HealthChoice

Medicare Supplement Plans Handbook
Evidence of Coverage

Plan Year
2025

OKLAHOMA
Employees Group
Insurance Division

5157

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INTRODUCTION

HealthChoice Medicare Supplement Handbook effective Jan. 1 through Dec. 31, 2025

This handbook/Evidence of Coverage replaces and supersedes any Medicare Supplement handbook/Evidence of Coverage the Employees Group Insurance Division (EGID) previously issued. EGID is a division of the Oklahoma Health Care Authority (OHCA). This handbook/Evidence of Coverage will, in turn, be superseded by any subsequent Medicare Supplement handbook/Evidence of Coverage EGID issues. The most current version can be found on the HealthChoice website at **HealthChoiceOK.com**.

This handbook, your enrollment form, Confirmation Statement and HealthChoice SilverScript Medicare documents represent our responsibilities to you. This handbook provides details about your benefits, formulary, pharmacy network, premiums, deductibles, copays and coinsurance for 2025. It explains what is covered and what you pay as a member of the plan. Be aware that these amounts may change at the beginning of the next plan year, which starts over every year on Jan. 1. This is an important document, so keep it in a safe place. Please note, the HealthChoice Medicare Supplement plans are often referred to throughout this handbook as the plan or plans.

HealthChoice SilverScript members

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

Read this handbook carefully

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

All benefits and limitations of these plans are governed in all cases by the relevant plan documents, insurance contracts, handbooks, EGID Administrative Rules and the regulations governing the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The Code of Federal Regulations at 42 CFR §§ 423 et seq. and the rules of the Oklahoma Administrative Code, pertaining to the Employees Group Insurance Division of the Oklahoma Health Care Authority, are controlling in all aspects of plan benefits.

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

HEALTHCHOICE PLAN CONTACT INFORMATION

HealthChoice Customer Service
Medical benefit coverage, claims, certification inquiries
800-323-4314 or TTY 711
HealthChoiceOK.com

Claims and correspondence
P.O. Box 30511
Salt Lake City, UT 84130-0511

Appeals and provider inquiries
P.O. Box 30546
Salt Lake City, UT 84130-0546

Pharmacy benefit manager
Pharmacy benefits
CVS Caremark, 24/7
Live operator available 7 a.m. to midnight Central Time
Caremark.com
SilverScript plans: 866-275-5253 or TTY 711
Without Part D plans: 877-720-9375 or TTY 711

Pharmacy prior authorization
SilverScript plans: 855-344-0930 or TTY 711
Without Part D plans: 800-294-5979 or TTY 711
CVS Specialty Pharmacy: 800-237-2767

Eligibility and enrollment
EGID Member Services
Monday through Friday, 8 a.m. to 4:30 p.m. Central Time
405-717-8780 or 800-752-9475
TTY 711

HEALTHCHOICE PLAN IDENTIFICATION

Plans
HealthChoice SilverScript High
HealthChoice SilverScript Low
HealthChoice High Without Part D
HealthChoice Low Without Part D

Plan administrator
Employees Group Insurance Division
405-717-8780 or 800-752-9475
P.O. Box 11137
Oklahoma City, OK 73136-9998
Oklahoma.gov/omes

INFORMATION ABOUT YOUR PREMIUMS

Medicare premiums

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

Late enrollment penalty

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

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

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

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

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

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

Income-related monthly adjustment amount

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

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

Paying your plan premiums

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

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

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

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

Changes in your monthly premium

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

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

Nonpayment of premiums

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

GENERAL INFORMATION

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

These plans are designed to provide supplemental benefits to Medicare Part A and Part B. These plans also cover Part D prescription drug benefits. Except as noted otherwise in this handbook, services not covered by Medicare are not covered by the plans. The medical benefits are based on Medicare's approved amounts. For more information, review your 2025 *Medicare & You* handbook, visit **Medicare.gov** or call Medicare toll-free at 800-MEDICARE (800-633-4227) or TTY 877-486-2048.

