



# Schedule of Benefits

2017

## State, Education, and Local Government Employees

HIOS ID – 85408OK0060005

GlobalHealth Plan ID – MSTSB17



GlobalHealth, Inc.  
701 NE 10th Street, Suite 300  
Oklahoma City, OK 73104-5403  
[www.globalhealth.com/state](http://www.globalhealth.com/state)



# HELPFUL NUMBERS

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**Plan Issuer:**

GlobalHealth, Inc.  
PO Box 2393  
Oklahoma City, OK 73101-2393  
[www.globalhealth.com/state](http://www.globalhealth.com/state)

**GlobalHealth Customer Care, Language Assistance, and Disease Management:**

[CommercialAnswers@globalhealth.com](mailto:CommercialAnswers@globalhealth.com)

405.280.5600  
1.877.280.5600 (toll-free)  
711 (TTY)  
Mon – Fri, 9 am – 5 pm

**24/7 Nurse Help Line:**

Information Line  
1.877.280.2993 (toll-free)

**GlobalHealth Compliance Officer:**

405.280.5852  
1.877.280.5852 (toll-free)  
[compliance@globalhealth.com](mailto:compliance@globalhealth.com)

**GlobalHealth Privacy Officer:**

405.280.5524  
[privacy@globalhealth.com](mailto:privacy@globalhealth.com)

**Behavioral Health:**

[CommercialAnswers@globalhealth.com](mailto:CommercialAnswers@globalhealth.com)  
405.280.5600  
1.877.280.5600 (toll-free)

711 (TTY)  
Mon – Fri, 9 am – 5 pm

Pharmacy Benefits Manager:  
Express Scripts Holding Company  
1.866.274.1612 (toll-free)  
1.800.899.2114 (TTY)

Medication Prior Authorizations:  
[gh.pharmacy@globalhealth.com](mailto:gh.pharmacy@globalhealth.com)  
918.878.7361

Mail Claims to:  
Express Scripts  
Attn: Commercial Claims  
PO Box 14711  
Lexington, KY 40512-4711

**Mail Order Pharmacy:**

Express Scripts Customer Service Center  
1.866.274.1612 (toll-free)  
1.800.899.2114 (TTY)  
24 hours/7 days a week  
[www.express-scripts.com](http://www.express-scripts.com)

**\*Specialty Pharmacy:**

Accredo Specialty Pharmacy  
1.888.608.9010  
[www.accredo.com](http://www.accredo.com)

\*Accredo Specialty Pharmacy is not the exclusive Specialty Drug Pharmacy. You have the option to use other pharmacies.

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# IMPORTANT INFORMATION

## Member Materials

Please read this *Schedule of Benefits* and your other Member materials carefully. **This is an important legal document. Please keep it in a safe place.**

- This *Schedule of Benefits* lists the Copayment, Coinsurance, and maximum out-of-pocket amounts for this specific Plan.
- See your *Member Handbook for State, Education, and Local Government Employees* (“*Member Handbook*”) for details of how to use this Plan, such as:
  - Coverage requirements
  - Description of Covered Services and benefit details
  - How and when you reach your maximum out-of-pocket
  - Network of Providers, Referrals, and Preauthorizations
- The *Physicians and Health Providers Directory* (“*Provider Directory*”) lists our Network of physicians, Facilities, and pharmacies.
- The *Formulary Drug List for State, Education, and Local Government Employees* (“*Drug Formulary*”) lists drugs we cover. It explains the drug Tier and any restrictions for each drug.

When this document says “we”, “us”, or “our”, it means GlobalHealth, Inc. Words or phrases that start with a capital letter are defined in the *Member Handbook* glossary.

Member materials are available on our website. Contact Customer Care for printed copies at no charge. But, be aware that the most current *Drug Formulary* and *Provider Directory* lists are on the website.

