

HealthChoice

Health Plans Handbook

High and High Alternative
Basic and Basic Alternative
High Deductible Health Plan

Plan Year
2026



OKLAHOMA
Employees Group
Insurance Division

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This health handbook replaces and supersedes any health handbook the Employees Group Insurance Division previously issued. This health handbook will, in turn, be superseded by any subsequent health handbook EGID issues. The most current version of this health handbook can be found by going to [HealthChoiceOK.com](https://www.healthchoiceok.com).

NOTICES

Please read this handbook carefully

The Employees Group Insurance Division (EGID) provides health care benefits to eligible state, education and local government employees, former employees, and their dependents in accordance with the provisions of 74 O.S. §§ 1301 et seq. EGID is a division of the Oklahoma Health Care Authority (OHCA).

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

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

Information available online

HealthChoice website

The HealthChoice website at HealthChoiceOK.com is for active and prospective HealthChoice members to find detailed information, including an overview of each of the HealthChoice plans for active and pre-Medicare former employees. The HealthChoice handbooks are available online, and members can search for HealthChoice network providers. The website also includes access to many forms and applications along with other helpful resources such as direct links to pharmacy benefits and HealthChoice Select.

HealthChoice member portal

You can log in to the HealthChoice member portal from the HealthChoice website. This online tool gives you quick and easy access to your member and dependent claims, benefit information, account balances, member ID card and more. You can also use the member portal to find a network provider or chat with HealthChoice Customer Service via secure message. You may also access the HealthChoice Health Center and Wellness portal from the member portal. If you haven't already registered for the HealthChoice member portal, you need to create a unique username and password to access your information. Your covered dependents age 18 and older must register independently for their own access.

HealthChoice benefits app

The HealthChoice benefits app is designed to give you immediate access to all your benefit information including your claims and explanation of benefits using your phone or tablet. You can search for network providers, connect with a care guide to schedule a visit with a network provider or access SwiftMD, a Revive company, for a virtual visit. You can easily retrieve a digital copy of your health and pharmacy insurance cards and use them at any time. The app also offers live texting capabilities which allow you to chat directly with a care guide 24/7. Care guides can answer your benefit questions about \$0 HealthChoice Select services, schedule appointments and review billing questions. Download the free HealthChoice benefits app from your favorite app store for Apple and Android devices.

HEALTHCHOICE PLAN CONTACT INFORMATION

HealthChoice Customer Service

Medical Benefits, claims and certification inquiries

800-323-4314

TTY 711

HealthChoiceOK.com

Medical claims and correspondence

P.O. Box 30511

Salt Lake City, UT 84130-0511

Disputed claim appeals (members and providers)

P.O. Box 30546

Salt Lake City, UT 84130-0546

Pharmacy benefit manager

CVS Caremark

CVS Customer Care: 877-720-9375

Specialty pharmacy: 800-237-2767

Pharmacy prior authorization: 800-294-5979

TTY 711

Caremark.com

SwiftMD (a Revive Company)

Telemedicine services

833-980-1442

SwiftMD.com

Subrogation administrator

McAfee & Taft

405-235-9621 or 800-235-9621

Two Leadership Square, 8th Floor

211 N. Robinson Ave.

Oklahoma City, OK 73102

Eligibility and enrollment

EGID Member Services

405-717-8780 or 800-752-9475

TTY 711

HEALTHCHOICE PLAN IDENTIFICATION

Plan names

HealthChoice High
HealthChoice High Alternative
HealthChoice Basic
HealthChoice Basic Alternative
HealthChoice High Deductible Health Plan

Plan administrator

Employees Group Insurance Division
405-717-8780 or toll-free 800-752-9475
TTY 711
P.O. Box 11137
Oklahoma City, OK 73136-9998
HealthChoiceOK.com

THE HEALTHCHOICE PROVIDER NETWORK

You can seek care from a network or non-network provider; however, the amount you are responsible for paying is substantially higher when you use a non-network provider for non-emergency services. With a statewide and multistate network of more than 25,000 physicians, hospitals and other health care professionals and facilities, the HealthChoice Provider Network is one of the largest in Oklahoma.

Finding a HealthChoice network provider

You can find a HealthChoice network provider through **HealthChoiceOK.com**, the HealthChoice member portal or HealthChoice benefits app.

You can also contact HealthChoice Customer Service to find a network provider. A representative can give you the names of network providers in your area.

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

Refer to HealthChoice Plan Contact Information.

Importance of selecting a HealthChoice network provider

Network providers

Network providers include doctors, hospitals and other health care professionals who have a contract with HealthChoice. These providers agree to accept the HealthChoice approved amount for their services (refer to Allowable amount in Plan Definitions for more details).

When you see a network provider, you pay your plan's applicable copay, deductible and/or coinsurance. You don't have to pay the difference between what the provider charges and what HealthChoice allows. You may still have to pay for services that aren't covered by your plan.

Non-network providers

Non-network providers include doctors, hospitals and other health care professionals who do not have a contract with HealthChoice. They can charge more than the HealthChoice-approved amount for their services.

You are responsible for paying the difference between what the provider bills and what HealthChoice allows. This is called balance billing, which costs you more out of pocket (refer to Balance billing in Plan Definitions for more details).

Even if you reach your plan's out-of-pocket maximum, you still have to pay any balance-billed amounts when you use non-network providers.

Providers may be required to meet eligibility criteria and comply with Oklahoma law to qualify for reimbursement. You should be aware that non-network providers are not subject to HealthChoice credentialing or oversight requirements. Because EGID cannot monitor or verify the affiliations of non-network providers, you assume the risk if you choose to receive non-network services. If a non-network provider is later determined to be affiliated with activities that violate state policy, your claims for those services may be denied.

HealthChoice Select Program

HealthChoice Select is available to all HealthChoice members. It offers certain medical procedures at no cost to you **when all related Select services are received on the same day at a HealthChoice Select facility.**

If you have one of the qualifying Select procedures done at a participating facility and all Select services are performed together that day, you won't pay a copay, deductible or coinsurance for those services.

Note: High Deductible Health Plan members must meet their annual deductible before they are eligible to have any costs waived (unless the service is considered preventive). However, since HealthChoice Select facilities accept one bundled payment for certain procedures at a reduced rate, HDHP members can still save by utilizing a Select facility for one of these procedures.

In addition to offering these services at no cost to you, HealthChoice will also pay you a \$100 incentive payment when you have a qualifying colonoscopy or sigmoidoscopy at a Select participating facility. HealthChoice will also pay \$100 to HDHP members who have a qualifying preventive colonoscopy or sigmoidoscopy done at a participating Select facility even if your deductible has not been met.

Note: If HealthChoice is not the primary payer, the Select benefit does not apply.

To find out what other procedures qualify under the HealthChoice Select Program and which network facilities throughout Oklahoma are participating for those procedures, go to [HealthChoiceOK.com](https://www.healthchoiceok.com) or call HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information. In addition, Care Guides are available through the HealthChoice benefits app to help guide you through the HealthChoice Select process and ensure that all members have a positive, beneficial experience.

HEALTHCHOICE HIGH AND HIGH ALTERNATIVE PLANS

Plan features

If you use the HealthChoice medical or pharmacy provider networks, costs that you are responsible for include but may not be limited to the following:

- Calendar year deductibles.
- Calendar year out-of-pocket maximum.
- Coinsurance.
- Non-covered services.
- Office visit copays.

Calendar year deductible

The High and High Alternative plans have an embedded deductible, so individual members on a family plan may meet their individual deductible before the family deductible is met, but no member may contribute more than the total individual deductible toward the family deductible. Once the individual deductible is met, the member shares the cost of services with HealthChoice by paying coinsurance. When three or more family members are covered, a family deductible applies and can be met by any combination of the family members. Once the family deductible is met, coinsurance will begin for everyone.

| High plan | High Alternative plan |
|-------------------------------------|---------------------------------------|
| Individual medical deductible \$750 | Individual medical deductible \$1,000 |
| Family medical deductible \$2,000 | Family medical deductible \$2,750 |

Note: Refer to Pharmacy Benefits for the separate pharmacy deductible.

Copays

These are fixed amounts you pay for certain covered services. Copays apply before you meet your deductible, but they do not count toward your deductible. Copays are applied toward your out-of-pocket maximum.

| Service | Copay |
|--|----------------------------|
| General physician office visit (network general practitioners, internal medicine physicians, OB/GYNs, pediatricians, psychiatrists, geriatricians, preventive medicine practitioners, physician assistants and nurse practitioners) | \$30 |
| Urgent care (urgent care visits at a network urgent care facility) | \$30 |
| Specialist office visit (network specialist providers) | \$50 |
| Emergency department (network or non-network visit; waived if the patient is admitted to the hospital or if death occurs prior to admission) | \$200 |
| Non-network inpatient admission (non-network hospital/facility admissions; patient is subject to balance billing) | \$300 |
| Preventive services (qualified preventive care office visits and services) | \$0 |
| Pharmacy | Refer to Pharmacy Benefits |

Coinsurance

You must meet the deductible before coinsurance applies. You are responsible for the cost of all non-covered services regardless of your provider's network or non-network status.

| Coinsurance | Network | Non-Network |
|--------------------------|-------------------------|--------------------------|
| Member pays | 20% of allowable amount | 50% of allowable amount* |
| HealthChoice pays | 80% of allowable amount | 50% of allowable amount |

*Plus, you pay the difference between the amount billed by the provider and the allowable amount.