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

The HealthChoice plans supplement Medicare Part A (hospitalization) by paying for:

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

The HealthChoice plans supplement Medicare Part B (medical) by paying for:

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

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

HealthChoice SilverScript Medicare Supplement plans

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

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

HealthChoice Medicare Supplement plans without Part D

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

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

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

Provider-patient relationship

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

Medicare's limiting charge

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

Certification

Since HealthChoice is secondary to your Medicare coverage, certification through HealthChoice by your provider is required only for the additional 365 lifetime reserve days for hospitalization covered by HealthChoice. If you have questions, call HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

HealthChoice explanation of benefits

Each time a medical claim is processed, the claims administrator processes an explanation of benefits (EOB), which explains how your benefits are applied. You will receive your EOB in the mail. They are also available through the HealthChoice member portal at **HealthChoiceOK.com**. If you have not already registered, create a username and password to access your information.

Plan ID cards

Unless enrolled in a plan without Part D, HealthChoice members have two ID cards, one for medical and/or dental benefits and one for pharmacy benefits. HealthChoice issues you ID cards when you enroll in a HealthChoice plan.

New ID cards are not issued unless at least one of the following occurs:

- Dependents are added to your plan.
- You change HealthChoice health plans.
- You request a replacement ID card.

Medical/dental card

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

To request a replacement medical/dental card, visit **HealthChoiceOK.com** or call HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

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

Prescription drug card

Please present your HealthChoice SilverScript prescription drug card when you purchase prescriptions. The pharmacy provides automatic claims processing to HealthChoice for its share of drug costs. You do not need to present your Medicare card at the pharmacy.

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

To request a replacement prescription drug card, visit **Caremark.com** or call the pharmacy benefit manager. Refer to HealthChoice Plan Contact Information.

Your contact information

It is important to keep your contact information current. You risk delaying claims processing, missing communications and even being disenrolled from the plan when your information is incorrect. Additionally, Medicare requires that you report any changes in your name, address or phone number to your insurance plan. Be sure to keep your email address updated with HealthChoice as well. You can fax changes to EGID Member Accounts at 405-717-8939 or send changes in writing to HealthChoice, P.O. Box 11137, Oklahoma City, OK 73136-9998.

Let HealthChoice know if you move

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

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

HEALTHCHOICE HIGH AND LOW OPTION MEDICARE SUPPLEMENT PLANS

Medicare Part A (hospitalization) services

All benefits are based on Medicare-approved amounts.

Services or items	Description	Medicare Part A pays	HealthChoice pays	You pay
Hospitalization Includes semiprivate room, meals, drugs as part of your inpatient treatment, and other hospital services and supplies.	First 60 days	All except Part A deductible	100% of Part A deductible	0%
	Days 61 through 90	All except the coinsurance per day	Coinsurance per day	0%
	Days 91 and after while using Medicare's 60 lifetime reserve days.	All except the coinsurance per day	Coinsurance per day	0%
	Once Medicare's lifetime reserve days are used, HealthChoice provides additional lifetime reserve days. Limited to 365 days.	0%	100% of Medicare eligible expenses. Certification by HealthChoice is required.	0%
	Beyond the 365 lifetime reserve days.	0%	0%	100%
Skilled nursing facility care Must meet Medicare requirements, including inpatient hospitalization for at least three days and entering a Medicare-approved facility within 30 days of leaving the hospital; limited to 100 days per calendar year.	First 20 days.	All approved amounts	0%	0%
	Days 21 through 100	All except the coinsurance per day	Coinsurance per day	0%
	Days 101 and after	0%	0%	100%

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

Medicare Part A (hospitalization) services

All benefits are based on Medicare-approved amounts.

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

Medicare Part B (medical) services

All benefits are based on Medicare-approved amounts.

Services or items	Description	Medicare Part B pays	HealthChoice pays	You pay
Medical expenses Medically necessary outpatient services and supplies.	Includes doctor's visits, outpatient hospital treatments, surgical services, physical and speech therapy and diagnostic tests.	80% coinsurance after Part B deductible	20% coinsurance after Part B deductible	Part B deductible
Clinical diagnostic laboratory services	Blood tests, urinalysis and tissue pathology.	100%	0%	0%
Home health care Medicare-approved services.	Intermittent skilled care and medical supplies.	100%	0%	0%
Durable medical equipment	Items such as nebulizers, wheelchairs and walkers.	80% coinsurance after Part B deductible	20% coinsurance after Part B deductible	Part B deductible

Medicare Part B (medical) services

All benefits are based on Medicare-approved amounts.

