# GlobalHealth, Inc.

www.GlobalHealth.com/fehb

**Customer Care 877-280-2989**

GlobalHealth

# 2019

## A Health Maintenance Organization (High and Standard 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. This Plan is accredited. See page 12.

**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 13 for requirements.**

**IMPORTANT**
- Rates: Back Cover
- Changes for 2019: Page 14
- Summary of benefits: Page 101

**Enrollment code for this Plan:**

IM1 High Option - Self Only
IM3 High Option - Self Plus One
IM2 High Option - Self and Family

IM4 Standard Option - Self Only
IM6 Standard Option - Self Plus One
IM5 Standard Option - Self and Family

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

**Important Notice from GlobalHealth, Inc.**
**About Our Prescription Drug Coverage and Medicare**

The Office of Personnel Management (OPM) has determined that the GlobalHealth, Inc. 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.

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**Please be advised**

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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 800-772-1213 TTY 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 800-MEDICARE 800-633-4227, TTY 877-486-2048.

# Table of Contents

## Introduction

This brochure describes the benefits of GlobalHealth, Inc. 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 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 2328
Oklahoma City, OK 73101-2328

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 Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2019, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each Plan annually. Benefit changes are effective January 1, 2019, and changes are summarized on page 14. 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 meets 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, Inc.
- 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 healthcare 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 healthcare providers, authorized health benefits Plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare 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 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 877-280-2989 and explain the situation.
  - If we do not resolve the issue:

**CALL - THE HEALTHCARE 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 (TCC).
- 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 by your provider 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.

## Discrimination is Against the Law

GlobalHealth complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, GlobalHealth does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

If a carrier is a covered entity, its members may file a 1557 complaint with HHS Office of Civil Rights, OPM, or FEHB Program carriers. For purposes of filing a complaint with OPM, covered carriers should use the following:

You can also file a civil rights complaint with the Office of Personnel Management by mail at:

Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Attention: Assistant Director, FEIO
1900 E Street NW, Suite 3400-S
Washington, D.C. 20415-3610

# Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions, and understand answers.

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications 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 medication 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 medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

**3. Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

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

**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**

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. 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 healthcare providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.
- 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 healthcare professionals working to improve patient safety.

**Preventable Healthcare Acquired Conditions ("Never Events')**

When you enter the hospital for treatment of one medical problem, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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 to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB Plan 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 these 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 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, and one eligible family member, or 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 Plus One or Self and Family 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 are married.

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, you or they cannot be enrolled in or covered as a family member by another enrollee in 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 your spouse, or 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. |

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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 in 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 in 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 in Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM
- 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 lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not 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 or Plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new Plan or option, your claims will be paid according to the 2019 benefits of your old Plan or option.** However, if your old Plan left the FEHB Program at the end of the year, you are covered under that Plan's 2018 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 assistance with enrolling in a conversion policy (a non-FEHB individual policy).

- **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 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.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 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 ACA'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). OPM requires that FEHB Plans be accredited to validate that Plan operations and/or care management meet nationally recognized standards. GlobalHealth holds the following accreditations: National Committee for Quality Assurance. To learn more about this Plan's accreditation, please visit the following website: www.ncqa.org. We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your healthcare services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We give you a choice of enrollment in a High Option or a Standard Option. 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, coinsurance, and deductibles 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 and Standard Options

GlobalHealth's High Option Plan features no deductibles and both the High Option and the Standard Option have 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 on the High Option, you will begin to pay copayments only from the first point of service. For benefits that have coinsurance (durable medical equipment, orthotics, prosthetics that are not surgically implanted, hearing aids, and specialty drugs), you pay a percentage of our allowed amount.

## 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 cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

### Preventive care services

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

### Annual deductible

The annual deductible must be met before Plan benefits are paid for care (other than preventive care services, primary care physician, specialist, lab/x-ray, behavioral health office visits, and prescription drugs) in our Standard Option.

### Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services including all deductibles, copayments, and coinsurance to no more than $6,750 for Self Only enrollment, or $13,500 for Self Plus One or Self and Family enrollment. Your specific Plan limits may differ.

## Your rights and responsibilities

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.**

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, GlobalHealth at www.GlobalHealth.com/fehb. You can also contact us to request that we mail a copy to you. Member Rights and Responsibilities and Patient Bill of Rights notices are on our website.

If you want more information about us, call 877-280-2989, or write to P.O. Box 2393, Oklahoma City, OK 73101-2393. You may also visit our website at www.GlobalHealth.com/fehb.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website GlobalHealth at www.GlobalHealth.com/fehb to obtain a Notice of our Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

**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 or urgent care benefits. We will not pay for any other healthcare 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 2019

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.

**Changes to both High and Standard Options**

- We will add the coverage of genetic expression testing for the treatment of malignancies, such as breast or prostate cancer. See page 35.
- We will remove the 25 hour per week limitation for coverage of applied behavioral analysis. See page 35.
- We will remove the cost share for applied behavioral analysis provided in the office. See page 34.
- We will remove the prior authorization requirements for chiropractic care. See page 44.
- We will remove the prior authorization requirements for FIT-DNA. See page 28.
- We will add the coverage of childhood rhabdomyosarcoma and mantle cell (non-Hodgkin's lymphoma) transplants. See page 50.
- We will remove the cost share for mental health and substance use disorder professional services for intensive outpatient treatment in a provider's office or other professional setting. See page 64.
- We will remove prior authorization and the cost share for naloxone-based agents. See page 71.
- We will add prior authorization requirements for initial fills on opioid prescription drugs for acute conditions. See page 68.

**Changes to High Option only**

- Your share of the premium will increase for Self only, Self Plus One, and Self and Family. See page 106.
- We will decrease the copayment for rehabilitation services to $20 per outpatient visit. See page 36.
- We will add pulmonary rehabilitation for chronic obstructive pulmonary disease for up to 3 visits per week for 12 weeks at a cost share of $20 per outpatient visit. See page 35.
- We will decrease the copayment for habilitation services to $20 per outpatient visit. See page 36.
- We will decrease the copayment for foot care to $20 per outpatient visit. See page 39.

**Changes to Standard Option only**

- Your share of the premium will increase for Self Only, Self Plus One, and Self and Family. See page 106.
- We will decrease the copayment for rehabilitation services to $25 per outpatient visit. See page 36.
- We will add pulmonary rehabilitation for chronic obstructive pulmonary disease for up to 3 visits per week for 12 weeks at a cost share of $25 per outpatient visit. See page 35.
- We will decrease the copayment for habilitation services to $25 per outpatient visit. See page 36.
- We will decrease the copayment for foot care to $25 per outpatient visit. See page 39.

# 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 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 deductibles (Standard Option only), copayments, and/or coinsurance.

- **Plan providers**

Plan providers are physicians and other healthcare 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 healthcare.

- **Primary care**

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

When you enroll, you choose a primary care physician from the GlobalHealth provider network. Each member of the family may choose a different primary care physician, including a pediatrician for children. Your primary care physician can be a family practitioner, internist, pediatrician (for members under the age of 18), or a general practitioner. You have complete freedom of choice of primary care physicians in our network. Your primary care physician will provide most of your healthcare, 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, routine mammograms, behavioral and mental health/chemical dependency counseling services, physical therapy evaluations, routine eye exams or eye wear, chiropractic care, and after hours urgent care visits.

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 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*.

You must get prior approval for certain services. Failure to do so may result in non coverage of the service.

- **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 preauthorize 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 counseling services, routine eye exams or eye wear, chiropractic care, and physical therapy evaluations. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

You must obtain prior authorization for:

- Specialist visits, except those listed above
- Non-routine lab, x-ray, and other diagnostic tests
- Specialized scans, imaging, and diagnostic exams
- Preventive care
  - BRCA test
  - Colorectal test (other than fecal immunochemical test (FIT), FIT-DNA test, or fecal occult blood test (FOBT))
  - Breastfeeding equipment and supplies
  - Voluntary sterilization
  - Abdominal aortic aneurysm screening
  - Lung cancer screening
- Infertility treatment
- Chemotherapy, radiation, dialysis, infusion therapy, growth hormone therapy
- Applied behavioral analysis
- Physical therapy, occupational therapy, and speech therapy
- Cardiac rehabilitation
- Hearing aids and implanted hearing-related devices
- Orthopedic and prosthetic devices
- Durable medical equipment
- Diabetic supplies
- Home health services
- All surgical procedures provided in specialists' offices
- Inpatient hospital admissions, except for childbirth
- Outpatient hospital or other covered facility visits
- Extended care benefits/Skilled nursing care facility benefits
- Hospice care
- Non-emergency ambulance services
- Certain prescription drugs

**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 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 or not it is an urgent care claim by applying the judgment of a prudent layperson that 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 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 877-280-2989. You may also call OPM's FEHB 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 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, 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 primary care physician, 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 unless it is an urgent or emergency occurrence or situation. For a list of network healthcare professionals who specialize in obstetrics and gynecology, refer to the online provider directory or contact Customer Care.

You do not need preauthorization of a maternity admission for routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for authorization of additional days. Further, if your baby stays after your are discharged, then your physician or the hospital must contact us for authorization of additional days for your baby.

- **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 unless you are having contractions and there is inadequate time to effect a transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of you or your unborn child. 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 healthcare 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., deductible, 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 up to a maximum of $750 per admission under our High Option.

**Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The calendar year deductible is $300 per person under our Standard Option. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $300 under Standard Option. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $600 under Standard Option. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $600 under Standard Option.
- We do not have a deductible under High Option.

Note: If you change Plans during Open Season, you do not have to start a new deductible under your old Plan between January 1 and the effective date of your new Plan. If you change Plans at another time during the year, you must begin a new deductible under your new Plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

**Coinsurance**

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: In our Plan, you pay 20% of our allowance for durable medical equipment under our High Option.

**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, orthotics and prosthetics that are not surgically implanted, hearing aids, and specialty drugs which have coinsurance. The copayments do not vary depending on the allowed amount.

Balance billing occurs when a provider bills you the difference between its billed charge and the total amount the provider received from your cost-share and our usual and customary reimbursement for approved covered services. In-network providers may not balance bill you. Out-of-network providers may balance bill you and you will be responsible for the difference between our payment and the provider's billed amount.

**Your catastrophic protection out-of-pocket maximum**

High Option: After your 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.***

Standard Option: After your deductible, copayments, and coinsurance total $6,500 for Self Only, or $7,500 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 $6,500 applies to each individual, regardless of whether the individual is enrollment 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 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.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

**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. High and Standard Option Benefits

See page 14 for how our benefits changed this year. Page 101 and page 102 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

# Section 5. High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of 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 High and Standard Option benefits, contact us at FederalAnswers@globalhealth.com, 877-280-2989, or on our website at www.GlobalHealth.com/fehb.

You may choose to receive covered services in either a preferred or in a non-preferred facility. Be sure to ask when you make an appointment which type of facility it is. Your cost-sharing may be different depending on where you receive services.

