oklahoma complete health | SoonerSelect

Oklahoma Complete Health Member Handbook

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OklahomaCompleteHealth.com

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You can get this handbook and other plan information in large print for free. To get materials in large print, call Member Services at **1-833-752-1664** (TTY: **711**).

If English is not your first language (or if you are reading this on behalf of someone who doesn't read English), we can help. Call **1-833-752-1664** (TTY: **711**). You can ask us for the information in this handbook in your language. We have access to interpreter services and can help answer your questions in your language. Members can get these services for free. To ask for aids or services, call Member Services at **1-833-752-1664** (TTY: **711**).

Si el inglés no es su lengua materna (o si está leyendo esto en representación de alguien que no sabe inglés), podemos ayudarle. Llame al **1-833-752-1664** (TTY: **711**). Puede solicitarnos la información de este manual en su idioma. Tenemos acceso a servicios de interpretación y podemos ayudarle a responder a sus preguntas en su idioma. Los miembros pueden obtener estos servicios de forma gratuita. Para solicitar ayudas o servicios, llame a Servicios para Miembros al **1-833-752-1664** (TTY: **711**).

Statement of Non-Discrimination

Oklahoma Complete Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Oklahoma Complete Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Oklahoma Complete Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Oklahoma Complete Health at **1-833-752-1664** (TTY: **711**). We're here for you Monday-Friday from 8 a.m. to 5 p.m.

If you believe that Oklahoma Complete Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with Oklahoma Complete Health by mail, phone, fax or email at:

1557 Coordinator
P.O. Box 31384, Tampa, FL 33631
Phone: **1-855-577-8234** (TTY: **711**)
Fax: **1-866-388-1769**
Email: **SM_Section1557Coord@centene.com**

If you need help filing a grievance, our **1557 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
Phone: **1-800-368-1019**, **1-800-537-7697** (TDD).

Complaint forms are available at **https://www.hhs.gov/ocr/complaints/index.html**.

This notice is available at Oklahoma Complete Health website:
https://www.oklahomacompletehealth.com/about-us/Statement_of_Non_Discrimination.html

Declaración de No Discriminación

Oklahoma Complete Health cumple con las leyes Federales vigentes sobre derechos civiles y no discrimina por motivos de raza, color de piel, nacionalidad de origen, edad, discapacidad o sexo (incluido el embarazo, la orientación sexual y la identidad de género). Oklahoma Complete Health no excluye a personas ni las trata de forma diferente por motivos de raza, color de piel, nacionalidad de origen, edad, discapacidad o sexo (incluido el embarazo, la orientación sexual y la identidad de género).

Oklahoma Complete Health:

- Proporciona asistencia y servicios gratuitos a personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los que se indican a continuación:
  - Intérpretes de lengua de señas calificados
  - Información escrita en otros formatos (letra grande de imprenta, audio, formatos electrónicos accesibles u otros formatos)
- Proporciona servicios lingüísticos a personas cuya lengua materna no es el inglés, como los siguientes:
  - Intérpretes calificados
  - Información escrita en otros idiomas

Si necesita estos servicios, llame a Oklahoma Complete Health al **1-833-752-1664** (TTY: **711**). Estamos aquí para usted De lunes a viernes de 8 a.m. a 5 p.m.

Si considera que Oklahoma Complete Health no le proporcionó estos servicios o lo discriminó de otra manera por motivos de raza, color de piel, nacionalidad de origen, edad, discapacidad o sexo (incluidos el embarazo, la orientación sexual y la identidad de género), puede presentar una queja ante Oklahoma Complete Health por correo postal, teléfono, fax o correo electrónico:

1557 Coordinator
P.O. Box 31384, Tampa, FL 33631
Teléfono: **1-855-577-8234** (TTY: **711**)
Fax: **1-866-388-1769**
Email: **SM_Section1557Coord@centene.com**

Si necesita ayuda para presentar una queja, nuestro **Coordinador 1557** está disponible para ayudarlo.

También puede presentar un reclamo de derechos civiles a la Office for Civil Rights del U.S. Department of Health and Human Services de manera electrónica mediante el Portal de Reclamos de la Office for Civil Rights, disponible en **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, o por correo postal o teléfono mediante la siguiente información:

U.S. Department of Health and Human Services,
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Teléfono: **1-800-368-1019**, **1-800-537-7697** (TDD).

Los formularios de reclamo están disponibles en **https://www.hhs.gov/ocr/complaints/index.html**.

Esta notificación está disponible en el sitio web de Oklahoma Complete Healt:
https://www-es.oklahomacompletehealth.com/about-us/Statement_of_Non_Discrimination.html

If you need this material in another language or format, translation services are available at no cost including written, visual and audible aids. Call Oklahoma Complete Health at **1-833-752-1664** (TTY: **711**).

Español (Spanish)	Si necesita este material en otro idioma o formato, contamos con servicios de traducción disponibles sin costo alguno, entre los que se incluyen ayudas escritas, visuales y auditivas. Llame a Oklahoma Complete Health al **1-833-752-1664** (TTY: **711**).
Tiếng Việt (Vietnamese)	Nếu quý vị cần tài liệu này bằng ngôn ngữ hoặc định dạng khác, chúng tôi cung cấp dịch vụ dịch thuật miễn phí bao gồm hỗ trợ bằng văn bản, hình ảnh và âm thanh. Gọi Oklahoma Complete Health theo số **1-833-752-1664** (TTY: **711**).
中文 (Chinese)	如需其他語言或格式的資料，您可以免費使用翻譯服務，包括書面、視覺和語音輔助。請撥打 Oklahoma Complete Health 電話 **1-833-752-1664** (TTY：**711**)。
한국어 (Korean)	다른 언어 또는 형식으로 이 자료가 필요한 경우 서면 및 시청각 도구 등의 번역 서비스를 무료로 이용할 수 있습니다. **1-833-752-1664**(TTY: **711**)번으로 Oklahoma Complete Health에 전화해 주십시오.
Deutsch (German)	Wenn Sie dieses Material in einer anderen Sprache oder in einem anderen Format benötigen, stehen Ihnen kostenlose Übersetzungsdienstleistungen zur Verfügung, einschließlich schriftlicher, visueller und akustischer Hilfsmittel. Sie erreichen Oklahoma Complete Health unter **1-833-752-1664** (TTY: **711**).
العربية (Arabic)	إذا كنت بحاجة إلى هذه المواد بلغة أو تنسيق آخر، تتوفر خدمات الترجمة بدون تكلفة بما في ذلك الوسائل المساعدة المكتوبة والمرئية والصوتية. اتصل بـ Oklahoma Complete Health على الرقم **1-833-752-1664** (TTY: **711**).

မြန်မာ **(Burmese)**	ဤအကြောင်းအရာကို အခြားဘာသာစကားဖြင့်ဖြစ်စေ၊ အခြားဖောမတ်ဖြင့်ဖြစ်စေ လိုအပ်ပါက စာဖြင့်ရေးသားထားသော၊ ရုပ်ပုံဖြင့်ပြထားသော၊ အသံကြားနိုင်စေရန်ပြုလုပ်ထားသော အထောက်အကူများအပါအဝင် ဘာသာပြန်ဝန်ဆောင်မှုများကို အခမဲ့ ရရှိနိုင်ပါသည်။ Oklahoma Complete Health ဖုန်းနံပါတ် **1-833-752-1664** (TTY- **711**) ကို ခေါ်ဆိုပါ။
Hmong (Hmong)	Yog tias koj xav tau cov ntaub ntawv no ua lwm hom lus los sis lwm hom ntawv, yuav muaj cov kev pab cuam txhais lus yam tsis tau them nqi nrog rau kev sau ntawv, cov ntaub ntawv pom thiab cov khoom pab mloog kom hnov lus. Hu rau Oklahoma Complete Health ntawm **1-833-752-1664** (TTY: **711**).
Tagalog (Tagalog)	Kung kailangan ninyo ang materyal na ito sa ibang wika o format, available ang mga serbisyo sa pagsasalin nang libre kabilang ang mga nakasulat, visual, at audible na tulong. Tawagan ang Oklahoma Complete Health sa **1-833-752-1664** (TTY: **711**).
Français (French)	Si vous avez besoin de ce document dans une autre langue ou un autre format, des services de traduction sont disponibles gratuitement, y compris des aides écrites, visuelles et sonores. Appelez Oklahoma Complete Health au **1-833-752-1664** (TTY : **711**).
ພາສາລາວ **(Laotian)**	ຫາກທ່ານຕ້ອງການເອກະສານນີ້ໃນພາສາ ຫຼື ຮູບແບບອື່ນມີບໍລິການແປພາສາໃຫ້ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ ລວມທັງບໍລິການຊ່ວຍເຫຼືແປຂຽນ, ແບບຮູບພາບ ແລະ ສຽງ. ໂທຫາ Oklahoma Complete Health ທີ່ເບີ **1-833-752-1664** (TTY: **711**).

ไทย (Thai)	**หากคุณต้องการเอกสารนี้ในภาษาหรือรูปแบบอื่น คุณสามารถใช้บริการแปลภาษาได้โดยไม่มีค่าใช้จ่าย รวมถึงเอกสารคู่มือ ภาพ และเสียง โทรติดต่อ** Oklahoma Complete Health **ที่ 1-833-752-1664** (TTY: **711**)
اُردُو (Urdu)	اگر آپ اس مواد کو کسی دوسری زبان یا فارمیٹ میں چاہتے ہیں تو بغیر کسی قیمت کے ترجمہ کی خدمات دستیاب ہیں جن میں تحریری، ویزوئل اور قابل سماعت امداد شامل ہیں۔ Oklahoma Complete Health کو **1-833-752-1664** (TTY: **711**) پر کال کریں۔
ᏣᎳᎩ ᎦᏬᏂᎯᏍᏗ (Cherokee)	ᎢᏯᏍᏛᏁ ᎤᏂᎬᎢ ᏯᎠ ᎤᏩᏒᎥᏍᎢ ᏗᏥ anᏂᏲᏂb, ᏳᏓᎴᏯ ᎬᏗ ᎠᎴ ᏍᎾᏍᏛ,ძᏔᏣᏛᏁᏗ ᎠᎡᏍᎥᎡᏍᎩ ᎠᎦᏘᎳᏗ ᎾᏍᎩ ᏯᎬᏩᏩᏗ ᏓᏁᏂᏗᏥ ᎪᏪᎵᎠ, ᎤᏍᏗ ᎠᏍᎥᏂᏍᎩ ᎠᎴ ᎦᏙᎤᏍᏗ ᎠᏍᎥᏂᏍᎩ. ᎦᎠᏛᎩ Oklahoma Complete Health ᎠᎢ **1-833-752-1664** (TTY: **711**).
فارسی (Persian)	اگر این مطالب را به زبان یا در قالب دیگری نیاز دارید، خدمات ترجمه رایگان ازجمله کتبی، دیداری، و شفاهی دردسترس است. ازطریق شماره **1-833-752-1664** (TTY: **711**) با Oklahoma Complete Health تماس بگیرید.

Your Oklahoma Complete Health Quick Reference Guide

I WANT TO:	I CAN CONTACT:
Find a doctor, specialist, or health care service	My primary care provider (PCP) is the primary doctor providing care to me. For help with choosing my PCP, I can call Member Services at **1-833-752-1664** (TTY: **711**).
Get the information in this handbook in another format or language	Member Services at **1-833-752-1664** (TTY: **711**).
Keep better track of my appointments and health services	My PCP or Member Services at **1-833-752-1664** (TTY: **711**).
Get help with getting to and from my doctor's appointments	Member Services at **1-833-752-1664** (TTY: **711**). I can also find more information on Transportation Services in this handbook on page 30.
Get help to deal with my stress or anxiety	Oklahoma Mental Health Lifeline at **988** at any time, 24 hours a day, 7 days a week. If I am in danger or need immediate medical attention, I will call **911**.
Get answers to basic questions or concerns about my health, symptoms or medicines	Nurse Advice Line at **1-833-752-1664** (TTY: **711**) at any time, 24 hours a day, 7 days a week, or talk with your PCP.
· Understand a letter or notice · I got in the mail from my health plan · File a complaint about my health plan · Get help with a recent change or denial of my health care services	Member Services at **1-833-752-1664** (TTY: **711**).
Update my address or personal information	Call the SoonerCare Helpline at **1-800-987-7767** or visit **www.MySoonerCare.org**.
Find my plan's provider directory or other general information about my plan	Visit my plan's website at **OklahomaCompleteHealth.com** or call Member Services at **1-833-752-1664** (TTY: **711**).

Key Words Used in This Handbook

As you read this handbook, you may see some new words. Here is what we mean when we use them.

Words/Phrases

Abuse: Provider or member practices that result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary.

Advance Directive: A set of directions you give about the medical and behavioral health care you want if you ever lose the ability to make decisions for yourself. This may include a living will, the appointment of a health care proxy or both.

Adverse Benefit Determination: A decision your plan can make to reduce, stop or restrict your health care services.

American Indian/Alaskan Native (AI/AN): An individual who is a member of a federally recognized American Indian Tribe; an individual who resides in an urban center and qualifies as a member of an American Indian Tribe, Alaskan Native, or is considered to be an American Indian under federal regulations; an individual considered by the federal government to be an American Indian for any purpose. AI/AN may be used to refer to this population.

Appeal: A request to your health plan to review a decision the plan made about reducing, stopping or restricting your health care services.

Behavioral Health Emergency: A situation in which there is a high risk of behaving in a way that could result in serious harm or death to yourself or others.

Behavioral Health Services: Mental health (emotional, psychological and social well-being) and substance use (alcohol and drugs) disorder diagnostic, treatment, and rehabilitation services.

Benefits: Medical and behavioral health care services covered by your health plan.

Care Manager: A specially trained health professional who works with you and your doctors to make sure you get the right care when and where you need it.

Words/Phrases

Copay: A fee you pay when you get certain health care services or a prescription.

Durable Medical Equipment: Certain items (such as a walker or a wheelchair) your doctor can order for you to use if you have an illness or an injury.

Emergency Medical Condition: A situation in which your life could be threatened, or you could be hurt permanently if you don't get care right away (such as a heart attack or broken bones).

Emergency Medical Transportation: Ambulance transportation to the nearest hospital or medical facility for an emergency medical condition.

Emergency Room Care: Care you receive in a hospital if you are experiencing an emergency medical condition.

Emergency Services: Services you receive to evaluate, treat or stabilize your emergency medical condition.

Excluded Benefits: Services or benefits that are not covered by the health plan.

Expansion Adult: An individual who is age 19-64, with income at or below 138% of the federal poverty level, and who is determined eligible for Medicaid.

Expedited (faster) Appeal: If your health plan made a decision about reducing, stopping or restricting your health care services and you think waiting 30 days for an appeal decision will harm your health, this is a request to review the decision within 72 hours.

Fraud: Intentional deception or misrepresentation made by a person resulting in some unauthorized benefit to themselves or another person.

Grievance: A complaint you can file if you have a problem with your health plan, provider, care or services.

Words/Phrases

Habilitation Services and Devices: Health care services that help you keep, learn or improve skills and functioning for daily living.

Health Insurance: A type of insurance coverage that pays for your health and medical costs. Your Medicaid coverage is a type of insurance.

Home Health Care: Certain services you receive outside a hospital or a nursing home to help with daily activities of life, such as home health aide services or skilled nursing.

Hospice Services: Special services for patients and their families during the final stages of illness. Hospice services include certain physical, psychological and social services that support terminally ill individuals and their families or caregivers.

Hospital Outpatient Care: Care you receive at a hospital or medical facility without being admitted or for a stay of less than 24 hours (even if this stay occurs overnight).

Hospitalization: Admission to a hospital for treatment that lasts more than 24 hours.

Indian Health Care Provider (IHCP): A health care program operated by Indian Health Services or by an American Indian Tribe, Tribal Organization, or Urban Indian Organization. IHCP may be used to refer to this kind of provider. Any individual who is an American Indian or Alaskan Native (AI/AN) may choose an IHCP as their primary care provider.

Managed Care: An organized way for providers to work together to coordinate and manage all your health needs.

Medicaid: A health plan that helps some individuals pay for health care. For example, the SoonerSelect plan is a Medicaid health program that pays for health coverage.

Medically Necessary: Medical services or treatments that you need to get and stay healthy. Services must follow standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability.

Words/Phrases

Member: A person enrolled in and covered by a health plan.

Network (or Provider Network): A group of doctors, hospitals, pharmacies and other health care professionals who have a contract with your health plan to provide health care services for its members.

Non-Emergency Medical Transportation: Transportation your plan can arrange to help you get to and from your appointments, including personal vehicles, taxis, vans, mini-buses and public transportation.

