GlobalHealth, Inc.

http://www.globalhealth.com/fehb
Customer Care 1-877-280-2989

GlobalHealth

2016

A Health Maintenance Organization (high option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details.

IMPORTANT
- Rates: Back Cover
- Changes for 2016: Page 13
- Summary of benefits: Page 80

Serving: *The state of Oklahoma*

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 12 for requirements.

Enrollment code for this Plan:

IM1 High Option - Self Only

IM3 High Option - Self Plus One

IM2 High Option - Self and Family

NCQA Health Plan Accreditation

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-834

Important Notice from GlobalHealth
About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the GlobalHealth prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227), (TTY) 1-877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of GlobalHealth under our contract (CS 2893) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer Care may be reached at 1-877-280-2989 or through our website: www.globalhealth.com/fehb. The address for GlobalHealth, Inc. (GlobalHealth) administrative offices is:

GlobalHealth, Inc.
P.O. Box 2393
Oklahoma City, OK 73101-2393

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 13. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means GlobalHealth.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.

- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-877-280-2989 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more, and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use GlobalHealth preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We don’t determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self and Family or Self Plus One enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

  The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and one eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or

- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans during Open Season and you receive care between January 1 and the effective date of coverage under your new plan, your claims will be paid according to the 2016 benefits of your old plan.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2015 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC).

- **Upon divorce**

If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC: Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Finding replacement coverage**

In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at 1-877-280-2989 or visit our website at www.globalhealth.com/fehb.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of the most recent provider directory. You will be responsible for the cost of care if you obtain services, other than medical emergencies, from an out-of-network provider.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our High Option.

GlobalHealth's FEHB plan features no deductibles and a copayment system with few benefits that have coinsurance. What this means for you is that you know exactly what you are going to pay because you know exactly what the copayments are. Because you have no deductible, you will begin to pay copayments only from the first point of service.

How we pay providers.

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments or annual limits when received from a network provider.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including all copayments for services and prescriptions, cannot exceed $5,000 for Self Only enrollment, or $7,000 for Self Plus one or Self and Family enrollment.

Health education resources and accounts management tools

Health and Wellness: You have access to an Internet-based health and wellness program at www.globalhealth.com/fehb. Our website offers links to interactive assessment tools and interventions on key topics to better your health. You can access links in four main categories: (1) Maintain Your Health, (2) Improve Your Health, (3) Manage Long-Term Conditions, and (4) Tools/Calculators.

24/7 Nurse Help Line: Life happens, and the GlobalHealth Nurse Help Line is available 24/7 each day of the year. It's not always easy to determine when to seek emergency care, treat symptoms yourself, or see a primary care physician (PCP). Call 1-877-280-2993 to speak with an experienced registered nurse.

Disease Management: Call Customer Care at 1-877-280-2989 to enroll in a program if you or a family member has Coronary Artery Disease (CAD), Chronic Heart Failure (CHF), and/or Chronic Obstructive Pulmonary Disease (COPD). Contact Care Management through www.globalhealth.com/fehb or Customer Care at 1-877-280-2989 for more information on case and disease management programs.

Medication Therapy Management Program: Members taking multiple medications for chronic conditions can receive support from our Medication Therapy Management program. Enrollment in this program is automatic for qualified members. You will receive personalized service from registered pharmacists and staff. The goal of this program is to help eliminate duplicate drug therapies, reduce potential for negative drug interactions and side effects, and optimize member benefits by advising of the lowest cost alternatives.

MYGLOBAL Member Portal: You may now register for a secure member portal called MYGLOBAL. Through MYGLOBAL, you can monitor claims, referrals, and change your PCP in addition to other features that help you manage your account.

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- **GlobalHealth is a Health Maintenance Organization (HMO) operating since 2003.**
- **GlobalHealth is a for profit organization.**

If you want more information about us, call 1-877-280-2989, or write to P.O. Box 2393, Oklahoma City, OK 73101-2393. You may also contact us by fax at (405) 280-5270 or visit our website at www.globalhealth.com/fehb.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is the following counties in their entireties: **Adair, Alfalfa, Atoka, Beaver, Beckham, Blaine, Bryan, Caddo, Canadian, Carter, Cherokee, Choctaw, Cimarron, Cleveland, Coal, Comanche, Cotton, Craig, Creek, Custer, Delaware, Dewey, Ellis, Garfield, Garvin, Grady, Grant, Greer, Harmon, Harper, Haskell, Hughes, Jackson, Jefferson, Johnston, Kay, Kingfisher, Kiowa, Latimer, Le Flore, Lincoln, Logan, Love, Major, Marshall, Mayes, McClain, McCurtain, McIntosh, Murray, Muskogee, Noble, Nowata, Okfuskee, Oklahoma, Okmulgee, Osage, Ottawa, Pawnee, Payne, Pittsburg, Pontotoc, Pottawatomie, Pushmataha, Roger Mills, Rogers, Seminole, Sequoyah, Stephens, Texas, Tillman, Tulsa, Wagoner, Washington, Washita, Woods, and Woodward counties**.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2016

Do not rely on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- Self Plus One enrollment type has been added effective January 1, 2016.
- We have removed the exclusion for services, drugs, or supplies related to sex transformations. See page 62.

Changes to this Plan

- Your share of the non-Postal premiums will increase for Self Only and Self and Family. See page 82.
- Section 4. Catastrophic protection out-of-pocket maximum
  - The limit has increased to $5,000 for Self Only, and $7,000 for both Self Plus One and Self Plus Family. See page 19.
- Section 5(a). Professional services of physicians.
  - The PCP copayment has decreased to $0 (nothing) per visit. See page 24.
  - The specialist copayment has decreased to $35 per visit. See page 24.
- Section 5(a) Specialized scans, imaging and diagnostic exams.
  - The copayment remains at $250 per scan done in a free-standing/low-cost facility. See page 25.
  - The copayment increases to $500 per scan in a hospital-owned facility. See page 25.
- Section 5(a). Maternity care.
  - The copayment for all postpartum care decreased to a one-time-only $25 copayment on the first visit. See page 27.
- Section 5(a). Treatment therapies (chemotherapy and radiation).
  - The physician copayment has increased to $50. See page 29.
- Section 5(a). Rehabilitation services.
  - The copayment has decreased to $30 per visit. See page 30.
  - The limits are now 60 visits per calendar year for physical, occupational, or speech therapy, or a combination of all three. See page 30.
- Section 5(a). Habilitation services.
  - The copayment has decreased to $30 per outpatient visit. See page 30.
  - The limits are now 60 visits per calendar year for physical, occupational, or speech therapy, or a combination of all three. See page 30.
- Section 5(a). Hearing services.
  - The PCP copayment has decreased to $0 (nothing) per visit. See page 30.
  - The specialist copayment has decreased to $35 per visit. See page 30.
  - A 20% coinsurance has been added for hearing aids for children up to the age of 22. See page 30.
- Section 5(a). Orthopedic and prosthetic devices.
  - A 20% coinsurance up to a $200 maximum has been added. See page 32.
- Section 5(c). Inpatient hospital.
  - Maternity care: The copayment has decreased to $250 per admission. See page 44.
  - All other stays: The copayment has decreased to $250 per day with a maximum of $750 copayment per admission. See page 44.
- Section 5(c). Outpatient hospital or ambulatory surgical center.
  - Copayments are assessed according to the facility type:

- Free-standing/low-cost facility: The copayment will remain at $250. See page 45.
- Hospital-owned facility: The copayment will increase to $750. See page 45.

