

HealthChoice

Medicare Supplement Plans Handbook Evidence of Coverage

HealthChoice SilverScript
High and Low Option Plans

HealthChoice High and Low
Option Plans Without Part D

Plan Year 2016
Jan.1 – Dec. 31, 2016



Monthly Premiums

HealthChoice SilverScript Medicare Supplement Plans Jan. 1 through Dec. 31, 2016

Medicare Supplement Plan Premiums Per Covered Person*	
HealthChoice SilverScript High Option Medicare Supplement Plan	\$324.18
HealthChoice SilverScript Low Option Medicare Supplement Plan	\$253.09
COBRA Medicare Supplement Plan Premiums Per Covered Person**	
HealthChoice SilverScript High Option Medicare Supplement Plan	\$324.18
HealthChoice SilverScript Low Option Medicare Supplement Plan	\$253.09

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

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

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

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 This Medicare supplement handbook/Evidence of Coverage will, in turn, be superseded by any subsequent Medicare supplement handbook/Evidence of Coverage OMES issues.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

Introduction

HealthChoice Medicare Supplement Handbook Effective Jan. 1 through Dec. 31, 2016

This handbook, your enrollment form, "Confirmation Statement" and "HealthChoice SilverScript Medicare Formulary" represent our responsibilities to you. This handbook provides details about your benefits, formulary, pharmacy network, premiums, deductibles, copays and/or coinsurance for 2016. It explains what is covered and what you pay as a member of the Plan. Be aware that these amounts may change at the beginning of the next plan year which begins on Jan. 1. This is an important document, so keep it in a safe place. Please note, the HealthChoice Medicare supplement plans are often referred to throughout this handbook as the "Plan" or "Plans."

Read this Handbook Carefully

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

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

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

Plan Identification and Contact Information

Plan Administrator

Office of Management and Enterprise Services (OMES)
Employees Group Insurance Department (EGID)
3545 N.W. 58th St., Ste. 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. CST
1-405-717-8780 or toll-free 1-800-752-9475
TDD 1-405-949-2281 or toll-free 1-866-447-0436
www.healthchoiceok.com

HealthChoice Medical Claims Administrator

HP Administrative Services, LLC, Monday through Friday, 7:30 a.m. to 6:00 p.m. CST
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

CVS/caremark, 24 hours a day, 7 days a week
SilverScript Plans: Toll-free 1-866-275-5253 or TTY 711
www.healthchoice.silverscript.com
Without Part D Plans: Toll-free 1-877-720-9375 or TTY 711
www.caremark.com

HealthChoice Certification Administrator

APS Healthcare, Monday through Friday, 7:00 a.m. to 7:00 p.m. CST
55 N. Robinson, Ste. 600, Oklahoma City, OK 73102
Toll-free 1-800-848-8121 or 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 TTY 1-877-486-2048
www.medicare.gov

Social Security Administration

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

Information About Your Premiums

Medicare Premiums

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

Paying Your Plan Premiums

You must pay your full monthly Plan 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; or
- ◆ Paid directly to EGID. You will receive a monthly premium statement.

COBRA participants must pay premiums directly to EGID. Your premiums can be:

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

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

People with limited incomes may get Extra Help from Medicare, known as the *Low-Income Subsidy*, paying for prescription drug costs, including premiums, deductibles and copays. To learn more or apply, call Social Security toll-free at 1-800-772-1213. TTY users call toll-free 1-800-325-0778. More information is also available at www.socialsecurity.gov. You can also call Medicare toll-free at 1-800-MEDICARE (1-800-633-4227). TTY users call toll-free 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. Be aware that if you qualify for Extra Help, some of the information in this handbook will not apply to you.

Income-Related Monthly Adjustment Amount

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

If you have to pay this extra amount, Social Security will notify you. For more information, call Social Security toll-free at 1-800-772-1213. TTY users call toll-free 1-800-325-0778.

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

Changes in Your Monthly Premium

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

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

Late Enrollment Penalty

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

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

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

Non-Payment of Premiums

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

General Information

This *HealthChoice Medicare Supplement Plans Handbook* provides a guide to 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 2016 *Medicare & You* handbook, visit www.medicare.gov or call Medicare toll-free at 1-800-MEDICARE (1-800-633-4227) or 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 more information about Medicare enrollment, visit the Social Security website at www.socialsecurity.gov or call Social Security toll-free at 1-800-772-1213 or TTY 1-800-325-0778.

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

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

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

- ◆ Outpatient medical expenses;
- ◆ Durable medical equipment; and
- ◆ Limited outpatient prescription drugs.

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

HealthChoice SilverScript Medicare Supplement Plans

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

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

HealthChoice Medicare Supplement Plans Without Part D

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

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

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

Provider-Patient Relationship

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

Medicare's Limiting Charge

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

Certification

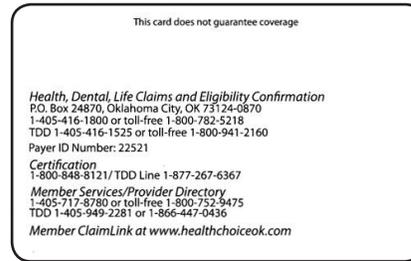
Since HealthChoice is secondary to your Medicare coverage, certification through the HealthChoice certification administrator is required only for the additional 365 lifetime reserve days for hospitalization covered by HealthChoice. If you have questions, contact the certification administrator toll-free at 1-800-848-8121 or TDD 1-877-267-6367

Plan ID Cards

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

Medical/Dental Card

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



If your medical/dental card is damaged, lost or stolen, you can request a new card by calling:

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

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

Prescription Drug Card

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



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

To request a replacement prescription drug card, visit www.healthchoice.silverscript.com. You can also request a card by calling the pharmacy benefit manager:

- ◆ SilverScript Plans toll-free 1-866-275-5253 or TTY 711
- ◆ Without Part D Plans toll-free 1-877-720-9375 or TTY 711

HealthChoice Explanation of Benefits

Each time a medical claim is processed, the medical claims administrator sends you an "Explanation of Benefits" (EOB) which explains how your benefits are applied. EOBs are also available online by going to www.healthchoiceok.com and selecting "ClaimLink" in the top menu bar. 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, contact the medical claims administrator. Refer to the "Plan Identification and Contact Information" section.

HealthChoice Fitness Center Discounts

HealthChoice has arranged for a special fitness center discount for HealthChoice members and their dependents. All you have to do is present your HealthChoice identification card at any of the participating fitness centers to receive your special discount rate. The listing of participating fitness centers is available at www.healthchoiceok.com. If your favorite fitness center is not on the list and you would like us to contact them, call HealthChoice Member Services, Monday through Friday, 7:30 a.m. to 4:30 p.m. CST.

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

Your Contact Information

It is important to keep your contact information current. You risk delaying claims processing, missing communications and even being disenrolled from the Plan when your information is incorrect. **Additionally, Medicare requires that you report any changes in your name, address or telephone number to your insurance plan.** If you have an email address on file with HealthChoice, be sure to keep it updated as well. Changes can be faxed to Member Accounts at 1-405-717-8939 or sent in writing to HealthChoice, 3545 N.W. 58th St., Ste. 110, Oklahoma City, OK 73112.

Let HealthChoice Know if You Move

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

If you move within our service area, the United States and its territories, you still need to let HealthChoice know so your member record can be updated.