Non-Expansion Adult: An adult who qualifies for Oklahoma's Medicaid program and meets eligibility requirements such as pregnant women and parent/caretakers of dependents under age 19 who meet income limits.

Non-Participating Provider/Out-of-Network Provider: A physician or other provider who has not contracted with or is not employed by the health plan to deliver services under the SoonerSelect program.

Notice of Adverse Resolution: Written information the plan sends you if the appeal is denied.

Notice of Resolution: Written information the plan sends you if your appeal is granted.

Oklahoma Health Care Authority (OHCA): The state agency for Medicaid in Oklahoma, and the agency that oversees the SoonerSelect program.

Out-of-Network Referral: If your health plan does not have the specialist you need in its provider network, they may find one for you to visit who is outside your health plan.

Participating Provider: A physician or other provider, including a pharmacy, who is contracted with or employed by the health plan to deliver services under the SoonerSelect program.

Physician Services: The services provided by an individual licensed under state law to practice medicine or osteopathy, but not services offered by doctors while you are admitted in the hospital.

Words/Phrases

Plan (or Health Plan): The company providing you with health insurance coverage. Your health plan is Oklahoma Complete Health SoonerSelect Program.

Premium: A monthly payment made for health insurance coverage. You do not have a premium in SoonerSelect.

Prescription Drugs: A drug that, by law, requires a prescription by a doctor.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

(general) **Primary Care Provider:** A medical doctor who is trained to prevent, diagnose and treat a broad array of illnesses and injuries in the general population.

(specific to you) **Primary Care Provider (PCP):** The medical provider who takes care of and coordinates all your health needs, including referrals and prior authorizations. Your PCP is often the first person you should contact if you need care. Your PCP can be a physician, including an OB/GYN, a nurse practitioner, a physician assistant, or a certified nurse midwife. If you are an individual who is American Indian or Alaskan Native (AI/AN), you may choose an Indian Health Care Provider as your PCP.

Prior Authorization (PA) (or Preauthorization): The approval needed from your plan before you can get certain health care services or medicines.

Provider: A health care professional or a facility that delivers health care services, such as a doctor, hospital, or pharmacy.

Rehabilitation Services and Devices: Health care services and equipment that help you regain skills, abilities or knowledge that may have been lost or compromised because of an illness, accident, injury or surgery. These services can include physical or speech therapy or behavioral rehabilitation services.

Skilled Nursing Care: Care that requires the skill of a licensed nurse.

Words/Phrases

Specialist: A doctor who is trained and practices in a specific area of medicine.

Specialty Care: Advanced medically necessary care that focuses on specific health conditions or are provided by a specialist.

Standard Appeal: A request to your health plan to review a decision the plan made about reducing, stopping or restricting your health care services. Your plan will make a decision on your appeal within 30 days.

State Fair Hearing: If you are unhappy with the final decision your health plan made on your appeal, you may request a hearing to make your case before an administrative law judge.

Substance Use: A condition that includes the misuse or addiction to alcohol and/or legal or illegal drugs.

Urgent Care: Care for a health condition that needs prompt medical attention but is not an emergency medical condition. You can get urgent care in a walk-in clinic for a non-life-threatening illness or injury (such as the flu or sprained ankle).

Waste: The overuse or misuse of health care services that increases Medicaid costs.

Welcome to Oklahoma Complete Health's SoonerSelect Program

Welcome to Oklahoma Complete Health's SoonerSelect Program

This handbook will be your guide to the full range of Medicaid health care services available to you. If you have questions about the information in your welcome packet, this handbook, or your new health plan, call Member Services at **1-833-752-1664** (TTY: **711**) or visit our website at **OklahomaCompleteHealth.com.** We can also help you make an appointment with your doctor and tell you more about the services you can get with your new health plan.

How SoonerSelect Works

The Plan, Our Providers and You

Many people get their health benefits through programs like SoonerSelect, which works like a central home for your health. SoonerSelect helps coordinate and manage all your health care needs.

Oklahoma Complete Health has a contract with the Oklahoma Health Care Authority (OHCA) to meet the health care needs of people with Oklahoma Medicaid. In turn, we partner with a group of health care providers to help us meet your needs. These providers (doctors, therapists, specialists, hospitals, home care providers and other health care facilities) make up our provider network. You will find a list of participating providers in our provider directory. You can visit our website at **OklahomaCompleteHealth.com** to find the provider directory online. To view online, choose "SoonerSelect," then click "Member Resources" and click "Member Handbook and Forms" to view our provider directory and other important materials.

This tool will have the most up-to-date information about our provider network, such as:

- Provider names, addresses, and phone numbers.
- The provider's sex and spoken language(s).
- Whether the provider is taking new patients.
- Professional qualifications, such as where the provider went to school and what certifications they have.

For more information about a provider, or to get a free printed copy of the provider directory, call Member Services at **1-833-752-1664** (TTY: **711**).

When you join Oklahoma Complete Health, our providers are here to support you. Most of the time, that person will be your primary care provider (PCP). The PCP is the medical provider who takes care of and coordinates all your health needs, including referrals and prior authorizations. If you need to have a test, see a specialist or go into the hospital, your PCP can help arrange it. You can choose any PCP in our network. Your PCP can be a:

- Family general practitioner.
- Internist.
- Obstetrician / gynecologist (OB/GYN).
- Specialist who performs PCP functions.
- Nurse practitioner.

To make an appointment with your PCP, call your PCP's office. If you need help making an appointment or getting a ride to your appointment, please call Member Services at **1-833-752-1664** (TTY: **711**).

If you need to speak to your PCP after hours or weekends, call and leave a message with information on how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can go to certain doctors for some services without checking with your PCP. See page 11 for details.

How to Use This Handbook

This handbook will tell you how Oklahoma Complete Health will work. This handbook is your guide to health and wellness services. It tells you the steps to take to make the plan work for you.

The first several pages will tell you what you need to know right away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time.

When you have a question, check this handbook, ask your PCP or call Member Services at **1-833-752-1664** (TTY: **711**). You can also visit our website at **OklahomaCompleteHealth.com**.

Help from Member Services

There is someone to help you at Member Services. Just call Member Services at **1-833-752-1664** (TTY: **711**).

For help with non-emergency issues and questions, call Member Services at **1-833-752-1664** (TTY: **711**). We are here for you Monday through Friday, from 8 a.m. to 5 p.m. After business hours, calls to Member Services may be answered by the Nurse Advice Line, or you will have the option to leave a voicemail.

In case of a medical emergency, call **911**.

You can call Member Services to get help when you have a question. You may call us to choose or change your PCP, to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report the birth of a new baby, or to ask about any change that might affect you or your family's benefit.

If you are pregnant or become pregnant, your child will become part of Oklahoma Complete Health on the day your child is born. If you become pregnant, call your plan to choose a doctor for both you and your baby before your baby is born.

If English is not your first language (or if you are reading this on behalf of someone who does not read English), we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk with you in your own language. We have a group of people who can help. Members can get these services for free. To ask for aids or services, call Member Services at **1-833-752-1664** (TTY: **711**).

Other Ways We Can Help

- If you have basic questions or concerns about your health, you can call our Nurse Advice Line at **1-833-752-1664** (TTY: **711**) at any time, 24 hours a day, 7 days a week. You can get advice on when to go to your PCP or ask questions about symptoms or medications.
- If you are experiencing emotional or mental distress, call the Oklahoma Mental Health Lifeline at **988** at any time, 24 hours a day, 7 days a week, to speak with someone who will listen and help. We are here to

help you with problems like stress, depression or anxiety. We can connect you to the support you need to feel better. **If you are in danger or need immediate medical attention, call 911.**

For people with disabilities: If you use a wheelchair or have trouble hearing or understanding, call us if you need extra help. If you are reading this on behalf of someone who is blind, deaf-blind, or has difficulty seeing, we can also help. We can tell you if a doctor's office is wheelchair accessible or is equipped with special communications devices. Also, we have services like:

- TTY machine. Our TTY phone number is TTY: **711**.
- Information in large print.
- Help in making or getting to appointments.
- Names and addresses of providers who specialize in your condition.

Auxiliary Aids and Services

If you have a hearing, vision, or speech impairment, you have the right to receive information about your health plan, care and services in a format that you can understand and access. Oklahoma Complete Health provides free aids and services to help people communicate effectively with us, like:

- A TTY machine. Our TTY phone number is TTY: **711**.
- Qualified American Sign Language interpreters.
- Closed captioning.
- Written information in other formats (like large print, audio, accessible electronic format, and other formats).

These services are available to members for free. To ask for aids or services, call Member Services at **1-833-752-1664** (TTY: **711**).

Oklahoma Complete Health complies with federal civil rights laws and does not leave out or treat people differently because of race, color, national origin, age, sex, sexual orientation, gender identity or disability. Oklahoma Complete Health will not discriminate against anyone on the basis of frequent or high-cost care, health status, or need for health care services or due to an adverse change in enrollment, disenrollment, or re-enrollment with Oklahoma Complete Health. If you believe that Oklahoma Complete Health failed to provide these services, you can file a grievance or appeal. To file a grievance or appeal, or to learn more, call Member Services at **1-833-752-1664** (TTY: **711**). You may also file a complaint about your plan with the Oklahoma Insurance Department.

How You Become a Member of the SoonerSelect Program

As an American Indian/Alaskan Native (AI/AN) individual, you may disenroll from the SoonerSelect program for any reason. As an AI/AN individual, if you choose not to enroll or later decide to disenroll from the SoonerSelect program, you will be able to opt in again during the next open enrollment period. Open enrollment periods happen about every 12 months.

All other individuals who are determined eligible for SoonerCare and the SoonerSelect program will be enrolled in the SoonerSelect program by SoonerCare. You may not disenroll from the SoonerSelect program, but you may change health plans as discussed below.

How You Become a Member of Oklahoma Complete Health

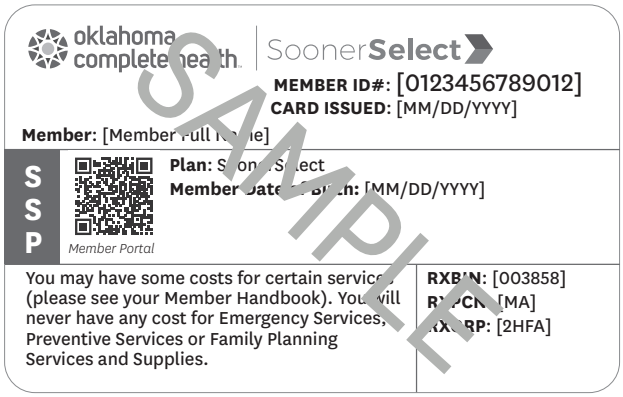
As an AI/AN individual, if you choose to opt in to the SoonerSelect program, you will have the option to choose your health plan when first enrolled and during open enrollment periods. If you opt in to the SoonerSelect program and don't choose a health plan, SoonerCare will assign one to you. You can disenroll from your assigned health plan and choose a different health plan any time within the first 90 days after your health plan benefits begin. You can also change plans during the yearly open enrollment period.

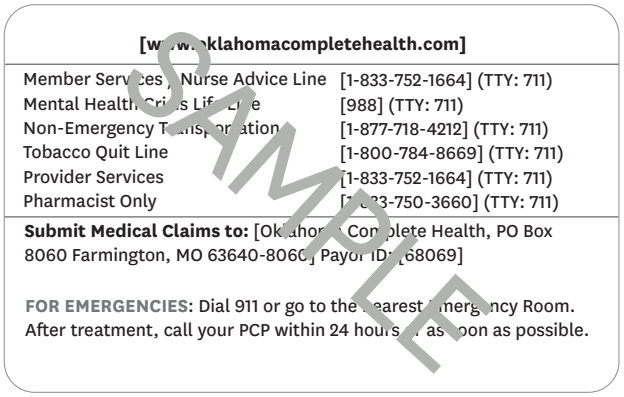
All other individuals who are enrolled in the SoonerSelect program will have the option to choose a health plan when first enrolled and during the yearly open enrollment periods. If you don't choose a health plan, SoonerCare will assign one to you. You can disenroll from your assigned health plan and choose a different health plan any time within the first 90 days after your health plan benefits begin or during an open enrollment period.

Your Health Plan ID Card

Your Oklahoma Complete Health ID card is mailed to you within 7 days after you enroll in your health plan. We use the mailing address on file at Oklahoma Health Care Authority. It will have your Medicaid identification number and information on how you can contact us if you have any questions. Your ID card will have Oklahoma Complete Health's claims information for providers to use. If anything is wrong on your Oklahoma Complete Health ID card, call us right away. If you lose your card, we can help; call Member Services at **1-833-752-1664** (TTY: **711**). Carry your ID card always and show it each time you go for care.

Members or their caretakers can make a secure account on our member portal by visiting **Member.OklahomaCompleteHealth.com**. Once you make an account, you can print an ID card.





PART I: FIRST THINGS YOU SHOULD KNOW

How to Choose Your PCP

Your primary care provider (PCP) is a doctor, nurse practitioner, physician assistant, or another type of provider who will care for your health, coordinate your needs, and help you get referrals for specialized services if you need them. There are lots of types of health care providers. Yours may be a general practitioner or family medicine, internal medicine, pediatrics or Indian Health Care Provider. When you enroll in Oklahoma Complete Health, you will have an opportunity to choose your own PCP. To choose your PCP, call Member Services at **1-833-752-1664** (TTY: **711**). If you do not select a PCP, we will choose one for you. If we choose a provider for you, we will try to choose a provider you have seen before. Any provider we choose for you will be close to your home. (See "How to Change Your PCP" to learn how you can change your PCP.)

When deciding on a PCP, you may want to find a PCP who:

- You have seen before;
- Understands your health needs;
- Is taking new patients;
- Can serve you in your language; and
- Is easy to get to.

Each family member enrolled in Oklahoma Complete Health can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children from birth through 18. Family practice doctors treat the whole family. Internal medicine doctors treat adults ages 19 and older. Call Member Services at **1-833-752-1664** (TTY: **711**) to get help with choosing a PCP who is right for you and your family.

You can find the list of all the doctors, clinics, hospitals, labs, and others who partner with Oklahoma Complete Health in our provider directory. You can visit our website at **OklahomaCompleteHealth.com** to look at the provider directory online. To view the provider directory online, choose "SoonerSelect," then click "Member Resources" and click "Member Handbook and Forms."

You can also use the "Find a Provider" tool at **findaprovider.OklahomaCompleteHealth.com**. Type in either your address, city, county, or ZIP code, then click "Select your plan." Choose "SoonerSelect" from the dropdown menu and press "Continue." Click the tile that says, "Medical Professionals," then choose "Primary Care" or "Medical Specialist."

You can also call Member Services at **1-833-752-1664** (TTY: **711**) to get a copy of the provider directory.

Women can choose an OB/GYN to serve as their PCP but do not have to. Women do not need a PCP referral to see an OB/GYN doctor or another provider who offers women's health care services.

Women can get routine check-ups, follow-up care if needed, and regular care during pregnancy.

If you have a complex health condition or a special health care need, you may be able to choose a specialist to act as your PCP. To pick a specialist as your PCP, call Member Services at **1-833-752-1664** (TTY: **711**).

If your provider leaves Oklahoma Complete Health, we will tell you within 15 calendar days from when we know about this. If the provider who leaves Oklahoma Complete Health is your PCP, we will contact you to help you choose another PCP. If you are currently getting treatment for a serious or chronic medical condition, you can keep getting that treatment until it is finished or for up to 90 calendar days, whichever is less. If you are pregnant and in your second or third trimester, you may continue to get care through the postpartum period, which lasts for about six weeks after childbirth. To choose a new PCP, visit our member portal at **Member.OklahomaCompleteHealth.com**.

If you are an American Indian/Alaskan Native, you may choose an Indian Health Care Provider as your PCP, but you do not have to.

You can choose any PCP in our network. Your PCP can be a:

- Family general practitioner.
- Internist.
- Obstetrician / gynecologist (OB/GYN).
- Specialist who performs PCP functions.
- Nurse practitioner.

How to Change Your PCP

When you enroll in Oklahoma Complete Health, you can select a primary care provider (PCP) from our network after your benefits with Oklahoma Complete Health begin. If you do not pick a PCP, we will choose one for you. Whether you choose a PCP for yourself or Oklahoma Complete Health chooses a PCP for you, you can change your PCP within the first month and that change will become effective the next business day. After that, you can change your PCP any time and the change will become effective the next business day. You do not have to give us a reason for the change. If you would like to change your PCP, you can do so by calling Member Services at **1-833-752-1664** (TTY: **711**). You can also change your PCP by visiting our secure member portal at **Member.OklahomaCompleteHealth.com**.