- Section 5(c). Extended care benefits/Skilled nursing care facility benefits.
  - The copayment was changed to $250 per admission. See page 45.
- Section 5(d). Emergency within our service area.
  - The PCP copayment has decreased to $0 (nothing) per visit. See page 48.
  - The specialist copayment has decreased to $35 per visit. See page 48.
  - The urgent care center copayment has decreased to $25 per visit. See page 48.
- Section 5(d). Emergency outside our service area.
  - The doctor's office copayment has decreased to $35 per visit. See page 48.
  - The urgent care center copayment has decreased to $25 per visit. See page 48.
- Section 5(e). Mental health and substance abuse benefit professional services
  - The copayment for outpatient care has decreased to $0 (nothing) per office visit. See page 50.
- Section 5(e). Mental health and substance abuse benefit inpatient hospital or other covered facility. See page 51.
  - The copayment has decreased to $250 per day with a maximum of $750 copayment per admission. See page 51.
- Section 5(e). Mental health and substance abuse benefit outpatient hospital or other covered facility.
  - The copayment for office visits has decreased to $0 (nothing) per visit. See page 51.
  - The copayment has decreased to $250 per admission. See page 51.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-877-280-2989 or write to us at: P.O. Box 2393, Oklahoma City, OK 73101-2393. You may also request replacement cards through our website: www.globalhealth.com/fehb.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

You may choose a primary care physician by calling Customer Care at 1-877-280-2989 or by going to our website, www.globalhealth.com/fehb.

- **Primary care**

Your primary care physician can be a family practitioner, internist, pediatrician (for members under the age of 18), or a general practitioner. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one. We will also help you select a new primary care physician if you need to change from a pediatrician to an adult care physician.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may self-refer for in-network obstetrical/gynecological services and well-woman exams, in-network routine mammograms, and behavioral and mental health/chemical dependency services.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist.

If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or,
  - reduce our service area and you enroll in another FEHB plan;

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Care Department immediately at 1-877-280-2989. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician will obtain prior authorization for any specialty care you may need. GlobalHealth must pre-authorize all inpatient and outpatient services at a contracting facility, except stays in connection with childbirth, emergency room care, after hours urgent care, obstetrical/gynecological services and well-woman exams, routine mammograms, behavioral health/chemical dependency services, routine eye exams, routine hearing and speech exams for children, or physical therapy evaluations. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

Please review covered services in Section 5 to see if your PCP or specialists must obtain preauthorization before starting treatment. Contact Customer Care at 1-877-280-2989 for a complete listing of services that require precertification.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 877-280-2989 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number, and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us as 1-877-280-2989. You may also call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-877-280-2989. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

GlobalHealth will only cover the costs of your care when provided by your PCP, or a network provider specializing in obstetrics or gynecological care. You will be responsible for the cost of your care if you obtain services from an out-of-network provider. For a list of network health care professionals who specialize in obstetrics and gynecology, refer to the online provider directory or contact Customer Care.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

You must obtain an authorized referral prior to a scheduled hospital stay or outpatient surgery. Referrals are not required for emergency room visits or stays in connection with childbirth. You must go to a network facility for childbirth. If you choose to obtain services, other than emergencies, from an out-of-network provider, you are financially responsible.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

To file an appeal with OPM

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your cost for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., coinsurance and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see your primary care physician, you pay a copayment of $0 per office visit, and when you go in the hospital, you pay $250 per day with a maximum of $750 per admission.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care.

Example: In our Plan, you pay 50% of our allowance for infertility services and 20% of our allowance for durable medical equipment.

Differences between our Plan allowance and the bill

Plan allowance is the allowed amount we will pay for services rendered based on contractual rates with our providers.

GlobalHealth offers set copayments on all services except durable medical equipment which has coinsurance. The copayments do not vary depending on the allowed amount.

Your catastrophic protection out-of-pocket maximum

After your out-of-pocket expenses, including any applicable copayments and coinsurance total $5,000 for Self Only, or $7,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. ***The maximum annual limitation on cost sharing listed under Self Only of $5,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a $5,000 Self Only maximum out-of-pocket limit and a $7,000 Self Plus One or Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $5,000 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket of $7,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $2,000 for the calendar year before their qualified medical expenses will begin to be covered in full.

However, copayments and coinsurance, if applicable for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay all charges for these services:

- Expenses for services and supplies that exceed the stated maximum dollar or day limit
- Expenses from utilizing out-of-network providers

Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the plan's calculation of your out-of-pocket maximum is reflected accurately.

Carryover

If you changed to this Plan during Open Season from a Plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

See page 13 for how our benefits changed this year. Page 80 is a benefits summary. Make sure that you review the benefits that are available.

Section 5. Benefits Overview

This Plan offers a High Option. Our benefit package is described in Section 5. Make sure that you review the benefits that are available.

Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at CommercialAnswers@globalhealth.com, 1-877-280-2989, or on our website at www.globalhealth.com/fehb.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office	Nothing per visit to your primary care physician $35 copayment per visit to a specialist
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion	Nothing per visit to your primary care physician $35 copayment per visit to a specialist Nothing for inpatient and urgent care center services
At home	Nothing per visit from your primary care physician $35 copayment per visit from a specialist
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG Note: See Section 5(c) for services billed for by a facility, such as colonoscopies to diagnose or treat a specific condition. Note: Your provider must use a contracted laboratory or radiologist.	Nothing

Benefit Description	You pay
Specialized scans, imaging and diagnostic exams	**High Option**
Specialized scans, imaging and diagnostic exams • CT scans • PET scans • SPECT scans • MRI scans • Nuclear scans • Sleep studies Note: We only cover specialty scans, imaging, and diagnostic exams when we preauthorize the treatment. We will only cover these services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Free-standing/low-cost facility: *$250 copayment per scan Hospital-owned facility: *$500 copayment per scan *per body part scanned
Preventive care, adult	**High Option**
Routine physical (one per calendar year) which includes: Routine screenings, such as: • Biometric Screening - Body mass index (BMI) - Lipid or cholesterol levels - Blood pressure - Glucose or Hemoglobin A1c - Obesity screening and referrals for behavior change interventions (12 - 26 sessions) for adults with a BMI over 30 kg/m2 • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 Note: You may be required to pay an office visit copayment if preventive service is not the primary purpose of the visit or if your doctor bills for the preventive service separately from the office visit.	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing
Well-woman care: visits as necessary to obtain all preventive services based on a woman's health status, needs, and other risk factors, including but not limited to: • Routine Pap test • BRCA counseling about genetic testing for women at higher risk • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing
Routine mammogram - covered for women age 35 and older, as follows:	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
• From age 35 through 39, one during this five-year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years Note: 3D mammograms are not considered routine screening tests.	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): • Hepatitis A • Hepatitis B • Herpes Zoster (Shingles) • Human Papillomavirus ("HPV") • Influenza (Flu Shot) • Measles, Mumps, and Rubella ("MMR") • Meningococcal (Meningitis) • Pneumococcal (Pneumonia) • Tetanus, Diphtheria, Pertussis ("TDap") • Varicella (Chicken Pox)	Nothing
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/.	
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel* • *Genetic testing/screening related to family history or cancer or other disease, except for BRCA testing/screening as described on page 25* • *Screening services requested solely by the member, such as commercially advertised heart scans*	*All charges*
Preventive care, children	**High Option**
Childhood immunizations recommended by the American Academy of Pediatrics: • Tetanus, Diphtheria, and Pertussis ("TDap") • Haemophilus influenza type b (Hib) • Hepatitis A • Hepatitis B • Human Papillomavirus ("HPV") • Inactivated Poliovirus (Polio) • Influenza (Flu Shot) • Measles, Mumps, Rubella ("MMR") • Meningococcal (Meningitis) • Pneumococcal (Pneumonia) • Rotavirus ("RV")	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**High Option**
• Varicella (Chicken Pox)	Nothing
• Well-child care visits for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye screening to determine the need for specialist referral - Hearing screening to determine the need for specialist referral - Oral health risk assessment Note: These screenings are performed by the child's PCP during the well-child visits.	Nothing
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/.	
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care - including ultrasound, laboratory, and diagnostic tests • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 44 for other circumstances, such as extended stays for you or your baby • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. Your newborn child has medical coverage during the first 31 days of life. To continue coverage under a Self Plus One or Self and Family enrollment, the newborn must be enrolled within the first 31 days. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury	Nothing for prenatal care $25 one-time copayment for all outpatient postpartum care at first visit Nothing for inpatient professional delivery services
Breastfeeding support, counseling, supplies, equipment rental for each birth. Note: Limited to purchase or rental of breast pump from a network supplier with preauthorization. Includes only breastfeeding supplies contained in the breast pump kit. Limited to one pump per calendar year for women who are pregnant and/or nursing. Contact Customer Care for a list of network suppliers.	Nothing
Not covered: • *Elective abortions* • *Childbirth preparation, Lamaze, and other birthing/parenting classes*	*All charges*