Services or items	Description	Medicare Part B pays	HealthChoice pays	You pay
Diabetes monitoring supplies	Includes coverage for glucose monitors, test strips and lancets for those with diabetes. Must be requested by your doctor.	80% coinsurance after Part B deductible	20% coinsurance after Part B deductible	Part B deductible
Ostomy supplies	Includes ostomy bags, wafers and other ostomy supplies for those with a need based on their condition.	80% coinsurance after Part B deductible	20% coinsurance after Part B deductible	Part B deductible
Blood	Includes amounts in addition to the coverage under Part A unless you or someone else donates blood to replace what you use.	80% coinsurance after Part B deductible	20% coinsurance after Part B deductible	Part B deductible
Outpatient prescription	Includes infused, oral end-stage renal disease and some cancer and transplant drugs.	80% coinsurance after Part B deductible	20% coinsurance after Part B deductible	Part B deductible

Coverage for additional medical services

Services or items	Medicare pays	HealthChoice pays	You pay
Foreign travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.	0%	80% coinsurance after the first $250 and until the $50,000 lifetime maximum	You pay the first $250 each calendar year, then 20% and all amounts over the $50,000 lifetime maximum
Bariatric surgery Medicare covers some bariatric surgical procedures when you meet certain conditions related to morbid obesity and the deductible is met (copayments may apply)	0%	100% after Part B deductible	Part B deductible
National Diabetes Prevention Program Medicare Part B covers the Medicare Diabetes Prevention Program once in a lifetime when certain conditions apply.	0%	100%	You pay $0

Medicare preventive services

Medicare Part B covers many preventive services, such as your annual flu vaccination, wellness visit and screening mammogram, at 100% when you use a doctor or other health care provider who accepts Medicare assignment; however, certain preventive services may still require the normal Part B deductible and/or coinsurance. Coinsurance can apply depending on where you receive certain services.

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

For a list of preventive services and details on coverage, go to **CMS.gov** or **Medicare.gov**. You can also refer to the 2025 *Medicare & You* handbook.

HEALTHCHOICE SILVERSCRIPT HIGH OPTION MEDICARE SUPPLEMENT PLAN

Pharmacy copay structure for network benefits

Pharmacy deductible You pay the first $100 in drug costs before copays apply.		
Prescription drugs	**30-day supply**	**31- to 90-day supply**
Generic (Tier 1) drugs	Up to $10 copay	Up to $25 copay
Preferred (Tier 2) drugs	Up to $45 copay	Up to $90 copay
Non-preferred (Tier 3) drugs	Up to $75 copay	Up to $150 copay
Specialty (Tier 4) drugs	Up to $100 copay	30-day copay applies to each 30-day supply
Preferred tobacco cessation	$0 copay	$0 copay
Insulin	Up to $35 copay. Copay is applied before the deductible.	30-day copay applies to each 30-day supply and is applied before the deductible.
Vaccinations	$0 copay	$0 copay
Pharmacy out-of-pocket maximum The annual out-of-pocket maximum is $2,000. Only your deductible and copays for covered prescription drugs purchased at network pharmacies count toward the out-of-pocket maximum. Once you reach the pharmacy out-of-pocket maximum, you pay $0 for covered prescription drugs purchased at network pharmacies for the remainder of the calendar year.		

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

HEALTHCHOICE SILVERSCRIPT LOW OPTION MEDICARE SUPPLEMENT PLAN

Pharmacy copay structure for network benefits

Pharmacy deductible	Standard coverage	Catastrophic coverage	Insulin
You pay the first $590 in drug costs.	After the deductible, you and HealthChoice share prescription drug costs. You pay 25% and HealthChoice pays 75% until your total out-of-pocket drug spending reaches $2,000.	After you reach $2,000 out of pocket, you pay $0 for covered prescription drugs at network pharmacies for the remainder of the calendar year.	You pay up to $35 copay per 30-day supply. Copay is applied before the deductible.

