

HealthChoice Medicare Supplement Plans Handbook

Evidence of Coverage

Plan Year January 1 through December 31, 2012

HealthChoice Employer PDP High and Low Option Plans With Part D

HealthChoice High and Low Option Plans Without Part D



State Animal, Buffalo



State Bird, Scissortailed Flycatcher



State Reptile, Mountain Boomer

www.sib.ok.gov or www.healthchoicelok.com

Monthly Premiums

HealthChoice Medicare Supplement Plans

January 1, 2012 – December 31, 2012

<i>Medicare Supplement Plan Premiums Per Enrolled Person*</i>	
HealthChoice Employer PDP High Option With Part D	\$332.54
HealthChoice Employer PDP Low Option With Part D	\$273.02
HealthChoice High Option Without Part D	\$383.34
HealthChoice Low Option Without Part D	\$323.82
<i>COBRA – Medicare Supplement Plan Premiums Per Enrolled Person</i>	
HealthChoice Employer PDP High Option With Part D	\$332.54
HealthChoice Employer PDP Low Option With Part D	\$273.02
HealthChoice High Option Without Part D	\$391.01
HealthChoice Low Option Without Part D	\$330.30

*The premiums listed above do not reflect contributions from any retirement system. You must pay your full monthly premium (unless you qualify for Extra Help from Medicare) and your Part A, Part B, and/or Part D premiums, if applicable.

Contracting Statement for the Plans With Part D Prescription Drug Coverage

The Oklahoma State and Education Employees Group Insurance Board (OSEEGIB), a division of the Office of State Finance, contracts with the Centers for Medicare and Medicaid Services (CMS), a division of the federal government, to provide Medicare Part D Prescription Drug coverage for its plans with Part D. OSEEGIB is a Medicare approved Part D plan sponsor. Its contract with CMS is renewed annually, and it is not guaranteed beyond the 2012 contract year. OSEEGIB has the right to refuse to renew its contract with CMS or CMS can refuse to renew its contract with OSEEGIB. Termination or non-renewal of the contract will terminate your enrollment in a HealthChoice Employer PDP Medicare Supplement Plan With Part D.

Materials for the Visually Impaired

A text version of this handbook/Evidence of Coverage is available on the HealthChoice website at www.sib.ok.gov or www.healthchoiceok.com. This handbook is also available in CD format at the Oklahoma Library for the Blind and Physically Handicapped (OLBPH). Contact OLBPH, Monday through Friday, 8:00 a.m. to 5:00 p.m. with the exception of state holidays, at:

- ◆ 1-405-521-3514 or toll-free 1-800-523-0288
- ◆ TDD users call 1-405-521-4672

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. 33,500 copies have been printed at a cost of \$1.075 each. Copies have been deposited with the Publications Clearinghouse of the Oklahoma Department of Libraries.

HealthChoice Medicare Supplement Handbook Evidence of Coverage

Effective January 1 through December 31, 2012

This HealthChoice handbook/Evidence of Coverage, including the Annual Notice of Change, your enrollment form, Confirmation Statement, and HealthChoice Medicare Formulary, represent our responsibilities to you. This handbook provides details about your health and prescription drug benefits. It explains what is covered and what you pay as a member of the plan. This handbook explains your rights and responsibilities, as well as the rules you must follow to get the services, supplies, and medications you need. This is an important document, so keep it in a safe place. Please note, the HealthChoice Medicare Supplement Plans are often referred to throughout this handbook as the *Plan* or *Plans*.

Table of Contents

Plan Identification and Contact Information.....	2
Who to Contact About Complaints, Appeals, Grievances, or Coverage Decisions.....	3
How Your Plan Will Change for 2012 – Annual Notice of Change	4
Information About Your Premiums.....	6
General Information.....	10
Summary of HealthChoice High and Low Option Medicare Supplement Plans.....	14
Pharmacy Benefit Information.....	21
Claim Procedures.....	43
Eligibility, Enrollment, and Disenrollment.....	47
Your Responsibilities.....	56
Your Rights as a HealthChoice Member.....	57
Grievances and Appeals.....	62
Fraud, Waste, and Abuse Compliance	69
Health Education Lifestyle Planning	70
Notifications.....	71
Plan Definitions.....	73

Plan Identification and Contact Information

Plan Administrator

Oklahoma State and Education Employees Group Insurance Board (OSEEGIB)
A division of the Office of State Finance
Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time
3545 NW 58 Street, Suite 110, Oklahoma City, OK 73112
1-405-717-8701 or toll-free 1-800-543-6044
TDD 1-405-949-2281 or toll-free 1-866-447-0436

HealthChoice Medicare Supplement Plans

Member Services, Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time
With Part D Plans: 1-405-717-8699 or toll-free 1-800-865-5142
Without Part D Plans: 1-405-717-8780 or toll-free 1-800-752-9475
All Members TDD: 1-405-949-2281 or toll-free 1-866-447-0436
Website: www.sib.ok.gov or www.healthchoiceok.com

HealthChoice Health Claims Administrator

HP Administrative Services, LLC, Monday through Friday, 7:30 a.m. to 6:00 p.m., Central time
P.O. 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

HealthChoice Pharmacy Benefit Manager

Medco Customer Service, 24 hours a day/7 days a week
With Part D Plans: Toll-free 1-800-590-6828 or toll-free TDD 1-800-716-3231
Without Part D Plans: Toll-free 1-800-903-8113 or toll-free TDD 1-800-825-1230
Website: www.medco.com

HealthChoice Certification Administrator

APS Healthcare, Monday through Friday, 7:00 a.m. to 7:00 p.m., Central time
P.O. Box 700005, Oklahoma City, OK 73107-0005
Toll-free 1-800-848-8121 or toll-free TDD 1-877-267-6367

Medicare

Customer Service, 24 hours a day/7 days a week
Toll-free 1-800-MEDICARE (1-800-633-4227) or toll-free TTY 1-877-486-2048
Website: www.medicare.gov
Website for Questions and Answers: <http://questions.medicare.gov>

Social Security Administration

Customer Service, Monday through Friday, 7:00 a.m. to 7:00 p.m., Central time
Toll-free 1-800-772-1213 or toll-free TTY 1-800-325-0778
Website: www.socialsecurity.gov

Calls to HealthChoice received before or after hours, on weekends, or holidays are answered by an automated phone system. Leave a message, including your name and telephone number, and a Member Services Representative will return your call the next business day.

Who to Contact About Complaints, Appeals, Grievances, or Coverage Decisions

Plans With Part D

Health Appeals

HP Administrative Services, LLC: Monday through Friday, 7:30 a.m. to 6:00 p.m., Central time
1-405-416-1800 or toll-free 1-800-782-5218
TDD 1-405-416-1525 or toll-free 1-800-941-2160

Pharmacy Coverage Decisions (Prior Authorizations/Exceptions)

Medco, 24 hours a day/7 days a week
Toll-free 1-800-753-2851 or toll-free TDD 1-800-825-1230

Pharmacy Coverage Redeterminations (Appeal Level 1)

HealthChoice Member Services, ask for the Pharmacy Unit
Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time
1-405-717-8699 or toll-free 1-800-865-5142
TDD 1-405-949-2281 or toll-free 1-866-447-0436
Mail or bring your appeal to the HealthChoice Pharmacy Unit at:
OSEEGIB, 3545 NW 58 Street, Suite 110, Oklahoma City, OK 73112

Pharmacy Grievances

HealthChoice Member Services, Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time
1-405-717-8699 or toll-free 1-800-865-5142
TDD 1-405-949-2281 or toll-free 1-866-447-0436

Quality Improvement Organization

Health Integrity, LLC, Monday through Friday, 8:00 a.m. to 7:00 p.m., Eastern time
Toll-free 1-877-772-3379 or toll-free TDD 1-800-855-2880
Email: MEDICinfo@healthintegrity.org

Plans Without Part D

Health Appeals

HP Administrative Services, LLC, Monday through Friday, 7:30 a.m. to 6:00 p.m., Central time
1-405-416-1800 or toll-free 1-800-782-5218
TDD 1-405-416-1525 or toll-free 1-800-941-2160

Pharmacy Appeals

HealthChoice Member Services, ask for the Pharmacy Unit
Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time
1-405-717-8780 or toll-free 1-800-752-9475
TDD 1-405-949-2281 or toll-free 1-866-447-0436
Fax 1-405-717-8925
Mail or bring your appeal to the HealthChoice Pharmacy Unit at:
OSEEGIB, 3545 NW 58 Street, Suite 110, Oklahoma City, OK 73112

How Your Plan Will Change for 2012

Annual Notice of Change

This Annual Notice of Change provides a summary of the changes in benefits for 2012. For more specific benefit information, see the *Summary of HealthChoice High and Low Option Medicare Supplement Plans* and *Pharmacy Benefit Information* sections of this handbook.

Monthly Plan Premiums

Plan Name	2011	2012	Increase
HealthChoice Employer PDP High Option With Part D	\$308.34	\$332.54	\$24.20
HealthChoice Employer PDP Low Option With Part D	\$251.66	\$273.02	\$21.36
HealthChoice High Option Without Part D	\$363.06	\$383.34	\$20.28
HealthChoice Low Option Without Part D	\$306.38	\$323.82	\$17.44

Medicare Deductibles

	2011	2012	Increase or (Decrease)
Part A — Hospitalization	\$1,132.00	\$1,156.00	\$24.00
Part B — Medical	\$ 162.00	\$140.00	(\$22.00)
Part D — Prescription Drugs	\$ 310.00	\$320.00	\$10.00

HealthChoice Health Benefits

HealthChoice Plans provide supplemental benefits to Medicare Parts A and B. Benefits are adjusted January 1 of each year to coincide with changes made by Medicare.

HealthChoice Pharmacy Network

The HealthChoice Pharmacy Network includes nearly 60,000 pharmacies across Oklahoma and throughout the nation. The number of pharmacies in the network equals or exceeds Medicare's requirements for pharmacy access in your area. To locate a HealthChoice Network Pharmacy near you, visit the HealthChoice website at www.sib.ok.gov or www.healthchoicelok.com or contact Medco, 24 hours a day, 7 days a week at:

- ◆ With Part D call toll-free 1-800-590-6828 or toll-free TDD 1-800-716-3231
- ◆ Without Part D call toll-free 1-800-903-8113 or toll-free TDD 1-800-825-1230

HealthChoice Medicare Formulary

There are changes to the HealthChoice Medicare Formulary. Some drugs have been added to the formulary while other drugs have been removed. Some brand-name drugs have been replaced with generic drugs. Additionally, some restrictions have been added to certain drugs.

A comprehensive version of the formulary is available on the HealthChoice website at www.sib.ok.gov or www.healthchoiceok.com. Click the *Member* tab in the top menu and then select *Medicare Members*, or contact HealthChoice Member Services, Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time, at:

- ◆ With Part D call 1-405-717-8699 or toll-free 1-800-865-5142
- ◆ Without Part D call 1-405-717-8780 or toll-free 1-800-752-9475
- ◆ TDD users call 1-405-949-2281 or toll-free 1-866-447-0436

HealthChoice Pharmacy Benefits

- ◆ In accordance with the Centers for Medicare and Medicaid Service's (CMS) guidelines, the initial coverage limit is increasing from \$2,840 to \$2,930. See the *Pharmacy Benefit Information* section for details.
- ◆ Certain tobacco cessation products are available for a \$0 copay. Additionally, HealthChoice partners with the Oklahoma Tobacco Settlement Endowment Trust and Alere Wellbeing to provide members with over-the-counter nicotine replacement therapy products (patches, gum, and lozenges) and telephone coaching at no charge. See the *Pharmacy Benefit Information* section for more information.
- ◆ For members without Part D, copays for a 30-day fill of **specialty** medications are increasing:
 - Preferred medication copays are increasing from \$57.50 to \$60.00
 - Non-Preferred medication copays are increasing from \$115 to \$120

Information About Your Premiums

2012 Medicare Premiums

If you currently pay a premium for Medicare Part A and/or Part B, you must continue to pay your premiums in order to keep your Medicare coverage. If you do not qualify for premium-free Part A, you can buy it. The premium for Part A is \$451. You must be at least 65 years old and meet certain other requirements. You can also buy Part A if you are under age 65 and were once entitled to Medicare because of a disability.

The standard premium for Part B is \$99.90. People with higher incomes may pay more. If you did not sign up for Part B when you first became eligible, your premiums for Part B may be higher than if you enrolled when you were first eligible. You can delay your enrollment in Part B if you are still working and have insurance through your employer.

For more information, contact Social Security, Monday through Friday, 7:00 a.m. to 7:00 p.m., Central time, at:

- ◆ Toll-free 1-800-772-1213 or toll-free TTY/TDD 1-800-325-0778

Paying Your Plan Premiums

You must pay your full monthly premium unless you qualify for Extra Help from Medicare. Payment of your monthly premium is handled in one of three ways:

- ◆ Withheld from your retirement check
- ◆ Withdrawn automatically from your bank account through an automatic draft
- ◆ Paid directly to OSEEGIB – you will receive a monthly premium statement

COBRA participants must pay premiums directly to OSEEGIB. Your premiums can be withdrawn automatically from your bank account through an automatic draft, or paid directly to OSEEGIB – you will receive a monthly premium statement.

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

There is a program available to help people who have limited income and resources as determined by Social Security. You may be able to get Extra Help paying your monthly premiums, pharmacy deductibles, and pharmacy copays. This Extra Help also counts toward your out-of-pocket maximum. If you think you may qualify or want more information, visit the Social Security website at www.socialsecurity.gov or call Social

Security, Monday through Friday, 7:00 a.m. to 7:00 p.m., Central time, at:

- ◆ Toll-free 1-800-772-1213 or toll-free TTY/TDD 1-800-325-0778

You can also visit www.medicare.gov, or call Medicare, 24 hours a day, 7 days a week, at:

- ◆ Toll-free 1-800-MEDICARE (1-800-633-4227)
- ◆ Toll-free TTY/TDD 1-877-486-2048

After you apply for Extra Help, you will get a letter letting you know whether or not you qualify and what you need to do next. You may receive full or partial help depending on your income, family size, and resources.

