Bodily injury or illness arising out of or in the course of any employment not specifically excluded by 85A O.S. 2013, § 2 of the *Workers' Compensation Code.*
25. Surgical procedures or treatments, including medications, performed for cosmetic or elective reasons unless such procedure is specifically included as a covered charge or is necessary as a result of an accident; coverage must be continuous from the date of the accident to the date of corrective surgery.
26. Breast implants are not covered unless they are necessitated by the removal of diseased tissue.
27. Dental expenses unless incurred as the result of an accidental bodily injury to natural teeth or gums while coverage is in effect; coverage must have been continuous from the date of the accident to the date of corrective surgery; broken or lost artificial teeth, bridges or dentures are not covered.
28. Wrongful act or negligence of another when an employee or dependent has released the responsible party, unless subrogation has been waived or reduced in writing in an individual case, solely at EGID's option, and only for good cause.
29. Eye examinations for the fitting of corrective lenses or any charges related to such examinations, orthoptics, visual training for any diagnosis other than mild strabismus, eyeglasses, except for the first lens(es) used as a prosthetic replacement after the removal of the natural lens, other corrective lenses, or radial keratotomy or LASIK (exceptions may apply to eye exams, refer to the Preventive Services section).
30. Sex transformation surgeries and treatment for sexual dysfunction including implants of any nature, reversal of elective sterilization, and in vitro fertilization or artificial insemination.
31. All treatments for obesity, including but not limited to morbid obesity, gastrointestinal tract modifications and all complications and procedures, even when obesity or morbid obesity is diagnosed, expenses for weight loss treatment, advise or training, except when performed at an MBSA-QIP certified-comprehensive center of excellence. Refer to the Preventive Services and Covered Services, Supplies and Equipment sections for certain coverage allowed for obesity screening, prevention and treatment. Plan limitations and exclusions apply as defined.
32. Hearing aids and examinations for fitting or prescription, except for eligible individuals up to age 18; hearing aids must be prescribed, filled and dispensed by a licensed audiologist.
33. Preoperative or postoperative care generally rendered by the operating surgeon, unless the surgeon itemizes his charges and the total amount charged is no more than the total allowable fees for the surgery.
34. Counseling for tobacco cessation; refer to the Preventive Services section for certain coverage allowed for tobacco cessation.
35. Some infertility treatment is covered by the plan. Coverage includes prescription drugs, but excludes artificial insemination, embryo transplant, in vitro fertilization, surrogate parenting, ovum transplant, donor semen, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and reversal of voluntary sterilization.

36. Impotency medications are covered by the plan only in the event of radical prostatectomy surgery.
37. Intentionally self-inflicted injuries or illness, except when the injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a documented medical condition (including both physical and mental health conditions) that is covered under the health plan.
38. Acupressure.
39. Alopecia.
40. Biofeedback.
41. Confinement to a facility unless approved by EGID or its designee.
42. Custodial care.
43. Dyslexia testing.
44. Electromyography without needle.
45. Food or nutritional supplements (exceptions may apply, refer to the Preventive Services section).
46. Home dialysis training.
47. Home exercise programs.
48. Home uterine monitoring.
49. Kinesiology (movement therapy).
50. Lost, stolen or damaged medications or lost, stolen or environmentally damaged (e.g., mold, insect, etc.) equipment/devices, some damage to equipment/devices may be covered.
51. Marriage counseling.
52. Nutritional analysis.
53. Medications available for purchase without a written prescription except as required by ACA.
54. Over-the-counter vitamins except as required by ACA.
55. Rolf technique (Rolfing).
56. Surrogate mother expenses for non-covered participants.
57. Venipuncture by a physician when also billing for lab charges.
58. Off-label use of medications (use of a drug for the treatment of conditions that are not indicated on the drug's label).
59. Cough and cold medications.
60. Over-the-counter braces, bandages, dressings, ointments and other OTC items.
61. Most compression garments, over-the-counter or otherwise.
62. Products marketed with 510(k) clearance are not covered under the pharmacy benefit.
63. Prescription scar treatments are considered cosmetic and are not covered.
64. Medical devices billed under pharmacy benefits are not covered, with the exception of diabetic testing supplies, ostomy supplies and products required by ACA.

Claims Procedures

Claims Filing and Payment

Network

Network providers file your claims for you and payment is automatically made to your provider.

Non-Network

If you use a non-network provider, you may have to file your claims personally. Send your claim to customer care. For contact information, refer to Plan Identification Information.

Claims should be filed as soon as the services are received and completed. Your claim must be submitted on the appropriate form in order to be processed. Physician services must be billed on a *CMS 1500*, and hospital and outpatient facility services must be billed on a *UB-04*. Items such as cash register receipts,

pull-apart forms and billing statements are not acceptable. Non-network providers are not required to submit claims on your behalf and may not use the appropriate form. If this occurs, ask if the provider will submit the claim on your behalf using the appropriate form or if they can provide you with a completed form so that you can file the claim yourself.

Non-network claims are usually paid to you; however, you can choose to assign benefits to be paid directly to your provider.

When a valid assignment of benefits to the provider is submitted with your claim, payment is made to the provider. When there is no valid assignment of benefits, payment is made to you, and you are responsible for paying your provider.

Claims Filing Deadline

Claims must be submitted to HealthChoice no later than 365 days following the date of service or date the supply was rendered. For example, if the date of service is Feb. 1, 2019, the claim is accepted through Feb. 1, 2020.

Claims for Services Outside the United States

If you receive medical treatment, services, supplies or prescription drugs outside the United States, follow these claim procedures:

- Make arrangements to pay for the services or supplies.
- Submit an itemized statement for reimbursement.
- Have claims translated into English with U.S. dollar amounts before you file your claim.
- Convert charges to U.S. dollars using the exchange rates applicable for the date of service.
- File the original claim along with the translation; the plan does not pay any costs for translating claims or medical records.

Itemized bills should be sent to:

HealthChoice
P.O. Box 99011
Lubbock, TX 79490-9011

Allowable fees are paid in accordance with your plan's non-network benefits. You are responsible for amounts above the allowable fees.

Coordination of Benefits

If you or your covered dependents have medical or pharmacy coverage with another group health plan, HealthChoice benefits are coordinated so the total benefits received are not greater than the charges billed, benefits allowed or your responsibility.