Some features apply to both options:

- $0 unlimited primary care physician office visits
- $0 lab and x-rays

Each option offers unique features:

- **High Option**
  - No deductible
  - Lower cost-sharing than our Standard Option
- **Standard Option**
  - Lower premium than our High Option
  - $300 deductible (Self Only) and $600 deductible (Self Plus One or Self and Family)
  - PCP, specialist, lab/x-ray, behavioral health office visits, preventive care, and prescription drugs are all exempt from the deductible (you only pay the copayment or coinsurance, even if you haven't met your annual deductible)

## Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare 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. Professional services are included in the facility copay.
- The calendar year deductible for the Standard Option is: $300 per person ($600 per Self Plus One enrollment, or $600 per Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. We added "(No deductible") to show when the calendar year deductible does not apply. The High Option does not have a deductible.
- 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 | |
|---|---|---|
| **Note: The calendar year deductible applies to some Standard Option benefits in this Section. We say "(No deductible") when it does not apply.** | | |
| **Diagnostic and treatment services** | **High Option** | **Standard Option After the calendar year deductible...** |
| Professional services of physicians<br>• In physician's office<br>• At home<br><br>Note: With limited exceptions, we only cover specialist visits 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 17. | Nothing per visit to your primary care physician<br><br>$35 copayment per visit to a specialist | Nothing per visit to your primary care physician (No deductible)<br><br>$45 copayment per visit to a specialist (No deductible) |
| Professional services of physicians<br>• In an urgent care center<br>• During a hospital stay<br>• In a skilled nursing facility<br>• Office medical consultations<br>• Second surgical opinion<br>• Advance care planning | Nothing per visit to your primary care physician<br><br>$35 copayment per visit to a specialist<br><br>Nothing for inpatient and urgent care center services | Nothing per visit to your primary care physician (No deductible)<br><br>$45 copayment per visit to a specialist (No deductible)<br><br>Nothing for inpatient services<br><br>Nothing for urgent care center services (No deductible) |

*Diagnostic and treatment services - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Diagnostic and treatment services (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| Note: With limited exceptions, we only cover specialist visits 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 17. | Nothing per visit to your primary care physician<br>$35 copayment per visit to a specialist<br>Nothing for inpatient and urgent care center services | Nothing per visit to your primary care physician (No deductible)<br>$45 copayment per visit to a specialist (No deductible)<br>Nothing for inpatient services<br>Nothing for urgent care center services (No deductible) |
| **Telehealth services** | **High Option** | **Standard Option After the calendar year deductible...** |
| Services covered include primary care, specialty consultations, and behavioral health counseling. Availability of these services is determined by the provider. We encourage you to reach out to your provider. | Nothing per visit from your primary care physician or behavioral health counselor<br>$35 copayment per visit from a specialist | Nothing per visit to your primary care physician (No deductible) or behavioral health counselor (No deductible)<br>$45 copayment per visit to a specialist (No deductible) |
| **Lab, X-ray, and other diagnostic tests** | **High Option** | **Standard Option After the calendar year deductible...** |
| Tests, such as:<br>• Blood tests<br>• Urinalysis<br>• Non-routine Pap tests<br>• Pathology<br>• X-rays<br>• Non-routine mammograms (including 3D)<br>• Ultrasound<br>• Electrocardiogram and EEG<br>• Genetic expression testing for the treatment of malignancies<br><br>Note: Your provider must use a contracted laboratory or radiologist.<br><br>Note: We only cover non-routine lab, x-rays, and other diagnostic tests 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 17. | Nothing | Nothing (No deductible) |
| Specialized scans, imaging, and diagnostic exams | Preferred facility: *$250 copayment per scan | Preferred facility: *$350 copayment per scan |

*Lab, X-ray, and other diagnostic tests - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Lab, X-ray, and other diagnostic tests (cont.)** | **High Option** | **Standard Option<br>After the calendar year deductible...** |
| • CT scans<br>• PET scans<br>• SPECT scans<br>• MRI scans<br>• Nuclear scans<br>• Sleep studies<br><br>Note: See Section 5(c) for services billed for by a facility, such as colonoscopies, to diagnose or treat a specific condition.<br><br>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 17. | Preferred facility: *$250 copayment per scan<br><br>Non-preferred facility: *$500 copayment per scan<br><br>*per body part scanned | Preferred facility: *$350 copayment per scan<br><br>Non-preferred facility: *$700 copayment per scan<br><br>*per body part scanned |
| **Preventive care, adult** | **High Option** | **Standard Option<br>After the calendar year deductible...** |
| Routine physical (one per calendar year) which includes:<br><br>Screenings, such as:<br>• Total Blood Cholesterol<br>• Depression<br>• Diabetes<br>• High Blood Pressure<br>• HIV<br>• Colorectal Cancer Screening, including<br>  - Fecal occult blood test<br>  - Sigmoidoscopy screening - every five years starting at age 50<br>  - Colonoscopy screening - every ten years starting at age 50<br>  - FIT-DNA<br><br>Individual counseling on prevention and reducing health risks | Nothing | Nothing (No deductible) |

*Preventive care, adult - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Preventive care, adult (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| Note: We only cover colorectal cancer tests (other than FIT, FIT-DNA, and FOBT), abdominal aortic aneurysm screening, and lung cancer screening 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 17. | Nothing | Nothing (No deductible) |
| Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older | Nothing | Nothing (No deductible) |
| Well-woman care; based on current recommendations such as:<br>• Cervical cancer screening (Pap smear)<br>• Human Papillomavirus (HPV) testing<br>• Chlamydia/Gonorrhea screening<br>• Osteoporosis screening<br>• Breast cancer screening<br>• Annual counseling for sexually transmitted infections<br>• Annual counseling and screening for human immune-deficiency virus<br>• Contraceptive methods and counseling<br>• Screening and counseling for interpersonal and domestic violence | Nothing | Nothing (No deductible) |
| Routine mammogram (including 3D) - covered for women | Nothing | Nothing (No deductible) |
| Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule | Nothing | Nothing (No deductible) |
| Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.<br><br>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ | | |

*Preventive care, adult - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Preventive care, adult (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| HHS: www.healthcare.gov/preventive-care-benefits/<br><br>CDC: www.cdc.gov/vaccines/schedules/index.html<br><br>**Women's preventive services:** www.healthcare.gov/preventive-care-women/<br><br>For additional information: healthfinder.gov/myhealthfinder/default.aspx | | |
| *Not covered:*<br>• *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel*<br>• *Immunizations, boosters, and medications for travel or work-related exposure*<br>• *Genetic testing/screening related to family history of cancer or other disease, except for BRCA testing/screening*<br>• *Screening services requested solely by the member, such as commercially advertised heart scans* | *All charges* | *All charges* |
| **Preventive care, children** | **High Option** | **Standard Option After the calendar year deductible...** |
| Well-child visits, examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics | Nothing | Nothing (No deductible) |
| Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.<br><br>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/<br><br>HHS: www.healthcare.gov/preventive-care-benefits/ | | |

*Preventive care, children - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Preventive care, children (cont.)** | **High Option** | **Standard Option**<br>**After the calendar year deductible...** |
| CDC: www,cdc,gov/vaccines/schedules/index.html<br><br>For additional information: healthfinder.gov/myhealthfinder/default.aspx<br><br>Note: For a complete list of the American Academy of Pediatrics Bright Future Guidelines go to brightfutures.aap.org/Pages/default.aspx | | |
| **Maternity care** | **High Option** | **Standard Option**<br>**After the calendar year deductible...** |
| Complete maternity (obstetrical) care, such as:<br>• Prenatal care - including ultrasound, laboratory, and diagnostic tests<br>• Screening for gestational diabetes for pregnant women<br>• Delivery<br>• Postnatal care | Nothing for prenatal care<br><br>$25 one-time copayment for all outpatient postpartum care at first visit<br><br>Nothing for inpatient professional delivery services | Nothing for prenatal care (No deductible)<br><br>$45 one-time copayment for all outpatient postpartum care at first visit (No deductible)<br><br>Nothing for inpatient professional delivery services |
| Breastfeeding support, counseling, supplies, equipment rental for each birth<br><br>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.<br><br>Note: We only cover breastfeeding supplies and equipment 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 17. | Nothing | Nothing (No deductible) |
| Note: Here are some things to keep in mind:<br>• You do not need to precertify your vaginal delivery; see page 54 for other circumstances, such as extended stays for you or your baby.<br>• You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. | | |

*Maternity care - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Maternity care (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment.<br>• We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.<br>• Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b).<br><br>Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. | | |
| *Not covered:*<br>• *Elective abortions*<br>• *Childbirth preparation, Lamaze, and other birthing/parenting classes*<br>• *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)*<br>• *Maternity care for women not enrolled in this Plan*<br>• *Home uterine monitoring devices* | *All charges* | *All charges* |
| **Family planning** | **High Option** | **Standard Option After the calendar year deductible...** |
| Contraceptive counseling on an annual basis | Nothing | Nothing (No deductible) |
| A range of voluntary family planning services, limited to:<br>• Voluntary sterilization (e.g., tubal ligation, vasectomy)<br>• Surgically implanted contraceptives<br>• Injectable contraceptive drugs (such as Depo provera)<br>• Intrauterine devices (IUDs)<br>• Diaphragms and contraceptive rings | Nothing | Nothing (No deductible) |

*Family planning - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Family planning (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| Note: We cover oral contraceptives under the prescription drug benefit.<br><br>Note: We only cover surgical contraceptive 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 17. | Nothing | Nothing (No deductible) |
| *Not covered:*<br>• *Reversal of voluntary surgical sterilization*<br>• *Genetic testing and counseling*<br>• *Contraceptive devices not described above*<br>• *Over-the-counter (OTC) contraceptives, except as described in Section 5(f)*<br>• *Pre-implantation genetic diagnosis (PGD)* | *All charges* | *All charges* |
| **Infertility services** | **High Option** | **Standard Option After the calendar year deductible...** |
| Diagnosis and treatment of infertility, such as:<br>• Artificial insemination:<br>- Intravaginal insemination (IVI)<br>- Intracervical insemination (ICI)<br>- Intrauterine insemination (IUI)<br>• Fertility drugs<br><br>Note: We cover injectable fertility drugs under medical benefits and oral and self-injectable fertility drugs under the prescription drug benefit.<br><br>Note: See Section 5(c) for surgery benefits and Section 5(f) for prescription drug benefits.<br><br>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 17. | Nothing per visit to your primary care physician<br><br>$35 copayment per visit to a specialist | Nothing per visit to your primary care physician (No deductible)<br><br>$45 copayment per visit to a specialist (No deductible) |
| *Not covered:*<br>• *Assisted reproductive technology (ART) procedures, such as:*<br>- *In vitro fertilization (IVF)* | *All charges* | *All charges* |

*Infertility services - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Infertility services (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)*<br>• *Services and supplies related to ART procedures*<br>• *Cost of donor sperm*<br>• *Cost of donor egg*<br>• *Cryopreservation or storage of sperm (sperm banking), eggs, or embryos*<br>• *Services, supplies, or drugs provided to individuals not enrolled in this Plan*<br>• *Genetic counseling and genetic screening* | *All charges* | *All charges* |
| **Allergy care** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Testing and treatment<br>• Allergy injections | Nothing per visit to your primary care physician<br>$35 copayment per visit to a specialist | Nothing per visit to your primary care physician (No deductible)<br>$45 copayment per visit to a specialist (No deductible) |
| Allergy serum | Nothing | Nothing (No deductible) |
| *Not covered:*<br>• *Provocative food testing*<br>• *Sublingual allergy desensitization* | *All charges* | *All charges* |
| **Treatment therapies** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Chemotherapy and radiation therapy<br>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ tissue transplants on page 48.<br>• Respiratory and inhalation therapy<br>• Cardiac rehabilitation following qualifying event/condition is provided for up to 3 visits per week for 12 weeks<br>• Dialysis – hemodialysis and peritoneal dialysis<br>• Intravenous (IV)/infusion therapy – home IV and antibiotic therapy<br>• Growth hormone therapy (GHT)<br>• Hyperbaric oxygen treatment | All other treatments: $50 copayment per visit<br>Infusion, drug only, $30 copayment per treatment if administered in physician's office<br>Cardiac rehabilitation: $20 copayment per visit<br>Pulmonary rehabilitation: $20 copayment per visit<br>Nothing during covered inpatient admission | All other treatments: $60 copayment per visit<br>Infusion, drug only, $30 copayment per treatment if administered in physician's office<br>Cardiac rehabilitation: $25 copayment per visit<br>Pulmonary rehabilitation: $25 copayment per visit<br>Nothing during covered inpatient admission |

