QualChoice

www.qualchoice.com

2016

A Health Maintenance Organization (High and Standard Option) and Point of Service Product

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details

Serving: Entire State of Arkansas.

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 2016: Page 15
- Summary of benefits: Page 90

Enrollment codes for this Plan:

DH1 High Option-Self Only

DH3 High Option - Self Plus One

DH2 High Option - Self and Family

DH4 Standard Option - Self Only

DH6 Standard Option - Self Plus One

DH5 Standard Option - Self and Family

urac
ACCREDITED
HEALTH PLAN WITH
HEALTH INSURANCE
MARKETPLACE

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-860

Important Notice from QualChoice About Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

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

Table of Contents

Introduction

This brochure describes the benefits of the **QualChoice Benefit Plan** under our contract (CS 2921) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at (800) 235-7111 or through our website: www.qualchoice.com. The address for the QualChoice administrative offices is:

QualChoice
P.O. Box 25610, Little Rock, AR 72221
12615 Chenal Parkway, Little Rock, AR 72211

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

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 15. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisifes 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.com for more information on the individual requirement for MEC.

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

Plain Language

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

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

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at (800) 235-7111 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

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

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

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- 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) or
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include; falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone 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 service received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

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

3. Get the results of any test or procedure.

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

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:

-"Exactly what will you be doing?"

-"About how long will it take?"

-"What will happen after surgery?"

-"How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

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

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

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

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

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

Never Events

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

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

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use QualChoice 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 ACA's 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/insure/health for enrollment information as well as: • Information on the FEHB Program and plans available to you • A health plan comparison tool • A list of agencies that participate in Employee Express • A link to Employee Express • Information on and links to other electronic enrollment systems Also, your employing or retirement office can answer your questions, and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you: • When you may change your enrollment, • How you can cover your family members, • What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire, • What happens when your enrollment ends, • When the next Open Season for enrollment begins. We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.
Types of coverage available for you and your family	Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support. If you have a Self Only enrollment, you may change to a Self and Family or Self Plus One enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

The Self and Family or Self Plus One 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 orSelf and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

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

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

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

Family member coverage

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

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

You can find additional information at www.opm.gov/insure .

Children's Equity Act

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a Point of Service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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

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

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans 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 2016 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 2015 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

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

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

Upon divorce

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

Temporary Continuation of Coverage (TCC)

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The 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 age 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 TCCfrom your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides/healthcare/plan-information/guides. 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 your 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.

I you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must apply in writing to us 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 apply in writing to us 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, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Health Insurance Marketplace

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

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us in order to receive maximum benefits. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory. We give you a choice of enrollment in a High Option, or a Standard Option.

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

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from you primary care physician or by another participating provider in the network.

We have Point of Service (POS) benefits

Our HMO offers Point-of-Service (POS) benefits under the High Option Plan. This means you can receive covered services from a non-participating provider. However, out-of-network benefits may have higher out-of-pocket-costs than our in-network benefits.

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 as long as you seek services from these providers you will only be responsible for your deductible, copayments or coinsurance.

Your rights

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

- Years in existence - we have been in business since 1996.
- Profit status - we are a for profit organization.

If you want more information about us, call (800) 235-7111, or write to QualChoice, P.O. Box 25610, Little Rock, AR 72221. You may also contact us by fax at (501) 228-0135 or visit our website at www.qualchoice.com.

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 entire State of Arkansas. We have certain healthcare providers in our network in some areas immediately surrounding Arkansas.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior Plan approval. You are responsible for calling for prior approval, call (800) 235-7017.

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 Point of Service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2016

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

Program-wide changes

- Self Plus One enrollment type has been added effective January 1, 2016.
- We have removed the exclusion for services, drugs, or supplies related to sex transformation. See page 67.

Changes to this Plan

Changes to High Option

- Your share of the non-Postal premium will increase for Self Only or for the Self and Family enrollment categories. See page 92.
- The in-network, out-of-pocket maximum will be $5,000 for Self Only enrollment or $10,000 for Self Plus One and Self and Family enrollment.
- The Tier I drug copay will be $10.
- For diagnostic and treatment services, the specialist copay will be $35.

Changes to Standard Option

- Your share of the non-Postal premium will increase for Self Only or for the Self and Family enrollment categories. See page 92.
- The in-network, out-of-pocket maximum will be $5,500 for Self Only enrollment or $11,000 for Self Plus One and Self and Family enrollment.
- The Tier I drug copay will be $10.
- For diagnostic and treatment services, the specialist copay will be $40.

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 (800) 235-7111 or write to us at QualChoice, P.O. Box 25610, Little Rock, AR 72221. You may also request replacement cards through our website: www.qualchoice.com

Where you get covered care

Under High Option, you can use both In-Network and Out-of-Network Providers. In-Network Providers will submit claims to us on your behalf and obtain any necessary preauthorization. You have direct access to In-Network Providers without a referral. Under the High Option Point of Service Plan, you can also get care from Out-of-Network Providers. It is your responsibility to obtain pre-authorizations for Out-of-Network services. If you use In-Network Providers, you will pay less.

Under Standard Option, you have direct access to see In-Network Providers without a referral. You must use In-Network Providers under the Standard Option to be eligible for benefits, except in circumstances such as emergency care. In-Network Providers will submit claims on your behalf and obtain any necessary preauthorization**.**

Plan providers

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

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

Plan facilities

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members.

We publish an online directory listing of physicians, facilities, and other healthcare providers who have contractually agreed to provide covered services to enrollees and have them reimbursed at In-Network Benefits. You may search the directory on our website at www.qualchoice.com. Because agreements can change, you should verify that a physician or provider is participating in our Network before you seek care.

What you must do to get covered care

Under High Option, you can go to any In-Network Provider you want to, but in some circumstances, we must approve your care in advance. You also have Out-of-Network benefits under this Plan option. If you receive care from Out-of-Network Providers, you will be responsible for a separate deductible and coinsurance amount and you will be responsible for any difference between our allowance and the billed amount. Please refer to Section 4, "Your costs for covered services", for related benefits information.