For the prescription drug portion of your coverage, you pay \$0 or a reduced monthly premium if you qualify for Extra Help. It also helps you pay your prescription drug costs. If you qualify for Extra Help in 2012, the information below shows the assistance you will receive for the prescription drug portion of your coverage.

If you qualify for full help, the following benefits apply:

- ◆ A premium reduction of \$31.10
- ◆ No pharmacy deductible
- ◆ Continuous coverage (no Coverage Gap)
- ◆ Maximum copays of \$2.60 for generic/Preferred drugs and \$6.50 for other drugs

If you qualify for partial help, the following benefits apply:

- ◆ A premium reduction between \$7.80 and \$31.10
- ◆ A pharmacy deductible of \$65
- ◆ Continuous coverage (no Coverage Gap)
- ◆ Coinsurance of 15% (up to the out-of-pocket maximum)

If you qualify for Extra Help, Medicare notifies HealthChoice and then HealthChoice notifies you of the amount of Extra Help you will receive.

Note: Extra Help applies to either the High or Low Option Plans **with** Part D. If you qualify for Extra Help, HealthChoice will automatically move you to the Low Option Plan so you pay the lowest premium. If you want to elect the High Option Plan, please notify HealthChoice in writing at:

HealthChoice
3545 NW 58 Street, Suite 110
Oklahoma City, OK 73112

Your request can also be faxed to 1-405-747-8939.

Be aware that if you qualify for Extra Help, some of the information in this handbook/Evidence of Coverage will not apply to you.

If you qualify for Extra Help and believe you are paying an incorrect copay amount, HealthChoice will work with CMS to verify your copay level. If it is determined that your copay is incorrect, the Plan will update its system so that you pay the correct copay. If you paid a higher copay than you should have, HealthChoice will pay you back.

Note to members who live in a long-term care facility: If the pharmacy hasn't collected copays from you and is carrying your copays as a debt you owe, HealthChoice can make payment directly to the pharmacy.

Your Premium for Part D Could be Higher – Part D Income-Related Premium Adjustment

As a member of a Medicare supplement plan offered through OSEEGIB, your premium for Part D prescription drug coverage is included in your monthly premium. If your income is above a certain level (\$85,000 for individuals or \$170,000 for married couples), you must pay an additional premium for your Part D coverage. If you have to pay an extra amount, the Social Security Administration will send you a letter telling you the amount. For more information, call Social Security at 1-800-772-1213, Monday through Friday, 7 a.m. to 7 p.m., Central time. TTY users call toll-free 1-800-325-0778.

If you fail to pay any Part D income-related premium adjustment, HealthChoice must move you to a plan without Part D.

Changes in Your Monthly Premium

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

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

For more information, see the 2012 *Medicare and You* handbook, visit www.medicare.gov, or call Medicare, 24 hours a day, 7 days a week, at the following numbers:

- ◆ Toll-free 1-800-MEDICARE (1-800-633-4227)
- ◆ Toll-free TTY/TDD 1-877-486-2048

Late Enrollment Penalty

Medicare applies a late enrollment penalty to your Part D premium when:

- ◆ You don't join a Medicare Part D plan, or other plan with creditable prescription drug coverage, when you first become Medicare eligible at age 65 or when you become eligible prior to age 65 due to a disability
- ◆ You have a lapse in creditable prescription drug coverage that lasts longer than 63 continuous days

The late enrollment penalty is applied at the time you enroll in creditable prescription drug coverage. The penalty is calculated based on the number of months you were without Creditable Coverage and the amount of the average monthly premium for Part D plans. The amount of the penalty can change from year to year, and once a penalty is applied, it will follow you as long as you have Part D prescription drug coverage.

OSEEGIB pays the late enrollment penalty if it applies to a HealthChoice member, but the penalty could be applied if you leave OSEEGIB and enroll in another insurance plan.

In some cases, you do not have to pay a penalty even though your enrollment is late. The penalty is not applied if you:

- ◆ Have creditable prescription drug coverage through another group or government plan like TRICARE, Veterans Administration, or Indian Health Services
- ◆ Were without Creditable Coverage for less than 63 days
- ◆ Receive Extra Help from Medicare

If you become Medicare eligible because of a disability, the late enrollment penalty is eliminated when you reach your Initial Enrollment Period at age 65 as long as you remain enrolled in a Part D plan.

If you have questions about the late enrollment penalty, please contact Medicare toll-free at 1-800-MEDICARE (1-800-633-4227) or toll-free TTY 1-877-486-2048.

Non-Payment of Premiums

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

General Information

This Medicare supplement handbook/Evidence of Coverage provides a guide to the features of the Plans. It is not a complete description of the Plans. Please read this handbook carefully for information about eligibility rules and benefits. These Plans are designed to provide supplemental benefits to Medicare Part A and Part B, as well as Part D prescription drug benefits. **Except as noted otherwise in this handbook, services not covered by Medicare are not covered by the Plans.** The Plans' medical benefits are based on Medicare's approved amounts. For more information, review your 2012 *Medicare & You* handbook, visit www.medicare.gov, or call Medicare, 24 hours a day, 7 days a week, at:

Toll-free at 1-800-MEDICARE (1-800-633-4227)
Toll-free TTY 1-877-486-2048

All HealthChoice medical benefits are paid as if you are enrolled in both Medicare Part A and Part B. If you are not enrolled in Medicare, HealthChoice estimates Medicare's benefits and provides coverage as if Medicare were your primary insurance carrier. For complete information about Medicare enrollment, visit the Social Security Administration website at www.socialsecurity.gov or contact Social Security customer service, Monday through Friday, 7:00 a.m. to 7:00 p.m., Central time, at:

- ◆ Toll-free 1-800-772-1213
- ◆ Toll-free TTY/TDD 1-800-325-0778

Other websites that can be helpful are the Centers for Medicare and Medicaid Services at www.cms.gov or Medicare Questions and Answers at <http://questions.medicare.gov>

The Plans With Part D

The Plans with Part D benefits include Medicare Part D prescription drug coverage.

The Plans Without Part D

The Plans without Part D include pharmacy benefits, but they are not Medicare Part D plans. These plans are specifically for members who:

- ◆ Already have Medicare Part D coverage through another plan or employer
- ◆ Receive a subsidy for prescription drug benefits from their or their spouse's employer
- ◆ Receive Veterans Administration health benefits for prescription drugs

Note: Premiums for the plans without Part D are higher because HealthChoice does not receive a subsidy from Medicare for members enrolled in these plans.

Provider-Patient Relationship

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

Federal Limiting Charge

Providers who do not accept Medicare assignment cannot charge a Medicare beneficiary more than 115% of Medicare approved amounts. For more information, refer to the section of your *Medicare and You* handbook titled *Keeping Your Costs Down with Assignment*.

Certification

Certification through the HealthChoice certification administrator, APS Healthcare, is required for inpatient hospital admissions and certain outpatient surgical procedures if Medicare is not your primary carrier. If you have questions, contact APS Healthcare, Monday through Friday, 7:00 a.m. to 7:00 p.m., Central time, at:

- ◆ Toll-free at 1-800-848-8121 or toll-free TDD 1-877-267-6367

The HealthChoice Plans Supplement Medicare Part A (hospitalization) by:

- ◆ Paying the inpatient hospitalization deductible and coinsurance in full
- ◆ Paying for an additional 365 lifetime reserve days for hospitalization
- ◆ Paying the Part A coinsurance for skilled nurse facility care for days 21 through 100
- ◆ Paying for the first three pints of blood while hospitalized

The HealthChoice Plans Supplement Medicare Part B (medical) by:

- ◆ Paying the 20% of medical expenses not paid by Part B*
- ◆ Paying the 20% of durable medical equipment expenses not paid by Part B*
- ◆ Paying for some prescription drugs

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

The HealthChoice Plans Provide Prescription Drug Coverage

2012 Plan Year	Low Option Plan	High Option Plan
Pharmacy Deductible	\$ 320.00	Not Applicable
Cost Sharing/Copay	The next \$2,610.00 in prescription costs You pay 25% or \$652.50 Plan pays 75% or \$1,957.50	Applicable copay per prescription fill
Coverage Gap	\$3,727.50*	Not Applicable
Annual Out-of-Pocket Maximum	\$4,700.00	\$4,700.00
After Annual Out-of-Pocket Maximum	100%	100%

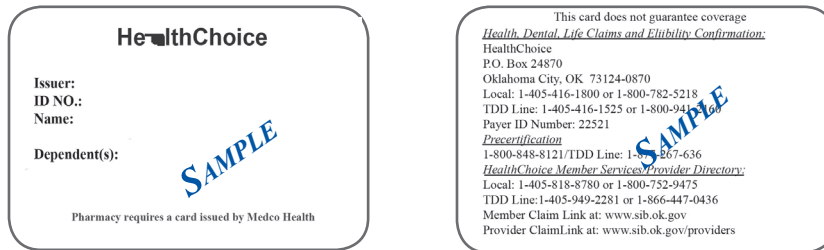
*Members with Part D who reach \$2,930 in total drug costs receive certain discounts when purchasing covered medications. See *Medicare Coverage Gap Discount Program* in the *Pharmacy Benefit Information Section*.

Plan ID Cards

There are two ID cards; one card is for health and dental benefits and the other card is for pharmacy benefits. If you are currently a HealthChoice member, continue using your current ID cards. If you are new to HealthChoice, you are issued new ID cards.

Health/Dental ID Card

Please present your HealthChoice health/dental ID card when you receive services. When you receive health services, you also need to present your red, white, and blue Medicare card to your provider. Following is an example of your health/dental ID card:



To request replacement health/dental ID cards, contact HP Administrative Services, LLC, Monday through Friday, 7:30 a.m. to 6:00 p.m., Central time, at:

- ◆ 1-405-416-1800 or toll-free 1-800-782-5218
- ◆ TDD users call 1-405-416-1525 or toll-free 1-800-941-2160

Prescription Drug ID Card

Please present your HealthChoice prescription drug ID card when you purchase prescriptions. The pharmacy automatically bills HealthChoice for its share of your covered prescription drug cost. You do not need to present your Medicare ID card at the pharmacy. Following is a sample of your prescription drug ID card:



If you don't have your prescription drug ID card when you fill a prescription, have your pharmacy contact HealthChoice for your information. If your pharmacy cannot get the needed information, you may have to pay for your medication and then ask HealthChoice to pay you back by filing a paper pharmacy claim. See the *Claim Procedures* section.

To request a replacement prescription drug ID card, visit www.medco.com. You can also request a replacement card by calling Medco, 24 hours a day, 7 days a week:

- ◆ With Part D call toll-free 1-800-590-6828 or toll-free TDD 1-800-716-3231
- ◆ Without Part D call toll-free 1-800-903-8113 or toll-free TDD 1-800-825-1230

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. 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 registered to access ClaimLink, you will need to create a user name and password to gain access to your information. If you prefer to go paperless and not receive paper EOBs, contact the health claims administrator. Also, see *Pharmacy Explanation of Benefits (EOB)* in the *Pharmacy Benefit Information* section.

Your Contact Information

It is important to keep your contact information current. You risk delaying claims processing, missing communications, and even disenrollment from the Plan when your information is incorrect. **Additionally, Medicare requires that you report any changes in your name, address, or telephone number to your insurance plan.** Changes can be faxed to 1-405-717-8939 or sent in writing to:

HealthChoice, 3545 NW 58 Street, Suite 110, Oklahoma City, OK 73112

Summary of HealthChoice High and Low Option Medicare Supplement Plans

Medicare Part A (Hospitalization) Services

All benefits are based on Medicare Approved Amounts

Services or Items	Medicare Part A Pays	HealthChoice Pays	You Pay	
Hospitalization: Semiprivate room, meals, drugs as part of your inpatient treatment, and other hospital services and supplies	First 60 days	All except \$1,156, the Part A deductible	\$1,156, the Part A deductible	0%
	Days 61 through 90	All except \$289 per day	\$289 per day	0%
	Days 91 and after while using Medicare's 60 lifetime reserve days	All except \$578 per day	\$578 per day	0%
	Once Medicare's lifetime reserve days are used, HealthChoice provides additional lifetime reserve days Limited to 365 days	0%	100% of Medicare eligible expenses Certification by HealthChoice is required	0%
	Beyond the additional 365 days	0%	0%	100%
Skilled Nurse Facility Care: Must meet Medicare requirements, including inpatient hospitalization for at least 3 days and entering a Medicare approved facility within 30 days of leaving the hospital. Limited to 100 days per calendar year	First 20 days	All approved amounts	0%	0%
	Days 21 through 100	All except \$144.50 per day	\$144.50 per day	0%
	Days 101 and after	0%	0%	100%

Services or Items		Medicare Part A Pays	HealthChoice Pays	You Pay
Hospice Care	Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	0%	Balance
Blood	Limited to the first 3 pints unless you or someone else donates blood to replace what you use	0%	100%	0%

Supplemental Benefits for Medicare Part B (Medical)
All Benefits are Based on Medicare Approved Amounts

Services or Items		Medicare Part B Pays	HealthChoice Pays	You Pay
Medical Expenses: Inpatient and outpatient hospital treatment, such as physician services, medical and surgical services and supplies, physical and speech therapy, and diagnostic tests (Medicare limits apply)	You pay \$140, the Part B deductible	0%	0%	\$140, the Part B deductible
	Remainder of Medicare approved amounts	80%	20%	0%
	Part B charges above Medicare approved amounts	0%	100%	0%
Clinical Laboratory Services	Blood tests and urinalysis for diagnostic services	100%	0%	0%
Home Health Care: Medicare approved services	Medically necessary skilled care services and medical supplies	100%	0%	0%

Medicare Part B Continued

Services or Items		Medicare Part B Pays	HealthChoice Pays	You Pay
Durable Medical Equipment: Items such as wheelchairs, walkers, and hospital beds	You pay \$140, the Part B deductible	0%	0%	\$140, the Part B deductible
	Remainder of Medicare approved amounts	80%	20%	0%
Blood	Amounts in addition to the coverage under Part A unless you or someone else donates blood to replace what you use	80% after the Part B deductible	20% after the Part B deductible	0%
Hospice Prescription	Covered for Medicare beneficiaries with a terminal illness	80%	20%	0%

The \$140 Medicare Part B deductible is credited towards your HealthChoice deductible upon receipt of Medicare’s Explanation of Benefits (EOB). Once you meet the Part B deductible, your HealthChoice deductible is met for the plan year.