HealthChoice High and Low Option Medicare Supplement Plans

Medicare Part A (Hospitalization) Services

All Benefits are Based on Medicare-Approved Amounts

Services or Items	Description	Medicare Part A Pays	HealthChoice Pays	You Pay
Hospitalization Semiprivate room, meals, drugs as part of your inpatient treatment, and other hospital services and supplies	First 60 days	All except the Part A deductible	100% of the Part A deductible	0%
	Days 61 through 90	All except the coinsurance per day	Coinsurance per day	0%
	Days 91 and after while using Medicare's 60 lifetime reserve days	All except the coinsurance per day	Coinsurance per day	0%
	Once Medicare's lifetime reserve days are used, HealthChoice provides additional lifetime reserve days Limited to 365 days	0%	100% of Medicare eligible expenses Certification by HealthChoice is required	0%
	Beyond the 365 lifetime reserve days	0%	0%	100%
Skilled 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 the coinsurance per day	Coinsurance per day	0%
	Days 101 and after	0%	0%	100%

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

Medicare Part A (Hospitalization) Services

All Benefits are Based on Medicare-Approved Amounts

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

Medicare Part B (Medical) Services

All Benefits are Based on Medicare-Approved Amounts

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

Medicare Part B (Medical) Services

All Benefits are Based on Medicare-Approved Amounts

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

Medicare Preventive Services

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

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

For a list of preventive services and details on coverage, go to www.cms.gov or www.medicare.gov. You can also refer to the 2016 *Medicare & You* handbook.

HealthChoice SilverScript High Option Medicare Supplement Plan

Pharmacy Copay Structure for Network Benefits

There is no annual deductible and no Coverage Gap.

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

The Pharmacy Out-of-Pocket Maximum

Out-of-Pocket Maximum	After Out-of-Pocket Maximum is Met
The annual out-of-pocket maximum is \$4,850. Only copays for covered prescription drugs purchased at Network Pharmacies count toward the out-of-pocket maximum. Refer to the chart above for copay amounts.	Once the pharmacy out-of-pocket maximum is reached, you pay 0% of Allowable Fees for covered prescription drugs purchased at Network Pharmacies for the remainder of the calendar year.

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

HealthChoice SilverScript Low Option Medicare Supplement Plan

Pharmacy Copay Structure for Network Benefits

Pharmacy Deductible is \$360.00	Initial Coverage Limit is \$2,950.00	Coverage Gap is \$3,752.50	Catastrophic Coverage Begins at \$4,850.00
You pay 100% of \$360.00	After the deductible, you and HealthChoice share the costs of the next \$2,950.00 of prescription drug costs. You pay 25% (\$737.50) and HealthChoice pays 75% (\$2,212.50)	You pay 100% of the next \$3,752.50 of prescription drug costs. During the Coverage Gap, you pay 58% of the cost of generic drugs and 45% of the cost of brand-name drugs.	After you spend \$4,850.00 out-of-pocket, HealthChoice pays 100% of Allowable Fees for covered prescription drugs purchased at Network Pharmacies for the remainder of the calendar year

Your Costs for Covered Medications

You Pay	HealthChoice Pays
Annual deductible of \$360.00	\$0
\$737.50 (25 percent) of the next \$2,950.00 of prescription drug costs, the Initial Coverage Limit	\$2,212.50 (75 percent) of the next \$2,950.00
During the Coverage Gap, you are responsible for the next \$3,752.50 of prescription drug costs; however, you receive a 42 percent discount on the cost of generic drugs and a 55 percent discount on the cost of brand-name drugs	HealthChoice pays the 42 percent discount on the cost of generic drugs and 5 percent of the 55 percent discount on the cost of brand-name drugs during the Coverage Gap
\$0 after you have spent \$4,850.00 out-of-pocket for prescription drugs	100 percent of Allowable Fees for covered prescription drugs purchased at Network Pharmacies for the remainder of the calendar year

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

HealthChoice High Option Medicare Supplement Plan Without Part D

Pharmacy Copay Structure for Network Benefits

There is no annual deductible and no Coverage Gap.

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

The Pharmacy Out-of-Pocket Maximum

Out-of-Pocket Maximum	After Out-of-Pocket Maximum is Met
The annual out-of-pocket maximum is \$4,850. Only copays for covered prescription drugs purchased at Network Pharmacies count toward the out-of-pocket maximum. Refer to the chart above for copay amounts.	Once the pharmacy out-of-pocket maximum is reached, you pay 0 percent of Allowable Fees for covered prescription drugs purchased at Network Pharmacies for the remainder of the calendar year.

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

HealthChoice Low Option Medicare Supplement Plan Without Part D

Pharmacy Copay Structure for Network Benefits

Pharmacy Deductible is \$360.00	Initial Coverage Limit is \$2,950.00	Coverage Gap is \$3,752.50	Catastrophic Coverage Begins at \$4,850.00
You pay 100% of \$360.00	After the deductible, you and HealthChoice share the costs of the next \$2,950.00 of prescription drug costs. You pay 25% (\$737.50) and HealthChoice pays 75% (\$2,212.50)	You pay 100% of the next \$3,752.50 of prescription drug costs.	After you spend \$4,850.00 out-of-pocket, HealthChoice pays 100% of Allowable Fees for covered prescription drugs for the remainder of the calendar year

Your Costs for Covered Medications

You Pay	HealthChoice Pays
Annual deductible of \$360.00	\$0
\$737.50 (25 percent) of the next \$2,950.00 of prescription drug costs, the Initial Coverage Limit	\$2,212.50 (75 percent) of the next \$2,950.00
Coverage Gap of \$3,752.50 of prescription drug costs	\$0
\$0 after you have spent \$4,850.00 out-of-pocket for prescription drugs	100 percent of Allowable Fees for covered prescription drugs purchased at Network Pharmacies for the remainder of the calendar year

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

Your Prescription Drug Coverage

Basic Rules for Part D Coverage

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

- ◆ You must have a prescription written by your physician or other provider (CMS requires your doctors and other prescribers to either accept Medicare or to file documentation with CMS that shows they are qualified to write prescriptions);
- ◆ You must use a HealthChoice SilverScript Network Pharmacy (except in an emergency; refer to "Non-Network Pharmacies" on page 17);
- ◆ Your drug must be on the *HealthChoice SilverScript Medicare Formulary* (drug list); and
- ◆ 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 \$4,850. 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. Once you reach the \$4,850 out-of-pocket maximum, the Plan pays 100 percent 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 does not count toward your pharmacy out-of-pocket maximum. Medications must be covered Part D drugs and listed on the *HealthChoice SilverScript 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 copays (HealthChoice SilverScript high option plan)
- ◆ Your deductible and coinsurance (HealthChoice SilverScript low option plan)
- ◆ Amount discounted by brand-name drug manufacturers once you reach \$3,310 in total prescription drug costs (HealthChoice SilverScript low option plan)

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

- ◆ Amounts paid by HealthChoice for medications once you reach the Coverage Gap of \$3,752.50 in total prescription drug costs (only HealthChoice SilverScript low option plan);
- ◆ 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 VA or Indian Health Services; and
- ◆ Payments for medications made by a third-party with a legal obligation to pay.

Medicare Coverage Gap Discount Program (HealthChoice SilverScript Low Option Plan)

Members who do not receive Extra Help and reach the Coverage Gap are provided discounts on certain Part D drugs purchased at Network Pharmacies. HealthChoice and 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 your total drug costs reach \$3,310.

*Discounts are available only for brand-name drugs whose manufacturers have agreed to pay the discounts. **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 68,000 pharmacies nationwide. Network Pharmacies contract with our Plans to provide covered prescription drugs to members. They also provide electronic claims 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;
- ◆ Supply drugs to residents of long-term care facilities; usually, each facility has its own pharmacy, and residents can get their prescription drugs through the facility's pharmacy as long as it is in the HealthChoice Pharmacy Network; and
- ◆ Serve the Indian Health Service/Tribal/Urban Indian Health Program.

Sometimes a pharmacy leaves the HealthChoice Network. When this occurs, you have to get your prescriptions filled at another Network Pharmacy.