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

HEALTHCHOICE HIGH OPTION MEDICARE SUPPLEMENT PLAN WITHOUT PART D

Pharmacy copay structure for network benefits

Prescription drugs	30-day supply	31- to 90-day supply
Generic (Tier 1) drugs	Up to $10 copay	Up to $25 copay
Preferred (Tier 2) drugs	Up to $45 copay	Up to $90 copay
Non-Preferred (Tier 3) drugs	Up to $75 copay	Up to $150 copay
Specialty (Tier 4) drugs	Generic – $10 copay Preferred – $100 copay Non-Preferred – $200 copay	30-day copay applies to each 30-day supply
Preferred tobacco cessation	$0 copay	$0 copay
Insulin	Up to $30 copay. Copay is applied before the deductible.	Up to $90 copay. Copay is applied before the deductible.
Vaccinations	$0 copay	$0 copay

Pharmacy out-of-pocket maximum

The annual out-of-pocket maximum is $2,000. Only your copays for covered prescription drugs purchased at network pharmacies count toward the out-of-pocket maximum. Once you reach the pharmacy out-of-pocket maximum, you pay $0 for covered prescription drugs purchased at network pharmacies for the remainder of the calendar year.

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

HEALTHCHOICE LOW OPTION MEDICARE SUPPLEMENT PLAN WITHOUT PART D

Pharmacy copay structure for network benefits

Pharmacy deductible	Standard coverage	Catastrophic coverage	Insulin
You pay the first $590 in drug costs.	After the deductible, you and HealthChoice share prescription drug costs. You pay 25% and HealthChoice pays 75% until your out-of-pocket total drug spending reaches $2,000.	After you spend $2,000 out of pocket, you pay $0 for covered prescription drugs for the remainder of the calendar year.	You pay up to $30 copay per 30-day supply and up to $90 copay per 31- to 90-day supply. Copay is applied before the deductible.

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

Pharmacy out-of-pocket maximum

All the plans have a pharmacy out-of-pocket maximum of $2,000. This total includes amounts you spend, including deductibles, copays and coinsurance, at network pharmacies. There is no coverage gap in plan year 2025. Once you reach the out-of-pocket maximum, HealthChoice pays 100% for covered drugs purchased at network pharmacies for the remainder of the calendar year.

Costs that do not apply to the pharmacy out-of-pocket maximum

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

HealthChoice Pharmacy Network

The HealthChoice Pharmacy Network includes more than 60,000 pharmacies nationwide. Pharmacies contract with our plans to provide covered prescription drugs to members. They also provide electronic claims processing, so there are no paper claims to file.

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

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

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

You can locate a HealthChoice network pharmacy at **HealthChoiceOK.com**.

- **HealthChoice SilverScript members:** Select HealthChoice SilverScript Pharmacy Network. You can also call the pharmacy benefit manager. Refer to HealthChoice Plan Contact Information.
- **HealthChoice Medicare Supplement without Part D members:** Select HealthChoice Pharmacy Network. You can also call the pharmacy benefit manager. Refer to HealthChoice Plan Contact Information.

Non-network pharmacies

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

SilverScript plans

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

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

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

If you must use a non-network pharmacy, you must pay the full cost for your drugs and then file a paper claim for HealthChoice to repay you for its share of the cost. Before you fill a prescription under these circumstances, check for a network pharmacy in your area by calling the pharmacy benefit manager. Refer to HealthChoice Plan Contact Information.

Without Part D plans

When you fill your prescriptions at a non-network pharmacy, a reduced benefit applies. When you use a non-network pharmacy, you pay the full amount and submit your claim to the pharmacy benefit manager for reimbursement.

Before you fill your prescriptions at a non-network pharmacy, when possible, check to find out if there is a network pharmacy in your area by calling the pharmacy benefit manager. Refer to HealthChoice Plan Contact Information.

Drug formularies

HealthChoice SilverScript Medicare Formulary (SilverScript plans)

To find out how your drugs are covered, call the pharmacy benefit manager. Refer to HealthChoice Plan Contact Information. You can also visit their website at **Caremark.com** or go to **HealthChoiceOK.com**.

HealthChoice formulary lists (without Part D plans)

The HealthChoice Comprehensive Formulary is a list of drugs covered by the without Part D plans. To find out how your drugs are covered, call the pharmacy benefit manager. Refer to HealthChoice Plan Contact Information. You can also go to **HealthChoiceOK.com**.