If your other group coverage includes pharmacy benefits, your pharmacy claims can usually be processed electronically; however, if your pharmacy cannot file electronically, you will need to file a paper claim. When HealthChoice is not the primary payer, claims must include a copy of the explanation of benefits from your primary plan or a copy of your pharmacy that lists your name, the name of the medication and the amount you paid for the prescription.

To obtain paper pharmacy claim forms, contact the pharmacy benefit manager. For contact information, refer to Plan Identification Information. You can also print a Prescription Reimbursement Claim Form from the HealthChoice website at **www.healthchoiceok.com**. Under Resources, select Member, then Member Home, then Member Forms and Applications. Please complete, sign and date the claim form, attach your pharmacy receipts, and mail them to the appropriate address listed on the form.

If you terminate your other group coverage or if it does not include pharmacy benefits, please send written notice and supporting documentation to customer care. For contact information, refer to Plan Identification Information.

If you have questions about coordination of benefits, contact customer care. If you have questions about how your pharmacy benefits will be affected by coordination of benefits, contact the pharmacy benefit manager. For contact information, refer to Plan Identification Information.

Verification of Other Insurance Coverage

If you have other group health insurance, verification of other insurance coverage provides HealthChoice with information about your other group health insurance. This information is used to coordinate your HealthChoice benefits with your other insurance plan. When a VOIC is needed to process your claim, customer care will notify you. You can update your VOIC information by contacting customer care or by visiting **www.healthchoiceconnect.com**. **Failure to provide VOIC causes your claim to be denied for non-compliance.**

Explanation of Benefits

Each time a claim is processed, customer care creates an explanation of benefits that explains how your benefits are applied. Your EOB includes:

- Provider.
- Date of service.
- Explanation code.
- Coinsurance.
- Total benefits.
- Deductible.
- Amount not covered.
- Copay.
- Total billed amount.
- Provider write-off.
- Amount allowed.

Your EOBs are available through HealthChoice Connect at **www.healthchoiceconnect.com**. If you have difficulty accessing your EOB online, contact customer care. For contact information, refer to Plan Identification Information.

Claims Requiring Additional Information

If your medical claim requires additional information for processing, your EOB identifies the specific information needed. In some instances, a letter is also sent that explains what information is required to complete claim processing. Your claim is closed until this information is received.

Please be sure to include your member ID number and claim number when returning the requested information. Once the information is provided to customer care, your claim is automatically processed. You do not need to resubmit your claim.

Disputed Claims Procedure

If your claim is denied in whole or in part for any reason, either you or your authorized representative can request that the claim be reviewed by calling customer care or by submitting a written request to the HealthChoice Appeals Unit at the address listed below within 180 days of your receipt of a denial.

HealthChoice Appeals Unit
P.O. Box 3897
Little Rock, AR 72203

Please follow the steps below to make sure that your appeal at any level is processed in a timely manner:

- If applicable, send a copy of any letter regarding a decision of your appeal.
- Send a copy of the EOB with any relevant additional information (e.g., benefit documents, medical records, etc.) that could help to determine if your claim is covered under the plan.
- Provide a letter summarizing the request for reconsideration that includes your name, the claim or transaction number, HealthChoice member ID number, the name of the patient and their relationship to member.
- Include "Attention: Appeals Unit" on all supporting documents. Be certain the member ID appears on each document.
- If you choose to designate an authorized representative, you must provide this designation to us in writing.
- If your situation is medically urgent, you may request an expedited appeal, which is generally conducted within 72 hours. If you believe your situation is urgent, follow the instructions above for filing an internal appeal and also call customer care to request a simultaneous external review.

Your HealthChoice plan's internal appeals process includes two internal review levels. If you are not satisfied with the final internal review determination due to denial of payment, coverage or service requested, you may be able to ask for an independent, external review of our decision by either an independent review organization or a grievance panel. The entity that performs the external review depends on the nature of your appeal.

When considering complaints by insured members, the three-member grievance panel shall determine by a preponderance of the evidence whether EGID has followed its statutes, rules, plan documents, policies and internal procedures. The grievance panel shall not expand upon or override any EGID statutes, rules, plan documents, policies and internal procedures.

In order to request access to and copies of all documents, records and other information about your claim, free of charge, or to find out how to start an external review, contact customer care.

Subrogation

Subrogation is the process through which HealthChoice has the right to recover any benefit payments made to you or your dependents by a third party or an insurer because of an injury or illness caused by the third party. Third party means another person or organization.

Subrogation applies when you are sick or injured as a result of the negligent act or omission of another person or party. If you or your covered dependents receive HealthChoice benefits and have a right to recover damages, the plan has the right to recover any benefits paid on your behalf. All payments from a third party, whether by lawsuit, settlement or otherwise, must be used to repay HealthChoice. The Make

Whole and Common Fund Doctrines do not apply.

Example: While in your vehicle, you are hit by another driver who is at fault. In the accident, you have injuries that require medical attention. HealthChoice processes your medical claims, and when the auto insurance claim is settled, the other driver's insurance (the third party) or your uninsured/underinsured/med pay motorist policy repays HealthChoice the amounts it paid for your accident-related medical claims. If the third party or an insurer pays you or your dependent directly, you are responsible for repaying HealthChoice.

If you are asked to provide information about the injury or accident to the HealthChoice subrogation administrator at the law firm of McAfee & Taft, any related claims are pended until you have supplied the necessary information.

For the subrogation administrator's contact information, refer to Plan Identification Information.

General Provisions

Provider-Patient Relationship

You can choose any provider or practitioner who is licensed or certified under the laws of the state in which they practice, and who is **recognized by the plan**. Each provider offering health care services and/or supplies is an independent contractor. Providers retain the provider-patient relationship with you and are solely responsible to you for any medical advice and treatment or subsequent liability resulting from that advice or treatment.

Although a provider recommends or prescribes a service or supply, this does not necessarily mean it is covered by the plan.

For information on the types of providers recognized by the plan, contact customer care. You can also search the HealthChoice Network Provider Directory on the HealthChoice website at **www.healthchoiceok.com**. Under Resources, select Find a Provider, then Medical and Dental Provider, and then select Specialty in the top menu bar of the Provider Search page.

Intentional Misrepresentation

Coverage obtained by means of intentional misrepresentation of material fact is canceled retroactive to the effective date, and premiums you paid for coverage are refunded. Refunded premiums are reduced by any claims paid by HealthChoice.

Confirmation Statements and Corrections to Benefit Elections

When a change is made to your coverage, you are mailed a confirmation statement, which lists your coverage and the effective date and premium amount for your coverage. It is provided so you can review changes and identify errors as soon as possible.