*Treatment therapies - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Treatment therapies (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Pulmonary rehabilitation for chronic obstructive pulmonary disease for up to 3 visits per week for 12 weeks<br><br>Note: Home nursing visits associated with home IV/infusion therapy are covered as shown under *Home health services* on page 43.<br><br>Note: We only cover treatment therapies 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 17.<br><br>Note: See Section 5(c) for Treatment therapy services received in the outpatient department of a hospital or facility. | All other treatments: $50 copayment per visit<br><br>Infusion, drug only, $30 copayment per treatment if administered in physician's office<br><br>Cardiac rehabilitation: $20 copayment per visit<br><br>Pulmonary rehabilitation: $20 copayment per visit<br><br>Nothing during covered inpatient admission | All other treatments: $60 copayment per visit<br><br>Infusion, drug only, $30 copayment per treatment if administered in physician's office<br><br>Cardiac rehabilitation: $25 copayment per visit<br><br>Pulmonary rehabilitation: $25 copayment per visit<br><br>Nothing during covered inpatient admission |
| Applied behavioral analysis (ABA) - Members with autism spectrum disorder<br>• Limited to specific diagnoses<br>- Autistic disorder - childhood autism, infantile psychosis, and Kanner's syndrome;<br>- Childhood disintegrative disorder - Heller's syndrome;<br>- Rett's syndrome; and<br>- Specified pervasive developmental disorder - Asperger's disorder, atypical childhood psychosis, and borderline psychosis of childhood.<br><br>Note: We only cover ABA 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 17. | Home and office visit: Nothing<br><br>*Natural environment: $30 copayment per day<br><br>*a counselor may choose to accompany the member to school, doctor appointments, etc. | Home and office visit: Nothing<br><br>*Natural environment: $30 copayment per day<br><br>*a counselor may choose to accompany the member to school, doctor appointments, etc. |
| **Rehabilitation services** | **High Option** | **Standard Option After the calendar year deductible...** |
| 60 visits per calendar year for the services of each of the following or a combination of all three.<br>• Qualified physical therapists<br>• Occupational therapists<br>• Speech therapists | $20 copayment per outpatient visit<br><br>Nothing per visit during covered inpatient admission | $25 copayment per outpatient visit<br><br>Nothing per visit during covered inpatient admission |

*Rehabilitation services - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Rehabilitation services (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| Note: We only cover therapy when a provider:<br>• Orders the care<br>• Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and<br>• Indicates the length of time the services are needed.<br><br>Note: A physical therapist may submit a referral directly to GlobalHealth for up to 30 days of therapy. Your primary care physician must submit a referral for services necessary beyond the 30 days.<br><br>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 17. | $20 copayment per outpatient visit<br><br>Nothing per visit during covered inpatient admission | $25 copayment per outpatient visit<br><br>Nothing per visit during covered inpatient admission |
| *Not covered:*<br>• *Long-term rehabilitative therapy*<br>• *Exercise programs*<br>• *Massage therapy*<br>• *Voice therapy related to gender reassignment* | *All charges* | *All charges* |
| **Habilitation services** | **High Option** | **Standard Option After the calendar year deductible...** |
| 60 visits per calendar year for the services of each of the following or a combination of all three.<br>• Qualified physical therapists<br>• Occupational therapists<br>• Speech therapists<br><br>Note: We only cover therapy when a provider:<br>• Orders the care<br>• Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and<br>• Indicates the length of time the services are needed. | $20 copayment per outpatient visit | $25 copayment per outpatient visit |

*Habilitation services - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Habilitation services (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| Note: A physical therapist may submit a referral directly to GlobalHealth for up to 30 days of therapy. Your primary care physician must submit a referral for services necessary beyond the 30 days.<br><br>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 17. | $20 copayment per outpatient visit | $25 copayment per outpatient visit |
| **Hearing services (testing, treatment, and supplies)** | **High Option** | **Standard Option After the calendar year deductible...** |
| • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist<br><br>Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*<br><br>Note: We only cover hearing services provided by a specialist 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 17. | Nothing per visit to a primary care physician<br><br>$35 copayment per visit to a specialist | Nothing per visit to your primary care physician (No deductible)<br><br>$45 copayment per visit to a specialist (No deductible) |
| • External hearing aids<br><br>Note: For benefits for the devices, see Section 5(a) *Orthopedic and Prosthetic Devices.*<br><br>Note: We only cover hearing aids and hearing-related devices 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 17. | 20% coinsurance | 30% coinsurance |
| • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants | Nothing | Nothing |

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

| Benefit Description | You pay | |
|---|---|---|
| **Hearing services (testing, treatment, and supplies) (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| Note: For benefits for the devices, see Section 5(a) *Orthopedic and Prosthetic Devices.*<br><br>Note: We only cover hearing aids and hearing-related devices 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 17. | Nothing | Nothing |
| *Not covered:*<br>• *Hearing services that are not shown as covered*<br>• *Hearing services for age-related hearing loss* | *All charges* | *All charges* |
| **Vision services (testing, treatment, and supplies)** | **High Option** | **Standard Option After the calendar year deductible...** |
| One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)<br><br>Note: Special features such as tinting, progressive lenses, transitional lenses, and other upgrades are not covered. | Nothing | Nothing |
| Annual eye exam including refraction<br><br>Note: See *Preventive care, children* for eye exams for children. | $40 copayment per visit | $40 copayment per visit |
| *Not covered:*<br>• *Eyeglasses or contact lenses, except as shown above*<br>• *Eye exercises and orthoptics*<br>• *LASIK, INTACS, radial keratotomy and other refractive surgery*<br>• *Computer programs of any type, including, but not limited to, those to assist with vision therapy*<br>• *Special multifocal ocular implant lenses* | *All charges* | *All charges* |

| Benefit Description | You pay | |
|---|---|---|
| **Foot care** | **High Option** | **Standard Option After the calendar year deductible...** |
| Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes<br><br>Note: See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.<br><br>Note: See Section 5(b) for our coverage of surgical procedures.<br><br>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 17. | Nothing per visit to your primary care physician<br><br>$20 copayment per visit to a specialist | Nothing per visit to your primary care physician (No deductible)<br><br>$25 copayment per visit to a specialist (No deductible) |
| *Not covered:*<br>• *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*<br>• *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* | *All charges* |
| **Orthopedic and prosthetic devices** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Artificial limbs and eyes<br>• Prosthetic sleeve or sock<br>• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy<br>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome<br>• External hearing aids<br>• Replacement, repair, and adjustment of covered devices<br><br>Note: Hearing aids 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). | 20% coinsurance, with a $200 maximum cost per service | 30% coinsurance |

*Orthopedic and prosthetic devices - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Orthopedic and prosthetic devices (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants<br>• Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy | Nothing | Nothing |
| • Wigs for hair loss due to treatment of cancer, limited to one synthetic wig per year | $15 copayment per wig | $15 copayment per wig |
| Note: Orthopedic and prosthetic devices provided by physicians and professionals included in facility copayment. See Section 5 (c).<br><br>Note: Shoes and orthotics are covered only for diabetes and other members with diagnoses pertaining to peripheral vascular disease.<br><br>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 17. | | |
| *Not covered:*<br>• *Orthopedic and corrective shoes (other than Denis Browne), arch supports, foot orthotics, heel pads and heel cups*<br>• *Lumbosacral supports*<br>• *Corsets, trusses, elastic stockings, support hose, and other supportive devices*<br>• *Prosthetic replacements provided less than 3 years after the last one we covered*<br>• *Over-the-counter orthotics*<br>• *Hearing aid accessories or supplies (including remote controls and warranty packages)*<br>• *Bioelectric, computer programmed prosthetic devices* | *All charges* | *All charges* |

| Benefit Description | You pay | |
|---|---|---|
| **Durable medical equipment (DME)** | **High Option** | **Standard Option After the calendar year deductible...** |
| We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:<br>• Oxygen and oxygen equipment<br>• Dialysis equipment<br>• Hospital beds<br>• Wheelchairs<br>• Crutches<br>• Walkers<br>• Dynamic orthotic cranioplasty (DOC) devices when medically necessary<br>• Audible prescription reading devices<br>• Speech generating devices<br>• Other items that we determine to be DME, such as compression stockings for lymphedema diagnosis only<br><br>Note: Call us at 877-280-2989 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.<br><br>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 17. | 20% coinsurance | 30% coinsurance |
| Diabetic supplies<br>• Blood glucose monitors<br>• Shoes and orthotics<br>• Insulin pumps<br><br>Note: Diabetic medications and other supplies which include disposable needles and syringes for the administration of covered medications, test strips, and lancets, are covered with a prescription under your prescription drug benefits. Blood glucose monitors are covered under your prescription drug benefits. See Section 5(f) *Prescription Drug Benefits*. | 20% coinsurance | 20% coinsurance |

*Durable medical equipment (DME) - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Durable medical equipment (DME) (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| Note: We only cover diabetic supplies and equipment 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 17. | 20% coinsurance | 20% coinsurance |
| *Not covered:*<br>• *Bathroom equipment such as tub seats, benches, rails, and lifts*<br>• *Home modifications such as elevators or wheelchair ramps*<br>• *Lifts, such as seat, chair, or van lifts*<br>• *Car seats*<br>• *Breast pumps, except as described on page 31*<br>• *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)*<br>• *Equipment for cosmetic purposes*<br>• *Devices or programs to eliminate bed wetting*<br>• *Routine foot care, shoes, and shoe inserts, except for medically necessary foot care for those persons diagnosed with diabetes or peripheral vascular disease*<br>• *Orthopedic and corrective shoes (other than Denis Browne) splint for children*<br>• *Corrective shoes, arch supports, and supportive devices for the feet*<br>• *Mattresses and other bedding or bed-wetting alarms*<br>• *Equipment or devices not medical in nature such as braces worn for athletic or recreational use, ear plugs, elastic supports, corsets, or garter belts*<br>• *Jacuzzi/whirlpools*<br>• *Power-operated vehicles that may be used as wheelchairs* | *All charges* | *All charges* |