Drug tiers

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

- Tier 1 – Generic drugs.
- Tier 2 – Preferred brand-name drugs.
- Tier 3 – Non-preferred drugs.
- Tier 4 – Specialty drugs.

The drugs in Tiers 1 and 2 offer the preferred (lowest) copay while Tier 3 drugs are non-preferred and have a higher copay. Tier 4 drugs include preferred very high-cost and unique formulary drugs. Drugs not listed in the formulary are not covered.

Drugs covered under Medicare Part A and Part B

Medicare Part A and Part B provide coverage for some drugs.

- Medicare Part A covers drugs you receive during a Medicare-covered stay in a hospital or skilled nursing facility or for symptom control or pain relief as part of hospice care.
- Medicare Part B covers certain chemotherapy drugs and certain drug injections you receive in an office visit setting or are given at a dialysis facility.

Drugs covered under Medicare Part D and Part B

Most drugs are covered under Part D, but there are some drugs that can be covered under both Part B or Part D depending on what the drug is used for and how it is administered. Your physician must provide this information to get prior authorization to determine how the drug should be billed.

Some drugs have restrictions

Some drugs have additional requirements or coverage limits. If there is a restriction on a drug you are taking, your provider must take extra steps for HealthChoice SilverScript to cover your drug. Refer to the HealthChoice SilverScript Medicare formulary.

Prior authorization

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

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

Quantity limits

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

Limited availability

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

Step therapy

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

Requesting a pharmacy prior authorization

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

1. Have your physician’s office call the pharmacy benefit manager toll-free at:
   a. SilverScript plans 855-344-0930.
   b. Without Part D plans 800-294-5979.

2. The pharmacy benefit manager will assist your physician's office with completing a prior authorization form.
3. If your prior authorization is approved, your physician's office is notified of the approval within 24 to 48 hours. You are also notified in writing.
4. If your prior authorization is denied, your physician's office is notified of the denial within 24 to 48 hours. You are also notified in writing.

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

Tier exception (High Option plans only)

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

Non-formulary or excluded drug prior authorization

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

- Ask your physician for a prescription for a generic (Tier 1) or preferred (Tier 2) drug that is listed on the formularies.
- Continue your non-covered/non-formulary/excluded drug and pay the full cost.
- Request a prior authorization to receive your drug at the non-preferred copay.

For more information, call the pharmacy benefit manager. Refer to HealthChoice Plan Contact Information.

Drug quantities

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

Specialty drugs

Specialty drugs are usually high-cost drugs that require special handling and extensive monitoring. These drugs may be limited to a 30-day supply.

Tobacco cessation products

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

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

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

Vaccinations covered under your pharmacy benefits

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

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

Without Part D plans

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

When you are hospitalized

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

When you are admitted to a skilled nursing facility

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

When you receive hospice care

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

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

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

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

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

Drug safety programs

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

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

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

Creditable prescription drug coverage

The HealthChoice Medicare Supplement plans provide creditable coverage. Prescription drug coverage is creditable if it meets or exceeds Medicare's prescription drug coverage guidelines. The HealthChoice plans provide coverage equal to (Low Option plans) or better than (High

Option plans) the standard benefits set by Medicare. HealthChoice is not required to send you a Creditable Coverage letter, but if you need one, call EGID Member Services. Refer to HealthChoice Plan Contact Information.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan (M3P) is a new program designed to help ease the financial burden of prescription drug costs. This program offers Medicare Part D enrollees the option of paying out-of-pocket drug costs in monthly payments spread over the course of the plan year rather than all at once at the pharmacy. Under M3P, enrollees will pay nothing at the pharmacy for Part D covered drugs, and their out-of-pocket costs will instead be billed to them in evenly distributed monthly payments throughout the plan year. Any Medicare Part D enrollee can use this payment option, all Part D plans offer this program, and member **participation is voluntary**.

If you have questions about the program, call the drug plan number on your prescription card. Also, you can visit Medicare.gov/prescription-payment-plan to learn more about this payment option and if it might be a good fit for you.

Types of drugs NOT covered

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

- Purchased outside the United States.
- Prescribed for off-label use (any use of a drug other than those indicated on the drug's label).

