The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. Please read the FEHB Plan brochure (RI 73-834) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can get the FEHB Plan brochure at www.GlobalHealth.com, and view the Glossary at www.GlobalHealth.com. You can call 1-877-280-2989 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300/Self Only $600/Self Plus One $600/Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services, office visits, lab work and prescriptions are covered before you meet a deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,850/Self Only $10,000/Self Plus $10,000/Self and Family	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.GlobalHealth.com or call 1-877-280-2989 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge. Deductible does not apply	Not covered	None
	Specialist visit	$45/visit. Deductible does not apply	Not covered	Except for obstetrician/gynecologist, referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
	Preventive care/screening/ immunization	No charge. Deductible does not apply	Not covered	*See Preventive Care Benefits in this plan's FEHB Brochure for details. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge. Deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	Preferred facility: $350/scan Non-preferred facility: $700/scan	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.GlobalHealth.com	Generic drugs (Tier 1)	Retail – $6/prescription, low-cost generic Deductible does not apply $15/prescription, preferred generic Deductible does not apply Home delivery/ESN – $12/prescription, low-cost generic Deductible does not apply $30/prescription, preferred generic Deductible does not apply	Not covered	Retail is a 30-day supply. Home delivery or ESN (extended supply network) is a 90-day supply.
	Preferred brand drugs (Tier 2)	Retail – $70/prescription Deductible does not apply Home delivery/ESN – $150/prescription Deductible does not apply	Not covered	Preauthorization and some restrictions may apply. Otherwise, you will have to pay the entire cost of the services. Retail is a 30-day supply. Home delivery or ESN (extended supply network) is a 90-day supply.
	Non-formulary drugs (Tier 3)	Preferred retail – $105/prescription Deductible does not apply Home delivery/ESN – $270 copayment/prescription Deductible does not apply	Not covered	Preauthorization and some restrictions may apply. Chemotherapy drug copayment is a maximum of $100/prescription. Deductible does not apply. Otherwise, you will have to pay the entire cost of the services. Retail is a 30-day supply. Home delivery or ESN (extended supply network) is a 90-day supply.
	Specialty drugs (Tier 4 – Preferred specialty)	10% coinsurance up to $200 copayment Deductible does not apply	Not covered	Oral chemotherapy drugs – 10% coinsurance up to $100 copayment. Deductible does not apply. Preauthorization and some restrictions may apply. Otherwise, you will have to pay the entire cost of the services.
	Specialty drugs (Tier 5 – Non-preferred specialty)	10% coinsurance up to $300 copayment Deductible does not apply	Not covered	Oral chemotherapy drugs – 10% coinsurance up to $100 copayment. Deductible does not apply. Preauthorization and some restrictions may apply. Otherwise, you will have to pay the entire cost of the services.
If you have	Facility fee (e.g., ambulatory	Preferred facility: $500/visit	Not covered	Referral and preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
outpatient surgery	surgery center)	Non-preferred facility: $1,000/visit		Otherwise, you will have to pay the entire cost of the services.
	Physician/surgeon fees	No charge	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
If you need immediate medical attention	Emergency room care	$300/visit	$300/visit	Emergency room copayment waived if admitted to the hospital.
	Emergency medical transportation	$75/occurrence	$75/occurrence	Limited to services within the United States.
	Urgent care	$45/visit. Deductible does not apply	$45/visit. Deductible does not apply	Limited to services within the United States.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500/day up to $1,500/admission	Not covered	Referral and preauthorization required, except for emergency care or childbirth. Otherwise, you will have to pay the entire cost of the services.
	Physician/surgeon fees	No charge	Not covered	Referral and preauthorization required, except for emergency care. Otherwise, you will have to pay the entire cost of the services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: No charge. Deductible does not apply Intensive outpatient program: $45/visit Partial hospitalization in facility: $500/day	Not covered	Other than office visits, referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services. Intensive outpatient program copay is for first 10 visits for each course of treatment, there is no copay for remainder of treatment.
	Inpatient services	$500/day up to $1,500/admission	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
If you are pregnant	Office visits	Prenatal care: No charge. Deductible does not apply Prenatal care: $45 / one time for all postnatal care. Deductible does not apply	Not covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery	No charge	Not covered	Childbirth/delivery professional services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
	professional services			included in facility services.
	Childbirth/delivery facility services	$300/day up to $900/admission	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
	Rehabilitation services	Inpatient: No charge Outpatient: $45/visit. Deductible does not apply	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services. 60 visit limit per plan year.
	Habilitation services	Outpatient: $45/visit. Deductible does not apply	Not covered	Outpatient and rehabilitation facilities: 60 visit limit per plan year.
	Skilled nursing care	$500/admission	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
	Durable medical equipment	30% coinsurance	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
	Hospice services	No charge	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
If your child needs dental or eye care	Children's eye exam	$40/visit. Deductible does not apply	Not covered	One exam limit per plan year.
	Children's glasses	No charge	Not covered	Limited to one pair of basic frames and lenses or first set of contact lenses following cataract surgery.
	Children's dental check-up	Not covered	Not covered	No coverage.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult)	• Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)		
• Bariatric surgery • Chiropractic care	• Hearing aids • Infertility treatment	• Routine eye care (Adult) • Routine foot care (Covered for diabetics only.)

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-877-280-2989 or visit www.opm.gov.insure/health. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact: For more information about your rights, this notice, or assistance, contact: GlobalHealth Customer Care at 1-877-280-2989 or visit www.GlobalHealth.com.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-280-2964 (TTY: 711).

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$45**
- **Hospital (facility) copayment** **$300 per day**
  $900 per admission
- **Other copayment** **$0**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$910**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$45**
- **Hospital (facility) copayment** **$500 per day**
  $1,500 per admission
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,930**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$300**
- **Specialist copayment** **$45**
- **Hospital (facility) copayment** **$500 per day**
  $1,500 per admission
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.