HealthChoice

Medicare Supplement Plans Handbook
Evidence of Coverage

HealthChoice SilverScript High and Low Option Plans

HealthChoice High and Low Option Plans Without Part D

Plan Year 2019

Jan.1 - Dec. 31

3897

Monthly Premiums

HealthChoice SilverScript Medicare Supplement Plans
Jan. 1 - Dec. 31, 2019

Medicare Supplement Plan Premiums Per Covered Person	
HealthChoice SilverScript High Option Medicare Supplement Plan	$375.58
HealthChoice SilverScript Low Option Medicare Supplement Plan	$300.60
COBRA Medicare Supplement Plan Premiums Per Covered Person	
HealthChoice SilverScript High Option Medicare Supplement Plan	$375.58
HealthChoice SilverScript Low Option Medicare Supplement Plan	$300.60

The premiums listed above do not reflect contributions from any retirement system.

You must pay your full monthly premium (unless you qualify for Extra Help from Medicare) and your Medicare Part A, Part B and Part D premiums, if applicable.

For more information about your premiums, refer to the Information About Your Premiums section.

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Introduction

HealthChoice Medicare Supplement Handbook
Effective Jan. 1 through Dec. 31, 2019

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 This Medicare supplement handbook/Evidence of Coverage will, in turn, be superseded by any subsequent Medicare supplement handbook/Evidence of Coverage EGID issues.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

This handbook, your enrollment form, confirmation statement and HealthChoice SilverScript Medicare documents represent our responsibilities to you. This handbook provides details about your benefits, formulary, pharmacy network, premiums, deductibles, copays and coinsurance for 2019. It explains what is covered and what you pay as a member of the plan. Be aware that these amounts may change at the beginning of the next plan year which begins on Jan. 1. This is an important document, so keep it in a safe place. Please note, the HealthChoice Medicare supplement plans are often referred to throughout this handbook as the plan or plans.

HealthChoice SilverScript Members

If you have Medicare Part D coverage through HealthChoice SilverScript, you should refer to this Evidence of Coverage handbook and other documents provided by HealthChoice SilverScript for additional rules and information about your plan.

Read this Handbook Carefully

A dispute concerning information contained within any EGID written or electronic materials or oral communications, regardless of the source, shall be resolved by a strict application of EGID *Administrative Rules* or benefit administration procedures and guidelines as adopted by the plan.

All benefits and limitations of these plans are governed in all cases by the relevant plan documents, insurance contracts, handbooks, *Administrative Rules* of the Office of Management and Enterprise Services Employees Group Insurance Division and the regulations governing the *Medicare Prescription Drug Benefit, Improvement, and Modernization Act* of 2003. The Federal Regulation at 42 C.F.R. §§ 423, et seq. and the rules of the Oklahoma Administrative Code, Title 260, are controlling in all aspects of plan benefits.

No oral statement of any person shall modify or otherwise affect the benefits, limitations or exclusions of any plan.

HealthChoice Medicare Supplement Plans Identification Information

Revised January 2019

Plan Names

HealthChoice SilverScript High and Low Options
HealthChoice High and Low Options Without Part D

Customer Care
Medical Benefit Coverage, Claims, Certification Inquiries

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, 24/7
Live operator available 7 a.m. to midnight Central time
Caremark.com
SilverScript plans: Toll-free 866-275-5253 or TTY 711
Without Part D plans: Toll-free 877-720-9375 or TTY 711

Pharmacy Prior Authorization
SilverScript plans: Toll-free 855-344-0930 or TTY 711
Without Part D plans: Toll-free 800-294-5979 or TTY 711

CVS Specialty Pharmacy
Toll-free 800-237-2767

Eligibility and Enrollment

EGID Member Services
Monday through Friday, 7:30 a.m. to 4:30 p.m. Central time
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
3545 NW 58th St., Ste. 600
Oklahoma City, OK 73112
www.healthchoiceok.com

Information About Your Premiums

Medicare Premiums

If you currently pay a premium for Medicare Part A or Part B, you must continue to pay your premiums to keep your Medicare coverage. Most people do not pay a premium for Part A. If you do not qualify for premium-free Part A, you can buy Part A if you are at least 65 years old and meet certain other eligibility requirements. You can also buy Part A if you are under age 65 and were once entitled to Medicare benefits because of a disability.

Late Enrollment Penalty

Medicare applies a late enrollment penalty to your Part B and Part D premiums when:

- You do not enroll in Part B or Part D coverage, or in creditable coverage, when you first become Medicare eligible at age 65 or when you become eligible prior to age 65 due to a disability.
- You have a lapse in creditable prescription drug coverage of 63 continuous days or longer.

EGID pays the Part D late enrollment penalty for its HealthChoice SilverScript plan members, but the penalty could be applied if you leave EGID and enroll in another insurance plan.

Extra Help Paying for Part D (Medicare Low Income Subsidy)

People with limited income may qualify for the Extra Help Medicare program, also known as the Low-Income Subsidy. This helps pay for prescription drug costs, including premiums, deductibles and copays. To learn more or apply, call Social Security toll-free at 800-772-1213. TTY users call toll-free 800-325-0778. More information is also available at **SSA.gov**. You can also call Medicare toll-free at 800-MEDICARE (800-633-4227). TTY users call toll-free 877-486-2048.

After you apply for Extra Help, you will get a letter letting you know whether or not you qualify and what you need to do next. You may receive full or partial help depending on your income, family size and resources. Be aware that if you qualify for Extra Help, some of the information in this handbook will not apply to you.

Income-Related Monthly Adjustment Amount

If you are a member of a HealthChoice SilverScript plan, your premium for Part D coverage is included in your regular monthly premium. Part B premiums are paid through Social Security. However, if your income is above a certain level, the law requires your Part B and Part D premiums be adjusted, which is called an income-related monthly adjustment amount.If you have to pay this extra amount, Social Security will notify you.

Note: If you fail to pay any Part D IRMAA, HealthChoice must move you to a without Part D plan.

Paying Your Plan Premiums

You must pay your full monthly plan premium unless you qualify for the Extra Help Medicare program. Monthly premiums are reduced if you qualify for Extra Help. Payment of your monthly premium is handled in one of three ways:

- Withheld from your retirement check.
- Withdrawn automatically from your bank account through an automatic draft.
- Paid directly to EGID. You will receive a monthly premium statement.

COBRA (*Consolidated Omnibus Budget Reconciliation Act*) participants must pay premiums directly to EGID. Your premiums can be:

- Withdrawn automatically from your bank account through an automatic draft.
- Paid directly to EGID. You will receive a monthly premium statement.

Changes in Your Monthly Premium

Generally, your premium does not change during the year; however, in certain cases, a premium change can occur if:

- You do not currently get Extra Help from Medicare but qualify for it during the plan year; your monthly premium will be lower.
- You currently get Extra Help from Medicare, but the amount of help you qualify for changes; your premium will be adjusted accordingly.
- You add or drop dependents to or from your coverage sometime during the plan year; your premium will be adjusted accordingly.

Non-Payment of Premiums

If your monthly plan premiums are late, HealthChoice notifies you in writing that you must pay your premium by a certain date, which includes a grace period, or we will end your coverage. HealthChoice has a grace period of two months. Refer to When HealthChoice Must End Your Coverage in the Eligibility, Enrollment and Disenrollment section.

General Information

This *HealthChoice Medicare Supplement Plans Handbook* provides a guide to features of the plans. It is not a complete description of the plans. Please read this handbook carefully for information about eligibility rules and benefits.