If you find errors to your benefit elections, you should submit corrections within 60 days. Current employees must submit corrections to their insurance/benefits coordinator, and former employees must submit corrections directly to EGID. Corrections reported after 60 days are effective the first of the month

following notification.

Member Audit Program

Despite your provider's best efforts, the complexity of arranging for your care and treatment may result in inaccurate billing, so it is important to check your bill carefully. If you discover certain mistakes in your bill, you can share in the savings through the Member Audit Program. You can receive up to 50 percent of any savings resulting from a billing error you find, limited to a maximum reimbursement of $200 per incident/$500 per year, per member or family. Please note that the error must have impacted the actual benefit amount paid by at least $50.

Eligible errors include charges for services not provided or charges that are billed incorrectly. Billing mistakes such as transposed numbers, addition mistakes and misplaced decimals are not eligible for the program. Only charges for services covered by the plan are eligible. Inpatient hospital and ambulatory surgery center charges are not eligible since billing is not based on individual items.

If you find an error on a medical bill and you wish to participate in the Member Audit Program, you can call the EGID toll-free hotline at 866-381-3815, email a message to **EGID.antifraud@omes.ok.gov**, or send a report in writing to:

EGID Compliance Officer
3545 NW 58th St., Ste. 600
Oklahoma City, OK 73112

Right of Recovery

HealthChoice retains the right to recover any payments made by the plans in excess of the maximum allowable fees. HealthChoice has the right to recover such payments, to the extent of excess, from one or more of the following:

- Any persons to, or for, or with respect to whom such payments were made.
- Any other insurers.
- Service plans or any other organizations.

HealthChoice Select

HealthChoice Select is a program designed to reduce the costs of select services by contracting with select medical facilities to provide these services and bill HealthChoice for a single amount for all costs associated with the service on the date the surgery or procedure is performed. The services covered under HealthChoice Select are covered at 100 percent of the bundled allowable fees with no out-of-pocket costs to members when they are received from facilities participating in HealthChoice Select. HDHP members must first meet the calendar year deductible.

The program is available to members of the HealthChoice High, High Alternative, Basic and Basic Alternative Plans and HDHP.

Colonoscopies and sigmoidoscopies are covered under the program. To encourage members to participate in HealthChoice Select for these services, HealthChoice provides a $100 incentive payment to members.

For a list of all services covered under HealthChoice Select and a list of facilities participating in the program, search the HealthChoice Select page of the HealthChoice website at **www.healthchoiceok.com**. Under Resources, select Members, then HealthChoice Select.

Eligibility and Effective Dates

You are eligible to participate in the HealthChoice plans if you work for a participating employer and are:

- A current **education** employee eligible to participate in the Oklahoma Teachers' Retirement System and working a minimum of four hours per day or 20 hours per week.
- A current **State of Oklahoma, local government, or certain nonprofit** employee regularly scheduled to work at least 1,000 hours a year and not classified as a temporary or seasonal employee.
- A person elected by popular vote (e.g., board members for education and elected officials of state and local government, state employees, rural water district board members), county election board secretaries, and any employee otherwise eligible who is on approved leave without pay not to exceed 24 months.

New Employee

As a new employee, your coverage is effective the first day of the month following your employment date or the date you become eligible with your employer. If you want to make changes to the coverage you initially elected, you have a 30-day window following your eligibility date to make benefit changes. These changes are effective the first day of the month following the date the changes are made.

Dependent Coverage

You must be enrolled in one of the health plans in order to enroll your dependents. If dependent coverage is selected, all of your eligible dependents must be covered. Note: Exceptions may apply for COBRA participants and surviving dependents. Refer to Excluding Dependents from Coverage in this section for exceptions to this rule.

If you are enrolled in one of the health plans and have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll your dependent provided you request enrollment within 30 days following the marriage, birth, adoption or placement for adoption. All other enrollments must be made during the annual Option Period.

Note: Former employees can make changes only within 30 days of a qualifying event. Dependents or new benefit plans, other than vision, cannot be added during the annual Option Period.

If your spouse is also a primary member of a HealthChoice health plan through their employer, dependent children can be covered under either parent's health plan, provided the parent is also enrolled. Dependent children cannot be covered under both parents' plans.

Eligible Dependents

Eligible dependents include:

- Your legal spouse (refer to the paragraph on common-law marriages in this section).
- Your daughter, son, stepdaughter, stepson, eligible foster child, adopted child, child for whom you have been granted legal guardianship, or child legally placed with you for adoption, up to age 26, whether married or unmarried. **Note:** Plan coverage which terminates upon the dependent's 26th birthday will terminate at the end of the month in which the birthday occurs.
- Your dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26; subject to medical review and approval of the Disabled Dependent Assessment form, which must be received at least 30 days prior to the dependent's 26th birthday.
- Other unmarried children up to age 26 who live with you and for whom you are primarily responsible. This requires completion of an acceptable Application for Coverage for Other Dependent Children. A tax return showing dependency can be provided in lieu of the application.

Common-law marriages are recognized by the plan. A new employee can add a common-law spouse at the time of enrollment. A current employee can request coverage on a common-law spouse during the annual Option Period or in the event the common-law spouse loses other health coverage.* To enroll a common-law spouse, the employee and spouse must sign and submit an enrollment or change form.

Note: A former employee can add a common-law spouse only if the common-law spouse loses other health coverage.*

*Other health coverage cannot be an excepted benefit. Refer to Excepted Benefits in Plan Definitions.

Adding a newborn to coverage:

- Newborns must be added the first of the month of the child's birth. You have 30 days from the date of birth to enroll a newborn in coverage. An Insurance Change Form must be completed and submitted to your insurance/benefits coordinator or EGID.
- Premiums must be paid for the full month of the child's birth.
- When one or more eligible dependents are currently covered, a newborn must be added to the same coverage, unless there is proof of other health coverage.
- When a newborn is added to coverage, all other eligible dependents must be enrolled in coverage if they are not already enrolled; however, you can elect to exclude your spouse from health and/or dental coverage.
- You can request coverage for a newborn grandchild by completing an Application for Coverage for Other Dependent Children. Coverage for a grandchild is retroactive to the first of the month of birth following the receipt and approval of an application and payment of premiums. After 30 days, a retired member cannot add a newborn to coverage without a qualifying event.
- A Social Security number for the newborn is not required at the time of initial enrollment, but must be provided when it is received from the Social Security Administration. Current employees must provide the number to their insurance/benefits coordinator. Former employees must provide it to EGID.

