
 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/2711/2017\\_uniformglossary.pdf](https://www.GlobalHealth.com/media/2711/2017_uniformglossary.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](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:
<b>What is the overall <a href="#">deductible</a>?</b>	\$2,000/individual or \$4,000/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive services</a> , office visits, lab work and some prescriptions are covered before you meet the <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$3,000/individual or \$6,000/family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance billing</a> charges, and healthcare this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.GlobalHealth.com">www.GlobalHealth.com</a> or call 1-877-280-2964 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay the least if you use a <a href="#">provider</a> in the Preferred Facility <a href="#">network</a> . You pay more if you use a <a href="#">provider</a> in the Non-preferred Facility network. You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	No charge. <a href="#">Deductible</a> does not apply.	Not covered	None.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copayment</a> /visit. <a href="#">Deductible</a> does not apply. Chiropractic care: \$35 <a href="#">copayment</a> /visit. <a href="#">Deductible</a> does not apply. Foot care: \$25 <a href="#">copayment</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	Except for obstetrician/gynecologist and chiropractic care, <a href="#">referral</a> and <a href="#">preauthorization</a> required. Otherwise, you will have to pay the entire cost of the services.
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	Not covered	*See <a href="#">Preventive Care</a> Benefits in this <a href="#">plan's</a> Member Handbook for details. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge. <a href="#">Deductible</a> does not apply.	Not covered	None.
	Imaging (CT/PET scans, MRIs)	PCP (primary care physician) visit: No charge. <a href="#">Deductible</a> does not apply. <a href="#">Specialist</a> visit: No charge. <a href="#">Deductible</a> does not apply. Preferred facility: \$300 <a href="#">copayment</a> /scan. Non-preferred facility: \$900 <a href="#">copayment</a> /scan.	Not covered	<a href="#">Referral</a> and <a href="#">preauthorization</a> required. Otherwise, you will have to pay the entire cost of the services. Included in <a href="#">specialist</a> visit <a href="#">copayment</a> .

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.GlobalHealth.com">www.GlobalHealth.com</a>	Generic drugs (Tier 1)	30-day supply – No charge, low-cost generic. <a href="#">Deductible</a> does not apply. \$15 <a href="#">copayment</a> /prescription, preferred generic. <a href="#">Deductible</a> does not apply. 90-day supply – No charge, low-cost generic. <a href="#">Deductible</a> does not apply. \$30 <a href="#">copayment</a> /prescription, preferred generic. <a href="#">Deductible</a> does not apply.	Not covered	A 30-day supply is through retail. a 90-day supply may be through retail or mail order.  <a href="#">Preauthorization</a> and some restrictions may apply. *See Prescription Drug Benefits in this <a href="#">plan's</a> Member Handbook for details. Otherwise, you will have to pay the entire cost of the services. A 30-day supply is through retail. a 90-day supply may be through retail or mail order. <a href="#">Specialty drugs</a> are only available in 30-day supplies.
	Preferred brand drugs (Tier 2)	30-day supply – \$70 <a href="#">copayment</a> /prescription. 90-day supply – \$175 <a href="#">copayment</a> /prescription.	Not covered	
	Non-preferred brand drugs (Tier 3)	30-day supply – \$95 <a href="#">copayment</a> /prescription. 90-day supply – \$285 <a href="#">copayment</a> /prescription.	Not covered	
	<a href="#">Specialty drugs</a> (Tier 4)	Preferred specialty – 20% <a href="#">coinsurance</a> up to \$500 <a href="#">copayment</a> /prescription. Non-preferred specialty – 20% <a href="#">coinsurance</a> up to \$700 <a href="#">copayment</a> /prescription. Oral chemotherapy drugs – 20% <a href="#">coinsurance</a> up to \$100 <a href="#">copayment</a> /prescription	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Preferred facility: \$300 <a href="#">copayment</a> /visit Non-preferred facility: \$900 <a href="#">copayment</a> /visit.	Not covered	<a href="#">Referral</a> and <a href="#">preauthorization</a> 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	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$300 <a href="#">copayment</a> /visit.	\$300 <a href="#">copayment</a> /visit.	Limited to services within the United States. Emergency room <a href="#">copayment</a> waived if admitted to the hospital.
	<a href="#">Emergency medical transportation</a>	\$150 <a href="#">copayment</a> /occurrence.	\$150 <a href="#">copayment</a> /occurrence.	
	<a href="#">Urgent care</a>	\$20 <a href="#">copayment</a> /visit. <a href="#">Deductible</a> does not apply.	\$20 <a href="#">copayment</a> /visit. <a href="#">Deductible</a>	

