HealthChoice

State Bird, Scissortailed Flycatcher

State Animal, Buffalo

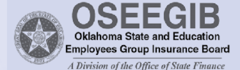
State Wild Flower, Indian Blanket

State Reptile, Mountain Boomer

High, High Alternative, Basic, and Basic Alternative Plans Handbook

www.sib.ok.gov or www.healthchoiceok.com

OKLAHOMA



MDIS #2614

Introduction

This handbook is intended to be an easy-to-use guide to the benefits of the HealthChoice High, High Alternative, Basic, and Basic Alternative Plans. It is not intended to be a complete description of the Plans. Please read all the sections of this handbook carefully for explanations of the eligibility rules and what the Plans pay, limit, and exclude.

All Plan provisions, processes, exclusions, and limitations apply to the High, High Alternative, Basic, and Basic Alternative Plans unless specifically stated otherwise.

Details of the HealthChoice Basic and Basic Alternative Plans are found on the blue-shaded pages 5 through 9.

Details of the HealthChoice High and High Alternative Plans are found on the gray-shaded pages 10 through 15.

The pharmacy benefits described on pages 32 through 42 are identical for the High, High Alternative, Basic, and Basic Alternative Plans.

Information Available on Our Website at www.sib.ok.gov or www.healthchoiceok.com

HealthConnect

This online benefit application is designed to give you quick and easy access to your benefit information. HealthConnect provides you with member and dependent coverage information, a link to the tobacco-free *Attestation*, access to *ClaimLink*, a secure messaging center, and access to *FAQs*.

ClaimLink

You can access your current plan information via the web. Using the *ClaimLink* option from the HealthChoice home page, you can view your eligibility, benefits, deductible, and claim status, as well as download your *Explanation of Benefits*. Registration is quick and easy. You will need to enter your name, date of birth, HealthChoice ID number, ZIP Code, and the last four digits of your Social Security number. If you have any questions, please contact the health claims administrator. For contact information, see *Plan Identification Information and Notice*.

Network Provider Directories

You can easily access the HealthChoice Network Provider Directory via the web. Click *Find a Provider* in the top menu bar on the home page and then click *Medical and Dental Providers* under *HealthChoice Provider Listings*.

It's also easy to locate a HealthChoice Network Pharmacy using the website. First click on the *Find a Provider* link on the home page and then click *Network Pharmacies* under *HealthChoice Provider Listings.*

HealthChoice Select Medication List

The online version of the *HealthChoice Select Medication List* allows you to search for medications by name or by treatment category. The list provides Preferred or non-Preferred status information and includes a feature that provides pricing and coverage information. To view the list, scroll over the *Member* link and click the *Pharmacy Benefits Information* link from the drop down menu and then click *HealthChoice Select Medication List*.

Frequently Asked Questions

The *FAQ* section of our website provides an interactive application that allows easy access to general Plan information by simply entering your question, a phrase, or a keyword on the search line. You also have the ability to search for information by category or topic using the advanced search feature.

HealthChoice High, High Alternative, Basic, and Basic Alternative Health Plans

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Any updates made to this handbook after printing can be found on the HealthChoice website at **www.sib.ok.gov** or **www.healthchoiceok.com**.

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A text version of this handbook is available on the HealthChoice website at www.sib.ok.gov or www.healthchoiceok.com. This guide is also available in CD format at the Oklahoma Library for the Blind and Physically Handicapped (OPLBPH). Contact the OLBPH at 1-405-521-3514, toll-free 1-800-523-0288, or TDD 1-405-521-4672.

Plan Identification Information and Notice

Revised January 2012

Plan Names:	HealthChoice High, High Alternative, Basic, and Basic Alternative Plans
Plan Administrator:	Oklahoma State and Education Employees Group Insurance Board (OSEEGIB), a division of the Office of State Finance 3545 NW 58 Street, Suite 110 Oklahoma City, OK 73112 1-405-717-8701 or toll-free 1-800-543-6044
Member Services:	HealthChoice Member Services and Provider Directory 1-405-717-8780 or toll-free 1-800-752-9475 TDD: 1-405-949-2281 or toll-free 1-866-447-0436 FAX: 1-405-717-8942 Website: **www.sib.ok.gov** or **www.healthchoiceok.com**
Health Claims Administrator:	HP Administrative Services, LLC PO Box 24870 Oklahoma City, OK 73124-0870 1-405-416-1800 or toll-free 1-800-782-5218 TDD: 1-405-416-1525 or toll-free 1-800-941-2160
Pharmacy Benefit Manager:	Medco Toll-free 1-800-903-8113 TDD: toll-free 1-800-825-1230 Website: **www.medco.com**
Certification Administrator:	APS Healthcare Toll-free 1-800-848-8121 TDD: toll-free 1-877-267-6367

NOTICE: The Oklahoma State and Education Employees Group Insurance Board (OSEEGIB), a division of the Office of State Finance, provides health care benefits to eligible state, education, and local government employees, former employees, survivors, and their dependents in accordance with the provisions of Oklahoma Statutes, Title 74, Sections 1301, et seq. The information provided in this handbook is a SUMMARY of the benefits, conditions, limitations, and exclusions of the HealthChoice High, High Alternative, Basic, and Basic Alternative Plans. It should not be considered an all-inclusive listing.

All references to you and your are interchangeable as related to the member. Please use this handbook to become familiar with your Plan's benefits and rules. Be aware that throughout this handbook, the High, High Alternative, Basic, and Basic Alternative Plans are often referred to as the Plan or Plans.

Plan benefits are subject to conditions, limitations, and exclusions. These conditions, limitations, and exclusions are described and located in *Oklahoma Statutes*, OSEEGIB *Rules*, and *Administrative Procedures* adopted by the Plan Administrator. You can obtain a copy of the official OSEEGIB *Rules* from the Office of the Oklahoma Secretary of State. An unofficial copy of the *Rules* is available on the HealthChoice website at **www.sib.ok.gov** or **www.healthchoiceok.com**. Under the heading *About OSEEGIB,* click the link *Rules*. A copy of the *Administrative Procedures* can be obtained from the Plan Administrator.

PLEASE READ THIS HANDBOOK CAREFULLY
A dispute concerning information contained within any Plan handbook or any other written materials, including any letters, bulletins, notices, or other written document, or oral communication, regardless of the source, shall be resolved by a strict application of OSEEGIB *Rules* or benefit administration procedures and guidelines as adopted by the Plan. Erroneous, incorrect, misleading, or obsolete language contained within any handbook, other written document, or oral communication, regardless of the source, is of no effect under any circumstance.

This publication was printed by the Oklahoma State and Education Employees Group Insurance Board, a division of the Office of State Finance, as authorized by 74 O.S., Section 1301, et seq. 5,000 copies have been printed at a cost of $1.79 each. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.

How the HealthChoice Health Plans Work

Cost Sharing Features

The benefits of the HealthChoice High, High Alternative, Basic, and Basic Alternative Plans are based on cost-sharing features that include deductibles, copays, and coinsurance. Please see *Plan Definitions* at the back of this handbook for an explanation of these terms.

The Certification Process

The Plans also have a certification process which requires providers to certify certain services through our certification administrator or the HealthChoice Health Care Management Division before services are performed. See *Certification*.

The HealthChoice Provider Network

HealthChoice allows you to seek care from a Network Provider or a non-Network provider; however, the amount you are responsible for paying is greatly increased when you use a non-Network provider. With a statewide and multi-state network of more than 15,000 physicians, hospitals, and other health care professionals and facilities, the HealthChoice Provider Network is one of the largest in Oklahoma.

Finding a HealthChoice Network Provider

You can find a HealthChoice Network Provider by clicking *Find a Provider* in the top menu bar of the HealthChoice website at **www.sib.ok.gov** or **www.healthchoiceok.com**. You can search for providers by name, specialty, or location, as well as search for Network Pharmacies.

You can also contact HealthChoice Member Services to find a Network Provider. A Member Services Representative can give you the names of Network Providers in your area. For contact information, see *Plan Identification Information and Notice*.

Allowed Charges

HealthChoice pays benefits based on set fees known as Allowed Charges. Allowed Charges represent the set dollar amounts the Plans allow for covered medical services and supplies. Regardless of the amounts billed by your provider, HealthChoice always calculates benefits based on its Allowed Charges.

The Importance of Selecting a HealthChoice Network Provider

HealthChoice Network Providers have contracted with the Plan and agreed to accept HealthChoice Allowed Charges for the services and equipment they provide. By contracting with HealthChoice, Network Providers have agreed not to bill you for charges that are greater than the Plans' Allowed Charges. You are still responsible for Plan copays, deductibles, and coinsurance amounts.

On the other hand, non-Network providers are **not contracted** with HealthChoice and **have not** agreed to accept the HealthChoice Allowed Charges. This means you are responsible for paying the difference between the amount the provider bills and HealthChoice Allowed Charges. This process, known as balance billing, can amount to quite a large amount of money out of your own pocket. Even after you reach your Plan's out-of-pocket limit, you are still responsible for all amounts above the HealthChoice Allowed Charges when you use non-Network providers.

As an example, let's say you receive services from a non-Network provider who charges $100,000; however, HealthChoice Allowed Charges are $30,000. Under the High and High Alternative Plans, you are responsible for 50% non-Network coinsurance until you reach your Plan's out-of-pocket limit plus the $70,000 above HealthChoice Allowed Charges. Your costs would be even greater under the Basic and Basic Alternative Plans. The cost of using a non-Network provider could financially ruin many of our members and demonstrates the importance of using HealthChoice Network Providers to keep out-of-pocket costs as low as possible.

HealthChoice ID Cards

HealthChoice issues one ID card for your health benefits and one ID card for your pharmacy benefits. The health claims administrator issues the health ID card and the pharmacy benefit manager issues the pharmacy ID card.

To request additional or replacement health ID cards, contact the health claims administrator. To request additional or replacement pharmacy ID cards, contact the pharmacy benefit manager. For contact information, see *Plan Identification Information and Notice*.

HealthChoice Basic and Basic Alternative Plans

Outline of Health Benefits*

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

Key Features

Basic Plan

1. **First Dollar Coverage** – The Plan pays 100% of the **first** $500 of Allowed Charges for covered medical services for each covered family member.

2. **Calendar Year Deductible** – You then pay 100% of Allowed Charges for the **next** $500/individual, or $1,000/family, for covered medical services. Only Allowed Charges for covered medical services count toward meeting your deductible.

3. **Coinsurance** – The Plan then pays 50% of Allowed Charges and you pay 50% of Allowed Charges for the **next** $10,000/individual, or $20,000/family, for covered medical services.

4. **Calendar Year Out-of-Pocket Limit** – The Plan then pays 100% of Allowed Charges for covered medical services for the remainder of the calendar year after you pay $5,500/individual, or $11,000/family, for covered medical services. Only Allowed Charges for covered medical services count toward meeting your out-of-pocket limit. You are always responsible for all amounts above the Allowed Charges when you use non-Network providers.

Basic Alternative Plan

1. **First Dollar Coverage** – The Plan pays 100% of the **first** $250 of Allowed Charges for covered medical services for each covered family member.

2. **Calendar Year Deductible** – You then pay 100% of Allowed Charges for the **next** $750/individual, or $1,500/family, for covered medical services. Only Allowed Charges for covered medical services count toward meeting your deductible.

3. **Coinsurance** – The Plan then pays 50% of Allowed Charges and you pay 50% of Allowed Charges for the **next** $10,000/individual, or $20,000/family, for covered medical services.

4. **Calendar Year Out-of-Pocket Limit** – The Plan then pays 100% of Allowed Charges for covered medical services for the remainder of the calendar year after you pay $5,750/individual, or $11,500/family, for covered medical services. Only Allowed Charges for covered medical services count toward meeting your out-of-pocket limit. You are always responsible for all amounts above the Allowed Charges when you use non-Network providers.

*See *Pharmacy Benefits* for information about the pharmacy benefits under the HealthChoice Basic and Basic Alternative Plans.

Basic and Basic Alternative Plans

1. **Pharmacy Network –** You have access to a nationwide pharmacy network.

2. **HealthChoice Provider Network** – The HealthChoice Provider Network helps limit your out-of-pocket costs. See *The Importance of Selecting a HealthChoice Network Provider* on page 4.

Calendar Year Deductible

Basic Plan

Per Member $500
Per Family of 2 or more $1,000
The family deductible can be met with a combination of two or more family members. No one person can meet more than $500 of the family deductible.

Basic Alternative Plan

Per Member $750
Per Family of 2 or more $1,500
The family deductible can be met with a combination of two or more family members. No one person can meet more than $750 of the family deductible.

50% Coinsurance

Basic and Basic Alternative Plans

Per Member $5,000
Per Family of 2 or more $10,000

Calendar Year Out-of-Pocket Limit

Basic Plan

Health – Per Member $5,500
Health – Family of 2 or more $11,000

Basic Alternative Plan

Health – Per Member $5,750
Health – Family of 2 or more $11,500

After meeting the out-of-pocket limit, the Plan pays 100% of Allowed Charges for the remainder of the calendar year. You are always responsible for all amounts above the Allowed Charges when you use non-Network providers.