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High Option**
• *Breastfeeding supplies other than those contained in the breast pump kit, including clothing (e.g., nursing bras), baby bottles, or items for personal comfort or convenience (e.g., nursing pads)* • *Maternity care for women not enrolled in this Plan* • *Home uterine monitoring devices*	*All charges*
Family planning	**High Option**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services for women, limited to: • Voluntary sterilization, tubal ligation, or tubal occlusion/tubal blocking procedures only (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms and contraceptive rings • Implantable contraceptives Note: We cover oral contraceptives under the prescription drug benefit. Note: See Section 5(b) for our coverage of voluntary sterilization for men.	Nothing
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Contraceptive devices not described above* • *Over-the-counter (OTC) contraceptives, except as described in Section 5(f)* • *Pre-implantation genetic diagnosis (PGD)*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility, such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral and self-injectable fertility drugs under the prescription drug benefit. Note: We only cover infertility treatment when we preauthorize the treatment. We will only cover these services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Nothing per visit to your primary care physician $35 copayment per visit to a specialist
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization (IVF)*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
- *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Cryopreservation or storage of sperm (sperm banking), eggs, or embryos* • *Services, supplies, or drugs provided to individuals not enrolled in this Plan* • *Genetic counseling and genetic screening* • *Male infertility treatment*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections	Nothing per visit to your primary care physician $35 copayment per visit to a specialist
Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/tissue transplants on page 38. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Home nursing visits associated with home IV/infusion therapy are covered as shown under Home health services on page 34. Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.* Note: See Section 5(c) for Treatment therapy services received in the outpatient department of a hospital or facility.	$50 copayment per visit Infusion, drug only, $30 copayment if administered in physician's office

Benefit Description	You pay
Rehabilitation Services	**High Option**
• Physical therapy • Occupational therapy • Speech therapy Note: Limited to 60 visits per calendar year for physical, occupational, or speech therapy, or a combination of all three, to help members regain, maintain, or prevent deterioration of a skill or function that has been acquired, but then lost due to illness, injury, or disabling condition. Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction is provided for up to 3 visits per week for 12 weeks. Note: We only cover therapies when we preauthorize the treatment, except for an evaluation performed by a licensed physical therapist. We will only cover these services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	$30 copayment per outpatient visit Nothing per visit during covered inpatient admission
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Massage therapy* • *Voice therapy related to gender reassignment*	*All charges*
Habilitation Services	**High Option**
• Physical therapy • Occupational therapy • Speech therapy Note: Limited to 60 visits per calendar year for physical, occupational, or speech therapy, or a combination of all three, to help members attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. Medically necessary devices are covered under DME or orthotics and prosthetics. Note: We only cover therapies when we preauthorize the treatment, except for an evaluation performed by a licensed physical therapist. We will only cover these services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	$30 copayment per outpatient visit
Hearing services (testing, treatment, and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.* Note: We only cover therapies when we preauthorize the treatment, except for an evaluation performed by a network audiologist. We will only cover these services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.* • External hearing aids.	Nothing per visit to a primary care physician $35 copayment per visit to a specialist 20% coinsurance for hearing aids for children up to age 22

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**
• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	Nothing per visit to a primary care physician $35 copayment per visit to a specialist 20% coinsurance for hearing aids for children up to age 22
Not covered: *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • One eye exam, including refraction, annually Note: See *Preventive care, children* for eye exams for children.	Maximum allowance of $100 $40 copayment per visit
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics* • *LASIK, INTACS, radial keratotomy and other refractive surgery* • *Computer programs of any type, including, but not limited to, those to assist with vision therapy* • *Special multifocal ocular implant lenses*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts. Note: See Section 5(b) for our coverage of surgical procedures. Note: We only cover foot care when we preauthorize the treatment. We will only cover these services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Nothing per visit to your primary care physician $35 copayment per visit to a specialist
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet, or bunions or spurs; and of any instability, imbalance, or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Benefit Description	You pay
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • External hearing aids for children up to age 22, limited to one (1) aid per ear every forty-eight (48) months unless medically necessary to replace more often. For members under the age of two (2), four (4) additional ear molds may be obtained per year (two for each ear). • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy • Replacement, repair, and adjustment of covered devices • Wigs for hair loss due to treatment of cancer, limited to $150 Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services. Note: We only cover orthopedic and prosthetic devices when we preauthorize the treatment. We will only cover these devices and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	20% coinsurance, with a $200 maximum cost per service
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups. Shoes and orthotics are covered only for diabetes and other members with diagnoses pertaining to peripheral vascular disease* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered* • *Over-the-counter orthotics* • *Hearing aid accessories or supplies (including remote controls and warranty packages)* • *Bioelectric, computer programmed prosthetic devices*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen and oxygen equipment • Dialysis equipment • Hospital beds • Wheelchairs • Crutches	20% coinsurance

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High Option**
• Walkers • Dynamic orthotic cranioplasty (DOC) devices when medically necessary • Audible prescription reading devices • Speech generating devices • Diabetic supplies: - Blood glucose monitors - Shoes and orthotics - Insulin pumps • Other items that we determine to be DME, such as compression stockings for lymphedema diagnosis only Note: Call us at 1-877-280-2989 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call. Note: We only cover durable medical equipment when we preauthorize the treatment. We will only cover these devices and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	20% coinsurance
Not covered: • *Bathroom equipment such as tub seats, benches, rails, and lifts* • *Home modifications such as elevators or wheelchair ramps* • *Lifts, such as seat, chair, or van lifts* • *Car seats* • *Diabetic supplies, except as described in Section 5(f)* • *Breast pumps, except as described on page 27* • *Communications equipment, devices, and aids (including computer equipment) such as "story boards" or other communication aids to assist communication-impaired individuals (except for speech-generating devices as listed above)* • *Equipment for cosmetic purposes* • *Topical Hyperbaric Oxygen Therapy (THBO)* • *Devices or programs to eliminate bed wetting* • *Routine foot care, shoes, and shoe inserts, except for Medically Necessary foot care for those persons diagnosed with diabetes or peripheral vascular disease* • *Orthopedic shoes unless permanently attached to a Denis Browne splint for children* • *Corrective shoes, arch supports, and supportive devices for the feet* • *Mattresses and other bedding or bed-wetting alarms* • *Equipment or devices not medical in nature such as braces worn for athletic or recreational use, ear plugs, elastic supports, corsets, or garter belts* • *Jacuzzi/whirlpools* • *Power-operated vehicles that may be used as wheelchairs*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High Option**
• *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* • *Bandages, pads, or diapers* • *Hot and cold packs*	*All charges*
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy, and medications Note: We only cover home health care when we preauthorize the treatment. We will only cover these services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*
Chiropractic	**High Option**
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Note: Chiropractic services limited to 20 visits per member per calendar year. Note: We only cover chiropractic care when we preauthorize the treatment. We will only cover these services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	$20 copayment per office visit
Not covered: Any services not specifically listed as covered	*All charges*
Alternative treatments	**High Option**
No benefit for acupuncture, biofeedback, self-care or self-help training, naturopathic services, or other alternative treatments.	*All charges*
Educational classes and programs	**High Option**
Coverage is provided for: • Tobacco cessation programs, including individual/group/telephone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. See Section 5(f) for coverage of smoking and tobacco cessation drugs. • Diabetes self-management	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence. Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
• Childhood obesity education	Nothing
• Disease management - Coronary Artery Disease (CAD) - Chronic Heart Failure (CHF) - Chronic Obstructive Pulmonary Disease (COPD)	Nothing