How to Get Regular Health Care

Regular health care means exams, regular check-ups, shots, or other treatments to keep you well, advice when you need it, and referrals to the hospital or specialists when you need them. It means you and your primary care provider (PCP) work together to keep you well or to see that you get the care you need.

Day or night, your PCP is only a phone call away. Be sure to call your PCP if you have a medical question or concern. If you call after hours or on weekends, leave a message and information on how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how your health plan works.

Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If you cannot keep an appointment, it is important to call to let your PCP know as soon as you know.

Making your first regular health care appointment. As soon as you choose or are assigned a PCP, call to make a first appointment. There are several things you can do to help your PCP get to know you and your health care needs. Your PCP will need to know as much about your medical history as possible. Make a list of your medical history, any problems you have now, and the questions you want to ask your PCP. Bring any medications and supplements that you are taking with you to the visit. In most cases, your first visit should be within 3 months of you joining the Oklahoma Complete Health.

If you need care before your first appointment, call your PCP's office to explain your concern. Your PCP will give you an earlier appointment. You should still keep the first appointment to talk about your medical history and ask questions.

If you need care before you choose or are assigned a PCP, call Member Services at **1-833-752-1664** (TTY: **711**) for help.

It is important to Oklahoma Complete Health that you can visit a doctor within a reasonable amount of time, depending on what the appointment is for. When you call for an appointment, use the appointment guide below to know how long you can expect to wait to be seen.

APPOINTMENT GUIDE	
IF YOU CALL FOR THIS TYPE OF SERVICE:	**YOUR APPOINTMENT SHOULD TAKE PLACE:**
PCP (services like routine health check-ups or immunizations)	Within 30 days from date of request for a routine appointment Within 72 hours for non-urgent sick visits Within 24 hours for urgent care
OB/GYN	Within 30 days from date of request for routine appointment
OB/GYN	Maternity care: First trimester — Within 14 calendar days Second trimester — Within 7 calendar days Third trimester — Within 3 business days
Specialty	Within 60 days from date of request for routine appointment Within 24 hours for urgent care
Mental Health	
Mental health	Within 30 days from date of request for routine appointment Within 7 days of residential care and of hospitalization Within 24 hours for urgent care For mental health emergencies, please call the Oklahoma Mental Health Lifeline at **988**
Substance Use Disorders	
Substance use	Within 30 days from date of request for routine appointment Within 7 days of residential care and of hospitalization Within 24 hours for urgent care

If you are having trouble getting the care you need within the time limits describe above, call Member Services at **1-833-752-1664** (TTY: **711**).

How to Get Specialty Care — Referrals

If you need specialized care that your primary care provider (PCP) cannot give, you can see a specialist who can. A specialist is a doctor who is trained and practices in a specific area of medicine (like a cardiologist or a surgeon).

You do not need a referral to get an exam from an in-network specialist. We will pay for your care. However, you should talk to your PCP about your healthcare needs before you see a specialist. Your PCP can help you find the right kind of provider. There are also some treatments and services that your PCP must ask Oklahoma Complete Health to approve before you can get them. Your PCP will be able to tell you what they are. Call Member Services at **1-833-752-1664** (TTY: **711**) if you have questions about whether you need a referral for a certain service.

Talk with your PCP or call Member Services at **1-833-752-1664** (TTY: **711**) to be sure you know how referrals work. If you think a specialist does not meet your needs, talk with your PCP. Your PCP can help you if you need to see a different specialist.

If you have trouble getting a referral you think you need, contact Member Services at **1-833-752-1664** (TTY: **711**).

If Oklahoma Complete Health does not have a specialist in our provider network who can give you the care you need, we will refer you to a specialist outside our plan. This is called an out-of-network referral. Your PCP or another network provider must ask Oklahoma Complete Health for approval before you can get an out-of-network referral.

When Oklahoma Complete Health gets a request for services by an out-of-network provider, we will consider your unique healthcare needs. Decisions for most non-urgent prior authorization requests are made within 72 hours. However, we can ask for up to 14 more calendar days to decide. Decisions for urgent prior authorizations will be made within 24 hours. For information about your request, please call Member Services at **1-833-752-1664** (TTY: **711**).

It is important you get a referral before seeing an out-of-network provider. If you do not, there may be a delay in services and you may be responsible for paying for the services out of pocket.

Sometimes we may not approve an out-of-network referral because we have a provider in Oklahoma Complete Health's network who can treat you. If you do not agree with our decision, you can appeal our decision. See page 51 to find out how.

Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you can get from an Oklahoma Complete Health provider. If you do not agree with our decision, you can appeal our decision. See page 51 to find out how.

If you have a complex health condition or a special health care need, you may be able to choose a specialist to act as your PCP. Member Services is ready to help you find a specialist to manage your specific needs. For help choosing a specialist as your PCP, please call Member Services at **1-833-752-1664** (TTY: **711**).

Out-of-Network Providers

A participating provider is a physician or other provider who is contracted with or employed by Oklahoma Complete Health to deliver services under the SoonerSelect program. A non-participating provider is a physician or other provider who has not contracted with or is not employed by Oklahoma Complete Health to deliver services under the SoonerSelect program. If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan, or an out-of-network provider. For help and more information about getting services from an out-of-network provider, talk to your primary care provider or call Member Services at **1-833-752-1664** (TTY: **711**).

You can receive family planning services (birth control) from a doctor that is not an Oklahoma Complete Health doctor. You do not have to get a referral from your PCP, but you must visit an Oklahoma Medicaid provider. If you are AI/AN, you may receive services from any Indian Healthcare Provider (IHCP), even if the IHCP is out of network.

Get These Services from Oklahoma Complete Health Without a Referral

You do not need a referral to get these services:

- Primary care;
- An exam or consult with a specialist;
- Behavioral health services;
- Substance use disorder treatment;
- Vision services;
- Emergency services;
- Well-child checkups/EPSDT;
- Family planning services and supplies;
- Prenatal care;
- Department of health providers, including mobile clinics; and
- Services provided by IHCPs to AI/AN health plan members.

Emergencies

If you believe you have an emergency, call **911** or go to the nearest emergency room. If you believe you have a mental health emergency, call **988**.

You do not need approval from your plan or your primary care provider (PCP) before getting emergency care, and you are not required to use our hospitals or doctors.

If you're not sure, call your PCP at any time, day or night. Your PCP is your main provider. If your condition is not life threatening or urgent, call your PCP first.

Tell the person you speak with what is happening. Your PCP's team will:

- Tell you what to do at home;
- Tell you to come to the PCP's office; or
- Tell you to go to the nearest urgent care clinic or emergency room.

If you are out of the area when you have an emergency, go to the nearest emergency room.

Remember: Use the emergency room only if you have an emergency. If you have questions, call your PCP or Oklahoma Complete Health Member Services at **1-833-752-1664** (TTY: **711**).

You are always covered for emergencies. An emergency medical condition is a situation in which your life could be threatened, or you could be hurt permanently, if you don't get care right away. Some examples of an emergency are:

- A heart attack or severe chest pain;
- Bleeding that won't stop;
- A bad burn;
- Broken bones;
- Trouble breathing, convulsions or loss of consciousness;
- When you feel you might hurt yourself or others;
- If you are pregnant and have signs like pain, bleeding, fever or vomiting; or
- Drug overdose.

Some examples of non-emergencies are colds, upset stomach or minor cuts and bruises. Non-emergencies may also be family issues or a break-up. These may feel like an emergency, but they are not a reason to go to the emergency room, unless you are in immediate danger of harm.

Urgent Care

You may have an injury or an illness that is not an emergency but still needs prompt care and attention. This could be:

- A child with an earache who wakes up in the middle of the night and won't stop crying;
- Flu symptoms;
- If you need stitches;
- A sprained ankle; or
- A bad splinter you cannot remove.

You can walk into an urgent care clinic to get care the same day or make an appointment for the next day. Whether you are at home or away, call your primary care provider any time, day or night. If you cannot

reach your PCP, call Member Services at **1-833-752-1664** (TTY: **711**). Tell the person who answers what is happening. They will tell you what to do

Care Outside Oklahoma

In some cases, Oklahoma Complete Health may pay for health care services you get from a provider located just beyond the Oklahoma border or in another state. Your PCP and Oklahoma Complete Health can give you more information about which providers and services are covered outside of Oklahoma by your health plan, and how you can get them if needed. If you need medically necessary emergency care while traveling anywhere within the United States and its territories, Oklahoma Complete Health will pay for your care. If you cannot get the care you need in Oklahoma, our plan will make sure you get these services from out-of-state providers. Oklahoma Complete Health will make such referrals as needed.

Your health plan will not pay for care received outside of the United States and its territories.

If you have any questions about getting care outside of Oklahoma or the United States, talk with your PCP or call Member Services at **1-833-752-1664** (TTY: **711**).

PART II: YOUR BENEFITS

The rest of this handbook is for your information when you need it. It lists covered and non-covered services. If you are having problems with your health plan, the handbook tells you what to do. The handbook has other information you may find useful. Keep it handy for when you need it.

How You Know if You are an Expansion Adult or a Non-Expansion Adult

Non-expansion adults are individuals who qualify for Oklahoma's Medicaid program and meet eligibility requirements such as those who are eligible for Medicare; pregnant women; or needy caretakers of dependents under age 19 who meet the income requirements listed at **https://oklahoma.gov/ohca/individuals/mysoonercare/apply-for-soonercare-online/eligibility/income-guidelines.html**.

Expansion adults are individuals who meet income requirements; are ages 19 to 64; and determined eligible for Medicaid, but do not meet requirements for aged, blind or disabled; breast and cervical cancer; or Medicare. Eligible income means someone earns at or below 138% of the federal poverty level. See the income guidelines at **https://oklahoma.gov/ohca/individuals/mysoonercare/apply-for-soonercare-online/eligibility/income-guidelines.html**.

Benefits

SoonerSelect provides benefits or health care services covered by your plan.

Oklahoma Complete Health will provide or arrange for most health services that you will need. Your health benefits can help you stay as healthy as possible if you:

- Are pregnant;
- Are sick or injured;
- Experience a substance use disorder or have other behavioral health care needs;
- Need help getting to the doctor's office; or
- Need medications.

The section below describes the specific services covered by Oklahoma Complete Health. Ask your primary care provider (PCP) or call Member Services at **1-833-752-1664** (TTY: **711**) if you have any questions about your benefits.

You can get some services without going through your PCP. These include primary care, emergency care, women's health services, family planning services, children's screening services, services provided at local health departments, school-based services, and some behavioral health services. You can find more information about these services on page 11.

You will receive all SoonerSelect dental benefits from a separate Dental Plan that you choose. Your choices are DentaQuest and LIBERTY Dental. Oklahoma Complete Health SoonerSelect Program will provide transportation to your dental appointments. See page 30 for more information on how to schedule transportation.

Services Covered by Oklahoma Complete Health's Network

In most situations, you must get the services below from the providers who are in Oklahoma Complete Health's network. Services must be medically necessary and provided, coordinated, or referred by your PCP. Talk with your PCP or call Member Services at **1-833-752-1664** (TTY: **711**) if you have any questions or need help with any health services.

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Advanced Practice Registered Nurse (APRN)	**Covered.**	**Covered: Four (4) outpatient visits per month.**	**Limit can be exceeded based on medical necessity.**
Allergy testing	**Covered.**	**Covered.** **Limited to 60 tests every three years.** **Some services may require prior authorization.** **Limit can be exceeded based on medical necessity.**	
Alternative treatment for pain management	**Covered.**	**Physical therapy when provided in a non-hospital-based setting:** a. Initial evaluation covered without prior authorization (PA). b. 12 hours per year requires PA. **Chiropractic services:** a. Initial evaluation covered without (PA). b. 12 visits per year requires PA. **Members ages 21 and over,** **PA limits can be exceeded based on medical necessity.**	
Ambulance or emergency transportation	**Covered.**		
Ambulatory surgical center	**Covered.**		

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Bariatric surgery	Covered, upon meeting pre-surgical evaluation and weight-loss requirements. Prior authorization required.	Covered, upon meeting pre-surgical evaluation and weight-loss requirements. Not covered for treatment of obesity alone. Prior authorization (PA) required.	
Certified registered nurse anesthetist and anesthesiologist assistants	Covered.		
Chemotherapy	Covered.		
Clinic services	Covered. Some services may require prior authorization (PA).		
Diabetes education	Covered, 10 hours per first year; 2 hours per subsequent year. Limits can be exceeded based on medical necessity and under EPSDT.	Covered, 10 hours per first year; 2 hours per subsequent year.	Covered, 10 hours per first year; 2 hours per subsequent year. Limit can be exceeded based on medical necessity.
Diagnostic testing entities	Covered. Some services may require prior authorization.		
Donor human breast milk	Covered during the first year of life. Prior authorization required.	Not covered.	
Durable medical equipment supplies and appliances	Covered. Requires prescription by a medical provider. Some services may require prior authorization (PA).		

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and early intervention services, including health and immunization history; physical exams; various health assessments and counseling; lab and screening tests; necessary follow-up care; and applied behavioral analysis (ABA) services	Covered. Some services may require prior authorization.	Not covered.	
Emergency room/ department	Covered.		
Eye care to treat a medical or surgical condition	Covered.		
Family planning services	Covered.		
Federally Qualified Health Center and Rural Health Clinic services	Covered.		
Genetic counseling and testing	Covered for pregnant members and members meeting medical necessity criteria. May require prior authorization (PA).		
Hearing services	Covered. May require prior authorization.	Not covered.	

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Home health care services	**Covered.**		
Hospice (non-hospital based)	**Covered for members with a life expectancy of 6 months or less.**	**Not covered.**	**Covered for members with a life expectancy of 6 months or less.**
Immunizations	**Covered.**		
Infusion therapy	**Covered.**	**Covered when medically necessary and not considered a compensable part of the procedure.**	
Inpatient hospital services	**Covered.**	**Covered:** a. Inpatient hospital services (inpatient stay): no limit. b. Inpatient physician services: covered. c. Inpatient surgical services: no limit. d. Inpatient rehabilitation hospital services: 90 days per individual per state fiscal year (SFY).	**Covered:** a. Inpatient hospital services (inpatient stay): no limit. b. Inpatient physician services: covered. c. Inpatient surgical services: no limit. d. Inpatient rehabilitation hospital services: 90 days per individual per SFY. Amount limits can be exceeded based on medical necessity.
Laboratory, X-ray, diagnostic imaging and imaging (CT/PET Scans and MRIs)	**Covered.** **Some services may require a prior authorization (PA).**		
Lactation consultant (help with breastfeeding)	**Covered for pregnant and postpartum members.**		

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Lodging and meals for the health plan member and/or one approved medical escort	Covered. Services require prior authorization.		
Long-term care hospital for children	Covered.	Not covered.	
Mammograms	Covered.		
Maternal and infant licensed clinical social worker (LCSW) services	Covered for pregnant and postpartum members.		
Non-emergency medical transportation	Covered.		
Nurse midwives	Covered under EPSDT.	Covered.	
Nursing facility and ICF-IID services	Covered for up to 60 days pending the level-of-care determination.		
Nutrition services (dietician)	Covered (includes dietician and nutritional counseling.)	Covered up to 6 hours per year Nutritional services for treatment of obesity are not covered. Services must be for diagnosing, treating or preventing, or minimizing effects of illness.	Covered up to 6 hours per year. Nutritional services for treatment of obesity are not covered. Services must be for diagnosing, treating or preventing, or minimizing effects of illness. Limits can be exceeded based on medical necessity.

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Orthotics	Covered.	Not covered.	Covered without limitations when medically necessary.
Outpatient hospital and surgery services	Covered.		
Parenteral/enteral nutrition (IV and tube-feeding)	Covered. Some services may require prior authorization (PA).		
Personal care	Covered.		
Physician and physician assistant services	Covered.	Covered. Limit 4 visits per month (hard limit).	Covered. Limit 4 visits per month. Limits can be exceeded based on medical necessity.
Podiatry	Covered.	Covered. All outpatient visits are subject to the 4-visit per month limit.	
Post-stabilization care services	Covered.		
Pregnancy and maternity services, including prenatal, delivery and postpartum	Covered.		
Preventive care and screening	Refer to EPSDT coverage.	Covered for outpatient hospital services, other laboratory and X-ray services, diagnosis and treatment of conditions found, clinic services, screening services and rehabilitative services. There is not a standalone preventive services benefit package for adults providing coverage for all services.	