## Deductible and Maximum Out-of-Pocket

Benefit Description	You Pay
<i>Deductible</i>	This Plan does not have an annual Deductible.
<i>Maximum Out-of-Pocket</i>	Per Member – \$3,500 per Plan Year Family – \$10,500 per Plan Year

# MEDICAL BENEFITS

## Devices, Appliances, Equipment, and Supplies

Benefit Description	You Pay
<i>Diabetic Supplies</i>	20% Coinsurance
<i>Durable Medical Equipment</i> (“ <i>DME</i> ”)	20% Coinsurance
<i>Orthotic Devices</i>	20% Coinsurance
<i>Prosthetic Appliances</i>	20% Coinsurance

<b>Emergencies / After Hours</b>	
<b>Benefit Description</b>	<b>You Pay</b>
<i>Ambulance</i>	\$100 Copayment/occurrence
<i>Emergency Room (“ER”) Services</i>	\$300 Copayment/visit  Waived if admitted to Inpatient Hospital
<i>Urgent Care Facility</i>	\$25 Copayment/visit

<b>Family Planning and Maternity Care</b>	
<b>Benefit Description</b>	<b>You Pay</b>
<i>Family Planning</i>	Women: No Copayment  Men: \$50 Copayment/visit if performed in an office setting
<i>Infertility Services</i>	PCP Visit: PCP Visit: No Copayment -OR- Specialist Visit: \$50 Copayment/visit  Treatment: 50% Coinsurance
<i>Maternity and Newborn Care</i> <ul style="list-style-type: none"> <li>• Delivery and Inpatient Hospital care for the 48/96 hour birth coverage, including newborn care</li> <li>• Outpatient postnatal care</li> <li>• Prenatal care and other services: <ul style="list-style-type: none"> <li>○ Prenatal care</li> <li>○ Breastfeeding pump and supplies</li> <li>○ Lactation support and counseling</li> </ul> </li> </ul>	Delivery and Inpatient Hospital for Mother and Baby: \$500 Copayment/admission  All Outpatient Postnatal Care: \$25 one-time Copayment  Prenatal Care and Other Services: No Copayment

<b>Home Care</b>	
<b>Benefit Description</b>	<b>You Pay</b>
<i>Applied Behavioral Analysis</i>	Home Visit: No Copayment  Natural Environment Training: \$50 Copayment/day
<i>Behavioral Health Case Management and Psychosocial Education</i>	No Copayment
<i>Home Healthcare</i>	No Copayment
<i>Hospice Care</i>	No Copayment

Inpatient and Outpatient Care	
Benefit Description	You Pay
<i>Behavioral Health, Facility Services</i>	Residential Treatment Center or Medical Detoxification: \$250 Copayment/day up to a maximum of \$750 per admission  Acute Hospitalization: \$250 Copayment/day up to \$750 Copayment/admission
<i>Inpatient Hospital, Facility Services</i>	Maternity: \$500 Copayment/admission  All Other Stays: \$250 Copayment/day up to \$750 Copayment/admission
<i>Inpatient Hospital or Outpatient Surgery, Physician Services</i>	Included in Facility services Copayment
<i>#Outpatient Surgery, Facility Services</i>	Preferred Facility: \$250 Copayment -OR- Non-preferred Facility: \$750 Copayment
<i>Skilled Nursing Facility Care</i>	\$250 Copayment/day up to a maximum of \$750 per admission

#You will pay less out-of-pocket if you choose to receive these services in a Preferred Facility rather than a Non-preferred Facility.

Lab and Diagnostic Tests	
Benefit Description	You Pay
<i>Lab, X-ray, and Other Diagnostic Tests</i>	No Copayment
<i>#Specialized Scans, Imaging and Diagnostic Exams</i>	PCP Visit: No Copayment -OR- Specialist Visit: Included in Specialist visit Copayment -OR- Preferred Facility: \$250 Copayment/scan -OR- Non-preferred: \$750 Copayment/scan

#You will pay less out-of-pocket if you choose to receive these services in a Preferred Facility rather than a Non-preferred Facility.