Medicare Part B - Preventive Services

Preventive Services	Who is Covered	Medicare Part B Pays	HealthChoice Pays	You Pay
One-time Initial Wellness Physical Exam: To be completed within 12 months of your enrollment in Medicare Part B	All Medicare beneficiaries	100% No Part B deductible	0%	0%

Medicare Part B - Preventive Services Continued

Preventive Services	Who is Covered	Medicare Part B Pays	HealthChoice Pays	You Pay
Preventive Exam: Limited to one every 12 months	All Medicare beneficiaries	100% No Part B deductible	0%	0%
Screening Mammogram: Limited to one every 12 months	All female Medicare beneficiaries age 40 and older	100% No Part B deductible	0%	0%
Cardiovascular Screenings: Limited to one every five years	All Medicare beneficiaries	100% No Part B deductible	0%	0%
Pap Test and Pelvic Exam: Limited to one every 24 months; includes a clinical breast exam Limited to one every 12 months if high risk/ abnormal Pap test in preceding 36 months	All female Medicare beneficiaries	100% No Part B deductible	0%	0%
Diabetes Screening Test: Limited to two per year	All Medicare beneficiaries at risk of diabetes	100% No Part B deductible	0%	0%
Diabetes Self-Management Training	All Medicare beneficiaries with diabetes (insulin and non-insulin users)	80% after the Part B deductible	20% after the Part B deductible	0%
Diabetes Monitoring Supplies: Includes coverage for glucose monitors, test strips, and lancets without regard to the use of insulin	All Medicare beneficiaries with diabetes - must be requested by your doctor	80% after the Part B deductible	20% after the Part B deductible	0%

Medicare Part B - Preventive Services Continued

Preventive Services	Who is Covered	Medicare Part B Pays	HealthChoice Pays	You Pay
Ostomy Supplies: Includes ostomy bags, wafers, and other ostomy supplies	All Medicare beneficiaries in need of ostomy supplies	80% after the Part B deductible	20% after the Part B deductible	0%
Colorectal Cancer Screening Fecal Occult Blood Test: Limited to one every 12 months	All Medicare beneficiaries age 50 and older	100% No Part B deductible	0%	0%
Flexible Sigmoidoscopy: Limited to one every 48 months for age 50 and older; for those not at high risk, 10 years after a previous screening	All Medicare beneficiaries age 50 and older	100% No Part B deductible	0%	0%
Colonoscopy: Limited to one every 24 months if you are at high risk for colon cancer; if not, once every 10 years, but not within 48 months of a screening flexible sigmoidoscopy	All Medicare beneficiaries; there is no minimum age	100% No Part B deductible	0%	0%
Barium Enema: Doctor can substitute for sigmoidoscopy or colonoscopy	All Medicare beneficiaries age 50 and older	100% No Part B deductible	0%	0%
Prostate Cancer Screening Digital Rectal Exam: Limited to one every 12 months	All male Medicare beneficiaries age 50 and older	80% for the digital rectal exam, after the Part B deductible	20% for the digital rectal exam	0%
Prostate Specific Antigen Test (PSA): Limited to one every 12 months		100% No Part B deductible	0%	0%

Medicare Part B - Preventive Services Continued

Services	Who is Covered	Medicare Part B Pays	HealthChoice Pays	You Pay
Bone Mass Measurements: Limited to one every 24 months	All Medicare beneficiaries at risk for losing bone mass	100% No Part B deductible	0%	0%
Glaucoma Screening: Limited to one every 12 months; must be performed or supervised by an eye doctor who is authorized to do this within the scope of their practice	Medicare beneficiaries at high risk or having a family history of glaucoma	80% after the Part B deductible	20% after the Part B deductible	0%
Smoking Cessation: Eight face-to-face visits in a 12-month period	All Medicare beneficiaries	80% after the Part B deductible	20% after the Part B deductible	0%
HIV Screening: Limited to once every 12 months or up to three times during pregnancy	Pregnant, high risk, or any Medicare beneficiary who requests the test	100% after the Part B deductible	0%	0%

Vaccinations Covered Under Medicare

Some vaccines are covered under Medicare Part B and others are covered under Medicare Part D. What you pay depends on the type of vaccine, where you purchase the vaccine, and who administers the vaccination shot. The rules for coverage of vaccinations can be complicated. If you are not sure how your vaccination is covered, before you go for your vaccination, you may want to contact HealthChoice Member Services, Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time, at:

- ◆ Members with Part D call 1-405-717-8699 or toll-free 1-800-865-5142
- ◆ Members without Part D call 1-405-717-8780 or toll-free 1-800-752-9475
- ◆ TDD users call 1-405-949-2281 or toll-free 1-866-447-0436

Vaccinations Covered Under Medicare Part B

Flu Vaccination: Limited to one per flu season	Medicare Part B covers the vaccination and administration at 100% if the provider accepts Medicare assignment.
Pneumococcal Vaccination: One-time vaccination	Medicare Part B covers the vaccination and administration at 100% if the provider accepts Medicare assignment.
Hepatitis B Vaccination: Limited to beneficiaries at medium to high risk for Hepatitis B	Medicare Part B covers the vaccination and administration at 100% if the provider accepts Medicare assignment.
Shingles Vaccination: e.g., ZOSTAVAX (<i>zoster vaccine live</i>)	The vaccine and the administration fee are not covered under Part B. See the <i>Pharmacy Benefit Information</i> section for coverage information.
Tetanus Vaccination: e.g., TETANUS TOXOID Covered only for those not immunized, following acute injury	Medicare Part B covers the vaccination and administration at 100% if the provider accepts Medicare assignment.

Services Covered Only by HealthChoice

Services	Benefits	Medicare Part B Pays	HealthChoice Pays	You Pay
Foreign Travel: Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A.	Contact Medicare for foreign travel exceptions that are covered by Medicare	0%	80% of billed charges after the first \$250 of each calendar year \$50,000 lifetime maximum	First \$250 of each calendar year, then 20% and all amounts over the \$50,000 lifetime max No Medicare deductible



Pharmacy Benefits for HealthChoice High Option Medicare Supplement Plans

What You and HealthChoice Pay for Covered Prescription Drugs Purchased at Network Pharmacies

Medications Purchased at Network Pharmacies	You Pay	HealthChoice Pays
Generic (Tier 1) and Preferred (Tier 2) medications costing \$100 or less	Copay up to \$30 per fill	Allowed Charges after your copay
Generic (Tier 1) and Preferred (Tier 2) medications costing more than \$100	Copay of 25% up to \$60 per fill	Allowed Charges after your copay
Non-Preferred (Tier 3) medications costing \$100 or less	Copay up to \$60 per fill	Allowed Charges after your copay
Non-Preferred (Tier 3) medications costing more than \$100	Copay of 50% up to \$120 per fill	Allowed Charges after your copay
Preferred (Tier 5) prescription tobacco cessation medications	Copay of \$0 per fill	Allowed Charges

Preferred, high-cost (**Tier 4**) medications have the same copays as the generic (**Tier 1**) and Preferred (**Tier 2**) medications. **Some medications require Prior Authorization.** See *Prior Authorization* later in this section.

The High Option plans do not have a pharmacy deductible.

Pharmacy benefits may cover up to a 34-day supply or 100 units, whichever is greater. See *Quantity Limits* later in this section.

If you take a specialty medication, see *Specialty Medications* later in this section.

High Option with Part D plan members who reach total drug costs of \$2,930 receive a 50% discount toward their copay costs when purchasing covered brand-name medications. See *Medicare Coverage Gap Discount Program* later in this section.

After You Reach the Pharmacy Out-of-Pocket Maximum

After You Pay	HealthChoice Pays
\$4,700, the pharmacy out-of-pocket maximum, in prescription drug copays	100% of covered medications for the remainder of the calendar year once you reach the \$4,700 pharmacy out-of-pocket maximum

Pharmacy Benefits for HealthChoice Low Option Medicare Supplement Plans



Pharmacy Benefit Information

What You and HealthChoice Pay for Covered Prescription Drugs Purchased at Network Pharmacies			
Pharmacy Deductible Stage \$320	Initial Coverage Limit Stage \$2,610	Coverage Gap Stage \$3,727.50	100% Benefit Stage After \$4,700
During the Deductible stage, you must pay the full cost of your covered prescription drugs, up to \$320 , before HealthChoice begins to pay.	During the Initial Coverage Limit stage, you and HealthChoice share the costs of the next \$2,610 of covered prescription drugs purchased at Network Pharmacies. You pay 25%, or a total of \$652.50 , and HealthChoice pays 75%, or a total of \$1,957.50 . You pay your 25% each time you fill a covered prescription drug at a Network Pharmacy. For example, if your drug costs \$60, you pay \$15.	During the Coverage Gap stage, you pay 100% of the next \$3,727.50 of covered prescription drugs purchased at Network Pharmacies (less discounts for members with Part D) until you reach the pharmacy out-of-pocket maximum of \$4,700 .	During the 100% Benefit stage, HealthChoice pays 100% of Allowed Charges for covered prescription drugs purchased at Network Pharmacies for the rest of the calendar year.
<p>To reach the 100% Benefit stage, you must pay the following costs:</p> <ol style="list-style-type: none"> 1. \$ 320.00 the Pharmacy Deductible stage 2. \$ 652.50 your 25% of costs during the Initial Coverage Limit stage 3. \$3,727.50 your costs during the Coverage Gap stage 			
<p>Low Option with Part D members who reach total drug costs of \$2,930 receive a 50% discount on the cost of covered brand-name medications, and HealthChoice pays 14% of the cost of generic medications. See <i>Medicare Coverage Gap Discount Program</i> later in this section.</p>			
<p>Pharmacy benefits may cover up to a 34-day supply or 100 units, whichever is greater. See <i>Quantity Limits</i> later in this section.</p>			
<p>For information on the copays for specialty medications, see <i>Specialty Medications</i> later in this section.</p>			

Your Prescription Drug Coverage

Basic Rules for Prescription Drug Coverage

HealthChoice generally covers your drugs as long as you follow these basic rules:

- ◆ You must have a prescription written by your physician or other provider.
- ◆ You must use a HealthChoice Network Pharmacy.
- ◆ Your drug must be on the HealthChoice Medicare Formulary (drug list).
- ◆ Your drug must be prescribed for a medically accepted indication. This means the drug is either approved by the Food and Drug Administration or accepted as the standard of good practice within the medical community.

Pharmacy Out-of-Pocket Maximum

All Plans have a pharmacy out-of-pocket maximum of \$4,700. This total includes amounts you spend on deductibles, copays, and coinsurance at Network Pharmacies. If you are a Low Option Plan member, this total includes amounts you spend during the Coverage Gap stage. Once you reach the \$4,700 out-of-pocket maximum, the Plan pays 100% for covered medications purchased at Network Pharmacies for the remainder of the calendar year.

Costs That Apply To the Pharmacy Out-of-Pocket Maximum

Medicare has rules about what does and what does not count toward your pharmacy out-of-pocket maximum. Medications must be covered Part D drugs and listed on the HealthChoice Medicare Formulary, or covered through one of the exceptions or appeals processes. Drugs must be purchased at Network Pharmacies for costs to apply to the out-of-pocket maximum. The following costs count toward your out-of-pocket maximum:

- ◆ Your deductible, if applicable
- ◆ Your coinsurance or copays
- ◆ Your costs during the Coverage Gap stage (Low Option Plans)
- ◆ Amounts discounted by brand-name drug manufacturers once you reach \$2,930 in total prescription drug costs

Costs That Do Not Apply To the Pharmacy Out-of-Pocket Maximum

- ◆ Amounts paid by HealthChoice for generic medications once you reach \$2,930 in total prescription drug costs (Low Option Plans with Part D)

- ◆ Costs for medications purchased outside the United States and its territories
- ◆ Costs for non-covered medications
- ◆ Costs for medications purchased at non-Network pharmacies when requirements are not met
- ◆ Costs for medications covered under Medicare Part A or Part B
- ◆ Payments made by another group health plan or government health plan such as TRICARE, the Veterans Administration, or Indian Health Services
- ◆ Payments for medications made by a third-party with a legal obligation to pay

Pharmacy Coverage Gap Stage (Low Option Plans)

After your total drug costs reach the Initial Coverage Limit stage (\$2,930), you pay the costs of Part D covered drugs (minus discounts) until you reach the out-of-pocket maximum of \$4,700. This period is known as the Coverage Gap stage.

Medicare Coverage Gap Discount Program (With Part D Plans)

Part D plan members who do not receive Extra Help and reach total drug costs of \$2,930 are provided discounts on certain Part D drugs purchased at Network Pharmacies. Prescription drug manufacturers provide discounts on brand-name drugs, and HealthChoice provides discounts on generic drugs.

The amounts discounted by brand-name manufacturers apply to your pharmacy out-of-pocket maximum; however, amounts discounted by HealthChoice do not. Discounts are automatically applied at your pharmacy when you reach \$2,930 in drug costs.

- ◆ **Low Option Plans with Part D:** After your total drug costs reach \$2,930 (\$320 deductible plus \$2,610 in additional drug costs), brand-name drug manufacturers provide a 50% discount* toward the cost of covered brand-name medications, and HealthChoice pays 14% toward the cost of generic drugs.
- ◆ **High Option Plans with Part D:** After your total drug costs reach \$2,930, brand-name manufacturers provide a 50% discount* toward your copay amounts for covered brand-name medications.

*The 50% discount is available only for brand-name drugs whose manufacturers have agreed to pay it. **If a brand-name manufacturer has not agreed to pay the discount, medications made by that manufacturer are not covered.**

HealthChoice Pharmacy Network

In most cases, your prescriptions are covered only if they are filled at a Network Pharmacy. The HealthChoice Pharmacy Network includes more than 900 pharmacies

across Oklahoma and nearly 60,000 pharmacies nationwide. Network Pharmacies contract with our Plans to provide covered prescription drugs to members. They also provide electronic claim processing, so generally, there are no paper claims to file.