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Private duty nursing	Covered up to 16 hours per day. Additional hours available for 30 days following a stay in the hospital or when regular caregiver is not available.	Not covered.	This service is substituted with skilled nursing under the home health services benefit.
Prosthetic devices	Covered when prior authorized.	Limited coverage with required prior authorization (PA); only breast prosthesis and support accessories and prosthetic devices are covered when part of surgery.	Covered without limitations when medically necessary.
Public health clinic services	Covered.	Covered: 4 visits per month.	Covered: 4 visits per month. Limit can be exceeded based on medical necessity.
Radiation	Covered.		
Reconstructive surgery	Covered. May require prior authorization.	Covered. Non-cosmetic breast reconstruction / implantation / removal is covered only when it is a direct result of a mastectomy which is medically necessary. May require prior authorization (PA).	
Renal dialysis facility services	Covered.		
Routine patient cost in qualifying clinical trials	Covered to the extent that the provision of the service would otherwise be covered outside of the participation in the clinical trial.		
School-based health related services	Covered.	Not covered.	

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Telehealth	**Covered.**		
Therapy services: physical therapy (PT), occupational therapy (OT), and speech therapy (ST)	**OT and PT:** a. Initial evaluation covered without prior authorization (PA). b. Treatment requires prior authorization (PA). **ST:** a. Evaluation and treatment require prior authorization (PA).	**Rehabilitative services:** a. 15 visits per year for each OT, PT and ST (cumulative total 45 visits).	**Habilitative services:** a. 15 visits per year for each OT, PT and ST (cumulative total: 45 visits). **Rehabilitative services:** a. 15 visits per year for each OT, PT and ST (cumulative total 45 visits).
Organ transplant services	**Covered when prior authorized (PA). (Cornea and kidney transplants do not require PA.)**		
Urgent care centers or facilities	**Covered.**	**Up to 4 outpatient visits per month.**	**Up to 4 outpatient visits per month.** **Limit can be exceeded based on medical necessity.**
Vision services	**Covered, with a limit of 2 eyeglass frames per year.**	**Coverage to treat a medical or surgical condition only. No coverage for routine eye exams.**	

Pharmacy

Service	Children (under 21)	Non-Expansion Adults	Expansion Adults
Prescription drugs	**Covered.** **Some medications are excluded and some may require prior authorization (PA).** **No monthly prescription limit for children.**	**Covered.** **6 prescriptions per month (includes specialty drugs, some exclusions apply).** **2 of 6 prescriptions can be brand name per month (a prior authorization can be requested for a third, brand name medication on the state's brand required list. If the PA is approved, the 3rd drug is exempt from the 2 brand name limit.)** **Formulary is posted on our website.** **Some may require prior authorization (PA).**	
Medication-assisted treatment services	Includes: · Drugs/agents used for substance use disorder treatment. · Opioid treatment programs (OTPs). · OTP services require prior authorization (PA).		
Tobacco cessation products (to help you quit using tobacco)	**Nicotine replacement therapy (NRT) products (including patches, gum, lozenges and nasal spray) and Zyban®/Bupropion to include combination therapy of these products are covered.** **Chantix®/Varenicline is covered up to 180 days per 12 months. Tobacco cessation products are covered without duration limits, PA or co-payment and do not count against monthly prescription limits.** **8 tobacco cessation counseling sessions with contracted providers per year.**		
Diabetic supplies (insulin, syringes, test strips, lancets and pen needles)	**Covered.**		
Family planning supplies	**Covered.**		

What pharmacy benefits are covered?

Oklahoma Complete Health covers most prescription medications when prescribed by an Oklahoma Complete Health provider. The pharmacy program does not cover all drugs. Some medications need prior authorization (PA). Some may have limits based on age, dosage, or the amount of medicine prescribed.

Oklahoma Complete Health also covers certain over-the-counter (OTC) medications with a prescription from an Oklahoma Complete Health provider.

Which drugs are covered?

The Oklahoma Complete Health *formulary*, or preferred drug list (PDL), is a list of brand-name and generic drugs that are approved by the Food and Drug Administration (FDA) and covered through your prescription drug benefit. The PDL can be found on the Oklahoma Complete Health website at **OklahomaCompleteHealth.com**. To view the PDL online choose "SoonerSelect," then click "Member Resources" and click "Member Handbook and Forms" to view your Preferred Drug List and other important materials.

The PDL has all drugs you can get with and without prior authorization (PA), as well as any limits based on age, dosage, or the amount of medicine prescribed. The PDL applies to drugs you get at retail pharmacies.

The PDL is developed and continuously reviewed by the state of Oklahoma and the Oklahoma Complete Health Pharmacy and Therapeutics (P&T) Committee. The committee is made up of the Oklahoma Complete Health medical director, pharmacy director, and several primary care physicians, pharmacists, and specialists.

Not all dosage, forms, or strengths of a drug may be covered. The PDL is periodically reviewed and updated weekly. Annual updates and major changes are sent to providers and members by direct mail (e.g. fax, email, mail), as needed.

You can also get a printed copy of the PDL for free by calling Member Services at **1-833-752-1664** (TTY: **711**).

What about specialty drugs?

A specialty drug is a prescription drug that needs special handling, administration, or monitoring. These are usually ordered through a specialty pharmacy.

How do I get medications?

You can have your prescriptions filled at an Oklahoma Complete Health network pharmacy. At the pharmacy, you will need to give the pharmacist your Oklahoma Complete Health ID card and your prescription from an Oklahoma Complete Health prescriber. If you need help finding a pharmacy near you, call us at **1-833-752-1664** (TTY: **711**).

You can also use the "Find a Provider" tool at **findaprovider.oklahomacompletehealth.com**. Type in your address, city, county, or ZIP code, then click "Select your plan." Choose "SoonerSelect" from the dropdown menu and press "Continue." Click the tile that says, "Pharmacy & Medical Supplies," then click "Pharmacy." If you like, you can choose a specialty from the dropdown menu or just press "Search." Only those pharmacies in the Oklahoma Complete Health network are listed.

Can I get more than a 30-day supply?

As a general rule, Oklahoma Complete Health members get a 30-day supply of their medications. However, members can get a 90-day supply of many *maintenance medications* (or medications you take each day). You can find a list of maintenance medications for which you can get a 90-day supply. OHCA maintains the 90 day supply list and can be found at **oklahoma.gov/ohca/providers/types/pharmacy/pharmacy.html**. Scroll down and select "Maintenance Drug List." The list is frequently updated.

Over the Counter (OTC) Medications

Members can get up to $30 per quarter for:

- Cold and cough medications.
- Allergy medications.
- Vitamins and supplements.
- Eyedrops and eardrops.
- Pain relievers.
- Gastrointestinal products.
- First aid care.
- Hygiene products.
- Insect spray.
- Oral care products.
- Skin care products.

Members can view the full OTC catalog on our website at **OklahomaCompleteHealth.com**. To view the catalog, Choose "SoonerSelect" from the dropdown menu and press "Benefits and Services," then click "Pharmacy." The scroll down to view the Over-the Counter Product catalog. You can place an order online at **cvs.com/benefits**, by phone at **1-888-628-2770** (TTY: **711**), or at any CVS Pharmacy.

Generic Substitution

Generic drugs are drugs that are not sold under a company's brand name. However, generic drugs have the same active ingredients as brand-name drugs. *Active ingredients* are the parts of the drug that directly affect you. The FDA requires generic drugs to be safe and to work the same as brand-name drugs.

Your provider should consider a generic drug before giving you a brand-name drug. That's because the generic version is usually less expensive, even though the drug works the same way.

In some cases, a brand-name drug may be preferred over a generic drug. If there is no generic available, there may be more than one brand-name drug to treat a condition.

Step Therapy

Some drugs listed on the Oklahoma Complete Health preferred drug list (PDL) may require that you try other medications first. This is called *step therapy*. If Oklahoma Complete Health has a record that you tried other medication(s) first, then your step therapy drug will be approved. If Oklahoma Complete Health does not have a record that you tried other medication(s) first, then you or your provider will need to tell us why you need the step therapy drug instead of trying other medications first. You or your provider can find the Step Therapy Exception Request Form on our website at **oklahomacompletehealth.com/providers/pharmacy.html**. The form is under the "Prior Authorization – Pharmacy Benefit/Retail Pharmacy" dropdown menu. If we do not approve the step therapy drug, we will tell you and your provider. We will also tell you how to file an appeal if you do not agree with our decision.

Dispensing Limits, Quantity Limits, and Age Limits

A 34-day supply is the maximum amount given for each new or refilled non-controlled substance. Exceptions are made for some maintenance medications, which let you have up to a 90-day supply. A total of 90 percent of the days supplied must have passed before the prescription can be refilled. Dispensing outside the quantity limit or age limit needs prior authorization (PA).

Oklahoma Complete Health may limit how much of a medication you can get at one time. If the physician / clinician feels that you have a medical reason for getting a larger amount, they can ask for prior authorization (PA). If Oklahoma Complete Health does not grant PA, we will notify you and your physician / clinician. We will also tell you how to file an appeal if you do not agree with our decision.

Some medications on the Oklahoma Complete Health preferred drug list (PDL) have age limits. These are set for certain drugs based on FDA-approved labeling, for safety concerns, and for quality standards of care. The age limit aligns with current FDA alerts for the appropriate use of pharmaceuticals. Prior authorization (PA) can be submitted if your prescriber feels that you have a medical reason for getting the medication outside of the age limits as given in the PDL.

Exception Requests and Medical Necessity Requests

If you need a medication that is not on the PDL, your provider can make a medical necessity request for the medication. Such exceptions are rare, since the PDL has medications to treat many medical conditions.

Talk with your pharmacist or call Member Services at 1-833-752-1664 (TTY: **711**) if you have any questions or need help with your pharmacy services.

Behavioral Health Services (Mental Health and Substance Use Disorder Services)

Behavioral health care includes mental health (your emotional, psychological, and social well-being) and substance use (alcohol and drugs) disorder treatment and rehabilitation services. All members have access to services to help with mental health issues like depression or anxiety, or to help with alcohol or other substance use disorders. These services can include:

- Medication-assisted therapy (MAT);
- Tobacco cessation (to help you quit using tobacco); and
- Behavioral health crisis services.

If you believe you need access to more intensive behavioral health services that your plan does not provide, talk with your PCP or call Member Services **1-833-752-1664** (TTY: **711**).

Service	Children (under 21)	Non-Expansion Adults	Expansion Adults
Applied behavioral analysis	**Covered.** **Requires prior authorization (PA).**	**Not covered.**	
Certified Community Behavioral Health Clinic (CCBHC) Services	**Covered.**		

Service	Children (under 21)	Non-Expansion Adults	Expansion Adults
Day treatment services	Covered when prior authorized for a minimum of 3 hours per day for 4 days per week.	Not covered.	
Inpatient hospital — freestanding psychiatric	Covered.	Ages 21-64: Covered when prior authorized. Maximum of 60 days per episode. Ages 65 and older: Covered when prior authorized.	
Inpatient hospital — general acute	Covered.		
Licensed behavioral health provider (who can bill independently)	Covered. Some services may require prior authorization (PA).	Not covered.	
Medication-assisted treatment services	Covered. Includes: · Suboxone® (buprenorphine/ naloxone SL films) · Vivitrol · Methadone		
Opioid treatment programs	Covered. Some services may require prior authorization (PA).		
Outpatient behavioral health agency services	Covered. Some services may require prior authorization (PA).		
Partial hospitalization	Covered when prior authorized for a minimum of 3 hours per day for 5 days per week. Prior authorization (PA) required.		
Peer recovery support services	Covered for ages 16-21 when prior authorized.	Covered. Prior authorization (PA) required.	

Service	Children (under 21)	Non-Expansion Adults	Expansion Adults
Program for Assertive Community Treatment (PACT) services	Covered for ages 18-21.	Covered.	
Psychiatric residential treatment facility	Covered. Prior authorization (PA) required.	Covered for individuals under 21. Prior authorization (PA) required.	
Psychiatrist	Covered.		
Psychologist (who can bill independently)	Covered. Some services may require prior authorization (PA).		
Substance abuse treatment (outpatient, inpatient, and residential)	Outpatient substance abuse treatment: Covered. Some services may require prior authorization (PA). Residential substance abuse treatment: Covered.		
Targeted case management	Covered for targeted populations when prior authorized.		
Therapeutic behavioral services, family support and training	Covered for children with SED in a systems of care wraparound team.	Not covered.	
Therapeutic foster care	Covered. Prior authorization (PA) required.	Not covered.	

Transportation Services

Important Contact Information		
You can contact	**Where**	**Times**
Transportation services for reservations or help getting a ride	**1-877-718-4212**	**Reservations: Monday through Friday, from 7 a.m. to 8 p.m., Central time.** **Ride Assist: 24 hours.**
Website	**Member information: mymodivcare.com** **Company information: modivcare.com**	**24 hours.**
Oklahoma Complete Health Member Services	**1-833-752-1664 (TTY: 711)**	**Monday through Friday, from 8 a.m. to 5 p.m., Central time.**
To find information about urgent care transportation after hours	**1-877-718-4212**	**24 hours.**
For an emergency	**911 or go to the nearest emergency room**	**24 hours.**

Emergency: If you need emergency transportation (an ambulance), call **911**.

Non-emergency: Oklahoma Complete Health can arrange and pay for your transportation to help you get to and from your appointments for Medicaid-covered care. This service is free to you. If you need an attendant to go with you to your doctor's appointment, or if your child (18 years old or younger) is a member of the plan, the transportation is also covered for the attendant or parent or guardian. Non-emergency transportation includes personal vehicles, taxis, vans, ambulatory vehicles, and public transportation.

How to get non-emergency transportation: Oklahoma Complete Health has a contract with ModivCare to give non-emergency ride services to covered members. This is called the Non-Emergency Medical Transportation Program. You are covered for non-emergency medical transportation. This means we will offer you transportation services, including a ride or mileage reimbursement, to get to your Medicaid-covered appointments. We work with a group of transportation providers to help meet your transportation needs.

Call ModivCare at **1-877-718-4212** to reserve a ride or request mileage reimbursement. Reservations require up to 72 hours before your appointment, excluding weekends and state holidays, to arrange transportation to and from your appointment. After hours, you can get a ride by dialing the same toll-free number used during normal business hours.

Non-emergency medical transportation is covered for medically necessary, covered services. This can include provider visits, *dialysis* (a way to rid your body of waste when your body can't on its own), and counseling visits.

If you need to change or cancel your ride, please call **1-877-718-4212** as soon as you know that you need to change or cancel your pickup time. If your ride does not show at the appointment time, please call transportation services at **1-877-718-4212** to get the location of the driver or to make other arrangements.

Members using non-emergency medical transportation may bring up to four children when childcare is not available*.

**Total number of passengers cannot exceed more than five people.*

What do I need to get a ride?

Please have the following information ready when you call:

- Your name, home address, and phone number.
- Your Medicaid ID number.
- The street address and phone number where you want to be picked up.
- The name, phone number, address, and ZIP code of the provider you are seeing.
- The date and time of your appointment.
- The end time of your appointment, if known.
- Any special needs, including the need for someone to ride with you.
- The general reason for the visit (for example, a PCP appointment, check-up, eye appointment, dentist appointment).

If you don't have this information with you when you call, we may not be able to set up your ride. We will give you a trip number once we have processed your transportation request.

What kind of rides can I get?

After we confirm that you need a ride, we will match you with the type of ride that best meets your needs. Types of rides may include:

- Mass transit and public transportation, like city buses or trains.
- Multi-load passenger vans.
- Medical vehicles, like wheelchair or stretcher vans.
- Private vehicles.
- Taxis.
- Ride share services.

What about standing order (recurring) trip requests?

A *recurring trip* is when you need a ride to appointments on a daily, weekly, or bi-weekly basis for an extended period. You may schedule recurring trips for up to 30 days at a time in most cases. Members may schedule for more than 30 days in advance for the following conditions or services, including but not limited to:

- Dialysis.
- Chemotherapy.
- Radiation treatment.
- Wound care.

For questions about recurring trips, please call transportation services at **1-877-718-4212**.

Members using transportation services must follow the conduct policies of the transportation providers. Any conduct that could harm the driver or other passengers may result in suspension of transportation

services. Depending on the circumstances, not cancelling a trip or cancelling less than 24 hours in advance may result in a no-show. Repeated no-shows may result in suspension from transportation services.

Under certain circumstances, such as overnight stays, very early travel, or late returns, you may be able to get meal or lodging *reimbursement*. This means we will pay you back for any money you spend. To find out more or to request prior authorization for reimbursement, please call transportation services at **1-877-718-4212**.

Transportation services can tell you:

- How to request, schedule, or cancel a trip.
- Any limitations on non-emergency medical transportation services.
- The expected member conduct and procedures for no-shows.
- How to get mileage reimbursement if you use your own car.

When taking a ride to your appointment, you can expect to:

- Arrive at your appointment on time and no sooner than one hour before the appointment.
- Not have to wait more than one hour after the appointment for a ride home.
- Not have to leave the appointment early.