You can locate a HealthChoice Network Pharmacy by going to our website at www.healthchoiceok.com. Select the "Member" tab in the top menu bar and then select "Medicare Members."

- ◆ If you are a HealthChoice SilverScript member, select "HealthChoice SilverScript Pharmacy Network." You can also call the pharmacy benefit manager toll-free at 1-866-275-5253. TTY users call 711.

- ◆ If you are a HealthChoice Medicare supplement without Part D member, select "HealthChoice Pharmacy Network." You can also call the pharmacy benefit manager toll-free at 1-877-720-9375. TTY users call 711.

HealthChoice pays for your prescriptions when they are filled at a non-Network pharmacy; however, a reduced benefit may apply. Refer to "Non-Network Pharmacies" below.

Non-Network Pharmacies

HealthChoice covers your prescriptions when they are filled at a non-Network pharmacy subject to the following provisions.

SilverScript Plans

When you fill your prescriptions at a non-Network Pharmacy, a reduced benefit applies. In certain emergency situations, your prescriptions can be covered as if they were filled at a Network Pharmacy. An exception can be made if you cannot access a Network Pharmacy due to the following emergencies:

- ◆ You travel outside the HealthChoice service area and lose or run out of medication or become ill and need a Part D medication;
- ◆ You cannot fill a specialty drug timely because it is not in stock;
- ◆ There is no Network Pharmacy within reasonable driving distance with 24/7 service;
- ◆ You receive a Part D drug while in an emergency, observation or other outpatient setting; or
- ◆ Evacuation or displacement from your residence due to a federal declared national disaster or other public health emergency.

You can replace medications that were lost or damaged due to a declared national disaster or public health emergency. Your pharmacy must contact the pharmacy helpline toll-free at 1-866-693-4620. The helpline staff will work with your pharmacy to provide early refills or override the maximum supply per fill. You must still pay the applicable copay per fill.

If you must use a non-Network Pharmacy, you must pay the full cost for your medications and then file a paper claim for HealthChoice to repay you for its share of the cost. Before you fill a prescription under these circumstances, check for a Network Pharmacy in your area by contacting the pharmacy benefit manager toll-free at 1-866-275-5253. TTY users call 711.

Without Part D Plans

When you fill your prescriptions at a non-Network pharmacy, a reduced benefit applies. In most cases, a non-Network pharmacy can file your prescription claim electronically so you will not have to file a paper claim.

Before you fill your prescriptions at a non-Network pharmacy, when possible, check to find out if there is a Network Pharmacy in your area by contacting the pharmacy benefit manager toll-free at 1-877-720-9375. TTY users call 711.

Medication Formularies

HealthChoice SilverScript Medicare Formulary (SilverScript Plans)

The new *HealthChoice SilverScript Medicare Formulary* was mailed to you by CVS/caremark. This drug list shows the medications covered by the SilverScript plans. Medicare has reviewed and approved this list of covered drugs. To find out how your medications are covered, please contact the pharmacy benefit manager toll-free at 1-866-275-5253. TTY users call 711. You can also visit our website at www.healthchoiceok.com. Select the "Member" tab in the top menu bar and then select "Medicare Members."

Be aware there can be a number of changes to the formulary. HealthChoice SilverScript has not changed its drug tiers; however, some new drugs have been added and some previously covered drugs have been replaced with less costly generic alternatives.

Also be aware of restrictions on certain drugs as noted in the formulary, such as Prior Authorization, Step Therapy and Quantity Limits.

HealthChoice Comprehensive Formulary (Without Part D Plans)

The *HealthChoice Comprehensive Formulary* is a list of medications covered by the without Part D plans. To find out how your medications are covered, please contact the pharmacy benefit manager toll-free at 1-877-720-9375. TTY users call 711. You can also visit our website at www.healthchoiceok.com. Select the "Member" tab in the top menu bar and then select "Pharmacy Benefits Information." Here you can also find lists of commonly prescribed medications, excluded medications with Preferred alternatives, and specialty medications.

Changes to the HealthChoice SilverScript Medicare Formulary During the Year

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

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

If a drug you take is affected by a change, HealthChoice SilverScript 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 SilverScript to continue to cover the drug for you.

If the FDA finds a drug is unsafe or a drug is removed from the market, HealthChoice SilverScript immediately removes the drug from our formulary and then notifies you of the change. Your doctor will also know about this change and can prescribe another medication for your condition.

Drug Tiers

HealthChoice SilverScript has a five-tier drug formulary, and in general, each tier represents a different cost group. 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 medications; and
- ◆ Tier 5 – Preferred tobacco cessation medications.

The drugs in Tiers 1 and 2 offer the Preferred (lowest) copay while Tier 3 drugs are non-Preferred and have a higher copay; Tier 4 drugs include specialty medications and Tier 5 drugs are tobacco cessation products that have a \$0 copay. Drugs not listed in the formulary are not covered.

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 medical treatment for your condition.

Drugs Covered Under Medicare Part A and Part B

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

- ◆ Medicare Part A covers drugs you receive during a Medicare-covered stay in a hospital or skilled nursing facility or drugs for symptom control or pain relief as part of hospice care; and
- ◆ 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 under the HealthChoice SilverScript Medicare supplement plans. In some cases, the law does not allow any Medicare plan to cover certain types of drugs. In other cases, HealthChoice SilverScript has decided not to include certain drugs in its formulary.

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 SilverScript to cover your drug.

1. Prior Authorization

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

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

Refer to "HealthChoice SilverScript Restricted Medications List" later in this section.

2. Quantity Limits

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

3. Limited Availability

Certain drugs are subject to limited availability (LA) and can be purchased only at certain pharmacies. For more information, contact the pharmacy benefit manager toll-free at 1-866-275-5253. TTY users call 711.

4. Part B versus Part D Drug

Part B versus Part D drugs (B/D) 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 drug's use and the place where the drug is administered.

5. Step Therapy

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

Requesting a Pharmacy Prior Authorization

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

1. Have your physician's office contact the pharmacy benefit manager toll-free at:
 - ◆ SilverScript Plans 1-855-344-0930
 - ◆ Without Part D Plans 1-800-294-5979
2. The pharmacy benefit manager will assist your physician's office with completing a prior authorization form.
3. If your prior authorization is approved, your physician's office is notified of the approval within 24 to 48 hours. You are also notified in writing.
4. If your prior authorization is denied, your physician's office is notified of the denial within 24 to 48 hours. You are also notified in writing.

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

Tier Exception (High Option Plans Only)

If you choose a non-Preferred drug when a Preferred drug is available, you must pay the non-Preferred copay, unless you get a tier exception for a lower copay. Specific medical guidelines must be met, and your physician must supply information to justify your request. Your physician can contact the pharmacy benefit manager toll-free at 1-855-344-0930.

Non-Formulary or Excluded Medication Prior Authorization

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

1. Ask your physician for a prescription for a generic (Tier 1) or Preferred (Tier 2) medication that is listed on the formularies;
2. Continue your non-covered/non-formulary/excluded medication and pay the full cost; or
3. Request a prior authorization to receive your medication at the non-Preferred copay. For more information, contact the pharmacy benefit manager toll-free at:
 - ◆ SilverScript Plans 1-855-344-0930
 - ◆ Without Part D Plans 1-800-294-5979

Transition Supply of Medication (SilverScript Plans Only)

A transition supply of medication is made available to provide time for you to change to a formulary drug or request a prior authorization. Up to a 90-day supply is available when:

- ◆ You enroll in a Medicare supplement plan;
- ◆ Your medication is no longer covered; or
- ◆ 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 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 the pharmacy helpline toll-free at 1-866-693-4620.