Under Standard Option, you **must** use **In-Network** Providers in order to receive benefits, except under the special situations listed below. In addition, we must approve certain types of care in advance. Please refer to Section 4, "Your costs for covered services", for related benefit information.

1. Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport as described in Section 5(d), Emergency services/accidents
2. Professional care provided at In-Network facilities by Out-of -Network radiologists, anesthesiologists, certified registered nurse anesthetists (CRNSs), laboratory, pathologists, emergency room physicians, and assistant surgeons

3. Special provider access situations

Unless otherwise noted in Section 5, when services of Out-of-Network Providers are covered in a special exception, you are responsible for the applicable deductible, coinsurance or copayment.

Primary care

Your primary care provider can be any one of the following provider types; a) Family or General Practitioner, b) Internal Medicine, c) Pediatrician, d) Geriatrics. We encourage you to utilize an In-Network Primary Care Provider to assist in the coordination of your health care services under this Plan. The utilization of an In-Network Primary Care Provider is a matter you control and you are not required to notify us of your In-Network Primary Care Provider relationship.

Specialty care

You are always encouraged to seek care directly from an In-Network Primary Care Provider first. You may also seek care with any In-Network Provider under this Plan without a Referral. The Specialty Care benefits will apply to services provided to you by a Specialty Care Provider, as described in Section 5.

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

If you have a medical condition that needs special services, you may need to see an In-Network specialist. If you require certain complex covered services for which expertise is not available In-Network, we may direct you to an Out-of-Network Provider. **In-Network Benefits will only be paid if the Out-of-Network Provider and services are approved by us.** Call (800) 235-7111 to request review. The following do not constitute approval for Benefits:

- A referral, whether written or oral, by your In-Network Provider to an Out-of-Network Provider
- An order or prescription for services to an Out-of-Network Provider

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
- 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 provider based on the above circumstances, you can continue to see your provider until the end of your postpartum care, even if it is beyond the 90 days.

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 service department immediately at (800) 235-7111. 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 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
- 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 we do not have a primary care physician requirement and we allow you to use non-Plan providers if you select the High Option plan, if you seek services from a non-Plan provider you need to obtain our approval before you receive certain services. The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section. A pre-service claim is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits
(1) requires precertification or prior approval and (2) will result in a denial or reduction of benefits if you do not obtain precertification or prior approval.

- **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**

Pre-authorization is a determination made prior to services or supplies being provided on whether the services or supplies are medically necessary. We must receive sufficient clinical information to establish medical necessity. The medical necessity for an Out-of-Network Referral will include the absence of or the exhaustion of all In-Network resources. Pre-authorizations are all time-limited.

QualChoice requires that certain covered services must be pre-authorized. The specific procedures requiring pre-authorization can change based upon new or changing medical technology. A listing of the services requiring pre-authorization is maintained on our website at www.qualchoice.com on the Member Home Page. You may also contact our Customer Service Department to obtain a copy of the listing.

Your physician must obtain pre-authorization for some services such as those listed below:

- Equipment such as Bone stimulators, DME exceeding $1,000, etc.
- ALL Inpatient services, including Hospice
- Home Care
- Medications, such as "off label" usage, Injectables, specialty medications
- Certain Outpatient Services**,** and out-of-network outpatient services
- Specialized scanning diagnostic exams, and advanced imaging procedures such as, MRI, CT Scans and PET Scans
- Surgical treatments
- Transplants
- Out of Network Services

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 (800) 235-7111 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

- number of days requested for hospital stay.

- **Non-urgent care claims**

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

If we need an extension because we have not received necessary inforamtion from you, our notice will describe the specific information required and we will allow you up to 45 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claims (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or abiliity 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 youof our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgement of a prudnet layperson who possesses an average knowledge of health and medicine.

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

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at (800) 235-7111. You may also call OPM's Health Insurance 3 at (202) 606-0755 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 (800) 235-7111. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

Concurrent care claims

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

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

- **Emergency inpatient admission** — If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- **Maternity Care** — Your OB/GYN or your contracted Medical Group will pre-arrange your hospital stay.
- **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

Your responsibility for obtaining pre-authorization varies depending on whether you use In-Network or Out-of-Network Providers. In-Network Providers are responsible for obtaining the necessary pre-authorizations for you. Out-of-Network Providers have no contractual relationship to QualChoice, and therefore are not responsible for obtaining required pre-authorizations. When you receive care from Out-of-Network Providers, you are responsible for making sure all the providers obtain the required pre-authorizations. The Out-of-Network Providers must supply the clinical information necessary for us to determine Medical Necessity. We will give no pre-authorization without the necessary clinical information.

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

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

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

- **To reconsider a non-urgent care claim** — Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

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

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

  2. Ask you or your provider for more information.

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

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

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

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

- **To file an appeal with OPM**

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

Section 4. Your cost for covered services

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

Cost-sharing

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

Copayments

A co-payment is a fixed dollar amount you must pay each time you receive a covered service to which a co-payment applies. Co-payment amounts do not apply to the satisfaction of the deductible amounts. Medical and Prescription Drug Co-payments do apply to satisfaction of catastrophic out-of-pocket limits for each enrollee or family. Please see your Benefits Summary for a list of those benefits to which co-payments apply.

Example: When you see your primary care physician, you pay a co-payment of $20 per office visit, and when you go in the hospital, you pay $100 per admission.

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.

- **Under Standard Option,** there is no calendar year deductible
- **Under High Option,** the calendar year deductible for In-Network Providers is $500 per person. 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 $500. 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 $1000. 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 reaches $1000. The calendar year deductible for Out-of-Network Providers is $1000 per person($3,000 Self Plus One and Self Plus Family). Deductibles for In-Network providers and Out-of-Network providers are accumulated separately.