*Durable medical equipment (DME) - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Durable medical equipment (DME) (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| • *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*<br>• *Bandages, pads, or diapers*<br>• *Hot and cold packs* | *All charges* | *All charges* |
| **Home health services** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Home healthcare 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<br>• Services include oxygen therapy, intravenous therapy, and medications<br><br>Note: We only cover home healthcare 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 17. | Nothing | Nothing |
| *Not covered:*<br>• *Nursing care requested by, or for the convenience of, the patient or the patient's family*<br>• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*<br>• *Nursing care on a full-time basis*<br>• *Custodial care*<br>• *Homemaker services*<br>• *Meals delivered to your home*<br>• *Charges imposed by immediate relatives or members of your household* | *All charges* | *All charges* |

| Benefit Description | You pay | |
|---|---|---|
| **Chiropractic** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Manipulation of the spine and extremities<br><br>*Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application*<br><br>Note: Chiropractic services limited to 20 visits per calendar year. | $20 copayment per office visit | $25 copayment per office visit (No deductible) |
| *Not covered:*<br>• *Any services not specifically listed as covered* | *All charges* | *All charges* |
| **Alternative treatments** | **High Option** | **Standard Option After the calendar year deductible...** |
| No benefit. | *All charges* | *All charges* |
| **Educational classes and programs** | **High Option** | **Standard Option After the calendar year deductible...** |
| Coverage is provided for:<br>• 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. | Nothing for counseling for up to two quit attempts per year.<br><br>Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence. | Nothing for counseling for up to two quit attempts per year. (No deductible)<br><br>Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence. (No deductible) |

## Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare 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.
- The calendar year deductible for the Standard Option is: $300 per person ($600 per Self Plus One enrollment, or $600 per Self and Family enrollment). The calendar year deductible applies to some benefits in this Section. We added "(No deductible") to show when the calendar year deductible does not apply. The High Option does not have a deductible.
- 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 healthcare professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.). Professional services are included in the facility copay.
- 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 | |
|---|---|---|
| **Note: The calendar year deductible applies to some Standard Option benefits in this Section. We say "(No deductible") when it does not apply.** | | |
| **Surgical procedures** | **High Option** | **Standard Option After the calendar year deductible...** |
| A comprehensive range of services, such as:<br>• Operative procedures<br>• Treatment of fractures, including casting<br>• Normal pre- and post-operative care by the surgeon<br>• Correction of amblyopia and strabismus<br>• Endoscopy procedures<br>• Biopsy procedures<br>• Removal of tumors and cysts<br>• Correction of congenital anomalies (see *Reconstructive surgery*)<br>• Surgical treatment of morbid obesity (see www.GlobalHealth.com/fehb for criteria)<br>• Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information | Nothing per visit to your primary care physician<br><br>$35 copayment per visit to a specialist | Nothing per visit to your primary care physician (No deductible)<br><br>$45 copayment per visit to a specialist (No deductible) |

*Surgical procedures - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Surgical procedures (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Voluntary sterilization (e.g., tubal ligation, vasectomy)<br>• Treatment of burns<br>• Injections<br>• Circumcision of a newborn after routine newborn stay<br><br>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.<br><br>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 17. | Nothing per visit to your primary care physician<br><br>$35 copayment per visit to a specialist | Nothing per visit to your primary care physician (No deductible)<br><br>$45 copayment per visit to a specialist (No deductible) |
| *Not covered:*<br>• *Reversal of voluntary sterilization*<br>• *Routine treatment of conditions of the foot (see Foot care)*<br>• *Cosmetic surgery*<br>• *LASIK, INTACS, radial keratotomy, and other refractive surgery*<br>• *Surgeries to correct congenital anomalies, unless there is a functional deficit*<br>• *Charges for photographs to document physical conditions*<br>• *Elective or voluntary enhancement procedures, including but not limited to: hair growth, athletic performance, and anti-aging* | *All charges* | *All charges* |
| **Reconstructive surgery** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Surgery to correct a functional defect<br>• Surgery to correct a condition caused by injury or illness if:<br>- the condition produced a major effect on the member's appearance and<br>- the condition can reasonably be expected to be corrected by such surgery | Nothing per visit to your primary care physician<br><br>$35 copayment visit to a specialist | Nothing per visit to your primary care physician (No deductible)<br><br>$45 copayment per visit to a specialist (No deductible) |

*Reconstructive surgery - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Reconstructive surgery (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| • 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.<br>• All stages of breast reconstruction surgery following a mastectomy, such as:<br>- Surgery to produce a symmetrical appearance of breasts;<br>- Treatment of any physical complications, such as lymphedemas;<br>- Breast prostheses and surgical bras and replacements (see *Orthopedic and prosthetic devices*)<br>• Gender reassignment surgery, limited to:<br>- Mastectomy<br>- Hysterectomy<br><br>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.<br><br>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 17. | Nothing per visit to your primary care physician<br><br>$35 copayment visit to a specialist | Nothing per visit to your primary care physician (No deductible)<br><br>$45 copayment per visit to a specialist (No deductible) |
| *Not covered:*<br>• *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*<br>• *Surgical procedures related to gender reassignment not mentioned above* | *All charges* | *All charges* |

| Benefit Description | You pay | |
|---|---|---|
| **Oral and maxillofacial surgery** | **High Option** | **Standard Option After the calendar year deductible...** |
| Oral surgical procedures, limited to:<br>• Reduction of fractures of the jaws or facial bones;<br>• Surgical correction of cleft lip, cleft palate, or severe functional malocclusion;<br>• Removal of stones from salivary ducts;<br>• Excision of leukoplakia or malignancies;<br>• Excision of cysts and incision of abscesses when done as independent procedures;<br>• Orthognathic surgery is covered only when medically necessary (e.g., malocclusion has produced significant inability to function); and<br>• Other surgical procedures that do not involve the teeth or their supporting structures.<br><br>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 17. | Nothing per visit to your primary care physician<br><br>$35 copayment visit to a specialist | Nothing per visit to your primary care physician (No deductible)<br><br>$45 copayment per visit to a specialist (No deductible) |
| *Not covered:*<br>• *Oral implants and transplants*<br>• *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*<br>• *Orthodontic care before, during, or after surgery except for care related to cleft palate* | *All charges* | *All charges* |
| **Organ/tissue transplants** | **High Option** | **Standard Option After the calendar year deductible...** |
| These **solid organ transplants** are covered. These solid organ transplants are subject to medical necessity and experimental/ investigational review by the Plan. See *Other services* under *You need prior Plan approval for certain services* on page 17. Solid organ transplants are limited to:<br>• Allogeneic islet transplantation<br>• Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis | Nothing | Nothing |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Organ/tissue transplants (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Cornea<br>• Heart<br>• Heart/lung<br>• Intestinal transplants<br>- Isolated small intestine<br>- Small intestine with the liver<br>- Small intestine with multiple organs, such as the liver, stomach, and pancreas<br>• Kidney<br>• Kidney-Pancreas<br>• Liver<br>• Lung: single/bilateral/lobar<br>• Pancreas<br><br>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.<br>• Autologous tandem transplants for:<br>- AL Amyloidosis<br>- Multiple myeloma (de novo and treated)<br>- Recurrent germ cell tumors (including testicular cancer) | Nothing | Nothing |
| **Blood or marrow stem cell transplants**<br><br>The Plan extends coverage for the diagnoses as indicated below.<br>• Allogeneic transplants for<br>- Acute lymphocytic or non-lymphocytic (i. e., myelogeneous) leukemia<br>- Acute myeloid leukemia<br>- Advanced Hodgkin's lymphoma with recurrence (relapsed)<br>- Advanced Myeloproliferative Disorders (MPDs)<br>- Advanced non-Hodgkin's lymphoma with recurrence (relapsed)<br>- Amyloidosis<br>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)<br>- Hemoglobinopathy | Nothing | Nothing |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Organ/tissue transplants (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia)<br>- Mucopolysaccaridosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)<br>- Myelodysplasia/Myelodysplastic syndromes<br>- Paroxysmal Nocturnal Hemoglobinuria<br>- Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)<br>- Severe combined immunodeficiency<br>- Severe or very severe aplastic anemia<br>• Autologous transplants for<br>- Acute lymphocytic or nonlymphocytic (i. e., myelogenous) leukemia<br>- Advanced Hodgkin's lymphoma with recurrence (relapsed)<br>- Advanced non-Hodgkin's lymphoma with recurrence (relapsed)<br>- Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas, and aggressive Dendritic Cell neoplasms)<br>- Amyloidosis<br>- Breast cancer<br>- Childhood rhabdomyosarcoma<br>- Epithelial ovarian cancer<br>- Ewing's sarcoma<br>- Mantle Cell (non-Hodgkin's lymphoma)<br>- Multiple myeloma<br>- Neuroblastoma<br>- Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors<br><br>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 17. | Nothing | Nothing |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Organ/tissue transplants (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| **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.<br><br>Refer to *Other services* in Section 3 for prior authorization procedures:<br>• Allogeneic transplants for<br>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia<br>- Acute myeloid leukemia<br>- Advanced Hodgkin's lymphoma with recurrence (relapsed)<br>- Advanced Myeloproliferative Disorders (MPDs)<br>- Advanced non-Hodgkin's lymphoma with recurrence (relapsed)<br>- Amyloidosis<br>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)<br>- Hemoglobinopathy<br>- Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia)<br>- Myelodysplasia/Myelodysplastic syndromes<br>- Paroxysmal Nocturnal Hemoglobinuria<br>- Severe combined immunodeficiency<br>- Severe or very severe aplastic anemia<br>• Autologous transplants for<br>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia<br>- Advanced Hodgkin's lymphoma with recurrence (relapsed)<br>- Advanced non-Hodgkin's lymphoma with recurrence (relapsed)<br>- Amyloidosis<br>- Neuroblastoma<br><br>**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. | Nothing | Nothing |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Organ/tissue transplants (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| 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.<br>• Autologous Transplants for<br>- Advanced childhood kidney cancers<br>- Advanced Ewing sarcoma<br>- Childhood rhabdomyosarcoma<br>- Epithelial ovarian cancer<br>- Mantle cell (Non-Hodgkin's lymphoma)<br><br>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 17. | Nothing | Nothing |
| 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:*<br>• *Donor screening tests and donor search expenses, except as shown above*<br>• *Implants of artificial or non-human organs*<br>• *Transplants not listed as covered*<br>• *Lodging, meals, and transportation (donor or recipient)* | *All charges* | *All charges* |
| **Anesthesia** | **High Option** | **Standard Option After the calendar year deductible...** |
| Professional services provided in –<br>• Hospital (inpatient)<br>• Hospital outpatient department<br>• Skilled nursing facility<br>• Ambulatory surgical center<br>• Office | Nothing<br><br>Note: When the anesthesiologist is the only provider of services, such as for pain management, the specialist copayment applies | Nothing<br><br>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** | **Standard Option After the calendar year deductible...** |
| Note: See Section 5(c) for anesthesia services provided by a facility. | Nothing<br><br>Note: When the anesthesiologist is the only provider of services, such as for pain management, the specialist copayment applies | Nothing<br><br>Note: When the anesthesiologist is the only provider of services, such as for pain management, the specialist copayment applies |

## 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.
- The calendar year deductible for the Standard Option is: $300 per person ($600 per Self Plus One enrollment, or $600 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. The High Option does not have a deductible.
- 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 included.
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

| Benefit Description | You pay | |
|---|---|---|
| **Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when it does not apply.** | | |
| **Inpatient hospital** | **High Option** | **Standard Option After the calendar year deductible...** |
| Room and board, such as<br>• Ward, semiprivate, or intensive care accommodations<br>• General nursing care<br>• Meals and special diets<br><br>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. | Maternity care: $250 copayment per admission<br><br>All other stays: $250 copayment per day up to a maximum of $750 copayment per admission | Maternity care: $300 copayment per day up to a maximum of $900 copayment per admission<br><br>All other stays: $500 copayment per day up to a maximum of $1,500 copayment per admission |
| Other hospital services and supplies, such as:<br>• Operating, recovery, maternity, and other treatment rooms<br>• Prescribed drugs and medications<br>• Diagnostic laboratory tests, X-rays, and pathology services<br>• Specialized scans, imaging, and diagnostic tests<br>• Chemotherapy, radiation, renal dialysis, and infusion therapy<br>• Administration of blood, blood plasma, and other biologicals | Nothing | Nothing |