These plans are designed to provide supplemental benefits to Medicare Part A and Part B. These plans also cover Part D prescription drug benefits. **Except as noted otherwise in this handbook, services not covered by Medicare are not covered by the plans.** The medical benefits are based on Medicare's approved amounts. For more information, review your 2019 *Medicare & You* handbook, visit **Medicare.gov** or call Medicare toll-free at 800-MEDICARE (800-633-4227) or TTY 877-486-2048.

The HealthChoice medical benefits are paid as if you are enrolled in both Medicare Part A and Part B. If you are not enrolled in Medicare, HealthChoice estimates Medicare's benefits and provides coverage as if Medicare were your primary insurance carrier.

The HealthChoice Plans Supplement Medicare Part A (Hospitalization) by Paying for:

- The inpatient hospitalization deductible and coinsurance.
- An additional 365 lifetime reserve days for hospitalization.
- The coinsurance for skilled nursing facility days 21 through 100.
- The first three pints of blood while hospitalized.

The HealthChoice Plans Supplement Medicare Part B (Medical) by Paying for:

- Outpatient medical expenses.
- Durable medical equipment.
- Limited outpatient prescription drugs.

You must meet the Part B deductible before Medicare or HealthChoice pays benefits.

HealthChoice SilverScript Medicare Supplement Plans

HealthChoice SilverScript Medicare supplement plans provide supplemental benefits to Medicare Part A and Part B. Benefits are adjusted Jan. 1 of each year to coincide with Medicare.

These plans provide Part D prescription drug coverage through our partnership with CVS/caremark and their SilverScript Employer Prescription Drug Plan.

HealthChoice Medicare Supplement Plans Without Part D

HealthChoice Medicare supplement plans without Part D include creditable prescription drug coverage but not Part D coverage. These plans were specifically designed for members who:

- Already have Medicare Part D coverage through another plan or employer.
- Receive a subsidy for prescription drug benefits from their or their spouse's employer.
- Receive VA benefits for prescription drugs but desire to maintain additional prescription coverage for medications not covered by the VA.
- Did not enroll in Part D coverage timely or at all and must wait for a Part D enrollment period or the next annual Option Period to enroll.

Note: Premiums for these plans are higher because HealthChoice does not receive a prescription drug subsidy from Medicare for members enrolled in these plans.

Provider-Patient Relationship

Your provider is responsible for the medical advice and treatment they provide or any liability resulting from that advice or treatment. **Although a provider may recommend or prescribe a service or supply, this does not of itself establish coverage by the plans.**

Medicare's Limiting Charge

Under Medicare guidelines, the highest amount you can be charged for a covered medical service is called the limiting charge. This applies when you receive services from doctors and other health care service suppliers who don't accept Medicare assignment. The limiting charge is 15 percent above the Medicare-approved amount and does not apply to medical supplies or equipment.

Certification

Since HealthChoice is secondary to your Medicare coverage, certification through customer care is required only for the additional 365 lifetime reserve days for hospitalization covered by HealthChoice. If you have questions, call customer care. For contact information, refer to Plan Idenitification Information.

HealthChoice Explanation of Benefits

Each time a medical claim is processed, customer care processes an explanation of benefits, which explains how your benefits are applied. You will receive your EOBs in the mail. They are also available through HealthChoice Connect at **www.healthchoiceconnect.com**. If you haven't already registered, create a username and password to access your information.

Plan ID Cards

HealthChoice members have two ID cards, one for medical and/or dental benefits and one for pharmacy benefits. HealthChoice issues you new ID cards when you enroll in a HealthChoice plan.

Medical/Dental Card

When you receive services, please present your HealthChoice medical/dental card*. When you receive medical services, you also need to present your red, white and blue Medicare card.

To request a replacement medical/dental card, visit **www.healthchoiceconnect.com**, or call customer

care. For contact information, refer to Plan Identification Information.

*While the medical card and dental card are the same, dental services are not covered unless you are also enrolled in the HealthChoice Dental Plan.

Prescription Drug Card

Please present your HealthChoice prescription drug card when you purchase prescriptions. The pharmacy automatically bills HealthChoice for its share of your covered prescription drug costs. You do not need to present your Medicare card at the pharmacy.

If you do not have your prescription drug card when you fill a prescription, have your pharmacy contact the pharmacy benefit manager for your information. If your pharmacy cannot get the needed information, you may have to pay for your medication and then file a paper pharmacy claim for reimbursement. Refer to the Claim Procedures section.

To request a replacement prescription drug card, visit **Caremark.com**, or call the pharmacy benefit manager. For contact information, refer to Plan Identification Information.

HealthChoice Fitness Center Discounts

HealthChoice has arranged for a special fitness center discount for HealthChoice members and their dependents. All you have to do is present your HealthChoice identification card at any of the participating fitness centers to receive your special discount rate. The listing of participating fitness centers is available at **www.healthchoiceok.com**. Under Resources, select Members, then Member Home, then Wellness. If your favorite fitness center is not on the list and you would like us to contact them, call EGID Member Services. For contact information, refer to Plan Identification Information.

Your Contact Information

It is important to keep your contact information current. You risk delaying claims processing, missing communications and even being disenrolled from the plan when your information is incorrect. **Additionally, Medicare requires that you report any changes in your name, address or telephone number to your insurance plan.** If you have an email address on file with HealthChoice, be sure to keep it updated as well. You can fax changes to EGID Member Accounts at 405-717-8939 or send in writing to HealthChoice, 3545 NW 58th St., Ste. 600, Oklahoma City, OK 73112.

Let HealthChoice Know if You Move

If you move outside the HealthChoice service area, the United States and its territories, you cannot remain a member of a SilverScript plan.

If you move within our service area, the United States and its territories, you still need to let HealthChoice know so we can update your information.

HealthChoice High and Low Option Medicare Supplement Plans

Medicare Part A (Hospitalization) Services
All Benefits are Based on Medicare-Approved Amounts

Services or Items	Description	Medicare Part A Pays	HealthChoice Pays	You Pay
Hospitalization Semiprivate room, meals, drugs as part of your inpatient treatment, and other hospital services and supplies.	First 60 days	All except the Part A deductible	100% of the Part A deductible	0%
	Days 61 through 90	All except the copay per day	Copay per day	0%
	Days 91 and after while using Medicare's 60 lifetime reserve days	All except the copay per day	Copay per day	0%
	Once Medicare's lifetime reserve days are used, HealthChoice provides additional lifetime reserve days. Limited to 365 days.	0%	100% of Medicare eligible expenses Certification by HealthChoice is required	0%
	Beyond the 365 lifetime reserve days	0%	0%	100%
Skilled Nursing Facility Care Must meet Medicare requirements, including inpatient hospitalization for at least 3 days and entering a Medicare-approved facility within 30 days of leaving the hospital. Limited to 100 days per calendar year.	First 20 days	All approved amounts	0%	0%
	Days 21 through 100	All except the copay per day	Copay per day	0%
	Days 101 and after	0%	0%	100%

Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115% of the Medicare-approved amount.