Newborn Limited Benefit

A newborn has limited coverage for a routine birth for the first 48 hours following a vaginal delivery or for the first 96 hours following a C-section delivery without an additional premium. There are no benefits for

services in addition to a routine hospital stay unless the newborn is enrolled in coverage and premiums are paid for the month of the birth.

Accepting the Newborn Limited Benefit (NOT adding a newborn to coverage):

- There is no additional premium for the Newborn Limited Benefit.
- The Newborn Limited Benefit is subject to the annual deductible, coinsurance and plan limitations.
- You are responsible for any charges over and above the Newborn Limited Benefit regardless of the facility's network or non-network status.
- Enrollment of other eligible dependents is not required.
- The Newborn Limited Benefit applies only if the mother or father of the newborn is covered under a HealthChoice health plan.

Declining the Newborn Limited Benefit (NOT recommended):

- A Newborn Limited Benefit Waiver must be completed and returned to EGID to exclude a newborn from the Newborn Limited Benefit. To obtain a waiver, current employees should contact their insurance/benefits coordinator and former employees should contact EGID Member Services. For contact information, refer to Plan Identification Information.

Coverage for Other Eligible Dependents

When you have not been granted custody, adoption or guardianship by a court and the dependent is not your natural child or stepchild, you can request coverage for other unmarried dependents up to age 26 by submitting an enrollment or change form and a copy of the portion of your most recent income tax return listing the children as dependents for income tax deduction purposes. Current employees must submit the form and tax return to their insurance/benefits coordinator, and former employees must submit these documents to EGID.

In the absence of a federal income tax return listing the children as dependents, you must provide and have approved an Application for Coverage for Other Dependent Children as specified by the plan.

Coverage for other eligible dependents begins on the first day of the month following the date you obtain physical custody or date the Application for Coverage for Other Dependent Children is approved and never applies retroactively, except in the case of a newborn. Coverage for a newborn is effective the first day of the month of birth.

You must request coverage within 30 days of the date of initial placement, otherwise:

- Current employees cannot add dependents to coverage until the next annual Option Period.
- Former employees cannot add dependents to coverage at any future date.

Note: You must meet all eligibility requirements, cover all eligible dependents and pay all premiums.

The plan has the right to verify the dependent status of children, request copies of the portion of your most recent income tax return listing the children as dependents, and discontinue coverage for dependents who are deemed ineligible for coverage.

Legal Adoption

An adopted dependent is eligible for coverage the first of the month you obtain physical custody of your child. You must submit an enrollment or change form, including a copy of your adoption papers. Current employees must submit the paperwork to their insurance/benefits coordinator and former employees must submit their paperwork directly to EGID. In the absence of adoption papers or other court records, someone involved in the adoption process, such as your attorney or a representative of the adoption agency, must provide proof of the date you actually received custody of your child pending the final adoption hearing.

You must request coverage within 30 days of the date of the initial placement for adoption, otherwise:

- Current employees cannot add dependents to coverage until the next annual Option Period.
- Former employees cannot add dependents to coverage at any future date.

Legal Guardianship

Legal guardianship follows the same guidelines as an adoption. Refer to Legal Adoption in this section.

Excluding Dependents from Coverage

Any of your eligible dependents can be excluded from coverage if they have other qualified health coverage or are eligible for Indian Health Services or military health benefits. Excepted benefits do not qualify as other coverage. You can exclude your eligible dependent children who do not reside with you, are married, or are not financially dependent on you for support.

You can also exclude your spouse from health coverage. If you exclude your spouse and cover other eligible dependents, your spouse must sign the Spouse Exclusion Certification section of your enrollment or change form.

Changes to Coverage After Initial Enrollment/ HIPAA Special Enrollment Rights

If you declined enrollment in a health plan because you had other individual* or group health insurance coverage or Indian Health Services or military health benefits, you can enroll:

- Within 30 days of the date you lose other coverage.
- During the annual Option Period (only current employees).

*To qualify, the individual coverage cannot be an excepted benefit. Excepted benefits include:

- Benefits that are generally not health coverage.
- Limited scope vision or dental benefits.
- Benefits for long-term care, nursing home care, home health care, or community-based care.
- Coverage for only a specified disease or illness, such as a cancer-only policy, and hospital indemnity or other fixed indemnity insurance.
- Coverage supplemental to Medicare, the Civilian Health and Medical Program of the Department

of Veterans Affairs, or TRICARE, or similar coverage that is supplemental to coverage provided under a group health plan.
- Coverage provided under a separate policy, certificate or contract of insurance.

Certain qualifying events allow a midyear benefit change; however, an enrollment or change form must be completed within 30 days of the qualifying event. Examples of midyear qualifying events include:

- A change in your legal marital status, such as marriage, divorce or death of your spouse.
- A change in the number of your dependents, such as the birth of a child.
- A change in employment status that affects your eligibility or that of your spouse or dependent.
- An event that causes your dependent to meet, or fail to meet, eligibility requirements.
- Commencement or termination of adoption proceedings.
- Judgments, decrees or orders (your employer may allow changes only to health and dental).
- Medicare eligibility for you or a dependent.
- Medicaid eligibility for you or a dependent; only two changes are allowed per plan year, once out and once back in or vice versa.
- Changes in the coverage of your spouse or dependent under another employer's plan.
- Eligibility for leave under the *Family and Medical Leave Act* (FMLA).
- The *Uniformed Services Employment and Reemployment Rights Act* of 1994 (USERRA).

To request special enrollment or obtain more information, current employees contact your insurance/benefits coordinator. Former employees contact EGID member services. For contact information, refer to Plan Identification Information.

Current Employees

You can make changes to coverage only within 30 days of a qualifying event or during the annual Option Period.

All changes to coverage must be in compliance with the rules of your employer's Section 125 plan, or if no 125 plan is offered, in compliance with allowed midyear coverage changes as defined by Title 26, Section 125, of the Internal Revenue Codes (as amended) and pertinent regulations. Current employees must contact their insurance/benefits coordinator and complete an enrollment or change form.

Former Employees and Surviving Dependents

You can make changes to coverage only within 30 days of a qualifying event. Dependents or new benefit plans, other than vision, cannot be added during the annual Option Period.

Former employees and surviving dependents must submit a written request for changes in coverage to:

EGID
3545 NW 58th St., Ste. 600
Oklahoma City, OK 73112

Requests for changes can also be faxed to 405-717-8939. Verbal requests for changes in coverage are not accepted.