Office Visits	
Benefit Description	You Pay
<i>Allergy Care</i>	PCP Visit: No Copayment -OR- Specialist Visit: \$50 Copayment/visit

<b>Benefit Description</b>	<b>You Pay</b>
	Serum: \$30 Copayment/6-week supply of antigen and administration
(Continued) <i>Behavioral Health Services, including Applied Behavioral Analysis</i>	No Copayment/visit
<i>Chiropractic Care</i>	\$25 Copayment/visit
<i>Physician Services</i>	PCP Visit: No Copayment -OR- Specialist Visit: \$50

### Preventive Care Services

<b>Benefit Description</b>	<b>You Pay</b>
<i>Preventive care</i>	No Copayment  Office visit Copayment may apply if in conjunction with other services. See "Physician Services".

### Rehabilitation Services

<b>Benefit Description</b>	<b>You Pay</b>
<i>Cardiac and Pulmonary Rehabilitation</i>	\$50 Copayment/visit
<i>Physical, Occupational, and/or Speech Therapy</i>	Inpatient: Included in Hospital Facility Copayment  \$50 Copayment/visit -OR- Rehabilitation Facility: \$250 Copayment/day up to \$750 Copayment/admission

### Special Programs

<b>Benefit Description</b>	<b>You Pay</b>
<i>Special Programs</i>	No Copayment

### Temporomandibular Joint Dysfunction

<b>Benefit Description</b>	<b>You Pay</b>
<i>Temporomandibular Joint Dysfunction</i>	\$100 Copayment/treatment plan

### Treatment Therapies

<b>Benefit Description</b>	<b>You Pay</b>
<i>#Treatment Therapies</i>	\$50 Copayment/treatment



Benefit Description	You Pay
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#You will pay less out-of-pocket if you choose to receive these services in a Preferred Facility rather than a Non-preferred Facility.

Vision Care	
Benefit Description	You Pay
<i>Exam</i>	\$50 Copayment/visit
<i>Eyeglasses or Contacts</i>	All charges after maximum reimbursement of \$100

## PRESCRIPTION DRUGS

Retail Pharmacy – 30-day supply	
Benefit Description	You Pay
<i>ACA</i>	No Copayment
<i>Tier One</i>	Low-cost Generic: \$5 Copayment/prescription Preferred Generic: \$10 Copayment/prescription
<i>Tier Two</i>	\$50 Copayment/prescription
<i>Tier Three</i>	\$75 Copayment/prescription
<i>Tier Four</i>	Preferred Specialty: \$100 Copayment/prescription  Non-preferred Specialty: \$200 Copayment/prescription

Home Delivery or Extended Retail Supply – 90-day supply	
Benefit Description	You Pay
<i>ACA</i>	No Copayment
<i>Tier One</i>	Low-cost Generic: \$10 Copayment/prescription Preferred Generic: \$20 Copayment/prescription
<i>Tier Two</i>	\$100 Copayment/prescription
<i>Tier Three</i>	\$150 Copayment/prescription

# EXCLUSIONS AND LIMITATIONS

All benefits described below are excluded or limited under this Plan for all types of services.

## General Limitations

We cover certain benefits only as follows:

Benefit	Limitation Description
Ancillary services and supplies	<ul style="list-style-type: none"> <li>• Hearing aids are limited to coverage for:               <ul style="list-style-type: none"> <li>○ Children through the month in which he or she turns eighteen (18) years of age, one (1) aid per ear every forty-eight (48) months unless Medically Necessary to replace more often.</li> <li>○ Children less than two (2) years of age, four (4) additional ear molds per year.</li> </ul> </li> <li>• Corrective lenses and fittings limited to first set of basic frames and lenses (up to \$100.00) following cataract surgery.</li> <li>• Routine foot care, shoes, shoe inserts, arch supports, and supportive devices limited to foot care for Members diagnosed with diabetes or peripheral vascular disease.</li> <li>• Orthopedic or corrective shoes limited to those permanently attached to a Denis Browne splint for children.</li> <li>• Wigs and scalp prostheses limited to \$150 reimbursement per Plan Year when required due to loss of hair resulting from chemotherapy or radiation therapy.</li> <li>• Breast pumps limited to one (1) per Plan Year for women who are pregnant or nursing.</li> <li>• Orthotic devices limited to:               <ul style="list-style-type: none"> <li>○ Members with diagnoses pertaining to peripheral vascular disease or diabetes.</li> </ul> </li> </ul>
Behavioral health services	<ul style="list-style-type: none"> <li>• Autism Screening is limited to children at ages eighteen (18) months and twenty-four (24) months.</li> <li>• Developmental Screening is limited to children up to the age of three (3) years.</li> <li>• Compulsive disorders treatment is limited to programs for feeding and eating disorders.</li> <li>• Residential treatment center care limited to 100 days per Plan Year.</li> <li>• Medical detoxification limited to 100 days per Plan Year.</li> <li>• Behavioral health case management limited to eight (8) hours per month and twenty-four (24) hours per Plan Year.</li> <li>• Psychosocial rehabilitation limited to eight (8) hours per month and twenty-four (24) hours per Plan Year.</li> <li>• Psychological testing limited to eight (8) hours per Plan Year.</li> <li>• Psychiatric or psychological treatment for developmental disorders limited to mental retardation, pervasive developmental disorder and other specific disorders, such as autism, Rett's, or Asperger's.</li> <li>• Applied behavioral analysis limited to:               <ul style="list-style-type: none"> <li>○ Members under age nine (9) or if not diagnosed or treated until after age three (3) for at least six (6) years;</li> </ul> </li> </ul>