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: Under Standard Option, you pay 30% of our allowance for many covered services and Under High Option, you pay 20% of our allowance for many covered services in-network and you pay 40% of our allowance out-of-network.

Differences between our Plan allowance and the bill

Our **"Plan allowance"** is the amount we use to calculate our payment for certain types of covered services. Often, the provider's bill is more than the plan's allowance.

In-Network providers. These providers have agreements with QualChoice to limit what they bill our members. Because of that, when you use an In-Network provider, your share of the provider's bill for covered care is limited.

- **Under High Option,** your cost consists only of your deductible and coinsurance or copayment. Here is an example involving a copayment: You see an In-Network physician who charges $150, but our allowance is $100. You pay just $20 of our $100 allowance. Because of the agreement, your In-Network provider will not bill you for the $50 difference between our allowance and his/her bill.
- **Under Standard Option,** your cost consists only of your copayment or coinsurance amount, since there is no calendar year deductible. Here is an example involving a copayment: You see an In-Network specialist provider who charges $150 for covered services subject to a $40 copayment. Even though our allowance may be $100, you still pay just the $40 copayment. Because of the agreement, your Preferred physician will not bill you for the $110 difference.

Out-of-Network providers. These **providers** have no agreement to limit what they will bill you.

- **Under High Option,** when you use an Out-of-Network provider, you will pay your deductible and coinsurance –**plus** any difference between our allowance and the charges on the bill (except in certain circumstances – see pg. 12). For example, you see an Out-of-Network provider who charges $150. The Plan allowance is again $100, and you have met your deductible. You are responsible for your coinsurance, so you pay 40% of the $100 Plan allowance or $40. Plus, because there is no agreement between the Non-participating physician and us, the physician can bill you for the $50 difference between our allowance and his/her bill.
- **Under Standard Option, there are no benefits for care performed by Out-of-Network providers; you pay all charges.** See pg. 17 for the exceptions to this requirement.

Your catastrophic protection out-of-pocket maximum

- Standard Option-After your out-of-pocket expenses, any copayments and coinsurance total $5,500 for self only enrollment or $11,000 for self plus one and self plus family enrollment in any calendar year, you do not have to pay any more for covered for services. ***The maximum annual limitation on cost sharing listed under Self Only of $5,500 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***
- High Option-After your out-of-pocket expenses, an deductibles, copayments and coinsurance total $5,000 for self only enrollment or $10,000 for self plus one and self plus family enrollment in any calendar year, you do not have to pay any more for covered services. The Out-of-Network Out-of-Pocket limit under the High Option Plan is $13,200 for self only enrollment and $26,400 for self plus one and self plus family enrollment. ***The maximum annual limitation on cost sharing listed under Self Only of $5,000 applies to each individual, regardless of whether the individual is enrolled in Self Only, Self Plus One, or Self and Family.***

Example Scenario: Your plan has a $5,000 Self Only maximum out-of-pocket limit and a $10,000 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 maximum of $10,000, 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 $5,000 for the calendar year before their qualified medical expenses will begin to be covered in full.

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

- Prescription copayments

- Eyeglass and or contact lense discount plan

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

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.

High and Standard Option Benefits

See page 15 for how our benefits changed this year. Page 90 and page 91 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 High and Standard Option benefits, contact us at (800) 235-7111 or on our website at www.qualchoice.com.

Each option offers unique features:

High Option
When you have High Option, you can use both In-network and Out-of-network providers (See section 5 (i) for POS Benefits). In-Network providers will submit claims to us on your behalf and obtain any necessary preauthorizations. High Option has a calendar year deductible for some services, a $20 copayment for primary care physician office visits and a $35 copayment for specialist office visits. **You have direct access to In-Network providers without a referral.** The High Option also features both a preferred retail and mail order prescription drug program.

Standard Option
The Standard Option does not have a calendar year deductible. Most services are subject to copayments ($20 for primary care physician office visits and $40 for specialist office visits). **You have direct access to see In-Network specialists without a referral.** You must use In-Network providers under the Standard Option to be eligible for benefits, except in circumstances such as emergency care. In-Network providers will submit claims to us on your behalf. Standard Option offers a preferred retail and mail order prescription drug program.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option**, there is no calendar year deductible and you must use In-Network providers in order to receive benefits.
- **Under High Option**, the calendar year deductible for In-Network Providers is $500 per person ($1,000 per Self Plus One enrollment, or $1000 per Self and Family Enrollment). The calendar year deductible for Out-of-Network Providers is $1,000 per person ($3,000 per Self Plus One enrollment, or $3000 per Self Plus Family enrollment). Deductibles for In-Network providers and Out-of-Network providers are accumulated separately. The calendar year deductible applies to almost all benefits in this Section. The phrase "(No deductible)" is used to show when the calendar year deductible does not apply.
- **Under High Option**, the amounts allowed for Covered Services accessed under your Out-of-Network Benefits will be subject to a Plan allowance. You will be responsible for the applicable Cost-Sharing Amounts related to such Covered Services and the difference between the charges billed by the Out-of-Network provider and the Plan allowance.
- Please refer to Section 3, **How you receive benefits**, for a list of providers we consider to be primary care providers (under Standard Option) and other health care professionals.
- Be sure to read Section 4, **Your costs for covered services**, for valuable information about how cost- sharing works, with special sections for members who are age 65 or over. Also, read Section 9 about coordinating benefits with other coverage, including Medicare.

