This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.globalhealth.com/state or by calling 1-877-280-5600.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,500** person / **$10,500** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for healthcare expenses.
What is not included in the out–of–pocket limit?	**Premiums**, healthcare this plan doesn't cover, and out-of-network charges.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.globalhealth.com/state or call **1-877-280-5600** for a list of participating **providers**.	If you use an in-network doctor or other healthcare **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. You must see an in-network **specialist** and you must receive a referral and written **preauthorization**.	This plan will pay some or all of the costs to see a **specialist** for covered services, but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-877-280-5600** or visit us at www.globalhealth.com/state. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.globalhealth.com/state or call 1-877-280-5600 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered healthcare, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	----------none----------
	Specialist visit	$50 copay/visit	Not covered	Referral and **preauthorization** required.
	Other practitioner office visit	No charge	Not covered	
	Preventive care/screening/immunization	No charge	Not covered	See this plan's Schedule of Benefits for details.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)	Free-standing/low-cost facility: $250 copay/scan -OR- Hospital-owned facility: $750 copay/scan	Not covered	Referral and **preauthorization** required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.globalhealth.com/state	Generic drugs	Preferred Retail – $5 copay preferred generic, $10 copay non-preferred generic Non-preferred Retail – $10 copay preferred generic, $15 copay non-preferred generic Home Delivery – $10 copay preferred generic, $20 copay non-preferred generic	Not covered	----------none----------
	Preferred brand drugs	Preferred Retail – $50 copay Non-preferred Retail – $55 copay Home Delivery – $100 copay	Not covered	**Preauthorization** and some restrictions may apply.
	Non-preferred brand drugs	Preferred Retail –$75 copay Non-preferred Retail – $80 copay Home Delivery – $150 copay	Not covered	**Preauthorization** and some restrictions may apply.
	Specialty drugs	Preferred Retail – $100 copay preferred specialty, $200 copay non-preferred specialty Non-preferred Retail – $105 copay preferred specialty, $205 copay non-preferred specialty	Not covered	**Preauthorization** required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Free-standing/low-cost facility: $250 copay -OR- Hospital-owned facility: $750 copay	Not covered	Referral and **preauthorization** required.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room services	$300 copay/visit	$300 copay/visit	Limited to services within the United States.
	Emergency medical transportation	$100 copay/occurrence	$100 copay / occurrence	
	Urgent care	$25 copay/visit	$25 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/day up to $750 copay/admission	Not covered	Referral and **preauthorization** required, except for emergency care or childbirth.
	Physician/surgeon fee	No charge	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge	Not covered	You may directly self-refer to MHNet. Call 1-866-904-5234.
	Mental/Behavioral health inpatient services	$250/day up to $750 copay/admission	Not covered	
	Substance use disorder outpatient services	No charge	Not covered	
	Substance use disorder inpatient services	$250/day up to $750 copay/admission	Not covered	
If you are pregnant	Prenatal and postnatal care	No charge/prenatal care $25 one-time copay/all postnatal care	Not covered	Referral and **preauthorization** required except for delivery.
	Delivery and all inpatient services	$500 copay/stay	Not covered	
If you need help recovering or have other special health needs	Home healthcare	No charge	Not covered	Referral and **preauthorization** required. Limited to 100 days per year.
	Rehabilitation services	Outpatient: $50 copay/visit -OR- Rehabilitation facility: $250/day up to $750 copay/admission	Not covered	Referral and **preauthorization** required. Outpatient limited to 60 visits per year. Rehabilitation facility limited to 100 days per year.
	Habilitation services	Not covered	Not covered	Member pays 100% of service
	Skilled nursing care	$250/day up to $750 copay/admission	Not covered	Referral and **preauthorization** required. Limited to 100 days per year
	Durable medical equipment	20% coinsurance/device	Not covered	Referral and **preauthorization** required.
	Hospice service	No charge	Not covered	
If your child needs dental or eye care	Eye exam	$50 copay/visit	Not covered	Limited to one exam per year.
	Glasses	Not covered	Not covered	Member pays 100% of service
	Dental check-up	Not covered	Not covered	Member pays 100% of service

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Dental care (Adult)
- Dental care (Pediatric)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (except for diabetics)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Cosmetic surgery (Repair of conditions resulting from accidental injury or congenital defects, when medically necessary. See Member Handbook for limitations.)
- Hearing aids (Up to age 18 only)
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep this health insurance coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-280-5600. You may also contact your state insurance department at 800-522-0071 or www.ok.gov/oid/Consumers, the U.S. Department of Labor, Employees Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: GlobalHealth Customer Care at 1-877-280-5600 or visit www.globalhealth.com/state, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or the Oklahoma Insurance Department 1-800-522-0071 or (405) 521-2991 (in-state only) http://www.ok.gov/oid/Consumers.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have healthcare coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-280-5600.

GlobalHealth's Customer Care Department is here to help.

- CommercialAnswers@globalhealth.com
- (405) 280-5600 (local)
- 1-877-280-5600 (toll-free)
- 1-800-722-0353 or 711 (TTY/TDD/Voice)
- 9 am to 5 pm, Monday through Friday

Customer Care can access a multilingual hotline to assist you, with over 150 languages available. Just ask for an interpreter.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

These examples are based on the per member deductible and maximum out-of-pocket amounts.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,040
- **Patient pays** $500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$500
Coinsurance	$0
Limits or exclusions	$0
Total	**$500**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,020
- **Patient pays** $1,380

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,000
Coinsurance	$300
Limits or exclusions	$80
Total	**$1,380**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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