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)	
			does not apply.	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,000 <a href="#">copayment</a> /stay.	Not covered	<a href="#">Referral</a> and <a href="#">preauthorization</a> 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. <a href="#">Deductible</a> does not apply. Intensive outpatient program: No charge. <a href="#">Deductible</a> does not apply. Partial hospitalization program: No charge.	Not covered	Other than office visits, <a href="#">referral</a> and <a href="#">preauthorization</a> required. Otherwise, you will have to pay the entire cost of the services.
	Inpatient services	Residential treatment center: \$100 <a href="#">copayment</a> /day. Inpatient hospital facility: \$1,000 <a href="#">copayment</a> /stay	Not covered	
If you are pregnant	Office visits	No charge / prenatal or postnatal care. <a href="#">Deductible</a> does not apply.	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Childbirth/delivery professional services included in facility services.
	Childbirth/delivery professional services	No charge.	Not covered	
	Childbirth/delivery facility services	\$750 <a href="#">copayment</a> /stay.	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge.	Not covered	<a href="#">Referral</a> and <a href="#">preauthorization</a> required. Otherwise, you will have to pay the entire cost of the services. 30 visit limit per <a href="#">plan</a> year.
	<a href="#">Rehabilitation services</a>	Inpatient: No charge. Office visit: \$35 <a href="#">copayment</a> /visit. <a href="#">Deductible</a> does not apply. Rehabilitation outpatient facility: \$70 <a href="#">copayment</a> /day. Rehabilitation inpatient facility: \$225	Not covered	<a href="#">Referral</a> and <a href="#">preauthorization</a> 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 <a href="#">plan</a> year. Inpatient services included in hospital facility fee.

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)	
		<a href="#">copayment</a> /day.		
	<a href="#">Habilitation services</a>	Inpatient: No charge. Office visit: \$35 <a href="#">copayment</a> /visit. <a href="#">Deductible</a> does not apply. Habilitation outpatient facility: \$70 <a href="#">copayment</a> /day.	Not covered	<a href="#">Referral</a> and <a href="#">preauthorization</a> 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 diagnoses: <ul style="list-style-type: none"> <li>• Autistic disorder – childhood autism, infantile psychosis, and Kanner’s syndrome;</li> <li>• Childhood disintegrative disorder – Heller’s syndrome;</li> <li>• Rett’s syndrome; and</li> <li>• Specified pervasive developmental disorders – Asperger’s disorder, atypical childhood psychosis, and borderline psychosis of childhood.</li> </ul>
	<a href="#">Skilled nursing care</a>	\$100 <a href="#">copayment</a> /day.	Not covered	<a href="#">Referral</a> and <a href="#">preauthorization</a> required.
	<a href="#">Durable medical equipment</a>	25% <a href="#">coinsurance</a> .	Not covered	Otherwise, you will have to pay the entire cost of the services. Skilled nursing: 30-day limit per <a href="#">plan</a> year.
	<a href="#">Hospice services</a>	No charge.	Not covered	
If your child needs dental or eye care	Children’s eye exam	\$30 <a href="#">copayment</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	One exam limit per <a href="#">plan</a> 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 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](#).)

**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](http://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](http://www.cciio.cms.gov) or you may contact GlobalHealth at 1-877-280-2964 or [www.GlobalHealth.com](http://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](http://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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$750
■ Other <a href="#">copayment</a>	\$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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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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
<b>The total Peg would pay is</b>	<b>\$2,810</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$1,000
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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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
<b>The total Joe would pay is</b>	<b>\$3,030</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	\$1,000
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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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
<b>The total Mia would pay is</b>	<b>\$1,500</b>

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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: Executive Director, Compliance and Legal Services, 210 Park Ave, Ste 2800, Oklahoma City, OK 73102-5621, or E-mail: [compliance@globalhealth.com](mailto:compliance@globalhealth.com)**. You can file a grievance in person or by mail 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