The HealthChoice Pharmacy Network includes specialized pharmacies such as:

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

Sometimes a pharmacy leaves the Network. When this occurs, you have to get your prescriptions filled at another Network Pharmacy. To locate a HealthChoice Network Pharmacy near you, go to the HealthChoice website at www.sib.ok.gov or www.healthchoicook.com. Click *Find a Provider* in the top menu bar and then select *Network Pharmacies* under *HealthChoice Provider Listings*. You can also contact Medco, 24 hours a day, 7 days a week, at:

- ◆ With Part D call toll-free 1-800-590-6828 or toll-free TDD 1-800-716-3231
- ◆ Without Part D call toll-free 1-800-903-8113 or toll-free TDD 1-800-825-1230

In certain instances, HealthChoice pays for your prescriptions when they are filled at a non-Network pharmacy; however, a reduced benefit may apply. See *Non-Network Pharmacies* later in this section.

The HealthChoice Medicare Formulary

HealthChoice has a list of covered medications, known as the *HealthChoice Medicare Formulary*. This list tells which drugs are covered, which drug tier they are in, and if there are any restrictions that apply.

This formulary was designed with a team of doctors and pharmacists and lists the categories of drugs believed to be part of a good prescription drug program. Medicare has approved this formulary. If you were Medicare eligible during the annual Option Period, a copy of the HealthChoice Medicare Formulary was included in your Option Period enrollment materials.

The formulary is available on the HealthChoice website at www.sib.ok.gov or www.healthchoicook.com. To request a printed copy, contact HealthChoice Member Services,

Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time, at:

- ◆ With Part D call 1-405-717-8699 or toll-free 1-800-865-5142
- ◆ Without Part D call 1-405-717-8780 or toll-free 1-800-752-9475
- ◆ TDD users call 1-405-949-2281 or toll-free 1-866-447-0436

The formulary lists Preferred and non-Preferred drugs. **While most generics are Preferred, some brand-name medications are also Preferred.** Generally, HealthChoice does not cover brand-name drugs when generics are available. Generic drugs have the same active ingredients as brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs. Generics usually cost less than brand-name drugs. For more information, visit www.sib.ok.gov or www.healthchoiceok.com or contact Medco, 24 hours a day, 7 days a week, at:

- ◆ With Part D call toll-free 1-800-590-6828 or toll-free TDD 1-800-716-3231
- ◆ Without Part D call toll-free 1-800-903-8113 or toll-free TDD 1-800-825-1230

Changes to the Formulary During the Year

Most formulary changes occur at the beginning of each plan year; however, sometimes formulary changes occur midyear. HealthChoice may:

- ◆ Add or remove a drug from the formulary
- ◆ Add or remove a coverage restriction
- ◆ Replace a brand-name drug with a generic
- ◆ Move a drug to a higher or lower tier

If a drug you take is affected by a change, HealthChoice is required to notify you at least 60 days before the change, or at the time you request a refill. If you receive notice of a formulary change, work with your physician to switch your prescription to a covered drug. Depending on the type of change, you may be able to request a prior authorization and ask HealthChoice to continue to cover the drug for you.

If the Food and Drug Administration finds a drug is unsafe or a drug is removed from the market, HealthChoice will immediately remove the drug from our formulary and then notify you of the change. Your doctor will also know about this change and can prescribe another drug for your condition.

Using the HealthChoice Medicare Formulary

Brand-name and generic medications are listed in the formulary by the general medical condition they treat and also alphabetically at the back of the formulary. Brand-name medications appear in all capital letters (LIPITOR) and generic medications are listed

in lower-case italics (*atorvastatin*). Listed by each drug name is the drug tier and a code indicating restrictions, if applicable. See *Some Drugs Have Restrictions* in this section.

Drug Tiers

HealthChoice has a five-tier drug formulary, and in general, each tier represents a different cost group. Tier 1 medications usually have the lowest out-of-pocket costs, and Tier 3 drugs have the highest out-of-pocket costs. If a generic drug is not available, a Tier 2 drug is your next least expensive choice. Drug tiers are as follows:

- ◆ Tier 1 – Generic medications
- ◆ Tier 2 – Preferred, brand-name medications
- ◆ Tier 3 – Non-Preferred, brand-name medications
- ◆ Tier 4 – Preferred, very high cost, and unique formulary drugs
- ◆ Tier 5 – Preferred tobacco cessation medications with a \$0 copay

Medically Necessary Drugs

Your prescription drugs must be deemed reasonable and necessary for the treatment of your illness or injury. They must also be deemed the accepted treatment for your condition.

Drugs Covered Under Medicare Part A and Part B

Medicare Part A and Part B provide coverage for some medications. Your HealthChoice coverage does not affect drugs that are covered under Medicare Part A or Part B.

- ◆ Medicare Part A covers drugs you receive during Medicare-covered stays in a hospital or a skilled nursing facility
- ◆ Medicare Part B covers certain chemotherapy drugs and certain drug injections you receive in an office visit setting or given at a dialysis facility

Not All Drugs are Covered

Not all prescription drugs are covered. The law does not allow Medicare to cover certain types of drugs, and HealthChoice decided not to cover certain drugs.

Some Drugs Have Restrictions

Some drugs have additional requirements or coverage limits. If there is a restriction on a drug you are taking, your provider must take extra steps in order for HealthChoice to

cover your drug.

1. Prior Authorization (PA)

Prior authorization is required before HealthChoice will cover certain drugs, even though they are listed in the HealthChoice Medicare Formulary. It is required when the drug:

- Has a very high cost
- Has specific prescribing guidelines
- Might be covered under Medicare Part B
- Is generally used for cosmetic purposes

See *Medications Requiring Prior Authorization (PA)* later in this section.

2. Quantity Limits (QL)

Due to approved therapy guidelines, certain drugs have quantity limits. Quantity limits can apply to the number of refills you are allowed, or how much of the drug you can receive per fill. Quantity Limits also apply if the medication form is other than a tablet or capsule. See *Medications Subject to Quantity Limits (QL)* later in this section.

3. Limited Availability (LA)

Certain drugs are available at only certain pharmacies. For more information, contact Medco, 24 hours a day, 7 days a week, at:

- ◆ With Part D call toll-free 1-800-590-6828 or toll-free TDD 1-800-716-3231
- ◆ Without Part D call toll-free 1-800-903-8113 or toll-free TDD 1-800-825-1230

4. Enhanced Drug (ED)

These drugs are not normally covered, but HealthChoice has elected to cover them. The amounts you pay for these drugs **do not** count toward your total drug costs. If you receive Extra Help paying for your prescriptions, you will not receive help paying for an ED drug.

5. Part B versus Part D Drug (B/D)

These drugs may be covered by Medicare Part B or Part D depending on the situation. Prior authorization is required to determine how the drug must be billed. Your physician must provide information about the use and the place the drug is administered.

6. Step Therapy (ST)

Step Therapy requires you to first try a less costly drug to treat your medical condition

before HealthChoice covers another drug for that same condition. For example, drug A and B both treat the same medical condition. You must first try drug A, and if it does not work for you, HealthChoice will cover drug B.

Requesting a Pharmacy Prior Authorization

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

1. Have your physician's office contact Medco toll-free at 1-800-753-2851.
2. Medco will fax a *Prior Authorization Form* to your physician's office and request that it be completed and faxed back.
3. If your prior authorization is approved, your physician's office is notified of the approval within 24 to 48 hours. You are also notified in writing.
4. If your prior authorization is denied, your physician's office is notified of denial within 24 to 48 hours. You are also notified in writing.

Note: In most cases, a prior authorization is valid for one year from the date it is issued and must be renewed when it expires. For a list of medications that require prior authorization, see *Medications Requiring Prior Authorization (PA)* later in this section.

Non-Preferred Prior Authorization (High Option Plans)

If you choose a non-Preferred drug when a Preferred drug is available, you must pay the non-Preferred copay, unless you get a Tier Exception for a lower copay. Specific medical guidelines must be met and information must be supplied by your physician to justify your request. Your physician can contact Medco, 24 hours a day, 7 days a week, at:

- ◆ Toll-free 1-800-841-5409 or toll-free TDD 1-800-871-7138

Non-Formulary Medication Prior Authorization

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

1. Ask your physician for a prescription for a generic (Tier 1) or Preferred (Tier 2) medication that is on the *HealthChoice Medicare Formulary*.
2. Continue the non-covered/non-formulary medication and pay the full cost.
3. Request a prior authorization to receive the medication at the non-Preferred copay. For more information, contact HealthChoice Member Services, Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time, at:

- ◆ With Part D call 1-405-717-8699 or toll-free 1-800-865-5142

- ◆ Without Part D call 1-405-717-8780 or toll-free 1-800-752-9475
- ◆ TDD users call 1-405-949-2281 or toll-free 1-866-447-0436

Transition Supply of Medication (Plans with Part D)

A transition supply of medication is a temporary, 34-day supply that is made available to provide enough time for you to make a transition to a formulary drug or to request a prior authorization. This one-time supply is available when:

- ◆ You enroll in a Medicare supplement plan
- ◆ Your physician writes a new prescription for a drug that is non-formulary
- ◆ Your newly prescribed medication requires a prior authorization or has quantity limits
- ◆ Your medication is no longer covered
- ◆ You enter or leave a hospital or other setting such as a long-term care facility

Other situations may qualify for a transition supply, and under some circumstances, this 34-day supply can be extended. In rare instances, such as when a medication is excluded or when a medication is covered under Part B, a transition supply is not available.

For more information on how to obtain a covered transition supply of medication, have your pharmacy contact Medco at the Pharmacy Help Line 24 hours a day, 7 days a week including holidays, at:

- ◆ Toll-free 1-800-922-1557 or toll-free TTY/TDD 1-800-825-1230

Medication Quantities

Pharmacy benefits generally cover up to a 34-day supply or 100 units (tablets or capsules), whichever is greater. Quantities cannot exceed the FDA approved ‘usual’ dosing recommendations. Some drugs have more restrictive quantity and/or length of therapy limits. Quantities are subject to your doctor’s written orders.

Specialty Medications

Specialty medications are usually high-cost, injectable medications that require special handling.

◆ Plans With Part D

You must purchase your specialty medications from a Network pharmacy. Your costs for

Preferred medications are as follows:

- If the cost of the medication is \$100 or less, you pay up to a \$30 copay or the cost of medication, if less
- If the cost of the medication is more than \$100 you pay 25% up to a \$60 maximum copay

For more information, see the pharmacy benefit charts earlier in this section.

◆ **Plans Without Part D**

You must purchase your specialty medications from the HealthChoice specialized pharmacy, Accredo Health. You pay the applicable copay for each 30-day fill. Accredo provides free supplies, such as needles and syringes, free shipping, refill reminder calls, and personal counseling with a registered nurse or pharmacist. If you don't order your specialty medications through Accredo, you must pay the full cost. Your costs are:

- Preferred medications – \$60 copay for each 30-day supply
- Non-Preferred medications – \$120 copay for each 30-day supply

For more information, contact Accredo:

- ◆ Toll-free 1-800-501-7260 or toll-free TDD 1-800-759-1089

Tobacco Cessation Products

HealthChoice covers two, 90-day courses of the following tobacco cessation medications for a \$0 copay when they are purchased at a Network Pharmacy:

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

Additionally, HealthChoice partners with the Oklahoma Tobacco Settlement Endowment Trust (TSET) and Alere Wellbeing to provide over-the-counter nicotine replacement therapy products (patches, gum, and lozenges) and telephone coaching at no charge. To take advantage of these benefits, 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 Oklahoma call 1-866-QUIT-4-LIFE (1-866-784-8454).

Vaccines Covered Under Your Pharmacy Benefits

The rules for coverage of vaccinations are complicated. If you have a question about how a particular vaccine is covered, contact Medco, 24 hours a day, seven days a week, at:

- ◆ With Part D call toll-free 1-800-590-6828 or toll-free TDD 1-800-716-3231
- ◆ Without Part D call toll-free 1-800-903-8113 or toll-free TDD 1-800-825-1230

The coverage of vaccinations includes two parts – the cost of the medication itself and the cost of giving the vaccination shot. What you pay for a Part D covered vaccination depends on three things:

1. The type of vaccine – some vaccines are covered under Medicare Part D, while others are covered under original Medicare
2. Where you get the vaccine medication
3. Who gives you the vaccination shot

◆ **Plans With Part D**

- If the vaccine is purchased through and administered by a pharmacist who is certified to give vaccines, the pharmacy electronically submits a claim for the vaccine and the administration fee. You are responsible for the appropriate copay.
- If you purchase the vaccine from your pharmacy and take it to your physician's office for administration, your pharmacy electronically submits a claim for the vaccine medication, but you have to file a paper claim with Medco for reimbursement of the administration fee.
- If you get a Part D vaccine at your doctor's office, you must pay the entire cost of the vaccine and its administration. You can then file a paper claim for reimbursement of the vaccine and the administration fee, minus the appropriate copay.

◆ **Plans Without Part D**

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

When You are Hospitalized

If you are admitted to a hospital for a Medicare-covered stay, Part A should cover your prescription drug costs. Once you leave the hospital, HealthChoice covers your

prescription drugs as long as they meet the rules for coverage. HealthChoice also covers your drugs if they are approved through a coverage determination, exception, or appeal.

When You are Admitted to a Skilled Nursing Facility

If you are admitted to a skilled nursing facility for a Medicare-covered stay, after Medicare Part A stops paying for your prescriptions, HealthChoice covers them as long as they meet the rules for coverage. The facility must be a HealthChoice Network Pharmacy, and the drug cannot be covered under Part B. HealthChoice also covers your drugs if they are approved through a coverage determination, exception, or appeal.

When You Live in a Long-term Care Facility

Usually, a long-term care facility, such as a nursing home, has its own pharmacy, or a pharmacy that supplies drugs to its residents. If you reside in a long-term care facility, you can get your drugs through the facility's pharmacy as long as they are part of the pharmacy network.

Accessing Part D Medications During a Declared National Disaster or Public Health Emergency

Members with Part D can replace lost or damaged medications if the loss occurred as the result of a declared national disaster or public health emergency. Your pharmacy must contact Medco's Pharmacy Help Line toll-free at 1-800-922-1557. Medco will work with your pharmacy to authorize early refills or override the maximum days' supply per fill. You must still pay the applicable copay per fill.