Medicare Part A (Hospitalization) Services
All Benefits are Based on Medicare-Approved Amounts

Services or Items	Description	Medicare Part A Pays	HealthChoice Pays	You Pay
Hospice Care Your doctor and hospice provider must certify you are terminally ill and you elect hospice.	Physical care, counseling, equipment, supplies, respite care, inpatient care and drugs for pain and symptom control	All but very limited coinsurance for outpatient drugs and inpatient respite care	0%	Up to $5 per palliative drug or biological; 5% of Medicare amounts for inpatient respite care
Blood	Limited to the first 3 pints unless you or someone else donates blood to replace what you use	0%	100%	0%

Medicare Part B (Medical) Services
All Benefits are Based on Medicare-Approved Amounts

Services or Items	Description	Medicare Part B Pays	HealthChoice Pays	You Pay
Medical Expenses Medically necessary outpatient services and supplies	Doctor's visits, outpatient hospital treatments, surgical services, physical and speech therapy, and diagnostic tests	80% coinsurance after the Part B deductible	20% coinsurance after the Part B deductible	Part B deductible
Clinical Diagnostic Laboratory Services	Blood tests, urinalysis and tissue pathology	100%	0%	0%
Home Health Care Medicare-approved services	Intermittent skilled care and medical supplies	100%	0%	0%
Durable Medical Equipment	Items such as nebulizers, wheelchairs and walkers	80% coinsurance after the Part B deductible	20% coinsurance after the Part B deductible	Part B deductible

Medicare Part B (Medical) Services
All Benefits are Based on Medicare-Approved Amounts

Services or Items	Description	Medicare Part B Pays	HealthChoice Pays	You Pay
Diabetes Monitoring Supplies Must be requested by your doctor	Includes coverage for glucose monitors, test strips and lancets	80% coinsurance after the Part B deductible	20% coinsurance after the Part B deductible	Part B deductible
Ostomy Supplies	Ostomy bags, wafers and other ostomy supplies	80% coinsurance after the Part B deductible	20% coinsurance after the Part B deductible	Part B deductible
Blood	Amounts in addition to the coverage under Part A unless you or someone else donates blood to replace what you use	80% cionsurance after the Part B deductible	20% coinsurance after the Part B deductible	Part B deductible
Outpatient Prescription	Infused, oral end-stage renal disease and some cancer and transplant drugs	80% coinsurance after the Part B deductible	20% coinsurance after the Part B deductible	Part B deductible

Coverage for Additional Medical Services

Service	HealthChoice
Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.	You pay the first $250 each calendar year, then 20% and all amounts over the $50,000 lifetime maximum.

Medicare Preventive Services

Medicare Part B covers many preventive services at 100 percent when you use a doctor or other health care provider who accepts Medicare assignment; however, certain preventive services still require the normal Part B deductible and/or coinsurance. Coinsurance can apply depending on where you receive certain services.

For Medicare to cover preventive services, you must follow their guidelines for each service. Guidelines can include criteria for age, frequency and disease risk.

For a list of preventive services and details on coverage, go to **CMS.gov** or **Medicare.gov**. You can also refer to the 2019 *Medicare & You* handbook.

HealthChoice SilverScript
High Option Medicare Supplement Plan

Pharmacy Copay Structure for Network Benefits

Pharmacy Deductible

You pay the first $100 in medication costs before copays apply.

Prescription Medications	30-Day Supply	31- to 90-Day Supply
Generic (Tier 1) Drugs	Up to $10 copay	Up to $25 copay
Preferred (Tier 2) Drugs	Up to $45 copay	Up to $90 copay
Non-Preferred (Tier 3) Drugs	Up to $75 copay	Up to $150 copay
Specialty (Tier 4) Drugs	Up to $100 copay	Specialty drugs are available in only a 30-day supply
Preferred (Tier 5) Tobacco Cessation Drugs	$0 copay	$0 copay

Pharmacy Out-of-Pocket Maximum

The annual out-of-pocket maximum is $5,100. Only your deductible and copays for covered prescription drugs purchased at network pharmacies count toward the out-of-pocket maximum. Once you reach the pharmacy out-of-pocket maximum, you pay $0 for covered prescription drugs purchased at network pharmacies for the remainder of the calendar year.

- No Coverage Gap.
- Pharmacy benefits generally cover up to a 30- or 90-day supply. Specific therapeutic categories, medications and/or dosage forms may have more restrictive quantity and/or duration of therapy limitations.
- Some medications require prior authorization.

HealthChoice SilverScript
Low Option Medicare Supplement Plan

Pharmacy Copay Structure for Network Benefits

Pharmacy Deductible	Initial Coverage Limit	Coverage Gap	Catastrophic Coverage
You pay the first $415 in medication costs.	After the deductible, you and HealthChoice share prescription drug costs. You pay 25% ($851.25) and HealthChoice pays 75% ($2,553.75) until total drug spending reaches $3,820.	You pay 100% of prescription drug costs at discounted rates – 37% of the cost of generic drugs and 25% of the cost of brand-name drugs. What you pay for brand-name and generic drugs plus the brand manufacturer discount applies to your out-of-pocket to get out of the Coverage Gap.	After you reach $5,100 out-of-pocket, you pay $0 for covered prescription drugs at network pharmacies for the remainder of the calendar year.

- Pharmacy benefits generally cover up to a 30- or 90-day supply. Specific therapeutic categories, medications and/or dosage forms may have more restrictive quantity and/or duration of therapy limitations.
- Some medications require prior authorization.

HealthChoice High Option
Medicare Supplement Plan Without Part D

Pharmacy Copay Structure for Network Benefits

Prescription Medications	30-Day Supply	31- to 90-Day Supply
Generic (Tier 1) Drugs	Up to $10 copay	Up to $25 copay
Preferred (Tier 2) Drugs	Up to $45 copay	Up to $90 copay
Non-Preferred (Tier 3) Drugs	Up to $75 copay	Up to $150 copay
Specialty (Tier 4) Drugs	*Generic* – $10 copay *Preferred* – $100 copay *Non-Preferred* – $200 copay	Specialty drugs are available in only a 30-day supply
Preferred (Tier 5) Tobacco Cessation Drugs	$0 copay	$0 copay

Pharmacy Out-of-Pocket Maximum

The annual out-of-pocket maximum is $5,100. Only your copays for covered prescription drugs purchased at network pharmacies count toward the out-of-pocket maximum. Once you reach the pharmacy out-of-pocket maximum, you pay $0 for covered prescription drugs purchased at network pharmacies for the remainder of the calendar year.

- No Coverage Gap.
- Pharmacy benefits generally cover up to a 30- or 90-day supply. Specific therapeutic categories, medications and/or dosage forms may have more restrictive quantity and/or duration of therapy limitations.
- Some medications require prior authorization.
- Specialty medications are covered only when ordered through the CVS/caremark specialty pharmacy.

HealthChoice Low Option
Medicare Supplement Plan Without Part D

Pharmacy Copay Structure for Network Benefits

Pharmacy Deductible	Initial Coverage Limit	Coverage Gap	Catastrophic Coverage
You pay the first $415 in drug costs.	After the deductible, you and HealthChoice share prescription drug costs. You pay 25% ($851.25) and HealthChoice pays 75% ($2,553.75) until total drug spending reaches $3,820.	You pay 100% of the next $3,733.75 in prescription drug costs.	After you spend $5,100 out-of-pocket, you pay $0 for covered prescription drugs for the remainder of the calendar year.

- Pharmacy benefits generally cover up to a 30- or 90-day supply. Specific therapeutic categories, medications and/or dosage forms may have more restrictive quantity and/or duration of therapy limitations.
- Some medications require prior authorization.
- Specialty medications are covered only when ordered through the CVS/caremark specialty pharmacy.