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copayment applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- Balance billing occurs when a provider bills a member the difference between its billed charge and the total amount the provider received from the member's cost-share and GlobalHealth's contracted or usual and customary reimbursement. In-network providers may not balance bill you; however, out-of-network providers may balance bill you. You are responsible for the difference between our payment and the billed amount.
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (see *Bariatric surgery*) • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns • Injections • Circumcision of a newborn during routine newborn stay Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for a pacemaker and surgery benefits for insertion of the pacemaker.	Nothing per visit to your primary care physician $35 copayment per visit to a specialist Services provided by physicians and professionals included in facility copayment. See Section 5(c).

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
Note: We only cover surgical procedures when we preauthorize the treatment. We will only cover these procedures and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Nothing per visit to your primary care physician $35 copayment per visit to a specialist Services provided by physicians and professionals included in facility copayment. See Section 5(c).
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Cosmetic surgery* • *LASIK, INTACS, radial keratotomy, and other refractive surgery* • *Surgeries to correct congenital anomalies for individuals age 18 and older unless there is a functional deficit* • *Charges for photographs to document physical conditions*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: Protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. You may remain an inpatient for up to 24 hours after a lymph node dissection. Note: We only cover reconstructive surgery when we preauthorize the treatment. We will only cover surgery and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Nothing per visit to your primary care physician $35 copayment visit to a specialist Services provided by physicians and professionals included in facility copayment. See Section 5(c).
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury, required for a congenital anomaly, or following a mastectomy* • *Surgeries related to sex transformation*	*All charges*

Benefit Description	You pay
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate, or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Orthognathic surgery is covered only when medically necessary (e.g., malocclusion has produced significant inability to function). Sufficient clinical documentation must be provided and services must be preauthorized; and • Other surgical procedures that do not involve the teeth or their supporting structures. Note: We only cover oral and maxillofacial surgery when we preauthorize the treatment. We will only cover surgery and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Nothing per visit to your primary care physician $35 copayment visit to a specialist Services provided by physicians and professionals included in facility copayment. See Section 5(c).
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Orthodontic care before, during, or after surgery*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis These **tandem blood** or **marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated)	Services provided by physicians and professionals included in facility copayment. See Section 5(c).

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Recurrent germ cell tumors (including testicular cancer) Note: We only cover transplants when we preauthorize the treatment. We will only cover surgery and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Services provided by physicians and professionals included in facility copayment. See Section 5(c).
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Allogeneic transplants for • Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Advanced neuroblastoma • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Chronic myleogenous leukemia • Hemogloblinopathy • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccaridosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) • Myelodysplasia/Myelodysplastic syndromes • Paroxysmal Nocturnal Hemoglobinuria • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia • X-linked lymphoproliferative syndrome Autologous transplants for • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Aggressive non-Hodgkin's lymphoma • Amyloidosis • Breast Cancer • Ependymoblastoma	Services provided by physicians and professionals included in facility copayment. See Section 5(c).

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Epithelial ovarian cancer • Ewing's sarcoma • Medulloblastoma • Multiple myeloma • Neuroblastoma • Pineoblastoma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors • Waldonstrom's macroglobulinemia Autologous tandem transplants for • Recurrent germ cell tumors (including testicular cancer) • Multiple myeloma • De-novo myeloma Note: We only cover transplants when we preauthorize the treatment. We will only cover surgery and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Services provided by physicians and professionals included in facility copayment. See Section 5(c).
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Aggressive non-Hodgkin's lymphoma - Amyloidosis	Services provided by physicians and professionals included in facility copayment. See Section 5(c).

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Neuroblastoma These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. Tandem transplants for covered transplants: Subject to medical necessity. Autologous Transplants for • Advanced childhood kidney cancers • Advanced Ewing sarcoma • Breast cancer • Childhood rhabdomyosarcoma • Epithelial ovarian cancer • Mantle cell (Non-Hodgkin's lymphoma) Note: We only cover transplants when we preauthorize the treatment. We will only cover surgery and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Services provided by physicians and professionals included in facility copayment. See Section 5(c).
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial or non-human organs* • *Transplants not listed as covered* • *Lodging, meals, and transportation (donor or recipient)*	*All charges*
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Note: See Section 5(c) for anesthesia services provided by a facility. Dental anesthesia	Nothing Note: When the anesthesiologist is the only provider of services, such as for pain management, the specialist copayment applies

Anesthesia - continued on next page

Benefit Description	You pay
Anesthesia (cont.)	**High Option**
• 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 • For severely disabled members • 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 Includes inpatient and outpatient services required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. Note: We only cover dental anesthesia when we preauthorize the treatment. We will only cover surgery and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Nothing Note: When the anesthesiologist is the only provider of services, such as for pain management, the specialist copayment applies
Bariatric Surgery	**High Option**
The Bariatric Surgery benefit provides coverage for the LAP-BAND surgery. The criteria for eligibility is as follows: • History and/or diagnosis of morbid obesity for a period of two years prior to surgery, and • Body mass index above 40, or • Body mass index of 35 or greater and suffer from medical problems associated with obesity such as coronary heart disease, type 2 diabetes, sleep apnea or hypertension • Failure of weight-loss attempts including diets, exercise and weight loss programs In addition to the criteria above, prior authorization for bariatric surgery is subject to meeting all of the pre-surgical requirements listed below: • Participation in a medically-supervised, non-surgical weight loss program, including nutritional counseling, medication or maintenance therapy, behavior modification, exercise and increased activity for at least 12 months prior to the date of surgery • Pre-operative nutritional assessment and nutritional counseling about pre- and post-operative nutrition, eating and exercise • Evidence that attempts at weight loss in the 1-year period prior to surgery have been ineffective • Psychological clearance of your ability to understand and adhere to the pre- and post-operative program, based on a psychological assessment performed by a licensed professional mental health practitioner • You have not smoked in the 6 months prior to surgery • You have not been treated for substance abuse for 1 year prior to surgery and there is no evidence of substance abuse during the 1-year period prior to surgery Note: Requests for alternative bariatric procedures will be considered on a case-by-case basis. Medical notes substantiating the medical necessity for an alternative surgical procedure must be provided. All cases will be reviewed by our Medical Director and Patient Care Committee and all criteria for eligibility and prior authorization must be met.	Services provided by physicians and professionals included in facility copayment. See Section 5(c).

Bariatric Surgery - continued on next page

Benefit Description	You pay
Bariatric Surgery (cont.)	**High Option**
Note: We only cover surgical procedures when we preauthorize the treatment. We will only cover these procedures and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Services provided by physicians and professionals included in facility copayment. See Section 5(c).