*Inpatient hospital - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Inpatient hospital (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Dressings, splints, casts, and sterile tray services<br>• Medical supplies and equipment, including oxygen<br>• Anesthetics, including nurse anesthetist services<br>• Take-home items<br>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home | Nothing | Nothing |
| 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 17. | | |
| *Not covered:*<br>• *Custodial care*<br>• *Non-covered facilities, such as nursing homes, schools*<br>• *Personal comfort items, such as telephone, television, barber services, guest meals, and beds*<br>• *Private nursing care* | *All charges* | *All charges* |
| **Outpatient hospital or ambulatory surgical center** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Operating, recovery, and other treatment rooms<br>• Prescribed drugs and medications<br>• Diagnostic laboratory tests, X-rays, and pathology services<br>• Administration of blood, blood plasma, and other biologicals<br>• Blood and blood plasma, if not donated or replaced<br>• Pre-surgical testing<br>• Dressings, casts, and sterile tray services<br>• Medical supplies, including oxygen<br>• Anesthetics and anesthesia service<br>• Physician surgical services<br>• Chemotherapy and radiation therapy | Preferred facility: $250 copayment<br>Non-preferred facility: $750 copayment | Preferred facility: $500 copayment<br>Non-preferred facility: $1,000 copayment |

*Outpatient hospital or ambulatory surgical center - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Outpatient hospital or ambulatory surgical center (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Intravenous (IV) infusion therapy<br>• Renal dialysis<br>• Visits to a preferred or non-preferred facility for non-emergency treatment services<br><br>Note: We only cover outpatient 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 17. | Preferred facility: $250 copayment<br><br>Non-preferred facility: $750 copayment | Preferred facility: $500 copayment<br><br>Non-preferred facility: $1,000 copayment |
| **Extended care benefits/Skilled nursing care facility benefits** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Extended care benefit<br>• Skilled nursing facility (SNF)<br><br>Covered services include:<br>• Room and board<br>• Physician services<br>• General nursing care<br>• Meals and special diets<br>• Prescribed drugs and medications<br>• Diagnostic laboratory tests, X-rays, and pathology services<br>• Physical, occupational, and speech therapies<br>• Dressings, splints, casts, and sterile tray services<br>• Medical supplies and equipment, including oxygen<br>• Anesthetics, including nurse anesthetist services<br>• Take-home items<br>• Medical supplies, appliances, medical equipment, and any covered items during the skilled nursing facility admission<br><br>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 17. | $250 copayment per admission | $500 copayment per admission |
| *Not covered:* | *All charges* | *All charges* |

*Extended care benefits/Skilled nursing care facility benefits - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Extended care benefits/Skilled nursing care facility benefits (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| • *Custodial care* | *All charges* | *All charges* |
| **Hospice care** | **High Option** | **Standard Option After the calendar year deductible...** |
| 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.<br><br>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 17. | Nothing | Nothing |
| *Not covered:*<br>• *Independent nursing, homemaker services* | *All charges* | *All charges* |
| **End of life care** | **High Option** | **Standard Option After the calendar year deductible...** |
| Advance care planning involves multiple steps designed to help individuals a) learn about the healthcare options that are available for end of life care; b) determine which types of care best fit their personal wishes; and c) share their wishes with family, friends, and their physicians. In some cases, patients who have already considered their options may need only one advance care planning conversation with their physician. In other cases, patients may require a series of conversations with their physician or other health professionals to clearly understand and define their end of life wishes. | Nothing per visit to your primary care physician<br><br>$35 copayment per visit to a specialist<br><br>Nothing for inpatient services<br><br>Nothing for extended care benefits/skilled nursing care services | Nothing per visit to your primary care physician (No deductible)<br><br>$45 copayment per visit to a specialist (No deductible)<br><br>Nothing for inpatient services<br><br>Nothing for extended care benefits/skilled nursing care services |
| **Ambulance** | **High Option** | **Standard Option After the calendar year deductible...** |
| Local professional ambulance service when medically appropriate | $50 copayment | $75 copayment |

*Ambulance - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Ambulance (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| 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.<br><br>Note: We only cover non-emergency ambulance service when we preauthorize it. 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 17. | $50 copayment | $75 copayment |
| *Not covered:*<br>• *Wheelchair van services and gurney van services*<br>• *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*<br>• *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* | *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.
- The calendar year deductible for the Standard Option is: $300 per person ($600 per Self Plus One enrollment, or $600 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible") to show when the calendar year deductible does not apply. The High Option does not have a deductible.
- 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.

*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.

**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 an out-of-network hospital, your treating physician and/or GlobalHealth 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.

**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 facilities do not take the place of your PCP. Your PCP should be your first contact whenever you need non-emergency medical care. If you do need to go to an urgent care facility, it is a good idea to have the results of any exams or diagnostic tests sent to your PCP, along with a list of new prescriptions. That helps maintain continuity of 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.
5. All follow-up care must be approved or arranged through your primary care physician.

**Urgent care outside our service area**

If you are traveling outside of Oklahoma but within the U.S. 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 | |
|---|---|---|
| **Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible") when it does not apply.** | | |
| **Emergency within our service area** | **High Option** | **Standard Option After the calendar year deductible...** |
| Accidental injury or emergency medical care<br>• Emergency care at a doctor's office<br>• Emergency care at an urgent care center<br>• Emergency care as an outpatient at a hospital, including doctors' services<br><br>Note: We waive the ER copayment if you are admitted to the hospital. | Nothing per visit to your primary care physician<br><br>$35 copayment per visit to a specialist<br><br>$25 copayment per visit to an urgent care center<br><br>$250 copayment per visit in an emergency room | Nothing per visit to your primary care physician (No deductible)<br><br>$45 copayment per visit to a specialist (No deductible)<br><br>$45 copayment per visit to an urgent care center (No deductible)<br><br>$300 copayment per visit in an emergency room |
| *Not covered:*<br>• *Elective care or non-emergency care* | *All charges* | *All charges* |

| Benefit Description | You pay | |
|---|---|---|
| **Emergency outside our service area** | **High Option** | **Standard Option After the calendar year deductible...** |
| Accidental injury or emergency medical care<br>• Emergency care at a doctor's office<br>• Emergency care at an urgent care center<br>• Emergency care as an outpatient at a hospital, including doctors' services<br><br>Note: We waive the ER copayment if you are admitted to the hospital. | $35 copayment per visit at a doctor's office<br><br>$25 copayment per visit to an urgent care center<br><br>$250 copayment per visit in an emergency room | $45 copayment per visit to a specialist (No deductible)<br><br>$45 copayment per visit to an urgent care center (No deductible)<br><br>$300 copayment per visit in an emergency room |
| *Not covered:*<br>• *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*<br>• *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*<br>• *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area when there is adequate time to transfer to a network hospital and the transfer does not pose a threat to the health of the mother or the unborn child.*<br>• *Urgent care outside the U.S. (50 states and District of Columbia)* | *All charges* | *All charges* |
| **Ambulance** | **High Option** | **Standard Option After the calendar year deductible...** |
| Professional ambulance service, including air ambulance when medically appropriate.<br><br>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.<br><br>Note: See 5(c) for non-emergency service. | $50 copayment | $75 copayment |
| *Not covered:*<br>• *Air ambulance without prior approval*<br>• *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* | *All charges* |

*Ambulance - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Ambulance (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| • *Wheelchair van services and gurney van services*<br>• *Any mode of transportation to or from non-emergency services (such as doctor appointments)* | *All charges* | *All charges* |

## Section 5(e). Mental Health and Substance Use Disorder 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.
- The calendar year deductible for the Standard Option is: $300 per person ($600 per Self Plus One enrollment, or $600 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible") to show when the calendar year deductible does not apply. The High Option does not have a deductible.
- 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.
- We will provide medical review criteria or reasons for denials to enrollees, members, or providers upon request or as otherwise required.
- 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 | |
|---|---|---|
| **Note: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible") when it does not apply.** | | |
| **Professional services** | **High Option** | **Standard Option After the calendar year deductible...** |
| We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. | Your cost-sharing responsibilities are no greater than for other illnesses or conditions. | Your cost-sharing responsibilities are no greater than for other illnesses or conditions. |
| Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:<br>• Diagnostic evaluation<br>• Crisis intervention and stabilization for acute episodes<br>• Medication evaluation and management (pharmacotherapy)<br>• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment<br>• Treatment and counseling (including individual or group therapy visits) | Nothing | Nothing (No deductible) |

*Professional services - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Professional services (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Diagnosis and treatment of alcoholism and drug use, including detoxification, treatment, and counseling<br>• Electroconvulsive therapy<br>• Professional charges for intensive outpatient treatment in a provider's office or other professional setting | Nothing | Nothing (No deductible) |
| **Diagnostics** | **High Option** | **Standard Option After the calendar year deductible...** |
| • Outpatient diagnostic tests provided and billed by a licensed mental health and substance use treatment practitioner<br>• Outpatient diagnostic tests provided and billed by a laboratory, hospital, or other covered facility<br>• Inpatient diagnostic tests provided and billed by a hospital or other covered facility | Nothing | Nothing (No deductible) |
| **Inpatient hospital or other covered facility** | **High Option** | **Standard Option After the calendar year deductible...** |
| Inpatient services provided and billed by a hospital or other covered facility<br>• Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services<br><br>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 17. | $250 copayment per day up to a maximum of $750 copayment per admission | $500 copayment per day up to a maximum of $1,500 copayment per admission |
| **Outpatient hospital or other covered facility** | **High Option** | **Standard Option After the calendar year deductible...** |
| Outpatient services provided and billed by a hospital or other covered facility.<br><br>Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment | $250 copayment per admission | $500 copayment per admission |

*Outpatient hospital or other covered facility - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Outpatient hospital or other covered facility (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| 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 17. | $250 copayment per admission | $500 copayment per admission |

## 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 page 68.
- 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. See *Other Services* under *You Need Prior Plan Approval for Certain Services* on page 17.
- 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. On this Plan, a network physician or provider must write the prescription. The only exceptions are limited to:
  - Emergency room or urgent care physicians;
  - Non-network providers when member is preauthorized to see that provider; and
  - Dentists
- **Where you can obtain them.** You may fill the prescription at a network pharmacy or by mail.
  - See www.GlobalHealth.com/fehb for a list of network pharmacies.
  - 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.
  - Not all medications can be filled at a mail order pharmacy. Short-term acute care drugs such as antibiotics or acute pain medications should be obtained immediately and are more suitable to be filled by a local pharmacy. Magellan Home Delivery Pharmacies does not provide compounding services (medications that are mixed by a pharmacist to meet a member's specific needs, i.e., the exact strength, dosage and form, and it is not commercially available).
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. The drug formulary is a list of covered drugs.
  - 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 drug

  All covered drugs and products must be FDA-approved. 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 877-280-2989.