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all High Option benefits in this Section. We say ("No deductible") when the High Option deductible does not apply. There is no calendar year deductible under Standard Option.		
Diagnostic and treatment services	**High**	**Standard**
Professional services of physicians: • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinion • At home	$20 copayment for a primary care physician (No deductible) $35 copayment for a specialist physician (No deductible)	$20 copayment for a primary care physician $40 copayment for a specialist physician
Inpatient professional services: • During a hospital stay • In a skilled nursing facility	Nothing	Nothing
Not Covered: • *Online or telephonic medical evaluation and management services* • *Inpatient private duty nursing* • *Standby physicians* • *Routine radiological and staff consultations required by hospital rules and regulations*	*All charges.*	*All charges.*

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay	
Diagnostic and treatment services (cont.)	**High**	**Standard**
	High	Standard
Lab, X-ray and other diagnostic tests	**High**	**Standard**
Diagnostic tests provided, or ordered and billed by a physician, such as: • Blood tests or Laboratory test in the office • Urinalysis • Pathology • X-rays (Basic Imaging) • Bone density tests – screening or diagnostic (for women over age 50 and men over age 75)	20% of the Plan allowance after deductible	Nothing
Genetic testing *Note: Genetic Testing requires pre-authorization*	20% of the Plan allowance after deductible	30% of the Plan allowance
Advanced imaging such as: • CT Scans, MRI, MRA, DEXA, PET, SPECT • Radiation therapy • Blood tests or laboratory tests in an outpatient or inpatient facility • Diagnostic mammograms *Note* : See Section 5(c) for services billed for by a facility,such as the outpatient department of a hospital.	20% of the Plan allowance after deductible	30% of the Plan allowance
Preventive care, adult	**High**	**Standard**
Routine physical every year which includes: Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening - every five years starting at age 50 - Colonoscopy screening - every ten years starting at age 50 Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gove/preventive-care-benefits/	Nothing	Nothing
• Routine Prostate Specific Antigen (PSA) test - one annually for men age 40 and older	Nothing	Nothing
Well woman care; including, but not limited to: • Routine Pap test	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**High**	**Standard**
• Human papillomavirus testing for women age 30 and up, once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence.	Nothing	Nothing
Routine mammogram - covered for women age 35 and older, as follows: • From age 35 through 39, one during five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive years	Nothing	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): • Tetanus • Tetanus-diphtheria • Tetanus-diphtheria-acellular pertussis • Influenza Immunization • Pneumococcal polysaccharide vaccine • Zoster vaccine: (only for enrollees over age 60)	Nothing	Nothing
NOTE: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at http://www.uspreventiveservicestasksforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/		
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel*	*All charges.*	*All charges.*
Preventive care, children	**High**	**Standard**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing
• Well-child care for routine examinations and care (up to age 22) We provide benefits for the following services:	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You Pay	
Preventive care, children (cont.)	**High**	**Standard**
• All healthy newborn visits including routine screening (inpatient or outpatient) • The following routine services as recommended by the American Academy of Pediatrics for: - Routine physical examinations - Screening vision exam to determine the need for vision correction - Hearing exams through age 22 to determine the need for hearing correction - Laboratory tests - Immunizations - Human Papillomavirus (HPV) vaccines - Meningococcal vaccine - Rotavirus vaccines - Related office visits	Nothing	Nothing
NOTE: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare/gov/preventive-care-benefits/		
Maternity Care	**High**	**Standard**
Complete maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage when provided or ordered and billed by a physician or nurse midwife, such as: • Prenatal care (including ultrasound, laboratory, and diagnostic tests) • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Delivery - Postpartum care - Assistant surgeons/surgical assistance if required because of the complexity of the delivery - Anesthesia (including acupuncture) when requested by the attending physician and performed by a certified registered nurse anesthetist (CRNA) or a physician other than the operating physician (surgeon) or the assistant We cover one routine ultrasound between the 16th and 22nd week. All other ultrasounds must be preauthorized. This is the responsibility of your In-Network provider. If you use a Non- In-Network provider, it is your responsibility to tell your physician to call for the preauthorization.	Nothing for prenatal care or the first postpartum care visit; $20 per office visit for all postpartum care visits thereafter. Nothing for inpatient professional delivery services.	Nothing for prenatal care or the first postpartum care visit; $20 per office visit for all postpartum care visits thereafter. Nothing for inpatient professional delivery services.

Maternity Care - continued on next page

Benefit Description	You Pay	
Maternity Care (cont.)	**High**	**Standard**
NOTE: We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	Nothing for prenatal care or the first postpartum care visit; $20 per office visit for all postpartum care visits thereafter. Nothing for inpatient professional delivery services.	Nothing for prenatal care or the first postpartum care visit; $20 per office visit for all postpartum care visits thereafter. Nothing for inpatient professional delivery services.
Breastfeeding support, supplies and counseling for each birth	Nothing	Nothing
Note: Here are some things to keep in mind: • You do not need to pre-certify your normal delivery. • You may remain in the hospital up to 48 hours after a regular vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the child under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).		
Not Covered: • *No benefits for surrogate mothers*	*All Charges*	*All Charges*
Family Planning	**High**	**Standard**
• A range of voluntary family planning services, limited to: - Voluntary sterilization (See Surgical procedures Section 5 (b)) - Surgically implanted contraceptives - Injectable contraceptive drugs (such as Depo provera) - Intrauterine devices (IUDs) - Diaphragms **Note:** *We cover oral contraceptives under the prescription drug benefit.*	$20 copayment for a primary care physician (No deductible) $35 copayment for a specialist physician (No deductible)	$20 copayment for a primary care physician $40 copayment for a specialist physician
Contraceptive counseling on an annual basis	Nothing	Nothing
Not covered:	*All Charges.*	*All Charges.*