Note: Oklahoma law prohibits dropping your spouse/dependents if you are in the process of a divorce or legal separation at any time. If you are in the process of separation or divorce, it is important that you contact your legal counsel for advice before making any changes to your coverage.

Options for Current Employees Called to Active Military Service

Under the *Uniform Services Employment and Reemployment Rights Act* of 1994 (USERRA), coverage can be continued for up to 24 months. USERRA provides certain rights and protections for all employees called to serve our nation. All branches of the military, all military reserve units and all National Guard units come under USERRA.

In addition to health care provided by the military, you have the following four choices regarding your current coverage:

- Retain all coverage. Your current employer is responsible for collecting and forwarding all premiums to EGID.
- Discontinue member coverage but retain dependent coverage. This is the COBRA option and dependents are billed directly at 102 percent of premiums, the COBRA rate, for health, dental and/or vision coverage. Under COBRA rules, life insurance cannot be retained.
- Discontinue all coverage except life insurance. You are billed directly.
- Discontinue all member and dependent coverage.

Each month, you must pay the full premium for the coverage you selected. Failure to pay premiums timely can result in the termination of coverage at the end of the month for which the last full premium was received. There is no penalty for renewing coverage upon discharge from active duty if coverage is elected within 30 days of your return to the same employment.

Regardless of whether you receive written or verbal military orders, EGID staff and/or your insurance/benefits coordinator will assist you in making any benefit arrangements. If you are a member of a military reserve unit or the National Guard and anticipate being called to active service, notify your insurance/benefits coordinator at work.

Leave Without Pay – Current Employees

If you are on approved leave without pay through your employer, you can continue coverage for up to 24 months from the day you begin leave without pay status. You must make timely premium payments in full each month to your insurance/benefits coordinator.

If your coverage terminates for failure to pay premiums on time, you can re-enroll upon returning to work.

If you take leave under the *Family and Medical Leave Act* (FMLA), please make premium payment arrangements with your employer before you take leave.

Special Rules for Those Eligible for Medicare

If you are a current employee and you or your covered dependents become eligible for Medicare, either as a result of age or because of disability, your employer’s group plan remains primary and Medicare is your secondary coverage.

You can accept or reject coverage under your employer’s group health plan. If you reject your employer's plan, Medicare becomes the primary payer for Medicare-covered health services. Additionally, your employer cannot provide you with a plan that pays supplemental benefits for Medicare-covered services or subsidize such coverage. Upon termination of employment, Medicare coverage becomes your primary insurance carrier.

If you are a former employee and you or your covered dependent is under age 65 and eligible for Medicare, you must notify EGID and provide the Medicare ID number as it appears on the beneficiary's Medicare card. Medicare supplement coverage is effective the date you become eligible for Medicare, or the first day of the month following notice to EGID, whichever is later. Late notice does not allow for a refund of excess premiums paid.

For further information regarding Medicare enrollment, call Social Security toll-free at 800-772-1213. TTY users call toll-free 800-325-0778. You can also access information regarding Medicare enrollment at **Medicare.gov** or call Medicare toll-free at 800-633-4227. TTY users call toll-free 877-486-2048.

Proof of Creditable Prescription Drug Coverage

All of the HealthChoice health plans provide creditable prescription drug coverage. This means the prescription drug coverage offered through HealthChoice is at least as good as the **standard** Medicare Part D prescription drug coverage and meets the benefit guidelines set by Medicare.

If you or your spouse leave the employment that allows you to participate in HealthChoice coverage, you have the option to continue coverage through the HealthChoice Medicare supplement plans, which includes either Medicare Part D prescription drug coverage or creditable prescription drug coverage.

Continuing Coverage After Leaving Employment

If you leave employment, you and/or your eligible dependents may be able to begin or continue coverage through one of the following options:

- Vesting or retirement rights through a state-funded retirement system established by the State of Oklahoma.
- Years of service with state, education or local government employers; refer to Years of Service in this section.
- Receiving benefits through the HealthChoice Disability Plan administered by EGID.
- Survivor rights for your covered dependents in the event of your death.
- COBRA (*Consolidated Omnibus Budget Reconciliation Act*).

Each month, premiums must be paid in full. Failure to pay premiums on time can result in the termination of coverage at the end of the month for which the last premium was received.

Years of Service

You can begin or continue coverage after leaving employment if you make an election within 30 days following your employment termination date, and you meet one of the following conditions:

- You are eligible to participate in the Oklahoma Public Employees Retirement System and have eight or more years of service with a participating employer.
- You are an employee of a local government employer that participates in the plan but does not participate in the Oklahoma Public Employees Retirement System and have eight or more years of creditable service.
- You are eligible to participate in the Oklahoma Teachers' Retirement System and have 10 or more years of service with a participating employer.

- You are an employee of an education employer that participates in the plan but does not participate in the Oklahoma Teachers' Retirement System, and have 10 or more years of creditable service.

Education Employees

If you were a career tech employee or a common school employee who terminated active employment on or after May 1, 1993, you can continue coverage through the plan as long as the school system from which you retired or vested continues to participate in the plan. If your former school system terminates coverage under the plan, you must follow your former employer to its new insurance carrier.

If you were an employee of an education entity other than a common school (e.g., higher education, charter school, etc.), you can continue coverage through the plan as long as the education entity from which you retired or vested continues to participate in the plan. If your former employer terminates coverage with the plan, you must follow your former employer to its new insurance carrier.

Note: You cannot reinstate coverage that you discontinue or allow to lapse unless you return to work as an employee of a participating employer. Refer to Reinstatement in the Termination or Reinstatement of Coverage section.

Local Government Employees

If you were a local government employee who terminated active employment on or after Jan. 1, 2002, you can continue coverage through the plan as long as the employer from which you retired or vested continues to participate in the plan. If your former employer terminates coverage with the plan, you must follow your former employer to its new insurance carrier.

Note: You cannot reinstate coverage you discontinue or allow to lapse unless you return to work as an employee of a participating employer. Refer to Reinstatement in the Termination or Reinstatement of Coverage section.

Some reinstatement exceptions may apply if you are a state employee who terminated employment as a result of a reduction in force (RIF). Refer to State Government Reduction In Force and Severance Benefits Act in the Termination or Reinstatement of Coverage section.

New Employer Retirees

All retirees with former employers that joined the plan after the specified grandfathered dates must follow their former employer to its new insurance carrier.