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

The following charges do not count toward meeting your out-of-pocket limit and do not qualify for 100% payment after your out-of-pocket limit is met:

- Amounts above HealthChoice Allowed Charges
- Non-covered services or charges
- Amounts above maximum benefit limitations

Lifetime Maximum

Health – Per Member ....No Lifetime Maximum

Examples of How Claims are Paid Under the Basic Plan

Member Only Coverage – **1st Claim:** You receive medical services with Allowed Charges of $200 from a Network Provider. **2nd Claim:** You receive services with Allowed Charges of $400. The claims are paid as follows:

	1st Claim	2nd Claim
Allowed Charges	$200	$400
1st Dollar Coverage	$200	$300
Applied to deductible	$0	$100
Your responsibility	$0	$100

Family Coverage – You are covering a spouse and three children. All family members have received $500 in medical services earlier in the plan year covered by the Plan at 100%. You and your spouse both receive $500 (total of $1,000) in additional medical services, which counts toward the $1,000 family deductible. **Claim:** Child A receives services with Allowed Charges of $250. The claim is paid as follows:

	Member	Spouse	Child A	Child B	Child C
First Dollar coverage	$500	$500	$500	$500	$500
$1,000 Family deductible met	$500	$500			
Allowed Charge			$250		
Plan pays at 50%			$125 (50% of $250)		
Your coinsurance (50%)			$125		
Your responsibility			$125		

Non-Network Coverage – **Claim:** You receive medical services from a non-Network provider with billed charges of $9,000. The Allowed Charges are $5,000, which means that the balance of $4,000 is your responsibility because it exceeds Allowed Charges. The claim is paid as follows:

Billed charge	$9,000
Allowed Charges	$5,000
First Dollar coverage	$500
Applied to deductible	$500
Plan pays at 50%	$2,000 (50% of $4,000)
Your coinsurance (50%)	$2,000 (50% of $4,000)
Billed charges - Allowed Charges	$4,000 ($9,000-$5,000)
Your responsibility	$6,500 ($500+$2,000+$4,000)

Examples of How Claims are Paid Under the Basic Alternative Plan

Member Only Coverage – **1st Claim:** You receive medical services with Allowed Charges of $200 from a Network Provider. **2nd Claim:** You receive services with Allowed Charges of $400. The claims are paid as follows:

	1st Claim	2nd Claim
Allowed Charge	$200	$400
1st Dollar Coverage	$200	$ 50
Applied to deductible	$0	$350
Your responsibility	$0	$350

Family Coverage – You are covering a spouse and three children. All family members have received $250 in medical services earlier in the plan year covered by the Plan at 100%. You and your spouse both receive $750 (total of $1,500) in additional medical services, which counts toward the $1,500 family deductible. **Claim:** Child A receives services with Allowed Charges of $250. The claim is paid as follows:

	Member	Spouse	Child A	Child B	Child C
First Dollar coverage	$250	$250	$250	$250	$250
$1,500 Family deductible met	$750	$750			
Allowed Charge			$250		
Plan pays at 50%			$125 (50% of $250)		
Your coinsurance (50%)			$125		
Your responsibility			$125		

Non-Network Coverage – **Claim:** You receive medical services from a non-Network provider with billed charges of $9,000. The Allowed Charges are $5,000, which means that the balance of $4,000 is your responsibility because it exceeds Allowed Charges. The claim is paid as follows:

Billed charge	$9,000
Allowed Charges	$5,000
First Dollar coverage	$250
Applied to deductible	$750
Plan pays at 50%	$2,000 (50% of $4,000)
Your coinsurance (50%)	$2,000 (50% of $4,000)
Billed charges - Allowed Charges	$4,000 ($9,000-$5,000)
Your responsibility	$6,750 ($750+$2,000+$4,000)

HealthChoice High and High Alternative Plans

Outline of Health Benefits*

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

Key Features

High Plan

1. **Calendar Year Deductible** – You must pay a calendar year deductible of $500/individual, or $1,500/family, for medical services including, but not limited to, lab work, x-rays, surgical procedures, and hospital admissions. Only Allowed Charges for covered medical services count toward meeting your deductible. Office visits and certain other copay-related services received from a Network Provider are not subject to the deductible.

2. **Calendar Year Out-of-Pocket Limit** – The Plan pays 100% of Allowed Charges for covered medical services for the remainder of the calendar year after you pay $2,800/individual or $8,400/family for Network services, or $3,300/individual or $9,900/family for non-Network services, in Allowed Charges for covered medical services. Only Allowed Charges for covered medical services count toward meeting your out-of-pocket limit. You are always responsible for all amounts above the Allowed Charges when you use non-Network providers.

High Alternative Plan

1. **Calendar Year Deductible** – You must pay a calendar year deductible of $750/individual, or $2,250/family, for medical services including, but not limited to, lab work, x-rays, surgical procedures, and hospital admissions. Only Allowed Charges for covered medical services count toward meeting your deductible. Office visits and certain other copay-related services received from a Network Provider are not subject to the deductible.

2. **Calendar Year Out-of-Pocket Limit** – The Plan pays 100% of Allowed Charges for covered medical services for the remainder of the calendar year after you pay $3,050/individual or $9,150/family for Network services, or $3,550/individual or $10,650/family for non-Network services, in Allowed Charges for covered medical services. Only Allowed Charges for covered medical services count toward meeting your out-of-pocket limit. You are always responsible for all amounts above the Allowed Charges when you use non-Network providers.

High and High Alternative Plans

1. **Network Copays** – Copays are $30 for physician office visits and other copay-related services received from a physician. The $30 copay applies to general practitioners, internal medicine physicians, OB/GYNs, pediatricians, physician assistants, nurse practitioners, and physician type services received at rural health, VA, Military, and Indian Clinics. Copays for specialist office visits and other copay-related services received from a specialist are $50. Charges for additional services such as lab work and x-rays count toward your deductible first, then the Plan pays 80% (50% for non-Network providers) of the Allowed Charges

*See *Pharmacy Benefits* for information about the pharmacy benefits under the HealthChoice High and High Alternative Plans.

for covered medical services. **Plan benefits for services received from non-Network providers are based on deductible and coinsurance instead of copays.**

2. **Coinsurance** – When you use a HealthChoice Network Provider, the Plan pays 80% of Allowed Charges for covered medical services and you pay 20%. When services are provided by a non-Network provider, the Plan pays 50% of Allowed Charges and you pay 50% of Allowed Charges, plus you pay all amounts above the Allowed Charges. You are always responsible for the cost of all non-covered services regardless of your provider's Network or non-Network status.

3. **Pharmacy Network –** You have access to a nationwide pharmacy network.

4. **HealthChoice Provider Network** – The HealthChoice Provider Network helps limit your out-of-pocket costs. See *The Importance of Selecting a HealthChoice Network Provider* on page 4.

Calendar Year Deductible

High Plan

Per Member $500
Family of 3 or more $1,500
The family deductible can be met with a combination of three or more family members. No one person can meet more than $500 of the family deductible.

High Alternative Plan

Per Member $750
Family of 3 or more $2,250
The family deductible can be met with a combination of three or more family members. No one person can meet more than $750 of the family deductible.

Coinsurance

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

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

Calendar Year Out-of-Pocket Limits

High Plan

Network

Health – Per Member $2,800
Health – Per Family...$8,400

Non-Network

Health – Per Member $3,300
Health – Per Family..$9,900

High Alternative Plan

Network

Health – Per Member $3,050
Health – Per Family..$9,150

Non-Network

Health – Per Member $3,550
Health – Per Family..$10,650

High and High Alternative Plans

After meeting the out-of-pocket limit, the Plan pays 100% of Allowed Charges for the remainder of the calendar year. You are always responsible for all amounts above the Allowed Charges when you use non-Network providers.

Additional Copays

High and High Alternative Plans

Each **non-Network** hospital confinement ....Additional $300
Each Emergency Room Visit to a **Network** or **non-Network** Facility ....Additional $100
The additional emergency room copay is waived if the patient is admitted or if death occurs prior to admission.

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

The following charges do not count toward meeting the out-of-pocket limits and do not qualify for 100% payment after the out-of-pocket limits are met:

- Amounts above HealthChoice Allowed Charges
- Amounts above maximum benefit limitations
- Non-covered services or charges
- Network copays
- Emergency room copays
- Non-Network hospital confinement copays

Lifetime Maximum

Health Benefits – Per Member ....No Lifetime Maximum

Examples of How Claims are Paid Under the High Plan

Member Only Coverage – **1st Claim:** You receive medical services with Allowed Charges of $500 from a Network Provider. **2nd Claim:** You then receive medical services with Allowed Charges of $800 from a Network Provider. The claims are paid as follows:

	1st Claim	2nd Claim
Allowed Charges	$500	$800
Applied to deductible	$500	$0
Deductible already paid	$0	$500
Amount considered for Plan benefits	$0	$800
Plan pays at 80% (Network)	$0	$640 (80% of $800)
Your coinsurance (20%)	$0	$160 (20% of $800)
Your responsibility	$500	$160

Family Coverage – You are covering a spouse and two children. The family deductible has been met as indicated below. **Claim:** You receive medical services with Allowed Charges of $400 from a Network Provider. The claim is paid as follows:

	Spouse	Child A	Child B
Family deductible paid	$500	$500	$500

Allowed Charges	$400
Deductible already paid	$1,500
Applied to deductible	$0
Amount considered for Plan benefits	$400
Plan pays at 80% (Network)	$320 (80% of $400)
Your coinsurance (20%)	$80 (20% of $400)
Your responsibility	$80

Emergency Room Coverage – **1st Claim:** You receive services in the emergency room of a Network Hospital. These services have Allowed Charges of $2,000 and you have not yet met the calendar year deductible. **2nd Claim:** You again receive services in the emergency room of a Network Hospital. The Allowed Charges for these services are $800. The claims are paid as follows:

	1st Claim	2nd Claim
Allowed Charges for services	$2,000	$800
Emergency room copay	$100	$100
Applied to deductible	$500	$0
Amount considered for Plan benefits	$1,400 ($2,000-$100-$500)	$700 ($800-$100)
Plan pays at 80% (Network)	$1,120 (80% of $1,400)	$560 (80% of $700)
Your coinsurance (20%)	$280 (20% of $1,400)	$140 (20% of $700)
Your responsibility	$880 ($100+$500+$280)	$240 ($100+$140)

Non-Network Coverage – You already paid the $500 calendar year deductible. **Claim:** You have surgery at a non-Network hospital with billed charges of $9,000. The HealthChoice Allowed Charges are $5,000, so the balance of $4,000 is your responsibility because it is more than the Allowed Charges. The claim is paid as follows:

Billed charges	$9,000
Allowed Charges	$5,000
Non-network hospital confinement copay	$300
Amount considered for Plan benefits	$4,700 ($5,000-$300)
Plan pays at 50% (non-Network)	$2,350 (50% of $4,700)
Your coinsurance (50%)	$2,350 (50% of $4,700)
Billed charges - Allowed Charges	$4,000 ($9,000-$5,000)
Your responsibility	$6,650 ($300+$2,350+$4,000)

Examples of How Claims are Paid Under the High Alternative Plan

Member Only Coverage – **1st Claim:** You receive medical services with Allowed Charges of $750 from a Network Provider. **2nd Claim:** You then receive medical services with Allowed Charges of $800 from a Network Provider. The claims are paid as follows:

	1st Claim	2nd Claim
Allowed Charges	$750	$800
Applied to deductible	$750	$0
Deductible already paid	$0	$750
Amount considered for Plan benefits	$0	$800
Plan pays at 80% (Network)	$0	$640 (80% of $800)
Your coinsurance (20%)	$0	$160 (20% of $800)
Your responsibility	$750	$160

Family Coverage – You are covering a spouse and two children. The family deductible has been met as indicated below.
Claim: You receive medical services with Allowed Charges of $400 from a Network Provider. The claim is paid as follows:

	Spouse	Child A	Child B
Family deductible paid	$750	$750	$750

Allowed Charges	$400
Deductible already paid	$2,250
Applied to deductible	$0
Amount considered for Plan benefits	$400
Plan pays at 80% (Network)	$320 (80% of $400)
Your coinsurance (20%)	$80 (20% of $400)
Your responsibility	$80

Emergency Room Coverage – **1st Claim:** You receive services in the emergency room of a Network Hospital. These services have Allowed Charges of $2,000 and you have not yet met the calendar year deductible. **2nd Claim:** You again receive services in the emergency room of a Network Hospital. The Allowed Charges for these services are $800. The claims are paid as follows:

	1st Claim	2nd Claim
Allowed Charges	$2,000	$800
Emergency room copay	$100	$100
Applied to deductible	$750	$0
Amount considered for Plan benefits	$1,150 ($2,000-$100-$750)	$700 ($800-$100)
Plan pays at 80% (Network)	$920 (80% of $1,150)	$560 (80% of $700)
Your coinsurance (20%)	$230 (20% of $1,150)	$140 (20% of $700)
Your responsibility	$1,080 ($100+$750+$230)	$240 ($100+$140)

Non-Network Coverage – You already paid the $750 calendar year deductible. **Claim:** You have surgery at a non-Network hospital with billed charges of $9,000. The HealthChoice Allowed Charges are $5,000, so the balance of $4,000 is your responsibility because it is more than the Allowed Charges. The claim is paid as follows:

Billed charges	$9,000
Allowed Charges	$5,000
Non-network hospital confinement copay	$300
Amount considered for Plan benefits	$4,700 ($5,000-$300)
Plan pays at 50% (non-Network)	$2,350 (50% of $4,700)
Your coinsurance (50%)	$2,350 (50% of $4,700)
Billed charges - Allowed Charges	$4,000 ($9,000-$5,000)
Your responsibility	$6,650 ($300+$2,350+$4,000)

Certification

Certification is a review process used to determine if services are medically necessary according to HealthChoice guidelines. Certification is performed by either the HealthChoice certification administrator or by the HealthChoice HealthCare Management Division (HCMD) depending on the type of services.