Drug Safety Programs

Medco conducts drug reviews to make sure members receive safe and appropriate prescription therapies. These reviews can be very important to those who have more than one provider prescribing medications. Each time you fill a prescription, a review is conducted to look for possible problems such as:

- ◆ Medication errors
- ◆ Dosage errors
- ◆ Drugs that are not necessary because you take another drug for the same condition
- ◆ Drugs that may be unsafe or inappropriate because of your age or gender
- ◆ Combinations of drugs that could harm you if taken at the same time
- ◆ Drugs you are allergic to

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

Medication Therapy Management (Plans with Part D)

Medication Therapy Management (MTM) is a free program for members who suffer from multiple, chronic health conditions and are being treated with multiple medications. To be eligible, you must be expected to incur prescription drug costs that exceed \$3,100 annually.

If you qualify, you are automatically enrolled in the program and will receive a letter from Medco. The letter includes information about the program and a toll-free number you can call to speak with a Medco pharmacist. Medco's pharmacists are specially trained in patient counseling and are prepared to discuss such topics as medication use and compliance, drug education, health and safety, and cost saving measures. While the program is voluntary, HealthChoice encourages eligible members to participate. If you do not wish to participate in the program, you can contact Medco. For more information, contact Medco, 24 hours a day, 7 days a week, at:

- ◆ Toll-free 1-800-590-6828 or toll-free TDD 1-800-716-3231

Non-Network Pharmacies

Although HealthChoice may cover your prescriptions when they are purchased at a non-Network pharmacy, a reduced benefit applies. An exception can be made in the event of an emergency. It is considered an emergency when you:

- ◆ Travel outside the HealthChoice service area and run out of medication, or become ill and need a covered medication and are unable to access a Network Pharmacy
- ◆ Cannot timely get a covered medication within your plan's pharmacy network
- ◆ Fill a prescription for a medication that is not stocked at a Network Pharmacy
- ◆ Receive a prescription for a covered medication that is dispensed by a non-Network outpatient facility, such as an emergency room, clinic, or surgery center

If you must use a non-Network pharmacy, you must pay the full cost for your medication and then ask HealthChoice to repay you for its share of the cost. See the *Claim Procedures* section. Before you fill a prescription in this situation, check to see if there is a Network Pharmacy in your area. See the HealthChoice website at www.sib.ok.gov or www.healthchoiceok.com. You can also contact Medco, 24 hours a day, 7 days a week at:

- ◆ With Part D call toll-free 1-800-590-6828 or toll-free TDD 1-800-716-3231

- ◆ Without Part D call toll-free 1-800-903-8113 or toll-free TDD 1-800-825-1230

Pharmacy Explanation of Benefits (EOB)

A pharmacy EOB gives the total amount you have spent on your prescription drugs and the total amount the plan has paid for your prescription drugs. This report is to help you track your prescription drugs costs. HealthChoice is not required to send you a pharmacy EOB, but you can request one by calling Medco, 24 hours a day, 7 days a week, at:

- ◆ With Part D call toll-free 1-800-590-6828 or toll-free TDD 1-800-716-3231
- ◆ Without Part D call toll-free 1-800-903-8113 or toll-free TDD 1-800-825-1230

Creditable Prescription Drug Coverage

HealthChoice Medicare Supplement Plans **With and Without** Part D provide Creditable Coverage. Prescription drug coverage is called creditable if it meets or exceeds Medicare's prescription drug coverage guidelines. The HealthChoice Plans provide coverage equal to (Low Option Plans) or better than (High Option Plans) the standard benefits set by Medicare. HealthChoice is not required to send you a Creditable Coverage letter, but if you need one, it is available on the HealthChoice website at www.sib.ok.gov or www.healthchoiceok.com. Click the *Members* tab in the top menu bar and then select *Medicare Members*. You can also request one by contacting HealthChoice Member Services, Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time, at:

- ◆ With Part D call 1-405-717-8699 or toll-free 1-800-865-5142
- ◆ Without Part D call 1-405-717-8780 or toll-free 1-800-752-9475
- ◆ TDD users call 1-405-949-2281 or toll-free 1-866-447-0436

What Types of Drugs Are NOT Covered

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

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

Also, by law, the following drug categories are excluded from coverage:

- ◆ Most barbiturates and benzodiazepines
- ◆ Fertility drugs

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

If you receive Extra Help from Medicare to pay for your prescriptions, the Extra Help program does not pay for drugs that are excluded from coverage. Additionally, any amounts you pay for excluded drugs do not count toward your total drug costs.

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

**Part D covers medications lost or damaged as the direct result of a declared national disaster or public health emergency.

Medications Requiring Prior Authorization (PA)

This List Includes Only Formulary Medications and is Subject to Change

Note: In most instances, new and generic equivalent medications that become available in the drug categories listed below will automatically require prior authorization. New drug categories may be added throughout the year.

Generics are in lower case italics – Brand-names are in all capital letters

Adrenal Hormone Drugs	<i>a-methapred</i> (injection solution reconstituted) DEPO-MEDROL (injection suspension) <i>methylprednisolone</i> (oral tablet) <i>methylprednisolone acetate</i> (injection suspension) <i>methylprednisolone sodiumsuccinate</i> (injection solution reconstituted) <i>prednisolone sodium phosphate</i> (oral solution) <i>prednisone</i> (oral solution, oral tablet) PREDNISONO INTENSOL (oral concentrate) SOLU-MEDROL (injection solution reconstituted)
Anti-Hypertensive Drugs	REMODULIN (injection solution)
Anti-Infective Drugs	<i>amphotericin b</i> (injection solution reconstituted) CUBICIN (injection solution reconstituted) <i>foscarnet sodium</i> (injection solution) NEBUPENT (inhalation solution reconstituted) TOBI (inhalation nebulization solution) <i>vancomycin hcl</i> (injection solution)
Anti-Neoplastic and Immunosuppressant Drugs	AFINITOR (oral tablet) <i>azathioprine</i> (oral tablet) <i>azathioprine sodium</i> (injection solution reconstituted) CELLCEPT (oral capsule, oral suspension reconstituted, oral tablet) <i>cyclophosphamide</i> (oral tablet) <i>cyclosporine</i> (oral capsule, injection solution) <i>cyclosporine modified</i> (oral capsule, oral solution) <i>gengraf</i> (oral capsule, oral solution) <i>methotrexate</i> (oral tablet) <i>mycophenolate mofetil</i> (oral capsule, oral tablet) MYFORTIC (oral tablet delayed release) NEORAL (oral capsule, oral solution) NEXAVAR (oral tablet) PROGRAF (oral capsule, injection solution) RAPAMUNE (oral solution, oral tablet) RHEUMATREX (oral tablet) RITUXAN (concentrate)

Anti-Neoplastic and Immunosuppressant Drugs, continued	SANDIMMUNE (oral capsule, injection solution, oral solution) SUTENT (oral capsule) <i>tacrolimus</i> (oral capsule) TARCEVA (oral tablet) THALOMID (oral capsule) TORISEL (injection solution) ZORTRESS (oral tablet)
Cardiovascular, Hypertension, and Lipid Drugs	<i>nitroglycerin</i> (injection solution)
Erectile Dysfunction Drugs These medications are specifically excluded from coverage unless you have had radical retropubic prostatectomy surgery.	CAVERJECT (injection solution) CIALIS (oral tablet) LEVITRA (oral tablet) MUSE (oral tablet) VIAGRA (oral tablet)
Gastroenterology Drugs	CIMZIA (kit) <i>dronabinol</i> (oral capsule) EMEND (oral capsule) <i>granisetron</i> (oral tablet) <i>ondansetron hcl</i> (oral solution, oral tablet) <i>ondansetron odt</i> (oral tablet dispersible) REMICADE (injection solution) ZUPLENZ (film)
Immunology, Vaccines, and Biotechnology Drugs	ARANESP (injection solution) AVONEX (kit) BETASERON (injection solution reconstituted) ENERIX-B (injection suspension) EPOGEN (injection solution) HIZENTRA (injection solution) LEUKINE (injection solution reconstituted) NEULASTA (injection solution) NEUMEGA (injection solution reconstituted) NEUPOGEN (injection solution) NORDITROPIN FLEXPPO (injection solution) NORDITROPIN NORDIFLEX PEN (injection solution) OMNITROPE (injection solution) PRIVIGEN (injection solution) PROCRIT (injection solution) REBIF (injection solution) REBIF TITRATION PACK (injection solution) RECOMBIVAX HB (injection suspension) TEV-TROPIN (injection solution reconstituted)

Immunology, Vaccines, and Biotechnology Drugs	TWINRIX (injection suspension) VIVAGLOBIN (injection solution)
Miscellaneous Agents	<i>levocarnitine</i> (solution, oral tablet)
Miscellaneous Hormones	ALDURAZYME (injection solution) ANADROL-50 (oral tablet) ANDRODERM (oral tablet) ANDROGEL (topical gel) ANDROID (oral capsule) <i>androxy</i> (oral tablet) <i>calcitriol</i> (oral capsule, solution) CEREZYME (injection solution reconstituted) FABRAZYME (injection solution reconstituted) SOMAVERT (injection solution reconstituted) <i>testosterone cypionate</i> (oil) <i>testosterone enanthate</i> (oil) ZEMPLAR (oral capsule, injection solution)
Miscellaneous Neurological Drugs	COPAXONE (kit) GILENYA (oral capsule)
Non-Narcotic Analgesic Drugs	CELEBREX (oral capsule)
Osteoporosis Drugs	BONIVA (oral tablet)
Psychotherapeutic Drugs	<i>dextroamphetamine sulfate</i> (oral tablet) <i>dextroamphetamine sulfate er</i> (oral capsule) FOCALIN XR (oral capsule) METADATE CD (oral capsule) <i>methylphenidate hcl</i> (oral tablet) <i>methylphenidate hcl sr</i> (oral tablet) PROVIGIL (oral tablet) RITALIN LA (oral capsule)
Pulmonary Drugs	<i>acetylcysteine</i> (inhalation solution) <i>albuterol sulfate</i> (inhalation nebulization solution) <i>budesonide</i> (inhalation solution) <i>cromolyn sodium</i> (inhalation nebulization solution) <i>ipratropium bromide</i> (inhalation solution) <i>ipratropium bromide/albuterol sulfate</i> (inhalation solution) PERFOROMIST (inhalation solution) PULMICORT (inhalation suspension) PULMOZYME (inhalation solution) XOLAIR (injection solution reconstituted)
Rheumatologic Drugs	ENBREL (injection solution) HUMIRA (kit) SIMPONI (injection solution)

Medications Subject to Quantity Limits (QL)

This List Includes Only Formulary Medications and is Subject to Change

Note: Non-formulary medications that are approved for coverage by a prior authorization can also be limited in quantity. In most instances, new medications and generic equivalent medications that become available in the drug categories listed below will automatically have quantity limits. New drug categories may be added throughout the year.

Anticholinergic and Antispasmodic Drugs	OXYTROL (transdermal biweekly patch)
Antineoplastic and Immunosuppressant Drugs	AFFINITOR (oral tablet) NEXAVAR (oral tablet) REVLIMID (oral capsule) SPRYCEL (oral tablet) SUTENT (oral capsule) TARCEVA (oral tablet) TASIGNA (oral capsule) TYKERB (oral tablet) VANDETANIB (oral tablet) VIDAZA (injection suspension) VOTRIENT (oral tablet) ZOLINZA (oral capsule) ZYTIGA (oral tablet)
Antiviral Drugs	RELENZA DISKHALER (blister inhalation aerosol powder breath activated) TAMIFLU (oral capsule)
Diabetic Drugs and Supplies	All BD insulin syringes All insulins: APIDRA, BYETTA, HUMALOG, HUMULIN, LANTUS, LEVEMIR, NOVOLIN, NOVOLOG, SYMLIN
Diagnostic and Miscellaneous Drugs	<i>alendronate sodium</i> (40mg oral tablet)
Erectile Dysfunction Drugs: These medications are specifically excluded from coverage unless you have had radical retropubic prostatectomy surgery.	CAVERJECT (injection solution reconstituted) CAVERJECT IMPULSE (injection solution reconstituted) CIALIS (oral tablet) LEVITRA (oral tablet) MUSE (oral tablet) VIAGRA (oral tablet)

Estrogen and Progestin Therapy Drugs	ALORA (biweekly transdermal patch) CLIMARA PRO (transdermal weekly patch) COMBIPATCH (transdermal biweekly patch) DIVIGEL (transdermal gel) ESTRADERM (transdermal biweekly patch) <i>estradiol</i> (transdermal weekly patch) MENOSTAR (transdermal weekly patch) VIVELLE-DOT (transdermal biweekly patch)
Migraine Therapy Drugs	<i>butorphanol tartrate</i> (nasal solution) MAXALT (oral tablet) MAXALT-MLT (oral dispersible tablet) MIGRANAL (nasal solution) <i>naratriptan hcl</i> (oral tablet) RELPAK (oral tablet) <i>sumatriptan succinate</i> (injection solution, oral tablet) ZOMIG (nasal solution, oral tablet) ZOMIG ZMT (oral dispersible tablet)
Miscellaneous Gastrointestinal Drugs	CIMZIA (injection kit) EMEND (oral capsule) <i>ondansetron hcl</i> (oral tablet) <i>ondansetron odt</i> (oral dispersible tablet) SANCUSO (transdermal patch) ZUPLLENZ (film)
Miscellaneous Hormones	ANDRODERM (transdermal patch) ANDROGEL (transdermal patch gel) <i>calcitonin-salmon</i> (nasal solution) <i>fortical</i> (nasal solution) SOMAVERT (injection solution reconstituted)
Miscellaneous Neurological Drugs	COPAXONE (injection kit) GILENYA (oral capsule)
Multiple Sclerosis Therapy Drugs	AVONEX (injection kit, vial) BETASERON (injection solution reconstituted) REBIF (injection solution)
Narcotic Analgesic Drugs	<i>fentanyl</i> (transdermal 72-hour patch)
Non-Narcotic Analgesic Drugs	<i>butorphanol tartrate</i> (nasal solution)

Ophthalmic Therapy Drugs	RESTASIS (ophthalmic emulsion)
Osteoporosis Therapy Drugs	<i>alendronate sodium</i> (oral tablet) BONIVA (oral tablet) FORTEO (injection solution)
Psychotherapeutic Drugs	EMSAM (transdermal 24-hour patch) PROVIGIL (oral tablet) <i>zaleplon</i> (oral capsule) <i>zolpidem tartrate</i> (oral tablet) <i>zolpidem tartrate er</i> (oral tablet)
Pulmonary Drugs	<i>flunisolide</i> (nasal solution) <i>fluticasone propionate</i> (nasal suspension) XOLAIR (injection solution)
Rheumatoid Arthritis Therapy Drugs	ENBREL (injection kit) ENBREL (injection solution) ENBREL SURECLICK (injection solution) HUMIRA (injection kit) <i>leflunomide</i> (oral tablet) SIMPONI (injection solution)
Tobacco Cessation Drugs	<i>buproban</i> (oral tablet) CHANTIX (oral tablet) NICOTROL INHALER (inhaler) NICOTROL NS (nasal solution)
Topical Anesthetic Drugs	LIDODERM (external patch)

Claim Procedures

Deadline for Filing Claims

Claims must be received by HealthChoice no later than December 31 of the year following the year claims were incurred. For example, if the date of service was July 1, 2011, the claim is accepted through December 31, 2012.