Medication Quantities

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

Specialty Medications

Specialty medications are usually high-cost medications that require special handling and extensive monitoring. These types of medications are available only in a 30-day supply. For copay or coinsurance information, refer to pages 11-14.

SilverScript Plans

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

Without Part D Plans

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

The CVS/caremark specialty pharmacy provides free supplies, such as needles and syringes, free shipping, refill reminder calls and personal counseling with a registered nurse or pharmacist. If you do not order your specialty medications through CVS/caremark, you must pay the full cost. For more information, contact the CVS/caremark specialty pharmacy toll-free at 1-800-237-2767.

Tobacco Cessation Products

HealthChoice covers the following tobacco cessation medications for a \$0 copay when they are purchased at a Network Pharmacy:

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

Additionally, HealthChoice partners with the Oklahoma Tobacco Research Center 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 toll-free 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 toll-free 1-866-QUIT-4-LIFE (1-866-784-8454).

Vaccinations Covered Under Your Pharmacy Benefits

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

The coverage of vaccinations includes two parts – the cost of the vaccine itself and the cost of the vaccination, or administration of the shot. What you pay for a vaccination depends on the type of vaccine, where you purchase the vaccine, and who gives you the shot. The rules for coverage of vaccinations are complicated. If you have a question about how a particular vaccine is covered, contact the pharmacy benefit manager toll-free:

- ◆ SilverScript Plans 1-866-275-5253 or TTY 711
- ◆ Without Part D Plans 1-877-720-9375 or TTY 711

SilverScript Plans

- ◆ 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 the pharmacy benefit manager 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.

Without Part D Plans

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

When You Receive Hospice Care

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

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

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

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

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

Drug Safety Programs

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

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

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

Medication Therapy Management (SilverScript Plans Only)

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 for the program, the total costs of your medications must meet or exceed the annual limit set by Medicare.

If you qualify, you are automatically enrolled in the program and are contacted by an MTM provider. The MTM provider is specially trained in patient counseling and can discuss topics such as medication use and compliance, drug education, health and safety, and cost saving measures. While the program is voluntary, HealthChoice SilverScript encourages eligible members to participate. If you do not wish to participate in the program, you can call the pharmacy benefit manager toll-free at 1-866-275-5253. TTY users call 711.

Creditable Prescription Drug Coverage

The HealthChoice Medicare supplement plans 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, call HealthChoice Member Services 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.

What Types of Drugs Are NOT Covered

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

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

The following drug categories are also excluded from coverage:

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

*Part D covers medications lost or damaged as the direct result of a declared national disaster or public health emergency. Refer to page 17 for more information.

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

HealthChoice SilverScript Restricted Medications List

In most instances, new and generic equivalent medications that become available in the drug categories in this list will have the same restrictions. New drug categories may be added throughout the year.

Generic medications are in lower case letters and brand-name medications are in all capital letters.

Category/ Medication Name	Generic Available	Prior Authorization	Quantity Limits	Specialty Medication	Step Therapy
ANALGESICS	GA	PA	QL	SM	ST
COLCRYS			✓		
ULORIC					✓
OPIOID ANALGESICS	GA	PA	QL	SM	ST
acetaminophen w/ codeine soln			✓		
acetaminophen w/ codeine tabs			✓		
acetaminophen w/ codeine (Tylenol w/ Codeine #3)			✓		
acetaminophen w/ codeine (Tylenol w/ Codeine #4)			✓		
aspirin-caffeine-dihydrocodeine bitartrate			✓		
butorphanol nasal spray			✓		
BUTRANS			✓		
capital and codeine			✓		
CONZIP			✓		
SYNALGOS-DC			✓		
TRAMADOL HCL CP24			✓		
tramadol hcl er (biphasic)			✓		
tramadol hcl tab			✓		
trezix			✓		
tylenol with codeine			✓		
ULTRACET	✓		✓		
ULTRAM			✓		
ULTRAM ER	✓		✓		
OPIOID ANALGESICS, CII	GA	PA	QL	SM	ST
ABSTRAL		✓	✓		
ACTIQ	✓	✓	✓		
codeine sulfate			✓		
DILAUDID TAB			✓		
DOLOPHINE			✓		
DURAGESIC	✓		✓		
EMBEDA			✓		

endocet (generic of PERCOCET)			✓		
ENDODAN TAB			✓		
EXALGO			✓		
fentanyl citrate (generic of ACTIQ) LPOP		✓	✓		
FENTORA		✓	✓		
hycet			✓		
hydrocodone-acetaminophen			✓		
hydrocodone-ibuprofen tab			✓		
hydromorphone hcl			✓		
hydromorphone tab er			✓		
HYSINGLA ER			✓		
ibudone tab (generic of REPREXAIN)			✓		
KADIAN	✓		✓		
LAZANDA		✓	✓		
levorphanol tartrate tabs			✓		
methadone hcl soln			✓		
methadone hcl			✓		
METHADOSE CONC	✓		✓		
MORPHINE SULFATE TABS			✓		
morphine sulfate beads			✓		
MS CONTIN	✓		✓		
NORCO	✓		✓		
NUCYNTA			✓		
NUCYNTA ER			✓		
OPANA	✓		✓		
OPANA ER (CRUSH RESISTANT)			✓		
oxycodone hcl caps			✓		
oxycodone-ibuprofen			✓		
OXYCONTIN			✓		
PERCOCET	✓		✓		
PERCODAN	✓		✓		
reprexain tab			✓		
ROXICODONE	✓		✓		
SUBSYS		✓	✓		
vicodin (generic of XODOL)			✓		
vicodin es (generic of XODOL)			✓		
vicodin hp (generic of XODOL)			✓		
VICOPROFEN			✓		

XARTEMIS XR			✓		
XODOL TAB	✓		✓		
zamicet			✓		
ZOHYDRO ER (ABUSE DETERRENT)			✓		
ANTI-INFECTIVES, ANTI-BACTERIALS-MISCELLANEOUS	GA	PA	QL	SM	ST
TOBI PODHALER		✓			
ANTI-INFECTIVES-MISCELLANEOUS	GA	PA	QL	SM	ST
CAYSTON		✓			
FURADANTIN	✓	✓			
MACROBID	✓	✓			
MACRODANTIN	✓	✓			
ANTIFUNGALS	GA	PA	QL	SM	ST
ketoconazole tabs		✓			
LAMISIL TABS	✓		✓		
ONMEL		✓			
SPORANOX	✓	✓			
SPORANOX PULSEPAK		✓			
ANTIMALARIALS	GA	PA	QL	SM	ST
QUALAQUIN	✓	✓			
ANTIRETROVIRAL COMBINATION AGENTS	GA	PA	QL	SM	ST
TRUVADA			✓		
ANTITUBERCULAR AGENTS	GA	PA	QL	SM	ST
SIRTURO		✓			
ANTIVIRALS	GA	PA	QL	SM	ST
HARVONI		✓			
PEG-INTRON		✓			
PEG-INTRON REDIPEN		✓			
SOVALDI		✓			
BIOLOGIC RESPONSE MODIFIERS	GA	PA	QL	SM	ST
ERIVEDGE		✓			
FARYDAK		✓			
IBRANCE		✓			
KEYTRUDA		✓			
LYNPARZA		✓			
PERJETA		✓			
RITUXAN		✓			