  If you are new to GlobalHealth and are undergoing a current course of treatment using a non-formulary drug, your doctor can request an exception. See *Requesting an Expedited Exception* on the next page.

- **These are the dispensing limitations.** GlobalHealth follows FDA dispensing guidelines. 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. Specialty drugs may only be dispensed for up to a 30-day supply through a specialty pharmacy.

  If a member is called to active duty, he or she may obtain a medium-term supply by sending a request to GlobalHealth. The member pays the extended supply network copayments for maintenance medications corresponding to the number of months needed (one copayment for each 90-day supply). Members affected by a national or other emergency may send a request to GlobalHealth. Call 877-280-2989 for assistance. 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 Magellan Rx Management, LLC. However, if you fill a prescription without your member ID card, you may be required to pay the pharmacy. If this happens, call 800-424-1789 (toll-free) or 711 (TTY).

**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. See your drug formulary for any restrictions to a specific drug. The following chart describes prior authorization, step therapy, quantity limits, and exceptions:

| Term | 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:<br>• The alternative drug is included on the Plan's formulary;<br>• The drug in the lower tier or additional utilization restrictions would not be as effective in treating your condition; and<br>• It would cause you to have adverse medical effects.<br><br>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<br>• 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.<br><br>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. A decision is made within 72 hours of receiving your request and sufficient information to begin the review.<br><br>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:<br>• You are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or<br>• You are undergoing a current course of treatment using a non-formulary drug.<br><br>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.<br><br>You may submit your request by calling 918-878-7361. |

| Benefit Description | You pay | |
|---|---|---|
| **Covered medications and supplies** | **High Option** | **Standard 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:<br>• 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*<br>• Compound drugs - prior authorization required and limitations apply. See our website for our policy on compound drugs<br>• Insulin<br>• Oral and self-injectable fertility drugs<br>• Drugs for sexual dysfunction<br>• Opioid prescriptions for acute conditions - prior authorization required and limitations apply<br><br>Retail or specialty pharmacy up to a 30-day supply per prescription or refill<br><br>Note: Drugs on the specialty medications list are available through any retail pharmacy or mail order pharmacy that handles specialty drugs, including the Magellan Specialty Pharmacy (800-424-1789, toll-free or 711, TTY). | **Tier One** - Covered generic drugs<br>• $4/$12 copayment - at a network pharmacy<br><br>**Tier Two** - Covered preferred brand name drugs<br>• $50 copayment - at a network pharmacy<br><br>**Tier Three** - Covered non-preferred drugs<br>• $80 copayment - at a network pharmacy<br><br>**Tier Four** - Covered preferred specialty drugs<br>• 10% coinsurance with a maximum of $150 - at a network pharmacy (oral chemotherapy drugs have a maximum of $100)<br><br>**Tier Five** - Covered non-preferred specialty drugs<br>• 10% coinsurance with a maximum of $250 - at a network pharmacy (oral chemotherapy drugs have a maximum of $100 | **Tier One** - Covered generic drugs<br>• $6/$15 copayment - at a network pharmacy<br><br>**Tier Two** - Covered preferred brand name drugs<br>• $70 copayment - at a network pharmacy<br><br>**Tier Three** - Covered non-preferred drugs<br>• $105 copayment - at a network pharmacy (oral chemotherapy drugs have a maximum of $100)<br><br>**Tier Four** - Covered preferred specialty drugs<br>• 10% coinsurance with a maximum of $200 - at a network pharmacy (oral chemotherapy drugs have a maximum of $100)<br><br>**Tier Five** - Covered non-preferred specialty drugs<br>• 10% coinsurance with a maximum of $300 - at a network pharmacy (oral chemotherapy drugs have a maximum of $100) |

*Covered medications and supplies - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Covered medications and supplies (cont.)** | **High Option** | **Standard Option** |
| Note: The list of covered specialty drugs is subject to change. For the most up-to-date listing, contact Customer Care.<br><br>Note: See our website for a list of drugs in the low-cost generic program.<br><br>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. | **Tier One** - Covered generic drugs<br>• $4/$12 copayment - at a network pharmacy<br><br>**Tier Two** - Covered preferred brand name drugs<br>• $50 copayment - at a network pharmacy<br><br>**Tier Three** - Covered non-preferred drugs<br>• $80 copayment - at a network pharmacy<br><br>**Tier Four** - Covered preferred specialty drugs<br>• 10% coinsurance with a maximum of $150 - at a network pharmacy (oral chemotherapy drugs have a maximum of $100)<br><br>**Tier Five** - Covered non-preferred specialty drugs<br>• 10% coinsurance with a maximum of $250 - at a network pharmacy (oral chemotherapy drugs have a maximum of $100<br><br>Note: If there is no generic equivalent available, you will still have to pay the brand name copayment. | **Tier One** - Covered generic drugs<br>• $6/$15 copayment - at a network pharmacy<br><br>**Tier Two** - Covered preferred brand name drugs<br>• $70 copayment - at a network pharmacy<br><br>**Tier Three** - Covered non-preferred drugs<br>• $105 copayment - at a network pharmacy (oral chemotherapy drugs have a maximum of $100)<br><br>**Tier Four** - Covered preferred specialty drugs<br>• 10% coinsurance with a maximum of $200 - at a network pharmacy (oral chemotherapy drugs have a maximum of $100)<br><br>**Tier Five** - Covered non-preferred specialty drugs<br>• 10% coinsurance with a maximum of $300 - at a network pharmacy (oral chemotherapy drugs have a maximum of $100)<br><br>Note: If there is no generic equivalent available, you will still have to pay the brand name copayment. |
| Extended supply retail and home delivery - 90-day supply per prescription refill<br><br>Note: You may purchase a 90-day extended supply from an extended supply network (ESN) retail pharmacy, or through mail order. Your doctor must write the prescription for a 90-day supply. Some restrictions may apply. Check on our website or with Customer Care for information on the ESN retail pharmacies and mail order.<br><br>Note: Specialty drugs in Tiers Four and Five are not available in extended supply.<br><br>Note: See our website for a list of drugs in the low-cost generic program. | **Tier One** - Covered generic drugs<br>• $8/$24 copayment - at a network pharmacy<br><br>**Tier Two** - Covered preferred brand name drugs<br>• $125 copayment - at a network pharmacy<br><br>**Tier Three** - Covered non-preferred drugs<br>• $240 copayment - at a network pharmacy | **Tier One** - Covered generic drugs<br>• $12/$30 copayment - at a network pharmacy<br><br>**Tier Two** - Covered preferred brand name drugs<br>• $150 copayment - at a network pharmacy<br><br>**Tier Three** - Covered non-preferred drugs<br>• $270 copayment - at a network pharmacy |

*Covered medications and supplies - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Covered medications and supplies (cont.)** | **High Option** | **Standard Option** |
| Women's contraceptive drugs and devices<br>• Selected FDA-approved contraceptive prescriptions will be provided for no copayment for women of childbearing age<br>• All others are subject to prescription copayments and possible prior authorizations<br>• Over-the-counter contraceptive drugs and devices, including the "morning after pill", approved by the FDA require a written prescription by an approved provider<br><br>Note: Benefits are limited to recommended prescribing limits.<br><br>Note: See drug formulary for contraceptive drugs provided for no copayment. | See retail pharmacy and extended supply sections below | See retail pharmacy and extended supply sections below |
| Diabetic supplies limited to:<br>• Blood glucose monitors<br>• Disposable needles and syringes, test strips, and lancets for the administration of covered medications<br>• Insulin pumps and orthopedic shoes and inserts are covered under Section 5(a). Durable medical equipment. | Nothing | Nothing |
| **Preventive care medications** | **High Option** | **Standard Option** |
| The following are covered:<br>• Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age<br>• Folic acid supplements for women of childbearing age 400 & 800 mcg<br>• Liquid iron supplements for children age 6 months - 1 year<br>• Vitamin D supplements (prescription strength) (400 & 1000 units) for members 65 or older<br>• Pre-natal vitamins for pregnant women<br>• Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 | Nothing | Nothing |

*Preventive care medications - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Preventive care medications (cont.)** | **High Option** | **Standard Option** |
| • Statins for primary preventive of cardiovascular disease for adults age 40-75 with no history of cardiovascular disease (CVD), 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults aged 40 to 75 years.)<br>• Naloxone-based agents (Prior authorization is not required)<br><br>Note: Preventive medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a healthcare professional and filled by a network pharmacy. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.<br><br>Note: Drugs at this cost-share are noted in the Drug Formulary with "Tier 0" and "HCR." | Nothing | Nothing |
| *Not covered:*<br>• *Drugs prescribed by non-authorized out-of-network physicians in non-emergencies*<br>• *Drugs to enhance athletic performance, hair growth, cosmetic purposes, and anti-aging*<br>• *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies*<br>• *Vitamins, nutrients, and food supplements not listed as a covered benefit even if a physician prescribes or administers them*<br>• *Nonprescription medications: 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* | *All charges* | *All charges* |

*Preventive care medications - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Preventive care medications (cont.)** | **High Option** | **Standard Option** |
| • *Saline and medications for irrigation*<br>• *Biological sera, medication prescribed for parenteral use or administration*<br>• *Dietary formulas including, but not limited to, total parenteral nutrition and other enteral formulas, except FDA-approved low-protein formulas specifically covered*<br>• *Lost or stolen prescriptions*<br>• *Prescription medications to improve energy level, stamina, or slow the aging process (such as AndroGel®)*<br><br>Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefits. (See page 44.) | *All charges* | *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*.
- The calendar year deductible for the Standard Option is: $300 per person ($600 per Self Plus One enrollment, or $600 per Self and Family enrollment). The calendar year deductible applies to all benefits in this Section. The High Option does not have a deductible.
- 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 | |
|---|---|---|
| **Note: The calendar year deductible applies to all Standard Option benefits in this Section.** | | |
| **Accidental injury benefit** | **High Option** | **Standard Option After the calendar year deductible...** |
| We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.<br><br>Note: Masticating (biting or chewing) incidents are not considered to be accidental injuries. You must go to the emergency room to receive this benefit coverage. | $250 copayment per visit | $300 copayment per visit |
| *Not covered*<br>• *Replacement, re-implantation, and follow-up care of those teeth, even if the teeth are not saved by emergency stabilization* | | |
| **Dental anesthesia** | **High Option** | **Standard Option After the calendar year deductible...** |
| Dental anesthesia for a member who:<br>• Has a medical or emotional condition that requires hospitalization or general anesthesia for dental care<br>• Is severely disabled | Nothing | Nothing |

*Dental anesthesia - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Dental anesthesia (cont.)** | **High Option** | **Standard Option After the calendar year deductible...** |
| • In the judgment of the treating practitioner is not of sufficient emotional development to undergo a medically necessary dental procedure without the use of anesthesia<br>• Requires inpatient or outpatient services because of an underlying medical condition and clinical status or because of the severity of the dental procedure<br><br>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 17. | Nothing | Nothing |
| 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. See Section 5 (c). | | |
| **Dental benefits** | **High Option** | **Standard Option After the calendar year deductible...** |
| We have no other dental benefits. | | |
| *Not covered*<br>• *Diagnostic and preventive services, including examination, prophylaxis (cleaning), x-rays of all types and fluoride treatment*<br>• *Basic dental services*<br>• *Major dental services, including restorative services*<br>• *Orthodontic care before, during, or after surgery except for care related to cleft palate*<br>• *Accidental injury services provided in any setting other than an emergency room* | *All charges* | *All charges* |

