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://globalhealth.com/media/ygvgbeg5/cert_lggrp_ok_2021_ng_platinum1.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 www.GlobalHealth.com/uniformglossary or call 1-877-280-2964 to request a copy.

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?	$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 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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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.	Not covered	None.
	Specialist visit	$50 copayment/visit. Chiropractic care: $25 copayment/visit. Foot care: $20 copayment/visit.	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.	Not covered	*See Preventive Care Benefits Section. 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)	PCP (primary care physician) visit: No charge. Specialist visit: No charge. Preferred facility: $250 copayment/scan. Non-preferred facility: $750 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.
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 – No charge, low-cost generic. $15 copayment/prescription, preferred generic. 90-day supply – No charge, low-cost generic. $30 copayment/prescription, preferred generic.	Not covered	A 30-day supply is through retail. a 90-day supply may be through retail or mail order.

* 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)	
	Preferred brand drugs (Tier 2)	30-day supply – $60 copayment/prescription. 90-day supply – $120 copayment/prescription.	Not covered	Preauthorization and some restrictions may apply. *See Prescription Drug Benefits section. 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. Specialty drugs are only available in 30-day supplies.
	Non-preferred brand drugs (Tier 3)	30-day supply – $90 copayment/prescription. 90-day supply – $180 copayment/prescription.	Not covered	
	Specialty drugs (Tier 4)	Preferred specialty – 15% coinsurance up to $400 copayment. Non-preferred specialty – 15% coinsurance up to $600 copayment. Oral chemotherapy drugs – 15% coinsurance up to $100 copayment.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Preferred facility: $250 copayment/visit. Non-preferred facility: $750 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	$100 copayment/occurrence.	$100 copayment/ occurrence.	
	Urgent care	$15 copayment/visit.	$15 copayment/visit.	
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copayment/day up to $1,500 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	

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: No charge. Intensive outpatient program: No charge. Partial hospitalization program: No charge.	Not covered	*See Behavioral Health Benefits Section. 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: $75 copayment/day – Inpatient hospital facility: $300 copayment/day up to $1,500 copayment/stay.	Not covered	
If you are pregnant	Office visits	No charge / prenatal and postnatal care.	Not covered	Cost sharing does not apply for preventive services. 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 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: $25 copayment/visit. Rehabilitation outpatient facility: $50 copayment/day. Rehabilitation inpatient facility: $200 copayment /day.	Not covered	Includes physical therapy, speech therapy, and occupational therapy. 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 in hospital facility fee.
	Habilitation services	Inpatient: No charge. Office visit: $25 copayment/visit. Habilitation outpatient	Not covered	*See Medical Benefits section. Referral and preauthorization required except for physical therapy evaluation. 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)	
		facility: $50 copayment/day.		Inpatient services included in hospital facility fee.
	Skilled nursing care	$75 copayment/day.	Not covered	*See Medical Benefits section. Referral and preauthorization required. Otherwise, you will have to pay the entire cost of the services. Skilled nursing: 30-day limit per plan year.
	Durable medical equipment	20% coinsurance.	Not covered	
	Hospice services	No charge.	Not covered	
If your child needs dental or eye care	Children's eye exam	$30 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 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, 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 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 assistance, contact: GlobalHealth Customer Care at 1-877-280-2964 or visit www.GlobalHealth.com, the Department of Labor's Employee Benefits Security

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

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 1-877-280-2964 (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** **$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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$510**

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 $1,500/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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,630**

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 $1,500/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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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