The following drug categories are also excluded from coverage:

- Cough and cold drugs.
- Fertility drugs.
- Over-the-counter drugs.
- Lost, stolen or damaged drugs.
- Drugs used for the treatment of anorexia, weight loss or weight gain.
- Drugs not approved by the FDA, except those used for the treatment of COVID-19 that have FDA Emergency Use Authorization.
- Impotency drugs such as Cialis, Levitra, Viagra and Caverject.*
- Drugs used for cosmetic purposes or hair regrowth.
- All over-the-counter and prescription vitamins, except prenatal vitamins.

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

CLAIMS PROCEDURES

Claims filing deadline

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

If you have questions about any of the following medical claim procedures, call HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

Filing a medical claim

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

If you have to file your claim with HealthChoice yourself, once you receive your Medicare Summary Notice for Part A and Part B services, you can file your claim by sending a copy of the notice to HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

Medical coordination of benefits

If you or your covered dependents are covered by another group health plan, HealthChoice coordinates benefits with your other plan so total benefits are not more than the amount billed or your liability. If your other group coverage is primary over your HealthChoice coverage, you must file claims with your primary plan first. If your other health coverage terminates, call HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

Medicare beneficiaries with end-stage renal disease

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

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

Filing a direct pharmacy claim

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

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

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

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

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

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

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

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

Claims for services outside the United States

If you receive medically necessary emergency treatment outside the United States, follow these claim procedures:

- Arrange to pay for the services or supplies.
- Have claims translated into English before you file your claim.
- Convert charges to U.S. dollars using the exchange rates for the dates of service.

Contact HealthChoice Customer Service for assistance. Refer to HealthChoice Plan Contact Information.

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

Private contracts with physicians and practitioners

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

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

Subrogation

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

Subrogation applies when you are sick or injured as a result of the negligent act or omission of another person or party. If you or your covered dependents receive HealthChoice benefits and have a right to recover damages, the plan has the right to recover any benefits paid on your behalf. All payments from a third party, whether by lawsuit, settlement or otherwise, must be used to repay HealthChoice, in addition to reimbursing Medicare. Medicare holds first priority regarding such recovery, and HealthChoice maintains second priority. 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 pays your medical claims and when the auto insurance claim is settled, the other driver's insurance (the third party) or your uninsured/underinsured/med pay motorist policy repays HealthChoice the amounts it paid on your medical claims related to the accident. If the third party or an insurer pays you or your dependent directly, you are responsible for repaying HealthChoice.

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

The subrogation administrator can be reached by phone at 405-235-9621 or toll-free 800-235-9621, fax at 405-235-0439 or mail at Two Leadership Square, 8th Floor, 211 N. Robinson Ave., Oklahoma City, OK 73102.

ELIGIBILITY, ENROLLMENT AND DISENROLLMENT

Medicare eligibility

Medicare is the federal health insurance program for people:

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

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

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

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

Enrollment in Medicare

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

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

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

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

When you become Medicare eligible

Approximately two months before you turn 65, EGID sends you a letter advising you of your options for Medicare Supplement and Medicare Advantage prescription drug plans. An Application for Medicare Supplement With Prescription Drug Plan and an Application for Medicare Advantage Prescription Drug Plan will be enclosed with your letter. You must complete and return the appropriate application for the plan you wish to enroll in. You can choose a different insurance carrier than the one you currently have when you become Medicare eligible, but you must be eligible for the plan you select, and your election must be made within your initial enrollment period. Once your plan election is made and your enrollment is effective, you cannot make another plan change until the annual Option Period or during a special enrollment period.

If you or your covered dependents become Medicare eligible before 65, you must notify EGID and provide your Medicare number as it appears on your Medicare Health Insurance card. EGID will mail you an Application for Medicare Supplement With Prescription Drug Plan and an Application for Medicare Advantage Prescription Drug Plan. You must complete and return the appropriate application for the plan you wish to enroll in by the deadline indicated on the form. You can choose a different insurance carrier than the one you currently have when you become Medicare eligible, but you must be eligible for the plan you select, and your election must be made within your initial enrollment period. Once your plan election is made and your enrollment is effective, you cannot make another plan change until the annual Option Period or during a special enrollment period. Your enrollment will be effective on the first day of the month following receipt of your completed application or on the effective date of your Medicare coverage, whichever is later.