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in an in-network facility.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Note: We only cover hospitalization when we preauthorize the treatment, except for stays in connection with childbirth or emergencies. We will only cover these services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Maternity care: $250 copayment per admission All other stays: $250 copayment per day with a maximum of $750 copayment per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home Note: We only cover hospitalization when we preauthorize the treatment, except for stays in connection with childbirth or emergencies. We will only cover these services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Physician surgical services • Chemotherapy and radiation therapy • Intravenous (IV) infusion therapy • Renal dialysis • Visits to the outpatient department of a hospital or free-standing facility for non-emergency treatment services Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Note: We only cover outpatient surgery when we preauthorize the treatment. We will only cover these services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Free-standing/low-cost facility: $250 copayment Hospital-owned facility: $750 copayment
Extended care benefits/Skilled nursing care facility benefits	**High Option**
• Extended care benefit • Skilled nursing facility (SNF) Note: We only cover extended care or skilled nursing care when we preauthorize the treatment. We will only cover these services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	$250 copayment per admission
Not covered: Custodial care	*All charges*

Benefit Description	You pay
Hospice care	**High Option**
Supportive and palliative care provided in the home or hospice facility for a terminally ill member is covered when directed by a Plan provider who certifies the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less. Note: We only cover hospice care when we preauthorize the treatment. We will only cover these services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	**High Option**
Local professional ambulance service when medically appropriate Note: Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons.	$50 copayment
Not covered: • *Wheelchair van services and gurney van services* • *Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests not associated with covered inpatient hospital care* • *Air ambulance when the patient does not require the assistance of medically trained personnel and can be safely transferred or transported by other means*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Balance billing occurs when a provider bills a member the difference between its billed charge and the total amount the provider received from the member's cost-share and GlobalHealth's contracted or usual and customary reimbursement. In-network providers may not balance bill you; however, out-of-network providers may balance bill you. You are responsible for the difference between our payment and the billed amount.

What is an accidental injury?

An accidental injury is an injury caused by an external force or element such as a blow or fall and which requires immediate medical attention, including animal bites and poisonings.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

1. Go to the nearest hospital emergency room or call 911.

2. Identify yourself as a GlobalHealth member by showing your ID card.

3. Call your primary care physician's office within 48 hours, unless it is not reasonably possible to do so. Let your doctor know you have been treated in an emergency room. Remember, the condition must be a true emergency.

4. If you are admitted to the hospital, your primary care physician may arrange to transfer you to a contracting hospital.

5. If you need preventive, routine, or follow-up care after being treated in an emergency room, the care must be arranged or provided by your primary care physician.

If You're in an Accident

If you are in an accident and are outside the service area or have no control over where you are taken following the accident, you must notify your primary care physician within 48 hours, unless it was not reasonably possible to do so. There is a physician on call 24 hours a day to take your call at the number on your member ID card.

Emergencies within our service area

Follow the instructions for *What to do in case of emergency.*

Urgent care within our service area

Urgent care is defined as care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Urgent care is a covered benefit, subject to scheduled copayments. *Use of the emergency room for urgent care services that are not preauthorized by your primary care physician will not be covered.*

1. If you need urgent medical care, call your primary care physician's office and inform them that you are a GlobalHealth member.
2. Inform your primary care physician or office personnel that you have an urgent medical problem and need assistance and describe your condition or symptoms.

3. During office hours, your call will be given to your primary care physician or a medical staff person who will give you instructions.

4. After office hours, you have two options:

- Call the number on your member ID card for your primary care physician. Your primary care physician's answering service will take your name and phone number. Your primary care physician will call you back. You will be given medical direction at that time, which may include directing you to an urgent care facility.
- You may self-refer to an in-network urgent care facility. For a list of facilities, please refer to the GlobalHealth *Physician & Health Providers Directory*, also available online at www.globalhealth.com/fehb.

Emergencies outside our service area

Follow the instructions for *What to do in case of emergency.*

Urgent care outside our service area

If you are traveling and require urgent care that cannot be delayed until you return to the GlobalHealth service area, contact your primary care physician for medical advice and direction, and/or self-refer to an urgent care facility.

All follow-up care must be provided or arranged through your primary care physician.

Benefit Description	You pay
Emergency within our service area	**High Option**
Accidental injury or emergency medical care • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copayment if you are admitted to the hospital.	Nothing per visit to your primary care physician $35 copayment per visit to a specialist $25 copayment per visit to an urgent care center $250 copayment per visit in an emergency room
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	**High Option**
Accidental injury or emergency medical care • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copayment if you are admitted to the hospital.	$35 copayment per visit at a doctor's office $25 copayment per visit to an urgent care center $250 copayment per visit in an emergency room
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*

Benefit Description	You pay
Ambulance	**High Option**
Professional ambulance service, including air ambulance when medically appropriate. Note: Air ambulance to nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation. Air ambulance will not be covered if transport is beyond the nearest available suitable facility, but is requested by patient or physician for continuity of care or other reasons. Note: See 5(c) for non-emergency service. Prior approval required.	$50 copayment
Not covered: • *Air ambulance without prior approval* • *Air ambulance when the patient does not require the assistance of medically trained personnel and can be safely transferred or transported by other means* • *Wheelchair van services and gurney van services* • *Ambulance and any other modes of transportation to or from services*	*All charges*

Section 5(e). Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- Balance billing occurs when a provider bills a member the difference between its billed charge and the total amount the provider received from the member's cost-share and GlobalHealth's contracted or usual and customary reimbursement. In-network providers may not balance bill you; however, out-of-network providers may balance bill you. You are responsible for the difference between our payment and the billed amount.

Benefit Description	You pay
Professional services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment, and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	Nothing

Benefit Description	You pay
Diagnostics	**High Option**
Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner Outpatient diagnostic tests provided and billed by a laboratory, hospital, or other covered facility Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services Note: We only cover hospitalization when we preauthorize the treatment, except for emergencies. We will only cover these services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	$250 copayment per day with a maximum of $750 copayment per admission
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility	Nothing for office visit
Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment Note: We only cover outpatient facility services when we preauthorize the treatment. We will only cover these services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on page 16.*	$250 copayment per admission
Not covered	**High Option**
• *Services that are not part of a preauthorized approved treatment plan* • *Services related to applied behavioral analysis*	*All charges*

Preauthorization	To be eligible to receive these benefits, you must obtain a treatment plan and follow all of the following network authorization processes. Behavioral health care services (e.g., treatment or care for mental disease or illness, alcohol abuse, and/or substance abuse) are managed by MHNet Behavioral Health ("MHNet"). MHNet makes initial coverage determinations and coordinates referrals; any behavioral health care referrals will be made to providers affiliated with GlobalHealth/MHNet, unless your needs for covered services extend beyond the capability of the affiliated providers. Emergency care is covered. (See Section 5 (d), *Emergency services/accidents*). You can receive information regarding the appropriate way to access the behavioral health care services that are covered under the Plan by calling customer care at 1-877-280-2989. You may also access MHNet directly by calling 1-866-904-5234.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You must fill your prescriptions at certain pharmacies or by mail order. There is an exception for medical emergencies and urgently needed care. If it is a medical emergency or urgently needed care, we cover prescriptions you get from doctors who are not Plan providers and prescriptions that are filled at non-Plan pharmacies. You must fill the prescription at a Plan pharmacy or by mail for a maintenance medication. See www.globalhealth.com/fehb.
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Certain drugs require your doctor to get precertification from the Plan before they can be prescribed under the Plan. Visit our website at www.globalhealth.com/fehb to review our formulary guide or call 1-877-280-2989.
  - Tier 1: Generic drugs, including low cost generics
  - Tier 2: Preferred band name drugs
  - Tier 3: Non-preferred drugs (brand names and generics)
  - Tier 4: Preferred specialty drugs
  - Tier 5: Non-preferred specialty drugs
- **These are the dispensing limitations.** Covered prescription drugs prescribed by a licensed physician obtained at a participating Plan retail pharmacy may be dispensed for up to a 30-day supply. Members must obtain a 31-day up to a 90-day supply of covered prescription medication through mail order or an extended supply network retail pharmacy. In no event will the copayment exceed the cost of the prescription drug.
- **A generic equivalent will be dispensed if available**, unless your physician specifically requires a brand name. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

Why use generic drugs? Generic drugs are produced and sold under their chemical names, rather than under the names of the companies that manufacture them. A generic drug is a lower cost version of a brand name drug. Some brand name drugs have a generic equivalent and others do not. Generic drugs cost less, but generic and brand name drugs are the same in terms of quality and how they work. The law requires that a generic drug must contain the same amount of the same active drug ingredient as the brand name drug. However, a generic drug may differ in certain other ways, such as its color or its flavor, the shape of the pill or tablet, and the inactive (non-drug) ingredients it contains. You pay less for formulary drugs if you get a generic drug rather than a brand name drug. The GlobalHealth formulary list includes most generic drugs. When there is a generic drug available, the formulary list usually includes only the generic drug. GlobalHealth's plan pharmacies and mail order service fill prescriptions using generic drugs rather than brand name drugs whenever possible**.**

When you do have to file a claim. Medications filled at a network pharmacy will usually be billed directly to Express Scripts (ESI). However, if you fill a prescription without your member ID card, you may be required to pay the pharmacy. If this happens, call ESI at 1-866-274-1612 (toll-free) or 1-800-899-2114 (TTY/TDD/Voice).