Family Planning - continued on next page

Benefit Description	You Pay	
Family Planning (cont.)	**High**	**Standard**
• *Reversal of voluntary surgical sterilization*	*All Charges.*	*All Charges.*
Infertility services	**High**	**Standard**
Diagnosis and treatment of infertility is covered except for services in the Not Covered section of this document • Intravaginal insemination (IVI) *Note:* All infertility testing and treatment related services require preauthorization. *NOTE:* Infertility drugs are excluded from this Plan.	20% of the Plan allowance after deductible	30% of the Plan allowance
Not covered: • *In Vitro Fertilization* • *Embryo transfer* • *Gamete intrafallopian transfer (GIFT)* • *Zygote Intra-Fallopian Transfer (ZIFT)* • *Intracervical insemination* • *Intrauterine insemination* • *Medications used to treat infertility or to enhance fertility are not covered*	*All Charges*	*All Charges*
Allergy care	**High**	**Standard**
• Testing and treatment • Allergy injections ***Note***: Certain allergy testing requires preauthorization. For allergy injections only you owe nothing.	$20 copayment for a primary care physician (No deductible) $35 copayment for a specialist physician (No deductible)	$20 copayment for a primary care physician $40 copayment for a specialist physician
Allergy serum	Nothing	Nothing
Treatment therapies	**High**	**Standard**
Inpatient and outpatient treatment therapies: • Chemotherapy and radiation therapy *Note:* High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on pg. 43. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy – Home IV and antibiotic therapy • Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder • Growth hormone therapy (GHT)	20% of the Plan allowance after deductible	30% of the Plan allowance

Treatment therapies - continued on next page

Benefit Description	You Pay	
Treatment therapies (cont.)	**High**	**Standard**
Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 18.	20% of the Plan allowance after deductible	30% of the Plan allowance
Physical and Occupational therapies	**High**	**Standard**
Habilitative and Rehabilitative services The following therapies are covered: • Physical therapy • Occupational therapy • Cardiac rehabilitation *Note:* We only cover therapy when a provider: • orders the care Benefits are limited to 60 visits or two consecutive months, per condition for physical, or occupational, or a combination of both. *Note:* Habilitative services and Cardiac rehabilitation requires preauthorization Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 36 sessions (3 times per week for up to 12 weeks).	$20 copayment for services provided by a licensed physical or occupational therapist $35 copayment for a specialist physician who is not a licensed physical or occupational therapist (No deductible)	$20 copayment for services provided by a licensed physical or occupational therapist $40 copayment for a specialist physician who is not a licensed physical or occupational therapist
Not covered: • *Recreational or education therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Maintenance or palliative rehabilitative therapy* • *Exercise programs* • *Hippotherapy (exercise on horseback)* • *Services provided by a massage therapists*	*All Charges*	*All Charges*
Speech Therapy	**High**	**Standard**
Habilitative and Rehabilitative benefits are limited to 60 visits or two consecutive months per person, per calendar year. NOTE: Habilitative services require pre-authorization	$20 copayment when provided by a licensed speech therapist $35 copayment for a specialist physician who is not a licensed speech therapist(No deductible)	$20 copayment when provided by a licensed speech therapist $40 copayment for a specialist physician who is not a licensed speech therapist

Benefit Description	You Pay	
Hearing services (testing, treatment, and supplies)	**High**	**Standard**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	$35 copayment for a specialist physician (No deductible)	$40 copayment for a specialist physician
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*		
Not covered: •Hearing services that are not shown as covered	*All Charges*	*All Charges*
Vision services (testing, treatment, and supplies)	**High**	**Standard**
• Routine vision exam covered 1 every 24 months • Bi-annual eye refractions • Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18 ***Note:***See *Preventive care, children* for eye exams for children. Benefits are limited to one pair of eyeglasses, replacement lenses, or contact lenses per incident prescribed: • To correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts); • If the condition can be corrected by surgery, but surgery is not an appropriate option due to age or medical condition.	$20 copayment for a primary care physician (No deductible) $35 copayment for a specialist physician (No deductible)	$20 copayment for a primary care physician $40 copayment for a specialist physician
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Eye exercises and orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described above* • *Radial keratotomy and other refractive surgery*	*All Charges*	*All Charges*

Benefit Description	You Pay	
Foot care	**High**	**Standard**
Routine foot care when you are under active treatment for diabetes.	20% of the Plan allowance after deductible	30% of the Plan allowance
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Orthotripsy*	*All Charges*	*All Charges*
Orthopedic and prosthetic devices	**High**	**Standard**
Orthopedic braces and prosthetic appliances such as: • Artificial limbs and eyes • Functional foot orthotics when prescribed by a physician • Rigid devices attached to the foot or a brace, or place in shoe • Replacement, repair, and adjustment of covered devices • Following a mastectomy, breast prostheses and surgical bras, including necessary replacements • Hearing aids for adults and children limited to one hearing aid per ear per 36-month period • Hearing aids and testing to fit them • Surgically implanted penile prostheses to treat erectile dysfunction *Note:* We provide benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants and surgically implanted breast implants following mastectomy. For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services. *Note:* Hearing aids are not subject to deductible and coinsurance and Cochlear implants are limited to $20,000 per calendar year maximum.	20% of the Plan allowance after deductible	30% of the Plan allowance
• Wigs (scalp hair prosthesis) due to hair loss due to chemotherapy for the treatment of cancer	Nothing	Nothing

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay	
Orthopedic and prosthetic devices (cont.)	**High**	**Standard**
Note: Benefits for wigs are paid at 100% of the billed amount, limited to $350 for one wig. Pre-authorization required.	Nothing	Nothing
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • Prosthetic replacements provided less than 3 years after the last one we covered Shoes and over-the-counter orthotics • *Wigs (including cranial prostheses), except for scalp hair prosthesis for hair loss due to chemotherapy for the treatment of cancer, as stated above*	*All Charges*	*All Charges*
Durable medical equipment (DME)	**High**	**Standard**
Durable medical equipment (DME) is equipment and supplies that: • Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury) • Are medically necessary • Are primarily and customarily used only for a medical purpose • Are generally useful only to a person with an illness or injury • Are designed for prolonged use • Serve a specific therapeutic purpose in the treatment of an illness or injury We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen, • Dialysis equipment, • Hospital beds, • Wheelchairs, • Crutches, • Walkers, • Blood glucose monitors, • Insulin pumps, and • Speech-generating devices.	20% of the Plan allowance after deductible	30% of the Plan allowance