Your provider must obtain certification under certain situations, including when you or your covered dependents:

- Are admitted to a hospital or are advised to enter a hospital
- Require a certain surgical procedure that is performed in an outpatient facility
- Require a certain diagnostic imaging procedure
- Have an observation stay that lasts longer than 24 hours
- Have HealthChoice as the second or third carrier

Guidelines

Certification is required within three working days prior to scheduled hospital admissions, specific surgical procedures in an outpatient facility, and specific diagnostic imaging procedures, or within one day following emergency/urgent services. To request certification, your provider must contact the certification administrator. For contact information, see *Plan Identification Information and Notice*.

If certification is not initiated and approved within the time frames described above but is approved after services are performed, and all other Plan rules and guidelines are met, a 10% penalty is applied. If certification is initiated and denied, either before or after services are performed, because medical necessity guidelines are not met, the claim is denied.

When using a non-Network provider, you are responsible for paying the 10% penalty and for any services that are not medically necessary according to HealthChoice guidelines.

Hospitalization

Inpatient hospital services require certification through the certification administrator. See *Guidelines* in this section.

Surgical Procedures

The following surgical procedures require certification through the certification administrator. See *Guidelines* in this section.

- Blepharoplasty - Correction to the eye lid
- Rhinoplasty - Reconstruction of the nose

- Breast implant removal - Removal of breast implants
- Scar revision - Removal of scar tissue
- Breast reduction - Reduction in breast size
- Panniculectomy - Reduction in abdomen size
- Surgical treatment of varicose veins
- Spinal cord stimulator (neurostimulator) placement

Diagnostic Imaging

The following diagnostic imaging procedures require certification through the certification administrator. See *Guidelines* in this section.

- Sinus CT / MRI
- Head / Brain CT / MRI
- Chest CT including spiral CT (RAD)
- Spine CT / MRI
- Shoulder MRI
- PET Scans

Other Services That Require Certification

The following services require certification through the HealthChoice Health Care Management Division. To request certification, your provider must contact the HealthChoice Health Care Management Division at 1-405-717-8879 or toll-free 1-800-543-6044 ext. 8879. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

- Non-emergency ground or air ambulance
- Hospice
- Physical medicine services
- Chiropractic care
- Durable medical equipment
- Oral surgery
- Home health care services
- Speech therapy for ages 17 and younger
- Mental health outpatient services
- Botox injections
- TMD treatment

This list is not all-inclusive. See *Covered Services, Supplies, and Equipment*.

For authorization processes related to pharmacy benefits, see *Pharmacy Benefits.*

Covered Services
Supplies and Equipment

Following is a list of covered services, supplies, and equipment. Benefits are based on the use of Network or non-Network Providers and the provisions of your plan. See pages 5-9 for Basic and Basic Alternative Plan guidelines and pages 10-15 for High and High Alternative Plan guidelines.

Acupuncture
- Covered only as anesthesia for surgery

Allergy Serum
- Subject to deductible and coinsurance

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

Ambulance
- Medically necessary ground or air services
- Non-emergency ground and air ambulance requires certification through the HealthChoice Health Care Management Division
- See *Certification* section

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

Anesthesia
- Eligible services for covered illness or surgery
- Includes services provided by a Certified Registered Nurse Anesthetist (CRNA)

Birthing Center

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

Cardiac Rehabilitation

Chelation Therapy
- Covered only for heavy metal poisoning

Chiropractic Therapy
- Limited to 60 visits per calendar year
- For High and High Alternative Network benefits, office visit copay applies per visit

- Visits exceeding 20 per calendar year require certification through the HealthChoice Health Care Management Division
- See *Certification* section

Christian Science Nurse

- Limited to 15 visits per calendar year

Christian Science Practitioner

- For High and High Alternative Network benefits, office visit copay applies per visit

Contraceptive Services

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

Dental Accident

- Medically necessary treatment for the repair of injury to sound natural teeth or gums, provided the accident occurs while the individual is a member of the Plan and the treatment is performed within 12 months following the date of the accident
- Review is required

Diabetic Supplies

- Covered under pharmacy benefits
- See *Pharmacy Benefits* section

Diagnostic X-Ray, Including Ultrasound

- See *Ancillary Services* in this section

Durable Medical Equipment and Supplies

- Certification through the HealthChoice Health Care Management Division is required
- See *Certification* section

Emergency Room Treatment

- Medically necessary services and supplies for treatment of an emergency illness or injury
- Use of a Network Facility does not guarantee the treating physician or any other provider of services is a HealthChoice Network Provider
- See *Emergency Care Coverage* section

Eyeglasses/Corrective Lenses

- Covered only for the first pair after cataract surgery

Foot Orthotics

- Covered for diabetics only
- Certification through the HealthChoice Health Care Management Division is required
- See *Certification* section

Fundus Photography

- Covered for diabetes, glaucoma, and macular degeneration

Gynecological Examinations

- Subject to calendar year limits for routine examinations
- For High and High Alternative Network benefits, office visit copay applies per visit
- Laboratory charges for a pap test are subject to the deductible and coinsurance
- See *Preventive Health Care and Immunizations* section

Hearing Exams and Tests

- Limited to one screening exam and one test per calendar year
- Does not include a comprehensive hearing exam
- For High and High Alternative Network benefits, office visit copay applies per visit – not subject to the deductible

Hearing Aids

- Covered only for participating dependent children up to the age of 18
- Must be prescribed, filled, and dispensed by a licensed audiologist
- Limited to one every 48 months per impaired ear
- Up to four additional ear molds per year for children up to two years of age
- Certification through the HealthChoice Health Care Management Division is required
- See *Certification* section

Home Health Care

- May be approved for up to 100 visits per calendar year
- Monitored by a HealthChoice nurse case manager
- Certification through the HealthChoice Health Care Management Division is required
- See *Certification* section

Home Health Care Medications

- Eligible home health care prescription medications are covered under the health benefit
- Certain home health care medications such as Colymycin M, Pulmozyme, Tobramycin, and Dornase Alfa Inhaler Solution are covered under the pharmacy benefit; for information, contact the pharmacy benefit manager. For contact information, see *Plan Identification Information and Notice*

Home Intravenous (I.V.) Therapy

- Certification through the HealthChoice Health Care Management Division is required
- See *Certification* section

Hospice

- Requires a physician's statement of life expectancy of six months or less
- Certification through the HealthChoice Health Care Management Division is required
- See *Certification* section

Hospital

- See *Inpatient Hospital Benefits* or *Outpatient Hospital/Facility Services* in this section

Immunizations for Adults and Children

- Covered in accordance with the current Centers for Disease Control and Prevention guidelines
- Administration charges are subject to deductible and coinsurance
- See *Preventive Health Care and Immunizations* section

Infertility Services

- Covered services related to the diagnosis and treatment of infertility
- Prescription drugs for treatment of infertility
- See *Plan Exclusions and Limitations* section for services that are not covered

Inpatient Hospital Benefits

- Semi-private room - unlimited days if medically necessary
- Includes intensive care, coronary care, and all other covered hospital services, such as physician hospital visits, anesthesia, radiology, and laboratory
- High and High Alternative Plan members must pay an additional copay for each non-Network hospital stay
- Certification through the certification administrator is required
- See *Certification* section

Laboratory

- Includes laboratory work related to physical examinations
- See *Ancillary Services* in this section

Mammogram (Radiological or Digital)

- See *Preventive Health Care and Immunizations* section

Manipulative Therapy

- See *Physical Therapy/Physical Medicine* in this section

Maternity Care

- Includes hospital and delivery with prenatal and postnatal care
- Includes one skilled nurse home health visit if the delivery is at home or in a birthing center; certification through the HealthChoice Health Care Management Division is required
- See *Certification* section
- Includes lab work associated with prenatal visits
- Includes the Mommy & Me Program. See *Mommy & Me* in the *General Provisions* section.
- You must complete a change form within 30 days following the birth to enroll the baby in the Plan; a separate calendar year deductible applies to the newborn. See *Dependent Coverage* in the *Eligibility* section

Mental Health Treatment

Inpatient

- High and High Alternative Plan members pay an additional copay for each non-Network hospital stay
- Certification through the certification administrator is required for inpatient mental health, day treatment, and residential treatment
- See *Certification* section

Outpatient

- Outpatient benefits that exceed 15 visits per calendar year require certification through the HealthChoice Health Care Management Division
- See *Certification* section

Nurse Midwife Services

- Provider must be licensed by the state in which services are provided

Occupational Therapy

- Limited to 60 visits per calendar year
- Visits exceeding 20 per calendar year require certification through the HealthChoice Health Care Management Division
- See *Certification* section

Office Visits

- Medically necessary services for evaluation and medical management of an illness or injury, including preventive care, routine age-based adult examinations, and well child care
- For High and High Alternative Network benefits, office visit copay applies per visit
- See *Ancillary Services* in this section

Oral Surgery

- Includes the removal of tumors or cysts
- Does not include removal of wisdom teeth
- For emergency oral surgery, see *Emergency Room Treatment* in this section
- Certification through the certification administrator is required
- See *Certification* section

Organ Transplants

- Medically necessary treatment for the non-experimental transplant of cornea, peripheral stem cell, bone marrow, skin, liver, heart, lung, pancreas, or kidney
- The organ or tissue must be of human origin
- The donor does not have to be a member of the Plan
- Procurement and harvesting are eligible for coverage
- Non-member donor medical expenses are limited to 90 days after transplant
- Certification through the certification administrator is required
- See *Certification* section

Ostomy Supplies

- Wafers and bags are covered under pharmacy benefits; other ostomy supplies are covered under health benefits

Outpatient Chemotherapy

Outpatient Hospital/Facility Services

- Includes hospital, surgery facility, and all other covered outpatient services, including diagnostic services in conjunction with a surgical procedure or non-emergency care
- Certification through the certification administrator is required for certain surgical procedures performed in an outpatient facility
- See *Certification* section

Oxygen

- Certification through the HealthChoice Health Care Management Division is required
- See *Certification* section

Pharmacy

- See *Pharmacy Benefits* section

Physical Therapy/Physical Medicine

- Limited to 60 visits per calendar year
- Visits exceeding 20 per calendar year require certification through the HealthChoice Health Care Management Division
- For High and High Alternative Network benefits for physical examinations, you pay an office visit copay applies and all additional ancillary services and treatments are subject to the deductible and coinsurance
- See *Certification* section

Preventive Services

- See *Preventive Health Care and Immunizations* section

Prostheses/Orthopedic Appliances

- Covered as durable medical equipment
- Certification through the HealthChoice Health Care Management Division is required
- See *Certification* section

Rehabilitation (Inpatient)

- Certification through the certification administrator is required
- See *Certification* section

Skilled Nurse Facility

- Services prescribed by a physician and provided in a licensed, skilled nurse facility when medically necessary
- Limited to a maximum of 100 days per calendar year
- Certification through the certification administrator is required
- See *Certification* section
- High and High Alternative Plan members pay an additional copay for each stay in a non-Network facility

Speech Therapy

- Covered for restoring existing speech lost due to disease or injury. Therapy must be expected to restore the level of speech the participant had before the disease or injury.
- Not covered for learning disabilities or birth defects
- Limited to 60 visits per calendar year
- For ages 17 and younger, visits exceeding 20 per calendar year require certification through the HealthChoice Health Care Management Division
- See *Certification* section

Standby Services

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

Substance Use Disorder

Inpatient

- Certification through the certification administrator is required for inpatient substance abuse, day treatment, and residential treatment

- See *Certification* section
- High and High Alternative Plan members must pay an additional copay for each non-Network hospital stay

Outpatient

- Visits exceeding 15 per calendar year require certification through the HealthChoice Health Care Management Division
- See *Certification* section

Surgeon, Assistant Surgeon, Perfusionist, and Anesthesiologist

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

Surgical Benefits

- Inpatient or outpatient facility for covered illness or injury
- See *Outpatient Hospital/Facility Services* in this section
- Certification required for inpatient admissions and certain outpatient surgeries
- See *Certification* section

Temporomandibular Joint Dysfunction (TMD)

- Certification required through the HealthChoice Health Care Management Division
- See *Certification* section

Thermograms

- Covered for whiplash only

Tobacco Cessation Product Therapy

- $0 copay for certain prescription tobacco cessation medications purchased at a Network Pharmacy
- Limited to two 90-day courses of a prescription product per year
- Over-the-counter nicotine replacement therapy products (patches, gum, and lozenges) and telephone coaching are available at no charge to HealthChoice members through a partnership with the Tobacco Settlement endowment Trust (TSET) and Alere Well Being
- Other over-the-counter medications are not covered

Transplants

- See *Organ Transplants* in this section

Ultrasound

- See *Ancillary Services* in this section

Ultraviolet Treatment - Actinotherapy

- Covered for psoriasis only

Wigs and Scalp Prostheses

- Covered for individuals who experience hair loss due to radiation or chemotherapy treatment resulting from a covered medical condition
- Coverage is subject to annual deductibles and coinsurance
- Maximum annual benefit is $150
- Must be obtained from a licensed cosmetologist or DME provider

Emergency Care Coverage

An emergency is defined as a sudden and unexpected symptom that you could reasonably expect the absence of immediate medical attention would result in placing your health, or the health of others, in serious jeopardy.