Your Prescription Drug Coverage

Pharmacy Out-of-Pocket Maximum

All the plans have a pharmacy out-of-pocket maximum of $5,100. This total includes amounts you spend, including deductibles, copays and coinsurance, at network pharmacies. If you are a Low Option plan member, this total includes amounts you spend during the Coverage Gap. Once you reach the out-of-pocket maximum, HealthChoice pays 100 percent for covered medications purchased at network pharmacies for the remainder of the calendar year.

Costs that Do Not Apply to the Pharmacy Out-of-Pocket Maximum

- Amounts paid by HealthChoice for medications in the Coverage Gap (HealthChoice SilverScript Low Option).
- Costs for medications purchased outside the United States and its territories.
- Costs for non-covered medications.
- Costs for medications purchased at non-network pharmacies when exception requirements are not met.
- Costs for medications covered under Medicare Part A or Part B.
- Payments made by another group health plan or government health plan such as TRICARE, the VA or Indian Health Service.
- Payments for medications made by a third party with a legal obligation to pay.

HealthChoice Pharmacy Network

The HealthChoice Pharmacy Network includes more than 68,000 pharmacies nationwide. Pharmacies contract with our plans to provide covered prescription drugs to members. They also provide electronic claims processing, so there are no paper claims to file.

The HealthChoice Pharmacy Network includes specialized pharmacies, such as pharmacies that:

- Supply drugs for home infusion therapies.
- Supply drugs to residents of long-term care facilities; usually, each facility has its own pharmacy, and residents can get their prescription drugs through the facility's pharmacy as long as it is in the HealthChoice Pharmacy Network.
- Serve the Indian Health Service/Tribal/Urban Indian Health Program.

Sometimes a pharmacy leaves the HealthChoice network. When this occurs, you must get your prescriptions filled at another network pharmacy.

You can locate a HealthChoice network pharmacy by going to our website at **www.healthchoiceok.com**. Under Resources, select Members, then Medicare Members.

- If you are a HealthChoice SilverScript member, select HealthChoice SilverScript Pharmacy Network. You can also call the pharmacy benefit manager. For contact information, refer to Plan Identification Information.

- If you are a HealthChoice Medicare supplement without Part D member, select HealthChoice Pharmacy Network. You can also call the pharmacy benefit manager. For contact information, refer to Plan Identification Information.

Non-Network Pharmacies

Without Part D Plans

Medications purchased at non-network pharmacies are not covered for plans without Part D.

Medication Formularies

HealthChoice SilverScript Medicare Formulary (SilverScript Plans)

To find out how your medications are covered, please call the pharmacy benefit manager. For contact information, refer to Plan Identification Information. You can also visit their website at **Caremark.com**.

HealthChoice Formulary Lists (Without Part D Plans)

The *HealthChoice Comprehensive Formulary* is a list of medications covered by the Without Part D plans. To find out how your medications are covered, please call the pharmacy benefit manager. For contact information, refer to Plan Identification Information. You can also visit our website at **www.healthchoiceok.com**. Under Resources, select Members, then Member Home, then Pharmacy Benefits Information. Here you can also find lists of commonly prescribed medications, excluded medications with preferred alternatives and specialty medications.

Drug Tiers

HealthChoice has a five-tier drug formulary, and in general, each tier represents a different cost group:

- Tier 1 – Generic medications.
- Tier 2 – Preferred brand-name medications.
- Tier 3 – Non-Preferred medications.
- Tier 4 – Preferred very high cost and unique formulary medications.
- Tier 5 – Preferred tobacco cessation medications.

The drugs in Tiers 1 and 2 offer the preferred (lowest) copay while Tier 3 drugs are non-preferred and have a higher copay; Tier 4 drugs include specialty medications, and Tier 5 drugs are tobacco cessation products. Drugs not listed in the formulary are not covered.

Drugs Covered Under Medicare Part A and Part B

Medicare Part A and Part B provide coverage for some medications. HealthChoice does not pay for drugs covered under Medicare Part A or Part B.

- Medicare Part A covers drugs you receive during a Medicare-covered stay in a hospital or skilled nursing facility or for symptom control or pain relief as part of hospice care.

- Medicare Part B covers certain chemotherapy drugs and certain drug injections you receive in an office visit setting or are given at a dialysis facility.

Some Drugs Have Restrictions

Some drugs have additional requirements or coverage limits. If there is a restriction on a drug you are taking, your provider must take extra steps for HealthChoice to cover your drug. The abbreviations for the following restrictions are indicated in the formulary:

Prior Authorization

Prior authorization is required before HealthChoice will cover certain drugs, even though they are listed in the formularies. Generally, prior authorization is required because the medication:

- Has a very high cost.
- Has specific prescribing guidelines.
- Has preferred alternatives available.
- Is generally used for cosmetic purposes.

Quantity Limits

Due to approved therapy guidelines, certain drugs have quantity limits. Quantity limits can apply to the number of refills you are allowed, or how much of the drug you can receive per fill. Quantity limits also apply if the medication is in a form other than a tablet or capsule.

Limited Availability

Certain drugs are subject to limited availability and can be purchased only at certain pharmacies. For more information, call the pharmacy benefit manager toll-free. For contact information, refer to Plan Identification Information.

Step Therapy

Step therapy requires you to first try a less costly drug to treat your medical condition before HealthChoice covers another drug for that same condition. For example, two drugs both treat the same medical condition, but drug A is less costly. You must first try drug A, and if it does not work, HealthChoice SilverScript will cover drug B.

Requesting a Pharmacy Prior Authorization

A request for prior authorization must be submitted by your physician. Your request must be approved before you fill your prescription. To apply:

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.

Note: In most cases, a prior authorization is valid for one year from the date it is issued and must be renewed when it expires.

Tier Exception (High Option Plans Only)

If you choose a non-preferred drug when a preferred drug is available, you must pay the non-preferred copay, unless you get a tier exception for a lower copay. Specific medical guidelines must be met, and your physician must supply information to justify your request. Your physician can call the pharmacy benefit manager toll-free at 855-344-0930.

Non-Formulary or Excluded Medication Prior Authorization

If you are prescribed a medication that is non-formulary or excluded, you can:

1. Ask your physician for a prescription for a generic (Tier 1) or preferred (Tier 2) medication that is listed on the formularies.
2. Continue your non-covered/non-formulary/excluded medication and pay the full cost.
3. Request a prior authorization to receive your medication at the non-preferred copay. For more information, call the pharmacy benefit manager. For contact information, refer to Plan Identification Information.

Medication Quantities

Pharmacy benefits generally cover up to a 30- or 90-day supply. Quantities cannot exceed the FDA approved usual dosing recommendations. Some drugs have more restrictive quantity and length of therapy limits. Quantities are also subject to your doctor's written orders.

Specialty Medications

Specialty medications are usually high-cost medications that require special handling and extensive monitoring. These types of medications are available only in a 30-day supply.

SilverScript Plans

You must purchase your specialty medications from a HealthChoice SilverScript Network Pharmacy.

Without Part D Plans

You must purchase your specialty medications from the CVS/caremark specialty pharmacy.

The CVS/caremark specialty pharmacy provides free supplies, such as needles and syringes, free shipping, refill reminder calls, and personal counseling with a registered nurse or pharmacist. If you do not order your specialty medications through CVS/caremark, you must pay the full cost. For more information, call the CVS/caremark specialty pharmacy. For contact information, refer to Plan Identification Information.