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable medical equipment (DME) (cont.)	**High**	**Standard**
Note: Call us at (800) 235-7111 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% of the Plan allowance after deductible	30% of the Plan allowance
Not covered: • *Exercise and bathroom equipment* • *Lifts, such as seat, chair, or van lifts* • *Car seats* • *Air conditioners, humidifiers, dehumidifiers, and purifiers* • *Breast pumps* ***Note:*** *Electric breast pumps can be covered for a limited time at a rental rate for mothers that have newborn babies in extended stays in the hospital.* • *Communications equipment, devices, and aids (including computer equipment) such as "story boards" or other communication aids to assist communication-impaired individuals* • *Equipment for cosmetic purposes* • *Topical Hyperbaric Oxygen Therapy (THBO)* • *Tanning beds*	*All Charges*	*All Charges*
Home health services	**High**	**Standard**
Home health care ordered by a In-Network physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or licensed therapist. Services include: • Intravenous therapy • Wound care • Therapy • Medications ***Note***: Home health services are limited to 40 visits per year	20% of the Plan allowance after deductible	30% of the Plan allowance
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All Charges*	*All Charges*

Benefit Description	You Pay	
Chiropractic	**High**	**Standard**
• Chiropractic care - Manipulation of the spine and extremities - Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application ***Note:***Chiropractic x-ray's require preauthorization Limits: • 20 visits annual benefit maximum for chiropractic care	$35 copayment for a specialist physician (No deductible)	$40 copayment for a specialist physician
Alternative treatments	**High**	**Standard**
Biofeedback is covered for a limited number of diagnoses: • Urinary incontinence; female • Tension headaches (muscle, thermal or skin biofeedback only; EEG biofeedback is considered experimental and investigational for this indication) • Temporomandibular joint (TMJ) syndrome • Neuromuscular rehabilitation of stroke and traumatic brain injury (TBI) (see note below) • Fecal incontinence • Raynaud's disease • Irritable bowel syndrome • Refractory severe subjective tinnitus • Levator ani syndrome • Treatment of migraine headaches when chemoprophylaxsis has been ineffective	20% of the Plan allowance after deductible	30% of the Plan allowance
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback except as stated above* • *AutoMove AM800*	*All Charges*	*All Charges*
Educational classes and programs	**High**	**Standard**
Coverage is provided for: • Tobacco Cessation programs, including individual/group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco depedence.	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence.
	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You Pay	
Educational classes and programs (cont.)	**High**	**Standard**
• Diabetes self management for one educational course • Childhood obesity education QualChoice offers health coaching, call a coach at (800) 235-7111 ***Note:*** Further diabetic education sessions will be covered if medically necessary according to our medical criteria and approved by a care manager	Nothing	Nothing
Not covered: • *Marital, family, educational, or other counseling or training services when performed as part of an educational class or program* • *Premenstrual syndrome (PMS), lactation, headache, eating disorder (except as described above), and other educational clinics* • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Services performed or billed by a school or halfway house or a member of its staff*	*All charges*	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option**, there is no calendar year deductible. You must use In-Network providers to receive benefits.
- **Under High Option**, the calendar year deductible for In-Network Providers is $500 per person ($1,000 per Self Plus One enrollment or $1,000 per Self and Family enrollment). The calendar year deductible for Out-of-Network Providers is $1,000 per person ($3,000 per Self Plus One enrollment or $3,000 per Self and Family enrollment). Deductibles for In-Network providers and Out-of-Network providers are accumulated separately. The calendar year deductible applies to almost all benefits in this Section. The phrase "(No deductible)" is used to show when the calendar year deductible does not apply.
- Be sure to read Section 4, ***Your costs for covered services***, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRECERTIFICATION. Please refer to the prior approval and precertification information shown in Section 3 to be sure which services require prior approval or precertification.**
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

Benefit Description	You Pay	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	**High**	**Standard**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices. See 5(a) for *Orthopedic and prosthetic devices* for device coverage information • Surgical treatment of severe obesity (bariatric surgery).	$100 copayment (No deductible)	$200 copayment

Surgical procedures - continued on next page

Benefit Description	You Pay	
Surgical procedures (cont.)	**High**	**Standard**
Note: You must get prior approval for surgery for morbid obesity. QualChoice offers Health coaching, call a coach at (800) 235-7111. For consideration for this surgery, several criteria must be met, such as: - Have presence of severe obesity that has persisted for at least 3 years - Be between the ages of 18-64; and - Have been evaluated by a psychiatrist; and - Has participated in clinically supervised nutrition and exercise program - Before surgery, you must participate in organized multidisciplinary surgical preparatory regimen of at least three months duration. See www.qualchoice.com for more policy detail regarding Morbid obesity (bariatric surgery). See 5(a) – Orthopedic and prosthetic devices for device coverage information	$100 copayment (No deductible)	$200 copayment
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see foot care* • *Services of a standby physician* • *Cosmetic Surgery* • *LASIK, INTACS, radial keratotomy and other refractive surgery*	*All Charges*	*All Charges*
Reconstructive surgery	**High**	**Standard**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance, and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are; protruding ear deformities, cleft lip, cleft palate, birth marks and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas;	$100 copayment (No deductible)	$200 copayment

Reconstructive surgery - continued on next page

Benefit Description	You Pay	
Reconstructive surgery (cont.)	**High**	**Standard**
- breast prostheses and surgical bras and replacements (see Prosthetic devices) ***Note:*** If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$100 copayment (No deductible)	$200 copayment
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High**	**Standard**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Benefits are provided for surgical treatment of temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex of muscles, nerves, and other tissues related to that joint. • Other surgical procedures that do not involve the teeth or their supporting structures.	$100 copayment (No deductible)	$200 copayment
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Orthognathic surgery*	*All Charges*	*All Charges*
Organ/tissue transplants	**High**	**Standard**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the plan. See *Other services* in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High**	**Standard**
• Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	Nothing	Nothing
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing	Nothing
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myleogenous leukemia - Hemoglobinopathy - Infantile malignant osteopetrosis	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High**	**Standard**
- Marrow Failure and related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Neuroblastoma - Amyloidosis - Multiple myeloma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer	Nothing	Nothing
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphona with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High**	**Standard**
- Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing	Nothing
These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early state (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphona - Advanced non-Hodgkin's lymphoma	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High**	**Standard**
- Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early state (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myelodysplasia/Myelodysplastic Syndromes • Autologous Transplants for: - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphoma (Mantle Cell lymphoma, adult T-cell leukemia/ lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma)	Nothing	Nothing
National Transplant Program (NTP) *Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.*		
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High**	**Standard**
Professional services provided in: Hospital (inpatient) **Note: QualChoice will provide Benefits for anesthesia and facilities for dental procedures which would ordinarily be done under local anesthesia provided:**	Nothing	Nothing