Following Your Employer to a New Carrier

When you terminate employment, your benefits are tied to your most recent employer. If your employer discontinues participation with EGID, some or all of the employer’s retirees and their dependents (depending on the type of employer) must follow the employer to its new insurance carrier. This is true regardless of the amount of time you were employed with any participating employer.

If you retire and then return to work for another employer and enroll in benefits through your new employer, your benefits are tied to your new employer.

Continuation through the Disability Program

You can keep health coverage in effect if you are receiving benefits through the HealthChoice Disability Plan. You can continue coverage as long as you are covered under the HealthChoice Disability Plan and pay premiums on time. You must maintain continuous coverage. If you discontinue coverage or allow coverage to lapse, it cannot be reinstated unless you return to work as an employee of a participating employer. Refer to Reinstatement in the Termination or Reinstatement of Coverage section.

Survivor Rights

Your surviving spouse and dependents have 60 days following your death to notify EGID they wish to continue coverage. Coverage is effective the first day of the month following your death.

- Your surviving spouse is eligible to continue insurance coverage indefinitely as long as premiums are paid.
- Surviving dependent children are eligible to continue coverage until age 26 as long as premiums are paid.
- Disabled dependent children are eligible to continue coverage as long as they continue to meet the HealthChoice definition of a disabled dependent and premiums are paid.

Note: COBRA continuation of coverage is available for dependent children who lose eligibility.

COBRA

If your or your dependent's coverage is terminated for any of the reasons listed below, each covered member has the right to elect temporary continuation of coverage under the *Consolidated Omnibus Budget Reconciliation Act*.

You are eligible to continue coverage for up to 18 months if you lose coverage due to:

- A reduction in your hours of employment.
- Termination of your employment for reasons other than gross misconduct.

Your covered spouse is eligible to continue coverage if coverage is lost due to:

- Your death (refer to Survivor Rights in this section).
- Termination of your employment for reasons other than gross misconduct.
- A reduction in your hours of employment resulting in loss of coverage.
- A divorce or legal separation.*

Your covered dependent children are eligible to continue coverage if coverage is lost due to:

- Your death (refer to Survivor Rights in this section).
- Termination of your employment for reasons other than gross misconduct.
- A reduction in your hours of employment resulting in loss of coverage.
- A divorce or legal separation of the parents.*
- Your dependent no longer meets the eligibility requirements for dependent status.

*Oklahoma law prohibits dropping your spouse/dependents if you are in the process of a divorce or legal separation at any time. It is important you contact your legal counsel for advice before attempting to make changes to your coverage.

If you are a **current employee**, it is your responsibility to notify your employer within 30 days of a divorce, legal separation or your child's loss of dependent status under this plan.

If you are a **former employee**, you must notify EGID in writing within 30 days of a divorce, legal separation or your child's loss of dependent status under this plan.

You and/or your eligible dependents must elect continuation of coverage within 60 days after the later of the following events occurs:

- The date the qualifying event would cause you and/or your dependents to lose coverage.
- The date your employer notifies you and/or your dependents of continuation of coverage rights.

If the qualifying event is related to termination of employment or reduced hours, coverage can be continued for a maximum of 18 months. If the qualifying event is for any other eligible reason, coverage for dependents can be continued for a maximum of 36 months. Continuation of coverage terminates immediately for you and/or all covered dependents under the following circumstances:

- The plan ceases to provide coverage.
- Premiums are not paid on time.
- You and/or your dependents become covered under another group health plan or qualify for Medicare.

If you have questions regarding COBRA, contact your insurance/benefits coordinator or EGID.

If you continue coverage under COBRA, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify EGID of a disability or second qualifying event in order to extend the coverage continuation period. Failure to provide timely notice of a disability or second qualifying event can affect your right to extend the coverage continuation period.

Termination or Reinstatement of Coverage

Termination

Your coverage, as well as any dependent coverage, ends on the last day of the month when one or more of the following events occur:

- You terminate employment with a participating employer and do not continue coverage through vesting, non-vesting, retirement, disability or COBRA.
- You do not pay premiums.
- The plan is terminated.
- Your death occurs.

In addition, a dependent's coverage ends on the last day of the month they cease to be an eligible dependent. Upon review by EGID, if you or your dependent is found to be ineligible, coverage is terminated effective on the first day of the month of discovery. EGID reserves the right to recover any benefits paid on behalf of an ineligible member.

Reinstatement

If you are currently employed by a participating employer and discontinue coverage on yourself or your dependents, you cannot apply for reinstatement of coverage for at least 12 months. To reinstate discontinued coverage, you must enroll within 30 days of:

- The expiration of the 12-month waiting period; if coverage is not reinstated within 30 days of the end of the waiting period, you cannot enroll in coverage until the next annual Option Period.
- The loss of other health coverage* or other qualifying event.

To reinstate coverage, proof of the loss of other health coverage* or other qualifying event must be submitted.

*Other health coverage cannot be an excepted benefit. Refer to Excepted Benefits in Plan Definitions.

Former employees who did not continue coverage upon leaving active employment, or who later discontinued coverage, must return to work with a participating employer for three years to be eligible to add or keep that coverage when they re-retire.

State Government Reduction In Force and Severance Benefits Act

You can reinstate health insurance coverage at any time within two years following the date of reduction in force from the state if you are a former state employee who:

- Had a vested or retirement benefit based on the provisions of any of the state public retirement systems.
- Was separated from state service as a result of a reduction in force anytime after July 1, 1997.
- Was offered severance benefits pursuant to the *State Government Reduction in Force and Severance Benefits Act.*

For further information, contact EGID Member Services. For contact information, refer to Plan Identification Information.

State of Oklahoma
Office of Management and Enterprise Services
Privacy Notice
Revised February 2019

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

For questions or complaints regarding privacy concerns with OMES, please contact:

OMES HIPAA Privacy Officer
3545 NW 58th St., Ste. 600, Oklahoma City, OK 73112
Telephone 405-717-8780, Toll-free 800-543-6044
TTY 711
OMES.OK.gov

Why is the Notice of Privacy Practices Important?

This notice provides important information about the practices of OMES pertaining to the way OMES gathers, uses, discloses, and manages your protected health information (PHI) and it also describes how you can access this information. PHI is health information that can be linked to a particular person by certain identifiers including, but not limited to, names, social security numbers, addresses and birth dates.