Tobacco Cessation Products

HealthChoice covers the following tobacco cessation medications for a $0 copay when they are purchased at a network pharmacy:

- Buproban 150mg Tabs.
- Bupropion HCl SR 150mg Tabs.
- Chantix 0.5 and 1mg Tabs.
- Nicotrol NS 20mg/mL Nasal Spray.
- Nicotrol 10mg Cartridge.

HealthChoice partners with the Oklahoma Tobacco Research Center and Alere Wellbeing to provide free over-the-counter nicotine replacement therapy products (patches, gum and lozenges) and telephone coaching. To take advantage of these benefits, call the Oklahoma Tobacco Helpline toll-free at 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 Oklahoma call toll-free 866-QUIT-4-LIFE (866-784-8454).

Vaccinations Covered Under Your Pharmacy Benefits

Generally, HealthChoice covers all commercially available vaccinations needed to prevent illness.

The coverage of vaccinations includes two parts – the cost of the vaccine itself and the cost of the vaccination (administration of the shot). What you pay for a vaccination depends on the type of vaccine, where you purchase the vaccine and who gives you the shot. The rules for coverage of vaccinations are complicated. If you have a question about how a particular vaccine is covered, call the pharmacy benefit manager. For contact information, refer to Plan Identification Information.

Without Part D Plans

You are responsible for administration fees for vaccines covered under pharmacy benefits.

When You are Hospitalized

Part A covers your prescription drugs as part of your inpatient treatment for a Medicare-covered stay. Once you leave the hospital, HealthChoice covers your prescription drugs as long as they meet the rules for coverage. HealthChoice also covers your drugs if they are approved through a coverage determination, exception or appeal.

When You are Admitted to a Skilled Nursing Facility

Part A covers your prescription drugs during all or part of a Medicare-covered stay. If Part A stops paying for your prescriptions, HealthChoice covers them as long as they meet the rules for coverage. The facility's pharmacy must be a network pharmacy, and the drug cannot be covered under Part B. HealthChoice also covers your drugs if they are approved through a coverage determination, exception or appeal.

When You Receive Hospice Care

The hospice medications you receive for symptom control or pain relief are covered under Medicare Part A.

Medications for the treatment of conditions unrelated to the terminal illness are covered under Part D. Drugs are never covered under both Part A and Part D at the same time.

Prior Authorization is required on drugs prescribed for hospice patients. If you are receiving hospice care and are prescribed an anti-nausea, laxative, pain or anti-anxiety medication that is not covered by Medicare because it is unrelated to your terminal illness, your prescriber or hospice provider must notify HealthChoice SilverScript before the plan can cover your drug.

To prevent delays in receiving medications that are covered by HealthChoice SilverScript, you can ask your hospice provider or prescriber to make sure they have notified the plan that your drug is unrelated to your terminal illness before you ask a pharmacy to fill your prescription.

In the event you revoke your hospice election or are discharged from hospice, HealthChoice should cover all your drugs. To prevent any delays at your pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation of, or discharge from, hospice care.

Drug Safety Programs

The pharmacy benefit manager conducts drug reviews to make sure members receive safe and appropriate prescription therapies. These reviews can be important if you have more than one provider prescribing different types of medications. Each time you fill a prescription, a review is conducted to look for possible problems such as:

- Medication errors.
- Dosage errors.
- Medications that are unnecessary because you already take another drug for the same condition.
- Medications that may be unsafe or inappropriate because of your age or gender.
- Medication combinations that could harm you if you take them at the same time.
- Medications you are allergic to.

If any possible problems are detected, the pharmacy benefit manager notifies your pharmacist at the time your prescription is filled.

Creditable Prescription Drug Coverage

The HealthChoice Medicare supplement plans provide creditable coverage. Prescription drug coverage is creditable if it meets or exceeds Medicare's prescription drug coverage guidelines. The HealthChoice plans provide coverage equal to (Low Option plans) or better than (High Option plans) the standard benefits set by Medicare. HealthChoice is not required to send you a Creditable Coverage letter, but if you need one, call EGID Member Services. For contact information, refer to Plan Identification Information.

What Types of Drugs are NOT Covered

If you take a drug that is excluded from coverage, you must pay for the drug yourself. Generally, HealthChoice cannot cover drugs that are:

- Covered under Medicare Part A or Part B.
- Purchased outside the United States.
- Prescribed for off-label use – this means any use of a drug other than those indicated on the drug's label.

The following drug categories are also excluded from coverage:

- Cough and cold medications.
- Fertility drugs.
- Over-the-counter drugs.
- Lost, stolen or damaged medications.
- Drugs used for the treatment of anorexia, weight loss or weight gain.
- Drugs not approved by the FDA.
- Impotency medications such as Cialis, Levitra, Viagra and Caverject.*
- Drugs used for cosmetic purposes or hair regrowth.
- Brand-name drugs from manufacturers that do not participate in the Coverage Gap Discount Program.
- All over-the-counter and prescription vitamins, except prenatal vitamins.

*These drugs are specifically excluded from coverage unless you have had radical retropubic prostatectomy surgery or certain other medical conditions. Prior authorization is required.

Claim Procedures

Claims Filing Deadline

Claims must be received by HealthChoice no later than 365 days following the date of service.

If you have questions about any of the following medical claims procedures, please call customer care. For contact information, refer to Plan Identification Information.

Filing a Medical Claim

Most providers file your claims with Medicare and then automatically file your claims with HealthChoice. To process your claim electronically, your and your dependents' Medicare numbers must be on file with the plan.

If you have to file your claim with HealthChoice yourself, once you receive your Medicare Summary Notice for Part A and Part B services, you can file your claim by sending a copy of the notice to customer care. For contact information, refer to Plan Identification Information.

Medical Coordination of Benefits

If you or your covered dependents are covered by another group health plan, HealthChoice coordinates benefits with your other plan so total benefits are not more than the amount billed or your liability. If your other group coverage is primary over your HealthChoice coverage, you must file claims with your primary plan first. If your other health coverage terminates, please call customer care. For contact information, refer to Plan Identification Information.

Medicare Beneficiaries with End-Stage Renal Disease

If you are diagnosed with end-stage renal disease, Medicare is the secondary payer to HealthChoice for the first 30 months of coverage. This rule applies regardless of whether you are a primary member or covered as a dependent under a group health plan. During this 30-month time period, HealthChoice always pays first.

If you have questions about coverage of ESRD, visit **Medicare.gov** or call Medicare toll-free at 800-MEDICARE (800-633-4227) or TTY 877-486-2048.

Filing a Direct Pharmacy Claim

Usually, your claim is processed electronically at the pharmacy. If your pharmacist has questions, have them call the pharmacy helpline:

- SilverScript plans toll-free 866-693-4620.
- Without Part D plans toll-free 800-364-6331.

In some cases, you may need to pay the full cost of your drug and then ask HealthChoice to repay you for its share. You may need to file a paper claim for reimbursement when:

- You use a non-network pharmacy due to an emergency.
- You pay the full cost for a drug because you did not have your plan ID card.
- Your drug has a restriction, and you decide to purchase the drug immediately.

To ask for reimbursement, send your pharmacy receipt and CVS/caremark Prescription Reimbursement Claim Form to the pharmacy benefit manager at the appropriate address listed on the form.

If your claim involves coordination of benefits with other group insurance, include a copy of the pharmacy receipt that lists your name, the medication and the amount you paid for the prescription. When your claim is received, the pharmacy benefit manager will let you know if more information is needed.