<b>Benefit</b>	<b>Limitation Description</b>
	<ul style="list-style-type: none"> <li>○ A maximum of twenty-five (25) hours per week; and</li> <li>○ A maximum of \$25,000 per Plan Year.</li> </ul>
Chiropractic care	<ul style="list-style-type: none"> <li>● Limited to fifteen (15) visits per Plan Year.</li> </ul>
Cosmetic services	<ul style="list-style-type: none"> <li>● Treatment, item, supply, drug, procedure, or any portion of a procedure performed primarily to improve physical appearance limited to: <ul style="list-style-type: none"> <li>○ Repairing conditions resulting from an accidental injury;</li> <li>○ Improvement of the physiological functioning of a malformed body member not related to dentistry or dental processes to the teeth and surrounding tissue; and</li> <li>○ Breast reconstruction following a mastectomy.</li> </ul> </li> </ul>
Dental services – medical coverage	<ul style="list-style-type: none"> <li>● Dentistry or dental processes to the teeth and surrounding tissue limited to: <ul style="list-style-type: none"> <li>○ Emergency room services to treat accidental injury to the jaw, sound natural teeth, mouth, or face.</li> <li>○ Improvement of the physiological functioning of a malformed body member resulting from a congenital defect.</li> </ul> </li> <li>● General anesthesia/IV sedation for dental services limited to Members who are: <ul style="list-style-type: none"> <li>○ Under the age of nine (9) when he or she has a medical or emotional condition that requires Hospitalization or general anesthesia for dental care;</li> <li>○ Severely disabled;</li> <li>○ A minor four (4) years of age or under who, in the judgment of the Practitioner treating the child, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia; and</li> <li>○ Require Inpatient or Outpatient services because of an underlying medical condition and clinical status or because of the severity of the dental procedure.</li> </ul> </li> </ul>
Experimental or Investigational therapies	<ul style="list-style-type: none"> <li>● Drugs, items, devices, and procedures limited to: <ul style="list-style-type: none"> <li>○ Off-label uses of certain drugs used in the treatment of cancer or the study of oncology; and</li> <li>○ Certain investigational uses of drugs, including chemotherapy for cancer treatment, if administered as part of an Approved Clinical Trial.</li> </ul> </li> </ul>
General care or Hospital services	<ul style="list-style-type: none"> <li>● Hospital private room limited to when the Member is required under the infection control policy of the Hospital to be in isolation to prevent contagion.</li> <li>● Treatment of injuries or illnesses sustained or contracted as the result of being under the influence of any narcotic, unless prescribed by a physician, limited to injury as a result of a medical condition (including both physical and mental health conditions).</li> </ul>
Genetic analysis, services, or testing	<ul style="list-style-type: none"> <li>● Genetic counseling and testing is limited to women whose family history is associated with an increased risk for deleterious mutations in BRCA 1 and BRCA 2 genes.</li> </ul>