We want you to be satisfied with the care you get from our transportation providers. Let us know right away if you are not happy with our transportation provider services. If you wish to file a complaint, please call **1-877-718-4212**.

If we deny you transportation services, you have the right to appeal our decision. See page 51 for more information on appeals. If you have questions about transportation, call Member Services at **1-833-752-1664** (TTY: **711**).

We also offer enhanced transportation (ride) services for members that include:

- Fifteen (15) roundtrips per member per year to support social determinants of health needs. These may be:
  - Food resources like grocery stores, food pantries, or farmer's markets.
  - WIC.
  - Childcare.
  - Job interviews.
  - Education activities.
  - Support groups.
- One roundtrip per day for parent or guardian to visit a child in the hospital.
- Members using non-emergency medical transportation may be allowed to bring up to four (4) children when childcare is not available.*

***Total number of passengers cannot be more than five people.**

To schedule enhanced transportation rides, please call Member Services at **1-833-752-1664** (TTY: **711**) or speak to your care manager. If you need a ride outside of business hours, please call your transportation specialist.

Other Covered Services

- Post-stabilization care services (provided after you have had an emergency medical condition to keep you safe);
- School-based health related services;
- Public health clinic services;
- Federally Qualified Health Center (FQHC) services; and
- Services provided at your local health department.

Value-Added Services

Oklahoma Complete Health offers value-added services that suit the needs of families and individuals in our service areas. Please see Oklahoma Complete Health's website at **OklahomaCompleteHealth.com** for a list of services. Choose "SoonerSelect" from the left-hand menu, then click "Benefits and Services" on the left side of the screen and "Value Added Services." You can also call Member Services at **1-833-752-1664** (TTY: **711**) for more details.

Benefit	Description	Limits
Boys & Girls Club memberships	**Oklahoma Complete Health gives Boys & Girls Club memberships to members ages 6-18.**	**Ages 6-18. Up to $125 per year.**
Breathe Better at Home	**Oklahoma Complete Health offers asthma self-management through these benefits:** • Home visits by a care manager or community health worker to check the home for things like dust, pests, mold, etc. • In-home asthma education. • Help quitting tobacco. • Grants to help with things like getting special bedding, pest control, carpet cleaning, special cleaners, and air purifiers. • Another nebulizer for member ages 0-18	**Must have an asthma diagnosis. Up to $250 per member per year.**

Benefit	Description	Limits
ConnectionsPlus®	**Through ConnectionsPlus®, Oklahoma Complete Health gives no-cost cell phones and data plans to members who do not have safe, reliable access to telephone or web services. ConnectionsPlus® lets members have access to providers, care managers, telehealth services, and 911.**	**Must be in care management and ineligible for federal phone programs.**
Digital behavioral health (BH) app	**Oklahoma Complete Health offers members access to myStrength® Complete, our digital BH app for health education and coaching. myStrength® has personalized online tools to help members with depression, anxiety, stress, substance use, chronic pain, and sleep problems. Members can use the app through our website any time.** **myStrength® also supports the physical and spiritual aspects of whole-person health. Members ages 18 and older can access two more areas through myStrength® Complete:** • Virtual BH provider visits. • Choose Tomorrow suicide prevention support.	**Ages 13 and older.** **Must be 18 or older to access more benefits.**
Educational support and work skills	**Oklahoma Complete Health offers three benefits to help members improve their grades in school or to get their diploma or GED. Benefits include:** • GED tutoring and testing vouchers for members ages 16 and older without their high school diploma. • In-person or virtual tutoring for qualified members in grades K-12. Members must be at risk of failing one or more core subjects. • Scholarships to attend Rose State College for adult members in care management who wish to get their community health worker (CHW) micro-certification.	**No limitations on GED testing or tutoring.** **K-12 tutoring limited to 24 sessions per year to members in care management living in the following ZIP codes: 73084, 73111, 73117, 73129, 73141, 74106, 74110, 74115, 74126, 74127, 74330, and 74944.** **One scholarship per member.**

Benefit	Description	Limits
Enhanced transportation services	**Oklahoma Complete Health offers these enhanced transportation benefits:** • Fifteen roundtrips per member per year to support social determinants of health needs. These may be: – Food resources like grocery stores, food pantries, or farmer's markets. – Women, Infants, and Children (WIC) services. – Childcare services. – Job interviews. – Education activities. – Support groups. • One roundtrip per day for parents or guardians to visit a child in the hospital. • Members using non-emergency medical transportation can bring up to four children when childcare is not available.* ***Total number of passengers cannot be more than five people.**	
Health, wellness, and health literacy	**Oklahoma Complete Health helps members take charge of their health, learn about their conditions, and engage in healthy behaviors. Our benefits include:** • No-cost access to our online Krames Staywell Health Library, which has more than 4,000 easy-to-read articles. Members can learn about wellness, illnesses, care plans, medications, and other health tips and facts. • Our Healthy Kids Club mails youth members a $10 gift card for a new book, a welcome packet, a Kids Club membership card, and a quarterly newsletter when signed up by a parent or guardian. • Reach Out and Read with a grant for services in Health Empowerment Zones. This program advises families about the importance of reading with their children and shares books that aid in healthy childhood growth.	

Benefit	Description	Limits
Healthy weight	**Oklahoma Complete Health offers WeightWatchers® memberships to members whose body mass index (BMI) is equal to or greater than 30. Members can also join if a provider refers the member to the program as a way to reduce BMI through healthy eating and increased physical activity.**	**Ages 18 and older. Must be in care management and meet BMI requirements or must be referred by a provider.**
Housing insecurity and homelessness	**Oklahoma Complete Health supports members experiencing housing insecurity or homelessness by:** • Partnering with organizations that give shelter for members experiencing homelessness after discharge from an Oklahoma City hospital. • Partnering with Legal Aid Services to offer support to members in care management who need help with education, employment, housing, social service benefits, personal and family safety, or health-related legal matters.	
My Health Pays®	**Oklahoma Complete Health members can earn rewards by completing healthy activities like yearly screenings, tests, and more. Spend rewards at Walmart® or on necessities like rent, utilities, or childcare*. After you complete a healthy activity, we will add funds directly to your My Health Pays Visa® prepaid card.** ***Rewards cannot be used to buy alcohol, tobacco, or firearm products.**	
Nutrition support and food security	**Oklahoma Complete Health offers these benefits:** • Up to $100 per year in Food Rx healthy food vouchers for members who screen positive for food insecurity. • Fourteen specialty home-delivered meals for qualified members upon hospital discharge, including those with high-risk pregnancies. • For members who need more nutritional counseling for chronic conditions, we will expand the state's nutritional counseling benefit by four more hours per year.	**Must be in care management.** **$100 dollars per year (365 days from issue date).**

Benefit	Description	Limits
Over-the-counter (OTC) products	Oklahoma Complete Health gives all members an OTC benefit. Funds can be used on items like cold, cough, or allergy medicines, vitamins, supplements, eye/ear preparations, pain relievers, gastrointestinal products, first aid care, hygiene products, insect repellant, oral hygiene products, and skin care. Members can view the full OTC catalog on our website. Order online (**cvs.com/benefits**), by phone (**1-888-628-2770**, TTY: **711**), or at any CVS Pharmacy.	Limited to $30 per quarter.
Prescription limit expansion	Important medicines will not count toward members' six prescription monthly limit. These include most medicines that treat infections, seizures, mental health, heart health, and diabetes.	
Pyx Health (Pyx)	Pyx is a mobile app that reduces social isolation. It provides companionship and resources to adult members who screen positive for social isolation or who have a health condition that would benefit from daily contact with Pyx. Members get phone calls from the Pyx Compassionate Call Center and have daily interaction with Pyx, a friendly 24/7 chatbot that provides an interactive and supportive experience.	Limited to adults in care management.
Ready for My Recovery	Our Ready for My Recovery benefit helps members on their recovery journey. It gives a $30 My Health Pays® reward for every six months of active participation in recovery treatment, as well as a recovery backpack that includes a water bottle, self-care kit, journal, pen, and BH information and resources.	One backpack per member.
Remote patient monitoring for high-risk pregnancies	Our Remote patient monitoring program combines telehealth with cellular technology and real-time readings for blood pressure, blood sugar, and fetal health. It also gives virtual access to medical professionals during and after pregnancy. Call your Oklahoma Complete Health care manager to learn more about this service.	Must be pregnant, have a diagnosis of high blood pressure, and have or be at risk of having preeclampsia. Needs approval from your provider.

Benefit	Description	Limits
Respite care	**Oklahoma Complete Health gives up to 48 more hours per year of respite services for members with respite services or private duty nursing who have used all covered and community-based respite services. This helps reduce caregiver burnout and allows time to attend foster care training or personal appointments.**	**Needs care manager approval.**
Sports and camp physicals	**Oklahoma Complete Health covers sports or camp physicals for youth members. The physical exam checks:** • Height, weight, and blood pressure. • Vision. • The heart and lungs. • Joints and motion.	**Members ages 5-18.**
Start Smart for Your Baby® extra benefits	**In addition to our evidence-based Start Smart for Your Baby® program, members get several more benefits, like:** • $30 per month diaper club for members ages 0-1. • A hospital-grade breast pump to support breastfeeding (one per pregnancy). • A portable crib and safe sleep education (one crib per pregnancy). • Unlimited 24/7 access to virtual care during pregnancy and for up to 12 months after delivery in identified high-risk counties. Benefits include doulas, lactation support, social support, NICU transitions, etc. • Support for members during pregnancy and for up to 12 months after delivery through Health in Her HUE. Health in Her HUE connects Black women and women of color to culturally sensitive healthcare providers, evidence-based health content, community events, and more. • Rides to appointments for members in care management with high-risk pregnancies. • Prenatal education and parenting classes when referred by a care manager.	**Must be in Start Smart for Your Baby® program and care management.** **Breast pump for members due to deliver within 6 weeks or members who have delivered a baby within the past 30 days (90 days for NICU).** **Crib for members due to deliver within 12 weeks or members who have delivered a baby within the past 30 days (90 days for NICU) without safe sleep alternatives.**

Benefit	Description	Limits
Tobacco cessation	Oklahoma Complete Health can help if you want to stop using tobacco. Quitting tobacco can help with certain chronic health conditions. Oklahoma Complete Health also offers My Health Pays® rewards to members who want to quit. Earn $25 for the first prescription fill of medication to quit and $50 for completing the program.	One reward per year.
Traditional healing grants	Oklahoma Complete Health respects your cultural preferences for healthcare. We give a yearly grant for ceremonial or spiritual healing that may help with improved behavioral or physical health management and overall well-being.	Limited to $250 per year. Member must be enrolled in a federally recognized tribe.
Vision services for adults	Oklahoma Complete Health expands the state's covered vision services for members ages 21 and older by offering an annual routine eye exam and $150 towards the cost of glasses or contact lenses every two years.	Ages 21 and older. Must be an in-network provider.
YMCA memberships	We give adult and youth memberships to local YMCAs to support members' physical activity and healthy lifestyles. YMCA membership can be renewed up to a full year.	

In Lieu of Services

It is possible to get other service options in *lieu* (instead) of services if you have unique needs. Your case manager will be happy to talk to you about these options.

Tell Us About Your Health

The My Health Screening will ask you questions about your current health. Your provider and health plan will use this information to learn about any health changes you've had or to better meet your health needs. That's why it's important to complete this form each year. With this information, we can meet your specific health needs with more services.

Scan with your phone to complete this form on the member portal.

Completing the My Health Screening Form

There are several ways to complete the form:

1. See your My Health Screening form in the back of this handbook. Fill it out and mail it back to us in the prepaid envelope.
2. Scan the QR code to complete the form online.
3. Go to **Member.OklahomaCompleteHealth.com** to complete the form on the member portal.

This form is confidential (private). Make sure to complete one form for each Oklahoma Complete Health member in your household. If you are in our care management program, a member of our care coordination team will call you to complete the screening over the phone.

Remember to do this screening each year. As part of our My Health Pays® program, you will earn a $10 reward for completing the form.

Notification of Pregnancy

Take Care of Yourself and Your Baby

Our Start Smart for Your Baby® program gives custom support and care for pregnant individuals and new parents. This program helps you focus on your health during your pregnancy and your baby's first year.

Start Smart for Your Baby® offers these benefits at no cost to you:

- Information about pregnancy and newborn care.
- Community help with housing, food, clothing, and cribs.
- Breastfeeding support and resources.
- Medical staff to work with you and your provider if you have any issues during your pregnancy.
- Text and email health tips for you and your newborn.

Getting Started

If you are pregnant, complete our Notification of Pregnancy Form online. You can also find the form in the back of this handbook. Fill it out and mail it back to us using the prepaid envelope. We will follow up to talk with you about the details of our Start Smart for Your Baby® program.

Earn $25 in My Health Pays® rewards for completing the Notification of Pregnancy within your first trimester (13 weeks) or $10 for completing it in your second trimester (weeks 14 to 27)*.

*Restrictions may apply.

Start Earning My Health Pays® Rewards

It's easy to earn rewards! After you complete a healthy activity, we will add the reward amount directly to your My Health Pays Visa® prepaid card*.

If you don't have a card yet, we will mail you one after you complete your first healthy activity. You can keep earning My Health Pays® rewards by completing more healthy activities. We will add new rewards to your card once we are notified.

You can earn rewards for doing things like annual screenings, tests, and more.

Spend rewards at stores like Walmart or on necessities like rent, utilities, and childcare**.

**This My Health Pays® Visa® prepaid card is issued by The Bancorp Bank, N.A., pursuant to a license from Visa U.S.A. Inc. Card cannot be used everywhere Visa debit cards are accepted.*

***Rewards cannot be used to buy alcohol, tobacco, or firearm products.*

Extra Support to Manage Your Health

Managing your health care alone can be hard, especially if you are dealing with many health problems at the same time. If you need extra support to get and stay healthy, we can help. As a member of Oklahoma Complete Health SoonerSelect Program you may have a care manager on your health care team. A care manager is a specially trained health professional who works with you and your doctors to make sure you get the right care when and where you need it.

Your care manager can:

- Coordinate your appointments and help arrange for transportation to and from your doctor;
- Help you when you are leaving the hospital or other short-term medical setting so you can get the services you need at home;
- Support you in reaching your goals to better manage your ongoing health conditions;
- Answer questions about what your medicines do and how to take them;
- Follow up with your doctors or specialists about your care;
- Connect you to helpful resources in your community; and
- Help you continue to receive the care you need if you switch health plans or doctors.

Oklahoma Complete Health SoonerSelect Program can also connect you to a care manager who specializes in supporting you in:

- Getting a referral for case management services.
- Developing an individualized and person-centered care plan to address your physical, behavioral, and social needs.
- Arranging follow-up care for primary care and behavioral health needs.
- Addressing your social and community needs, providing referrals to services, and connecting you to community resources.
- Coordinating transitions of care, such as:
  - When benefits or coverage ends.
  - When you move from pediatric (youth) to adult care.
  - When you move from a different level of care or discharging home.

To learn more about how you can get extra support to manage your health, talk to your PCP or call Member Services at **1-833-752-1664** (TTY: **711**).

Help with Problems Beyond Medical Care

It can be hard to focus on your health if you have problems with your housing or worry about having enough food to feed your family. Oklahoma Complete Health can connect you to resources in your community to help you manage issues beyond your medical care.

Call Member Services at **1-833-752-1664** (TTY: **711**) if you would like to discuss resources in areas such as employment, housing stability, food, and/or transportation.

Members can use our custom FindHelp portal to explore community resources in their area at: **ochpublic.findhelp.com**.

Other Programs to Help You Stay Healthy

Oklahoma Complete Health SoonerSelect Program wants to help you and your family get and stay healthy. If you want to quit smoking or are a new mom who wants to learn more about how to best feed your baby, we can help connect you with the right program for support.

Call Member Services at 1-833-752-1664 (TTY: 711) to learn more about:

- Tobacco cessation services (support to help you stop smoking or dipping).
- SoonerStart, Oklahoma's early intervention program is designed to meet the needs of families with infants or toddlers (ages birth to 3 years old) with developmental delays and/or disabilities in accordance with the Individuals with Disabilities Education Act (IDEA). The program builds upon and provides supports and resources to assist family members to enhance infants or toddler's learning and development through everyday learning opportunities.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit

Plan members under age 21 can get any treatment or health service that is medically necessary to treat, prevent or improve a health problem. This special set of benefits are called Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Members who need EPSDT benefits:

- Can get EPSDT services through their health plan;
- Do not have to pay any copays for EPSDT services; and
- Can get help with scheduling appointments and arranging for free transportation to and from the appointments.