If your claim is for a covered medication and you followed all plan guidelines, HealthChoice reimburses you for its share of the cost.

If your claim is for a non-covered medication or you did not follow plan guidelines, HealthChoice sends you a letter letting you know the reason your request was denied and what your rights are to appeal the decision.

Claims for Services Outside the United States

When traveling outside the U.S. and its territories, you must pay for your medical expenses and then ask HealthChoice to pay you back. Your itemized bill must be translated to English and converted to U.S. dollars using the exchange rates applicable for the dates of service. Medical claims must be submitted to customer care. For contact information, refer to Plan Identification Information.

Note: HealthChoice does not pay for medications purchased outside the United States.

Private Contracts with Physicians and Practitioners

A private contract is a written agreement between a Medicare beneficiary and a doctor or practitioner who **does not** provide services through the Medicare program. These providers have opted out of Medicare, and you must sign a private contract with them before they will provide care. If you sign a private contract, be aware that:

- Medicare's limiting charge does not apply. You pay what the practitioner charges.
- Claims for these services are not covered by Medicare or HealthChoice, and neither Medicare nor HealthChoice pay anything for these services.

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.

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 pays 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 on your medical claims related to the accident. 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.

The subrogation administrator can be reached by phone at 405-235-9621 or toll-free 844-724-9386, fax at 405-235-0439, or mail at Two Leadership Square, 10th Floor, 211 N. Robinson Ave., Oklahoma City, OK 73102.

Eligibility, Enrollment and Disenrollment

Medicare Eligibility

Medicare is the federal health insurance program for people:

- Ages 65 and older.
- Under age 65 with qualified disabilities.
- With ESRD.

CMS manages the Medicare program. The Social Security Administration determines eligibility, enrolls people in Medicare and collects Medicare premiums. For information about Medicare, visit the CMS website at **CMS.gov** or the Social Security website at **SSA.gov**. You can also call Social Security toll-free at 800-772-1213 or TTY 800-325-0778.

Medicare is divided into several parts. The parts of Medicare that apply to your plan include:

- Part A, which covers services provided by hospitals, skilled nursing facilities and home health agencies.
- Part B, which covers most other medical services, such as physician office visits, outpatient services and durable medical equipment and supplies.
- Part D, which covers prescription drugs.

Enrollment in Medicare

Enrollment in Medicare is handled in two ways – either you are automatically enrolled or you must apply.

If you receive Social Security or Railroad Retirement Board benefits before you turn 65, you are automatically enrolled, and your Medicare ID card is mailed to you about three months before your 65th birthday.

Otherwise, you must apply for Medicare by contacting Social Security, or, if appropriate, the Railroad Retirement Board, 60-90 days before you turn 65.

If you have been a disabled beneficiary under Social Security or Railroad Retirement for 24 months, you will automatically get a Medicare ID card in the mail.

When You Become Medicare Eligible

Approximately two months before you turn age 65, HealthChoice sends you a letter advising you of your options for Medicare supplement coverage and an Application for Medicare Supplement With Prescription Drug Plan. You must complete and return this application to HealthChoice within the time frame indicated in the letter to be enrolled in a HealthChoice SilverScript Medicare supplement plan.

If you or your covered dependents become Medicare eligible before age 65, you must notify EGID and provide your Medicare ID number as it appears on your Medicare ID card. EGID will mail you an Application for Medicare Supplement With Prescription Drug Plan that you must complete and return to EGID. Your enrollment in a HealthChoice SilverScript Medicare supplement plan will be effective the first of the month following receipt of your completed application or on the effective date of your Medicare coverage, whichever is later.

Eligibility Requirements

You are eligible to enroll in a HealthChoice SilverScript Medicare supplement plan if you are:

- Entitled to Medicare Part A or enrolled in Medicare Part B.
- Listed as eligible in Medicare's system for Part D.
- A permanent resident of the United States or its territories.

If you live abroad or are in prison, you cannot enroll in a HealthChoice SilverScript plan; however, you can enroll in one of the HealthChoice Medicare supplement plans without Part D.

Enrollment Periods

There are three time periods when you can enroll in or disenroll from the HealthChoice Medicare supplement plans.

- **Initial Enrollment Period** – When you first become eligible for Medicare. Effective date is the first of the month you become eligible, or the first of the month following receipt of your completed application, whichever is later.
- **Annual Coordinated Election Period** – Medicare’s annual election period, Oct. 15 through Dec. 7, which EGID follows for Option Period plan changes. Effective date is Jan. 1.
- **Special Enrollment Periods** – When you can make midyear changes under certain circumstances (effective date follows receipt of your completed application), such as:
    - You move outside the United States.
    - CMS or HealthChoice terminates the plan's participation in the Part D program.
    - You lose creditable coverage for reasons other than failure to pay premiums.
    - You meet other exception rules as set out by CMS.

For more information about Special Enrollment Periods, call toll-free 800-MEDICARE (800-633-4227). TTY users call toll-free 877-486-2048.

Confirmation Statement

Anytime a change is made to your coverage, EGID mails you a confirmation statement that lists the coverage you are enrolled in, the effective date of coverage and the premium amounts. Review your statement as soon as you receive it so any errors can be corrected as soon as possible.

If you do not make any changes to your coverage, you will not receive a confirmation statement.

Dependent Coverage

Dependents can be added to coverage only if one of the following conditions is met:

- Your dependent loses other group or qualified individual health coverage. Application for enrollment and proof of termination of the other health coverage must be submitted within 30 days of the loss. You must cover all eligible dependents. Some exceptions apply. Refer to Excluding Dependents from Coverage in this section.
- You marry and want to add your new spouse and dependent children to your coverage. You must add them within 30 days of your marriage.

- You gain a new dependent through birth, adoption or legal guardianship. You must add them within 30 days of the birth, adoption or gaining legal guardianship.

COBRA continuation of coverage is available for dependents who lose eligibility. Refer to COBRA in this section.

Eligible Dependents

Eligible dependents include:

- Your legal spouse (including common-law).
- 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, guardianship or other legal custody, up to age 26, whether married or unmarried. **Note:** Plan coverage that terminates upon the dependent's 26th birthday will terminate at the end of the month in which the birthday occurs.
- A dependent, regardless of age, who is incapable of self-support due to a disability 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 may be provided in lieu of the application.

You can enroll dependents only in the same coverage and plans as you. Dependents who are not enrolled within 30 days of your eligibility date cannot be enrolled unless there is a qualifying event such as birth or marriage, or one of the above events occur.

If you drop eligible dependents from coverage, you cannot re-enroll them unless they lose other group or qualified individual health coverage.

If your spouse is enrolled separately in a plan offered through EGID, your dependents can be covered under only one parent’s health, dental or vision plan; however, both parents can cover dependents under Dependent Life insurance.

In the event of the birth of a child when Medicare is primary, please contact HealthChoice for coverage information.

Excluding Dependents from Coverage

Eligible dependents can be excluded from coverage if they have other group or qualified individual health coverage or are eligible for Indian or military health benefits. You can exclude eligible dependent children who do not live with you, are married or are not financially dependent on you for support. You can also exclude your spouse. If you exclude your spouse while covering other eligible dependents, you and your spouse must both sign the Spouse Exclusion Certification on your Application for Retiree/Vested/Non-Vested/Defer Insurance Coverage, or your Option Period Enrollment/Change Form if you drop your spouse during Option Period.