Calendar year out-of-pocket maximum

No member contributes more than the individual maximum. Once the individual maximum is met, HealthChoice pays 100% of the allowed amount for that person. When three or more family members are covered, a family maximum applies and can be met by any combination of the family members. Once the family maximum is met, HealthChoice pays 100% of the allowable amounts for covered services for everyone on the plan.

| High plan | High Alternative plan |
|--------------------------------|--------------------------------|
| Network individual \$3,300 | Network individual \$3,550 |
| Network family \$8,400 | Network family \$8,400 |
| Non-network individual \$3,800 | Non-network individual \$4,050 |
| Non-network family \$9,900 | Non-network family \$9,900 |

Charges that do not count toward the out-of-pocket maximum

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

- Amounts above HealthChoice allowable amounts.
- Non-network copays and balance-billed charges.
- Non-covered services or charges.
- Amounts above maximum benefit limitations.*

*Some services have an annual cap on the dollar amount or the total number of visits that will be covered. After the annual limit is reached, you must pay all associated health care costs for the remainder of the calendar year.

Note: No lifetime maximum per member.

HEALTHCHOICE BASIC AND BASIC ALTERNATIVE PLANS

Plan features

If you use the HealthChoice medical or pharmacy provider networks, you are responsible for:

- Calendar year deductibles.
- Calendar year out-of-pocket maximum.
- Coinsurance.

First-dollar medical coverage

For each enrolled member, this is the initial amount that HealthChoice pays toward allowable amounts for covered network and/or non-network services before anything is owed by you. This includes but is not limited to amounts for office visits, lab work, X-rays, surgical procedures, hospital admissions, etc. Expenses for non-covered services and any expense beyond the allowable amount for non-network services do not qualify for first-dollar coverage. Once your first-dollar coverage limit is reached, you are responsible for your deductible. First-dollar coverage does not apply to pharmacy benefits.

| Basic plan | Basic Alternative plan |
|-----------------------------|-----------------------------|
| First-dollar coverage \$500 | First-dollar coverage \$250 |

Calendar year deductible

After you reach your first-dollar coverage limit, allowable amounts for covered network and/or non-network services go toward your deductible. The Basic and Basic Alternative plans have an embedded deductible, so individual members on a family plan may meet their individual deductible before the family deductible is met, but no member may contribute more than the total individual deductible toward the family deductible. Once the individual deductible is met, the member shares the cost of services with HealthChoice by paying coinsurance. When two or more family members are covered, a family deductible applies and can be met by any combination of the family members. Once the family deductible is met, coinsurance will begin for everyone.

| Basic plan | Basic Alternative plan |
|---------------------------------------|---------------------------------------|
| Individual medical deductible \$1,000 | Individual medical deductible \$1,250 |
| Family medical deductible \$1,500 | Family medical deductible \$1,750 |

Note: Refer to Pharmacy Benefits for the separate pharmacy deductible.

Copays

Only one medical copay applies to members on the HealthChoice Basic and Basic Alternative plans, which is a copay of \$300 per non-network hospital/facility inpatient admission.

Coinsurance

You must meet your deductible before coinsurance applies. You are responsible for the cost of all non-covered services regardless of your provider’s network or non-network status.

| Coinsurance | Network | Non-network |
|-------------------|-------------------------|--------------------------|
| Member pays | 50% of allowable amount | 50% of allowable amount* |
| HealthChoice pays | 50% of allowable amount | 50% of allowable amount |

*Plus, you pay the difference between the amount billed by the provider and the allowable amount.

Calendar year out-of-pocket maximum

No member contributes more than the individual maximum. Once the individual maximum is met, HealthChoice then pays 100% of the allowed amount for that person. When three or more family members are covered, a family maximum applies and can be met by any combination of the family members. HealthChoice then pays 100% of the allowable amounts for covered services for everyone on the plan.

| Basic plan | Basic Alternative plan |
|--------------------------|--------------------------|
| Network and non-network* | Network and non-network* |
| Individual \$4,000 | Individual \$4,000 |
| Family \$9,000 | Family \$9,000 |

*There is not a separate out-of-pocket maximum for network vs. non-network services. All eligible charges are applied to the combined out-of-pocket maximum.

Charges that do not count toward the out-of-pocket maximum

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

- Amounts above HealthChoice allowable amounts.
- Non-network copays and balance-billed charges.
- Non-covered services or charges.
- Amounts above maximum benefit limitations.*

*Some services have an annual cap on the dollar amount or the total number of visits that will be covered. After the annual limit is reached, you must pay all associated health care costs for the remainder of the calendar year.

Note: No lifetime maximum per member.

HEALTHCHOICE HIGH DEDUCTIBLE HEALTH PLAN

Plan features

If you use the HealthChoice medical and pharmacy provider networks, you are responsible for:

- Calendar year combined medical and pharmacy deductible.
- Office visit copays.
- Coinsurance.
- Calendar year out-of-pocket maximum.

Calendar year deductible

Both pharmacy and medical expenses apply toward the combined deductible in the HDHP only. There is not a separate pharmacy deductible with HDHP, unlike the High and Basic plans. There is no embedded deductible with HDHP, so the applicable deductible must be met before any benefits will be paid by the plan.

For plans with one member, the individual deductible must be met before benefits are paid by the plan. Once the individual deductible is met, the member shares in the cost of services by paying copays or coinsurance.

For plans with a family of two or more, the family deductible must be met before benefits for any member will be paid by the plan. The family deductible can be met by one individual or any combination of covered family members. Once the family deductible is met, all family members share in the cost of services by paying copays or coinsurance.

| Individual | Family |
|--|--|
| Combined medical and pharmacy deductible \$1,750 | Combined medical and pharmacy deductible \$3,500 |

Copays

These are fixed amounts you pay for certain covered services. Copays apply after you meet your combined medical and pharmacy deductible. Copays do not count toward your deductible, but they do count toward your out-of-pocket maximum.

| Service | Copay |
|--|-----------------------------|
| General physician office visit (network general practitioners, internal medicine physicians, OB/GYNs, pediatricians, psychiatrists, geriatricians, preventive medicine practitioners, physician assistants and nurse practitioners) | \$30* |
| Urgent care (urgent care visits at a network urgent care facility) | \$30* |
| Specialist office visit (network specialist providers) | \$50* |
| Emergency department (network or non-network visit; waived if the patient is admitted to the hospital or if death occurs prior to admission) | \$200* |
| Non-network inpatient admission (non-network hospital/facility admissions; patient is subject to balance billing) | \$300* |
| Preventive services (qualified preventive care office visits and services) | \$0 |
| Pharmacy | Refer to Pharmacy Benefits* |

*Applies after deductible is met.

Coinsurance

You must meet the deductible before coinsurance applies. You are responsible for the cost of all non-covered services regardless of your provider's network or non-network status.

| Coinsurance | Network | Non-network |
|--------------------------|-------------------------|--------------------------|
| Member pays | 20% of allowable amount | 50% of allowable amount* |
| HealthChoice pays | 80% of allowable amount | 50% of allowable amount |

*Plus, you pay the difference between the amount billed by the provider and the allowable amount.

Calendar year out-of-pocket network maximum

No member contributes more than the individual maximum. Once the individual maximum is met, HealthChoice then pays 100% of the allowed amount for that person. A family maximum applies when two or more family members are covered and can be met by any combination of the family members. HealthChoice then pays 100% of the allowable amounts for covered services for everyone on the plan.

| Network individual | Network family |
|-------------------------------|--------------------------------|
| \$6,000 calendar year maximum | \$12,000 calendar year maximum |

Charges that do not count toward the out-of-pocket maximum

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

All non-network expenses, including:

- Non-network covered services up to the allowable amount.
- Non-network expenses above the HealthChoice allowable amount.
- Non-network pharmacy charges.
- Non-network pharmacy expenses.
- Non-covered services or charges.
- Amounts above maximum benefit limitations.*

*Some services have an annual cap on the dollar amount or the total number of visits that will be covered. After the annual limit is reached, you must pay all associated health care costs for the remainder of the calendar year.

Note: No lifetime maximum per member.

COVERED SERVICES, SUPPLIES AND EQUIPMENT

Covered supplies and equipment are based on use of network or non-network providers and are subject to plan provisions and criteria for coverage. Non-emergent covered services through a non-network provider are subject to balance billing unless the services are provided at a network facility, as applicable by law. Some services are covered only through network providers. Refer to the HealthChoice High and High Alternative Plans, HealthChoice Basic and Basic Alternative Plans or the HealthChoice High Deductible Health Plan section.

This is not a comprehensive list. Some services may have limited coverage and/or require certification of medical necessity for coverage; refer to Plan Exclusions or Certification for additional information. For questions or information about benefits or coverage, contact HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

Acupuncture

- Covered only as an alternative to anesthesia for surgery.

Allergy serum, treatment and testing

- Limited to one battery of 60 tests every 24 months; excludes testing of the home environment.

Ambulance

- Air and ground services.
- Refer to Emergency Care Coverage for additional information.

Anesthesia

- Eligible services for covered illness or surgery.

Autism spectrum disorders

- Screening and diagnosis services provided by a licensed physician or a licensed doctoral-level psychologist.
- Specific to applied behavior analysis (ABA):
 - Treatment services provided by a Board Certified Behavior Analyst (BCBA), a licensed physician or psychologist, Board Certified Assistant Behavior Analyst (BCaBA) or a Registered Behavior Technician.
 - Proposed treatment plan with script is required upon receipt of the first claim each rolling year from a medical doctor or clinical psychologist.
- Refer to Exclusions and Preventive Services for additional information.

Bariatric surgery

- Must be age 18 or older.
- Must be covered by HealthChoice for 12 consecutive months prior to surgery.
- Must be performed at a network bariatric facility.

Birth center

- Must be associated with an inpatient obstetrical and neonatal facility.