Anesthesia - continued on next page

Benefit Description	You Pay	
Anesthesia (cont.)	**High**	**Standard**
1. The procedure is performed in a Network Facility; and 2. The situation meets Medical Necessity criteria, and the patient is: • A Child under 7 years of age who is determined by two network dentists to be unable to undergo the procedure without general anesthesia and who cannot wait until an older age for the procedure, when undergoing the procedure without general anesthesia would be possible; • A person with a serious mental health condition that prevents use of local anesthesia for the procedure; • A person with a serious physical condition making hospital care necessary for the safe performance of dental work; or • A person with a significant behavioral problem (as certified by a Network Physician) which precludes safe performance of the dental work under local anesthesia.	Nothing	Nothing
Professional services provided in: • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	Nothing

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.
- **Under Standard Option,** there is no calendar year deductible. You must use In-Network providers in order to receive benefits.
- **Under High Option,** the calendar year deductible for In-Network Providers is $500 per person ($1,000 per Self Plus One enrollment or $1,000 per Self and Family enrollment). The calendar year deductible for Out-of-Network Providers is $1,000 per person ($3,000 per Self Plus One enrollment or $3,000 per Self and Family Enrollment). Deductibles for In-Network providers and Out-of-Network providers are accumulated separately. The calendar year deductible applies to almost all benefits in this Section. The phrase "(No deductible)" is used to show when the calendar year deductible does not apply.
- 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.
- If you are utilizing In-Network providers, it is their responsibility to preauthorize any hospital stays. If you utilize our National Network or a Out-of-Network provider it is **YOUR RESPONSIBILITY TO PREAUTHORIZE** any hospital stays.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).

Benefit Description	You Pay	
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".		
Inpatient hospital	**High**	**Standard**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care, • Meals and special diets.	$100 copayment per day up to a maximum of $500 per admission	$200 copayment per day up to a maximum of $1,000 per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing	Nothing

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**High**	**Standard**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All Charges*	*All Charges*
Outpatient hospital or ambulatory surgical center	**High**	**Standard**
Outpatient surgery and related medical services performed and billed by a hospital or freestanding ambulatory facility, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biological • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 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.	$100 copayment	$200 copayment
Extended care benefits/Skilled nursing care facility benefits	**High**	**Standard**
Extended care benefit/Skilled nursing facility (SNF) • Includes inpatient rehab **Note:** Skilled nursing facility has a limit of 60 days per calendar year	$100 copayment per day up to a maximum of $500 per admission	$200 copayment per day up to a maximum of $1,000 per admission
Not Covered: • *Custodial care*	*All Charges*	*All Charges*

Benefit Description	You Pay	
Hospice care	**High**	**Standard**
The following hospice services, when ordered by a physician, are covered during the period when the hospice has admitted an Enrollee to its program, provided the hospice program was pre-authorized: • In-patient care in a freestanding hospice, a hospice unit within a hospital or skilled nursing facility, or in an acute care hospital bed; and • Home care services provided by the hospice either directly or under arrangements with other licensed providers, including, but not limited to, the following: - Intermittent nursing care by registered nurses, licensed practical nurses, or home health aides; - Respiratory therapy; - Social services; - Nutritional services; - Laboratory examinations; - Chemotherapy and radiation therapy when require for control of symptoms; - Medical supplies; and - Medical care provided by a physician	Nothing	Nothing
Not covered: • *Independent nursing* • *Homemaker services*	*All Charges*	*All Charges*
Ambulance	**High**	**Standard**
When an accident or other medical emergency occurs, we cover transport to the nearest hospital when emergency services are required. We cover ambulance transportation from one hospital to another hospital for one of the reasons identified below as long as it is coordinated through our Care Management department: • To access equipment or expertise necessary to care for you properly; • To receive a test or service which is not available at the hospital where you have been admitted and you return after the test or service is completed; • To transport you from a Out-of-Network Provider hospital to a In-Network Provider; and • To transport you directly from an acute care setting to an alternate level of care. ***Note*:** Air/Sea Ambulance benefit is limited to $10,000 per trip	Ground: $100 copayment per trip Air/Sea: $150 copayment per trip	Ground: $100 copayment per trip Air/Sea: $150 copayment per trip

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.
- **Under Standard Option,** there is no calendar year deductible.
- **Under High Option,** the calendar year deductible for In-Network Providers is $500 per person ($1,000 per Self Plus One enrollment and $1,000 per Self and Family enrollment). The calendar year deductible for Out-of-Network Providers is $1,000 per person ($3,000 per Self Plus One enrollment and $3,000 per Self and Family enrollment). Deductibles for In-Network providers and Out-of-Network providers are accumulated separately. The calendar year deductible applies to almost all benefits in this Section. The phrase "(No deductible)" is used to show when the calendar year deductible does not apply.
- 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.

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

Go to the nearest urgent or emergency care facility.

Emergencies within our service area

We cover the cost of emergency health services an enrollee incurs while in the Service Area. An Enrollee is encouraged to seek services for emergency health services from In-Network Providers.