To Request Coverage Changes

All requests for changes in coverage must be made in writing. Verbal requests for changes are not

accepted, unless directed by Medicare. A request for change must be made within 30 days of a qualifying event. Please send all requests for changes to HealthChoice, 3545 NW 58th St., Ste. 600, Oklahoma City, OK 73112; or fax your request to 405-717-8939.

When Your Employer Changes Insurance Carriers

Education Retirees

If you were a career tech employee or a common school employee who terminated 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 school system terminates coverage with 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.

Local Government Retirees

If you were a local government employee who terminated 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.

New Employer Retirees

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

Following Your Employer to a New Plan

When you terminate employment, your benefits are tied to your most recent employer. If that employer discontinues participation with EGID, some or all of their retirees and 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 work for any participating employer. If you retire and then return to work for another employer and enroll in benefits through that employer, your benefits are tied to your new employer.

If You Return to Work

If you return to work and enroll in a group health plan offered through your employer, that plan is your primary insurance carrier; however, you may be eligible to continue Medicare as your primary carrier with HealthChoice as your supplement plan.*

If you are able to opt out of your employer's group health plan and keep your HealthChoice Medicare supplement plan, Medicare is your primary insurance carrier and HealthChoice is your secondary carrier.*

If you are a retired or vested member returning to work and you did not continue health coverage at the time you retired or vested, you must meet all the eligibility requirements of a new employee.

*Be aware that your employer cannot provide a Medicare supplement plan, or pay for any premiums related to a Medicare supplement plan.

Ending Your Coverage With HealthChoice

Ending your coverage with HealthChoice can be voluntary or involuntary. You can choose to leave the plan, or HealthChoice may be required to end your coverage.

You have the option to leave the plan during Option Period. Medicare defines certain situations, known as Special Enrollment Periods, when you can leave the plan at other times of the year.

If you terminate coverage in retirement or as a vested member, you cannot re-enroll in the plans offered through EGID. As a retiree, you will forfeit any retirement system contribution paid toward your health insurance premium. Your terminated health, dental or life coverage cannot be reinstated at a later date unless you return to work as an employee of a participating employer for at least three years. Vision coverage is the only benefit that can be elected during Option Period as long as you keep one other benefit through EGID.

If your dependent is dropped from your plan, they cannot be re-enrolled unless they lose other group or qualified individual health coverage.

If you are enrolled in a HealthChoice SilverScript plan and you drop that coverage, you must enroll in another Part D plan within 63 days to avoid a late enrollment penalty.

When HealthChoice Must End Your Coverage

HealthChoice must end your coverage in the plan when:

- You fail to pay premiums.
- You move out of the United States or its territories for more than 12 months.
- You go to prison.
- You lie about or withhold information about other prescription coverage you have.*
- You continuously behave in a way that is disruptive.*
- You allow someone else to use your ID card to purchase prescription drugs.

*We cannot end your coverage for these reasons unless we first get permission from Medicare. If HealthChoice ends your coverage, we send you a letter explaining our reasons and include instructions about how you can file a complaint with the plan.

In the Event of Your Death

Your surviving dependents can continue any coverage that is in effect at the time of your death as long as all premiums are paid. Surviving dependents have 60 days from the date of your death to elect survivor benefits.

If your dependents are enrolled in a HealthChoice SilverScript plan, their coverage is continued automatically; however, they have the option to cancel coverage.

Coverage is effective the first day of the month following your death. Surviving dependents will receive new ID cards and a bill for premiums through current month.

Notice of your death should be directed to your retirement system and HealthChoice.

COBRA

COBRA is federal legislation that gives members and their covered dependents who lose health benefits the right to choose to continue group health benefits for limited periods of time under certain circumstances.

If you are not Medicare eligible before you begin COBRA coverage, your health coverage will end once you gain Medicare. If you are already Medicare eligible when you elect COBRA coverage, you must continue your employee status coverage and cannot enroll in the Medicare supplement plan until the next Option Period.

It is the policy of EGID that for any benefit continued under COBRA, one person must always pay the primary member premium. In cases where a spouse, child or children are insured under a particular benefit but the member did not keep that coverage, one person will always be billed at the primary member rate.

When You are Enrolled in Vested, Non-Vested or Retirement Coverage and Your Dependents Become Eligible for COBRA

Your covered spouse and dependent children are eligible to continue coverage for up to 36 months if coverage is lost for reasons such as:

- Divorce or legal separation.*
- Your dependent loses eligibility.
- Your death (refer to In the Event of Your Death in this section).

As 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. 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 your dependents to lose coverage.
- The date EGID notifies your dependents of continuation of coverage rights.

If you have questions about COBRA, call EGID Member Services. For contact information, refer to Plan Identification Information.

*Oklahoma law prohibits dropping your spouse or other dependents in anticipation of a divorce or legal separation. If you are in the process of a divorce or legal separation, contact your legal counsel for advice before making changes to your coverage.

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.

Information the Plan Must Provide to You

You have the right to get several kinds of information from HealthChoice. This handbook provides much of the information you need concerning your health and pharmacy benefits, eligibility, premiums, and grievances and appeals processes. It also provides information about the rules you must follow when you use your prescription drug benefits, as well as why some drugs are not covered by the plan.

More information about the HealthChoice Pharmacy Network and coverage of specific medications is available at **www.healthchoiceok.com** or call the pharmacy benefit manager. For contact information, refer to Plan Identification Information.

Support for Your Right to Make Decisions About Your Care

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself. This means, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you are unable to make decisions for yourself.
- Provide your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents you can use to give your instructions are called advance directives. These documents are also called a living will or power of attorney for health care. If you want to use an advance directive, you must:

- Get the form (search online for Oklahoma Statutory Advance Directive), fill it out and sign it.
- Give copies to the appropriate people.
- Take a copy with you if you are going to be hospitalized.

You may also want to consult your attorney or ask them to help you prepare the document.

Grievances and Appeals

What to do if you have a complaint, a denied claim or you disagree with a decision that has been made about your medical or pharmacy benefits. You cannot be disenrolled from the plan or penalized in any way for making a complaint, grievance or appeal.

When Your Medical Claim is Denied Under HealthChoice

If your medical claim was denied by Medicare and you would like to appeal it, you should contact Medicare and follow its appeal procedures. If the claim was approved by Medicare, but the balance was denied in whole or in part for any reason by HealthChoice, 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.

When Your Pharmacy Claim is Denied

We encourage you to contact us as soon as possible if you have questions, concerns or problems related to your prescription drug coverage. If your pharmacy claim is denied and you have questions concerning the denial, please call the pharmacy benefit manager. For contact information, refer to Plan Identification Information.

SilverScript Plans

If you want to appeal a denied pharmacy claim based on clinical criteria provided by your physician, please contact the pharmacy benefit manager.

Without Part D Plans

If you want to appeal a denied pharmacy claim based on clinical criteria provided by your physician, you can mail or fax your written appeal to:

HealthChoice Pharmacy Unit
3545 NW 58th St., Ste. 600
Oklahoma City, OK 73112
Fax: 405-717-8925

If your appeal is denied, you have the right to file a grievance with EGID. Please follow the same procedures used when appealing a denied medical claim.

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 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 he or she provides, since the compliance officer is not able to divulge or reconfirm these if they are forgotten.