Blood and blood products

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

Breast pumps

- Limited to two total per pregnancy: one preventive pump and one under Plan standard benefits.
- Refer to Preventive Services for additional information.

Chelation therapy

- Covered only for heavy metal poisoning.

Chemotherapy

- Home, outpatient or inpatient services when medically necessary.
- Refer to Pharmacy Benefits for medication coverage.

Chiropractic therapy

- Limited to 20 visits per calendar year without certification; maximum of 60 visits per year.
- Includes manipulative therapy.

Clinical trials

- Must be registered with the U.S. National Library of Medicine at clinicaltrials.gov or with the National Cancer Institute at cancer.gov.
- Routine medical care services required for the provision of the item or service associated with the clinical trial.
- Includes standard lab work, MRI, CT and PET scans.

Cochlear implant device

- Analysis, implant and related services/supplies.

Continuous positive airway pressure (CPAP)/bilevel positive airway pressure (BiPAP)

- Covered as durable medical equipment/supplies.
- Unit covered as rent-to-purchase once every five years when medically necessary.
- Unit supplies limited to once every 90 days, no more than four times per calendar year.

Contraceptive services

- Implantable contraceptives (e.g., Nexplanon).
- Diaphragm or cervical cap.

- Depo Provera injections.
- Elective sterilization – tubal ligation, vasectomy.
- IUD insertion, surgical removal and equipment.
- Refer to Preventive Services and Pharmacy Benefits for additional information.

Corrective lenses

- Eyeglasses one-time following cataract surgery.
- Contact lenses for the diagnosis of keratoconus when medically necessary, limited to one set per calendar year.

Dental accident

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

Diabetic services

- Equipment and supplies covered as durable medical equipment/supplies.
 - Continuous glucose monitor.
 - Insulin pumps and related supplies.
- Education services limited to 10 visits per calendar year.
- Refer to Pharmacy Benefits for additional information.

Durable medical equipment and supplies

- Purchase, rental, repair and/or replacement when medically necessary.
- Limit of two braces per injury or occurrence.

Emergency department treatment

- Refer to Emergency Care Coverage.

Foot orthotics

- Covered as durable medical equipment/supplies with a diagnosis of diabetes.
- Limit of one pair of therapeutic shoes and three inserts per foot per calendar year.

Fundus photography

- Covered for certain diagnoses (e.g., diabetes, glaucoma and macular degeneration).

Genetic testing and cancer imaging

- Clinical genetic testing for an inherited gene mutation when an individual has a personal or family history of cancer and when medically necessary.
- Evidence-based cancer imaging for individuals with an increased risk of cancer when medically necessary.
- Refer to certification and plan exclusion and limitations for additional information.

Gynecological examinations

- Routine and diagnostic services.
- Refer to Preventive Services for additional information.

Hearing aids

- Limit of one per impaired ear every 48 months up to age 18 when medically necessary.
- Limit of four additional ear molds per calendar year for children up to age 2.
- Must be prescribed, filled and dispensed by a licensed audiologist.

Hearing exams and tests

- Limit of one hearing screening and three hearing tests per calendar year.
- Refer to Preventive Services for additional information.

Home health care and medications

- Limited to 100 visits per calendar year when medically necessary.
 - Home visits, inclusive of home health and hospice, limited to 100 visits combined.
 - Administration of medication and injections.
 - Nursing care, occupational, physical and speech therapy.

Hospice

- Inpatient services when medically necessary.
- Home visits, inclusive of home health and hospice, limited to 100 visits combined.
- Home health aide.
- Hospice services in the home or in a long-term care facility when medically necessary.
- Requires a provider's statement of life expectancy of six months or less.

Hospital services

- Inpatient – Requires admission to a health care facility (i.e., hospitals, skilled or long-term acute care facilities).
 - Includes observation stays 72 hours or more.
- Outpatient – Does not require admission to a health care facility (i.e., hospitals or surgical centers).
 - Includes observation stays less than 72 hours.

Infertility services

- Diagnostic testing – Includes hysteroscopy, lab tests, ultrasounds and hysterosalpingograms.
- Treatment is limited to prescription coverage only, except as required by Oklahoma law.

Infusion therapy

- Home services when medically necessary.

- Not subject to home health care limitations.
- Outpatient or inpatient services when medically necessary.

Mammogram

- Routine and diagnostic services.
- Refer to Preventive Services for additional information.

Mastectomy

- Prophylactic mastectomy with certification.
- Bras, limit of two per calendar year.
- Breast prosthesis is limited to one per affected side per calendar year.

Maternity care

- Prenatal and postnatal care; including office visits, lab work and ultrasound.
- Hospital facility and provider services for delivery.
- One skilled nurse home health visit if the delivery is at home or in a birthing center.
- Refer to Preventive Services for additional information.

Mental health treatment

- Inpatient, outpatient, intensive outpatient, residential and partial hospital services when medically necessary.
- Outpatient services require certification after 20 visits per calendar year.
- Refer to Autism Spectrum Disorder in this section for details regarding ABA services.
- Refer to Preventive Services for additional information.

Nurse midwife services

- Provider must be a certified nurse midwife and licensed by the state in which services are provided.

Occupational therapy

- Home, inpatient and outpatient services.
- Outpatient services limited to 20 visits per calendar year without certification; maximum 60 visits per calendar year.

Office visits

- Routine and diagnostic.
- Refer to Preventive Services for additional information.

Oral surgery

- Inpatient and outpatient services when medically necessary.
- Includes removal of tumors or cysts, osteotomies, arthroplasties and mandibular/maxillary reconstruction.

Organ transplants

- Non-experimental transplant of (human origin) bone marrow, peripheral stem cells, cornea and the following solid organs: kidney, liver, pancreas, kidney/pancreas, heart, lung, heart/lung and/or intestine when medically necessary.
- Procurement and harvesting.
 - Donor charges covered if recipient is covered by HealthChoice; limited to 90 days following transplant.

Ostomy supplies

- Supplies covered as durable medical equipment/supplies.
- Education services are limited to three visits per calendar year.
- Refer to Pharmacy Benefits for additional information.

Oxygen and respiratory equipment

- Covered as durable medical equipment/supplies.

Physical therapy/physical medicine

- Home, inpatient and outpatient services.
- Outpatient services limited to 20 visits per calendar year without certification; maximum 60 visits per calendar year.
- Includes manipulative therapy services.

Preventive services

- Refer to Preventive Services.

Prostheses/orthopedic appliances

- Covered as durable medical equipment/supplies.

Radiology

- Routine and diagnostic.
- Includes X-rays, ultrasounds, mammograms, imaging scans (MRI, CT, PET).
- Refer to Preventive Services for routine coverage information.

Rehabilitation

- Inpatient and outpatient services when medically necessary.
- Refer to Physical therapy/physical medicine, Occupational therapy, Speech therapy and Mental health treatment.

Skilled nursing facility

- Limit of 100 days per calendar year when medically necessary.

Speech therapy

- Home, inpatient and outpatient services.
- Outpatient services limited to 60 visits per calendar year.
- For members under age 18, coverage is limited to restoring existing speech loss due to disease or injury when medically necessary.
 - Therapy must be expected to restore the level of speech the member had before the disease or injury.

Standby services

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

Substance use disorder

- Inpatient, outpatient, intensive outpatient, residential and partial hospital services when medically necessary.
- Outpatient services require certification after 20 visits per calendar year.

Telemedicine/telehealth services

- Refer to Telemedicine/Telehealth Services.

Temporomandibular joint disorder (TMJ/TMD)

- Treatment covered when medically necessary.

Ultrasound

- Routine and diagnostic services.

Ultraviolet treatment – actinotherapy

- Covered only for psoriasis.

Vaccinations/immunizations for adults and children

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

Wigs and scalp prostheses

- Covered as durable medical equipment/supplies.
- Limited to one wig or one scalp prosthesis per calendar year for individuals who experience hair loss due to radiation or chemotherapy treatment resulting from a covered medical condition.
- Must be obtained from a licensed cosmetologist or durable medical equipment provider.

CERTIFICATION

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

Guidelines

Providers are responsible for obtaining certification. To request certification, your provider must contact HealthChoice Customer Service or log in to **HealthChoiceOK.com** to complete the request online. For non-urgent services, certification requests must be initiated within three business days prior to the scheduled service. For urgent services, certification must be initiated within two business days following the service. Services rendered in an emergency department and/or ambulance are not subject to certification requirements. For more information on the difference between emergency and urgent services, refer to Plan Definitions.

If certification approval is not obtained for services that require it and/or if certification is denied either before or after the services are provided, claims for those services will be denied. For certifications approved after services are provided, a 10% penalty deduction on the allowable amounts may be applied. The allowed amount for these purposes is defined as the total amount allowed on the claim and not the fee schedule allowable. Network providers are not allowed to impose certification penalties on members or their covered dependents. If you use a non-network provider, you should ensure that the provider obtains certification prior to receiving services. Otherwise, you may be held responsible for paying the full amount (if certification is denied) or the 10% penalty (if applied because of late certification), as well as any billed amounts over allowable amounts (balance billing).

For more detailed information on certification, contact HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

Medical services that require certification

- Bariatric surgery (eligibility criteria also required).
- Chiropractic therapy.
 - Required only after initial 20 visits per calendar year.
 - Visits are limited to 60 total per calendar year (some exceptions apply).
- Drugs and medical injectables (some exceptions apply).
 - Required for specified medications covered under the HealthChoice medical benefit; this is not inclusive of requirements under the HealthChoice pharmacy benefit.
 - Required for Botox injections that are non-cosmetic and rendered in the physician's office.
- Durable medical equipment.
- Enteral feeding.

