
 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.** For more information about your coverage, or to get a copy of the complete terms of coverage call 1-877-280-2964 or visit us at https://www.globalhealth.com/media/3579/largegroup_gold_withoutdental_memberhandbook.pdf. 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 view the Glossary at https://www.GlobalHealth.com/media/2711/2017_uniformglossary.pdf or call 1-877-280-2964 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,000/individual or \$4,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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 some prescriptions are covered before you meet the 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?	\$3,000/individual or \$6,000/family	The out-of-pocket limit 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 , balance billing charges, 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 1-877-280-2964 for a list of network providers .	This plan uses a provider network . You will pay the least if you use a provider in the Preferred Facility network . You will pay more if you use a provider in the Non-preferred Facility 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)	
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	\$50 copayment /visit. Deductible does not apply.	Not covered	Except for obstetrician/gynecologist and chiropractic care, 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 Member Handbook 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)	PCP (primary care physician) visit: No charge. Deductible does not apply. Specialist visit: No charge. Deductible does not apply. Preferred facility: \$300 copayment /scan. Non-preferred facility: \$900 copayment /scan.	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services. Included in specialist visit copayment .

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.GlobalHealth.com.

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)	
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 – No charge, low-cost generic. Deductible does not apply. \$15 copayment /prescription, preferred generic. Deductible does not apply. Home delivery/ESN – No charge, low-cost generic. Deductible does not apply. \$30 copayment /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. Preauthorization and some restrictions may apply. *See Prescription Drug Benefits in this plan's Member Handbook for details. 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.
	Preferred brand drugs (Tier 2)	Retail – \$70 copayment /prescription. Home delivery/ESN – \$175 copayment /prescription.	Not covered	
	Non-preferred brand drugs (Tier 3)	Retail – \$95 copayment /prescription. Home delivery/ESN – \$285 copayment /prescription.	Not covered	
	Specialty drugs (Tier 4)	Preferred specialty – 20% coinsurance up to \$250 copayment /prescription. Non-preferred specialty – 20% coinsurance up to \$350 copayment /prescription. Oral chemotherapy drugs – 20% coinsurance up to \$100 copayment /prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Preferred facility: \$300 copayment /visit Non-preferred facility: \$900 copayment /visit.	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services. Physician/surgeon fees included in facility fee.
	Physician/surgeon fees	No charge.	Not covered	
If you need immediate medical attention	Emergency room care	\$300 copayment /visit.	\$300 copayment /visit.	Limited to services within the United States. Emergency room copayment waived if admitted to the hospital.
	Emergency medical transportation	\$150 copayment /occurrence.	\$150 copayment /occurrence.	
	Urgent care	\$30 copayment /visit. Deductible does not apply.	\$30 copayment /visit. Deductible does not apply.	

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.GlobalHealth.com.

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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,000 copayment /stay.	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 included in facility fee.
	Physician/surgeon fees	No charge.	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: No charge. Deductible does not apply. Intensive outpatient program: \$10 copayment /day. Partial hospitalization facility: \$75 copayment /day.	Not covered	Other than office visits, referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
	Inpatient services	Residential treatment center: \$100 copayment /day. Inpatient hospital facility: \$1,000 copayment /stay	Not covered	
If you are pregnant	Office visits	No charge / prenatal care. Deductible does not apply. \$50 copayment / one-time for all postnatal care. Deductible does not apply.	Not covered	Cost sharing does not apply for preventive services . Childbirth/delivery professional services included in facility services.
	Childbirth/delivery professional services	No charge.	Not covered	
	Childbirth/delivery facility services	\$750 copayment /stay.	Not covered	
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. 30 visit limit per plan year.
	Rehabilitation services	Inpatient: No charge. Office visit: \$35 copayment /visit. Deductible does not apply. Rehabilitation outpatient facility: \$70 copayment /day.	Not covered	Referral and preauthorization required except for physical therapy evaluation. Otherwise, you will have to pay the entire cost of the services Outpatient and rehabilitation facilities: 30 visit limit per plan year. Inpatient services included

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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)	
		Rehabilitation inpatient facility: \$225 copayment /day.		in hospital facility fee.
	Habilitation services	Inpatient: No charge. Office visit: \$35 copayment /visit. Deductible does not apply. Habilitation outpatient facility: \$70 copayment /day.	Not covered	Referral and preauthorization required except for physical therapy evaluation. Otherwise, you will have to pay the entire cost of the services. Inpatient services included in hospital facility fee. Limited to the following diagnosis: <ul style="list-style-type: none"> • Autistic disorder – childhood autism, infantile psychosis, and Kanner’s syndrome; • Childhood disintegrative disorder – Heller’s syndrome; and • Specified pervasive developmental disorders – Asperger’s disorder, atypical childhood psychosis, and borderline psychosis of childhood.
	Skilled nursing care	\$100 copayment /day.	Not covered	Referral and preauthorization required.
	Durable medical equipment	25% coinsurance .	Not covered	Otherwise, you will have to pay the entire cost of the services. Skilled nursing: 30-day limit per plan year.
	Hospice services	No charge.	Not covered	
If your child needs dental or eye care	Children’s eye exam	\$30 copayment /visit. Deductible does not apply.	Not covered	One exam limit per plan year.
	Children’s glasses	Frames: \$40 copayment . Prescription lenses: 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.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.GlobalHealth.com.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Bariatric surgery
- Dental care (Adult)
- Dental care (Children's dental check-up)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care
- Cosmetic surgery (Repair of conditions resulting from accidental injury or congenital defects, when [medically necessary](#). See Member Handbook for limitations.)
- Hearing aids (Limited to one aid per ear every 48 months.)
- Infertility treatment
- Routine eye care (Adult)
- Routine foot care (Covered for diabetics only.)
- Weight loss programs (Covered only if provided by network [providers](#).)

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.GlobalHealth.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The U.S. Department of Labor, Employees Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov or you may contact GlobalHealth at 1-877-280-2964 or www.GlobalHealth.com. 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: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: GlobalHealth Customer Care at 1-877-280-2964 or visit www.GlobalHealth.com, 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 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	\$2,000
■ Specialist copayment	\$50
■ Hospital (facility) copayment	\$750
■ 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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Peg would pay is	\$2,810

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$50
■ Hospital (facility) copayment	\$1,000
■ 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$1,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$30
The total Joe would pay is	\$3,030

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$50
■ Hospital (facility) copayment	\$1,000
■ 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,300
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500

Notice about non-discrimination

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- 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 Customer Care at 1-877-280-2964 (toll-free).

If you believe that GlobalHealth, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **Attn: Director, Compliance and Legal Services, 210 Park Ave, Ste 2800, Oklahoma City, OK 73102-5621, Fax: (405) 280-5894, or E-mail: compliance@globalhealth.com**. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Customer Care 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, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language	Translation
Spanish	Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de GlobalHealth. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-877-280-2964.
Vietnamese	Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bản về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình GlobalHealth. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-877-280-2964.
Chinese	本通知有重要的訊息。本通知有關於您透過[插入SBM項目的名稱 GlobalHealth 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康