<b>Benefit</b>	<b>Limitation Description</b>
Home Healthcare	<ul style="list-style-type: none"> <li>Limited to 100 visits per Plan Year.</li> </ul>
Physical, occupational, and speech therapy	<ul style="list-style-type: none"> <li>Physical, occupational, and/or speech therapy services limited to sixty (60) combined visits per Plan Year for you to regain, maintain, or prevent deterioration of a skill or function that has been acquired, but then lost or impaired due to illness, injury, or disabling condition.</li> </ul>
Prescription Drugs	<ul style="list-style-type: none"> <li>Inhaler extender devices, peak flow meters, Ana-Kits, and EpiPens are limited to three (3) per Plan Year.</li> <li>Prescription diaphragms are limited to two (2) per Plan Year.</li> <li>The Pharmacy and Therapeutics Committee's standard quantity limits, prior authorization criteria, and step therapies apply.</li> <li>Specialty Drugs are limited to a one-month supply.</li> <li>Smoking cessation products are limited to two (2) full 90-day courses of any FDA-approved tobacco cessation product per Plan Year, if prescribed by your PCP. Limited to Members who are at least eighteen (18) years old.</li> <li>Drugs prescribed or administered by Out-of-network physicians in non-emergencies is limited to those prescribed by dentists.</li> <li>Non-prescription contraceptive jellies, ointments, foams, or devices limited to those that are FDA-approved and prescribed by a Network physician for a woman.</li> <li>Biological sera, medication prescribed for parenteral use or administration, allergy sera, immunizing agents, and immunizing injectable drugs limited to immunizations covered under Preventive Care guidelines and administered at a Network pharmacy.</li> <li>Prescription drugs for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy, hyporgasmy, or decreased libido limited to post-prostate surgery indications.</li> </ul>
Sexual dysfunction	<ul style="list-style-type: none"> <li>Services related to sexual dysfunction limited to drugs and supplies for post-prostate surgery indications.</li> </ul>
Skilled Nursing Facility care	<ul style="list-style-type: none"> <li>Limited to 100 days per Plan Year.</li> </ul>
Transgender services	<ul style="list-style-type: none"> <li>Limited to individually appropriate Preventive Care services.</li> </ul>
Vision	<ul style="list-style-type: none"> <li>Routine services limited to one (1) check-up, including eye refraction, per Plan Year.</li> <li>Treatment for orthoptics or visual training limited to a diagnosis of mild strabismus.</li> </ul>

### **General Excluded Services**

The following benefits are not covered:

<b>Benefit</b>	<b>Excluded Service Description</b>
Ancillary services and supplies	<ul style="list-style-type: none"> <li>Mattresses and other bedding or bed-wetting alarms.</li> <li>Equipment or devices not medical in nature such as braces worn for athletic or recreational use, ear plugs, elastic stockings or supports, or</li> </ul>

Benefit	Excluded Service Description
	<ul style="list-style-type: none"> <li>• garter belts.</li> <li>• Jacuzzi/whirlpools.</li> <li>• Power-operated vehicles that may be used as wheelchairs.</li> <li>• Purchase or rental of equipment or supplies for common household use including, but not limited to: Physical fitness equipment, traction tables, air conditioners, water purifiers, air-cleaning machines or filtration devices, cervical or lumbar pillows, grab bars, raised toilet seats, shower benches, beds, or chairs.</li> <li>• Bandages, pads, or diapers.</li> </ul>
Behavioral health services	<ul style="list-style-type: none"> <li>• Education, tutoring, and services for the purpose of diagnosing or treating a learning disability, disruptive, impulse-control, or conduct disorder.</li> <li>• Marital counseling.</li> </ul>
Dental services – medical coverage	<ul style="list-style-type: none"> <li>• General dental services.</li> <li>• Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and the alveolar bones).</li> <li>• Correction of occlusive jaw defects, dental implants, or grafting of alveolar ridges.</li> <li>• Treatment of soft tissue for the purpose of facilitating dental procedures or dentures.</li> </ul>
Experimental or Investigational therapies	<ul style="list-style-type: none"> <li>• Drugs, therapies, and technologies whose long-term efficacy or effect is undetermined or unproven or whose efficacy is no greater than that of traditionally accepted standard treatment.</li> <li>• New procedures, services, supplies, and drugs until they are reviewed for safety, efficacy, and cost-effectiveness and approved by GlobalHealth.</li> </ul>
General care or Hospital services	<ul style="list-style-type: none"> <li>• Treatment of any kind which is excessive or not Medically Necessary.</li> <li>• Services received without an authorization, when one is required, and complications arising from those services.</li> <li>• Treatment of any kind received before your start date of coverage or after the time coverage ends, even if authorized.</li> <li>• Care or services provided outside the GlobalHealth Service Area if the need for such care or services could have been foreseen before leaving the Service Area.</li> <li>• Services, other than Hospital services for behavioral health, for which you do not allow the release of information to GlobalHealth.</li> <li>• Services for travel, insurance, licensing, employment, school, camp, sports, premarital, or pre-adoption purposes.</li> <li>• Personal or comfort items.</li> <li>• Services received while outside of the United States (50 states and District of Columbia).</li> <li>• Charges for injuries resulting from war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.</li> <li>• Treatment of injuries or illnesses resulting from an attempt or</li> </ul>