High and High Alternative Plans

In addition to the $500 deductible for the High Plan or the $750 deductible for the High Alternative and the coinsurance required under each plan, there is a $100 emergency room copay for each emergency room visit. This copay is your responsibility regardless of the facility's Network or non-Network status. This copay is waived if the patient is admitted or death occurs prior to admission. If emergency treatment cannot be provided and the patient is referred to another emergency room for treatment, the emergency room copay is waived on the emergency room that could not provide treatment.

If an inpatient admission occurs as a result of an emergency, you must notify the certification administrator within one working day of the admission. For contact information, see *Plan Identification Information and Notice*.

Basic and Basic Alternative Plans

The benefits of the Basic and Basic Alternative Plans do not require you to pay the $100 emergency room copay.

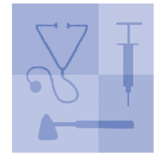
If an inpatient admission occurs as a result of an emergency, you must notify the certification administrator within one working day of the admission. For contact information, see *Plan Identification Information and Notice*.

Non-Network Services

Non-Network emergency services are reimbursed and subject to Network provider rates and benefits. All non-Network ancillary services incurred in the emergency room setting on the same day as the emergency room hospital services are covered at the Network rate and benefits. You are still responsible for non-covered services and amounts over Allowed Charges.

You may qualify for additional benefits when, as the result of an emergency, you have no option but to seek care at a non-Network emergency room or facility. To qualify, you must notify the HealthChoice Health Care Management Division by calling 1-405-717-8879 or toll-free 1-800-543-6044, ext. 8879 for review. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

Preventive Health Care and Immunizations



Preventive Services Visits – High, High Alternative, Basic, and Basic Alternative Plans

One preventive services visit per calendar year, including one comprehensive metabolic panel and one comprehensive lipid panel, is covered at 100% with no copay or out-of-pocket costs when using a Network Provider.

Routine Examinations for Men

Age 18 through 35 – 1 exam every 2 calendar years
Age 36 and older – 1 exam every calendar year

Prostate-Specific Antigen (PSA) Test – High, High Alternative, Basic, and Basic Alternative Plans
Age 50 and older – 1 routine PSA screening every calendar year. The maximum benefit is $65. The deductible and copay are waived when using a Network Provider.

Note: Claims with a non-routine diagnosis are subject to all Plan provisions including deductible and coinsurance.

Routine Examinations for Women (including gynecological exam)

Age 18 and older – 1 exam every calendar year

Mammograms – High and High Alternative
Under age 40 – 1 mammogram per year, $30 copay*/$50 copay specialist**
Age 40 and older – 1 mammogram per year, Plan pays 100% when using a Network Provider***

Mammograms – Basic and Basic Alternative Plans
Under age 40 – 1 mammogram per year, subject to Plan provisions
Age 40 and older* – 1 mammogram per year, Plan pays 100% when using a Network Provider**

*The $30 copay applies to general practitioners, internal medicine physicians, OB/GYNs, pediatricians, physician assistants, and nurse practitioners.
**Women age 39 and under can get one mammogram per year for $30/$50 when using a Network Provider. Any additional mammograms during the year, or any mammograms provided by a non-Network provider are subject to deductible and coinsurance.
***For women age 40 and older, the deductible and coinsurance are waived for one mammogram per year when provided by either a Network or non-Network Provider. The maximum benefit for a mammogram performed by a non-Network provider is $115. Any additional mammograms during the year are subject to deductible and coinsurance.

Preventive Services – High, High Alternative, Basic, and Basic Alternative Plans

Effective January 1, 2012, the following preventive services are covered at 100% of Allowed Charges when using a HealthChoice Network Provider for members who meet the clinical criteria. The preventive services are based upon government recommendations.

Preventive Service		Member Information
1.	Abdominal Aortic Aneurysm, Screening	One per calendar year for men, age 65 through 75, pre-Medicare Billing code: G0389
2.	Alcohol Misuse Screening and Behavioral Counseling Interventions	Two total per calendar year, for members and dependents age 18 and older Billing codes: 99408, 99409
3.	Aspirin for the Prevention of Cardiovascular Disease	Over-the-counter aspirin is covered for members and dependents age 45-79 Pharmacy benefit only Prescription required
4.	Asymptomatic Bacteriuria in Adults, Screening	One per calendar year for women age 18 and older with a pregnancy diagnosis Billing code: 81007
5.	Breast cancer, Screening See mammograms in this section	One per calendar year for women age 40 and older Billing code: 96040
6.	Breast and Ovarian Cancer Susceptibility Genetic Risk Assessment and BRCA Mutation Testing (6a) Prophylactic chemo for women with breast cancer	One per calendar year for women age 18 and older Billing code: 96040 (6a) Handled on a case by case basis
7.	Breastfeeding, Primary Care Interventions to Promote	Included in the prenatal and postpartum care
8.	Cervical Cancer, Screening	One per calendar year for women age 18 and older Billing codes: 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175, G0101
9.	Chlamydial Infection, Screening	One free per calendar year for women age 18 and older Billing code: 87110

	Preventive Service	Member Information
10.	Colorectal Cancer, Screening	One total Fecal Occult Blood Test per calendar year for members and dependents Billing codes: 82270, 82271, 82272, 82274 One colon/sigmoidoscopy every three years for members and dependents age 50 through 75 with diagnosis codes V76.41 and V76.51 Billing codes: 45378, G0121, G0105 and any other CPT/HCPCS for colon/sigmoidoscopies
11.	Congenital Hypothyroidism, Screening	One per calendar year for children up to age 1 Billing codes: 84443
12.	Dental Caries in Preschool Children, Prevention	Pharmacy Benefit Only: Oral fluoride - all dosage forms for children through age 5 Prescription required
13.	Depression (Adults), Screening	One evaluation and management visit per calendar year for members and dependents age 18 and older with a primary diagnosis of depression
14.	Diet, Behavioral Counseling in Primary Care to Promote a Healthy Diet	Any combination of the three billing codes for members and dependents age 18 and older Maximum of three total per calendar year Billing codes: 97802, 97803, 97804
15.	Gonorrhea, Screening	One screening code total per calendar year for women age 18 and older Billing codes: 87590, 87591, 87592
16.	Gonorrhea, Prophylactic Medication	Pharmacy Benefit Only: Erythromycin Opthalmic ointment for infants age 1 or younger
17.	Hearing Loss in Newborns, Screening	Included in office visit, age 1 or younger
18.	Hepatitis B Virus Infection, Screening	One per calendar year for women age 18 and older with a diagnosis of pregnancy Billing code: 87340
19.	High Blood Pressure, Screening	Included in the well child care visit for members and dependents age 18 and 19 Included in the preventive services visit for members and dependents age 20 and older
20.	HIV, Screening	One per calendar year for members and dependents age 12 and older Billing code: 86701
21.	Iron Deficiency Anemia, Prevention	Pharmacy Benefit Only: Over-the-counter iron solution drops covered for infants less than age 1. This does not include the various baby formulas. Prescription required.
22.	Iron Deficiency Anemia, Screening	Included in prenatal services for pregnant women.

	Preventive Service	Member Information
23.	Lipid Disorders in Adults, Screening	One per calendar year for members and dependents age 20 and older Billing code: 80061
24.	Major Depressive Disorder in Children and Adolescents, Screening	One total per calendar year for any evaluation and management code for members and dependents age 12 through 17 with a primary diagnosis of major depression
25.	Obesity in Adults, Screening	One total per calendar year for any evaluation and management code for members and dependents age 18 and older with a diagnosis of morbid obesity Additional benefits are available in combination with the benefits available for Diet, Behavioral Counseling in Primary Care to Promote a Healthy Diet Maximum of 3 total per calendar year Billing codes: 97802, 97803, 97804
26.	Osteoporosis in Postmenopausal Women	One total per calendar year for women age 60 and older Billing codes: 77080, 77081
27.	Phenylketonuria, Screening	One per calendar year for infants up to age 1 Billing code: 84030
28.	Rh (D) Incompatibility, Screening	Two per calendar year for women Billing code: 86901
29.	Sexually Transmitted Infections, Counseling	Three total per calendar year for members and dependents age 12 and older Billing code: 99412
30.	Sickle Cell Disease, Screening	One per calendar year for infants up to age 1 Billing code: 82489
31.	Syphilis Infection, Screening	One total per calendar year for members and dependents age 18 and older Billing code: 86592, 86593
32.	Tobacco Use and Tobacco-Caused Disease, Counseling	One free per calendar year for members and dependents age 18 and older Billing code: 99406 Pharmacy Benefit Only: Tobacco cessation products, over-the-counter and prescription, for members and dependents age 18 and older Prescription required Limited to two 90-day courses per year
33.	Type 2 Diabetes Mellitus in Adults, Screening	One every three years for members and dependents age 18 and older Billing code: 82947

	Preventive Service	Member Information
34.	Visual Impairment in Children Under Age 5, Screening	One total per calendar year for members and dependents through age 4 Billing codes: 99172, 99173
35.	Folic Acid	Pharmacy Benefit Only: Over-the-counter folic acid supplement, 0.4 to 0.8 mg/day, for women through age 50 Prescription required
36.	Childhood Obesity Screening and Interventions	One total per calendar year for members and dependents age 1 through 19 with a primary diagnosis of obesity Billing codes: 99383, 99384, 99385, 99393, 99394, 99395
37.	Cover Pediatric Immunizations (according to ACIP Schedule)	Routine immunizations for children according to the current Centers for Disease Control and Prevention guidelines
38.	Adult Immunizations	Routine immunizations for adults according to the current Centers for Disease Control and Prevention guidelines
39.	Pediatric Preventive Health Care "Bright Futures"	Children up to Age 20 Age 0 to 12 months, 8 visits Billing codes: 99381,99391 Age 1 year through 2 years, 4 visits per age Billing codes: 99382, 99392 Age 3 years through 5 years, 2 visits per age Billing codes: 99382, 99383, 99392, 99393 Age 6 years through 11 years, 1 visit per age Billing codes: 99383, 99393 Age 12 years through 17 years, 1 visit per age Billing codes: 99384, 99394 Age 18 years through 19 years, 1 visit per age Billing codes: 99385, 99395
40.	Adult Preventive Exam	One total per calendar year for members and dependents age 20 and over Billing codes: 99385, 99386, 99387, 99395, 99396, 99397

Note: These services are subject to change.

Immunizations for Adults – High, High Alternative, Basic, and Basic Alternative Plans

The following routine immunizations are covered according to the current Centers for Disease Control and Prevention guidelines:

- Flu
- Hepatitis B for those in high-risk groups
- Human Papillomavirus (HPV)
- Pneumonia
- Shingles
- Tetanus

This list is not all-inclusive.

Immunizations for adults are paid at 100% of Allowed Charges; however, any charge for administration of the immunization or office visit is subject to Plan provisions regarding copays, deductibles, and coinsurance. See note below.

Immunizations for Children – High, High Alternative, Basic, and Basic Alternative Plans

Routine immunizations for healthy infants and children are covered according to the current Centers for Disease Control and Prevention guidelines. Immunizations for children are paid at 100% of Allowed Charges; however, any charge for administration of the immunization or office visit is subject to Plan provisions regarding copays, deductibles, and coinsurance. See note below.

Note: Vaccines obtained at a walk-in clinic, pharmacy, etc., such as those giving the flu vaccine, typically are not covered by HealthChoice.

- Vaccines must be obtained from a recognized health provider to be covered by HealthChoice. Your provider may charge for an office visit or for the administration of the vaccine; these charges are subject to your plan's copays, deductibles, and coinsurance.
- Vaccines (serums) are covered under your plan's health benefit at 100% of Allowed Charges.
- **Vaccines are not covered under your plan's pharmacy benefit.**
- If you use a non-Network provider, you may be balance billed for amounts above Allowed Charges.
- Certain pharmacists have contracted with HealthChoice to provide health services. Vaccines administered by these pharmacists are still covered under your plan's health benefit.

Pharmacy Benefits

The pharmacy benefits for the HealthChoice High, High Alternative, Basic, and Basic Alternative Plans are identical and include the following features:

- Electronic point of sale claims processing
- An extensive pharmacy network
- Coverage of up to a 90-day supply of medications
- Coverage of certain tobacco cessation medications for no copay

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

HealthChoice pharmacy benefits include the following provisions:

- Generic medications are Preferred medications.
- If no generic exists, then a Preferred medication is usually the next least expensive choice.
- If you choose a non-Preferred medication instead of a Preferred medication, you are responsible for the higher non-Preferred copay.
- If you choose a brand-name medication when a generic is available, you are responsible for the difference in cost, plus the copay.
- **The generic-brand cost difference, the non-Preferred copay, medications purchased at non-Network pharmacies, and excluded medications do not count toward your medical deductible or pharmacy out-of-pocket limit.**
- Certain medications require prior authorization for coverage. See *Pharmacy Prior Authorization*.
- Ostomy bags and wafers are covered under pharmacy benefits and should be purchased at a HealthChoice Network Pharmacy; other ostomy supplies are covered under health benefits.
- Diabetic supplies, including insulin syringes with needles, testing strips, lancet devices, and glucometers are covered under pharmacy benefits; quantity limitations apply.
- Home health medications such as Colymycin M, Pulmozyme, Tobramycin, and Dornase Alfa Inhaler Solution are covered under pharmacy benefits rather than health benefits.