- Foot orthotics.
- Genetic testing.
- Glucose monitors: continuous.
- Hearing aids.
- Home health care/home hospice (visits limited to 100 combined per calendar year).
- Home intravenous therapy (not subject to home health care limits).
- Hyperbaric oxygen therapy (outpatient).
- Inpatient admissions.
- Mastectomy.
 - Total prophylactic mastectomy.
 - Subcutaneous prophylactic mastectomy.
- Maternity care.
 - Required if patient and baby are not discharged within 48 hours of vaginal delivery or within 96 hours of C-section delivery.
- Mental health treatment.
 - Inpatient, residential and partial hospitalization.
 - Required for outpatient services after initial 20 visits per calendar year.
 - Required for intensive outpatient therapy services.
 - Required for transcranial magnetic stimulation treatment.
 - Required for Applied Behavior Analysis services.
- Myocardial PET scan.
- Observation stays 48 hours or longer.
- Occupational therapy (outpatient).
 - Required after initial 20 visits per calendar year.
 - Maximum of 60 visits per calendar year.
- Oral splints and appliances (some exceptions apply).
- Oral surgery (inpatient/outpatient).
- Outpatient surgical procedures:
 - Blepharoplasty.
 - Correction of lid retraction.
 - Knee replacements.
 - Mammoplasty (including reduction, removal of implants and symmetry).
 - Panniculectomy.
 - Rhinoplasty.
 - Septoplasty.
 - Sleep apnea related surgeries, limited to:
 - Radiofrequency ablation (coblation, somnoplasty).
 - Uvulopalatopharyngoplasty, including laser-assisted procedure.

- Varicose vein surgeries and procedures.
 - Including sclerotherapy.
- Organ transplants.
- Oxygen.
- Physical medicine/physical therapy (outpatient).
 - Required after initial 20 visits per calendar year.
 - Maximum of 60 visits per calendar year (some exceptions apply).
- Prophylactic and gynecomastia mastectomies.
- Prostheses and orthopedic appliances (some exceptions apply).
- Proton beam radiation therapy.
- Skilled nursing facility.
- Speech therapy.
 - Required only for ages 17 and younger.
 - Visits limited to 60 total per calendar year (some exceptions apply).
- Spinal cord stimulator placement and revision.
- Spinal surgical procedures.
 - Cervical.
 - Lumbar.
 - Thoracic.
- Substance use disorder treatment.
 - Inpatient, residential and partial hospitalization.
 - Outpatient services after initial 20 visits per calendar year.
 - Intensive outpatient treatment.
- Temporomandibular Joint Disorder (TMJ/TMD).
- Unlisted and not otherwise specified – required for specified codes.

EMERGENCY CARE COVERAGE

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

- All related facility and professional emergency department claims and all emergency ambulance transport claims are processed in accordance with your network benefits, regardless of network status. This includes your plan provisions for copays, deductible and coinsurance.
- You may be responsible for charges for non-covered services.
- If you receive emergency services from a non-network provider, you should not be responsible for charges above the allowable amount if you are billed by the provider. Balance billing for emergency services is prohibited by federal law.
- There is a \$200 emergency room copay for each emergency department visit under the High option plans and the HDHP. The Basic option plans do not require a \$200 emergency room copay.
 - This copay is waived if the patient is admitted or if death occurs prior to admission.
 - If emergency treatment cannot be provided and the patient is referred to another emergency room for treatment, the emergency room copay is waived on the emergency room that could not provide treatment.
- Certification is required for inpatient admission. Refer to Certification.

PREVENTIVE SERVICES

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

HealthChoice covers qualifying preventive care services at 100% of allowable amounts when rendered by a participating network provider. Qualifying coverage may be determined by age, gender or other factors. There may be exceptions, limitations or clinical criteria to qualify for these services at no cost. If you receive services during a preventive care visit other than for qualifying preventive care, you may have to pay for those services.

In addition to Affordable Care Act specific requirements, HealthChoice follows the recommendations of the United States Preventive Services Task Force and the American Academy of Pediatrics Bright Futures recommendations for the basis of coverage and criteria.

For more details on qualifying preventive care services and coverage criteria, you can visit [HealthChoiceOK.com](https://www.healthchoiceok.com) or contact HealthChoice Customer Service and a member advocate will be happy to assist you. Refer to HealthChoice Plan Contact Information.

Note: For all HealthChoice plans, benefits for preventive care services are applied before the plan deductible. This excludes diagnostic mammography for HealthChoice HDHP.

Preventive services

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

- Abdominal aortic aneurysm screening.
- Alcohol misuse: screening and counseling.
- Blood pressure screenings.
- BRCA screening/assessment.
- Breast cancer screening.
- Breastfeeding supply and services.
- Bright Futures screenings.
- Cervical cancer screening.
- Colorectal cancer screening.
- Depression screening.
- Diabetes Prevention Program (CDC recognized).
- Diabetes screening.
- Gonorrhea screening.
- Mammography screenings and diagnostic services.
- Newborn screening and medication.
- Hepatitis B screening.
- Hepatitis C screening.
- HIV Pre-exposure Prophylaxis.
- HIV screening.
- Intimate partner violence screening.
- Lung cancer screening.
- Obesity screening.
- Osteoporosis screening.
- Prenatal screenings, services and tests.
- Sexually transmitted infection screening.
- Tobacco use counseling.
- Tuberculosis screening.
- Unhealthy Drug Use screening.
- Vaccinations.
- Vision screening (children).

Vaccinations for adults and children

Vaccinations, including the vaccine and its administration, are covered under both medical and pharmacy benefits. Qualifying preventive vaccinations are covered at 100% by the plan when using a network pharmacy or medical provider, such as a provider or health department.

HealthChoice covers all CDC-recommended vaccinations through a network pharmacy or provider, such as for shingles, under the preventive services benefits. There may be limitations or qualification criteria for coverage. When using a non-network provider, you are subject to non-network benefits and can be balance billed for amounts above the allowable amounts.

Note: Free-standing ambulatory care clinics located inside pharmacies, grocery stores or supercenters may not be participating network providers, and your services may not be covered at these locations. Always verify network provider status – visit the HealthChoice website or call HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

The following vaccinations are covered under medical or pharmacy benefits:

- Anthrax.
- COVID-19.
- Flu.
- Haemophilus influenzae.
- Hepatitis A.
- Hepatitis B.
- Human papillomavirus.
- Influenza A.
- Influenza HD.
- Japanese encephalitis.
- Measles.
- Meningococcal.
- Mumps.
- Pneumococcal.
- Poliomyelitis.
- Rabies (human diploid).
- Rabies (purified chick embryo cell vaccine).
- Rotavirus.
- Rubella.
- Shingrix (shingles).
- Smallpox (vaccinia) vaccine.
- Tetanus booster.
- Tetanus, diphtheria, pertussis.
- Typhoid.

- Varicella.
- Yellow fever.
- Zoster (shingles).

Note: This list is not all-inclusive.

SERVICES AND SUPPORTS

Many people are affected by mental health and addiction, including prevention, treatment, and recovery support services. Sometimes, you may feel helpless and hopeless. But you're not alone. HealthChoice is partnering with Oklahoma Department of Mental Health and Substance Abuse (ODMHSAS) and 1-800-QUIT-NOW to provide resources for members and families.



24/7 CALL,TEXT,CHAT

988 Suicide & Crisis Lifeline

988 is a direct, three-digit lifeline that connects you with trained behavioral health professionals that can get all Oklahomans the help they need. It all starts when you call 988. You'll be connected to a mental health professional to talk you through what's going on and get the resources you need for either yourself or your loved one. About 90% of the time, things can get sorted out with just a phone call. But if you need more help, we got you. For further information, please go to 988 Mental Health Lifeline website at 988oklahoma.com.



Opioid Overdose Prevention

Whether you are concerned about yourself, a family member, a friend or someone in the community, educating yourself is a great first step toward getting help and support. The OK I'M READY program offers safe, effective and lifesaving tools available to help people experiencing substance use and people who want to help prevent substance abuse in their community. Resources include Naloxone kits for emergency opioid overdose reversal and fentanyl test strips, as well as information about treatment, prevention, education and support. All materials offered through OK I'M READY are available at no cost and can be accessed online at okimready.org/overdose. Free naloxone kits and fentanyl test strips can be ordered and mailed to your home. Visit **OK I'M READY** to get started.



SCAN TO ORDER NALOXONE KITS.



Oklahoma's #1 Resource for Quitting Tobacco

The Oklahoma Tobacco Helpline is FREE and available 24/7. Tools and support are provided to help you quit tobacco your own way and you are never lectured or judged. When you use nicotine replacement therapy, known as NRTs, you increase your odds of success. The Oklahoma Tobacco Helpline will provide all members with at least a two-week supply of patches, gum or lozenges along with a FREE Quit Guide. Call 1-800-QUIT-NOW and helpful staff will assist you.

TELEMEDICINE/TELEHEALTH SERVICES

Telemedicine

HealthChoice offers its members the option to initiate telemedicine visits at a \$0 cost to the member for many common, minor medical conditions through SwiftMD, a Revive company. SwiftMD is available to HealthChoice members ages 3 and up.

SwiftMD is available toll-free at 833-980-1442 or by visiting [SwiftMD.com](https://www.swiftmd.com). Be sure to activate your SwiftMD membership online before calling for an appointment. To register online, select **Log In**, then **Get Started** and use Group Passcode: HCOK20.

Telehealth

HealthChoice offers members the option for telehealth visits with local network and non-network providers in accordance with standard plan benefits including copays, deductibles and coinsurance. Some limitations and exclusions may apply.