## Section 5(h). Wellness and Other Special Features

| Feature | Description |
|---|---|
| **Flexible benefits option** | Under the flexible benefits option, we determine the most effective way to provide services.<br>• 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.<br>• 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.<br>• By approving an alternative benefit, we do not guarantee you will get it in the future.<br>• 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.<br>• 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.<br>• 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). |
| **24 hour nurse and information 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 877-280-2989 anytime. |
| **Services for deaf and hearing impaired** | 711 |
| **Centers of excellence** | GlobalHealth's transplant Center of Excellence Program includes OptumHealth Network, LifeTrac Network, and CignaLife Source Network. |
| **Health improvement programs** | • Nutritional Training for Diabetes<br>• Diabetes preventive program<br>• Health resources - Address other diseases, medications, weight programs, nutrition<br><br>Contact Customer Care at 877-280-2989. |
| **Tobacco cessation** | Cessation attempts: We cover 2 tobacco cessation attempts per calendar year. One attempt is considered:<br>• Four tobacco cessation counseling sessions; and<br>• All FDA-approved tobacco cessation drugs (including both prescription and over-the-counter).<br><br>Prior authorization is not required. You pay more for additional treatment or non-generic drugs.<br><br>Studies show that the most effective method to stop smoking involves:<br>• Counseling;<br>• Social support; and<br>• The use of cessation medication. |

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| | Counseling and medication are both effective for treating tobacco dependence, and using them together is more effective than using either one alone.<br><br>Counseling:<br>• You may attend individual, group, or telephone counseling sessions of at least 10 minutes each through your PCP or behavioral health provider.<br>• You may also call the Oklahoma Tobacco Helpline at 800-QUIT-NOW (800-784-8669). You will talk to a trained cessation expert. He or she will tailor a plan for your specific needs.<br><br>Prescriptions:<br>• Smoking cessation products are limited to 2 full 90-day courses of any FDA-approved tobacco cessation product per calendar year, if prescribed by your PCP or behavioral health provider. This benefit is available to you as well as your enrolled dependents who are at least 18 years old.<br>• The covered drugs listed in the formulary include: Chantix™ (varenicline), Nicotrol® Inhaler (nicotine), Nicotrol® Nasal Spray (nicotine), and bupropion SR 150 mg (generic for Zyban®).<br>• We also cover FDA-approved over-the-counter products (such as nicotine patches, gum, inhalers, nasal sprays, and lozenges) with a prescription written by your physician.<br>• Your drug formulary will indicate if the prescription is available without a cost-share as part of preventive services. However, if your provider recommends a particular drug based on determination of medical necessity for you, we will cover the drug at no cost-share. See "Exception Requests" in Section 5(f).<br>• Not all products that may be used for tobacco cessation are included. For example, we do not cover electronic cigarettes available over-the-counter (e-cigarettes).<br><br>Enroll: You can enroll by contacting Customer Care or on our website. |
| **Translation services** | Our health Plan offers over 150 languages from professional, certified medical interpreters. Call Customer Care for help or 711 (TTY). Spanish (Español): Para obtener asistencia en Español llame al 877-280-2989. |
| **Medical Therapy Management Program** | If you are taking multiple medications for chronic conditions, you can receive support from our Medication Therapy Management Program. You may self-refer or be referred by your provider or a GlobalHealth staff member. You receive personalized service from registered pharmacists and staff. The goal of the program is:<br>• To slow disease progression by supporting drug compliance.<br>• To help eliminate duplicate drug therapies.<br>• To reduce potential for negative drug interactions and side effects.<br>• To optimize your benefits by advising of the lowest cost alternatives.<br><br>We conduct drug use reviews to help make sure that you are getting safe and appropriate care. These reviews are especially important if you have more than one provider who prescribes drugs for you.<br><br>During these reviews, we look for potential problems such as:<br>• Possible drug errors;<br>• Drugs that may not be necessary because you are taking another drug to treat the same medical condition;<br>• Drugs that may not be safe or appropriate because of your age or gender;<br>• Certain combinations of drugs that could harm you if taken at the same time;<br>• Prescriptions written for drugs that have ingredients you are allergic to; and |

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| | • Possible errors in the amount (dosage) of a drug you are taking.<br><br>If we see a possible problem in your use of drugs, we will work with your provider to correct the problem.<br><br>This program is voluntary and at no cost to you. You can contact Customer Care if you would like to participate in the program. If you decide to opt out at any time, please contact Customer Care and we will withdraw you from the program. |
| **Quality Improvement Program** | You may request information regarding our Quality Improvement Program and work plan by contacting Customer Care. Ask to be connected to the Quality Department or email quality@globalhealth.com. |
| **Care management programs** | If you have a chronic disease or complex healthcare needs, you have four types of care management programs that provide patient education and clinical support.<br><br>Proactive Outreach: For members with complex healthcare needs, we provide you with the services of a professional case manager to assess your needs and when appropriate, coordinate, evaluate, and monitor your care.<br><br>Diabetes Prevention Program: We provide an intensive behavioral and lifestyle change program for members with high blood glucose readings but have not been diagnosed with diabetes.<br><br>Prenatal Outreach Program: Our clinical staff reach out to pregnant members to encourage using prenatal benefits and follow up after the birth of the baby to help you have a healthy pregnancy and healthy baby.<br><br>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 healthcare 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.<br><br>Your Satisfaction: We distribute member satisfaction surveys to see how well you believe your doctors and health Plan are serving your needs. They may include:<br>• New Member Survey;<br>• Customer Satisfaction Study; and<br>• Consumer Assessment of Healthcare Provides and Systems (CAHPS).<br><br>GlobalHealth performs an audit that is approved by the National Committee for Quality Assurance (NCQA) called HEDIS (Healthcare Effectiveness Data Information Systems). It measures 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.<br><br>A physician-directed committee reviews all requests for new technology. This includes:<br>• New technology; or<br>• New application of existing technology.<br><br>The committee reviews medical and behavioral healthcare 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. |

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| | Before approving coverage, GlobalHealth requires documented evidence to ensure the efficacy and safety of the new technology. The new technology must:<br>• Improve the net health outcome of the member;<br>• Be as beneficial as established alternatives;<br>• Be available outside the investigational setting;<br>• Significantly improve the quality of life of the member; and<br>• Clearly demonstrate safe medical care to the member.<br><br>Contact Customer Care. |
| **Drug cost calculator** | https://www.globalhealth.magellanrx.com/ |
| **MYGLOBAL™ Member Portal** | You may 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. |

# 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 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 844-280-5555 for information.

**Medicare Advantage HMO** - As a member of one of GlobalHealth's Medicare Advantage Plans, you benefit from low or no Plan copayments, 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 844-280-5555.

**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.

# 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, coinsurance, or deductible.

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, mental health, and substance abuse 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 877-280-2989, or at our email at FederalAnswers@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

877-280-2989 (toll-free)

711 (TTY)

**Mental health and substance abuse benefits**

**Submit your claims to:**

Beacon Health Claims
P.O. Box 1850
Hicksville, NY 11802-1850

888-434-9201

866-835-2755 (TTY)

**Prescription drugs**

**Submit your claims to:**

Magellan Health Services Claims Department
11013 W Broad Street, Suite #500
Glen Allen, VA 23060

800-424-1789 (toll-free)

**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, a healthcare professional with knowledge of your medical condition will be permitted 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 healthcare 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 call your plan's customer services representative at the phone number on your enrollment card, plan brochure, or plan website.

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 FederalAnswers@globalhealth.com, writing GlobalHealth, P.O. Box 2393, Oklahoma City, OK 73101-2393, or calling 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 healthcare 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:<br><br>a) Write to us within 6 months from the date of our decision; and<br><br>b) Send your request to us at GlobalHealth, P.O. Box 2393, Oklahoma City, OK 73101-2393; and<br><br>c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and<br><br>d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.<br><br>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.<br><br>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:<br><br>a) Pay the claim; or |

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| | b) Write to you and maintain our denial; or<br><br>c) Ask you or your provider for more information.<br><br>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.<br><br>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.<br><br>You must write to OPM within:<br>• 90 days after the date of our letter upholding our initial decision; or<br>• 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or<br>• 120 days after we asked for additional information.<br><br>Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630.<br><br>Send OPM the following information:<br>• A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;<br>• Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;<br>• Copies of all letters you sent to us about the claim;<br>• Copies of all letters we sent to you about the claim; and<br>• Your daytime phone number and the best time to call.<br>• 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.<br><br>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.<br><br>Note: You are the only person who has a 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 healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.<br><br>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.<br><br>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.<br><br>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. |

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| | 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 877-280-2989. 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 FEHB 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 healthcare 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 our website at www.GlobalHealth.com/fehb.

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 healthcare 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**

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 877-888-3337, (TTY 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 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.

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 800-MEDICARE (800-633-4227), (TTY 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 800-772-1213 TTY 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 800-772-1213 TTY 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 did not 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 healthcare. 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 and 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 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 | High Option: $0<br><br>Standard Option: $300 self only/$600 Self Plus One or Self and Family | High Option: $0<br><br>Standard Option: $300 self only/$600 Self Plus One or Self and Family |
| Out-of-Pocket Maximum | High Option: $5,000 self only/$7,000 Self Plus One or Self and Family<br><br>Standard Option: $6,500 self only/$7,500 Self Plus One or Self and Family | High Option: $5,000 self only/$7,000 Self Plus One or Self and Family<br><br>Standard Option: $6,500 self only/$7,500 Self Plus One or Self and Family |
| Primary Care Physician | $0 | $0 |
| Specialist | High Option: $35 copayment<br><br>Standard Option: $45 copayment | High Option: $35 copayment<br><br>Standard Option: $45 copayment |
| Inpatient Hospital | High Option: $250 per admission/maternity; $250 copayment per day up to $750 copayment per admission/ other<br><br>Standard Option: $300 copayment per day up to $900 copayment per admission/ maternity; $500 copayment per day up to $1,500 copayment per admission/ other | High Option: $250 per admission/maternity; $250 copayment per day up to $750 copayment per admission/ other<br><br>Standard Option: $300 copayment per day up to $900 copayment per admission/ maternity; $500 copayment per day up to $1,500 copayment per admission/ other |
| Outpatient Hospital | High Option: $250 copayment/preferred facility; $750 copayment/non-preferred facility<br><br>Standard Option: $500 copayment/preferred facility; $1,000 copayment/non-preferred facility | High Option: $250 copayment/preferred facility; $750 copayment/non-preferred facility<br><br>Standard Option: $500 copayment/preferred facility; $1,000 copayment/non-preferred facility |

