The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. **This is only a summary.** Please read the FEHB Plan brochure (RI 73-834) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can get the FEHB Plan brochure at https://globalhealth.com/media/4148/2020-final-brochure.pdf, and view the Glossary at https://www.globalhealth.com/media/2711/2017_uniformglossary.pdf. You can call 1-877-280-2989 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. All services are covered before you meet a deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,000/Self Only $7,000/Self Plus One $7,000/Self and Family	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.GlobalHealth.com or call 1-877-280-2989 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	None
	Specialist visit	$35 copayment/visit	Not covered	Except for obstetrician/gynecologist, referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
	Chiropractic care	$20 copayment/visit	Not covered	Chiropractic services are limited to 20 visits per calendar year.
	Preventive care/screening/ immunization	No charge	Not covered	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	Not covered	None
	Imaging (CT/PET scans, MRIs)	Preferred facility: $250 copayment/scan Non-preferred facility: $500 copayment/scan	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.GlobalHealth.com	Generic drugs (Tier 1)	30-day supply: $4 copayment/prescription, low-cost generic $12 copayment/prescription, preferred generic 90-day supply: $8 copayment/prescription, low-cost generic $24 copayment/prescription, preferred generic	Not covered	A 30-day supply is filled through retail. A 90-day supply may be filled through retail or by mail order.
	Preferred brand drugs (Tier 2)	30-day supply: $50 copayment/prescription 90-day supply: $125 copayment/prescription	Not covered	Preauthorization and some restrictions may apply. Otherwise, you will have to pay the entire cost of the services. A 30-day supply is filled through retail. A 90-day supply may be filled through retail or by mail order.
	Non-preferred drugs (Tier 3)	30-day supply: $80 copayment/prescription 90-day supply: $240 copayment/prescription	Not covered	Preauthorization and some restrictions may apply. Otherwise, you will have to pay the entire cost of the services. A 30-day supply is filled through retail. A 90-day supply may be filled through retail or by mail order.
	Specialty drugs (Tier 4 – Preferred specialty)	10% coinsurance up to $150 copayment	Not covered	Oral chemotherapy drugs – 10% coinsurance up to $100 copayment. Preauthorization and some restrictions may apply. Otherwise, you will have to pay the entire cost of the services. Retail is a 30-day supply.
	Specialty drugs (Tier 5 – Non-preferred specialty)	10% coinsurance up to $250 copayment	Not covered	Oral chemotherapy drugs – 10% coinsurance up to $100 copayment. Preauthorization and some restrictions may apply. Otherwise, you will have to pay the entire cost of the services. Retail is a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Preferred facility: $250 copayment/visit	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
		Non-preferred facility: $750 copayment/visit		
	Physician/surgeon fees	No charge	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services. Included in facility fee.
If you need immediate medical attention	Emergency room care	$250 copayment/visit	$250 copayment/visit.	Emergency room copayment waived if admitted to the hospital.
	Emergency medical transportation	$50 copayment/occurrence	$50 copayment/occurrence.	Limited to services within the United States.
	Urgent care	$25 copayment/visit	$25 copayment/visit.	Limited to services within the United States.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copayment/day up to $750 copayment/admission	Not covered	Referral and preauthorization required, except for emergency care. Otherwise, you will have to pay the entire cost of the services.
	Physician/surgeon fees	No charge	Not covered	Referral and preauthorization required, except for emergency care or childbirth. Otherwise, you will have to pay the entire cost of the services. Included in facility fee.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: No charge Intensive outpatient program: No charge Partial hospitalization in facility: $200 copayment/admission	Not covered	Other than office visits, referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
	Inpatient services	$250 copayment/day up to $750 copayment/admission	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
If you are pregnant	Office visits	Prenatal and postnatal care: No charge	Not covered	None
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	$250 copayment/admission	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
	Rehabilitation services	Inpatient: No charge. Outpatient: $20 copayment/visit	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services. 60 visit limit per plan year.
	Habilitation services	Outpatient: $20 copayment/visit	Not covered	60 visit limit per plan year.
	Skilled nursing care	$250 copayment/admission	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
	Durable medical equipment	20% coinsurance	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
	Hospice services	No charge	Not covered	Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services.
If your child needs dental or eye care	Children's eye exam	$40 copayment/visit	Not covered	One exam limit per plan year.
	Children's glasses	No charge	Not covered	Limited to one pair of basic frames and lenses or first set of contact lenses following cataract surgery.
	Children's dental check-up	Not covered	Not covered	No coverage.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)
- Routine foot care (Covered for diabetics only.)

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-280-2989 (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** **$35**
- **Hospital (facility) copayment** **$250 per day $500 per stay**
- **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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$310**

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** **$35**
- **Hospital (facility) copayment** **$250 per day $500 per stay**
- **Other copayment** **$0**

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$720
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$780**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$35**
- **Hospital (facility) copayment** **$250 per day $500 per 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)*

Total Example Cost	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$240
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$250**

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