PHARMACY BENEFITS

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

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

HealthChoice pharmacy benefits include the following provisions:

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

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

HealthChoice pharmacy network

In Oklahoma, there are more than 800 pharmacies that participate in the HealthChoice pharmacy network. To locate a HealthChoice network pharmacy, go to HealthChoiceOK.com, select Active Members, and then select Locate a Pharmacy under Find a provider. Follow additional prompts in Member Site or contact the pharmacy benefit manager. Refer to HealthChoice Plan Contact Information.

Network pharmacy benefits

Pharmacy deductible – Before benefits are available for HealthChoice High, High Alternative, Basic or Basic Alternative plan members, the separate pharmacy deductible of \$100 per individual/\$300 maximum per family must be met, and for HDHP members, the combined medical and pharmacy deductible of \$1,750 individual/\$3,500 per family must be met.

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

| Medication type | Up to a 30-day supply of a medication | 31- to 90-day supply of a medication |
|-----------------|--|--|
| Generic | Up to \$10 copay | Up to \$25 copay |
| Preferred | Up to \$45 copay | Up to \$90 copay |
| Non-Preferred | Up to \$75 copay | Up to \$150 copay |
| Specialty | Generic – \$10 copay Preferred – \$100 copay Non-preferred – \$200 copay | 31- to 60-Day Supply Generic - \$25 Preferred - \$200 Non-Preferred - \$400 61- to 90-Day Supply Generic - \$25 Preferred - \$300 Non-Preferred - \$600 |
| Insulin* | No more than \$30 | No more than \$90 |

All plan provisions apply. Only copays for preferred medications purchased at network pharmacies apply to the pharmacy out-of-pocket maximums for each plan. Some medications are subject to prior authorization and/or quantity limitations. When a generic is available, and you choose a brand-name medication for any reason, you will pay the cost difference between the brand-name medication and the generic plus the brand-name copay.

*Copay applies before the pharmacy deductible is met, HDHP plan combined deductible included.

Non-network pharmacy benefits

| PREFERRED MEDICATION | NON-PREFERRED MEDICATION |
|---|--|
| 50% of the contracted rate of the medication, plus the dispensing fee. | 75% of the contracted rate of the medication, plus the dispensing fee. |
| All plan provisions apply. Only copays for preferred medications purchased at network pharmacies apply to the pharmacy out-of-pocket maximums for each plan. | |

You pay the full amount at a non-network pharmacy and submit your claim to the pharmacy benefit manager for reimbursement. Refer to the Claims Procedures section for more information.

Calendar year out-of-pocket maximum

| High and Basic option plans network pharmacy | HDHP network pharmacy (combined medical and pharmacy) |
|--|---|
| \$2,500 individual/\$4,000 family | \$6,000 individual/\$12,000 family |

After meeting the out-of-pocket maximum, the plan pays 100% of the cost of formulary medications purchased at network pharmacies for the remainder of the calendar year. For preventive medication, copay charges will apply to member’s out-of-pocket maximum but will not apply toward their deductible.

Note: When a generic is available but you choose a brand-name medication for any reason, you will pay the difference in cost between the brand-name and the generic medication, plus the brand-name copay.

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

- Non-covered medications.
- Amounts paid by copay assistance programs, manufacturer copay cards or other third parties.
 - These amounts also do not apply toward the plan deductible.

HealthChoice Formulary

The HealthChoice Formulary is a list of medications covered by the plan. To find out how your medications are covered, contact the pharmacy benefit manager. Refer to HealthChoice Plan Contact Information. You can also go to [HealthChoiceOK.com](https://www.healthchoiceok.com). Here you can also find lists of commonly prescribed medications, excluded medications with preferred alternatives and specialty medications.

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

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

HealthChoice medication lists

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

These lists are on the HealthChoice website at [HealthChoiceOK.com](https://www.healthchoiceok.com).

Preventive Medication List

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

Standard Medication List

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

Specialty Formulary List

The specialty formulary is a list of commonly prescribed specialty medications that are preferred on the HealthChoice plans. This list also contains a summary of preferred alternatives to the specialty medications that are excluded from coverage. Specialty medications are usually high-cost medications that require special handling and extensive monitoring. For copay information refer to the Pharmacy Copay table Specialty on Page 31.

Excluded Medication List

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

Note: The formulary (medication lists) is updated four times a year, on a quarterly basis.

Pharmacy prior authorization

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

- Are high cost.
- Have specific prescribing guidelines.
- Are generally used for cosmetic purposes.
- Have quantity limits.

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

- Ask your provider to prescribe a preferred medication that you can receive at the preferred pharmacy copay.
- Continue with your current non-preferred medication and pay the non-preferred copay.
- Obtain a medical necessity authorization if you have specific health problems that require a non-preferred medication.

Follow the steps below to request a prior authorization:

- Have your provider's office call the pharmacy benefit manager. Refer to HealthChoice Plan Contact Information.
- The pharmacy benefit manager will assist your provider's office with completing a prior authorization form.
- If your prior authorization is approved, your provider's office is notified of the approval within 48 hours. You are also notified in writing.
- If your prior authorization is denied, your provider's office is notified of the denial within 48 hours. You are also notified in writing.

Types of prior authorizations

Traditional prior-authorization medications

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

Step-therapy medications

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

Brand-name authorizations and non-preferred medications

A prior authorization for a brand-name or non-preferred drug may be approved when you are unable to tolerate the generic or preferred drug.

Note: All of these reviews follow the same process as described in the Pharmacy prior authorization section.

Medication quantity limits

Certain medications are limited in the quantity you can receive per copay based on their recommended duration of therapy and routine use. If generics are available or become available for brand-name drugs that are limited in quantity, the generics are also limited in quantity. When new medications become available in drug categories that have quantity limits, they will automatically have quantity limits per copay. New drug categories also can become subject to quantity limits throughout the year.

Tobacco cessation products

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

- Bupropion 150 mg SR/SA tabs.
- Chantix.
- Nicotrol inhaler system.
- Nicotrol nasal spray.

HealthChoice covers up to a 168-day supply of these prescription products each calendar year.

PLAN EXCLUSIONS AND LIMITATIONS

The plan does not pay benefits for any of the following services, treatments, items or supplies, except as specifically provided for under Covered Services, Supplies and Equipment.

Exclusions are not covered even if they are prescribed by your provider or if they are the only available treatment for your condition. Some services may be medically necessary but not covered by the plan.

Alternative treatments

- Acupressure.
- Biofeedback.
- Kinesiology (movement therapy).
- Rolf technique (Rolfing).
- Art music therapy, dance therapy, equine therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health of the National Institutes of Health.

Dental

- Dental expenses that are covered under your dental plan.

Devices, appliances, prosthetics and supplies

- Devices that attach to a building (walls, ceilings, floors, etc.).
- Medical devices covered under pharmacy benefits are not covered, with the exception of diabetic testing supplies, ostomy supplies and products required by the ACA.
- Disposable medical supplies such as bandages, tape, gauze pads, alcohol, iodine, peroxide and saline that can be purchased over the counter or online.
- Devices, appliances, prosthetics and/or supplies, over the counter or otherwise, that are not primarily medical in nature and/or not considered medically necessary by the plan. Examples include but are not limited to braces, compression garments, room humidifiers, air purifiers, pulse oximeters, blood pressure cuffs, exercise equipment, swimming pools, Jacuzzi pumps, saunas, hot tubs, automobiles or adaptive equipment for automobiles, transport/tie-down options for wheelchairs, side guards for wheelchairs, seat lifts for wheelchairs, sun lamps, augmentative communication devices, patient lifts, adaptive bathroom and self-care equipment, assistive devices and cold/cryotherapy devices.
- Equipment that exceeds lifetime or maximum benefits (e.g., one walker per lifetime, two breast pumps per pregnancy, one CPAP every five years).
- Mattresses not specifically designed for the prevention or treatment of skin breakdown or healing, or any other bedding purchased for any other reason.
- Lost, stolen or damaged (e.g., mold, insect) equipment or devices.
- Any device not FDA approved for general use or sale in the United States.
- Breast prosthesis is limited to one per affected side per calendar year.

- Any covered items or services not used exclusively by the member or a covered dependent.
- Nutritional supplements, blenderized food, medical food, enteral formula and oral formula available without a prescription.
- Over-the-counter COVID-19 diagnostic tests.

Drugs

- Products marketed with 510(k) clearance (FDA-cleared).
- Prescription scar treatments.
- Off-label use of drugs (use of a drug for the treatment of conditions that are not indicated on the drug's label).
- Over-the-counter drugs and vitamins (e.g., cough and cold drugs) except as required by the ACA under pharmacy benefits.
- Drugs under investigation in approved clinical trials.
- Lost, stolen or damaged drugs. In case of declaration of emergency, disaster policy applies for replacement of drugs.
- Weight loss drugs and/or medications prescribed for weight loss.
- Certain non-FDA approved drugs as determined by the plan.
- Non-FDA authorized or approved drugs for the treatment of COVID-19.
- Prescription digital therapeutics (PDT). Impotency drugs, unless following prostatectomy surgery.

Experimental/investigational services

- Any treatment, appliance/device, drug or procedure, including any aspect of a treatment, deemed or considered experimental or investigational by the plan.
- Items and services provided solely to satisfy data collection and analysis needs, including any service(s) not necessary for routine care such as specialized lab tests or drugs.

Genetic testing and cancer imaging

- Genetic testing that does not have clinical utility or is not ordered or recommended by a licensed health care provider.
- Direct-to-consumer or at-home genetic testing kits that are not prescribed by a licensed provider.
- Experimental, investigational or research-only genetic tests that are not considered standard of care.
- Genetic testing that is not consistent with nationally recognized evidence-based clinical guidelines used by the plan.
- Genetic testing performed solely for non-medical purposes, such as ancestry, paternity or recreational/educational use.
- Repeat or duplicate genetic testing when a prior clinically valid result is available and sufficient for medical decision-making.
- Services related to genetic counseling, imaging or follow-up testing that are not otherwise covered under the plan.