| Benefit Description | Member Cost without Medicare | Member Cost with Medicare Part B |
|---|---|---|
| Rx | High Option pharmacy network:<br>• Tier 1 - $4/$12 copayment at in-network pharmacy<br>• Tier 2 - $50 copayment at in-network pharmacy<br>• Tier 3 - $80 copayment at in-network pharmacy<br>• Tier 4 - 10% up to $150 for preferred drugs at in-network pharmacy (oral chemotherapy drugs have a maximum of $100)<br>• Tier 5 - 10% up to $250 for non-preferred drugs at in-network pharmacy (oral chemotherapy drugs have a maximum of $100)<br><br>Standard Option pharmacy network:<br>• Tier 1 - $6/$15 copayment at in-network pharmacy<br>• Tier 2 - $70 copayment at in-network pharmacy<br>• Tier 3 - $105 copayment at in-network pharmacy (oral chemotherapy drugs have a maximum of $100)<br>• Tier 4 - 10% up to $200 for preferred drugs at in-network pharmacy (oral chemotherapy drugs have a maximum of $100)<br>• Tier 5 - 10% up to $300 for non-preferred drugs at in-network pharmacy (oral chemotherapy drugs have a maximum of $100) | High Option pharmacy network:<br>• Tier 1 - $4/$12 copayment at in-network pharmacy<br>• Tier 2 - $50 copayment at in-network pharmacy<br>• Tier 3 - $80 copayment at in-network pharmacy<br>• Tier 4 - 10% up to $150 for preferred drugs at in-network pharmacy (oral chemotherapy drugs have a maximum of $100)<br>• Tier 5 - 10% up to $250 for non-preferred drugs at in-network pharmacy (oral chemotherapy drugs have a maximum of $100)<br><br>Standard Option pharmacy network:<br>• Tier 1 - $6/$15 copayment at in-network pharmacy<br>• Tier 2 - $70 copayment at in-network pharmacy<br>• Tier 3 - $105 copayment at in-network pharmacy (oral chemotherapy drugs have a maximum of $100)<br>• Tier 4 - 10% up to $200 for preferred drugs at in-network pharmacy (oral chemotherapy drugs have a maximum of $100)<br>• Tier 5 - 10% up to $300 for non-preferred drugs at in-network pharmacy (oral chemotherapy drugs have a maximum of $100) |

| | | |
|---|---|---|
| Rx – Mail Order (90-day supply) | High Option pharmacy network:<br>• Tier 1 - $8/$24 copayment at in-network pharmacy<br>• Tier 2 - $125 copayment at in-network pharmacy<br>• Tier 3 - $240 copayment at in-network pharmacy<br><br>Standard Option pharmacy network:<br>• Tier 1 - $12/$30 copayment at in-network pharmacy<br>• Tier 2 - $150 copayment at in-network pharmacy<br>• Tier 3 - $270 copayment at in-network pharmacy | High Option pharmacy network:<br>• Tier 1 - $8/$24 copayment at in-network pharmacy<br>• Tier 2 - $125 copayment at in-network pharmacy<br>• Tier 3 - $240 copayment at in-network pharmacy<br><br>Standard Option pharmacy network:<br>• Tier 1 - $12/$30 copayment at in-network pharmacy<br>• Tier 2 - $150 copayment at in-network pharmacy<br>• Tier 3 - $270 copayment at in-network pharmacy |

**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 healthcare choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage Plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY 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 844-280-5555.

**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, coinsurance, or deductibles. 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 21.

**Copayment**

A copayment is a fixed amount of money you pay when you receive covered services. See page 21.

**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. See page 21.

**Experimental or investigational service**

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

**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.

**Healthcare professional**

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

**Medical necessity**

Services we determine are appropriate for the treatment or diagnosis of an illness or injury.

**Non-preferred facilities**

A facility which has a contract with GlobalHealth to provide services to you at a discount. You will pay the higher cost-share when you choose these facilities instead of a preferred facility.

**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, orthotics, prosthetics that are not surgically implanted, hearing aids, and specialty drugs which have 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.

**Preferred facility** A facility which has a contract with GlobalHealth to provide services to you at a discount. You will pay the lower cost-share when you choose these facilities instead of a non-preferred facility.

**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 evaluate whether or not 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 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 four 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 healthcare 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.

Fourth, the **Federal Employees' Group Life Insurance (FEGLI)** can help protect your family from burdensome funeral costs and the unexpected loss of your income.

### 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 healthcare flexible spending account (HCFSA) or a limited expense healthcare spending account (LEX HCFSA) is $2,600 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 healthcare 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 877-FSAFEDS 877-372-3337 (TTY, 866-353-8058), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time.

## 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. Beginning in 2019, FEDVIP is also available to TRICARE eligible retirees and their families during the 2018 Federal Benefits Open Season. Active duty family members are eligible to enroll in FEDVIP vision insurance. Both retirees and active duty family members must be enrolled in a TRICARE health plan in order to enroll in a FEDVIP vision plan.

**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 but it may be limited. 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 877-888-3337, (TTY 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. Long term care can be received in your home, in a nursing home, in an assisted living facility, or in adult day care. You must apply, answer health questions (called underwriting), and be approved for enrollment. Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Your qualified relatives can apply even if you do not. 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 800-LTC-FEDS 800-582-3337, (TTY 800-843-3557), or visit www.ltcfeds.com.

## The Federal Employees' Group Life Insurance Program - *FEGLI*

**Peace of Mind for You and Your Family**

The Federal Employees' Group Life Insurance Program (FEGLI) can help protect your family from burdensome funeral costs and the unexpected loss of your income. You can get life insurance coverage starting at one year's salary to more than six times your salary and many options in between. You can also get coverage on the lives of your spouse and unmarried dependent children under age 22. You can continue your coverage into retirement if you meet certain requirements. For more information, visit www.opm.gov/life.

# Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

# Summary of Benefits for the High Option of GlobalHealth, Inc. - 2019

- **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. You can obtain a copy of our Summary of Benefits and Coverage at www.GlobalHealth.com. 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 | 26 |
| • **Services provided by a hospital:**<br>- Inpatient<br>- Outpatient | Inpatient: $250 copay per day up to a maximum of $750 copay per admission; Outpatient: $250 copay in preferred facility; $750 copay in non-preferred facility | 54 |
| • **Emergency benefits:**<br>- In-area<br>- Out-of-area | Nothing per PCP visit; $35 copay per specialist visit; $25 copay per urgent care visit; $250 copay per emergency room visit | 60 |
| **Mental health and substance use disorder treatment:** | Office visit: Nothing; Inpatient: $250 copay per day with a maximum of $750 copay per admission; Outpatient hospital: $250 copay per admission | 63 |
| **Prescription drugs:**<br>• Retail and specialty pharmacy - 30-day supply | Tier One – Covered generic drugs - $4/$12 copay at in-network pharmacy<br>Tier Two – Covered preferred brand name drugs - $50 copay at in-network pharmacy<br>Tier Three – Covered non-preferred drugs - $80 copay at in-network pharmacy<br>Tier Four – Covered preferred specialty drugs - 10% coinsurance with a maximum of $150 at in-network pharmacy - oral chemotherapy drugs have a maximum of $100<br>Tier Five – Covered non-preferred specialty drugs - 10% coinsurance with a maximum of $250 at in-network pharmacy - oral chemotherapy drugs have a maximum of $100 | 68 |
| • Mail order and extended supply - 90-day supply | Tier One – Covered generic drugs - $8/24 copay at in-network pharmacy<br>Tier Two – Covered preferred brand name drugs - $125 copay at in-network pharmacy<br>Tier Three – Covered non-preferred drugs - $240 copay at in-network pharmacy | 64 |
| **Vision care:** | One eye refraction annually - $40 copay | 38 |
| **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. | 21 |

# Summary of Benefits for the Standard Option of GlobalHealth, Inc. - 2019

- **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. You can obtain a copy of our Summary of Benefits and Coverage at www.GlobalHealth.com. 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.
- Below, an asterisk (*) means the item is subject to the $300 calendar year deductible.

| Standard Option Benefits | You pay | Page |
|---|---|---|
| **Medical services provided by physicians:**<br><br>Diagnostic and treatment services provided in the office | Office visit copay: Nothing for primary care; $45 specialist | 26 |
| **Services provided by a hospital:**<br>• Inpatient<br>• Outpatient | *Inpatient: $500 copay per day up to a maximum of $1,500 copay per admission; *Outpatient: $500 copay in a preferred facility; $1,000 copay in a non-preferred facility | 54 |
| **Emergency benefits:**<br>• In-area<br>• Out-of-area | Nothing per PCP visit; $45 copay per specialist visit; $45 copay per urgent care visit; *$300 copay per emergency room visit | 60 |
| **Mental health and substance use disorder treatment:** | Office visit: Nothing; *Inpatient: $500 copay per day up to a maximum of $1,500 copay per admission; *Outpatient hospital: $500 copay per admission | 63 |
| **Prescription drugs:**<br>• Retail and specialty pharmacy - 30-day supply | Tier One – Covered generic drugs - $6/$15 copayment at in-network pharmacy<br>Tier Two – Covered preferred brand name drugs - $70 copayment at in-network pharmacy<br>Tier Three – Covered non-preferred drugs - $105 copayment at in-network pharmacy (oral chemotherapy drugs have a maximum of $100)<br>Tier Four – Covered preferred specialty drugs - 10% coinsurance with a maximum of $200 at in-network pharmacy (oral chemotherapy drugs have a maximum of $100)<br>Tier Five – Covered non-preferred specialty drugs - 10% coinsurance with a maximum of $300 at in-network pharmacy (oral chemotherapy drugs have a maximum of $100) | 68 |
| • Mail order and extended supply - 90-day supply (No deductible) | Tier One – Covered generic drugs - $12/30 copayment at in-network pharmacy<br>Tier Two – Covered preferred brand name drugs - $150 copayment at in-network pharmacy<br>Tier Three – Covered non-preferred drugs - $270 copayment at in-network pharmacy | 64 |
| **Vision care:** | One eye refraction annually - $40 copay | 38 |
| **Protection against catastrophic costs** (out-of-pocket maximum): | Nothing after $6,500/Self Only or $7,500/Self Plus One or $7,500/Self and Family enrollment per year. Some costs do not count toward this protection. | 21 |

## Notes

## Notes

## Notes

# 2019 Rate Information for GlobalHealth, Inc.

**To compare your FEHB health Plan options please go to www.opm.gov/fehbcompare.**

To review premium rates for all FEHB health plans options go to **www.opm.gov/FEHBpremiums** or **www.opm.gov/Tribalpremium**.

**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 certain United States Postal Service employees as follows:**

- **Postal Category 1** rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, NPMHU, and NRLCA.
- If you are a career bargaining unit employee represented by the agreement with NPPN, you will find your premium rates on https://liteblue.usps.gov/fehb.
- **Postal Category 2 rates** apply to career bargaining unit employees who are represented by the following agreement: PPOA.

**Non-Postal rates apply to all career non-bargaining unit Postal Service employees. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.**

If you are a Postal Service employee and have questions or require assistance, please contact:

USPS Human Resources Shared Service Center: 877-477-3273, option 5, Federal Relay Service 800-877-8339

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 |
| **State of Oklahoma, Oklahoma** | | | | | | | |
| **High Option Self Only** | IM1 | $214.27 | $71.42 | $464.25 | $154.75 | $68.57 | $59.28 |
| **High Option Self Plus One** | IM3 | $428.54 | $142.85 | $928.51 | $309.50 | $137.13 | $118.56 |
| **High Option Self and Family** | IM2 | $525.32 | $188.92 | $1,138.19 | $409.33 | $181.62 | $159.74 |
| **Standard Option Self Only** | IM4 | $208.44 | $69.48 | $451.62 | $150.54 | $66.70 | $57.67 |
| **Standard Option Self Plus One** | IM6 | $416.88 | $138.96 | $903.24 | $301.08 | $133.40 | $115.34 |
| **Standard Option Self and Family** | IM5 | $521.10 | $173.70 | $1,129.05 | $376.35 | $166.75 | $144.17 |