YERVOY		✓			
ZOLINZA		✓			
HORMONAL ANTINEOPLASTIC AGENTS	GA	PA	QL	SM	ST
leuprolide acetate kit		✓			
LUPRON DEP-PED INJ		✓			
LUPRON DEP-PED INJ (3-month)		✓			
LUPRON DEPOT		✓			
LUPRON DEPOT INJ		✓			
LUPRON DEPOT INJ (3-month)		✓			
MEGACE ES		✓			
MEGACE ORAL	✓	✓			
megestrol acetate tabs		✓			
TRELSTAR MIXJECT		✓			
XTANDI		✓			
ZYTIGA		✓			
KINASE INHIBITORS	GA	PA	QL	SM	ST
AFINITOR		✓			
AFINITOR DISPERZ		✓			
BOSULIF		✓			
CAPRELSA		✓			
COMETRIQ		✓			
GILOTRIF		✓			
GLEEVEC		✓			
ICLUSIG		✓			
IMBRUVICA CAP		✓			
INLYTA		✓			
JAKAFI		✓			
LENVIMA		✓			
MEKINIST		✓			
NEXAVAR		✓			
SPRYCEL		✓			
STIVARGA		✓			
SUTENT		✓			
TAFINLAR		✓			
TARCEVA		✓			
TASIGNA		✓			
TYKERB		✓			
VOTRIENT		✓			
XALKORI		✓			

ZELBORAF		✓			
ZYDELIG		✓			
ZYKADIA		✓			
MISCELLANEOUS	GA	PA	QL	SM	ST
POMALYST		✓			
SYLATRON		✓			
SYNRIBO		✓			
TARGETIN CAPS		✓			
ANTIARRHYTHMICS	GA	PA	QL	SM	ST
NORPACE	✓	✓			
NORPACE CR		✓			
ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS	GA	PA	QL	SM	ST
ZOCOR	✓		✓		
ANTILIPEMICS, MISCELLANEOUS	GA	PA	QL	SM	ST
JUXTAPID		✓			
KYNAMRO		✓			
DIGITALIS GLYCOSIDES	GA	PA	QL	SM	ST
DIGOXIN SOL		✓			
LANOXIN	✓	✓	✓		
PULMONARY ARTERIAL HYPERTENSION	GA	PA	QL	SM	ST
ADCIRCA		✓			
ADEMPAS		✓			
LETAIRIS		✓			
OPSUMIT		✓			
ORENITRAM		✓			
REVATIO SUSR		✓			
REVATIO TABS	✓	✓			
TRACLEER		✓			
CENTRAL NERVOUS SYSTEM ANTIANXIETY	GA	PA	QL	SM	ST
alprazolam conc			✓		
ATIVAN TABS	✓		✓		
fluvoxamine maleate			✓		
fluvoxamine maleate er			✓		
lorazepam conc			✓		
XANAX TAB	✓		✓		
ANTICONVULSANTS	GA	PA	QL	SM	ST
BANZEL SUS	✓				

BANZEL TAB	✓				
diazepam conc; soln		✓	✓		
FYCOMPA		✓			
KLONOPIN	✓		✓		
LYRICA CAPS			✓		
LYRICA SOLN			✓		
NEURONTIN CAPS	✓		✓		
NEURONTIN SOLN	✓		✓		
ONFI SUSP; TABS		✓			
phenobarbital elix; tabs		✓			
PHENOBARBITAL SODIUM		✓			
POTIGA			✓		
SABRIL PACK; TABS		✓	✓		
TRANXENE T	✓	✓	✓		
VALIUM	✓	✓	✓		
ANTIDEMENTIA	GA	PA	QL	SM	ST
NAMENDA TABS	✓	✓			
NAMENDA SOL		✓			
NAMENDA XR		✓			
NAMENDA XR TITRATION PACK		✓			
ANTIDEPRESSANTS	GA	PA	QL	SM	ST
amitriptyline hcl		✓			
ANAFRANIL	✓	✓			
doxepin hcl caps; conc		✓			
EMSAM		✓			
FORFIVO XL			✓		
SURMONTIL		✓			
TOFRANIL	✓	✓			
TOFRANIL-PM	✓	✓			
ANTIPARKINSONIAN AGENTS	GA	PA	QL	SM	ST
APOKYN		✓			
benztropine mesylate tabs		✓			
ANTIPSYCHOTICS	GA	PA	QL	SM	ST
ABILIFY DISCMELT TAB			✓		
ABILIFY MAINTENANCE			✓		
ABILIFY TABS	✓		✓		
CLOZAPINE TBDP 150mg		✓	✓		
CLOZAPINE ODT		✓	✓		
CLOZARIL	✓		✓		
FANAPT			✓		✓
FANAPT TITRATION PACK					✓

FAZACLO		✓	✓		
GEODON	✓		✓		
GEODON INJ			✓		
INVEGA			✓		
INVEGA SUST INJ					
INVEGA TRINZA			✓		
LATUDA			✓		
RISPERDAL SOLN	✓		✓		
RISPERDAL TABS	✓		✓		
RISPERDAL INJ			✓		
RISPERDAL M-TAB			✓		
SAPHRIS			✓		
SEROQUEL	✓		✓		
SEROQUEL XR	✓		✓		
thioridazine hcl tabs		✓	✓		
VERSACLOZ		✓	✓		
ZYPREXA SOLR	✓		✓		
ZYPREXA TABS	✓		✓		
ZYPREXA RELPREVV		✓	✓		
ZYPREXA ZYDI TAB		✓	✓		
ATTENTION DEFICIT HYPERACTIVITY DISORDER	GA	PA	QL	SM	ST
ADDERALL TAB	✓		✓		
ADDERALL XR	✓		✓		
APTENSIO XR			✓		
CONCERTA	✓		✓		
DAYTRANA			✓		
INTUNIV		✓			
METADATE CD	✓		✓		
METHYLIN	✓		✓		
METHYLIN CHEW TAB	✓		✓		
QUILLIVANT XR			✓		
RITALIN	✓		✓		
RITALIN LA	✓		✓		
STRATTERA			✓		
VYVANSE			✓		
HYPNOTICS	GA	PA	QL	SM	ST
AMBIEN	✓	✓	✓		
HETLIOZ		✓			
RESTORIL	✓	✓	✓		
ROZEREM			✓		

SILENOR			✓		
MIGRAINE	GA	PA	QL	SM	ST
ALSUMA			✓		
AMERGE	✓		✓		
AXERT	✓		✓		
DIHYDROERGOTAMINE MESYLATE			✓		
FROVA			✓		
IMITREX SOLN	✓		✓		
IMITREX TABS	✓		✓		
IMITREX STATDOSE REFILL	✓		✓		
IMITREX STATDOSE SYSTEM	✓		✓		
MAXALT	✓		✓		
MIGRANAL			✓		
RELPAK			✓		
SUMAVEL DOSEPRO			✓		
TREXIMET			✓		
ZOMIG	✓		✓		
ZOMIG NASAL SPRAY	✓		✓		
ZOMIG ZMT	✓		✓		
MISCELLANEOUS	GA	PA	QL	SM	ST
GRALISE			✓		
SAVELLA			✓		
XENAZINE		✓	✓		
MULTIPLE SCLEROSIS AGENTS	GA	PA	QL	SM	ST
AMPYRA		✓			
AUBAGIO		✓	✓		
AVONEX		✓	✓		
BETASERON		✓	✓		
COPAXONE		✓	✓		
EXTAVIA		✓	✓		
GILENYA CAP		✓	✓		
LEMTRADA		✓			
PLEGRIDY		✓	✓		
REBIF		✓	✓		
TECFIDERA CAP		✓	✓		
TYSABRI		✓			
MUSCULOSKELETAL THERAPY AGENTS	GA	PA	QL	SM	ST
BOTOX INJ		✓			