Some EPSDT services may require a prior authorization (PA). EPSDT includes services that can help treat, prevent, or improve a member's health issue, including, but not limited to:

- Health and immunization history;
- Physical exams;
- Various health assessments and counseling;
- Lab and screening tests;
- Necessary follow-up care; and
- Applied behavioral analysis (ABA) services.

If you have questions about EPSDT services, talk with your child's primary care provider (PCP). You can also find more information on EPSDT services online by visiting our website at **OklahomaCompleteHealth.com** or by visiting the SoonerCare EPSDT webpage at **oklahoma.gov/ohca/providers/types/child-health-epsdt.html**.

Services Not Covered

These are examples of some of the services that are not available from Oklahoma Complete Health if you get any of these services, you may have to pay the bill:

- Acupuncture;
- Chiropractic care for member under age 21;
- Cosmetic surgery;
- Infertility treatment;
- Weight loss programs;
- Services from a provider who is not part of Oklahoma Complete Health, unless it is a provider you are allowed to see as described elsewhere in this handbook or Oklahoma Complete Health or your primary care provider (PCP) sent you to that provider;
- Services for which you need a referral (approval) in advance and you did not get it;
- Services for which you need prior authorization (PA) in advance and you did not get it;
- Medical services provided out of the country; or
- Tattoo removal.

This list does not include all the services that are not covered. To determine if a service is not covered, call Member Services at **1-833-752-1664** (TTY: **711**).

You may have to pay for any service that your PCP or Oklahoma Complete Health does not approve. This includes:

- Services not covered (including those listed above);
- Unauthorized services; and
- Services provided by providers who are not part of Oklahoma Complete Health.

Oklahoma Complete Health can choose not to cover counseling or referral services because of an objection on moral or religious grounds. Currently, Oklahoma Complete Health does not object to any services based on moral or religious grounds. If this changes in the future, and if you want to leave our plan because of this objection, you have good cause and the right to do so. See page 58 for more information.

If You Get a Bill

In most cases, you do not have to pay for SoonerSelect services and should not get a bill from a provider. You may have to pay if you agreed in writing to pay for services not paid for by Oklahoma Complete Health SoonerSelect Program. If you get a bill for a treatment or service you do not think you should pay for, do not ignore it. Call Member Services at **1-833-752-1664** (TTY: **711**) right away. We can help you understand why you may have gotten a bill. If you are not responsible for payment, Oklahoma Complete Health will contact the provider and help fix the problem for you.

You have the right to file an appeal if you think you are being asked to pay for something Oklahoma Complete Health should cover. See the grievance and appeals section on page 51 in this handbook for more information. If you have any questions, call Member Services at **1-833-752-1664** (TTY: **711**).

New Technology

Oklahoma Complete Health wants to make sure you have access to the most up-to-date medical care. We have a team that watches for advances in medicine. This may include new medicine, tests, surgeries, or other treatment options. The team checks to make sure the new treatments are safe. We will tell you and your provider about new services covered under your benefits.

Plan Member Copays

Some members may be required to pay a copay, or a fee you pay when you get certain health care services from a provider or pick up a prescription from a pharmacy:

Your Copays Under the Plan

Service	Amount	Explanation
Inpatient hospital	**$10 per day.**	**Up to $75 maximum.**
Outpatient hospital services	**$4 per visit.**	
Outpatient clinic services	**$4 per visit.**	
Ambulatory surgery	**$4 per visit.**	
Physician services	**$4 per visit.**	
Physician assistant / anesthesiologist assistant	**$4 per visit.**	
Advanced practice nurse services	**$4 per visit.**	
Optometrist services	**$4 per visit.**	
Durable medical equipment	**$4 per item.**	**Blood glucose testing supplies and insulin syringes have $0 copay.**
Home health agency services	**$4 per visit.**	
Rural health clinic services	**$4 per visit.**	

Service	Amount	Explanation
Behavioral health and substance abuse services — Inpatient	$10 per day.	Up to $75 maximum.
Behavioral health and substance abuse services — Outpatient	$3 per visit.	
Laboratory and X-ray	$4 per visit.	
Prescription drugs	$4 per prescription (some exceptions apply).	· Tobacco cessation products $0 copay. · Prenatal vitamins $0 copay. · Birth control $0 copay. · Naloxone $0 copay. · Medication assisted treatments for opioid use $0 copay.
ACIP-recommended vaccines	$0 copay.	
Federally Qualified Health Centers (FQHC)	$4 per visit.	
State plan personal care services	$4 per visit.	
Physical therapy, occupational therapy, speech and audiologist therapy (PT/OT/ST)	$4 per visit.	
Alternative treatment for pain management	$4 per visit.	
Prosthetics and orthotics	$4 per visit.	

There are no copays for the following members or services:

- Members under age 21;
- Members who are pregnant (and in their postpartum period);
- Members receiving hospice care;
- American Indians/Alaskan Natives;
- Children in foster care;
- Emergency services;
- Family planning services;
- Preventative services delivered to expansion adults; or
- Provider preventable services.
- Members who have been assigned a copay exemption by the state.
- Members who have met their monthly cost share.

If you have any questions about copays, please call Member Services at **1-833-752-1664** (TTY: **711**).

PART III: PLAN PROCEDURES

Pharmacy Lock-in Program

To protect the health of our members, Oklahoma Complete Health has a pharmacy lock-in program. This is for members who abuse or misuse prescription drugs. Members are assigned to one pharmacy and one doctor. You may change your doctor or pharmacy one time a year unless you have a special situation like moving. If you are placed in the program, you may be enrolled for a minimum of two years. We will review your enrollment at least every year. You can appeal being placed in the lock-in program. See the grievance and appeals section on page 51 in this handbook for more information.

Prior Authorization and Actions

Oklahoma Complete Health will need to approve some treatments and services before you receive them. Oklahoma Complete Health may also need to approve some treatments or services for you to continue receiving them. This is called prior authorization. For a list of services that require a prior authorization, please see the chart in the "Services Covered by Oklahoma Complete Health's Network" section of this handbook on page 16.

Typically, your primary care provider (PCP) will submit the prior authorization to Oklahoma Complete Health for you through the provider portal. Asking for approval of a treatment or service is called a prior-authorization request. To get approval for these treatments or services you need to:

- You or your doctor may call Member Services at **1-833-752-1664** (TTY: **711**) to ask about prior authorization. However, all official prior authorization submissions must be done via our provider portal.

Prior Authorization Requests for Children Under Age 21

Special rules apply to decisions to approve medical services for children under age 21 receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. To learn more about EPSDT services, see page 42 or visit our website at **OklahomaCompleteHealth.com**.

What Happens After We Get Your Prior-Authorization Request?

The health plan has a review team to be sure you get the services we promise and that you need. Qualified health care professionals (such as doctors and nurses) are on the review team. Their job is to be sure that the treatment or service you asked for is covered by your plan and that it will help with your medical condition. They do this by checking your treatment plan against medically acceptable standards.

After we get your request, we will review it under either a standard or an expedited (faster) process. You or your doctor can ask for an expedited review if a delay will cause serious harm to your health. If your request for an expedited review is denied, we will tell you and your case will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so but no later than described timeframes noted within the next section of this handbook.

We will tell you and your provider in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options you will have for an appeal when you don't agree with our decision.

Any decision to deny a prior authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination. These decisions will be made by a health care professional. You can request the specific medical standards, called clinical review criteria, used to make the decision for adverse benefit determinations related to medical necessity.

Prior Authorization and Timeframes

We will review your request for a prior authorization within the following timeframes:

- **Standard review:** We will make a decision about your request within 72 hours after we receive it. Authorization decisions may be extended by up to 14 calendar days if we need more information.
- **Expedited (fast track) review:** We will decide about your request and your provider will hear from us within 24 hours.
- **Inpatient Behavioral Health:** We will make a decision about your request within 24 hours.

If additional information is needed to make the decision, the review could take up to a total of 14 days. If this happens, Oklahoma Complete Health will send you a written notice along with information on how to file an appeal on the extension.

In most cases, if you are receiving a service and a new request is made to keep receiving a service, we must tell you at least 10 days before we change the service if we decide to reduce, stop, or restrict the service. **If we approve a service and you have started to receive that service, we will not reduce, stop, or restrict the service during the approval period unless we determine the approval was based on information that was known to be false or wrong**.

If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills.

Utilization Review

The Oklahoma Complete Health Utilization Review (UR) Program reviews services to ensure the care you get will be the best way to help your medical condition. This includes reviewing your medical notes and talking with your doctor, hospital, or other care providers. There are different types of UR methods and timeframes for decisions and notifications. UR procedures may include, but are not limited to:

- Preservice reviews (before you get the service).
- Urgent concurrent review (while you are getting the service).
- Retrospective review (after you had the services).

How You Can Help with Plan Policies

We value your ideas. You can help us develop policies that best serve our members. Maybe you would like to work with one of the member committees in our health plan or with OHCA, like:

- Oklahoma Complete Health Advisory Board; and/or
- Oklahoma Complete Health Behavioral Health Advisory Board (BHAB).

Call Member Services at **1-833-752-1664** (TTY: **711**) to learn more about how you can help.

Appeals

If you are not satisfied with our decision about your care or received an adverse benefit determination, you have the right to file an appeal.

To file an appeal, write to:
Oklahoma Complete Health
ATTN: Appeals
P.O. Box 10353
Van Nuys, CA 91410-0353
Fax: 1-833-522-2803

For behavioral health appeals, write to:
Oklahoma Complete Health
ATTN: Appeals Department
P.O. Box 10378
Van Nuys, CA 91410-0378
Email Address: APPEALS@cenpatico.com
Fax: 1-866-714-7991

For pharmacy appeals, write to:
Oklahoma Complete Health
ATTN: Pharmacy Appeals
P.O. Box 31398
Tampa, FL 33631-3398
Fax: 1-888-865-6531
Verbal Appeals or Peer to Peers can be initiated by calling 1-833-331-1515.

To file an appeal by phone, call Member Services at **1-833-752-1664** (TTY: **711**).

If you are not satisfied with an action we took or what we decided about your prior-authorization request (PA) (see page 49 about prior authorizations and actions), you can file an appeal at any time. An appeal is a request for us to review the decision. You have 60 days after we send you a denial notice (adverse benefit determination notice) to file an appeal.

You can do this yourself or, with your written consent, your authorized representative or your provider can call Member Services at **1-833-752-1664** (TTY: **711**) or visit our website at **OklahomaCompleteHealth.com** if you need help filing an appeal.

The appeal can be made by phone or in writing. You don't have to use any specific or legal terms, as long as you clearly state that you are dissatisfied with the decision we made. We can help you complete the appeal form. If needed, auxiliary aids and services will be provided to you upon request and free of charge.

If your appeal review needs to be reviewed more quickly than the standard timeframe because you have an immediate need for health services, you may request an expedited appeal.

- **Standard appeals:** If we have all the information we need, we will tell you our decision in writing within 30 days after your appeal is received.
- **Expedited (fast track) appeals:** If we have all the information we need, we will call you and send you a written notice of our decision within 72 hours from when we receive your appeal. We'll let you know we received your expedited appeal within 24 hours.

You may file a grievance (see page 54 for more about grievances) if your request for an expedited (fast tracked) appeal is denied.

We will not treat you any differently or act badly toward you because you file an appeal.

Before and during the appeal, you or your representative can see your case file, including medical records and any other documents and records being used to decide your case.

You can ask questions and give any information (including new medical documents from your providers) that you think will help us to approve your request. You may do that in-person, in writing, or by phone.

If you need assistance with the appeals process, have questions, or want to check the status of your appeal, you can call Member Services at **1-833-752-1664** (TTY: **711**).

More Information for Appeals

If we need more information to make either a standard or an expedited (faster) decision about your appeal, we may extend the time to resolve your appeal. If so, we will:

- Write you and tell you what information is needed. For expedited appeals, we will call you right away and send a written notice later.
- Explain why the delay is in your best interest.
- Make a decision no later than 14 days from the original decision date.

If you need more time to gather your documents and information, just ask. You, your provider, or someone you trust may ask us to delay your case until you are ready. We want to make the decision that supports your health best. You can request more time by calling Member Services at **1-833-752-1664** (TTY: **711**) or writing to the applicable address listed on the prior page.

Our Decision on Your Appeal

If we agree with you that we should not have reduced or stopped services you were already receiving, we will send you a notice of resolution of the appeal telling you that we granted your appeal. If we still disagree with you and believe we were right to have reduced or stopped services you were already receiving, we will send you a notice of adverse resolution of the appeal telling you that we denied your appeal. If you disagree with the adverse resolution of the appeal, you have the right to request a State Fair Hearing. See the next section on page 53 for important details about timing and filing your request.

Your Care While You Wait for a Decision on Your Appeal

When the health plan's decision reduces or stops a service you were already receiving, you can ask to continue the services your provider had already ordered while we are making a decision on your appeal. You can also ask an authorized representative to make that request for you. Providers are not allowed to ask for your services to continue for you.

While you are waiting for us to make a decision on your appeal, if you want to continue services you were already receiving, be sure to ask us to continue those services at the time you file your appeal.

If we continue the services that you were already receiving, we will pay for those services if your appeal is decided in your favor. **Your appeal might not change the decision the health plan made about your services.**

When your appeal doesn't change the health plan's decision, you may have to pay for the services you got while waiting for a decision. If you are unhappy with the result of your appeal, you can ask for a State Fair Hearing (see next section in this handbook).

State Fair Hearings

After you receive a notice of adverse resolution to your appeal and you still don't agree with the decision we made that reduced, stopped, or restricted your services, you can ask for a State Fair Hearing. A State Fair Hearing is your opportunity to give more information and ask questions about the decision in front of an administrative law judge. The judge in your State Fair Hearing is not a part of your health plan in any way.

If you want to continue benefits while you wait for the administrative law judge's decision about your State Fair Hearing, you should say so at the time you request a State Fair Hearing.

If you need help with understanding the State Fair Hearing process, call Member Services at **1-833-752-1664** (TTY: **711**). You don't have to use any special legal or formal language to request a State Fair Hearing as long as you clearly state that you are dissatisfied with the decision we made.

Your Care While You Wait for a Decision on your State Fair Hearing

If you requested and received continued services during your appeal, we must continue providing those services until you do one of the following:

- You withdraw your appeal or your request for State Fair Hearing; or
- A State Fair Hearing officer issues a hearing decision that disagrees with you.

You can also ask a trusted representative to make that request for you.

If you ask your health plan to continue services you already receive during your State Fair Hearing case, the health plan will pay for those services if your case is decided in your favor. Your State Fair Hearing might not change the decision the health plan made about your services.

Requesting a State Fair Hearing

You don't have to use any special legal or formal language to request a State Fair hearing as long as you clearly state that you are dissatisfied with the decision we made.

You must first file an appeal with Oklahoma Complete Health and receive our decision before requesting a State Fair Hearing. If we don't decide your appeal within 30 days of your appeal request, you can also ask for a State Fair Hearing.

You don't need an attorney for your State Fair Hearing, but you may use one. You may represent yourself or allow someone else to represent you. If you allow someone else to represent you, they will have to show proof in writing that you asked for their help. Without this written proof, your appeal will be rejected.

You can ask for a State Fair Hearing at any time within 120 days from the day we send you notice of adverse resolution. You can use one of the following ways to request a fair hearing:

By phone: **1-405-522-7217**

By email: **docketclerk@okhca.org**

By mail: **Oklahoma Health Care Authority**
ATTN: Appeals Unit
4345 N Lincoln Blvd
Oklahoma City, OK 73105

If You Have Problems with Your Health Plan

We hope our health plan serves you well. If you have a problem, talk with your Primary care provider (PCP) and call Member Services at **1-833-752-1664** (TTY: **711**) or write to:

Oklahoma Complete Health
Attn: Grievance Department
P.O. Box 10353
Van Nuys, CA 91410-0353

Most problems can be solved right away. If you have a problem with your health plan, care, provider, or services, you can file your complaint with Oklahoma Complete Health. **This kind of complaint is called a grievance.** Problems that are not solved right away over the phone and any grievance that comes in the mail will be handled according to our grievance procedures described below.

You can ask someone you trust (your authorized representative) to file the grievance for you. If you need our help because of a hearing or vision impairment, if you need translation services, or if you need help filling out the forms, we can help you. We will not make things hard for you or take any action against you for filing a grievance.

If you need this material in another language or format, you can get translation services at no cost. This includes written, visual, and audible aids. Call Oklahoma Complete Health at **1-833-752-1664** (TTY: **711**) to ask for these services.

You may also file a complaint with the Oklahoma Insurance Department by going to **oid.ok.gov/consumers/file-an-online-complaint**.