Filing a Health Claim

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

If you have to file your claim with HealthChoice yourself, you must wait until Medicare sends you an Explanation of Benefits statement for Part A and Part B services. You can file your claim with HealthChoice by sending a copy of the Explanation of Benefits statement to:

HP Administrative Services, LLC
P.O. Box 24870
Oklahoma City, OK 73124-0870

Coordination of Health Benefits

If you or your covered dependents have claims that are covered by another group health plan, HealthChoice benefits are coordinated with your other plan so that total benefits are not more than the amount billed or your liability. If your other group coverage is primary over your HealthChoice coverage, you must file claims with your primary plan first. If your other group coverage terminates, please send written notice to:

HP Administrative Services, LLC
P.O. Box 24870
Oklahoma City, OK 73124-0870

If you have questions about coordination of benefits, please contact HP Administrative Services, LLC, Monday through Friday, 7:30 a.m. to 6:00 p.m., Central time, at:

- ◆ 1-405-416-1800 or toll-free 1-800-782-5218
- ◆ TDD users call 1-405-416-1525 or toll-free 1-800-941-2160

Medicare Beneficiaries with End-Stage Renal Disease

If you have End-Stage Renal Disease, Medicare is the secondary payer to your employer's group health plan for 30 months. This rule applies regardless of whether you are a primary member or covered as a dependent under a group health plan. During this 30-month time period, group health plans always pay first.

If you have questions about coverage of End-Stage Renal Disease, visit Medicare's website at www.medicare.gov or call Medicare, 24 hours a day, 7 days a week, at:

- ◆ Toll-free 1-800-MEDICARE (1-800-633-4227)
- ◆ Toll-free TTY/TDD 1-877-486-2048

Filing a Pharmacy Claim

Usually, your claim is processed electronically at the pharmacy. If your pharmacy has questions, have them contact the Medco Pharmacy Help Line, 24 hours a day, 7 days a week including holidays, at:

- ◆ Toll-free 1-800-922-1557 or toll-free TTY/TDD 1-800-825-1230

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

- ◆ You use a non-Network pharmacy
- ◆ You pay the full cost for a drug because you did not have your plan ID card
- ◆ Your drug has a restriction and you decide to purchase the drug immediately

To ask for reimbursement, send your pharmacy receipt and *Coordination of Benefits/Direct Claim Form* to:

- ◆ With Part D – Medco, P.O. Box 14718, Lexington, KY 40512
- ◆ Without Part D – Medco, P.O. Box 14711, Lexington, KY 40512

While you don't have to use a *Coordination of Benefits/Direct Claim Form*, it is helpful. You can access a form on our website at www.sib.ok.gov or www.healthchoiceok.com or by calling Medco, 24 hours a day, 7 days a week, at:

- ◆ With Part D call toll-free 1-800-590-6828 or toll-free TDD 1-800-716-3231
- ◆ Without Part D call toll-free 1-800-903-8113 or toll-free TDD 1-800-825-1230

If your claim involves other group health insurance, include a copy of the Explanation of

Benefits statement you received from your other plan. When your request for payment is received, Medco will let you know if more information is needed to process your claim.

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

If your claim is for a non-covered medication or you did not follow Plan guidelines, HealthChoice sends you a letter letting you know the reasons for not sending reimbursement and what your rights are to appeal the decision.

Coordination of Pharmacy Benefits

If you or a covered dependent have other group pharmacy coverage that is primary over HealthChoice, your pharmacy can still process your prescription claims electronically at the time of purchase. If your pharmacy can file claims electronically, show the pharmacist your HealthChoice Prescription Drug ID card and your primary insurance ID card. If the pharmacy cannot file your secondary HealthChoice claims electronically, have them contact the Medco Pharmacy Help Line, 24 hours a day, 7 days a week, at:

- ◆ Toll-free 1-800-922-1557 or toll-free TTY/TDD 1-800-825-1230

If you have to file a paper claim, see *Filing a Pharmacy Claim* in this section for instructions. If you have questions about pharmacy coordination of benefits, please contact Medco, 24 hours a day, 7 days a week, at:

- ◆ With Part D call toll-free 1-800-590-6828 or toll-free TDD 1-800-716-3231
- ◆ Without Part D call toll-free 1-800-903-8113 or toll-free TDD 1-800-825-1230

Claims for Services Outside the United States (see note next page)

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

HP Administrative Services, LLC, PO Box 24870, Oklahoma City, OK 73124-0870

For questions about claim filing, call HP Administrative Services, LLC, Monday through Friday, 7:30 a.m. to 6:00 p.m., Central time, at:

- ◆ 1-405-416-1800 or toll-free 1-800-782-5218
- ◆ TDD users call 1-405-416-1525 or toll-free 1-800-941-2160

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

Private Contracts with Physicians and Practitioners

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

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

Subrogation

Subrogation is a process that is followed when you become sick or injured as a result of the negligent act or omission of another person or party. Subrogation means HealthChoice has 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 the third party. Third party means another person or organization.

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

You must promptly notify HealthChoice if you file a claim against a third party for any illness or injury for which HealthChoice benefits have been or will be paid. You or your dependent must provide all the information HealthChoice requests. HealthChoice benefits can be withheld until information is received.

Once HealthChoice has the needed information, your covered claims are processed, regardless of whether a third party is eventually found liable for your health care costs.

For more information about subrogation, please contact OSEEGIB, Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time, at:

- ◆ 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

Do not contact the claims office, HP Administrative Services, LLC, regarding subrogation as this will only delay a response.

Eligibility, Enrollment, and Disenrollment

Medicare Eligibility

Medicare is the federal health insurance program for people:

- ◆ Age 65 and older
- ◆ Under age 65 with qualified disabilities
- ◆ With End-Stage Renal Disease

The Centers for Medicare and Medicaid Services (CMS) manage the Medicare program. The Social Security Administration determines eligibility, enrolls people in Medicare, and collects Medicare premiums. For information about Medicare, visit the CMS website at www.cms.gov or the Social Security website at www.ssa.gov. You can also contact Social Security, Monday through Friday, 7:00 a.m. to 7:00 p.m., Central time, at:

- ◆ Toll-free 1-800-772-1213 or toll-free TTY/TDD 1-800-325-0778

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

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

Enrollment in Medicare

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

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

If you are not already receiving Social Security or Railroad Retirement Board retirement benefits, you must apply for Medicare by contacting the Social Security Administration, or if appropriate, the Railroad Retirement Board.

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

When You Become Medicare Eligible

When you become Medicare eligible because you turned 65, you are automatically enrolled in the corresponding Medicare Supplement Plan With Part D. For example, if you are a HealthChoice High Option Plan member, you are moved to the High Option Medicare Supplement Plan With Part D. HealthChoice must have Medicare numbers on file for you and your covered dependents. To provide this information, send a copy of your and your dependents' Medicare ID cards to:

HealthChoice, 3545 NW 58 Street, Suite 110, Oklahoma City, OK 73112

If you become Medicare eligible before age 65 due to a disability, you must complete and return an *Application for Medicare Supplement With Part D* to enroll. You are enrolled in the Plan on the first day of the month following the receipt of your application or on the effective date of Medicare coverage, whichever is later.

Eligibility Requirements

To enroll in a HealthChoice Medicare Supplement Plan, you must be:

- ◆ Entitled to Medicare Part A and/or enrolled in Medicare Part B
- ◆ Listed as eligible in Medicare's system
- ◆ Reside in the United States or its territories

If you live abroad or you are in prison, you cannot enroll in a plan with Part D; however, you can enroll in a plan without Part D.

Enrollment Periods

There are three time periods when you can enroll in or disenroll from HealthChoice.

- ◆ **The Initial Enrollment Period** – The Initial Enrollment Period refers to the time you are first eligible to enroll in Medicare. This seven-month period begins three months before the month you become eligible and extends three months after the month of your eligibility. For example, Mrs. Smith turns 65 on April 20 and becomes eligible for Medicare Part A. Her Part B and Part D enrollment period begins on January 1 and ends on July 31.
- ◆ **The Annual Enrollment Period/Option Period** – Medicare has set the dates of the Annual Enrollment Period/Option Period as October 15 through December 7 of

each year. The final deadline of December 7 is strictly enforced by Medicare. Once the annual enrollment period ends, enrollments/disenrollments cannot be made until the next annual Option Period.

- ◆ **Special Enrollment Periods** – Special Enrollment Periods are allowed when:
 - You enter or leave a skilled nurse facility
 - You move outside the United States or its territories
 - The Plans’ participation in the Part D program is terminated
 - You lose Creditable Coverage for reasons other than failure to pay premiums
 - You meet other exception rules as set out by CMS
 - You gain or lose Extra Help

For information on Special Enrollment Periods, contact HealthChoice Member Services, Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time, at:

- ◆ With Part D call 1-405-717-8699 or toll-free 1-800-865-5142
- ◆ Without Part D call 1-405-717-8780 or toll-free 1-800-752-9475
- ◆ TDD users call 1-405-949-2281 or toll-free 1-866-447-0436

Effective Date of Coverage

- ◆ Initial Enrollment Period – Effective date is the first of the month you become Medicare eligible, or the first of the month following the processing of your application, whichever is later
- ◆ Annual Enrollment Period/Option Period – Effective date is January 1
- ◆ Special Enrollment Periods – Effective date always follows the processing of your application and can never be before that date.

Confirmation Statements

Anytime a change is made to your coverage, you are mailed a Confirmation Statement (CS). Your CS lists the coverage you are enrolled in, the effective date of coverage, and the premium amounts. Review your CS as soon as you receive it so any errors can be corrected as soon as possible.

Dependent Coverage

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

- ◆ Your dependent was insured under another group health plan and lost coverage under that plan. Application for enrollment and proof of the termination of other group health coverage must be submitted within 30 days of the loss. You must cover all eligible dependents. Some exceptions apply. See *Excluding Dependents*

from Coverage in this section.

- ◆ You marry and want to add your new spouse and dependent children to your coverage. You must add them within 30 days of your marriage.
- ◆ You gain a new dependent through birth, adoption, or legal guardianship. You must add them within 30 days of the birth, adoption, or gaining legal guardianship.

COBRA continuation of coverage is available for dependents who lose eligibility. See *Consolidated Omnibus Budget Reconciliation Act (COBRA)* in this section.

Eligible Dependents

Eligible dependents include:

- ◆ Your legal spouse (including common-law)
- ◆ Your daughter, son, stepdaughter, stepson, eligible foster child, adopted child or child legally placed with you for adoption up to age 26, married or unmarried
- ◆ A dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26; subject to medical review and approval
- ◆ 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

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

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

If your spouse is enrolled separately in a plan offered through OSEEGIB, your dependents can be covered under only one parent's health, dental, and/or vision plan (but not both); however, both parents can cover dependents under Dependent Life insurance.

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 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.

Excluding Dependents from Coverage

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 eligible dependent children who do not live with you, are married, or are not financially dependent on you for support. You can also exclude your spouse. You and your spouse must both sign the Spouse Exclusion section of your *Application for Retiree/Vested/Non-Vest/Defer Insurance* or the Spouse Exclusion section of your *Option Period Enrollment/Change Form* if you drop your spouse during the Annual Enrollment Period/Option Period.

To Request Coverage Changes

All requests for changes in coverage must be made in writing. Verbal requests for changes are not accepted. Please send all requests for changes to:

HealthChoice
3545 NW 58 Street, Suite 110
Oklahoma City, OK 73112

or fax your request to 1-405-717-8939.

When Your Employer Changes Insurance Carriers

◆ Education Retirees

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

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

◆ Local Government Retirees

If you were a **local government employee** who terminated employment on or after 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.

◆ New Employer Retirees

All retirees of employers that joined the Plan after the grandfathered dates listed on the previous page must follow their former employer to its new insurance carrier.

Following Your Employer to a New Plan

When you terminate employment, your benefits are tied to your most recent employer. If that employer discontinues participation with OSEEGIB, some or all of their retirees and dependents (depending on the type of employer) must follow the employer to its new insurance carrier. This is true regardless of the amount of time you work for any participating employer. If you retire and then return to work for another employer and enroll in benefits through that employer, your benefits are tied to your new employer.

If You Return to Work

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

If you are able to opt out of your employer's group health plan, Medicare is your primary insurance carrier, and you may be eligible to continue your HealthChoice Medicare Supplement Plan as your secondary carrier.*

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

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

Ending Your Coverage With HealthChoice

Ending your coverage with HealthChoice can be voluntary (your choice) or involuntary

(not your choice). You can choose to leave the Plan or HealthChoice may be required to end your coverage.

If you terminate coverage in retirement or as a vested member, you cannot re-enroll in the Plans offered through OSEEGIB.