Eligibility requirements

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

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

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

Enrollment periods and plan changes

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

Annual coordinated election period – This is Medicare's annual election period, Oct. 15 through Dec. 7, which EGID follows for Option Period plan changes. Effective date is Jan. 1.

Initial enrollment period – This is when you first become eligible for Medicare. The effective date is the first day of the month you become eligible or the first day of the month following receipt of your completed application, whichever is later.

- If initial Medicare eligibility occurs outside of the annual coordinated election period, you can switch health insurance carriers provided that:
  a. You are eligible for the plan you select, and your election must be made within your initial enrollment period.
  b. Once a plan election is made and your enrollment is effective, you cannot make another plan change until the annual Option Period or during a special enrollment period.
  c. The entire family must remain covered by the same carrier, and the receiving plan must be able to accommodate all family members.

Special enrollment period – This is when you can make midyear changes under certain circumstances (effective date follows receipt of your completed application), such as:

- You move outside the United States.
- CMS or HealthChoice terminates the plan's participation in the Part D program.
- You lose creditable coverage for reasons other than failure to pay premiums.
- You meet other exception rules as set out by CMS.

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

Confirmation Statement

Anytime a change is made to your coverage, EGID mails you a Confirmation Statement that lists the coverage you are enrolled in, the effective date of coverage and the premium

amounts. Review your statement as soon as you receive it so any errors can be corrected as soon as possible.

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

Dependent coverage

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

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

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

Eligible dependents

Eligible dependents include:

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

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

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

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

In the event of the birth of a child when Medicare is primary, call EGID Member Services for coverage information. Refer to HealthChoice Plan Contact Information.

Excluding dependents from coverage

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

To request coverage changes

All requests for changes in coverage must be made in writing. Verbal requests for changes are not accepted, unless directed by Medicare. A request for change must be made within 30 days of a qualifying event. Please send all requests for changes to HealthChoice, P.O. Box 11137, Oklahoma City, OK 73136-9998; or fax your request to 405-717-8939.

When your employer changes insurance carriers

Education retirees

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

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

Local government retirees

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

New employer retirees

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

Following your employer to a new plan

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

If you return to work

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

If you can opt out of your employer's group health plan and keep your HealthChoice Medicare Supplement plan, Medicare is your primary insurance carrier and HealthChoice is your secondary carrier. Be aware that your employer cannot provide a Medicare Supplement plan or pay for any premiums related to a Medicare Supplement plan.

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

Ending your coverage with HealthChoice

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

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

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

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

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

When HealthChoice must end your coverage

HealthChoice must end your coverage in the plan when:

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

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

In the event of your death

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

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

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

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

COBRA

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

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

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

When you are enrolled in vested, non-vested or retirement coverage and your dependents become eligible for COBRA

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

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

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

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

If you have questions about COBRA, call EGID Member Services. Refer to HealthChoice Plan Contact Information.

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

State of Oklahoma
Employees Group Insurance Division
Privacy Notice
Revised November 2024

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@omes.ok.gov
oklahoma.gov/omes

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 Health Choice 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.
    - We are not required to approve your request and may decline if it would affect your care.

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, 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.html**.

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.

For more information, refer to **hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html**.

Changes to the terms of this notice.

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

GRIEVANCES AND APPEALS

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

When your medical claim is denied under HealthChoice

If your medical claim was denied by Medicare and you would like to appeal it, you should contact Medicare and follow its appeal procedures. If the claim was approved by Medicare, but the balance was denied in whole or in part for any reason by HealthChoice, either you or your authorized representative can request that the claim be reviewed by calling HealthChoice Customer Service or by submitting a written request to the HealthChoice Appeals Unit at the address listed below within 180 days of your receipt of a denial.

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

Please follow the steps below to make sure that your appeal at any level is processed in a timely manner:

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

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

To request access to and copies of all documents, records and other information about your claim, free of charge, or to find out how to start an external review, contact HealthChoice Customer Service. Refer to HealthChoice Plan Contact Information.

When your pharmacy claim is denied

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

SilverScript plans

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

Without Part D plans

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

HealthChoice Pharmacy Unit
P.O. Box 11137
Oklahoma City, OK 73136-9998

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

FRAUD, WASTE AND ABUSE

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 the matter to the HealthChoice Health Care Management Unit immediately by:

- Sending a report in writing to the HealthChoice Health Care Management Unit at P.O. Box 11137, Oklahoma City, OK 73136-9998.
- Calling the EGID HealthChoice Fraud, Waste and Abuse toll-free hotline at 866-381-3815.