HealthChoice Pharmacy Network

In Oklahoma, there are more than 900 pharmacies that participate in the HealthChoice Pharmacy Network. Nationwide, there are nearly 60,000 participating pharmacies. To locate a HealthChoice Network Pharmacy, click *Find a Provider* in the top menu bar of our website at **www.sib.ok.gov** or **www.healthchoiceok.com** or contact the pharmacy benefit manager. For contact information, see *Plan Identification Information and Notice*.

Network Pharmacy Benefits

Medication Type	Up to a 30-Day Supply of a Medication	Up to a 90-Day Supply of a Medication
Generic	• You pay cost of medication up to a maximum copay of $10.	• You pay cost of medication up to a maximum copay of $25.
Preferred brand-name	• If cost of medication is $60 or less, you pay maximum copay of $15 or cost of medication, if less. • If cost of medication is more than $60, you pay 25% of cost up to a maximum copay of $30.	• If cost of medication is $120 or less, you pay maximum copay of $30 or cost of medication, if less. • If cost of medication is more than $120, you pay 25% of cost up to a maximum copay of $60.
Non-Preferred brand-name	• If cost of medication is $60 or less, you pay maximum copay of $30 or cost of medication, if less. • If cost of medication is more than $60, you pay 50% of cost up to a maximum copay of $60.	• If cost of medication is $120 or less, you pay maximum copay of $60 or cost of medication, if less. • If cost of medication is more than $120, you pay 50% of cost up to a maximum copay of $120.
Specialty Medications Specialty medications are covered for up to a 30-day supply and only when ordered through Accredo Health. Copays are as follows: • Preferred medication – $60 copay • Non-Preferred medication – $120 copay		
All Plan provisions apply. Only costs for Preferred medications purchased at Network Pharmacies apply to the annual $2,500 out-of-pocket limit. Some medications are subject to prior authorization and/or quantity limitations. If you choose a brand-name medication when a generic is available, you are responsible for the difference in the cost in addition to the copay.		
HealthChoice S-Account Plan – The pharmacy benefits above apply after the combined medical and pharmacy deductible ($1,500 individual/$3,000 family) has been met.		

Non-Network Pharmacy Benefits

Preferred Medication	Non-Preferred Medication
• If cost of medication is $90 or less, you pay maximum copay of $45 or cost of medication, if less, plus dispensing fee. • If cost of medication is more than $90, you pay 50% of ingredient cost, plus dispensing fee (no maximum).	• If cost of medication is $160 or less, you pay maximum copay of $120 or cost of medication if less, plus dispensing fee. • If cost of medication is more than $160, you pay 75% of ingredient cost, plus dispensing fee (no maximum).
All Plan provisions apply. Only costs for Preferred medications purchased at Network Pharmacies apply to the annual $2,500 out-of-pocket limit.	
HealthChoice S-Account Plan – The pharmacy benefits above apply after the combined medical and pharmacy deductible ($1,500 individual/$3,000 family) has been met.	

Calendar Year Out-of-Pocket Limit

Network Pharmacy – Per Member $2,500
Non-Network Pharmacy – Per Member ....No out-of-pocket limit

After meeting the out-of-pocket limit, the Plan pays 100% of Preferred medications purchased at Network Pharmacies for the remainder of the calendar year.

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

- Non-Network pharmacy purchases
- Non-Preferred medications
- Cost differences between generic and brand-name medications
- Non-covered medications

Note: If you choose a brand-name medication when a generic is available, you are responsible for the difference in cost, plus the copay. The brand-generic cost difference does not count toward your out-of-pocket limit and is always your responsibility even after your out-of-pocket limit is met.

Generics are Preferred Medications

If your medication is not a generic and does not appear on the HealthChoice Select Medication List, your options are to:

- Ask your physician for a prescription for a Preferred medication you can receive at the Preferred pharmacy copay.
- Continue with your current non-Preferred medication and pay the non-Preferred copay.
- Obtain a medical necessity exception if you have specific health problems that require a non-Preferred medication. To be considered for this exception, specific criteria must be met, and detailed documentation from your physician must justify your request for an exception.

HealthChoice Select Medication List

The HealthChoice Select Medication List is a list of medications that are Preferred by the Plan.

This list is subject to change. Contact the pharmacy benefit manager to check the current status of a particular medication or to obtain a copy of the HealthChoice Select Medication List. For contact information, see *Plan Identification Information and Notice*. This list is also available on the HealthChoice website at www.sib.ok.gov or www.healthchoiceok.com.

Your share of the cost of most medications is subject to:

- The cost of the medication
- Network copays
- Non-Network copays
- The cost differences between brand-name and generic medications if a brand-name is purchased when a generic is available
- Unit-of-use and quantity limitations

Pharmacy Prior Authorization (PA)

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

- Are very high cost
- Have specific prescribing guidelines
- Are generally used for cosmetic purposes
- Have quantity limitations

Follow the steps below to request a prior authorizaton:

1. Your physician must call 1-800-753-2851 to request a prior authorization form that must be completed and returned. To request a brand-name exception or non-Preferred medication review, your physician must call the pharmacy benefit manager at 1-800-841-5409.
2. Once the completed form is received by the pharmacy benefit manager, a decision is made within 24 hours.
3. The pharmacy benefit manager then sends notification of the approval or denial to you and your physician.
4. If approved, the prior authorization is entered in the pharmacy benefit manager's system within 48 hours. Your medication is subject to the applicable pharmacy copay. If the review is denied, you or your physician can file an appeal with HealthChoice.

Types of Prior Authorizations

1. Traditional Prior Authorization (PA) Medications

Traditional prior authorization reviews typically require that specific medical criteria be met before the medication is covered.

2. Step Therapy (ST) Medications

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

3. Brand-Name Exception and Non-Preferred Medication Review

Reviews are available for brand-name and non-Preferred drugs if you are unable to tolerate the generic or Preferred drugs.

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

Medications Limited in Quantity (QL)

Quantity limits are based on the recommended duration of therapy and/or routine use of each medication and are less than the standard benefit.

If generics are available or become available for brand-name drugs that are subject to quantity limits, the generics are also limited in quantity.

New medications that become available in the drug categories that are subject to quantity limits will automatically have quantity limits per copay. New drug categories can become subject to quantity limits throughout the year.

Specialty Medications

Specialty medications are covered only if you order them through Accredo Health, the HealthChoice specialty pharmacy. Specialty medications are generally high-cost medications that are injected. You must pay the applicable copay for each 30-day fill of a specialty medication. See *Specialty Medications* in the chart on page 33 for copay amounts.

Accredo Health also provides:

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

Be aware that if you don't order your specialty medications through Accredo Health, you will be responsible for the full cost of your medication.

For more information, contact Accredo Health toll-free at 1-800-501-7260. TDD users call toll-free 1-800-759-1089.

Restricted Medications List (This list is not all-inclusive and is subject to change)

The following is a list of medications that are subject to prior authorization, quantity limits, and/or step therapy or are specialty medications.

Category/Medication Name	Generic Available	Prior Authorization	Quantity Limits	Specialty Medication	Step Therapy
Allergic Reactions	**GA**	**PA**	**QL**	**SM**	**ST**
Epipen® (epinephrine auto injector)			✔		
Anti-Depressive Therapy	**GA**	**PA**	**QL**	**SM**	**ST**
Lexapro® (escitalopram oxalate)					✔
Anti-Influenza Agents	**GA**	**PA**	**QL**	**SM**	**ST**
Relenza® (zanamivir)			✔		
Tamiflu® Capsules/Suspensions (osteltamivir)			✔		
Anti-Narcolepsy Therapies	**GA**	**PA**	**QL**	**SM**	**ST**
Nuvigil®		✔	✔		
Provigil®		✔	✔		
Anti-Nausea Therapies	**GA**	**PA**	**QL**	**SM**	**ST**
Anzemet® (dolasetron)			✔		
Emend® (aprepitant)			✔		
Kytril® (granisetron HCL)	✔		✔		
Sancuso® (granisetron)			✔		
Zofran® (odansetron)	✔		✔		
Asthma Therapies	**GA**	**PA**	**QL**	**SM**	**ST**
Accolate® (zafirlukast)	✔				✔
Singulair® (montelukast)					✔
Zyflo®, Zyflo CR® (zileuton)					✔
COX II Inhibitors	**GA**	**PA**	**QL**	**SM**	**ST**
Celebrex® (celecoxib)		✔			
CNS Stimulants – prior authorization required for age 21 and older	**GA**	**PA**	**QL**	**SM**	**ST**
Adderall®, Adderall XR® (amphetamine/ dextroamphetamine)	✔	✔			
Concerta® (methylphenidate extended release tablets)	✔	✔			
Daytrana® (methylphenidate)		✔			
Desoxyn® (methamphetamine)	✔	✔			
Dexedrine®, Dexedrine Spansules®	✔	✔			
Dextrostat® (dextroamphetamine)	✔	✔			
Focalin® (dexmethylphenidate)	✔	✔			
Focalin XR® (dexmethylphenidate)		✔			
Metadate CD® (methylphenidate)		✔			
Methylin ER® (methylphenidate)	✔	✔			
Ritalin®, Ritalin SR® (methylphenidate)	✔	✔			
Ritalin LA® (methylphenidate)		✔			

Strattera® (atomoxetine)		✔			
Vynase® (lisdexamfetamine)		✔			
Diabetes Therapy	**GA**	**PA**	**QL**	**SM**	**ST**
Symlin® (pramlintide)			✔		
Byetta® (exenatide)			✔		
Victoza® (liraglutide)			✔		
Erythroid Stimulants	**GA**	**PA**	**QL**	**SM**	**ST**
Aranesp® (darbepoetin)		✔			
Procrit®/Epogen® (erythropoetin)		✔			
Estrogen Therapies (Topical)	**GA**	**PA**	**QL**	**SM**	**ST**
Alora® (estradiol transdermal)			✔		
Climara® (estradiol transdermal)			✔		
ClimaraPro® (estradiol/levonorgestrel transdermal)			✔		
CombiPatch® (estradiol, norethindrone acetate transdermal)			✔		
Esclim® (estradiol transdermal)			✔		
Estrogel® (estradiol transdermal)			✔		
Estrasorb® (estradiol transdermal)			✔		
Estraderm® (estradiol transdermal)			✔		
Generic estrogen patches	✔		✔		
Menostar® (estradiol transdermal)			✔		
Vivelle Dot® (estradiol transdermal)			✔		
Growth Hormones	**GA**	**PA**	**QL**	**SM**	**ST**
Genotropin® (somatropin)		✔		✔	
Humatrope® (somatropin)		✔		✔	
Norditropin® (somatropin)		✔		✔	
Nutropin®, Nutropin AQ® (somatropin)		✔		✔	✔
Omnitrope® (somatropin)	✔	✔		✔	
Protropin® (somatropin)		✔		✔	
Saizen® (somatropin)		✔		✔	✔
Serostim® (somatropin)		✔		✔	
Somavert® (somatropin)		✔		✔	
Tev-Tropin® (somatropin)		✔		✔	✔
Zorbtive® (somatropin)		✔		✔	
Hypertensive Therapies	**GA**	**PA**	**QL**	**SM**	**ST**
Atacand® (candesartan)					✔
Atacand HCT® (candesartan/HCTZ)					✔
Avalide® (irbesartan/HCTZ)					✔
Avapro® (irbesartan)					✔
Benicar® (olmesartan)					✔
Benicar HCT® (olmesartan/HCTZ)					✔
Cozaar® (losartan)	✔				✔
Diovan® (valsartan)					✔

Diovan HCT® (valsartan/HCTZ)					✔
Hyzaar® (losartan/HCTZ)	✔				✔
Micardis® (telmisartan)					✔
Micardis HCT® (telmisartan/HCTZ)					✔
Teveten® (eprosartan)					✔
Teveten HCT® (eprosartan/HCTZ)					✔
Impotency Agents – prior authorization approved only if you have had radical retropubic prostatectomy surgery, otherwise these medications are not covered					
	GA	**PA**	**QL**	**SM**	**ST**
Caverject® (alprostadil)		✔	✔		
Cialis® (tadalafil)		✔	✔		
Edex® Injection (alprostadil)		✔	✔		
Levitra® (vardenafil)		✔	✔		
Muse® (alprostadil)		✔	✔		
Viagra® (sildenafil)		✔	✔		
Yohimbine HCL®, both generic and brand-name	✔	✔	✔		
Insulin and Supplies	**GA**	**PA**	**QL**	**SM**	**ST**
Cartridges			✔		
Insulin, Test Strips, Lancets			✔		
Needles			✔		
Pens			✔		
Syringes			✔		
Pre-Filled Syringes			✔		
Diabetic Supplies (over-the-counter)			✔		
Migraine Therapies	**GA**	**PA**	**QL**	**SM**	**ST**
Amerge® (naratriptan)	✔		✔		
Axert® (almotriptan malate)			✔		✔
Frova® (frovatriptan succinate)			✔		✔
Imitrex®, Imitrex Injection®, Imitrex NS® (sumatriptan succinate)	✔		✔		
Maxalt® (rizatriptan benzoate)			✔		✔
Maxalt-MLT® (rizatriptan benzoate)			✔		✔
Migranal® Nasal Spray (dihydroergotamine mesylate)			✔		
Relpax® (eletriptan hydrobromide)			✔		✔
Stadol® Nasal Spray (butorphanol tartrate)			✔		
Treximet® (sumatriptan and naproxen)			✔		✔
Zomig®, Zomig NS®, Zomig-ZMT® (zolmitriptan)			✔		✔
Miscellaneous Devices	**GA**	**PA**	**QL**	**SM**	**ST**
Inhaler spacers (Limited to two per calendar year)			✔		

