



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 1-877-280-5600 or visit us at [Member Handbook](#). 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 [www.GlobalHealth.com/uniformglossary](http://www.GlobalHealth.com/uniformglossary) or call 1-877-280-5600 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. All services are covered before you meet a <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> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$4,000/individual or \$12,000/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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.globalhealth.com">www.globalhealth.com</a> or call 1-877-280-5600 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 <a href="#">network</a> . 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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 office or clinic</a>	Primary care visit to treat an injury or illness	No charge.	Not covered	None.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copayment</a> /visit. Chiropractic care: \$25 <a href="#">copayment</a> /visit. Foot care: \$20 <a href="#">copayment</a> /visit.	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. Chiropractic care: 15 visit limit per <a href="#">plan</a> year.
	<a href="#">Preventive care/screening/immunization</a>	No charge.	Not covered	*See <a href="#">Preventive Care</a> Benefits Section. 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)	\$10 <a href="#">copayment</a> /visit.	Not covered	None.
	Imaging (CT/PET scans, MRIs)	PCP (primary care physician) visit: No charge. <a href="#">Specialist</a> visit: No charge. Preferred facility: \$250 <a href="#">copayment</a> /scan. Non-preferred facility: \$750 <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> .
If you need drugs to treat your illness or condition 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 – \$20 <a href="#">copayment</a> /prescription, preferred generic. 90-day supply – \$40 <a href="#">copayment</a> /prescription, preferred generic.	Not covered	A 30-day supply is through retail. A 90-day supply may be through retail or mail order.
	Preferred brand drugs (Tier 2)	30-day supply – \$65 <a href="#">copayment</a> /prescription. 90-day supply – \$130	Not covered	<a href="#">Preauthorization</a> and some restrictions may apply. *See Prescription Drug Benefits section. Otherwise, you will have to pay the

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.GlobalHealth.com](http://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)	
		<a href="#">copayment</a> /prescription.		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.
	Non-preferred brand drugs (Tier 3)	30-day supply – \$90 <a href="#">copayment</a> /prescription. 90-day supply – \$180 <a href="#">copayment</a> /prescription. Diabetic insulin: 30-day supply – Maximum of \$30 <a href="#">copayment</a> /prescription. 90-day supply – Maximum of \$90 <a href="#">copayment</a> /prescription.	Not covered	
	<a href="#">Specialty drugs</a> (Tier 4)	Preferred specialty – \$200 <a href="#">copayment</a> /prescription Non-preferred specialty – \$400 <a href="#">copayment</a> /prescription. Chemotherapy drug <a href="#">copayment</a> is a maximum of \$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: \$800 <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>	\$400 <a href="#">copayment</a> /visit.	\$400 <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>	\$100 <a href="#">copayment</a> /occurrence.	\$100 <a href="#">copayment</a> /occurrence.	
	<a href="#">Urgent care</a>	\$25 <a href="#">copayment</a> /visit.	\$25 <a href="#">copayment</a> /visit.	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$300/day up to \$900 <a href="#">copayment</a> /stay.	Not covered	<a href="#">Referral</a> and <a href="#">preauthorization</a> required, except for emergency care or childbirth.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.GlobalHealth.com](http://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)	
	Physician/surgeon fees	No charge.	Not covered	Otherwise, you will have to pay the entire cost of the services. Physician/surgeon fees included in facility fee.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office visit: No charge. Intensive outpatient program: No charge. Partial <a href="#">hospitalization</a> program: No charge.	Not covered	*See Behavioral Health Benefits Section. 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: \$300/day up to \$900 <a href="#">copayment</a> /stay. Acute: \$300/day up to \$900 <a href="#">copayment</a> /stay.	Not covered	
<b>If you are pregnant</b>	Office visits	No charge / prenatal or postnatal care.	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Childbirth/delivery professional services included in facility services. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge.	Not covered	
	Childbirth/delivery facility services	\$500 <a href="#">copayment</a> /stay.	Not covered	
<b>If you need help recovering or have other special health needs</b>	<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. 100 visit limit per <a href="#">plan</a> year.
	<a href="#">Rehabilitation services</a>	Inpatient: No charge. Office visit: \$35 <a href="#">copayment</a> /visit. Rehabilitation outpatient facility: \$70 <a href="#">copayment</a> /visit.	Not covered	Includes physical therapy, speech therapy, and occupational therapy. <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: 60 visit limit per <a href="#">plan</a> year. Inpatient services included in hospital facility fee.
	<a href="#">Habilitation services</a>	Inpatient: No charge. Office visit: \$35 <a href="#">copayment</a> /visit. Rehabilitation	Not covered	*See Medical Benefits section. <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.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.GlobalHealth.com](http://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)	
		outpatient facility: \$70 <a href="#">copayment</a> /visit.		Inpatient services included in hospital facility fee.
	<a href="#">Skilled nursing care</a>	\$750 <a href="#">copayment</a> /stay.	Not covered	*See Medical Benefits section. <a href="#">Referral</a> and <a href="#">preauthorization</a> required. Otherwise, you will have to pay the entire cost of the services. Skilled nursing: 100-day limit per <a href="#">plan</a> year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> .	Not covered	
	<a href="#">Hospice services</a>	No charge.	Not covered	
<b>If your child needs dental or eye care</b>	Children's eye exam	\$50 <a href="#">copayment</a> /visit.	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (Children's dental check-up)</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Chiropractic care (Limited to 15 visits per year.)</li> <li>Cosmetic surgery (Repair of conditions resulting from accidental injury or congenital defects, when <a href="#">medically necessary</a>. See Member Handbook for limitations.)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids (Limited to one aid per ear every 48 months.)</li> <li>Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> <li>Routine foot care (Covered for diabetics only.)</li> <li>Weight loss programs (Covered only if provided by <a href="#">network providers</a>.)</li> </ul>

**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-EBSA (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 1-877-280-5600 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 on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or

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

assistance, contact: GlobalHealth Customer Care at 1-877-280-5600 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**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**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 1-877-280-5600 (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](#) \$0
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$500
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$600</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$300/day up to \$900/stay
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,460</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$300/day up to \$900/stay
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$810</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