Benefit	Excluded Service Description
	<p>commission of a felony, or as a result of being engaged in an illegal occupation.</p> <ul style="list-style-type: none"> <li>• Services as a result of recreational drug or alcohol use.</li> <li>• Elective or voluntary enhancement procedures, services, supplies, or medications, including but not limited to: <ul style="list-style-type: none"> <li>○ Hair growth</li> <li>○ Sexual performance</li> <li>○ Athletic performance</li> <li>○ Cosmetic purposes</li> <li>○ Anti-aging</li> </ul> </li> <li>• Separate charges for missed or canceled appointments, penalty or finance charges, maintenance and/or record-keeping, record copying, or Case Management services.</li> <li>• Treatment, supplies, drugs, and devices for which no charge was made. Treatment, supplies, drugs, and devices for which no payment would be requested if you did not have this coverage.</li> <li>• Custodial care, respite care, homemaker services, or domiciliary care.</li> <li>• Treatment for injury resulting from extreme activities including, but not limited to: <ul style="list-style-type: none"> <li>○ Base jumping</li> <li>○ Bungee jumping</li> <li>○ Bull riding</li> <li>○ Car racing</li> <li>○ Skydiving</li> <li>○ Motorcycle stunts</li> </ul> </li> <li>• Alternative drugs and/or treatments used in the place of standard therapy, to treat any condition or illness.</li> <li>• Screening services requested solely by you, such as commercially advertised heart scans.</li> </ul>
Obstetrical and Infertility services	<ul style="list-style-type: none"> <li>• Elective abortions.</li> <li>• Home uterine monitoring.</li> <li>• Expenses related to surrogate parenthood.</li> <li>• Alternative programs for delivery such as home delivery and use of midwives and birthing centers.</li> <li>• In vitro fertilization, artificial insemination, embryo transfers, reversal of voluntary sterilization, ovum transplant, gamete intrafallopian transfer (“GIFT”), zygote intrafallopian transfer (“ZIFT”), surrogate parenting, and donor semen expenses.</li> </ul>
Other coverage	<ul style="list-style-type: none"> <li>• Treatment for disabilities connected to military service for which you are legally entitled and to which you have reasonable accessibility (i.e., services through a federal governmental agency).</li> <li>• Services that are provided as a result of Workers’ Compensation laws or similar laws.</li> <li>• Treatment for which the cost is recoverable under any other coverage, including Workers’ Compensation, Occupational Disease law, or any state or government agency.</li> </ul>