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

You have the option to leave the Plan during the Annual Enrollment Period/Option Period; however, in certain situations, you can leave the Plan at other times of the year, known as Special Enrollment Periods.

As a retiree, if your health, dental, and/or life coverage is cancelled, it cannot be reinstated at a later date unless you return to work as an employee of a participating employer. You will forfeit any retirement system contribution paid toward your health insurance premium. Vision coverage is not affected by the cancellation rule and can be elected during the Annual Enrollment Period/Option Period as long as you keep one other benefit through OSEEGIB.

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

When HealthChoice Must End Your Coverage

HealthChoice must end your coverage in the Plan when:

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

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

In the Event of Your Death

Your surviving dependents can continue any coverage that was in effect at the time of

your death, as long as all premiums are paid. Surviving dependents have 60 days to notify HealthChoice they wish to continue their coverage.

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

Coverage is retroactive to the first day of the month following your death. Surviving dependents receive a bill for all past months' premiums. Claims for medical treatment and pharmacy purchases must be filed after your survivors are enrolled and premiums are received.

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

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA is federal legislation which gives members and their covered dependents who lose health benefits the right to choose to continue group health benefits for limited periods of time under certain circumstances. You and your covered dependents 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 and dependent children are eligible to continue coverage for up to 36 months if coverage is lost for reasons such as:

- ◆ A divorce or legal separation*
- ◆ Your dependent loses eligibility
- ◆ Your death (See *In the Event of Your Death* in this section)

As 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 and/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 or your dependents to lose coverage
- ◆ The date OSEEGIB notifies you or your dependents of continuation of coverage rights

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

person will always be billed at the primary member rate.

If you have questions about COBRA, contact HealthChoice Member Services, Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time, at:

- ◆ 1-405-717-8780 or toll-free 1-800-752-9475
- ◆ TDD users call 1-405-949-2281 or toll-free 1-866-447-0436

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

Your Responsibilities

The things you need to do as a HealthChoice member are listed below.

- ◆ Get familiar with your benefits and the rules you must follow to get covered services, supplies, and medications.
 - This handbook provides the information you need to get covered services, supplies, and medications. Please review it carefully.
- ◆ Let HealthChoice know if you have other health or prescription drug coverage in addition to your coverage through HealthChoice.
 - HealthChoice is required to follow rules set by Medicare to make sure you are using all of your coverage in combination when you get covered services, supplies, and medications. This is called coordination of benefits because it involves coordinating benefits you receive from HealthChoice with any other benefits available to you.
- ◆ Tell your doctor and pharmacist you are a HealthChoice plan member.
 - Show your HealthChoice ID card to your doctor or pharmacist when you receive services or medications. This helps to prevent fraud and protects your benefits.
- ◆ Help your doctors and other providers by giving them information, asking questions, and following through on your treatment.
- ◆ Pay what you owe.
- ◆ Let HealthChoice know if you move.
 - If you move outside the HealthChoice service area (the United States and its territories), you cannot remain a member of the Plan with Part D.
 - If you move within our service area, the United States and its territories, you still need to let HealthChoice know so your member record can be updated.

If you have questions or concerns, contact HealthChoice Member Services, Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time, at:

- ◆ With Part D call 1-405-717-8699 or toll-free 1-800-865-5142
- ◆ Without Part D call 1-405-717-8780 or toll-free 1-800-752-9475
- ◆ TDD users call 1-405-949-2281 or toll-free 1-866-447-0436

Your Rights as a HealthChoice Member

Your Medicare prescription drug benefits and your rights and responsibilities are governed by Oklahoma and federal laws. The primary federal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare and Medicaid Services (CMS). In addition, other federal and state laws apply.

For more information about your rights, you can visit www.medicare.gov to read or print the publication, *Your Medicare Rights and Protections*. You can also call Medicare, 24 hours a day, 7 days a week, at:

- ◆ Toll-free 1-800-MEDICARE (1-800-633-4227)
- ◆ Toll-free TTY/TDD 1-877-486-2048

You Can Make Complaints or ask the Plan to Reconsider Decisions

If you have problems or concerns about your covered services, the following *Grievances and Appeals* section tells you what you can do. It gives details about how to deal with problems and complaints. Regardless of whether you ask for a coverage decision, file an appeal, or make a complaint, HealthChoice is required to treat you fairly.

Non-Discrimination

HealthChoice must obey laws that protect you from discrimination or unfair treatment. OSEEGIB does not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin when it provides benefits. Federal laws that prohibit discrimination include Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and all other laws that apply to organizations that receive federal funding.

If you want more information or have concerns about discrimination or unfair treatment, please call the federal Office for Civil Rights at the following numbers:

- ◆ Toll-free 1-800-368-1019 or toll-free TDD 1-800-537-7697

Timely Access to Covered Drugs

You have the right to get your prescriptions filled or refilled at any Network Pharmacy

without long delays. If you don't think you are getting your Part D drugs in a reasonable amount of time, see the *Grievances and Appeals* section. This section will explain how you can file a grievance.

Protecting the Privacy of Your Personal Health Information

The laws that protect the privacy of your health information give you certain rights related to getting information and controlling how your health information is used. Your personal health information includes the personal information you gave HealthChoice when you enrolled as well as your medical records and other medical and health information.

Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you get access to this information. Please review this notice carefully.

OSEEGIB is a division of the Office of State Finance. OSEEGIB 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 members 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 Street, 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

Information the Plan Must Provide to You

You have the right to get several kinds of information from HealthChoice. This Medicare supplement handbook/Evidence of Coverage provides much of the information you need

concerning your health and pharmacy benefits, eligibility, premiums, and grievances and appeals processes. It also provides information about the rules you must follow when you use your prescription drug benefits, as well as why some drugs are not covered by the Plan.

More information about the HealthChoice Pharmacy Network and coverage of specific medications is available on our website at www.sib.ok.gov or www.healthchoiceok.com or contact Medco, 24 hours a day, 7 days a week, at:

- ◆ With Part D call toll-free 1-800-590-6828 or toll-free TDD 1-800-716-3231
- ◆ Without Part D call toll-free 1-800-903-8113 or toll-free TDD 1-800-825-1230

Providing Information in a Way That Works For You

HealthChoice is required to provide information in a way that works for you. This handbook/Evidence of Coverage is printed in a larger type to make it easier to read. Additionally, a text version of this handbook is available on the HealthChoice website at www.sib.ok.gov or www.healthchoiceok.com. This Medicare supplement handbook is also available in CD format at the Oklahoma Library for the Blind and Physically Handicapped (OLBPH). Contact OLBPH, Monday through Friday, 8:00 a.m. to 5:00 p.m. with the exception of state holidays, at:

- ◆ 1-405-521-3514 or toll-free 1-800-523-0288
- ◆ TDD users call 1-405-521-4672

If you are Medicare eligible because of a disability, HealthChoice is required to provide you information about plan benefits that is accessible and appropriate for you. If you have trouble getting information about your plan because of problems related to language or disability, HealthChoice will work with you to provide plan materials in an appropriate format. Please contact Member Services at:

- ◆ With Part D call 1-405-717-8699 or toll-free 1-800-865-5142
- ◆ Without Part D call 1-405-717-8780 or toll-free 1-800-752-9475
- ◆ TDD users call 1-405-949-2281 or toll-free 1-866-447-0436

If HealthChoice does not respond appropriately to your request, you can file a complaint with Medicare by calling toll-free 1-800-MEDICARE (1-800-633-4427), 24 hours a day, 7 days a week. TTY users call toll-free 1-877-486-2048.

Support for Your Right to Make Decisions About Your Care

Sometimes people become unable to make health care decision for themselves due to

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

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

The legal documents you can use to give your instructions are called *advance directives*. These documents are also called a living will or power of attorney for health care.

If you want to use an advance directive, here is what you do:

- ◆ Get the form*
- ◆ Fill it out and sign it
- ◆ Give copies to the appropriate people
- ◆ Take a copy with you if you are going to be hospitalized

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

*This form is free. For residents of Oklahoma, the form is available through a link on the Oklahoma Attorney General's website at www.oag.state.ok.us/oagweb.nsf/AdvanceDirective.

Grievances and Appeals

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

When Your Claim for Health Benefits is Denied (Plans with and without Part D)

If your health claim is denied in whole or in part for any reason, you have the right to have that claim reviewed. A request for review of your denied claim, along with any additional information you wish to provide, must be submitted in writing to:

Medical Claims Review
P.O. Box 24870
Oklahoma City, OK 73124-0870

or call Monday through Friday, 7:30 a.m. to 6:00 p.m., Central time, at:

- ◆ 1-405-416-1800 or toll-free 1-800-782-5218
- ◆ TDD users call 1-405-416-1525 or toll-free 1-800-941-2160

If your claim is reviewed and remains denied, you can appeal that decision to the Grievance Panel. 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 requests for hearings must be filed within one year of the date you are notified of the denial of a claim, benefit, or coverage. All medical claim reviews and final decisions of the Grievance Panel are made as quickly as possible. After exhausting claim review and grievance procedures, an appeal can be pursued in Oklahoma District Court.

The Grievance Panel is an independent review group as established by statute 74 O.S. Section 1306(6). For more information, contact:

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

- ◆ 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

When Your Claim for Pharmacy Benefits is Denied — Plans without Part D

We encourage you to contact us as soon as possible if you have questions, concerns, or problems related to your prescription drug coverage. If your pharmacy claim is denied and you have questions concerning the denial, please contact Medco, 24 hours a day, 7 days a week, at:

- ◆ Toll-free 1-800-903-8113 or toll-free TDD 1-800-825-1230

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

OSEEGIB Pharmacy Unit
3545 NW 58 Street, Suite 110
Oklahoma City, OK 73112
Fax: 1-405-717-8925

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

When Your Claim for Pharmacy Benefits is Denied — Plans with Part D

The following is a summary of the guidelines for filing a Medicare Part D prescription drug grievance or appeal. A complete *Grievance and Appeals Guide for Pharmacy Benefits* is available on our website at www.sib.ok.gov or www.healthchoiceok.com or by calling HealthChoice Member Services, Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time, at:

- ◆ 1-405-717-8699 or toll-free 1-800-865-5142
- ◆ TDD users call 1-405-949-2281 or toll-free 1-866-447-0436

Please let us know if you have questions, concerns, or problems related to your Part D coverage. The contact information for each of the processes can be found in the *Who to Contact About Complaints, Appeals, Grievances, or Coverage Determinations* section.

Making a Complaint – Filing a Grievance

The complaint/grievance process is used when you have problems related to the quality of your care, waiting time, or the customer service you receive. A complaint/grievance

does not involve coverage or payment. The Medicare program sets rules about what you need to do to make a complaint and what HealthChoice is required to do when a complaint is received.

Complaints about the quality of care you receive under Medicare are handled by Medco, HealthChoice, and/or by an independent organization known as the Quality Improvement Organization (QIO).

There is a Quality Improvement Organization in each state. In Oklahoma, the organization is called Health Integrity, LLC. Health Integrity has a group of doctors and other health professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Following are a few examples of quality of care issues:

- ◆ You are unhappy about the quality of care you received, for example, you think your pharmacist provided you with the wrong prescription or the wrong dosage.
- ◆ You believe someone did not respect your privacy or was rude or disrespectful.
- ◆ You believe a pharmacist or customer service representative kept you waiting too long.
- ◆ You think your hospital stay is ending too soon.
- ◆ You think your home health care, skilled nursing facility care, or outpatient rehabilitation care is ending too soon.

Following are some problems that might lead you to file a complaint/grievance:

- ◆ You feel you are being encouraged to disenroll from HealthChoice.
- ◆ You believe HealthChoice informational materials are difficult to understand.
- ◆ HealthChoice doesn't make a decision about your claim in the required time frame.
- ◆ You disagree with a HealthChoice decision not to fast track your request for a coverage determination or redetermination.
- ◆ HealthChoice fails to forward your case to a certified Independent Review Organization (IRO) when a decision is not made within the required time frame.

If you want to make a complaint about quality issues with the Part D prescription drug program, you or your physician can contact Medco, 24 hours a day, 7 days a week, at:

- ◆ Toll-free 1-800-590-6828 or toll-free TDD 1-800-716-3231

Coverage Decisions

Whenever you ask for coverage of a medication under Medicare Part D, it is called a coverage decision. An example is when you take your prescription to be filled at the pharmacy and coverage for your prescription is approved or denied.

If your request is denied, you can request a prior authorization/exception. You can ask HealthChoice for a prior authorization/exception if:

- ◆ You want to receive a non-Preferred drug at the Preferred copay.
- ◆ You want HealthChoice to pay for a non-covered medication.
- ◆ You disagree with the quantity limit set for a medication.
- ◆ You want HealthChoice to pay you back for a medication you already received.
- ◆ You are not getting a prescription medication that you believe is covered by the Plan.
- ◆ You want HealthChoice to pay for a medication that is not on the HealthChoice Medicare Formulary.
- ◆ You disagree with the Plans' requirement that you try another medication (Step Therapy) before HealthChoice will pay for the drug your doctor prescribed.
- ◆ You want HealthChoice to pay you back for a medication purchased at a non-Network pharmacy.

If your request for a prior authorization/exception is denied, you have the right to file an appeal. You can contact HealthChoice, Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time, at:

- ◆ 1-405-717-8699 or toll-free 1-800-865-5142
- ◆ TDD users call 1-405-949-2281 or toll-free 1-866-447-0436

or fax requests to 1-405-717-8925.

Appeals

An appeal refers to any of the procedures that deal with reviewing an unfavorable decision to your request for a prior authorization/exception. You can file an appeal if you want HealthChoice to reconsider and change a decision made about prescription drug benefits. If you are unhappy with a decision made at any level of the appeals process, you have 60 calendar days to file an appeal at the next level.

The Appeals Process

If your request for a prior authorization/exception is denied, you have the right to file an appeal. You must first decide if you want a *standard* or a *fast* coverage determination.

A standard determination is usually responded to within 72 hours. A fast determination/decision is handled within 24 hours, but this option is available only if you or your doctor believe that waiting any longer could seriously harm your health or your ability to

function. Fast determinations are not available if you already received your medication.

To make either kind of request, you, your appointed representative, or your physician should call the appropriate phone number in the *Who to Contact About Complaints, Appeals, Grievances, or Coverage Determinations* section.