Personal care, comfort or convenience

- Items which are furnished primarily for personal comfort or convenience and/or are not primarily medical in nature.
 - Includes but is not limited to exercise equipment, air purifiers, air conditioners, humidifiers, spas, elevators, telephones, tablets, computers, software applications, watches, televisions, cervical pillows, protective clothing or shoes, and supplies for hygiene or beautification.
- Exercise programs/fees/classes.
- Weight management/loss programs such as Weight Watchers, Jenny Craig, Diet Center, Zone diet or similar programs including any over-the-counter food or nutritional supplements (e.g., amino acid supplements, Optifast liquid protein meals, NutriSystem prepackaged foods, Medifast foods or phytotherapy).
- Appetite suppressants.

Procedures and treatments

- Treatment of alopecia.
- Cosmetic or elective surgical procedures, treatments or drugs not necessary as the result of an accident with continuous coverage from the date of the accident to the date of corrective surgery.
 - Complications from any such procedure not originally covered by HealthChoice.
- Breast reconstruction or implants not covered under the Women's Health and Cancer Rights Act of 1998 and/or the Oklahoma Breast Cancer Patient Protection Act of 1998.
- Custodial care.
- Dyslexia testing.
- Electromyography without needle.
- Any routine hygienic foot/hand care, including trimming nails, and any other service rendered in the absence of localized illness, injury or symptoms involving the feet or hands.
- Home dialysis training.
- Home uterine monitoring.
- Marriage counseling.
- Medical services or treatments not generally accepted as the standard of care by the medical community.
- Weight-loss (bariatric) surgery that involves any procedure performed outside of a network MSBSA-QIP certified comprehensive center of excellence.
- Tobacco cessation counseling outside preventive service benefit coverage.
- Venipuncture by a provider when also billing for lab charges.
- Preoperative or postoperative care generally rendered by the operating surgeon, unless the surgeon itemizes their charges and the total amount charged is no more than the total allowable amounts for the surgery.
- Services provided in a school or daycare setting.

- Manipulative and physical therapy for palliative care (treatment for only the relief of pain), elective care (care designed to relieve recurring subjective symptoms), or prolonged care (treatment that does not move toward resolution as documented in the evaluation or re-evaluation goals).
- Any confinement, medical care or treatment not recommended by a duly qualified practitioner.
- Medical and/or mental health treatment of any kind, including hospital care, medications and medical care or medical equipment, which is excessive or where medical necessity has not been proven.
- Ultraviolet treatment – actinotherapy in the home (tanning beds).
- Cord blood banking, collection and storage.
- Speech therapy for learning disabilities or birth defects.

Providers

- Services supplied by a provider who is a relative of the patient by blood or marriage or who normally lives with the patient, or any services a provider performs on themselves.
- Services supplied by an athletic trainer.

Reproduction/sexual health

- Infertility treatment, including artificial insemination, embryo transplant, in vitro fertilization, surrogate parenting, ovum transplant, donor semen, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and reversal of voluntary sterilization, except as required by Oklahoma law.
- Sex transformation surgeries.
- Treatment for sexual dysfunction including implants of any nature except following a prostatectomy subject to state law.
- Surrogate mother expenses for non-covered participants.

Services provided under another plan or program

- Injury or sickness which is covered under an Extended Benefits provision of previous health coverage, until such time as such individual has exhausted all extended benefits available thereunder.
- Expenses to the extent the insured person is reimbursed or is entitled to reimbursement or is in any way indemnified for such expenses by or through any public program (state or federal) or any such program of medical benefits sponsored and paid for by the federal government or any agency or subdivision thereof.
- Bodily injury or illness arising out of or in the course of any employment not specifically excluded by 85A O.S. § 2 of the Administrative Workers' Compensation Act.
- Any services required by state or federal law to be supplied by a public school system or school district.

Vision and hearing

- Eye examinations for the fitting of corrective lenses or any charges related to such examinations, orthoptics, visual training for any diagnosis other than mild strabismus, eyeglasses, except for the first lens(es) used as a prosthetic replacement after the removal of the natural lens, other corrective lenses, or radial keratotomy or LASIK (exceptions may apply to eye exams, refer to Preventive Services).
- Hearing aids and examinations for fitting or prescription for ages 18 and older.
- Batteries for hearing aids.

Other exclusions

- Charges for missed or canceled appointments, mileage, penalties, finance charges, separate charges for maintenance, record keeping or case management services.
- Fees or retainers paid to concierge medicine providers.
- Claims submitted later than 180 days from the date of service.
- Medical care and supplies for which no charge is made or no payment would be requested if the insured individual did not have this coverage.
- Expenses incurred prior to the effective date of an individual's coverage, or for expenses incurred during a period of confinement which had its inception prior to the effective date of an individual's coverage.
- Services that may otherwise be covered as preventive services but which are administered during an inpatient stay, emergency room visit or at a Skilled Nursing Facility may not qualify as preventive and will be considered under the Plan's standard policies and provisions.
- Hospitalization or other medical treatment furnished to the insured or dependent that begins after coverage has terminated.
- Complications from any non-covered or excluded treatments, items or procedures.
- Illness, injury or death as a result of committing or attempting to commit, or participating in the commission of, a violent act, an assault or any act that may be charged as a felony, including participation in a riot or insurrection as an aggressor.
- Intentionally self-inflicted injuries or illness, except when the injury (a) resulted from being the victim of an act of domestic violence or (b) resulted from a documented medical condition (including both physical and mental health conditions) that is covered under the health plan.
- Amounts billed for medical and surgical services and supplies in excess of the fee schedule for such services and supplies.
- Wrongful act or negligence of another when an employee or dependent has released the responsible party, unless subrogation has been waived or reduced in writing in an individual case, solely at EGID's option, and only for good cause.
- Travel costs, meals and/or lodging related to medical services.
- Charges for injuries or illnesses resulting from war assistance or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.

CLAIMS PROCEDURES

Claims filing and payment

Network

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

Non-network

Non-network providers are not required to submit claims on your behalf. You can ask the provider to submit the claim on your behalf, but if they will not, you will have to file the claim. You must log into the member portal at **HealthChoiceOK.com** and select **Submit a claim** to complete and submit the electronic claim form. For assistance, contact HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

Reimbursement for non-network claims is usually paid to you; however, you can choose to assign benefits to be paid directly to your provider. When a valid assignment of benefits to the provider is submitted with your claim, payment is made to the provider. When there is no valid assignment of benefits, payment is made to you, and you are responsible for paying your provider.

For HealthChoice to process a member self-submission claim, the following information is required.

- Member information: Name, date of birth, member ID and address.
- Patient name.
- Billing CPT/HCPCS code(s).
- Diagnosis code(s).
- Provider's information: Name, tax ID number (TIN) and NPI number.
- Date(s) of service.
- Total billed amount.
- Cash Option Agreement documentation (refer to Notifications for more details).

For questions on how to complete or submit a member claim, contact HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

Claims filing deadline

Claims must be submitted within 180 days from the date of service.

Claims for services outside the United States

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

- Arrange to pay for the services or supplies.
- Have claims translated into English with U.S. dollar amounts before you file your claim.
- Convert charges to U.S. dollars using the exchange rates applicable for the date of service.
- Log into the member portal at **HealthChoiceOK.com** and select Submit a claim.
- File the original claim along with the translation; the plan does not pay any costs for translating claims or medical records.
- Contact HealthChoice Customer Service for assistance. Refer to HealthChoice Plan Contact Information.

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

Coordination of benefits

You are required to annually verify if you or any of your covered dependents have other medical or pharmacy coverage. You should also notify us anytime you or your covered dependent(s) adds or drops other health insurance. You may complete your verification online by registering at **HealthChoiceOK.com** or by calling HealthChoice Customer Service at 800-323-4314. **Failure to verify other insurance coverage will result in denial of claims until verification is completed.** You have 180 days from the date of the denial to verify other insurance, or the claim will remain denied and you may be responsible for the full amount of billed charges.

This process establishes which insurance plan is primary when two plans must work together to pay claims for the same person. Coordinating benefits ensures that the two plans do not pay more than the total amount of the claim, thereby helping to reduce the cost of insurance premiums.

When HealthChoice is the secondary payer, it will pay benefits after the primary insurer has paid. Coverage is limited to what HealthChoice would have paid as the primary plan, and only up to the remaining balance owed by the member.

If you have questions about how your HealthChoice Plan pays when coordinating benefits, contact HealthChoice Customer Service. If you have questions about how your pharmacy benefits will be affected by coordination of benefits, contact the pharmacy benefit manager. Refer to HealthChoice Plan Contact Information.

Explanation of benefits

Each time a claim is processed, HealthChoice Customer Service creates an explanation of benefits (EOB) that explains how your benefits are applied. Your EOB includes:

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

Your EOBs are available through the HealthChoice member portal at HealthChoiceOK.com or by using the HealthChoice benefits app. If you have difficulty accessing your EOB online, contact HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

Claims requiring additional information

If your medical claim requires additional information for processing, your EOB identifies the specific information needed. In some instances, a letter is also sent that explains what information is required to complete claim processing. Your claim is denied until this information is received. You have 180 days to provide additional information, or the claim will remain denied and you may be responsible for the full amount of billed charges.

Include your member ID number and claim number when returning the requested information. Once the information is provided to HealthChoice Customer Service, your claim is automatically processed. You do not need to resubmit your claim.