Multiple Sclerosis Therapies	GA	PA	QL	SM	ST
Ampyra® (dalfampridine)		✔	✔	✔	
Avonex® (interferon beta-1a)		✔	✔	✔	
Betaseron® (interferon beta-1b)		✔	✔	✔	
Copaxone® (glatiramer acetate)		✔	✔	✔	
Extavia® (interferon beta-1b)		✔	✔	✔	✔
Gilenya® (fingolimod)					
Rebif® (interferon beta-1a)		✔	✔	✔	✔
Myeloid Stimulants	**GA**	**PA**	**QL**	**SM**	**ST**
Leukine® (sargramostim)		✔		✔	
Neulasta® (pegfilgrastim)		✔		✔	
Neumega® (oprelvekin)		✔		✔	
Neupogen® (filgrastim)		✔		✔	
NPlate® (romiplostim)		✔		✔	
Narcotic Therapy	**GA**	**PA**	**QL**	**SM**	**ST**
Actiq® (fentanyl)			✔		
Abstral® (fentanyl)			✔		
Fentora® (fentanyl)			✔	✔	
Onsolis® (fentanyl)					
Nasal Steroids	**GA**	**PA**	**QL**	**SM**	**ST**
Beconase AQ® (beclomethasone dipropionate)			✔		✔
Flonase® (fluticasone propionate)	✔		✔		
Nasacort® AQ (triamcinolone acetonide)	✔		✔		✔
Nasarel® (flunisolide)	✔		✔		
Nasonex® (mometasone furoate)			✔		✔
Omnaris® (ciclesonide)			✔		✔
Rhinocort AQ® (budesonide)			✔		✔
Veramyst® (fluticasone furoate)			✔		✔
Oncology	**GA**	**PA**	**QL**	**SM**	**ST**
Afinitor® (everolimus)		✔	✔	✔	
Gleevec® (imatinib mesylate)		✔	✔	✔	
Iressa® (gefitinib)		✔	✔		
Mozobil® (plerixafor)			✔	✔	
Nexavar® (sorafenib)		✔	✔	✔	
Revlimid® (lenalidomide)		✔	✔	✔	
Sprycel® (dasatinib)		✔	✔	✔	
Sutent® (sunitinib)		✔	✔	✔	
Tarceva® (erlotinib)		✔	✔	✔	
Tasigna® (nilotinib)		✔	✔	✔	
Temodar® (temozolomide) - oral version		✔	✔	✔	
Thalomid® (thalidomide)		✔	✔	✔	
Tykerb® (lapatinib)		✔	✔	✔	

Votrient® (pazopanib)		✔	✔	✔	
Xalkori® (crizotinib)		✔	✔	✔	
Zelboraf® (vemurafenib)		✔	✔	✔	
Zolinza® (vorinostat)		✔	✔	✔	
Zytiga® (abiraterone)		✔	✔	✔	
Ophthalmic Therapies	**GA**	**PA**	**QL**	**SM**	**ST**
Restasis® (cyclosporine)			✔		
Osteoporosis Therapy	**GA**	**PA**	**QL**	**SM**	**ST**
Actonel® (risedronate sodium) excludes 30 mg			✔		✔
Boniva® (ibandronate sodium)			✔		
Forteo® (teriparatide, RDNA origin)		✔	✔		
Fosamax® (alendronate sodium)	✔		✔		
Fosamax D® (alendronate & cholecalciferd)			✔		✔
Miacalcin® (calcitonin-salmon)			✔		
Proton Pump Inhibitors	**GA**	**PA**	**QL**	**SM**	**ST**
Aciphex® (rabeprazole)		✔			
Dexilant® (dexlansoprazole)		✔			
Prilosec® Suspension packets (omeprazole magnesium)		✔			
Rheumatoid Arthritis Therapies	**GA**	**PA**	**QL**	**SM**	**ST**
Arava® (leflunomide)	✔	✔	✔		
Cimzia® (certolizumab pegol)		✔	✔	✔	✔
Enbrel® (etanercept)		✔	✔	✔	
Humira® (adalimumab)		✔	✔	✔	
Kineret® (anakinra)		✔	✔	✔	
Simponi® (golimumab)		✔	✔	✔	✔
Sedative-Hypnotic Therapies	**GA**	**PA**	**QL**	**SM**	**ST**
Ambien®, Ambien CR® (zolpidem tartrate)	✔		✔		
Butisol® (butabarbital sodium)			✔		
chloral hydrate	✔		✔		
Dalmane® (flurazepam hydrochloride)	✔		✔		
Doral® (quazepam)			✔		
Edluar® (zolpidem tartrate)			✔		
Halcion® (triazolam)	✔		✔		
Lunesta® (eszopiclone)			✔		✔
ProSom® (estazolam)	✔		✔		
Restoril® (temazepam)	✔		✔		
Rozerem® (ramelteom)			✔		✔
Sonata® (zaleplon)	✔		✔		
Select Asthma Inhalers	**GA**	**PA**	**QL**	**SM**	**ST**
Intal® (cromolyn sodium aerosol)			✔		

Nasalcrom® (cromolyn sodium)			✔		
Tilade® (nedocromil sodium aerosol)			✔		
Select Transdermal Patches	**GA**	**PA**	**QL**	**SM**	**ST**
Androderm® (testosterone transdermal)			✔		
Androgel® (testosterone gel)			✔		
Catapres TTS® (clonidine transdermal)	✔		✔		
Daytrana® (methylphenidate transdermal)			✔		
Emsam® (selegiline transdermal)			✔		
fentanyl transdermal	✔		✔		
Lidoderm® (lidocaine transdermal)			✔		
nitroglycerin transdermal	✔		✔		
Ortho-Evra® (norelgestromin/ethinyl estradiol trandsermal)			✔		
Oxytrol® (oxybutynin transdermal)			✔		
Striant® (testosterone mucoadhesive system)			✔		
Testim Gel® (testosterone gel)			✔		
Transderm-Scope® (scopolamine transdermal)			✔		
Topical Retinoid Therapies (Prior authorization required for age 23 and older)					
	GA	**PA**	**QL**	**SM**	**ST**
Differin® (adapalene) all dosage forms	✔	✔			
Retin-A® (tretinoin) all dosage forms	✔	✔			
Tazorac® (tazarotene) all dosage forms		✔			

Tobacco Cessation Products

HealthChoice covers the following tobacco cessation medications at 100% when purchased at a Network Pharmacy:

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

HealthChoice covers two 90-day courses of a prescription product each calendar year. Additionally, HealthChoice partners with the Tobacco Settlement Endowment Trust (TSET) and Alere Well Being to provide members with over-the-counter nicotine replacement therapy products (patches, gum, and lozenges) and telephone coaching at no charge to HealthChoice health plan members.

To take advantage of the benefits available through TSET, which are over and above the benefits offered to the general public, contact the OKLAHOMA TOBACCO HELPLINE at 1-800-QUIT-NOW (1-800-784-8669) and identify yourself as a HealthChoice member. The Helpline hours of operation are 7 a.m. to 2 a.m., seven days a week. Members living outside of Oklahoma call toll-free 1-866-QUIT-4-LIFE (1-866-784-8454).

Plan Exclusions and Limitations

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

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

16. Medical services or treatments not generally accepted as the standard of care by the medical community
17. Expenses incurred prior to the effective date of an individual's coverage, or for expenses incurred during a period of confinement which had its inception prior to the effective date of an individual's coverage
18. Injury or any sickness which is covered under an "Extended Benefits" provision of the previous group health coverage, until such time as such individual has exhausted all extended benefits available thereunder
19. Hospitalization or other medical treatment furnished to the insured or dependent after coverage has terminated
20. Medical and surgical services and supplies in excess of the fee schedule for such service and supply
21. Expenses to the extent that the insured person is reimbursed or is entitled to reimbursement; or is in any way indemnified for such expenses by or through any public program, State or Federal, or any such program of medical benefits sponsored and paid for by the Federal Government or any agency or subdivision thereof
22. Bodily injury or illness arising out of or in the course of any employment not specifically excluded by 85 O.S. §2.1 or 2.6 (of the Workers' Compensation Act)
23. Surgical procedures or treatment, including medications, performed for cosmetic or elective reasons unless such procedure is specifically included as a covered charge or is necessary as a result of an accident; coverage must have been continuous from the date of the accident to the date of corrective surgery
24. Breast implants are not covered unless they are necessitated by removal of diseased tissue
25. Dental expenses unless incurred as the result of an accidental bodily injury to natural teeth or gums while the coverage is in effect. Coverage must have been continuous from the date of the accident to the date of corrective surgery. Broken or lost artificial teeth, bridges, or dentures are not covered
26. Wrongful act or negligence of another when an employee or dependent has released the responsible party, unless subrogation has been waived or reduced in writing in an individual case, solely at OSEEGIB's option, and only for good cause
27. Eye examinations for the fitting of corrective lenses or any charges related to such examinations; orthoptics, visual training for any diagnosis other than mild strabismus; or for eyeglasses, except for the first pair used as a prosthetic replacement after the removal of the natural lens; or for other corrective lenses, or for radial keratotomy or LASIK (exceptions may apply to eye exams, see *Preventive Health Care and Immunizations* section)
28. Sex transformation surgeries and treatment for sexual dysfunction including implants of any nature, reversal of elective sterilization, and in vitro fertilization or artificial insemination
29. All treatments for obesity, including but not limited to morbid obesity; all gastrointestinal tract modifications and all complications and procedures, even when obesity or morbid obesity is diagnosed; expenses for weight loss treatment, advice, or training
30. Hearing aids and examinations for fitting or prescription, except for eligible individuals up to age 18; must be prescribed, filled, and dispensed by a licensed audiologist
31. Preoperative or postoperative care generally rendered by the operating surgeon, unless the surgeon itemizes his charges and the total amount charged is no more than the total Allowed Charge for the surgery
32. Behavior modification programs for tobacco cessation
33. Some infertility treatment is covered by the Plan. Coverage includes prescription drugs, but excludes artificial insemination, embryo transplant, invitro fertilization, surrogate parenting,

ovum transplant, donor semen, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and reversal of voluntary sterilization

34. Impotency medications are covered by the Plan only in the event of radical retropubic prostatectomy surgery
35. Intentionally self-inflicted injury, or for attempted suicide whether sane or insane except when the injury results from a physical or mental medical condition covered under the health plan
36. Acupressure
37. Alopecia
38. Biofeedback
39. Confinement to a facility unless approved by OSEEGIB or its designee
40. Contraceptive devices such as a diaphragm
41. Custodial care
42. Dyslexia testing
43. Electromyography without needle
44. Food or nutritional supplements (exceptions may apply, see *Preventive Health Care and Immunizations* section)
45. Home dialysis training
46. Home exercise programs
47. Home sleep apnea studies
48. Home uterine monitoring
49. Kinesiology (movement therapy)
50. Lost, stolen, or damaged medications
51. Marriage counseling
52. Nutritional analysis
53. Medications available for purchase without a written prescription (exceptions may apply, see *Preventive Health Care and Immunizations* section)
54. Over-the-counter vitamins (exceptions may apply, see *Preventive Health Care and Immunizations* section)
55. Rolf technique (Rolfing)
56. Surrogate mother expenses
57. Venipuncture by a physician when also billing for lab charges
58. Off-label use of medications – use of a drug for the treatment of conditions that ar not indicated on the drug's label
59. Cough and cold medications

Claims Procedures

Claims Filing and Payment

Network

Network Providers will file your claims for you, and payment is automatically made to your provider.

Non-Network

If you use a non-Network provider, you may have to file your claims personally. Send your claim to the health claims administrator. For contact information, see *Plan Identification Information and Notice*.

Claims should be filed as soon as the services are received and completed. Your claim must be submitted on the appropriate form in order to be processed. Physician services should be billed on a *CMS 1500*, and hospital and outpatient facility services should be billed on a *UB-04*. Items such as cash register receipts, pull-apart forms, and billing statements are not acceptable. Non-Network providers are not required to submit claims on your behalf and may not use the appropriate form. If this occurs, ask if the provider will submit the claim on your behalf using the appropriate form or if they can provide you with a completed form so that you can file the claim yourself.

Note: Due to copyright laws, these forms cannot be made available on the HealthChoice website, and HealthChoice does not maintain a supply of these forms.

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

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

Claims Filing Deadline

Claims must be submitted to HealthChoice no later than the last day of the calendar year following the year the claim was incurred. For example, if the date of service is July 1, 2011, the claim will be accepted through December 31, 2012.

Claims for Services Outside the United States

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

- Make arrangements to pay for the services or supplies
- Submit a paper claim to HealthChoice for reimbursement
- Claims must be translated into English and converted to U.S. dollar amounts using the exchange

rates applicable for the dates of service; you must file the original claim along with the translation (Plan does not pay any costs for translating claims or medical records)

Allowed Charges are paid according to the provisions of your Plan including the non-Network rate of coinsurance if applicable. You are responsible for amounts above the Allowed Charges.