Oklahoma privacy laws and the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protect the privacy of an individual's health information. For HIPAA purposes, OMES has designated itself as a hybrid entity. This means that HIPAA only applies to areas of OMES operations involving health care, and not to all lines of service offered by OMES. This notice applies to the privacy practices of the following components included within OMES that may share or access your Protected Health Information as needed for treatment, payment and health care operations:

- The Employees Group Insurance Division (EGID).
- The Legal division.
- The Information Services division as it applies to maintenance and storage of PHI.

OMES is committed to protecting the privacy and security of your PHI as used within the components listed above.

Your Information. Your Rights. Our Responsibilities.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this using the contact information at the beginning of this notice.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for an accounting of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year free of charge but will charge a reasonable fee if you ask for another accounting within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will verify the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the beginning of this notice.
- You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. Complaints to HHS must be filed within 180 days of when you knew that the violation occurred.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent health or safety threat.

OMES does not share your information for purposes of marketing or by sale of your information.

Our Uses and Disclosures

How do we typically use or share your health information (PHI)?

Your PHI is used and disclosed by OMES employees and other entities under contract with OMES according to HIPAA Privacy Rules using the "minimum necessary" standard which releases only the minimum necessary health information to achieve the intended purpose or to carry out a desired function within OMES.

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Examples: We use health information about you to develop better services for you, provide customer service, resolve member grievances, member advocacy, conduct activities to improve members' health and reduce costs, assist in the coordination and continuity of health care, and to set premium rates.

Pay for your health services

We can use and disclose your health information as we pay for your eligible health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose summarized health information to your health plan sponsor for plan administration.

Example: Your employer contracts with us to provide a health plan, and we provide the employer with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, refer to **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.
- Reporting births and deaths.
- Reporting suspected abuse, neglect, or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.
- Public health investigations.

Do research

We can use or share your information for health research, as permitted by law.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy laws.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims.
- For law enforcement purposes or with a law enforcement official.
- With health oversight agencies for activities authorized by law.
- For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information (PHI).
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI.

- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your PHI other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, refer to **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will deliver a copy to you. You may also subscribe online to receive notice of changes to this page via email or text message.

Fraud, Waste and Abuse Compliance

The Office of Management and Enterprise Services Employees Group Insurance Division is committed to conducting its business activities with integrity and in full compliance with the federal, state and local laws governing its business. This commitment applies to relationships with members, providers, auditors and all public and government bodies. Most importantly, it applies to employees, subcontractors and representatives of EGID. This commitment includes the policy that all such individuals have an obligation to report problems or concerns involving ethical or compliance violations related to its business.

If you suspect that EGID has been defrauded or is being defrauded or that resources have been wasted or abused, report the matter to the EGID Compliance Officer immediately. You can report suspicious acts or claims by:

- Sending a report in writing to the EGID Compliance Officer at 3545 NW 58th St., Ste. 600, Oklahoma City, OK 73112.
- Emailing a message to **EGID.antifraud@omes.ok.gov**.
- Calling the EGID toll-free hotline at 866-381-3815.
- Visiting the EGID Compliance Officer in person.

Individuals are encouraged to provide adequate information in order to assist with further investigation of fraud. All investigations will be handled confidentially. Every attempt will be made to ensure the confidentiality of any report, but please remember that confidentiality may not be guaranteed if law enforcement becomes involved. There will be no retaliation against anyone who reports conduct that a reasonable person acting in good faith would have believed to be fraudulent or abusive. Any employee who violates the non-retaliation policy will be subject to disciplinary action up to and including termination.

You can also submit such reports anonymously. If you choose to submit information anonymously and want to receive updates on the status of the investigation, you are required to supply the compliance officer with an alias and a password as a means of obtaining secure updates. It is the reporting individual's responsibility to remember both the alias and password provided since the compliance officer is not able to divulge or reconfirm these if they are forgotten.

Examples of fraud, waste and abuse may include:

- An individual or organization pretends to represent HealthChoice, Medicare and/or Social Security, and asks you for your HealthChoice member ID, Medicare or Social Security number, bank

account number, credit card number, money, etc.
- Someone asked you to sell your prescription drug card or the account information on the card.
- Someone asks you to get medications for them using your prescription drug card or prescription coverage.
- You are encouraged to disenroll from your plan.
- You are offered cash or a gift worth more than $15 to sign up for a Medicare prescription drug plan.
- Your pharmacy does not give you all of your medications.
- You are billed for medications or health services that you did not receive.
- You are charged more than once for your insurance premium.
- Your prescription drug plan does not pay for your covered medications.
- You receive a different medication than your doctor ordered.

Notifications

Women's Health and Cancer Rights Act and Oklahoma Breast Cancer Patient Protection Act of 1998 Notice

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) and the *Oklahoma Breast Cancer Patient Protection Act* of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- Not less than 48 hours of inpatient care following a mastectomy and not less than 24 hours of inpatient care following a lymph node dissection;
- 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, coinsurance and policy provisions applicable to other medical services covered under this plan.

Coverage of Side Effects Associated With Prostate Related Conditions

HealthChoice provides coverage for side effects that are commonly associated with radical retropubic prostatectomy surgery, including but not limited to impotence and incontinence, and for other prostate related conditions.

If you have questions about the HealthChoice coverage of mastectomies and reconstructive surgery or prostate related conditions, contact customer care. For contact information, refer to Plan Identification Information.

Plan Definitions

ACA
Affordable Care Act.

Accidental Injury
Bodily injury sustained as the direct result of an accident, independent of any other cause, which occurs while insurance coverage is in force.

Allowable Fees
The set dollar amount allowed under the plans for a covered service or supply.

Balance Billing
When a provider bills you for the difference between the amount they charge and the amount HealthChoice pays. HealthChoice network providers cannot balance bill members, but non-network providers can.

Certification
A review process used to determine if services are medically necessary according to HealthChoice guidelines. Certification is performed by customer care.

Coinsurance
The percentage of allowable fees paid by you and by HealthChoice once your deductible is satisfied.

Copay
A cost-sharing arrangement in which you pay a set dollar amount for specific services.

Cosmetic Procedure
A procedure that primarily serves to improve appearance.

Deductible
- **High and High Alternative Plans and HDHP** – The initial amount of out-of-pocket expense you pay on allowable fees before a benefit is paid by the plan.
- **Basic and Basic Alternative Plans** – The amount of out-of-pocket expense you pay on allowable fees after the plan has paid $500 for the Basic Plan and $250 for the Basic Alternative Plan in allowable fees for covered medical services.