cyclobenzaprine hcl tabs		✓			
XEOMIN INJ		✓			
NARCOLEPSY/CATAPLEXY	GA	PA	QL	SM	ST
NUVIGIL		✓	✓		
PROVIGIL	✓	✓	✓		
XYREM		✓	✓		
PSYCHOTHERAPEUTIC-MISC	GA	PA	QL	SM	ST
BUNAVAIL MIS		✓	✓		
buprenorphine hcl		✓			
buprenorphine hcl-naloxone hcl sl		✓	✓		
CHANTIX		✓			
SUBOXONE MIS		✓	✓		
ZUBSOLV SUB		✓	✓		
ANDROGENS	GA	PA	QL	SM	ST
ANDRODERM		✓	✓		
ANDROGEL		✓	✓		
ANDROGEL PUMP		✓	✓		
AVEED		✓			
AXIRON		✓	✓		
DEPO-TESTOSTERONE		✓			
FORTESTA		✓	✓		
oxandrolone		✓			
STRIANT		✓	✓		
TESTIM		✓	✓		
testosterone enanthate soln		✓			
VOGELXO		✓	✓		
ANTIDIABETICS, INJECTABLE	GA	PA	QL	SM	ST
BYDUREON PEN; SUSR			✓		
BYETTA			✓		
SYMLINPEN		✓			
TANZEUM			✓		
TRULICITY			✓		
VICTOZA			✓		
ANTIDIABETICS, ORAL	GA	PA	QL	SM	ST
ACTOPLUS MET TAB	✓		✓		
ACTOPLUS MET XR			✓		
ACTOS	✓		✓		
AMARYL	✓		✓		
DUETACT	✓		✓		
FARXIGA			✓		
FORTAMET	✓		✓		

glipizide-metformin			✓		
GLUCOPHAGE	✓		✓		
GLUCOPHAGE XR	✓		✓		
GLUCOTROL	✓		✓		
GLUMETZA			✓		
GLYXAMBI			✓		
INVOKAMET TAB			✓		
INVOKANA TAB			✓		
JANUMET			✓		
JANUMET XR TAB			✓		
JANUVIA			✓		
JARDIANCE			✓		
JENTADUETO			✓		
KAZANO			✓		
KOMBIGLYZE XR			✓		
NESINA			✓		
ONGLYZA			✓		
OSENI TAB			✓		
PRANDIMET			✓		
PRANDIN			✓		
RIOMET			✓		
STARLIX			✓		
TRADJENTA			✓		
XIGDUO XR TAB			✓		
BISPHOSPHONATES	GA	PA	QL	SM	ST
alendronate sodium soln			✓		
BONIVA SOLN	✓		✓		
CHELATING AGENTS	GA	PA	QL	SM	ST
EXJADE		✓			
FERRIPROX		✓			
JADENU		✓			
ENDOMETRIOSIS	GA	PA	QL	SM	ST
LUPANETA PACK		✓			
ENZYME REPLACEMENTS	GA	PA	QL	SM	ST
ADAGEN		✓			
ALDURAZYME		✓			
CARBAGLU		✓			
CERDELGA		✓			
CEREZYME		✓			
CYSTAGON		✓			
ELAPRASE		✓			

ELELYSO		✓			
FABRAZYME		✓			
KUVAN		✓			
LUMIZYME		✓			
MYOZYME		✓			
NAGLAZYME		✓			
ORFADIN		✓			
PROCYSBI		✓			
RAVICTI		✓			
VIMIZIM		✓			
VPRIV		✓			
ZAVESCA		✓			
ESTROGENS	GA	PA	QL	SM	ST
ALORA		✓			
CLIMARA	✓	✓			
estrace tabs		✓			
jinteli		✓			
MENOSTAR		✓			
MINIVELLE		✓			
norethindrone acetate-ethinyl estradiol		✓			
VIVELLE-DOT	✓	✓			
GLUCOSE ELEVATING	GA	PA	QL	SM	ST
KORLYM		✓			
HUMAN GROWTH HORMONES	GA	PA	QL	SM	ST
GENOTROPIN		✓			
GENOTROPIN MINIQUICK		✓			
HUMATROPE		✓			
HUMATROPE COMBO PACK		✓			
NORDITROPIN FLEXPRO		✓			
NORDITROPIN NORDIFLEX PEN		✓			
NUTROPIN AQ INJ		✓			
NUTROPIN AQ NUSPIN 5		✓			
NUTROPIN AQ PEN		✓			
OMNITROPE		✓			
SAIZEN		✓			
SAIZEN CLICK.EASY		✓			
SEROSTIM		✓			
ZOMACTON		✓			
ZORBTIVE		✓			

MISCELLANEOUS	GA	PA	QL	SM	ST
CHORIONIC GONADOTROPIN SOLR		✓			
EGRIFTA		✓			
H.P. ACTHAR		✓		✓	
INCRELEX		✓			
NOVAREL INJ		✓			
PREGNYL W/DILUENT BENZYL		✓			
PROLIA				✓	
SAMSCA		✓			
SANDOSTATIN	✓	✓			
SANDOSTATIN LAR DEPOT	✓	✓			
SIGNIFOR		✓			
SIGNIFOR LAR		✓			
SOMATULINE DEPOT		✓			
SOMAVERT		✓			
XGEVA		✓			
PARATHYROID HORMONES	GA	PA	QL	SM	ST
FORTEO		✓			
NATPARA		✓			
GASTROINTESTINAL ANTIEMETICS	GA	PA	QL	SM	ST
CESAMET			✓		
MARINOL	✓		✓		
phenadoz		✓			
phenergan		✓			
phenergan inj		✓			
promethazine hcl supp; syrup; tabs		✓			
promethegan		✓			
SANCUSO			✓		
TRANSDERM-SCOP		✓	✓		
INFLAMMATORY BOWEL DISEASE	GA	PA	QL	SM	ST
ENTYVIO		✓			
RELISTOR		✓			
MISCELLANEOUS	GA	PA	QL	SM	ST
GATTEX		✓			
LOTRONEX	✓	✓			
XIFAXAN TAB		✓			
PROTON PUMP INHIBITORS	GA	PA	QL	SM	ST
ACIPHEX	✓		✓		

ACIPHEX SPR CAP			✓		
OMEPRazole-SODIUM BICARBONATE			✓		
PREVACID			✓		
PREVACID SOLUTAB			✓		
PRIOLOSEC CPDR	✓		✓		
PROTONIX PACK	✓		✓		
PROTONIX TBEC			✓		
ZEGERID CAPS			✓		
ZEGERID PACK			✓		
HEMATOPOIETIC GROWTH FACTORS	GA	PA	QL	SM	ST
ARANESP ALBUMIN FREE		✓			
EPOGEN		✓			
GRANIX		✓			
LEUKINE		✓			
MIRCERA		✓			
MOZOBIL		✓			
NEULASTA		✓			
NEUMEGA		✓			
NEUPOGEN		✓			
PROCRIT		✓			
MISCELLANEOUS	GA	PA	QL	SM	ST
BERINERT		✓			
CINRYZE		✓			
FIRAZYR		✓			
PROMACTA		✓			
RUCONEST		✓			
IMMUNOLOGIC AGENTS DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)	GA	PA	QL	SM	ST
ACTEMRA		✓			
CIMZIA		✓			
ENBREL		✓			
ENBREL SURECLICK		✓			
HUMIRA		✓			
HUMIRA PEN		✓			
HUMIRA PEN-CROHNS STARTER KIT		✓			
HUMIRA PEN-PSORIASIS STARTER KIT		✓			
KINERET		✓			