Prior Authorization, Step Therapy, Quantity Limits, and Exceptions: Your Plan includes utilization management programs based on current medical findings, FDA (U.S. Food and Drug Administration) approved manufacturer labeling information, cost, and manufacturer rate agreements. The following chart describes prior authorization, step therapy, quantity limits, and exceptions:

	Utilization Management - Call 918-878-7361
Prior Authorization	Physicians are required to obtain prior authorization for certain medications, including compound drugs. This promotes appropriate, cost-effective use. Any corresponding supplies or equipment also require prior authorization. We may not cover the drug, supply, or equipment without prior authorization.
Step Therapy	Step therapy requires one or more prerequisite, clinically equivalent drugs to be tried before a step therapy drug will be covered.
Quantity Limits	There are limits to the amount of certain medications that you may receive. These drugs, if taken inappropriately for too long a time period, could be unsafe and cause adverse effects.
Requesting a Standard Exception	You can request GlobalHealth to waive coverage restrictions and limits. Call 918-878-7361. Generally, we will only approve your request for an exception if: • The alternative drug is included on the Plan's formulary; • The drug in the lower tier or additional utilization restrictions would not be as effective in treating your condition; and • It would cause you to have adverse medical effects. In the case of a request to cover a non-formulary drug, the physician must include: • A justification supporting the need for the non-formulary drug to treat your condition; and • A statement that all covered formulary drugs on any tier will be or have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects. You, your designee, or your physician should contact us for instructions on obtaining a utilization restriction exception. Your physician may have to submit a prior authorization request form with supporting information. Generally, a decision is made within 72 hours of receiving your request and sufficient information to begin the review. If granted, the exception will be for the duration of the prescription, including refills. You may submit your request by calling 918-878-7361.
Requesting an Expedited Exception	You, your designee, or your prescribing physician may request an expedited exceptions process, when: • You are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or • You are undergoing a current course of treatment using a non-formulary drug. We will provide a decision to you, your designee, or the prescribing physician within 24 hours after receiving the request and sufficient information to begin the review. If granted, the exception will be for the duration of the prescription, including refills. You may submit your request by calling 918-878-7361.

Benefit Description	You pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*. • Compound drugs - prior authorization required and limitations apply. See our Drug Formulary for our policy on compound drugs. • Insulin, with a prescription • Diabetic supplies including disposable needles and syringes for the administration of covered medications, test strips, and lancets, with a prescription • Oral and self-injectable fertility drugs, subject to prior authorization to confirm covered diagnosis • Drugs for sexual dysfunction • Contraceptive drugs and devices Under the Patient Protection and Affordable Care Act, certain over-the-counter medicines and supplements to promote better health will be covered. To receive benefits, you must use an in-network retail pharmacy and present a written prescription from your physician to the pharmacist. Benefits are limited to recommended prescribing limits. • Iron supplements: For children from birth through 12 months • Oral fluoride supplements: For children from birth through 5 years • Folic acid supplements: For women of childbearing age • Aspirin: For men age 45 through 79 and women age 55 through 79 or for women at increased risk of preeclampsia after 12 weeks gestation • Vitamin D: For adults age 65 and older Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 34) Note: Off-label uses of medication used in the treatment of cancer or the study of oncology are covered. Certain investigational uses of chemotherapy for cancer treatment may be covered if administered as part of an approved clinical trial.	NOTE: Drugs on the specialty medication list are not available through retail or regular mail order network provider. See our website for contact information
Retail Pharmacy up to a 30-day supply per prescription or refill Note: Check our website or with Customer Care for a list of the Extended Supply Network retail pharmacies. Note: The list of covered specialty drugs is subject to change. For the most up-to-date listing, contact Customer Care. Note: You will pay the copayment or the cost of the prescription drug, whichever is less.	Tier One – Covered generic drugs (See our website for a list of drugs in the low-cost generic program.) • Preferred Pharmacy: $4/$12 copayment • Non-preferred Pharmacy: $9/$17 copayment Tier Two – Covered preferred brand name drugs • Preferred Pharmacy: $50 copayment • Non-preferred Pharmacy: $55 copayment Tier Three – Covered non-preferred drugs • Preferred Pharmacy: $80 copayment • Non-preferred Pharmacy: $85 copayment

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Extended Supply and Express Scripts Home Delivery - 90-day supply per prescription refill Note: You may purchase a 90-day extended supply from an Extended Supply Network (ESN) pharmacy, or through Express Scripts home delivery. Your doctor must write the prescription for a 90-day supply. Some restrictions may apply. See our website for information on home delivery. Note: Specialty drugs in Tiers Four and Five are not available in extended supply. Note: Check on our website or with Customer Care for information on the Extended Supply Network retail pharmacies. Note: Not all prescriptions are available in a 90-day supply.	Tier One – Covered generic drugs (See our website for information on home delivery or a list of extended supply retail pharmacies.) • Preferred Pharmacy: $8/24 copayment • Non-preferred Pharmacy: $13/$29 copayment Tier Two – Covered preferred brand name drugs • Preferred Pharmacy: $125 copayment • Non-preferred Pharmacy: $130 copayment Tier Three – Covered non-preferred drugs • Preferred Pharmacy: $240 copayment • Non-preferred Pharmacy: $245 copayment Tier Four – Covered preferred specialty drugs • 10% coinsurance with a maximum of $150 (30-day supply only) Tier Five – Covered non-preferred specialty drugs • 10% coinsurance with a maximum of $250 (30-day supply only)
Women's contraceptive drugs and devices • Selected FDA-approved contraceptive prescriptions will be provided for no copayment for women of childbearing age • All others are subject to prescription copayments and possible prior authorizations • Over-the-counter contraceptive drugs and devices, including the "morning after pill", approved by the FDA require a written prescription by an approved provider Note: Benefits are limited to recommended prescribing limits. Note: See Drug Formulary for contraceptive drugs provided for no copayment.	See retail pharmacy and extended supply sections above
Not covered: • *Drugs prescribed by out-of-network physicians in non-emergencies* • *Drugs to enhance athletic performance, hair growth, cosmetic purposes, and anti-aging* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* • *Vitamins, nutrients (except prenatal and other exceptions noted above), and food supplements, even if a physician prescribes or administers them* • *Nonprescription medicines: drugs and dietary supplements unavailable without a prescription (OTC) or for which there is a non-prescription equivalent available, even if ordered by a physician, unless an exception applies* • *Saline and medications for irrigation* • *Biological sera, medication prescribed for parenteral use or administration* • *Dietary formulas including, but not limited to, total parenteral nutrition and other enteral formulas, except FDA-approved low-protein formulas specifically covered* • *Lost or stolen prescriptions*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• *Prescription medications to improve energy level, stamina, or slow the aging process (such as AndroGel)* Note: You must have a physician's prescription which must be filled by a pharmacist or a network retail pharmacy. *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 34.)*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Balance billing occurs when a provider bills a member the difference between its billed charges and the total amount the provider received from the member's cost-share and GlobalHealth's contracted or usual and customary reimbursement. In-network providers may not balance bill you; however, out-of-network providers may balance bill you. You are responsible for the difference between our payment and the billed amount.