Disputed claims procedure

If your claim is denied in whole or in part for any reason, either you or your authorized representative can request the claim be reviewed. Log in at HealthChoiceOK.com and complete the online appeal submission form, or submit a written request within 180 days of the denial to:

HealthChoice Appeals Unit
P.O. Box 30546
Salt Lake City, UT 84130-0546

Follow these steps when submitting a written request to make sure that your appeal at any level is processed in a timely manner:

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

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

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

To request access to and copies of all documents, records and other information about your claim, free of charge, contact HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

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, as HealthChoice holds first priority with regard to any recovery. The Make Whole and Common Fund Doctrines do not apply.

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

If you are asked to provide information about the injury or accident to the HealthChoice subrogation administrator at the law firm of McAfee & Taft, any related claims are pended until you have supplied the necessary information. Failure to provide the required information in a timely manner may result in your claim being denied.

Refer to HealthChoice Plan Contact Information.

GENERAL PROVISIONS

Provider-patient relationship

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

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

For information on the types of providers recognized by the plan, contact HealthChoice Customer Service. You can also search for a HealthChoice network provider at **HealthChoiceOK.com**. In the menu bar under Providers, select Find a provider.

Intentional misrepresentation

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

Confirmation statements and corrections to benefit elections

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

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

Right of recovery

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

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

ELIGIBILITY AND EFFECTIVE DATES

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

- A current or new education employee eligible to participate in the Oklahoma Teachers' Retirement System and working a minimum of four hours per day or 20 hours per week.
- A current or new State of Oklahoma, local government, or certain nonprofit employee regularly scheduled to work at least 1,000 hours a year and not classified as a temporary or seasonal employee.
- A person elected by popular vote, e.g., board members for education and elected officials of state and local government, state employees, rural water district board members and county election board secretaries.

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

Dependent coverage

You must be enrolled in one of the health plans to enroll your dependents. If dependent coverage is selected, all of your eligible dependents must be covered.

Note: Exceptions may apply for COBRA participants and surviving dependents. Refer to Excluding dependents from coverage in this section for exceptions to this rule.

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

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

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

Eligible dependents

Eligible dependents include:

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

Common-law marriages are recognized by the plan. A new employee can add a common-law spouse at the time of enrollment. A current employee can request coverage on a common-law spouse during the annual Option Period or in the event the common-law spouse loses other health coverage. Other health coverage cannot be an excepted benefit. Refer to Excepted benefits in Plan Definitions. To enroll a common-law spouse, the employee and spouse must sign and submit an enrollment or change form.

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

Adding a newborn to coverage:

- Coverage for newborns is effective the first of the month of the child's birth. You have 30 days from the date of birth to enroll a newborn in coverage. An Insurance Change Form must be completed and submitted to your insurance coordinator, benefits partner or EGID.
- Premiums must be paid for the full month of the child's birth.
- When one or more eligible dependents are currently covered, a newborn must be added to the same coverage, unless there is proof of other health coverage.
- When a newborn is added to coverage, all other eligible dependents must be enrolled in coverage if they are not already enrolled; however, you can elect to exclude your spouse from health coverage.

- You can request coverage for a newborn grandchild by completing an Application for Coverage for Other Dependent Children. Coverage for a newborn grandchild is retroactive to the first of the month of birth following the receipt and approval of an application and payment of premiums. After 30 days, a retired member cannot add a newborn to coverage without a qualifying event.
- A Social Security number for the newborn is not required at the time of initial enrollment but must be provided when it is received from the Social Security Administration.
 - Current employees must provide the number to their insurance coordinator or benefits partner.
 - Former employees must provide it to EGID.

Newborn Limited Benefit

A newborn has limited coverage for a routine birth for the first 48 hours following a vaginal delivery or for the first 96 hours following a C-section delivery without an additional premium. There are no benefits for services in addition to a routine hospital stay unless the newborn is enrolled in coverage and premiums are paid for the month of the birth.

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

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

Declining the Newborn Limited Benefit (NOT recommended):

- A Newborn Limited Benefit Waiver must be completed and returned to EGID to exclude a newborn from the Newborn Limited Benefit. To obtain a waiver, current employees should contact their insurance coordinator or benefits partner and former employees should contact EGID Member Services. Refer to HealthChoice Plan Contact Information.

Coverage for other eligible dependents

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

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

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

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

- Current employees and COBRA members cannot add dependents to coverage until the next annual Option Period.
- Former employees cannot add dependents to coverage without a qualifying event.

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

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

Legal adoption

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

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

- Current employees and COBRA members cannot add dependents to coverage until the next annual Option Period.
- Former employees cannot add dependents to coverage without a qualifying event.

Legal guardianship

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

Excluding dependents from coverage

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

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

Changes to coverage after initial enrollment/HIPAA special enrollment rights

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

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

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

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

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

- A change in your legal marital status, such as marriage, divorce or death of your spouse.
- A change in the number of your dependents, such as the birth of a child.
- A change in employment status that affects your eligibility or that of your spouse or dependent.
- An event that causes your dependent to meet, or fail to meet, eligibility requirements.
- Commencement or termination of adoption proceedings.
- Judgments, decrees or orders (your employer may allow changes only to health and dental).

- Medicare eligibility for you or a dependent.
- Medicaid eligibility for you or a dependent; only two changes are allowed per plan year, once out and once back in or vice versa.
- Changes in the coverage of your spouse or dependent under another employer's plan.
- Eligibility for leave under the Family and Medical Leave Act.
- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

To request special enrollment or obtain more information, current employees contact your insurance coordinator or benefits partner. Former employees must contact EGID Member Services. Refer to HealthChoice Plan Contact Information.

Current employees

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

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

Former employees and surviving dependents

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

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

EGID
P.O. Box 11137
Oklahoma City, OK 73136-9998

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

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

Options for current employees called to active military service

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

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

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

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

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

Leave without pay – current employees

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

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

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

Special rules for those eligible for Medicare

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

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

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

For further information regarding Medicare enrollment, call Social Security toll-free at 800-772-1213. TTY users call toll-free 800-325-0778. You can also access information regarding Medicare enrollment at [Medicare.gov](https://www.medicare.gov) or call Medicare toll-free at 800-633-4227. TTY users call toll-free 877-486-2048.

Proof of creditable prescription drug coverage

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

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

CONTINUING COVERAGE AFTER LEAVING EMPLOYMENT

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

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

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

Years of service

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

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

Education employees

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

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

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

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

Local government employees

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

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

Some reinstatement exceptions may apply if you are a state employee who terminated employment because of a reduction in force. Refer to State Government Reduction in Force and Severance Benefits Act in Termination or Reinstatement of Coverage.

New employer retirees

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

Following your employer to a new carrier

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

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

Continuation through the Disability Plan

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

Survivor rights

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

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

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

COBRA

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TERMINATION OR REINSTATEMENT OF COVERAGE

Termination

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

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

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

Reinstatement

If you are currently employed by a participating employer and discontinue coverage on yourself or your dependents, you cannot apply for reinstatement of coverage until the next annual Option Period or the loss of other health coverage* or other qualifying event.

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

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

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

State Government Reduction-in-Force and Severance Benefits Act

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

- Had a vested or retirement benefit based on the provisions of any of the state public retirement systems.
- Was separated from state service as a result of a RIF.
- Was offered severance benefits pursuant to the State Government Reduction-in-Force and Severance Benefits Act.
- Is choosing to exercise applicable insurance retention rights available through a RIF or a severance agreement.

For further information, contact EGID Member Services. Refer to HealthChoice Plan Contact Information.

State of Oklahoma Employees Group Insurance Division Privacy Notice Revised November 2025

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 Employees Group Insurance Division (EGID), a division of the Oklahoma Health Care Authority (OHCA), please contact:

EGID HIPAA Privacy Officer
P.O. Box 11137, Oklahoma City, OK 73136
405-717-8780 or toll-free 800-752-9475
TTY 711
EGIDComplianceTeam@ohca.ok.gov
oklahoma.gov/egid

Why is the notice of privacy practices important?

This notice provides important information about the practices of EGID pertaining to the way it gathers, uses, discloses and manages your Protected Health Information and 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. Please note, in general the laws and regulations of HIPAA do not apply to the HealthChoice Disability Plan and HealthChoice Life Insurance Plan. EGID is designated as a HIPAA entity. This notice applies to the privacy practices of the following divisions and positions that may share or access your PHI as needed for treatment, payment and health care operations:

- OHCA EGID.
- OHCA General Counsel Legal.
- Office of Management and Enterprise Services (OMES) Information Services as it applies to maintenance and storage of PHI.

EGID 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 an electronic or paper copy of your health and claims records.

- You can ask to see or get an electronic copy of your medical record and other health information we have about you. Ask us how to do this using the contact information at the beginning of this notice.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based 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 using the contact information at the beginning of this notice.
- We may decline your request but will explain the reasons in writing within 60 days.

Request confidential communications.

- You can ask us to contact you in a specific manner, e.g., home or office phone, or to send mail to an alternate address.
- We will consider all reasonable requests.
 - If declining would put you in danger, tell us and we will automatically approve your request.

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 approve your request and may decline if it would affect your care.

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

- You can ask for an accounting of the times we have 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 free accounting per year but will charge a reasonable fee if you request an additional 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 promptly provide you with a paper copy.

Choose someone to act for you.

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

File a complaint if you feel your rights are violated.

- You can file a complaint 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 Ave., S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting hhs.gov/ocr/privacy/hipaa/complaints.
- 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.
- Contact you for fundraising efforts.

If you are not able to tell us your preference (e.g., if you are unconscious), we may 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.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes.
- Sale of your information.
- Most sharing of psychotherapy notes.