Coordination of Benefits (COB)

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

If your other group coverage includes pharmacy benefits, usually your pharmacy claims can still be processed electronically; however, if your pharmacy cannot file electronically, you will need to file a paper claim. Claims must include a copy of the Explanation of Benefits from your primary plan or a copy of your pharmacy statement showing the actual cost, your copay, or out-of-pocket expense.

To obtain paper pharmacy claim forms, contact the pharmacy benefit manager. For contact information, see *Plan Identification Information and Notice*. You can also print a pharmacy claim form from the HealthChoice website at **www.sib.ok.gov** or **www.healthchoiceok.com**. **Please complete the patient information at the top of the form, attach your pharmacy statements, and mail to the address listed on the claim form.**

If you terminate your other group coverage or if it does not include pharmacy benefits, please send written notice and supporting documentation to the health claims administrator. For contact information, see *Plan Identification Information and Notice*.

If you have questions about Coordination of Benefits, contact the health claims administrator. If you have questions about how your pharmacy benefits will be affected by Coordination of Benefits, contact the pharmacy benefit manager. For contact information, see *Plan Identification Information and Notice*.

Verification of Other Insurance Coverage (VOIC)

The VOIC form provides HealthChoice with information about other group health insurance you may have. This information is used to coordinate your HealthChoice benefits with your other insurance plan. When a VOIC form is needed to process your claim, the health claims administrator sends one to you to complete and return. **Failure to complete and return a VOIC when requested will cause your claim to be denied for non-compliance.**

Explanation of Benefits (EOB)

Each time a claim is processed, the health claims administrator sends you an EOB which explains how your benefits are applied. Your EOB lists the following information:

- The service provider
- Date of service
- Service code billed
- Amount not covered
- Member copay
- Member deductible

- Provider billed
- Provider write off
- Amount allowed
- Explanation code
- Member coinsurance
- Total benefits
- Deductible accumulators

Your EOBs are also available online by going to the HealthChoice website at **www.sib.ok.gov** or **www.healthchoiceok.com** and clicking *ClaimLink*. If you haven't already registered to access ClaimLink, you will need to create a unique user ID and password to gain access to your information. If you prefer to go paperless and not receive the paper version of your EOBs, contact the health claims administrator. For contact information, see *Plan Identification Information and Notice*.

Claims Requiring Additional Information

If your claim requires additional information for processing, your EOB will identify the specific information needed. In some instances, a letter is also sent further explaining what information is required to complete processing. Be aware that your claim is closed until the needed information is received.

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

Disputed Claims Procedure

If your claim is denied in whole or in part for any reason, you have the right to have that claim reviewed. Requests for review of your denied health claim, along with any additional information you wish to provide, must be submitted in writing to the health claims administrator or call the health claims administrator. For contact information, see *Plan Identification Information and Notice*.

If your claim remains denied after a claims review, you can appeal that decision to the Grievance Panel by writing to:

The Legal Grievance Department
3545 NW 58 Street, Ste 110
Oklahoma City, OK 73112

or calling 1-405-717-8701 or toll-free 1-800-543-6044. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

The Grievance Panel is an independent review group established by statute [74 O.S. Section 1306(6)].

All requests for hearings must be filed within one year of the date you are notified of the denial of a claim, benefit, or coverage.

You can submit a request for a Grievance Panel hearing and represent yourself in these proceedings. If you are unable to submit a request for a Grievance Panel hearing yourself, only attorneys licensed to

practice in Oklahoma are permitted to submit your hearing request for you, or to represent you through the hearing process [75 O. S. Section 310(5)].

All claim reviews and final decisions of the Grievance Panel are made as quickly as possible. After completing the claim review and grievance procedures, an appeal can be pursued in an Oklahoma District Court.

Subrogation

Subrogation applies when you are sick or injured as a result of the negligent act or omission of another person or party. Subrogation means the HealthChoice Plans have a right to recover any benefit payments made to you or your dependents by a third party's insurer, because of an injury or illness caused by that third party. Third party means another person or organization.

If you or your covered dependents receive HealthChoice benefits and have a right to recover damages from a third party, this Plan has the right to recover any benefits paid on your behalf. Payments from a third party, whether by lawsuit, settlement, or otherwise, must be used to repay HealthChoice.

You must promptly notify HealthChoice when you make a claim against a third party regarding an illness or injury for which HealthChoice benefits have been or will be paid. You or your dependent must provide information requested by HealthChoice, or benefits can be withheld.

After any requested information is received, HealthChoice will process your claims, regardless of whether any third party is eventually found liable for the expenses arising from the injury or illness.

For more information about subrogation, contact OSEEGIB. Do not contact the health claims administrator regarding subrogation as this will only delay a response.

General Provisions

Provider-Patient Relationship

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

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

For information on the types of providers recognized by the Plan, contact HealthChoice Provider Relations at 1-405-717-8790 or toll-free 1-800-543-6044. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436. This information can also be found by clicking *FAQ* in the top menu bar of the HealthChoice website at **www.sib.ok.gov** or **www.healthchoiceok.com**.

Inaccurate or Erroneous Information

Coverage obtained by means of inaccurate or erroneous information is cancelled retroactive to the effective date, and premiums for coverage refunded. Refunded premiums are reduced by any claims paid by HealthChoice.

Confirmation Statements (CS)

Anytime you make a change to your coverage, you are mailed a CS. The CS lists the coverage you are enrolled in, the effective date of your coverage, and the premium amount for your coverage. A CS is provided so you can review changes, and any errors can be identified and corrected as soon as possible.

Corrections to Benefit Elections

Review your CS to ensure the coverage listed is correct. Corrections must be submitted to your Insurance/Benefits Coordinator, or to OSEEGIB for former employees, within 60 days of the election. Corrections reported after 60 days are effective the first of the month following notification.

Member Audit Program

Despite your provider's best efforts, the complexity of arranging for your care and treatment may result in inaccurate billing. That is why it is important to check your bill carefully. If certain types of mistakes are made in your bill and you catch them, you can share in the savings through the Member Audit Program. You can receive up to 50% of any savings resulting from a billing error you find up to a maximum reimbursement of $200.

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

If you find an error on a medical bill and you wish to participate in the Member Audit Program, contact the health claims administrator. For contact information, see *Plan Identification Information and Notice*.

Right of Recovery

OSEEGIB retains the right to recover any payments made by the Plans in excess of the maximum Allowed Charges. OSEEGIB has the right to recover such payments, to the extent of excess, from one or more of the following:

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

Medical Case Management

The HealthChoice Health Care Management Division has medical case managers to assist you with information to maximize your benefits. Case managers assist you in coordinating your care based on individual needs and also provide certification for certain procedures and medical equipment.

Medical case managers are licensed, certified registered nurses who specialize in various medical fields. Examples of medical situations when a case manager can be helpful include:

- Cancer care
- Rehabilitation
- HIV/AIDS
- Terminal illness
- Stroke
- Pregnancy/pre-term babies
- Transplants
- Mental health/substance abuse
- Specialty durable medical equipment
- In or out-of-state emergencies

You can contact a HealthChoice case manager at 1-405-717-8879 or toll-free 1-800-543-6044, ext. 8879. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

HealthChoice Wellness Programs

Health Education Lifestyle Planning (H.E.L.P.)

The H.E.L.P. staff offers a wide variety of wellness opportunities if you choose to become and stay well. Wellness opportunities include:

- A walking club in which H.E.L.P. sends you various incentive items at each 100 miles logged
- Fitness facility discounts
- HealthVoice newsletters containing health tips and activities
- Online health and wellness information

H.E.L.P.✔

The **H.E.L.P.✔** Wellness Initiative includes a financial incentive payment to primary members who complete their preventive services visit, associated labwork, and the online health risk assessment available through *ClaimLink*. For more information and to register for the **H.E.L.P.✔** program, visit the HealthChoice website at **www.sib.ok.gov** or **www.healthchoiceok.com**.

Mommy & Me

Mommy & Me is a maternity wellness program that provides information and answers to your pregnancy related questions. The Preconception Program focuses on wellness prior to becoming pregnant. The Pregnancy Program focuses on having the healthiest pregnancy possible.

A risk assessment and information on all aspects of wellness and pregnancy are included in the program. You can enroll or contact Mommy & Me by calling toll-free 1-800-475-9926. TDD users call 1-405-949-2281 or toll-free 1-866-447-0436. You can also enroll on the HealthChoice website at **www.sib.ok.gov** or **www.healthchoiceok.com**.

For further information on wellness programs, call the H.E.L.P. line at 1-405-717-8991 or toll-free 1-800-318-BEOK(2365). TDD users call 1-405-949-2281 or toll-free 1-866-447-0436.

Eligibility and Effective Dates

You are eligible to participate in the HealthChoice Plans if you are:

- A current **Education** employee eligible to participate in the Oklahoma Teachers' Retirement System and working a minimum of four hours per day or 20 hours per week
- A current **State of Oklahoma** or **Local Government** employee regularly scheduled to work at least 1,000 hours a year and not classified as a temporary or seasonal employee

New Employee

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

Dependent Coverage

You must be enrolled in one of the health plans in order for your dependents to be enrolled. If dependent coverage is selected, all of your eligible dependents must be covered. See *Excluding Dependents* in this section for exceptions to this rule.

If you are enrolled in one of the health plans and have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you can enroll your dependents provided you request the enrollment within 30 days following the marriage, birth, adoption, or placement for adoption. All other enrollments must be made during the annual Option Period.
Note: Former employees can make changes **only** within 30 days of a qualifying event. Dependents or new benefit plans, other than vision, cannot be added during the annual Option Period.

Eligible Dependents

Eligible dependents include:

- Your legal spouse (see *common-law marriages* in this section).
- Your daughter, son, stepdaughter, stepson, eligible foster child, adopted child or child legally placed with you for adoption up to age 26, whether married or unmarried.
- Your dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26. A *Disabled Dependent Assessment Form* must be submitted at least 30 days prior to the dependent's 26th birthday. The *Disabled Dependent Assessment Form* must be approved by OSEEGIB before coverage begins or is extended past age 26.
- Other unmarried dependent children up to age 26, upon completion of an *Application for Coverage for Other Dependent Children*. Guardianship papers or a tax return showing dependency can be provided in lieu of the application.

Common-law marriages are recognized by the Plan. A new employee can add a common-law spouse at the time of enrollment. A current employee can request coverage on a common-law spouse during the annual Option Period or in the event the common-law spouse loses other group coverage. To

enroll a common-law spouse, the employee and spouse must sign and submit an enrollment or change form.
Note: A former employee can add a common-law spouse only if they lose other group coverage.

Newborn Limited Benefit – Newborns are covered for routine well-baby care for the first 48 hours following a vaginal delivery or the first 96 hours following a C-section delivery. Any additional services provided to your newborn that are considered non-routine are not covered unless you enroll your newborn for the month of the birth and pay the premium for that month. This means you are responsible for any charges over and above the Plan's payment of the newborn limited benefit regardless of the facility's Network or non-Network status. You have 30 days from the date of birth to enroll your newborn in coverage. A separate calendar year deductible and coinsurance may apply to the newborn depending on your plan. If you are a former employee and do not enroll your newborn during this 30-day time period, you cannot do so in the future. Your newborn's Social Security number is not required at the time of initial enrollment, but must be provided when it is received from the Social Security Administration. If you enroll your newborn, insurance premiums must be paid for the full month of your child's birth.

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

A dependent who is no longer eligible may apply for continuation of coverage under COBRA for a maximum of 36 months. See *Continuing Coverage After Leaving Employment* for more information.

Coverage for Other Eligible Dependents

You can cover certain other dependents if they are legally adopted, you have legal guardianship, or they meet other specific requirements. To cover these dependents, you must:

- Meet all eligibility requirements
- Request coverage within the set time frame
- Provide the necessary documentation
- Pay all premiums
- Cover all eligible dependents

Legal Adoption

An adopted dependent is eligible for coverage the first day of the month you obtain physical custody of your child. You must submit an enrollment or change form to your Insurance/Benefits Coordinator (former employees must submit the form to OSEEGIB), including a copy of your adoption papers. In the absence of adoption papers or other court records, someone involved in the adoption process, such as your attorney or a representative of the adoption agency, must provide proof of the date you actually received custody of your child pending the final adoption hearing.

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

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

Legal Guardianship

Guardianship follows the same guidelines as an adoption. See *Legal Adoption* in this section.

Other Forms of Custody

In the absence of a court order indicating adoption, guardianship, or divorce, you can request coverage for other eligible dependents by submitting an enrollment or change form and a copy of the portion of your most recent income tax return listing the children as dependents for income tax deduction purposes to your Insurance/Benefits Coordinator (former employees send the form and tax return to OSEEGIB).

Coverage for other eligible dependents begins on the first day of the month following the date you obtain physical custody and never applies retroactively.

In the absence of a federal income tax return listing the children as dependents, you are required to provide an *Application for Coverage for Other Dependent Children* as specified by the Plan. Coverage, if approved, begins on the first day of the month following approval and never applies retroactively.

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

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

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

Excluding Dependents from Coverage

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

You can also exclude your spouse. If excluding your spouse while covering other eligible dependents, your spouse must sign the Spouse Exclusion section of your enrollment or change form.

Late Enrollee – Current Employees

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

- Within 30 days of the date you lose other group coverage
- During the annual Option Period

Changes to Coverage After Initial Enrollment t

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

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

Current Employees

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

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

Former Employees

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

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

Oklahoma State and Education
Employees Group Insurance Board
a division of the Office of State Finance
3545 NW 58 Street, Ste 110
Oklahoma City, OK 73112
Fax: 1-405-717-8939

Verbal requests for changes in coverage are not accepted.