Benefit Description	You pay
Accidental injury benefit	
Emergency room services necessary to stabilize naturally sound teeth due to accidental injury will be covered. Replacement, re-implantation, and follow-up care of those teeth are not covered, even if the teeth are not saved by emergency stabilization. The need for these services must result from an accidental injury. Masticating (biting or chewing) indents are not considered to be accidental injuries. You must go the the emergency room to receive this benefit coverage.	$250 copayment per visit
Dental benefits	
Not covered • *Diagnostic and preventive services, including examination, prophylaxis (cleaning), x-rays of all types and fluoride treatment* • *Basic dental services* • *Major dental services, including restorative services* • *Orthodontia* • *Accidental injury services provided in any setting other than an emergency room*	*All charges*

Section 5(h). Special features

Feature	Description
Feature	**High Option**
Services for deaf and hearing impaired	TTY: 1-800-722-0353 or 711
Hearing aids for children	Hearing aids for children up to age 22 are covered when medically necessary and hearing loss is documented.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Health improvement programs	• Nutritional Training for Diabetes • Medically managed smoking cessation and Freedom from Smoking Classes • Disease Management - Learn skills to help manage asthma, diabetes, congestive heart failure, coronary artery disease, and chronic obstructive pulmonary disease • Wellness program - Address other diseases, medications, weight programs, nutrition Contact Customer Care at 1-877-280-2989.
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call and talk with a registered nurse who will discuss treatment options and answer your health questions. Call 1-877-280-2993 anytime.
Centers of excellence	GlobalHealth's Center of Excellence Program includes OptumHealth Network, LifeTrac Network, and CignaLife Source Network.
Translation Services	Our health plan offers over 150 languages from professional certified medical interpreters. Call Customer Care for help or 1-800-722-0353 or 711 (TTY/TDD/Voice).
Medication Therapy Management Program	If you are taking multiple medications for chronic conditions, you can receive support from our Medication Therapy Management program. Enrollment in this program is automatic. You receive personalized service from registered pharmacists and staff. The goal of this program is: • To help eliminate duplicate drug therapies. • To reduce potential for negative drug interactions and side effects. • To optimize your benefits by advising of the lowest cost alternatives.
MyStrength.com. The health club for your mind.™	An online wellness portal to help you improve your mental health and overall well-being. It is available 24/7. Go to www.MHNet.com. • Complete your free wellness assessment and profile.

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
	• myStrength.com will deliver a structured week by week action plan tailored to your needs and specifications. Powerful eLearning modules lead you towards rediscovering your inner peace and mental well-being.
Quality Improvement Program	You may request information regarding our Quality Improvement Program and work plan by contacting Customer Care.
Care Management Programs	If you have a chronic disease or complex health care needs, you have two types of care management programs that provide patient education and clinical support. Case Management: We provide you with complex health care needs with the services of a professional case manager to assess your needs and when appropriate, coordinate, evaluate, and monitor your care. Disease Management: We provide programs to help you adopt effective self-care habits to improve your self-management of chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), and chronic heart failure (CHF). If you have any questions regarding these programs, or would like to self-refer, please contact Customer Care.
Surveys	Your Health: Each year, we will send you a health appraisal that asks questions about your current health. Your answers help us know how to best serve you and your health care needs. The information you give us will remain confidential as required by law. It will not be used against you in any way or prevent you from obtaining services and treatment. Your Satisfaction: We distribute member satisfaction surveys to see how well you believe your doctors and health Plan are serving your needs. This may include: • New Member Survey; • Customer Satisfaction Study; and • Consumer Assessment of Healthcare Providers and Systems (CAHPS). GlobalHealth performs an audit that is approved by the National Committee for Quality Assurance (NCQA) called HEDIS (Healthcare Effectiveness Data Information Systems). It measure the quality of preventive care our network providers deliver. One part of this audit is the CAHPS survey. It is very important that you complete and return it. Your answers will help us improve service.
Technology Assessment Process	GlobalHealth has a technology assessment and guideline review process. It is designed to review requests for coverage of newly available devices, procedures, or treatments that are not considered established benefits. A physician-directed committee reviews all requests for new technology. This includes: • New technology; or • New application of existing technology The committee reviews medical and behavioral health care procedures, drugs, and devices using scientific medical evidence. An appropriate regulatory agency, such as the U.S. Food and Drug Administration ("FDA") must have approved the new device, procedure, or treatment before it will be considered. Before approving coverage, Globalhealth requires documented evidence to ensure the efficacy and safety of the new technology. The new technology must: • Improve the net health outcome of the member; • Be as beneficial as established alternatives; • Be available outside the investigational setting; • Significantly improve the quality of life of the member; and,

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
	• Clearly demonstrate safe medical care to the member. Contact Customer Care.

Non-FEHB benefits available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, contact the Plan at 1-877-280-2989 or visit their website at www.globalhealth.com/fehb.

Medicare Managed Care Plan

If you are Medicare eligible and are interested in enrolling in a Medicare HMO Plan sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-877-280-5774 for information.

Medicare Advantage HMO - As a member of one of GlobalHealth's Medicare Advantage plans, you benefit from low or no plan copayments, low or no deductibles, and virtually no paperwork. The service area for our Medicare Advantage plans includes the following counties: Adair, Alfalfa, Blaine, Caddo, Canadian, Cherokee, Cleveland, Cotton, Craig, Creek, Dewey, Garfield, Garvin, Grady, Grant, Haskell, Hughes, Jefferson, Kingfisher, Kiowa, Lincoln, Logan, Major, Mayes, McClain, McIntosh, Muskogee, Noble, Nowata, Okfuskee, Oklahoma, Okmulgee, Osage, Pawnee, Pittsburg, Pontotoc, Pottawatomie, Pushmataha, Rogers, Seminole, Tillman, Tulsa, Wagoner, and Woods. For more information, call toll-free 1-877-280-5774.

GlobalFit - Through the partnership with GlobalFit, you can register for the wellness benefit giving you access to:

- Discounts on gym memberships at thousands of fitness clubs nationwide, including 24-hour Fitness, Anytime Fitness, Curves, as well as a host of independent clubs and specialty studios - all with GlobalFit's guaranteed lowest price
- Special pricing and food discounts at 400 participating Jenny Craig Centers
- Discounts on at-home workout equipment and videos which include the newest workout in the Zumba Fitness series - Get in shape with the Latin-inspired dance fitness phenomenon for a special low price on the 5-DVD box set
- Health Coaching discounts - 12 week programs, with personalized access by phone or online to a professional health coach who will help you quit smoking, lose weight, reduce stress, start walking, or meet other health goals
- Monthly newsletters, ebooks, and podcasts providing education and tools to help employees stay motivated and up-to-date on the latest fitness and wellness news and training tips

Section 6. General exclusions – services, drugs, and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs, or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services, drugs, or supplies you would not be charged for if you had no health insurance.
- Services that you get without a referral from your primary care physician, when a referral from your primary care physician is required for getting that service.
- Services that you get without prior authorization, when prior authorization is required for getting that service.
- Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency.
- Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
- Nursing care on a full-time basis in your home.
- Custodial care is not covered by GlobalHealth *unless* it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating, and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
- Homemaker services.
- Meals delivered to your home.
- Charges imposed by immediate relatives or members of your household.
- Elective or voluntary enhancement procedures, services, supplies, and medications including but not limited to: Hair growth, athletic performance, cosmetic purposes, anti-aging, and mental performance.
- Cosmetic surgery or procedures, *unless* it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs, or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs, or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 1-877-280-2989, or at our website at CommercialAnswers@globalhealth.com.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number, and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