<b>Benefit</b>	<b>Excluded Service Description</b>
Other Excluded Services	<ul style="list-style-type: none"> <li>• Services resulting in whole or in part from an excluded condition, item, or service.</li> </ul>
Physical, occupational, and speech therapy	<ul style="list-style-type: none"> <li>• Kinesiology, movement therapy, or biofeedback.</li> <li>• Rolf technique.</li> <li>• Massage therapy.</li> <li>• Acupuncture/acupressure.</li> <li>• Recreational therapy including, but not limited to: <ul style="list-style-type: none"> <li>○ Animal-facilitated therapy</li> <li>○ Music therapy</li> </ul> </li> </ul>
Prescription Drugs	<ul style="list-style-type: none"> <li>• Drugs and dietary supplements available without a prescription (over-the-counter) or for which there is a non-prescription therapeutic equivalent available, even if ordered by a physician.</li> <li>• Saline and medications for irrigation.</li> <li>• Topical testosterone products (e.g., AndroGel®, Fortesta®, etc.).</li> <li>• Drugs prescribed for a non-FDA approved indication, dosage, or length of therapy.</li> </ul>
Repair and replacement	<ul style="list-style-type: none"> <li>• Drugs, eyewear, devices, appliances, equipment, dental work, or other items that are lost, missing, sold, or stolen.</li> <li>• Items that have been damaged or destroyed due to improper use or abuse.</li> </ul>
Transplants	<ul style="list-style-type: none"> <li>• Artificial or non-human organ transplants or transplants considered experimental, investigative, or unproven.</li> <li>• Donor Screening tests and donor search expenses.</li> </ul>
Transportation/lodging	<ul style="list-style-type: none"> <li>• Routine, non-emergent ambulance transport unless preauthorized by GlobalHealth.</li> <li>• Lodging, meals, and transportation costs.</li> </ul>
Vision	<ul style="list-style-type: none"> <li>• Non-prescription lenses.</li> <li>• LASIK, INTACS, radial keratotomy, and other refractive surgery.</li> <li>• Computer programs of any type, including, but not limited to, those to assist with vision therapy.</li> <li>• Special multifocal ocular implant lenses.</li> </ul>
Weight Reduction Programs	<ul style="list-style-type: none"> <li>• Gastric stapling, gastric balloon services, or any surgical treatment for obesity or weight-loss purposes.</li> </ul>

# NOTICE ABOUT NON-DISCRIMINATION

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We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

GlobalHealth, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. GlobalHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

GlobalHealth:

- 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 1-877-280-5600 (toll-free).

If you believe that GlobalHealth 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: Compliance Attorney, 701 NE 10<sup>th</sup> St, Ste. 300, Oklahoma City, OK 73104-5403, Fax: (405) 280-5894, or E-mail: [compliance@globalhealth.com](mailto:compliance@globalhealth.com). You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, the Compliance Attorney 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, 1-800-368-1019, 800-537-7697 (TDD).

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



Language	Translation
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-280-2964 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số {1-877-280-2964 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-280-2964 (TTY: 711)。
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-280-2964 OR (TTY: 711)번으로 전화해 주십시오.
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-280-2964 (TTY: 711).
Arabic	كل رفاوتت ةىوغلل ةدعاسملا تامدخ نإف، ةغلل ركذا ثدحتت تنك اذا: ةظوح لم 1-4692-082-778-1 (مقرب مكبل او مصلا فتاه 117). ل صتا. ن اجم اب
Burmese	သတိပို့ရန် - အကယုၣ် သဒ္ဓသညှုမနုမာစကား ကို ဂျဟပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သဒ္ဓအတကြ ဝီစဉ္ဇဆော့ရကြပေးပါမည့်။ ဖုန်းနံပါတ် 1-877-280-2964 (TTY: 711) သို့မူ ခေ့ဆိုပါ။
Hmong	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-280-2964 (TTY: 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-280-2964 (TTY: 711).
French	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-280-2964 (ATS: 711).
Laotian	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-280-2964 (TTY: 711).
Thia	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-280-2964 (TTY: 711).
Urdu	- سى بایتسد سىم تفم تامدخ سى دم سىک نابز وک پآ وت، سىم ےتلوب ودر پآ رگا: رادربخ سىرک لاک 1-877-280-2964 (TTY: 711).
Cherokee	Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 1-877-280-2964 (TTY: 711).
Persian	امش یارب ناگیار تروصب ینابز تالی هست، دینک یم وگتفگ سیراف نابز هب رگا: هجوت 1-877-280-2964 (TTY: 711) دشاب یم مهارف اب.







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