If You Are Unhappy with Your Plan: How to File a Grievance

If you are unhappy with your health plan, provider, care, or your health services, you can file a grievance (a formal complaint) with Oklahoma Complete Health. You can file a grievance by phone or in writing at any time.

- To file by phone, call Member Services at **1-833-752-1664** (TTY: **711**) Monday through Friday, from 8 a.m. to 5 p.m.
- To file in writing, you can write us with your grievance to:
  Oklahoma Complete Health
  Attn: Grievance Department
  P.O. Box 10353
  Van Nuys, CA 91410-0353

What Happens Next?

- We will let you know in writing that we got your grievance within 10 calendar days of receiving it;
- We will decide the resolution of a grievance within 30 days after receiving your grievance;
- We will tell you how we resolved it in writing within 3 days after we resolve the grievance;
- We may extend the resolution timeframe of your grievance by 14 days if we need more time to resolve your grievance. This must be in your best interest.
- If we extend your grievance, we will tell you within two days and mail you a written notification letter. You may also request an extension of your grievance.

Your Care When You Change Health Plans or Doctors

- If you choose to leave Oklahoma Complete Health SoonerSelect Program, we will share your health information with your new plan. You can finish receiving any services that have already been authorized by your previous health insurance or SoonerCare, even if the provider you are seeing is an out-of-network provider. Prior authorizations will be honored until the services are used or until 90 days after your new plan benefits begin, whichever comes first. After that, we will help you find a provider in our network to get any additional services if you need them.
- If you are pregnant when you join Oklahoma Complete Health SoonerSelect Program you can continue the care you were receiving before you joined our plan. You can continue seeing your doctor even if he or she is an out-of-network provider. If you are receiving chemotherapy or radiation treatment, dialysis, major organ or tissue transplant services, bariatric surgery, Synagis treatment, medications for Hepatitis C treatment or if you are terminally ill, when you change plans you can continue your current treatment plan.

- Children receiving private duty nursing services will continue to receive these services. These services will only change if we perform a new assessment and determine your child needs different services.
- We will continue to cover your out-of-state services and/or meals and lodging assistance if it is already being received from SoonerCare when you join our plan.
- If you are receiving services for hemophilia, those services will continue being provided by your current hemophilia providers for up to 90 days even if the provider is out-of-network. After 90 days, we can help you find a network provider.
- If you are on a current treatment plan and receiving behavioral health services, you may keep seeing your current behavioral health treatment provider(s) for up to 90 days, even if the provider is out-of-network. After 90 days, we can help you find a network provider.
- If you are waiting for durable medical equipment or supplies authorized and ordered prior to joining our plan, we will help you to receive these items on time.
- If your PCP leaves Oklahoma Complete Health, we will tell you in writing within 15 calendar days from when we know about this. We will tell you how to choose a new PCP, or we will choose one for you if you do not make a choice.
- If you are on a current treatment plan and getting treatment for a chronic or acute medical condition, you can keep getting treatment through the current period or active treatment, or for up to 90 calendar days, whichever is less. After this period, we can help you find an in-network provider.
- If you are pregnant and in the second or third trimester, you may continue your care through the postpartum period, which begins immediately after childbirth and extends for about six weeks. After this period, we can help you find an in-network provider.

If you have any questions, call Member Services at **1-833-752-1664** (TTY: **711**).

Member Rights and Responsibilities

Your Rights

As a member of Oklahoma Complete Health, you have a right to:

- Receive information on the SoonerSelect program and Oklahoma Complete Health.
- Be treated with respect and with due consideration for your dignity and privacy.
- Receive information on available treatment options and alternatives, in a way you understand regardless of cost or benefit coverage.
- Participate in decisions regarding your health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of your medical records, and to request that they be amended or corrected in accordance with HIPAA Rules and other applicable federal and state laws and regulations.
- Obtain available and accessible health care services covered by Oklahoma Complete Health.

- Voice a complaint or appeal about Oklahoma Complete Health or the care it provides.
- Get a copy of the member rights and responsibilities.
- Make recommendations about the member rights and responsibilities policy.
- Exercise your rights without Oklahoma Complete Health or its participating providers treating you differently.

Your Responsibilities

As a member of Oklahoma Complete Health, you agree to the following responsibilities:

- To give Oklahoma Complete Health and its providers accurate and complete medical information that they need to give you care.
- To follow the plan's instructions for care that you have agreed to with your provider.
- To understand your health problems.
- To work with your provider to make a treatment plan you both agree with.
- To check Oklahoma Complete Health's information; correct inaccuracies; and allow government agencies, employers and providers to release records to OHCA or Oklahoma Complete Health.
- Notify OHCA or Oklahoma Complete Health within 10 days if there are changes in income, the number of people living in the home, address or mailbox changes or health insurance changes.
- Transfer, assign, and authorize to OHCA all claims you may have against health insurance, liability insurance companies, or other third parties. This includes payments for medical services made by OHCA for any dependents.
- Respond to requests for assistance from the OHS Office of Child Support Services.
- Allow SoonerCare to collect payments from anyone who is required to pay for medical care.
- Share necessary medical information with any insurance company, person or entity who is responsible for paying the bill.
- Inspect any medical records to see if claims for services can be paid.
- Obtain permission for Oklahoma Human Services or Oklahoma Health Care Authority to make payment or overpayment decisions.
- Keep your identification card and know your Social Security number to receive health care services or prescriptions.
- Confirm that any care received is covered.
- Understand how and when to request non-emergency medical transportation services.
- Cost sharing.
- Ensure all information provided to OHCA or Oklahoma Complete Health is complete and true upon penalty of fraud or perjury.

Disenrollment Options

If You Want to Leave the Plan

You can try us out for 90 days. You may leave Oklahoma Complete Health and join another health plan at any time during the first 90 days after you begin to receive health plan benefits. You don't have to have a reason to switch plans.

You can also switch health plans once every 12 months. This change happens through open enrollment.

If you want to leave Oklahoma Complete Health at any other time, you can do so only with a good reason (good cause). Some examples of good cause include:

- You need related services to be performed at the same time, not all services are available within Oklahoma Complete Health's network, and getting the services separately would put your health at risk,
- You have a complex medical condition and another health plan can better meet your needs,
- You have filed and won a grievance about poor quality of care, lack of access to services we must provide, lack of access to providers experienced in dealing with your needs, or any other issue that would support disenrollment,
- You were enrolled by mistake, and
- You need services that Oklahoma Complete Health does not provide for moral or religious reasons. For more information on services not covered for moral or religious reasons, please see the next section.

If you have a good cause reason to disenroll from Oklahoma Complete Health, you must submit your request using the grievance process on page 55. We will review the request within 10 days from when you filed the grievance. If you are unhappy with the disenrollment decision, we will refer the request to the Oklahoma Health Care Authority for the final decision.

Oklahoma Complete Health can choose not to cover certain services because of an objection on moral or religious grounds. Currently, Oklahoma Complete Health does not object to any services based on moral or religious grounds. If this changes in the future, and you want to leave our plan because of this objection, you have the right to do so. It is considered a good cause.

You Could Become Ineligible for SoonerSelect

You may have to leave Oklahoma Complete Health if you:

- Are no longer eligible for Medicaid. If you become ineligible for Medicaid, all your services may stop immediately.
- Begin receiving Medicare.
- Transition to an eligibility group that does not participate in SoonerSelect.
- Become a foster child under state custody.
- Become a juvenile in the justice system under state custody.
- Become an inmate of a public institution.

- Commit fraud or provide fraudulent information.
- Are ordered by a hearing officer or court.

We Can Ask You to Leave Oklahoma Complete Health

You can also lose your Oklahoma Complete Health membership if you:

- Abuse or harm to plan members, providers or staff.
- Were enrolled in error.
- Have a complex medical condition and another health plan can better meet your needs.
- Do not fill out forms honestly or do not give true information. This is considered fraud.

Advance Directives

There may come a time when you become unable to manage your own health care and a family member or other person close to you is making decisions on your behalf. By planning in advance, you can arrange now for your wishes to be carried out. An advance directive is a set of directions you give about the medical and mental health care you want if you ever lose the ability to make decisions for yourself. For example, some people do not want to be put on life-support machines if they go into a coma.

Making an advance directive is your choice. If you become unable to make your own decisions, and you have no advance directive, your doctor or behavioral health provider will consult with someone close to you about your care. Discussing your wishes for medical and behavioral health treatment with your family and friends now is strongly encouraged, as this will help to make sure that you get the level of treatment you want if you can no longer tell your doctor or other physical or behavioral health providers what you want. Your advance directives, no matter the type, should be given to your primary care provider (PCP) and your care manager at Oklahoma Complete Health.

Oklahoma has three ways for you to make a formal advance directive. These include living wills, health care power of attorney and advance instructions for mental health treatment.

You can cancel your advance directive any time, without regard to your medical or mental health, and if any of the following are true:

- The member is pregnant and the physician is aware, the pregnant patient is to be given life-sustaining treatment unless the patient has specifically authorized to withhold treatment during the course of pregnancy.
- A physician is unable or unwilling to give care as per the advance directive, Oklahoma Complete Health will process the information. The physician will transfer care of the patient to another physician to comply with the patient's medical decisions. If refusal of treatment would, in reasonable medical judgment, likely result in the death of the patient, then the physician **must comply** with the medical treatment decision pending transfer of the patient to a physician or other healthcare provider who is willing to comply with the decision.
- An advance directive from another state is valid to the extent that it does not exceed authorizations allowed under Oklahoma law. It must have been executed by the individual the directive applies to, and it must specifically authorize withholding/withdrawal of artificial nutrition/hydration and be signed.

Living Will

In Oklahoma, a living will is a legal document that tells others whether or not you want to die a natural death if you:

- Become incurably sick with an irreversible condition that will result in your death within a short period of time;
- Are unconscious and your doctor determines that it is highly unlikely that you will regain consciousness; or
- Have advanced dementia or a similar condition which results in a substantial cognitive loss and it is highly unlikely the condition will be reversed.

In a living will, you can direct your doctor not to use certain life-prolonging treatments such as a breathing machine (called a "respirator" or "ventilator"), or to stop giving you food and water through a feeding tube.

A living will go into effect only when your doctor and one other doctor determine that you meet one of the conditions specified in the living will. Discussing your wishes with family, friends, and your doctor now is strongly encouraged so that they can help make sure that you get the level of care you want at the end of your life.

Health Care Power of Attorney

A health care power of attorney is a legal document in which you can name one or more people as your health care agents to make medical and behavioral health decisions for you as you become unable to decide for yourself, for as long as you choose. You can always say what medical or behavioral health treatments you would want and not want. You should choose an adult you trust to be your health care agent. Discuss your wishes with the people you want as your agents before you put them in writing. Your designated power of attorney will be able to have access to your medical information and medical records, for as long as that person is so designated, up to your death.

Again, it is always helpful to discuss your wishes with your family, friends, and your doctor. A health care power of attorney will go into effect when a doctor states in writing that you are not able to make or to communicate your health care choices. If, due to moral or religious beliefs, you do not want a doctor to make this determination, the law provides a process for a non-physician to do it.

The health care power of attorney becomes effective when the attending physician determines that the member is no longer able to make their own healthcare decisions, unless the member elected to have the agent's authority take effect upon execution of the health care power of attorney.

Advance Instruction for Mental Health Treatment

An advance instruction for mental health treatment is a legal document that tells doctors and mental health providers what mental health treatments you would want and what treatments you would not want if you later become unable to decide for yourself. It can also be used to nominate a person to serve as guardian if guardianship proceedings are started. Your advance instruction for behavioral health treatment can be a separate document or combined with a health care power of attorney or a general power of attorney. An advance instruction for behavioral health may be followed by a doctor or behavioral health provider when your doctor or an eligible psychologist determines in writing that you are no longer able to make or communicate behavioral health decisions.

You can change your mind and these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself. Talk to your primary care provider (PCP) or call Member Services at **1-833-752-1664** (TTY: **711**) if you have any questions about advance directives.

Fraud, Waste, and Abuse

If you suspect that someone is committing Medicaid fraud, report it. Some examples of Medicaid fraud include (not limited to):

- An individual does not report all income or other health insurance when applying for Medicaid;
- An individual who does not get Medicaid uses a Medicaid member's card with or without the member's permission; or
- A doctor or a clinic bills for services that were not provided or were not medically necessary.

You report suspected fraud and abuse in any of the following ways:

- Call the Oklahoma Complete Health Ethics and Compliance Fraud Hotline at **1-866-685-8664**.
- Call the Medicaid Fraud, Waste and Program Abuse Tip Line through the OK Department of Human Services, Office of Inspector General at **1-800-784-5887**.
- Call the U.S. Office of Inspector General's Fraud Line at **1-800-HHS-TIPS** (**1-800-447-8477**) (TTY: **1-800-377-4950**).

Important Phone Numbers

- Member Services: Monday through Friday, from 8 a.m. to 5 p.m. at **1-833-752-1664** (TTY: **711**).
- Behavioral Health Crisis Line: **988** 24 hours a day, 7 days a week.
- Nurse Advice Line: 24 hours a day, 7 days a week at **1-833-752-1664** (TTY: **711**).
- SoonerCare Helpline: **1-800-987-7767**, Monday - Friday, 8 a.m. to 5 p.m.
- Provider Service Line: Monday through Friday, from 8 a.m. to 5 p.m. at **1-833-752-1664** (TTY: **711**).
- Prescriber Service Line: Monday through Friday, from 8 a.m. to 5 p.m. at **1-833-752-1664** (TTY: **711**).
- Free Legal Aid Services of Oklahoma: Monday through Thursday, from 9 a.m. to 4 p.m.at **1-888-534-5243**.
- Advance Health Care Directive Registry: **1-405-426-8030**.
- OK Medicaid Fraud, Waste and Abuse Tip Line through the OK Department of Human Services, Office of Inspector General: **1-800-784-5887**.
- State Auditor Waste Line: **1-405-521-3495**.
- U.S. Office of Inspector General Fraud Line: **1-800-HHS-TIPS** (**1-800-447-8477**) (TTY: **1-800-377-4950**).

Keep Us Informed

Call Member Services at 1-833-752-1664 (TTY: 711) whenever these changes happen in your life:

- You have a change in Medicaid eligibility;
- You become pregnant or give birth;
- There is a change in Medicaid coverage for you or your children;
- Someone in your household goes into state custody;
- You begin receiving Medicare; or
- You move.

Third Party Liability (TPL) Reporting

Notify Member Services at 1-833-752-1664 (TTY: 711) or the Oklahoma Health Care Authority (OHCA) SoonerCare Help Line at 1-800-987-7767 if:

- Your family size changes.
- You move out of the state or have other address changes.
- You get or have health coverage under another policy or third party, or there are changes to that coverage.
- You have a workers' compensation claim, a pending personal injury or medical malpractice lawsuit, or are involved in an auto accident.

PART IV: HEALTH & WELLNESS INFORMATION

Oklahoma Complete Health wants you and your family to lead healthy lives. This is why we have health education resources for you. These resources can give you information to help you make healthy choices for you and your family.

Krames Health Library

- Easy access to more than 4,000 education sheets on health and medications. Not sure what to do when you have a cold or the flu? Or how much sunscreen to apply? Or what to do if you're expecting a child? Search for these topics and more on the Krames Health Library.

Healthy Kids Club

- Gives a new book, welcome packet, quarterly newsletter, and online activities for children and parents or guardians.

myStrength® Complete

- We all have our struggles. Finding support to focus on your emotional health is important. myStrength® Complete has personalized e-learning programs to help members with depression, anxiety, or substance use (drugs or alcohol).
- Each personalized program has tools, weekly exercises, and daily inspirations in a safe and private environment.
- myStrength® Complete also has information on how to find resources to support your emotional health.

How we protect your Personal Health Information (PHI)

These are some of the ways we protect your PHI:

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for business reasons with people who need to know.
- We keep your PHI secure when we send it or store it securely.
- We use technology to keep the wrong people from accessing your PHI.

We are committed to keeping your race, ethnicity, and language (REL), and sexual orientation and gender identity (SOGI) information confidential. Here are some of the ways that we protect your information:

- By keeping paper documents in locked file cabinets.
- By making sure that electronic data is on secure media.
- By keeping your electronic data in files that use passwords.

We may use or disclose your REL and SOGI information to perform our operations. This may include:

- Making programs to keep you healthy.
- Telling your providers about your language needs.
- Assessing healthcare disparities.

We will never use your REL and SOGI information for underwriting, rate setting, or benefit determinations. We will never give your REL or SOGI information to people who should not have it.

Oklahoma Complete Health
Notice of Privacy Practices

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

Effective 1/1/2026

For help translating or understanding this, please call **1-833-752-1664** (TTY: **711**).