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 please remember that confidentiality may not be guaranteed if law enforcement becomes involved. There will be no retaliation against anyone who reports conduct that a reasonable person acting in good faith would have believed to be fraudulent or abusive. Any employee who violates the non-retaliation policy will be subject to disciplinary action up to and including termination.

Examples of fraud, waste and abuse may include:

- An individual or organization contacts you pretending to represent HealthChoice, Medicare or Social Security and asks for your identification number, bank account number, credit card number, money, etc.
- Someone asks you to sell your prescription drug card or account information on the card.

- Someone asks you to get medications for them using your prescription drug card prescription coverage.
- You are encouraged to disenroll from your plan or are offered cash or a gift worth more than $15 to sign up for a Medicare prescription drug plan.
- Your pharmacy does not give you all your medications.
- You are billed for medications or health services you did not receive.
- You receive a different medication than your doctor ordered.
- Billing for unlicensed staff.
- Providing medically unnecessary services to members.
- Provider bills for duplicate equipment or supplies or bills a used device as a new purchase.
- You receive durable medical equipment that was not requested by you or prescribed by your doctor.

NOTIFICATIONS

Women's Health Cancer Rights Act of 1998 Notice*

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

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

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

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

Coverage of side effects associated with prostate-related conditions*

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

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

Wigs and scalp prostheses

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

PLAN DEFINITIONS

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

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

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

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

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

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

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

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

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

Covered drugs: Prescription drugs covered by the plans.

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

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

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

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 the member has been granted legal guardianship or child legally placed with you for adoption up to age 26, whether married or unmarried. **Note:** Plan coverage that terminates upon the dependent's 26th birthday will terminate at the end of the month in which the birthday occurs.
- Your dependent, regardless of age, who is incapable of self-support due to a disability that was diagnosed prior to age 26; subject to medical review and approval of the Disabled Dependent Assessment form, which must be received at least 30 days prior to the dependent's 26th birthday.
- Other unmarried children up to age 26 who live with you and for whom you are primarily responsible. This requires completion of an acceptable Application for Coverage for Other Dependent Children. A tax return showing dependency can be provided in lieu of the application.

Eligible former employee: An eligible employee who is participating in any of the plans authorized by or through the Oklahoma Employees Insurance and Benefits Act who retires, has a vesting right with a state-funded retirement plan or has the required years of service with an employer participating in the plan. Surviving dependents and COBRA participants are considered as former employees.

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

Exception: A type of coverage determination.

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

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

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

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

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

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

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

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

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

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

Medicare-eligible expenses: Medical costs recognized as reasonable and medically necessary by Medicare.

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

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

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

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

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

Option Period: A set time when you can change plans that follows Medicare's annual election period.

Out-of-pocket maximum: The maximum amount you pay annually as your cost share for formulary medications at network pharmacies.

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

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

Pharmacy deductible: Before benefits are available for HealthChoice SilverScript High and Low plan members, the separate pharmacy deductible of $100 must be met by the High plan members, and the pharmacy deductible of $590 must be met by the Low plan members.

Pharmacy prior authorization: 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 or dependent for a special enrollment period. Refer to the Eligibility section for a list of qualifying events.

Quantity limits: Benefit restrictions that limit the amount of a particular formulary drug that plan will cover during a specified time period.

Standard coverage (sometimes referred to as initial coverage phase): The out-of-pocket amount that you will expend as your cost share for formulary medications at network pharmacies after your deductible is met and before entering the catastrophic coverage phase.

Step therapy: A type of prior authorization for drugs that initiates treatment for a medical condition with the most preferred drug therapy and progresses to other therapies only if necessary, promoting better clinical decisions.

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 برقم800-323-4314 (رقم هاتف الصم والبكم:711).

(Burmese) သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို 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: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-323-4314 (TTY: 711).

(Thai) เรียน: 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 ۔ کال کریں 800-323-4314 (TTY: 711).

(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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OKLAHOMA

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a divison of the Oklahoma Health Care Authority.