ORENCIA		✓			
OTEZLA		✓			
REMICADE		✓			
SIMPONI		✓			
SIMPONI ARIA		✓			
XELJANZ		✓			
IMMUNOGLOBULINS	GA	PA	QL	SM	ST
BIVIGAM		✓			
CARIMUNE NANOFILTERED		✓			
FLEBOGAMMA		✓			
FLEBOGAMMA DIF		✓			
GAMMAGARD LIQUID		✓			
GAMMAGARD S/D		✓			
GAMMAGARD S/D IGA LESS TH		✓			
GAMMAKED		✓			
GAMMAPLEX		✓			
GAMUNEX-C		✓			
OCTAGAM		✓			
PRIVIGEN		✓			
IMMUNOMODULATORS	GA	PA	QL	SM	ST
ACTIMMUNE		✓			
ARCALYST		✓			
GRASTEK		✓			
RAGWITEK		✓			
REVLIMID		✓			
THALOMID		✓			
IMMUNOSUPPRESSANTS	GA	PA	QL	SM	ST
BENLYSTA		✓			
RESPIRATORY ANTICHOLINERGIC/BETA AGONIST COMBINATIONS	GA	PA	QL	SM	ST
ANORO ELLIPT AER			✓		
COMBIVENT RESPIMAT			✓		
STIOLTO RESPIMAT			✓		
ANTICHOLINERGICS	GA	PA	QL	SM	ST
ATROVENT HFA			✓		
INCRUSE ELLIPTA			✓		
SPIRIVA HANDHALER			✓		
SPIRIVA RESPIMAT			✓		
TUDORZA PRESSAIR			✓		

TUDORZA PRESSAIR (INSTITUTIONAL PACK)			✓		
ANTI-HISTAMINE COMBINATIONS	GA	PA	QL	SM	ST
DYMISTA SPR 137-50			✓		
ANTI-HISTAMINES	GA	PA	QL	SM	ST
hydroxyzine hcl soln		✓			
ARCAPTA NEOHALER			✓		
FORADIL AEROLIZER			✓		
PROAIR HFA			✓		
PROAIR RESPICLICK			✓		
PROVENTIL HFA			✓		
SEREVENT DISKUS			✓		
STRIVERDI RESPIMAT			✓		
VENTOLIN HFA			✓		
XOPENEX HFA			✓		
MISCELLANEOUS	GA	PA	QL	SM	ST
ARALAST NP		✓			
ESBRIET		✓			
GLASSIA		✓			
KALYDECO		✓			
OFEV		✓			
ORKAMBI		✓			
PROLASTIN-C		✓			
XOLAIR		✓			
ZEMAIRA		✓			
NASAL STEROIDS	GA	PA	QL	SM	ST
BECONASE AQ			✓		
flunisolide (nasal)			✓		
fluticasone propionate (nasal)			✓		
NASONEX			✓		
OMNARIS			✓		
QNASL			✓		
QNASL CHILDRENS			✓		
RHINOCORT AQUA	✓		✓		
triamcinolone acetonide (nasal)			✓		
VERAMYST			✓		
ZETONNA			✓		
STEROID INHALANTS	GA	PA	QL	SM	ST
AEROSPAN			✓		
ALVESCO			✓		

ARNUITY ELLIPTA			✓		
ASMANEX			✓		
ASMANEX HFA			✓		
FLOVENT DISKUS			✓		
FLOVENT HFA			✓		
PULMICORT FLEXHALER			✓		
QVAR			✓		
STEROID INHALANTS	GA	PA	QL	SM	ST
ADVAIR DISKUS			✓		
ADVAIR HFA			✓		
BREO ELLIPTA			✓		
DULERA			✓		
SYMBICORT			✓		
DERMATOLOGY, ANTIPRURITIC	GA	PA	QL	SM	ST
COSENTYX		✓			
COSENTYX SENSOREADY PEN		✓			
SORIATANE	✓	✓			
STELARA		✓			
TAZORAC		✓			
DERMATOLOGY, LOCAL ANESTHETICS	GA	PA	QL	SM	ST
LIDODERM	✓	✓			
DERMATOLOGY, MISCELLANEOUS AND MUCOUS MEMBRANE	GA	PA	QL	SM	ST
ELIDEL		✓			
PROTOPIC	✓	✓			
SOLARAZE	✓	✓			
TARGRETIN GEL		✓			
VALCHLOR		✓			
DERMATOLOGY, WOUND CARE AGENTS	GA	PA	QL	SM	ST
REGRANEX		✓			

Note: For the without Part D plans, the Restricted Medications List is the same as the list for the pre-Medicare HealthChoice plans. To access this list, please go to www.healthchoiceok.com. Under "Member" in the top menu bar, select "Pharmacy Benefits Information," then select "Pharmacy Prior Authorizations, Quantity Limits, Specialty Medications and Step Therapy."

Claim Procedures

Claims Filing Deadline

Claims must be received by HealthChoice no later than Dec. 31 of the year following the year claims were incurred. For example, if the date of service is July 1, 2016, the claim is accepted through Dec. 31, 2017.

Filing a Medical Claim

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

If you have to file your claim with HealthChoice yourself, once you receive your "Medicare Summary Notice" for Part A and Part B services, you can file your claim by sending a copy of the notice to the medical claims administrator at:

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

Medical Coordination of Benefits

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

HP Administrative Services, LLC
P.O. Box 24110
Oklahoma City, OK 73124-0110

If you have questions about coordination of benefits, please call the medical claims administrator 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 (ESRD), Medicare is the secondary payer to HealthChoice 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, HealthChoice always pays first.

If you have questions about coverage of ESRD, visit www.medicare.gov or call Medicare toll-free at 1-800-MEDICARE (1-800-633-4227) or TTY 1-877-486-2048.

Filing a Direct Pharmacy Claim

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

- ◆ SilverScript Plans toll-free 1-866-693-4620
- ◆ Without Part D Plans toll-free 1-800-364-6331

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

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

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

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

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

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

Claims for Services Outside the United States

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

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

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

For questions about claim filing, call the medical claims administrator 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.

Private Contracts with Physicians and Practitioners

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

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

Subrogation

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

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

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

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

The subrogation administrator can be reached at 1-405-235-0439.

Eligibility, Enrollment and Disenrollment

Medicare Eligibility

Medicare is the federal health insurance program for people:

- ◆ Ages 65 and older;
- ◆ Under age 65 with qualified disabilities;
- ◆ With end-stage renal disease.

CMS manages the Medicare program. The Social Security Administration determines eligibility, enrolls people in Medicare, and collects Medicare premiums. For information about Medicare, visit the CMS website at www.cms.gov or the Social Security website at www.ssa.gov. You can also contact Social Security toll-free at 1-800-772-1213 or TTY 1-800-325-0778.

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

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

Enrollment in Medicare

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

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

If you are not already receiving Social Security or Railroad Retirement Board benefits, you must apply for Medicare by contacting Social Security, 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

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

If you or your covered dependents become Medicare eligible before age 65, you must notify EGID and provide your Medicare ID number as it appears on your Medicare ID card. EGID will mail you an "Application for Medicare Supplement Plan" that must be completed and returned to EGID. Your enrollment in a HealthChoice SilverScript Medicare supplement plan will be effective the first day of the month following 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; and
- ◆ Reside in the United States or its territories.

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

Enrollment Periods

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

- ◆ **Initial Enrollment Period** – When you first become eligible for Medicare.
- ◆ **Annual Coordinated Election Period** – Medicare's annual election period, which EGID follows for Option Period plan changes effective Jan. 1.
- ◆ **Special Enrollment Periods** – When you can make midyear changes under certain circumstances, such as:
 - ◆ You move outside the United States;
 - ◆ CMS or HealthChoice terminates the Plans' participation in the Part D program;
 - ◆ You lose Creditable Coverage for reasons other than failure to pay premiums; or
 - ◆ You meet other exception rules as set out by CMS.

For more information about Special Enrollment Periods, call toll-free 1-800-MEDICARE (1-800-633-4227). TTY users call toll-free 1-877-486-2048.

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 receipt of your application, whichever is later.
- ◆ **Annual Coordinated Election Period/Option Period** – Effective date is Jan. 1.
- ◆ **Special Enrollment Periods** – Effective date always follows the receipt of your application.