Our uses and disclosures

How do we typically use or share your health information?

Your PHI is used and disclosed by EGID employees and other entities under contract with EGID according to HIPAA Privacy Rules and 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 EGID.

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 member 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 must comply with the law to share your information for these purposes. For more information, refer to hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.

Help with public health and safety issues

We can share your health information for certain situations such as:

- Preventing disease.
- Helping with product recalls.
- Reporting adverse reactions to medications.

- Reporting suspected abuse, neglect or domestic violence.
- Preventing or reducing a serious threat to anyone's health or safety.

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 ensure we are complying with federal privacy laws.

Respond to organ and tissue donation requests.

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director.

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions.

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

Our responsibilities

When it comes to your health information, we have specific obligations such as:

- We are required by law to maintain the privacy and security of your Protected Health Information.
- 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 notify us in writing that we can. You may change your mind at any time but must let us know in writing if you do.

Substance Use Disorder Treatment Disclosure.

If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a “Part 2 Program”) through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

For more information, refer to [ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2](https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2) or [hhs.gov/hipaa/for-individuals/notice-privacy-practices/index](https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index).

Changes to the terms of this notice.

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

FRAUD, WASTE AND ABUSE

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

If you suspect that EGID has been defrauded or is being defrauded or that resources have been wasted or abused, report it. Reporting suspected fraud, waste or abuse not only protects you but can also protect others. Filing a report can help reveal widespread health care fraud and abuse, prevent personal loss and help save health care dollars for everyone. You don’t need to identify yourself when making a report.

To make a report, call 800-356-5803.

Individuals are encouraged to provide adequate information 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 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 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 receive durable medical equipment that was not requested by you or prescribed by your doctor.

NOTIFICATIONS

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

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 and the Oklahoma Breast Cancer Patient Protection Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- Not less than 48 hours of inpatient care following a mastectomy and not less than 24 hours of inpatient care following a lymph node dissection.
- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, coinsurance and policy provisions applicable to other medical services covered under this plan.

Coverage of side effects associated with prostate-related conditions

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

If you have questions about the HealthChoice coverage of mastectomies and reconstructive surgery or prostate related conditions, contact HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

Cash option provisions

You may have the option to negotiate a cash price with a provider for medically necessary, covered health care services in accordance with the Cash Option provisions of Title 36 of Oklahoma Statutes. This option is available for services rendered by both network and non-network providers under limited instances. HealthChoice will credit payment toward your applicable network or out-of-network deductible and out-of-pocket maximum when proper documentation is submitted. To qualify under the Cash Option provisions, you must meet the statutory criteria outlined below:

- The provider must agree to accept your payment as full payment and cannot bill you or HealthChoice for any remaining amount.
- You must submit documentation of the agreement, payment and service to HealthChoice to have the amount count toward your deductible and out-of-pocket maximum.
- This option applies only if:
 - The service is covered by HealthChoice (all plan policies and provisions apply).
 - You pay out-of-pocket, and the provider agrees not to submit a claim.
 - The cash price you paid is lower than the average allowable amount.
 - You submit the required documentation electronically, including provider name, billed service and proof of payment, within 180 days from the date of service.

Note: HealthChoice does not allow members to submit their own claims when a network provider is used, unless the requirements above are fully met under 36 O.S. § 6060.52. Refer to Claims Procedures for more details.

PLAN DEFINITIONS

ACA: Affordable Care Act.

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

Allowable amount: HealthChoice pays benefits based on set amounts known as allowable amounts. This is the maximum amount HealthChoice will consider for payment for a covered service or supply, regardless of the amounts billed by a provider. A network provider will have agreed to accept the allowable amount as payment in full for the services rendered. A network provider cannot bill you for amounts above the allowable amounts. If you use a non-network provider that charges more than the plan's allowed amount, you may have to pay the difference. This is referred to as balance billing. (**Example:** A provider may charge \$150 for a service. HealthChoice's allowed amount is \$90. A network provider will accept the \$90 in full as payment for the service. HealthChoice will pay up to the \$90, depending on any copay or deductible you may owe. A network provider will write off the remaining \$60 and you cannot be billed for that amount. If you use a non-network provider, then you are responsible for everything that HealthChoice does not pay, up to the full charge of \$150, if you are billed by the provider.)

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

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

Billed charges: This applies to all properly billed charges for health services (including professional service fees, facility fees, and equipment) and supplies that the member has received from the provider, whether they are a covered service or not.

Brand-name drug: A drug sold by a pharmaceutical company under a specific name or trademark and that is protected by a patent. A brand-name drug has the same active-ingredient formula as generic versions of the drug.

Certification: A review process used to determine if services are medically necessary and meet clinical criteria according to HealthChoice guidelines.

Coinsurance: Coinsurance is a percentage of a medical charge that you pay, with the rest paid by your health insurance plan, after your deductible has been met. (**Example:** Your plan has coinsurance of 20% and you have met your deductible. If the plan's allowed amount for an office visit is \$100, you pay 20% of \$100, or \$20. Your insurance covers the other 80%, or \$80.)

Copays: This is a fixed amount you pay for certain covered services. Copays usually apply before you meet your deductible, but they do not count toward your deductible. Copays are applied toward your out-of-pocket maximum. **Note:** There are no network copays in the Basic plans, and your deductible must be met before copays apply in the HDHP.

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

Deductible: This is the initial total you must pay of allowable amounts for network and/or non-network covered services before any benefit is paid by the plan. This includes but is not limited

to amounts you pay for lab work, X-rays, surgical procedures, hospital admissions, etc. Copays do not count toward the individual or family deductible. Expenses for non-covered services and any expense you pay over the allowable amount for non-network services do not count toward your deductible. Once you meet your deductible, you will share the cost of covered services with HealthChoice by paying coinsurance. **Note:** For the HDHP, the cost of prescriptions and office visits are included in the deductible. For the Basic plans, the deductible applies after first-dollar coverage. (**Example:** Your plan has a deductible of \$1,000, and you have \$2,500 in covered medical charges. You pay the first \$1,000 of the allowed amount in covered charges to meet your deductible, and then you share the cost of covered services with HealthChoice by paying coinsurance.)

EGID: The Employees Group Insurance Division, also referred to as EGID.

Eligible dependent:

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

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

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

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

Embedded deductible: When a plan has an embedded deductible, there is an individual and family deductible. Members on a family plan with an embedded deductible who meet

the individual deductible will begin receiving coinsurance benefits from the plan. Members are only able to contribute up to the amount of the individual deductible toward the family deductible. (**Example:** You have enrolled your family of three in a health plan. If the plan has an embedded deductible, when you meet the individual deductible, you will begin having coinsurance applied to all your claims, even before the family deductible is met. Once the family deductible is met, the plan will pay coinsurance for covered services for all enrolled family members. If the plan does not have an embedded deductible, the family deductible must be met before the plan will share expenses for any services.)

Emergency services: Refer to Emergency Care Coverage for more details.

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

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.

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

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

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

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

Network provider: A provider who has entered into a contract with HealthChoice to accept the plan's allowable amounts for services and/or supplies provided to plan members.

Non-covered service: Any service, procedure or supply excluded from coverage and not eligible for payment by the plan.

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

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

Out-of-pocket maximum: This is the most you pay in a calendar year for covered services. This includes all eligible amounts you pay for your deductible, copays and coinsurance. Once your out-of-pocket maximum is reached, the plan pays 100% of the allowable for covered services. The out-of-pocket maximum does not apply to amounts you paid for non-covered services or balance billed charges from non-network providers.

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

Pharmacy deductible: Before benefits are available for HealthChoice High, High Alternative, Basic and Basic Alternative plan members, the separate pharmacy deductible of \$100 per individual/\$300 maximum per family must be met, and for HDHP members, the combined medical and pharmacy deductible of \$1,750 individual/\$3,500 per family must be met. **Note:** Medications on the HealthChoice Preventive Medication List are not subject to the deductible. Copays apply to the pharmacy out-of-pocket maximum, but they do not apply to the deductible.

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

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

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

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

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

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

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

HealthChoice provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). HealthChoice provides free language services to people whose primary language is not English, such as qualified interpreters. If you need these services, contact HealthChoice Customer Service at 800-323-4314 (TTY: 711).

If you believe that HealthChoice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with the civil rights coordinator, 2401 N. Lincoln Blvd, Ste. 300, Oklahoma City, OK 73105, 866-381-3815 (TTY: 711), 405-717-8609 (fax), DiscriminationComplaints@omes.ok.gov. You can file in person or by mail, fax or email. If you need help filing a grievance, the civil rights coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 800-368-1019, 800-537-7697 (TTY). Complaint forms are available at <https://www.hhs.gov/ocr/complaints/index.html>.

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 800-323-4314 (TTY: 711).

(Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-323-4314 (TTY: 711).

(Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-323-4314 (TTY: 711).

(Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-323-4314 (TTY: 711)。

(Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-323-4314 (TTY: 711) 번으로 전화해 주십시오.

(German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-323-4314 (TTY: 711).

(Arabic) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-323-4314 (رقم هاتف الصم والبكم: 711).

(Burmese) သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကားကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 800-323-4314 (TTY: 711) သို့ ခေါ်ဆိုပါ။

(Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-323-4314 (TTY: 711).

(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-323-4314 (TTY: 711).

(French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-323-4314 (TTY: 711).

(Laotian) ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-323-4314 (TTY: 711).

(Thai) 提醒您: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-323-4314 (TTY: 711).

(Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ (TTY: 711) 800-323-4314

(Cherokee) Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 800-323-4314 (TTY: 711)

(Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-323-4314 (TTY: 711) تماس بگیرید.

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