Si necesita ayuda para traducir o comprender esta información, llame al **1-833-752-1664** (TTY: **711**).

Covered Entity's Duties:

Oklahoma Complete Health is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Oklahoma Complete Health is required by law to maintain the privacy of your Protected Health Information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect, and notify you in the event of a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Oklahoma Complete Health reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Oklahoma Complete Health will promptly revise and distribute this Notice whenever there is a material change to the following:

- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice

We will make any revised Notices available on our website or through a separate mailing.

Internal Protections of Oral, Written and Electronic PHI:

Oklahoma Complete Health protects your PHI. We are also committed to keeping your race, ethnicity, and language (REL), and sexual orientation and gender identity (SOGI) information confidential. We have privacy and security processes to help.

These are some of the ways we protect your PHI:

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- ***Treatment —*** We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.
- ***Payment —*** We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, and reviewing services for medical necessity.
- ***Healthcare Operations —*** We may use and disclose your PHI to perform our healthcare operations. These activities may include providing customer service, responding to complaints and appeals, and providing care management and care coordination.

  In our healthcare operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes the following:

  – Quality assessment and improvement activities

  – Reviewing the competence or qualifications of healthcare professionals

  – Case management and care coordination

  – Detecting or preventing healthcare fraud and abuse

  Your race, ethnicity, language, sexual orientation, and gender identity are protected by the health plan's systems and laws. This means information you provide is private and secure. We can only share this information with health care providers. It will not be shared with others without your permission or authorization. We use this information to help improve the quality of your care and services. This information helps us to:

  – Better understand your healthcare needs.

  – Know your language preference when seeing healthcare providers.

  – Providing healthcare information to meet your care needs.

  – Offer programs to help you be your healthiest.

  This information is not used for underwriting purposes or to make decisions about whether you are able to receive coverage or services.
- ***Group Health Plan/Plan Sponsor Disclosures —*** We may disclose your PHI to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities —*** We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- ***Underwriting Purposes —*** We may use or disclose your PHI for underwriting purposes, such as to decide about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.
- ***Appointment Reminders/Treatment Alternatives —*** We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.
- ***As Required by Law —*** If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.
- ***Public Health Activities —*** We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA. This includes Substance Use Disorder (SUD) records.
- ***Victims of Abuse and Neglect —*** We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.
- ***Judicial and Administrative Proceedings —*** We may disclose your PHI in response to an administrative or court order. We may also be required to disclose your PHI to respond to a subpoena, discovery request, or other similar requests.
- ***Law Enforcement —*** We may disclose your relevant PHI to law enforcement when required to do so for the purposes of responding to a crime.
- ***Substance Use Disorder (SUD) Records —*** We will not use or disclose your SUD records in legal proceedings against you unless:
  - We receive your written consent, or
  - We receive a court order, you've been made aware of the request and been given a chance to be heard. The court order must include a subpoena or similar legal document requiring a response.
- ***Coroners, Medical Examiners and Funeral Directors —*** We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.
- ***Organ, Eye and Tissue Donation —*** We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of cadaveric organs, eyes, and tissues.
- ***Threats to Health and Safety —*** We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- ***Specialized Government Functions —*** If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI to authorized federal officials for national security concerns, intelligence activities, The Department of State for medical suitability determinations, the protection of the President, and other authorized persons as may be required by law.

- ***Workers' Compensation —*** We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work–related injuries or illness without regard to fault.
- ***Emergency Situations —*** We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interest. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- ***Inmates —*** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- ***Research —*** Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization:

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

- ***Sale of PHI —*** We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.
- ***Marketing —*** We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.
- ***Psychotherapy Notes —*** We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or healthcare operation functions.

You have the right to revoke your authorization in writing at any time except to the extent that we have already used or disclosed your PHI based on that initial authorization.

Individuals Rights

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

- ***Right to Request Restrictions —*** You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment, or healthcare operations, as well as disclosures to people involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

- ***Right to Request Confidential Communications —*** You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but you must state that the information could endanger you if the means of communication or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where your PHI should be delivered.
- ***Right to Access and Receive a Copy of your PHI —*** You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you with a written explanation and will tell you if the reasons for the denial can be reviewed. We will also tell you how to ask for such a review or if the denial cannot be reviewed.
- ***Right to Amend your PHI —*** You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- ***Right to Receive an Accounting of Disclosures —*** You have the right to receive a list of instances within the last 6-year period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.
- ***Right to File a Complaint —*** If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

  You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling **1-800-368-1019**, (TTY: **1-800-537-7697**) or **hhs.gov/hipaa/filing-a-complaint/index.html**.
  WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.
- ***Right to Receive a Copy of this Notice —*** You may request a copy of our Notice at any time by using the contact information listed at the end of the Notice. If you receive this Notice on our web site or by electronic mail (email), you are also entitled to request a paper copy of the Notice.

Contact Information

Questions about this Notice: If you have any questions about this notice, our privacy practices related to your PHI or how to exercise your rights, you can contact us in writing or by phone by using the contact information listed below.

Oklahoma Complete Health
Attn: Privacy Official
14000 Quail Springs Pkwy, Suite 650
Oklahoma City, OK 73134
Toll-free phone number: **1-833-752-1664** (TTY: **711**)

oklahoma complete health | SoonerSelect

Oklahoma Complete Health – My Health Screening

This My Health Screening form includes demographic (member) information for verification purposes only. This is completed following all care management procedures. This information is requested in compliance with applicable federal, HIPAA, contract specific requirements, and Oklahoma state laws.

Member Information (Demographics)

Scan with your phone to complete this form on the member portal

1. Member Name: _____
2. Preferred Phone Number: _____
3. Preferred Mailing Address: _____
4. Email Address: _____
5. Race:

- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Other (If answer is other, please go to question 6)
- ☐ I prefer not to answer.
- ☐ Unknown

6. Please list other race: _____
7. Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Other (if answer is other, please go to question 8)
- ☐ I prefer not to answer.
- ☐ Unknown

8. Please list other ethnicity: _____
9. What language do you prefer to speak?

- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ Mandarin
- ☐ Vietnamese
- ☐ Korean
- ☐ Other (if answer is other, please go to question 10)
- ☐ No response

10. Please list other language: _____

Physical Health

11 Do you have any past physical health conditions or surgeries? If so, please explain.

_____

12 In general, how would you rate your health?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor (If answer is poor, go to question 13)
- ☐ Unknown

13 Please explain reason for poor health rating. _____

14 Do you have a doctor or health care provider?

- ☐ Yes (If yes, go to question 15)
- ☐ No
- ☐ Unknown

15 What is your doctor or health care provider's name? _____

***It is important to identify a doctor or health care provider to help you stay healthy and in case you get sick.**

16 Have you seen your doctor or health care provider in the last 12 months?

- ☐ Yes (If yes, go to question 17)
- ☐ No
- ☐ Unknown

17 What did you see your doctor for in the past 12 months?

- ☐ Preventative Care/Wellness Visit
- ☐ Sick care visit
- ☐ Post hospital visit
- ☐ Post Emergency Room visit
- ☐ Other visit (If other visit, go to question 18)

18 What was the other visit for? _____

***Regular wellness exams can help make sure you stay as healthy as you can.**

19 How many times have you been in the hospital in the last 3 months?

- ☐ None
- ☐ One time
- ☐ Two times
- ☐ Three or more times
- ☐ Unknown

20 How many times have you been in the Emergency Department in the last 3 months?

- ☐ None
- ☐ One time
- ☐ Two times
- ☐ Three or more times
- ☐ Unknown

21 Have you ever been told by a doctor or health care provider that you have any of these conditions? (check all that apply)

- ☐ Arthritis (If yes, go to question 22)
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic Kidney Disease
- ☐ COPD/Emphysema
- ☐ Diabetes, Type 1
- ☐ Diabetes, Type 2
- ☐ Pre Diabetes
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Learning Disability
- ☐ Sickle Cell Disease (not trait)
- ☐ Stroke

Member Name: _____

Member ID: _____ Member DOB: _____

22 What type of arthritis?

☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Unknown

23 Have you ever had a transplant?

☐ Yes ☐ No

If yes, how long ago?

☐ More than 1 year ago ☐ On the transplant list

☐ In the last 12 months ☐ Unknown

24 Do you have any other conditions not listed above? _____

25 Do you use any assistive devices such as a cane, walker, wheelchair, scooter/power wheelchair, hospital bed, Hoyer lift, or oxygen?

☐ Yes, details: _____

☐ No ☐ Unknown ☐ No Response

26 Do you currently receive any services in your home such as Home Health, Homemaking, Home-Delivered meals, Hospice, or Personal Care in or out of state?

☐ Yes, details: _____

☐ No ☐ Unknown ☐ No Response

27 Are you actively receiving treatment for a physical health disorder, including services from an out of state provider?

☐ Yes (If yes, please go to question 28) ☐ No (If no, please go to question 29)

☐ Unknown

28 Please provide details of current treatment for your physical health disorder(s) including the name and location of the provider.

_____

29 Would you like help getting treatment for a physical health disorder?

☐ Yes ☐ No ☐ Unknown

30 Are you aware of any existing authorizations for services or procedures for physical or behavioral health including those from an out of state provider?

☐ Yes, details: _____

☐ No ☐ Unknown ☐ No Response

31 Are you pregnant?

☐ Yes (If yes, go to question 32) ☐ Unknown

☐ No ☐ Not applicable

32 Do you currently have an in or out of state OB/GYN? If yes, please provide details of your current treatment for pregnancy, and the name and location of the provider.

_____

33 When is your due date (month/day/year)? _____

Medications

34 How many medicines are you currently taking that were prescribed by your doctor or health care provider?

- ☐ 0 Prescriptions
- ☐ 1-3 Prescriptions (If 1-3, answer questions 35-37)
- ☐ 4-7 Prescriptions (If 4-7, answer questions 35-37)
- ☐ Greater than or equal to 8 Prescriptions (If 8+, answer questions 35-37)
- ☐ Unknown

35 Does anything prevent you from taking your medicines the way your doctor or health care provider wants you to?

☐ Yes (If yes, please go to question 36) ☐ No ☐ Unknown

36 What prevents you from taking your medicine? _____

37 Do you ever forget to take your medicines?

☐ Yes ☐ No ☐ Sometimes ☐ Unknown

Behavioral Health

38 Do you have any past Behavioral Health conditions? If so, please explain.

_____

39 During the past month, have you often been bothered by feeling down, depressed, or hopeless?

☐ Yes ☐ No ☐ Unknown

40 Are you actively receiving treatment for a behavioral health disorder, including services from an out of state provider?

☐ Yes (If yes, please go to question 41) ☐ No (If no, go to question 42) ☐ Unknown

41 Please provide details of current treatment for a behavioral health disorder(s) including the name and location of the provider.

_____

42 Would you like help getting treatment for a behavioral health disorder?

☐ Yes ☐ No ☐ Unknown

Social Determinants of Health

1 In the past 2 months, have you been living in stable housing that you own, rent, or stay in as part of a household?

☐ Yes ☐ No ☐ Unknown

Member Name: _____

Member ID: _____ Member DOB: _____

2. What is your housing situation today?

- ☐ I have housing.
- ☐ I do not have housing (staying with others, in a hotel, shelter, living outside, in a car, or in a park).
- ☐ I choose not to answer this question.

3. In the past 12 months has the electric, gas, or water company threatened to shut off services in your home?

☐ Yes ☐ No ☐ Already shut off

4. In the past 3 months, how often have you worried that your food would run out before you had money to buy more?

☐ Never ☐ Sometimes ☐ Often ☐ Very often

5. In the past 12 months, or since the last time we checked in, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

☐ Yes ☐ No ☐ Unknown

6. Do you always feel safe in your home and around all the people in your life?

☐ Yes ☐ No (If no, go to question 7) ☐ Unknown

7. Please explain any safety concerns you have: _____

8. Which of the following are you currently receiving help with at this time? (Select all that apply)

- ☐ Food, details: _____
- ☐ Housing, details: _____
- ☐ Transportation, details: _____
- ☐ Utilities (heat, electricity, water, etc.), details: _____
- ☐ Medical care, medicine, medical supplies, details: _____
- ☐ Dental services and Vision services, details: _____
- ☐ Applying for public benefits (WIC, SSI, SNAP, etc.), details: _____
- ☐ Understanding health information or completing medical forms, details:

_____

- ☐ More help with activities of daily living, details: _____
- ☐ Childcare/other child-related issues, details: _____
- ☐ Debt/loan repayment, details: _____
- ☐ Legal Issues, details: _____
- ☐ Employment, details: _____
- ☐ Access to a working telephone, details: _____
- ☐ Access to the Internet, details: _____
- ☐ Other, details: _____
- ☐ I don't receive help with any of these.

9 Which of the following would you like to receive help with at this time? (Select all that apply)

- ☐ Food, details: _____
- ☐ Housing, details: _____
- ☐ Transportation, details: _____
- ☐ Utilities (heat, electricity, water, etc.), details: _____
- ☐ Medical care, medicine, medical supplies, details: _____
- ☐ Dental services and Vision services, details: _____
- ☐ Applying for public benefits (WIC, SSI, SNAP, etc.), details: _____
- ☐ Understanding health information or completing medical forms, details:

_____

- ☐ More help with activities of daily living, details: _____
- ☐ Childcare/other child-related issues, details: _____
- ☐ Debt/loan repayment, details: _____
- ☐ Legal Issues, details: _____
- ☐ Employment, details: _____
- ☐ Access to a working telephone, details: _____
- ☐ Access to the Internet, details: _____
- ☐ Other, details: _____
- ☐ I don't want help with any of these.

General Information

Assessment Completed date: _____

Assessment Completed by: _____

Relationship to Member

- ☐ Self
- ☐ Member Representative with permission
- ☐ Parent/Guardian
- ☐ Envolve
- ☐ Health Plan
- ☐ Vendor (If vendor, go to question 2)
- ☐ Other (If other, go to question 1)

1 If other relationship to member, please explain: _____

2 Name of agency completing assessment: _____

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Start Smart FOR YOUR BABY

Member Notification of Pregnancy

This form is confidential. If you have any problems or questions, please call Oklahoma Complete Health at 1-833-752-1664 (TTY: 711) and for SoonerSelect Children's Specialty Program please call 1-833-752-1665 (TTY: 711). This form is also available online at OklahomaCompleteHealth.com.

***Member ID #:**

Your First Name:

Your Last Name:

***Your Birth Date MMDDYYYY:**

Gender Identification: Phone Number:

Mailing Address:

City: State: Zip Code:

Email Address:

Race/Ethnicity (select all that apply): White Black/African American Decline to share

American Indian/Native American Asian Native Hawaiian or Other Pacific Islander

Hispanic or Latino Other If other ethnicity, please specify:

What Provider/Clinic is helping me during my pregnancy:

First Name:

Last Name:

Phone Number:

Clinic Name (if applicable):

My Current Situation

Please check this box if you would answer no to any of the below:

I have a phone.

I feel good about where I live.

I feel safe at home and with the people in my life.

I have transportation for my daily needs.

I have enough food for me and my family each day.

I am able to pay my utility bills (gas, water, electric, etc).

My Current Pregnancy Information

I have been to my first prenatal visit? Yes No

If yes, how many weeks pregnant were you at your first visit:

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***Medicaid ID #:**

Name: Last, First:

My due date is (If you do not know your due date, when was the first day of your last period):

This is my first pregnancy ☐ Yes ☐ No

Where will I give birth to my baby (Hospital or birthing center):

Please check all that apply:

- ☐ Multiples (twins, triplets)
- ☐ Diabetes (high blood sugar; type I, type II, during pregnancy only)
- ☐ Asthma or other breathing problems
- ☐ Tobacco use (smoking cigarettes, chewing tobacco, or vaping)
- ☐ Depression (feeling blue)
- ☐ Anxiety (feeling worried or stressed)
- ☐ I do not have any of these
- ☐ Other health needs
- ☐ High blood pressure or heart problems
- ☐ Very bad nausea and vomiting
- ☐ Sickle cell
- ☐ Seizures/epilepsy
- ☐ Bipolar disorder
- ☐ Kidney disease
- ☐ Substance use (fentanyl, opiates, heroin, crack, cocaine, alcohol marijuana, methamphetamines)

Please explain

My Past Pregnancy History

Please check all that apply:

- ☐ Previous delivery before 37 weeks
- ☐ Gestational diabetes (high blood sugar while pregnant)
- ☐ High blood pressure in pregnancy/preeclampsia or heart problems
- ☐ Delivery less than 18 months ago
- ☐ Taking any form of progesterone
- ☐ Previous C-section
- ☐ I did not have any of these or this is my first pregnancy
- ☐ Other

Please explain

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