GlobalHealth

P.O. Box 2328

Oklahoma City, OK 73101-2328

1-877-280-2989

Prescription drugs

Submit your claims to:

Call Express Scripts:

- 1-866-211-7824 (toll-free)
- 1-800-899-2114 (TTY/TDD/Voice)

Other supplies or services

Submit your Mental Health and Substance Abuse claims to:

Call MHNet

- 1-866-940-5234 (toll-free)
- 1-866-200-3269 (TTY/TDD/Voice)

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7, and 8 of this brochure, please visit www.globalhealth.com/fehb.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs, or supplies have already been provided). In Section 3 *If you disagree with our Pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs, or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Care Department by emailing CommercialAnswers@globalhealth.com, writing GlobalHealth, P.O. Box 2393, Oklahoma City, OK 73101-2393, or calling 1-877-280-2989.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at GlobalHealth, P.O. Box 2393, Oklahoma City, OK 73101-2393; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim; or b) Write to you and maintain our denial; or c) Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has the right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM’s decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily function or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (405) 280-2989. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0737 between 8 a. m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant, or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at http://www.NAIC.org.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigation new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan covers some of these costs, providing the plan determines the services are medically necessary. We encourage you to contact the plan to discuss specific services if you participate in a clinical trial.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure.

For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure.

For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage.

It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-877-280-2989 or see our website at www.globalhealth.com/fehb.

We do not waive any costs if the Original Medicare Plan is your primary payor.

Please review the following table. It illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$0	$0
Out-of-Pocket Maximum	$5,000 self only/$7,000 family	$5,000 self only/$7,000 family
Primary Care Physician	$0	$0
Specialist	$35 copayment	$35 copayment
Inpatient Hospital	$250 copayment per day up to $750 copayment per admission	$250 copayment per day up to $750 copayment per admission
Outpatient Hospital	$250 copayment in free-standing/ low-cost facility $750 copayment in hospital-owned facility	$250 copayment in free-standing/ low-cost facility $750 copayment in hospital-owned facility
Rx	Tier 1 - $4/$12 copayment Tier 2 - $50 copayment Tier 3 - $80 copayment Tier 4 – Specialty (30-day supply) 10% up to $150 for preferred drugs 10% up to $250 for non-preferred drugs	Tier 1 - $4/$12 copayment Tier 2 - $50 copayment Tier 3 - $80 copayment Tier 4 – Specialty (30-day supply) 10% up to $150 for preferred drugs 10% up to $250 for non-preferred drugs
Rx – Mail Order (90 day supply)	Tier 1 - $8/$24 copayment Tier 2 - $125 copayment Tier 3 - $240 copayment	Tier 1 - $8/$24 copayment Tier 2 - $125 copayment Tier 3 - $240 copayment

Tell us about your Medicare coverage

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

Medicare Advantage (Part C)

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, some coordination of benefits will apply. For more information about our Medicare Advantage plans, please call 1-877-280-5774.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB Plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments or coinsurance. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

	Suspended FEHB coverage to enroll in a Medicare Advantage Plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.
Medicare prescription drug coverage (Part D)	When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of terms we use in this brochure

Calendar year
January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials cost categories
An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance
Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 19.

Copayment
A Copayment is a fixed amount of money you pay when you receive covered services. See page 19.

Cost-sharing
Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services
Care we provide benefits for, as described in this brochure.

Custodial Care
Care which is primarily for the purpose of assisting in the activities of daily living or in meeting personal rather than medical needs, which is not specific therapy for an illness or injury and is not skilled care.

Deductible
A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. We do not have a deductible.

Experimental or investigational service
Those procedures and/or items determined by GlobalHealth not generally accepted by the medical community.

Free-standing/low-cost facility
A facility that is not owned or operated by a hospital. Your cost-share will be less if you choose to receive services in one of these facilities. Be sure to ask when you make an appointment which type of facility it is.

Group Health Coverage
Health benefits provided to a group of people, usually through an employer, by a single policy or contract in exchange for a premium.

Health care professional
A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Hospital-owned facility
A facility that is owned by a hospital. It may or may not be in the hospital itself. Your cost-share will be more if you choose to receive services in one of these facilities. Be sure to ask when you make an appointment which type of facility it is.

Medical necessity
Medical or hospital services we determine are appropriate for the treatment or diagnosis of an illness or injury.

Plan allowance
Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance based on contractual rates with our providers.

GlobalHealth offers set copayments on all services except durable medical equipment which has coinsurance. The copayments do not vary depending on the allowed amount.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Reimbursement A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Urgent care claims A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Care Department at 1-877-280-2989. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We Us and We refer to GlobalHealth.

You You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll**.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,550 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for DCFSA.
- If you are a new or newly eligible employee, you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants, and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges, and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337, (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB Plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility, or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY 1-800-843-3557), or visit www.ltcfeds.com.

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Summary of benefits for the GlobalHealth High Option Plan - 2016

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page, we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: Nothing for primary care; $35 specialist	24
• **Services provided by a hospital:** - Inpatient - Outpatient	Inpatient: $250 copay per day with a maximum of $750 copay per admission; Outpatient: $250 copay in free-standing/low-cost facility; $750 copay in hospital-owned facility	44
• **Emergency benefits:** - In-area - Out-of-area	Nothing per PCP visit; $35 copay per specialist visit; $25 copay per urgent care visit; $250 copay per emergency room visit	48
Mental health and substance abuse treatment:	Office visit: Nothing; Inpatient: $250 copay per day with a maximum of $750 copay per admission; Outpatient hospital: $250 copay per admission	50
Prescription drugs: • Retail pharmacy - 30-day supply	Tier One – Covered generic drugs - Preferred Pharmacy: $4/$12 copay; Non-preferred Pharmacy: $9/$17 copay Tier Two – Covered preferred brand name drugs - Preferred Pharmacy: $50 copay; Non-preferred Pharmacy: $55 copay Tier Three – Covered non-preferred drugs - Preferred Pharmacy: $80 copay; Non-preferred Pharmacy: $85 copay	54
• Mail order and extended supply - 90-day supply	Tier One – Covered generic drugs - Preferred Pharmacy: $8/24 copay; Non-preferred Pharmacy: $13/$29 copay Tier Two – Covered preferred brand name drugs - Preferred Pharmacy: $125 copay; Non-preferred Pharmacy: $130 copay Tier Three – Covered non-preferred drugs - Preferred Pharmacy: $240 copay; Non-preferred Pharmacy: $245 copay Tier Four – Covered preferred specialty drugs - 10% coinsurance with a maximum of $150 (30-day supply only) Tier Five – Covered non-preferred specialty drugs - 10% coinsurance with a maximum of $250 (30-day supply only)	55
Vision care:	One eye refraction annually - $40 copay	31
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000/Self Only or $7,000/Self Plus One or $7,000/Self and Family enrollment per year. Some costs do not count toward this protection.	11

Notes

2016 Rate Information for GlobalHealth, Inc.

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal rates apply to United States Postal Service employees.

Postal Category 1 rates apply to career bargaining unit employees.

Postal Category 2 rates apply to career non-bargaining unit employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center: 1-877-477-3273, option 5, (TTY: 1-866-260-7507)

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees.

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	IM1	$207.25	$69.08	$449.04	$149.68	$57.34	$69.08
High Option Self Plus One	IM3	$414.50	$138.17	$898.09	$299.36	$114.68	$138.17
High Option Self and Family	IM2	$488.50	$202.34	$1,058.42	$438.40	$175.20	$202.34