Some examples of fraud, waste and abuse include:

- An individual or organization contacts you pretending to represent HealthChoice, Medicare or Social Security and asks for your identification number, bank account number, credit card number, money, etc.
- Someone asks you to sell your prescription drug card or account information.
- Someone asks you to get medications for them using your prescription drug card.
- You are encouraged to disenroll from your plan or 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 you did not receive.
- You receive a different medication than your doctor ordered.
- Billing for unlicensed staff.
- Providing medically unnecessary services to members.
- Provider bills for duplicate equipment or supplies, or bills a used device as a new purchase.

Notifications

Women's Health Cancer Rights Act of 1998 Notice*

Under the *Oklahoma Breast Cancer Patient Protection Act*, group health plans, insurers and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgeries effective for the first plan year beginning on or after Jan. 1, 1998. In the case of a participant or beneficiary who is receiving benefits under a plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending physician and the patient for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction on the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage is subject to a plan's annual deductibles and coinsurance provisions. These provisions are generally described in the plan's benefit handbook.

The *Health Insurance Portability and Accountability Act* of 1996 provides that the plan sponsor of a self-funded, non-federal, governmental plan can exempt the plan from the requirement; however, HealthChoice plans currently have comparable benefits for our members.

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 HealthChoice coverage of mastectomies and reconstructive surgery or prostate-related conditions, call customer care. For contact information, refer to Plan Identification Information.

Wigs and Scalp Prostheses

HealthChoice provides a benefit for one wig or one scalp prosthesis per calendar year for individuals who are experiencing hair loss due to radiation or chemotherapy treatment resulting from a covered medical condition. Coverage is subject to annual deductibles and coinsurance. The wig or scalp prosthesis must be obtained from a licensed cosmetologist or DME provider.

Plan Definitions

Appeal: A special kind of complaint you make if you disagree with the plan's decision to deny your request for benefits. There is a specific process that HealthChoice must use when you ask for an appeal.

Assignment: An arrangement with a physician or medical supplier who agrees to accept the Medicare-approved amount as full payment for services and supplies covered under Medicare Part B.

Brand-name Drug: A prescription drug that is manufactured and sold by the pharmaceutical company that developed the drug. A brand-name drug has the same active-ingredient formula as generic versions of the drug.

Centers for Medicare & Medicaid Services: The federal agency that runs the Medicare program.

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

Copay: The set amount you pay as your share of the costs for covered services or medications.

Coinsurance: The percentage of the costs of covered services or medications that you pay as your share of the expense.

Consolidated Omnibus Budget Reconciliation Act: Federal legislation that gives members and their covered dependents who lose health benefits the right to choose to continue group health benefits for limited periods of time under certain circumstances.

Cosmetic Procedure: A procedure that primarily serves to improve appearance.

Coverage Decision: A decision about whether a medication prescribed for you is covered by the plan and the amount you are required to pay for the prescription.

Covered Drugs: The prescription drugs covered by the plans.

Coverage Gap (Low Option Plans): The phase following the Initial Coverage Limit when you are responsible for the entire cost of your medications (minus discounts for the SilverScript plan).

Creditable Coverage: Coverage that is at least as good as the standard Medicare prescription drug coverage.

Deductible: The initial out-of-pocket expense you pay before the plan pays.

Disenrollment: The process of ending your coverage with the plan.

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 that 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 Former Employee: An eligible employee who is participating in any of the plans authorized by or through the *Oklahoma Employees Insurance and Benefits Act* who retires, has a vesting right with a state-funded retirement plan or has the required years of service with an employer participating in the plan.

Evidence of Coverage: This handbook, which explains your coverage, your rights and what you have to do as a member of our plan.

Exception: A type of coverage determination.

Generic Drug: A prescription drug that has the same active ingredient as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the FDA to be as safe and effective as brand-name drugs.

Grievance - Medical: A medical benefit grievance is an appeal you file with the plan when, after a review, your request for health care coverage remains denied.

Grievance - Pharmacy: A pharmacy benefit grievance is a complaint such as a problem you may have getting accurate and timely information from HealthChoice or from customer service at our pharmacy benefit manager. A grievance issue does not involve coverage or payment.

HealthChoice Comprehensive Formulary: A list of medications covered by the plans without Part D.

HealthChoice SilverScript Medicare Formulary: A list of medications covered by the SilverScript plans.

Initial Coverage Limit (Low Option Plans): The total retail value of formulary drug purchases you can make before entering the Coverage Gap.

Late Enrollment Penalty: An amount added to your Part B monthly premium if you do not enroll when you first become Medicare eligible; or to your Part D premium if you go without creditable coverage for 63 days or longer. You pay this higher amount as long as you have the Medicare coverage. There are some exceptions. HealthChoice pays the Part D late enrollment penalty for its SilverScript members.

Medically Necessary: Medicare-covered 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 level of which can safely be provided. For hospital stays, inpatient acute care is necessary due to the severity of your condition, or when safe and adequate care cannot be received outpatient or in a less intense medical setting. Services or supplies cannot be primarily for the convenience of you, your caregiver or your provider. Medicare does not cover services that are not medically necessary, and we follow their guidelines.

Medicare: The federal health insurance program for people age 65 or older, some people under 65 with disabilities, and people with ESRD (permanent kidney failure requiring dialysis or a kidney transplant).

- **Medicare Part A:** Covers services furnished by institutional providers such as hospitals, skilled nursing facilities and home health agencies.
- **Medicare Part B:** Covers most other medical services such as physician's services and other outpatient services.
- **Medicare Part D:** Covers prescription drugs.

Medicare-Approved Amount: The fee Medicare sets as reasonable for a covered medical service. Sometimes called the approved charge, you and Medicare pay this amount to a doctor or supplier for a service or supply.

Medicare-Eligible Expenses: Medical costs recognized as reasonable and medically necessary by Medicare.

Medicare's Limiting Charge: The highest dollar amount you can be charged for a covered service by doctors and other health care providers who don't accept Medicare assignment. The limit is 15 percent above Medicare's approved amount and does not apply to supplies or equipment.

Member (of HealthChoice): A person enrolled in a HealthChoice plan.

Network Pharmacy: Network pharmacies have contracted with our plan. In most cases, your prescriptions are covered at the maximum benefit only when they are filled at a HealthChoice network pharmacy.

Non-Covered Service: Any service, procedure or supply excluded from coverage.

Non-Network Pharmacy: A pharmacy that does not have a HealthChoice contract. Most services you get from non-network pharmacies are not covered by the plans except under certain conditions.

Option Period: A set time when you can change plans that follows Medicare's Annual Election Period.

Out-Of-Pocket Maximum: The maximum amount you pay before the plan pays 100 percent for covered services or medications.

Part D Drugs: Medications that Congress permits SilverScript to offer as part of a standard Medicare prescription drug benefit. HealthChoice may or may not cover all Part D drugs.

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

Pharmacy Prior Authorization: A medical review process that is required before certain medications are covered by the plans.

Quantity Limits: Benefit restrictions on the amount of medication you can receive.

Qualifying Event: An event that changes a member's family or health insurance situation and qualifies the member or dependent for a special enrollment period. Refer to the Eligibility section for a list of qualifying events.

Step Therapy: A requirement that you need to first try a specific, more cost-effective medication before moving to another medication which can be more costly or less cost effective.

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.

This publication was printed by the Office of Management and Enterprise Services as authorized by Title 62, Section 34. 100 copies have been printed at a cost of $1,692. A copy has been submitted to Documents.OK.gov in accordance with the Oklahoma State Government Open Documents Initiative (62 O.S. 2012, § 34.11.3).

HealthChoice is administered by EGID, a division of the
Oklahoma Office of Management and Enterprise Services.