Confirmation Statement

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

If you do not make any changes to your coverage, you will not receive a "Confirmation Statement."

Dependent Coverage

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

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

COBRA continuation of coverage is available for dependents who lose eligibility. Refer to "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, whether 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; and
- ◆ 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 enroll dependents only 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 or qualified individual health coverage.

If your spouse is enrolled separately in a plan offered through EGID, your dependents can be covered under only one parent's health, dental 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 apply. 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 Social Security. If you enroll your newborn, 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 or qualified individual health coverage or are eligible for Indian or military health benefits. You can exclude eligible dependent children who do not live with you, are married or are not financially dependent on you for support. You can also exclude your spouse. If you exclude your spouse while covering other eligible dependents, you and your spouse must both sign the "Spouse Exclusion" section of your "Application for Retiree/Vested/Non-Vest/Defer Insurance," or your "Option Period Enrollment/Change Form" if you drop your spouse during the annual Option Period.

To Request Coverage Changes

All requests for changes in coverage must be made in writing. Verbal requests for changes are not accepted. A request for change must be made within 30 days of a qualifying event. Please send all requests for changes to HealthChoice, 3545 N.W. 58th St., Ste. 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 Jan. 1, 2002, you can continue coverage through the Plan as long as the employer from which you retired or vested continues to participate in the Plan. If your former employer terminates coverage with the Plan, you must follow your former employer to its new insurance carrier.

New Employer Retirees

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

Following Your Employer to a New Plan

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

If You Return to Work

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

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

You have the option to leave the Plan during the Annual Coordinated Election 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 terminated, 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 the only benefit that can be elected during the Annual Coordinated Election Period/Option Period as long as you keep one other benefit through EGID.

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

When HealthChoice Must End Your Coverage

HealthChoice must end your coverage in the Plan when:

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

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

In the Event of Your Death

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

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

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

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

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The *Consolidated Omnibus Budget Reconciliation Act* (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; or
- ◆ 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; or
- ◆ Your death (refer to "In the Event of Your Death" in this section).

As a former employee, you must notify EGID in writing within 30 days of a divorce*, legal separation*, or your child's loss of dependent status under this Plan. You and/or your eligible dependents must elect continuation of coverage within 60 days after the later of the following events occurs:

- ◆ The date the qualifying event would cause you or your dependents to lose coverage; or
- ◆ The date EGID notifies you or your dependents of continuation of coverage rights.

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

If you have questions about COBRA, contact HealthChoice Member Services:

- ◆ 1-405-717-8780 or toll-free 1-800-752-9475
- ◆ TDD 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.

Privacy Notice

State of Oklahoma

Office of Management and Enterprise Services (OMES)

Revised: March 2015

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

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

OMES HIPAA Privacy Officer
3545 NW 58th, Suite 1000, Oklahoma City, OK 73112
Telephone: 1-405-717-8701, Toll-free 1-800-543-6044
TDD 1-405-949-2281, Toll-free TDD 1-866-447-0436
OMES.OK.gov

Why is the Notice of Privacy Practices Important?

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

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

- The State Wellness Program, Employees Group Insurance Department (EGID), and Section 125 plan within Human Capital Management;
- The Performance and Efficiency Division as it applies to operations of the Employees Group Insurance Department;
- The Legal Division; and
- The Information Services Division (ISD) as it applies to maintenance and storage of PHI.

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

Your Information. Your Rights. Our Responsibilities.

Your Rights

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

Get a copy of your health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the beginning of this notice.

- You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. Complaints to HHS must be filed within 180 days of when you knew that the violation occurred.
- We will not retaliate against you for filing a complaint.

Your Choices

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

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

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

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

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

Our Uses and Disclosures

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

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

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

Help manage the health care treatment you receive

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

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

Run our organization

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

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

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

Help with public health and safety issues

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

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

Do research

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

Comply with the law

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

Work with a medical examiner or funeral director

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information (PHI).
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your PHI other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will deliver a copy to you.

Information the Plan Must Provide to You

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

More information about the HealthChoice Pharmacy Network and coverage of specific medications is available at www.healthchoiceok.com or contact the pharmacy benefit manager:

- ◆ SilverScript toll-free 1-866-275-5253 or TTY 711
- ◆ Without Part D toll-free 1-877-720-9375 or TTY 1-800-863-5488

Support for Your Right to Make Decisions About Your Care

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

- ◆ Fill out a written form to give someone the legal authority to make medical decisions for you if you are unable to make decisions for yourself; or
- ◆ 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:

- ◆ Get the form*;
- ◆ Fill it out and sign it;
- ◆ Give copies to the appropriate people; and
- ◆ 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.ok.gov/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 medical or pharmacy benefits. You cannot be disenrolled from the Plan or penalized in any way for making a complaint, grievance or appeal.

When Your Medical Claim is Denied

If your medical 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 the medical claims administrator at:

Medical Claims Review
P.O. Box 24110
Oklahoma City, OK 73124-0110

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

- ◆ 1-405-416-1800 or toll-free 1-800-782-5218
- ◆ TDD 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. 1999, § 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. 2012, Section 1306(6). For more information, contact:

The Legal Grievance Department
3545 N.W. 58th St., Ste. 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

When Your Pharmacy Claim is Denied

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

- ◆ SilverScript Plans toll-free 1-866-275-5253 or TTY 711
- ◆ Without Part D Plans toll-free 1-877-720-9375 or TTY 1-800-863-5488

HealthChoice SilverScript Plans

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

Plans Without Part D

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

HealthChoice Pharmacy Unit
3545 N.W. 58th St., Ste. 110
Oklahoma City, OK 73112
Fax 1-405-717-8925

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

Fraud, Waste and Abuse Compliance

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

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

- ◆ Sending a report in writing to the EGID Compliance Officer at 3545 N.W. 58th St., Ste. 110, Oklahoma City, OK 73112
- ◆ Emailing a message to EGID.antifraud@omes.ok.gov
- ◆ Leaving a report in the secure drop box outside the EGID Board Room Floor 5
- ◆ Calling the EGID toll-free hotline at 1-866-381-3815
- ◆ Visiting the EGID Compliance Officer in person

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

Examples of fraud, waste and abuse may include:

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

You can contact EGID at 1-866-381-3815 to report complaints about one of these types of fraud, waste and abuse issues or a related complaint.

Notifications

Women's Health Cancer Rights Act of 1998 Notice*

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

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

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

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

Coverage of Side Effects Associated With Prostate-Related Conditions*

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

*If you have questions about HealthChoice coverage of mastectomies and reconstructive surgery or prostate-related conditions, contact HP Administrative Services.

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

Wigs and Scalp Prostheses

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

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 Coordinated Election 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 & 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 Health Care Management Unit, 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.

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

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

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

Covered Drugs: The prescription drugs covered by the Plans.

Coverage Gap (Low Option Plans): The period following the Initial Coverage Limit 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.

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

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

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

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

HealthChoice Comprehensive Formulary: A list of medications covered by the Without Part D Plans.

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

Initial Coverage Limit (Low Option Plans): After you meet the deductible, the next \$2,950 of prescription drug costs is known as the Initial Coverage Limit. You pay 25 percent (\$737.50) and HealthChoice pays 75 percent (\$2,212.50) of this amount for covered prescription drugs.

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

Medically Necessary: Medicare-covered health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medical practice. Services or supplies must be the most appropriate level of which can safely be provided. For hospital stays, inpatient acute care is necessary due to the severity of your condition, or when safe and adequate care cannot be received 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. Medicare does not cover services that are not medically necessary, and we follow their guidelines.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with ESRD (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 and 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-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.

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

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

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 does not 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 Coordinated Election Period: Refer to definition under "Annual Coordinated Election Period/Option Period" in this section.

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

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

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

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

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

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.