EGID
The Office of Management and Enterprise Services (OMES) Employees Group Insurance Division.

Eligible Dependent
- Your legal spouse (including common-law spouse).
- Your daughter, son, stepdaughter, stepson, eligible foster child, adopted child, child for whom the member has been granted legal guardianship, or child legally placed with you for adoption up to age 26, whether married or unmarried. **Note:** Plan coverage which terminates upon the dependent's 26th birthday will terminate at the end of the month in which the birthday occurs.
- Your dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26; subject to medical review and approval of the Disabled Dependent Assessment form, which must be received at least 30 days prior to the dependent's 26th birthday.
- Other unmarried children up to age 26 who live with you and for whom you are primarily responsible. This requires completion of an acceptable Application for Coverage for Other

Dependent Children. A tax return showing dependency can be provided in lieu of the application.

Eligible Employee
An employee of a participating employer who receives compensation for services rendered and is listed on that employer's payroll. This includes persons elected by popular vote (e.g., board members for education and elected officials of state and local government, state employees, rural water district board members), county election board secretaries, and any employee otherwise eligible who is on approved leave without pay not to exceed 24 months.

- Education employees must be eligible to participate in the Oklahoma Teachers' Retirement System and work a minimum of four hours per day or 20 hours per week.
- Local government employees, including rural water districts, must be employed in a position requiring a minimum of 1,000 hours work per year.

Eligible Former Employee
An employee who participates in any of the plans authorized by or through the *Oklahoma Employees Insurance and Benefits Act* who retired or vested their rights with a state-funded retirement system, or has the required years of service with a participating employer. Surviving dependents and COBRA participants are considered as former employees.

Emergency Services
Defined by the True Emergency Code List maintained by customer care at the direction of EGID. Refer to the Emergency Care Coverage section for more details.

Excepted Benefits
The four categories of benefits as established in section 2791 of the PHS Act, section 733 of ERISA and section 9832 of the Internal Revenue Code, as summarized in IRS Bulletin 2015-14 and subsequent regulatory guidance. These excepted benefits include but are not limited to vision coverage, dental coverage, long-term care insurance, Medicare supplement coverage, automobile liability insurance, workers compensation, accidental death and dismemberment insurance and specific disease coverage (such as cancer).

HealthChoice Standard Medication List
A list of preferred medications designed to maximize health outcomes and reduce costs.

Medications Limited in Quantity
Certain medications have a maximum quantity limitation due to approved therapy guidelines. These drugs have specific quantity limits per copay which are less than the standard benefit. Quantity limits are based on recommended duration of therapy and/or routine usage for each medication.

Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medical practice. Services or supplies must be the most appropriate supply or level of service which can safely be provided. For hospital stays, inpatient acute care is necessary due to the intensity of services you are receiving or the severity of your condition, or when safe and adequate care cannot be received as an outpatient or in a less intense medical setting. Services or supplies cannot be primarily for the convenience of you, the caregiver or provider. The fact that services or supplies are medically necessary does not, in itself, assure that the services or supplies are covered by the plan.

Network Provider
A provider who has entered into a contract with EGID to accept the plan's allowable fees for services and/

or supplies provided to plan participants.

Non-covered Service
Any service, procedure or supply excluded from coverage and not paid for by the plan.

Option Period
The annual time period established by EGID when changes can be made to coverage.

Out-of-Pocket Maximum
The amounts you are responsible for based on the use of network or non-network providers. The out-of-pocket maximum does not include charges for non-covered services and balance billed charges from non-network providers.

Participating Employer
Any municipality, county, education employer or other state agency whose employees or members are eligible to participate in any plan authorized by or through the *Oklahoma Employees Insurance and Benefits Act*.

Plan
The HealthChoice health insurance plans offered through EGID and described in this handbook.

Prior Authorization Medications
Prior authorization review is used to provide clinically driven, medically relevant criteria that must be met before a drug can be approved for coverage. Drugs that are subject to prior authorization review are generally medications that have limited therapeutic uses and drugs that require extensive monitoring for side effects.

Qualifying Event
An event that changes a member's family or health insurance situation and qualifies the member and/or dependent for a special enrollment period. The most common qualifying life events are the loss of health care coverage, a change in household (such as marriage or birth of a child), or a change of residence. A complete summary of qualifying events are set out in Title 26, Treasury Regulations, Section 125.

Step Therapy
Step therapy prior authorizations require you to first try a designated preferred drug to treat your medical condition before the plan covers another drug for that same condition. Some step therapy medications may also be limited in quantity.

Summary of Benefits and Coverage
A standardized document designed to provide specific information about select medical plan benefits to help individuals understand and compare them to the benefits provided under a different plan.

Urgent Services
A condition is considered urgent when it is not life threatening but requires care in a timely manner (within 24 hours). Examples include conditions which could deteriorate or are not bearable due to discomfort.

HealthChoice complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. HealthChoice does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

HealthChoice provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). HealthChoice provides free language services to people whose primary language is not English, such as qualified interpreters. If you need these services, contact HealthChoice at 800-323-4314 (TTY 800-545-8279).

If you believe that HealthChoice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with the civil rights coordinator, 3545 NW 58th, St., Ste. 600, OKC, OK 73112, 866-381-3815, 866-447-0436 (TDD), 405-717-8609 (fax), DiscriminationComplaints@omes.ok.gov. You can file in person or by mail, fax or email. If you need help filing a grievance, the civil rights coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800-323-4314 (TTY 800-545-8279).

(Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-323-4314 (TTY 800-545-8279).

(Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-323-4314 (TTY 800-545-8279).

(Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-323-4314 (TTY 800-545-8279).

(Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-323-4314 (TTY 800-545-8279) 번으로 전화해 주십시오.

(German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-323-4314 (TTY 800-545-8279).

(Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم800-323-4314 (رقم هاتف الصم والبكم: TTY 800-545-8279).

(Burmese) သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 800-323-4314 (TTY 800-545-8279) သို့ ခေါ်ဆိုပါ။

(Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-323-4314 (TTY 800-545-8279).

(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-323-4314 (TTY 800-545-8279).

(French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-323-4314 (TTY 800-545-8279).

(Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-323-4314 (TTY 800-545-8279).

(Thai) เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-323-4314 (TTY 800-545-8279).

(Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 800-323-4314 (TTY 800-545-8279).

(Cherokee) Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 800-323-4314 (TTY 800-545-8279).

(Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-323-4314 (TTY 800-545-8279) تماس بگیرید.

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