Appeal Levels

Federal regulations require five levels of appeal. At each level, your request is considered and a decision is made. If you are unhappy with a decision, you may be able to request an appeal at the next level. Whether you are able to take the next step may depend on the dollar value of the medication in question.

An appeal can be submitted by you, your appointed representative, or your prescribing physician. Following is a summary of the levels of appeal:

Appeal Level 1: The first step in the appeals process is requesting a coverage redetermination. You should ask for a coverage redetermination if you are unhappy with a coverage decision. In general, this process consists of the review of the prescribing and therapeutic guidelines of your medication. You are notified in writing of the decision from Medco concerning your drug. If you are not happy with the decision or the amount you have to pay for a drug, you can appeal to the next level.

Appeal Level 2: If HealthChoice denies your request for a coverage redetermination, you can request, in writing, a review by a federal government-contracted Independent Review Organization (IRO). For a standard appeal, the IRO has up to seven calendar days from the date your request is received to make a decision. A fast decision about a Part D drug you have not received should be handled within 72 hours. The IRO must notify you in writing about its decision.

Appeal Level 3: If the IRO denies your Level 2 appeal, you can ask for a review by an Administrative Law Judge (ALJ). The amount in controversy must exceed \$130. You must request a Level 3 appeal in writing. If the ALJ rules in your favor regarding a payment issue, HealthChoice must send payment to you within 30 calendar days of the date we receive notice.

For a standard decision about a drug you have not received, HealthChoice must authorize or provide you with the drug within 72 hours of the date we receive notice. For a fast decision about a drug you have not received, HealthChoice must authorize or provide you with that drug within 24 hours of the date we receive notice.

Appeal Level 4: At this level, you have the right to request that your case be reviewed by a Medicare Appeals Council (MAC). The MAC may or may not decide to review

your appeal. If the MAC reviews your appeal and makes a decision in your favor, HealthChoice must provide payment or authorization within the same time frames stated in Level 3. In the event of a denial, the written notice you receive from the MAC explains what you need to do if you choose to take your appeal to federal court.

Appeal Level 5: If the amount in question is more than \$1,350* and you want to continue your appeal, you must file a civil action in a United States Federal District Court. The letter you receive from the Medicare Appeals Council in Level 4 tells you how to request this review. The decision whether or not to review your case is made by a federal court judge. The judge's decision is final, and you cannot take your appeal any further.

*This amount is adjusted annually.

Complete instructions for filing an appeal at Levels 2 through 5 will be sent to you directly from the source that is handling the appeal.

For more information about the grievances and appeals process, download a copy of the *Grievance and Appeals Guide for Pharmacy Benefits* available on our website at www.sib.ok.gov or www.healthchoiceok.com. You can also request one by calling HealthChoice Member Services, Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time, at:

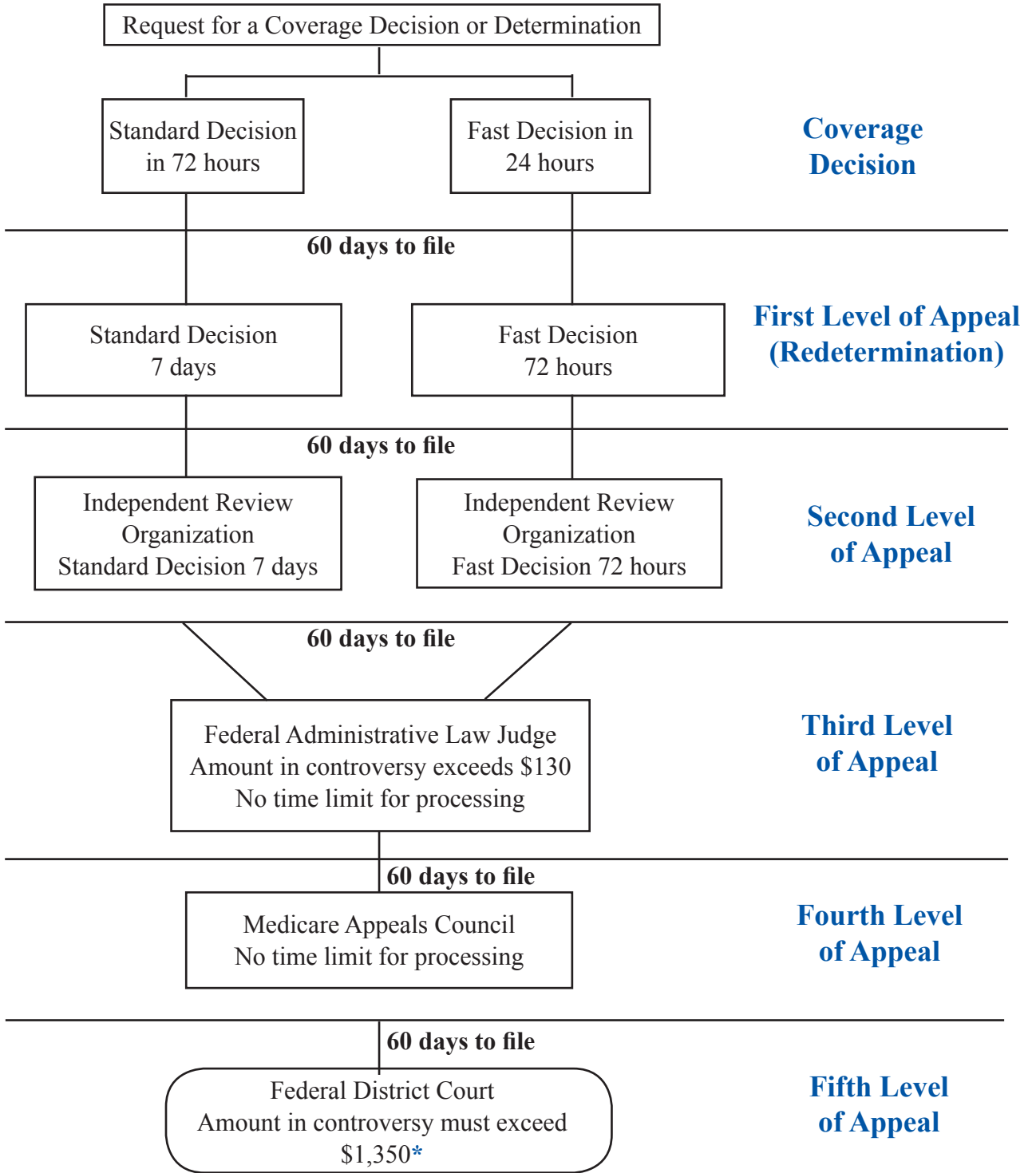
- ◆ 1-405-717-8699 or toll-free 1-800-865-5142
- ◆ TDD users call 1-405-949-2281 or toll-free 1-866-447-0436

Grievances and Appeals Data

To find out the number of grievances, appeals, and exceptions that Medicare Part D members have filed with the Plans, please contact HealthChoice Member Services, Monday through Friday, 7:30 a.m. to 4:30 p.m., Central time, at:

- ◆ Members with Part D call 1-405-717-8699 or toll-free 1-800-865-5142
- ◆ Members without Part D call 1-405-717-8780 or toll-free 1-800-752-9475
- ◆ TDD users call 1-405-949-2281 or toll-free 1-866-447-0436

Medicare Part D Appeals Process at a Glance



*This amount is adjusted annually.

Fraud, Waste, and Abuse Compliance

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

If you suspect that OSEEGIB and/or Medicare have been defrauded, are being defrauded, or that resources have been wasted or abused, report the matter to the OSEEGIB Compliance Officer immediately. You can report suspicious acts or claims by:

- ◆ Visiting the Compliance Officer in person
- ◆ Sending a report in writing to: OSEEGIB Compliance Officer, 3545 NW 58 Street, Suite 110, Oklahoma City, OK 73112
- ◆ Emailing a message to antifraud@sib.ok.gov
- ◆ Leaving a report in the secure drop box outside the OSEEGIB 5th Floor Board Room
- ◆ Calling the OSEEGIB toll-free hotline at 1-866-381-3815

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

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

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

H.E.L.P. offers wellness opportunities for Plan participants who are choosing to become and stay well. Wellness opportunities include:

HealthVoice Newsletter

You can find health and wellness information in the HealthVoice newsletter.

Online Health and Wellness Information

The home page of the HealthChoice website has featured articles on health and wellness.

Walking Club

HealthChoice encourages you and your covered dependents to join the HealthChoice Walking Club. Walking is one of the easiest types of exercise to do and one of the most beneficial for your overall health and well-being. Walking Club members receive log sheets to record dates and distances walked, walking tips, warm-up and cool down exercises, and shoe care instructions. We also offer incentives for walking every 100 miles up to 1,000 miles. This requires you to send us your completed log sheets (or copies) to be recorded. If you want to join this program, you can enroll online at www.sib.ok.gov or www.healthchoiceok.com or contact the H.E.L.P. Line, Monday through Friday, 8:00 a.m. to 5:00 p.m., Central time, 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

Fitness Center Discounts

HealthChoice has arranged for a special fitness center discount for HealthChoice members and their dependents. All you have to do is present your HealthChoice identification card at any of the participating fitness centers to receive your special discount rate. The listing of participating fitness centers is available on our website at www.sib.ok.gov or www.healthchoiceok.com. If your favorite fitness center is not on the list and you would like us to contact them, contact the H.E.L.P. Line, Monday through Friday, 8:00 a.m. to 5:00 p.m., Central time, 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

Notifications

Certificate of Coverage

When your health insurance terminates, a Certificate of Coverage is sent to your last known address. OSEEGIB mails certificates for education and local government employees, former employees, surviving dependents, and COBRA participants. This certificate may be required by your next health plan as proof of your previous group health coverage in order to waive 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

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

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

*Coverage of Side Effects Associated With Prostate Related Conditions**

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

*If you have questions about HealthChoice coverage of mastectomies and reconstructive surgery or prostate related conditions, contact HP Administrative Services, LLC, Monday through Friday, 7:30 a.m. to 6:00 p.m., Central time at:

- ◆ 1-405-416-1800 or toll-free 1-800-782-5218
- ◆ TDD users call 1-405-416-1525 or toll-free 1-800-941-2160

Wigs and Scalp Protheses

HealthChoice provides a benefit for wigs or other scalp protheses 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 maximum annual benefit is \$150. The wig or scalp prothesis must be obtained from a licensed cosmetologist or DME provider.

Read this Handbook/Evidence of Coverage Carefully

A dispute concerning information contained within any OSEEGIB written or electronic materials or oral communications, 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.

All benefits and limitations of these plans are governed in all cases by the relevant plan documents, insurance contracts, handbooks, Rules of the Oklahoma State and Education Employees Group Insurance Board, a division of the Office of State Finance, and the regulations governing the Medicare Prescription Drug Benefit, Improvement, and Modernization Act. The Federal Regulation at 42 C.F.R. § 423 et seq. and the Rules of the Oklahoma Administrative Code, Title 360, are controlling in all aspects of Plan benefits.

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

Plan Definitions

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

Annual Enrollment Period/Option Period: A set time when you can change plans.

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

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

Centers for Medicare and Medicaid Services (CMS): The federal agency that runs the Medicare program.

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

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

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

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

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

Covered Drugs: The prescription drugs covered by the Plans.

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

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

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

Dependent: An employee's spouse and dependent children up to age 26, whether married or unmarried, including an adopted child or stepchild. Dependents can also include children, regardless of age, who are incapable of self-support because of mental or physical incapacity that existed prior to reaching age 26 and other unmarried dependent children up to age 26, upon completion of an *Application for Coverage of Other Dependent Children*.

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

Evidence of Coverage/Handbook: This document, which explains your coverage, your rights, and what you have to do as a member of our Plan.

Exception: A type of coverage determination.

Extra Help/Low Income Subsidy: A Medicare program that helps people with limited income and resources pay Medicare Part D prescription drug costs.

Federal Limiting Charge: The highest dollar amount you can be charged for a covered service by doctors and other health care providers who don't accept Medicare assignment. The limit is 15% over Medicare's approved amount. The limiting charge only applies to certain services. It does not apply to supplies or equipment.

Former Employee: An eligible employee who is participating in any of the Plans authorized by or through the State and Education Employees Group Insurance Act who retires, or has a vesting right with a state funded retirement plan, or has the required years of service with an employer participating in the Plan.

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

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

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

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

Initial Coverage Limit Stage (Low Option Plans): After you meet your deductible, the next \$2,610 of prescription drug costs is known as the Initial Coverage Limit stage. You pay 25% (\$652.50) and HealthChoice pays 75% (\$1,957.50) of this amount for covered prescription drugs.

Late Enrollment Penalty: An amount added to your monthly premium for Medicare drug coverage if you go without Creditable Coverage for a continuous period of 63 days or longer. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. Currently, HealthChoice pays any late enrollment penalty for its members.

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, your caregiver, or your provider. The fact that services or supplies are medically necessary does not, in itself, assure that the services or supplies are covered by the Plans.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare Part A: This insurance generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities, or home health agencies.

Medicare Part B: This insurance covers most other medical services such as physician's services and other outpatient services.

Medicare Part D: This insurance covers prescription drugs.

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

Medicare Approved Amount: The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. The approved amount is sometimes called the approved charge.

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

Network Pharmacy: Network Pharmacies contract with our Plan. In most cases, your prescriptions are covered at the maximum benefit only when they are filled at a HealthChoice Network Pharmacy.

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

Non-Network Pharmacy: A pharmacy that doesn't have a contract with our Plans. Most services you get from non-Network pharmacies are not covered by the Plans except under certain conditions.

Option Period/Annual Enrollment Period: See definition under *Annual Enrollment Period* in this section.

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

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

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

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

Quality Improvement Organization: An organization paid by Medicare to check on and help improve the quality of care for people with Medicare.

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

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

HealthChoice

Oklahoma State and Education
Employees Group Insurance Board
A Division of the Office of State Finance
3545 NW 58 Street, Suite 110
Oklahoma City, OK 73112

Presorted
First Class
U. S. Postage
PAID
Okla. City, OK
Permit #1067

IMPORTANT PLAN INFORMATION