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

Options for Members Called to Active Military Service – Current Employees

Under the Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA), coverage can be continued for up to 24 months. USERRA provides certain rights and protections for all employees called to serve our nation. All branches of the military including the Army, Navy, Marines, Air Force, Coast Guard, all Military Reserve units, and all National Guard units come under USERRA.

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

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

There is no penalty for renewing coverage upon discharge from active duty if coverage is elected within 30 days of your return to the same employment.

Regardless of whether you receive written or verbal military orders, OSEEGIB staff and/or your Insurance/Benefits Coordinator will assist you in making any benefit arrangements.

If you are a member of a Military Reserve unit or the National Guard and anticipate being called to active service, notify your Insurance/Benefits Coordinator at work.

Loss of Other Group Insurance Coverage

You may not have enrolled in a HealthChoice Plan because you were covered under another group health plan. If you later lose coverage under your other group health plan, you can enroll in one of the HealthChoice Plans within 30 days of the loss of your other coverage.

You can elect to have HealthChoice coverage begin on the first day of the month in which you actually lost other group coverage, subject to payment of the full premium for that month. Otherwise, coverage is effective on the first day of the month following your election.

Participating former employees can add a spouse within 30 days of their spouse's loss of other group health insurance. Proof of loss is required. Loss of individual health coverage is not a qualifying event and does not allow enrollment under this Plan.

Loss of another type of group coverage, such as dental coverage, does not grant the right to enroll in a health plan. Also, loss of group health coverage does not grant the right to enroll in other types of coverage, such as dental or life.

Premium Payment

Each month, you must pay the full premium for the coverage you selected. Failure to pay premiums

timely can result in the termination of coverage at the end of the month for which the last premium was received.

Leave Without Pay – Current Employees

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

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

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

Special Rules for Those Eligible for Medicare

If you or your covered dependents become eligible for Medicare, either as a result of age or because of disability, your employer's group plan remains primary, and Medicare is your secondary coverage. Upon termination of employment, your Medicare coverage becomes the primary insurance carrier.

You can accept or reject coverage under your employer's group health plan. If you reject this Plan, Medicare is the primary payer for Medicare-covered health services. If you reject your employer's group health plan, your employer cannot provide you with a plan that pays supplemental benefits for Medicare-covered services or subsidize such coverage.

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

For further information regarding Medicare enrollment, call the Social Security Administration toll-free at 1-800-772-1213. TTY users call toll-free 1-800-325-0778. You can also access information regarding Medicare enrollment at **www.medicare.gov** or call Medicare toll-free at 1-800-633-4227. TTY users call toll-free 1-866-226-1819.

Proof of Creditable Part D Prescription Drug Coverage

All of the HealthChoice health plans provide *Creditable Part D Prescription Drug Coverage*. This means the prescription drug coverage offered through HealthChoice is at least as good as the *standard* Medicare Part D prescription drug coverage.

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

Continuing Coverage After Leaving Employment

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

- Vesting or retirement rights through one of the public employee retirement systems established by the State of Oklahoma
- Years of service with state, education, or local government employers; also see *Years of Service* below
- Receiving benefits through the HealthChoice Disability Plan administered by OSEEGIB
- Survivors' Rights for your covered dependents in the event of your death
- COBRA (Consolidated Omnibus Budget Reconciliation Act)

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

Years of Service

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

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

Education Employees

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

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

coverage with the Plan, you must follow your former employer to its new insurance carrier.

Note: You cannot reinstate coverage that you discontinue or allow to lapse unless you return to work as an employee of a participating employer.

Local Government Employees

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

Note: You cannot reinstate coverage that you discontinue or allow to lapse unless you return to work as an employee of a participating employer.

Some reinstatement exceptions may apply if you are a state employee who terminated employment as a result of a Reduction in Force (RIF). See *State Government Reduction In Force and Severance Act* in this section.

New Employer Retirees

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

Following Your Employer to a New Carrier

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

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

Continuation through the Disability Program

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

Survivors' Rights

Your surviving spouse and dependents have 60 days following your death to notify OSEEGIB that they wish to continue coverage. Coverage is effective the first day of the month following your death. Your surviving spouse is eligible to continue insurance coverage as long as premiums are paid.

Surviving dependent children are eligible to continue coverage until age 26.

Disabled dependent children are eligible to continue coverage as long as they continue to meet the HealthChoice definition of a disabled dependent.

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

COBRA (Consolidated Omnibus Budget Reconciliation Act)

If you or your dependents' coverage is terminated for any of the reasons listed below, each covered member has the right to elect temporary continuation of coverage under COBRA.

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

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

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

- Your death (see *Survivors' Rights*)
- Termination of your employment for reasons other than gross misconduct
- A reduction in your hours of employment resulting in loss of coverage
- A divorce or legal separation*

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

- Your death (see *Survivors' Rights*)
- Termination of your employment for reasons other than gross misconduct
- A reduction in your hours of employment resulting in loss of coverage
- A divorce or legal separation of the parents*
- Your dependent no longer meets the requirements for dependent status

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

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

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

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

If the qualifying event is related to termination of employment or reduced hours, coverage can be continued for a maximum of 18 months. If the qualifying event is for any other eligible reason, coverage for dependents can be continued for a maximum of 36 months. Continuation of coverage terminates

immediately for you and/or all covered dependents under the following circumstances:

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

If you have questions regarding COBRA, contact your Insurance/Benefits Coordinator or OSEEGIB.

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

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

Termination or Reinstatement of Coverage

Termination

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

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

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

Reinstatement

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

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

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

Former employees who did not continue coverage, or discontinued coverage, must return to work with a participating employer and carry coverage for three years to be eligible to continue that coverage when they re-retire.

State Government Reduction In Force and Severance Benefits Act

If you are a former state employee who:

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

You can reinstate health insurance coverage at any time within two years following the date of the reduction in force from the state.

For further information, contact HealthChoice Member Services. For contact information, see *Plan Identification Information and Notice.*

Oklahoma State and Education Employees Group Insurance Board (OSEEGIB) Privacy Notice

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.

OSEEGIB, a division of the Office of State Finance, is a State of Oklahoma governmental agency that is created and governed by Oklahoma law for the purpose of administering health, life, disability, and dental benefits to state, local government, and education employees, and other groups designated by statute, including each of the preceding group's respective retirees.

Oklahoma privacy laws and the federal Health Insurance Portability and Accountability Act (HIPAA) govern privacy matters between OSEEGIB and its participants concerning the privacy of an individual member's health information. Information contained in an OSEEGIB member's file is confidential by law and we at OSEEGIB are committed to protecting the privacy and security of members' information. This notice describes and gives you examples of how OSEEGIB will use and disclose your health information and your rights regarding this information.

OSEEGIB uses and discloses your protected health information (PHI) for payment of services to enable your medical treatment, and for OSEEGIB business operations in the administration of health plans. The health claims you submit, or health claims submitted by providers for your treatment, contain protected health information and are processed for payment and data collection by claims administrators according to contract terms with OSEEGIB. OSEEGIB and its claim administrators use and disclose your PHI for payment responsibilities that include: collecting premiums, determination of medical necessity according to certification procedures, eligibility issues, coordinating benefits with other insurers, producing Explanations of Benefits, subrogation, and claim adjudication. Contract terms with each of its claims administrators state that the claims administrator is a Business Associate as defined in OSEEGIB Rules, with obligations to protect members' information.

Your health information is used and disclosed by OSEEGIB employees and other entities under contract with OSEEGIB according to the "minimum necessary" standard. OSEEGIB or its claims administrators may use and disclose health information for HealthChoice plan operations that include: providing customer service, resolving grievances, conducting activities to improve member's health and reduce costs, case management and coordination of care, premium rate setting activities, law enforcement, public health threats, workers' compensation/disability, national security, and as permitted or required by law.

OSEEGIB provides limited member information to participating plan sponsors for enrollment purposes and premium comparison.

OSEEGIB will ask for your written permission before it uses or discloses your health information for purposes that are not described in this Notice.

You have the right to: a) inspect and copy your health information (generally EOBs), with the exception of psychotherapy notes and/or information that requires a court order; b) amend and restrict the health information that OSEEGIB discloses about you; however, OSEEGIB is not required to agree to a requested restriction; c) request your communications remain confidential with OSEEGIB; d) receive a copy of this Notice; e) file a complaint if you believe OSEEGIB improperly used or disclosed your information; f) request a listing of your protected health information disclosed by OSEEGIB except that, as a health plan, OSEEGIB is not required to account for disclosures for claims payment, OSEEGIB business operations, and disclosures you requested pursuant to your written Authorization; and, g) receive a paper copy of this Notice upon request, if you received this Notice electronically.

OSEEGIB reserves the right to change the terms of this Privacy Notice and will provide all interested persons a revised notice either by U.S. Postal Service delivered to the individual's mailing address on file with OSEEGIB, or through electronic communication by posting the revised Privacy Notice on the OSEEGIB website at www.sib.ok.gov and www.healthchoiceok.com

If you believe your privacy rights have been violated, call or send a written complaint to the OSEEGIB

HIPAA Information Officer at 3545 NW 58, Suite 110, Oklahoma City, OK, 73112, 1-405-717- 8701, toll-free 1-800-543-6044, TDD 1-405-949-2281, toll-free TDD 1-866-447-0436; the Secretary of the U. S. Department of Health and Human Services (HHS) at the Office of Civil Rights, 1301 Young Street, Suite 1169,Dallas, TX 75202, 1-214-767-4056, or submit an electronic complaint according to directions located on the HHS Office of Civil Rights website. Complaints to HHS must be filed within 180 days after the date on which you became aware, or should have been aware, of the violation. No retaliation is allowed against the individual filing a complaint.

Revised 2011

Notifications

Certificate of Coverage

When health insurance terminates, a *Certificate of Coverage* is sent to your mailing address on file with OSEEGIB. OSEEGIB mails certificates to education and local government employees, former employees, surviving dependents, and COBRA participants. The Employees Benefits Council (EBC) mails *Certificates of Coverage* to state employees. A *Certificate of Coverage* may be required as proof of previous group health coverage by your next health plan for a waiver of preexisting condition limitations.

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 January 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

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

Coverage of Side Effects Associated With Prostate Related Conditions*

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

If you have questions about the HealthChoice coverage of mastectomies and reconstructive surgery or prostate related conditions, contact the health claims administrator. For contact information, see *Plan Identification Information and Notice.

Wigs and Scalp Prostheses

HealthChoice provides a benefit for wigs or other scalp prostheses 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. The maximum annual benefit is $150.

Early Retiree Reinsurance Program

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families. If you have received this notice by email, you are responsible for providing a copy of this notice to your family members who are participants in this plan.

Plan Definitions

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

Allowed Charges: The set dollar amount allowed under the Plans for a covered service or supply.

Certification: A review process used to determine if services are medically necessary according to HealthChoice guidelines. Certification is performed by either the HealthChoice certification administrator or by the HealthChoice Health Care Management Division depending on the type of services.

Coinsurance: The percentage of Allowed Charges paid by you and by HealthChoice once your deductible is satisfied.

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

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

Deductible:

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

Eligible Dependent:

- Your legal spouse (including common-law spouse).
- Your daughter, son, stepdaughter, stepson, eligible foster child, adopted child or child legally placed with you for adoption up to age 26, whether married or unmarried.
- Your dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26. A *Disabled Dependent Assessment Form* must be submitted at least 30 days prior to the dependent's 26th birthday. The *Disabled Dependent Assessment Form* must be approved by OSEEGIB before coverage begins.
- Other unmarried dependent children up to age 26, upon completion of an *Application for Coverage for Other Dependent Children*. Guardianship papers or a tax return showing dependency may be provided in lieu of the application.

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

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

Eligible Participating Former Employee: An employee who participates in any of the Plans authorized by or through the State and Education Employees Group Insurance Act who retired or vested their rights with a state funded retirement system, or has the required years of service with a participating employer.

HealthChoice Select Medication List: A list of Preferred medications designed to maximize health outcomes and reduce costs.

Late Enrollee: Any eligible employee and/or eligible dependents who waived coverage or failed to enroll within 30 days of the initial enrollment offering, or any participating member or dependent who voluntarily terminates coverage and re-enrolls.

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

Medically Necessary: Direct care and treatment within the standards of good medical practice within the community that are appropriate and necessary for the symptoms, diagnosis, and treatment of the condition. Services or supplies must be the most appropriate supply or level of service which can safely be provided. For hospital stays, inpatient acute care is necessary due to the intensity of services you are receiving or the severity of your condition, or when safe and adequate care cannot be received as an outpatient or in a less intense medical setting. Services or supplies cannot be primarily for the convenience of you, the caregiver, or provider. The fact that services or supplies are medically necessary does not, in itself, assure that the services or supplies are covered by the Plan.

Network Provider: A provider who has entered into a contract with OSEEGIB to accept the Plan's Allowed Charges for services and/or supplies provided to Plan participants.

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

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

OSEEGIB: The Oklahoma State and Education Employees Group Insurance Board, a division of the Office of State Finance.

Out-of-Pocket Limit: The amounts you are responsible for based on the use of Network or non-Network providers. **You are always responsible for all amounts above the Allowed Charges when using non-Network providers.**

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

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

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

HealthChoice
Oklahoma State and Education
Employees Group Insurance Board
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