Emergencies outside of our service area

We cover the cost of emergency health services an enrollee incurs while traveling outside of the Service Area. An Enrollee is encouraged to seek services for emergency health services from health care providers In-Network in our QualChoice National Network (QCNN) when the Enrollee is out of the Service Area. An Enrollee may limit out-of-pocket expenses for emergency health services while outside of the Service Area to applicable Cost-Sharing Amounts by accessing such care from a QCNN provider.

If care is accessed by an Enrollee from providers not In-Network in the QCNN, reimbursement for Covered Services will be at the Out-of-Network benefit level. We will deny coverage for routine and follow up care after Emergency health services unless a Network Provider in Arkansas performs the services.

Your identification card contains contact information for our QualChoice National Network (QCNN). Providers may be identified by calling the number on the identification card. The Enrollee must present their identification card to the servicing provider indicating participation in the QCNN in order to receive this benefit. Submit a Claim for Benefits directly to us for processing.

Dependents who have notified us that they reside outside the Service Area may access the QCNN providers and facilities for Covered Services at the In-Network provider benefit level upon prior approval.

Benefit Description	You pay	
Emergency within our service area	**High**	**Standard**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$20 copayment for a primary care physician (No deductible) $35 copayment for a specialist physician (No deductible)	$20 copayment for a primary care physician $40 copayment for a specialist physician
• Emergency care as an outpatient at a hospital, including physician services ***Note:***We waive the emergency copayment if you are admitted to the hospital.	$150 copayment (No deductible)	$150 copayment
Emergency outside our service area	**High**	**Standard**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$20 copayment for a primary care physician (No deductible) $35 copayment for a specialist physician (No deductible)	$20 copayment for a primary care physician $40 copayment for a specialist physician
• Emergency care as an outpatient at a hospital, including physician services ***Note:*** We waive the emergency copayment if you are admitted to the hospital.	$150 copayment (No deductible)	$150 copayment
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*
Ambulance	**High**	**Standard**
Professional ambulance service when medically appropriate.	Ground: $100 copayment per trip Air/Sea: $150 copayment per trip	Ground: $100 copayment per trip Air/Sea: $150 copayment per trip

Ambulance - continued on next page

Benefit Description	You pay	
Ambulance (cont.)	**High**	**Standard**
When an accident or other medical emergency occurs, we cover transport to the nearest hospital when emergency services are required. We cover ambulance transportation from one hospital to another hospital for one of the reasons identified below as long as it is coordinated through our Care Management department: • To access equipment or expertise necessary to care for you properly; • To receive a test or service which is not available at the hospital where you have been admitted and you return after the test or service is completed; • To transport you from a Out-of-Network Provider hospital to a In-Network Provider; and • To transport you directly from an acute care setting to an alternate level of care. Note: Air/Sea Ambulance benefit is limited to $10,000 per trip	Ground: $100 copayment per trip Air/Sea: $150 copayment per trip	Ground: $100 copayment per trip Air/Sea: $150 copayment per trip

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

You need to get Plan approval for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

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 utilizing In-Network providers, it is their responsibility to preauthorize any hospital stays. If you utilize our National Network or an Out-of-Network provider it is **YOUR RESPONSIBILITY TO PREAUTHORIZE** any hospital stays.
- **Under Standard Option,** there is no calendar year deductible and you must use In-Network providers in order to receive benefits.
- **Under High Option,** the calendar year deductible for In-Network Providers is $500 per person ($1,000 per Self Plus One enrollment and $1,000 per Self and Family enrollment). The calendar year deductible for Out-of-Network Providers is $1,000 per person ($3,000 per Self Plus One enrollment and $3,000 per Self and Family enrollment). Deductibles for In-Network providers and Out-of-Network providers are accumulated separately. The calendar year deductible applies to almost all benefits in this Section. The phrase "(No deductible)" is used to show when the calendar year deductible does not apply.
- 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.
- Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must get Plan approval of your treatment plan.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You Pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Professional services	**High**	**Standard**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	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.

Benefit Description	You Pay After the calendar year deductible…	
Professional services (continued)	**High**	**Standard**
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmocotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$20 copayment for a primary care physician (No deductible) $35 copayment for a specialist physician (No deductible)	$20 copayment for a primary care physician (No deductible) $40 copayment for a specialist physician (No deductible)
Diagnostics	**High**	**Standard**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner	$20 copayment for a primary care physician (No deductible) $35 copayment for a specialist physician (No deductible)	$20 copayment for a primary care physician (No deductible) $40 copayment for a specialist physician (No deductible)
• Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	$100 copayment (No deductible)	$100 copayment (No deductible)
• Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing	Nothing
Inpatient hospital or other covered facility	**High**	**Standard**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accomodations, general nursing care, meals and special diets, and other hospital services	$100 copayment (No deductible)	$200 copayment
Outpatient hospital or other covered facility	**High**	**Standard**

Outpatient hospital or other covered facility - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Outpatient hospital or other covered facility (cont.)	**High**	**Standard**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$100 copayment (No deductible)	$200 copayment
Not Covered	**High**	**Standard**
• *Services we have not approved*	*All Charges*	*All Charges*

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 48.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal Law prevents the pharmacy from accepting unused medications.
- **Under Standard Option,** there is no calendar year deductible for prescribed drugs and medications.
- **Under High Option,** there is no calendar year deductible for prescribed drugs and medications.
- Some prescription drugs have additional requirements for coverage.
  - Some prescription drugs require prior authorization. In this case, your physician must provide the clinical information required to establish the medical necessity of the prescription drug before it would be covered.
  - Some prescription drugs are on step therapy. In these cases, you may be required to try a drug from one category or chemical group that is aimed at the same treatment response before using a drug from another category. Your pharmacist and your physician will be able to assist you with step therapy issues.
  - There are some prescription drugs for which there are limitations on the number of doses that may be dispensed over a specified period of time. Such limits are generally placed either because taking higher cumulative amounts is detrimental or because there is a larger dose size that could be used more efficiently.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription**. A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a In-Network pharmacy, a Out-of-Network pharmacy, or by mail.
  - In-Network pharmacies will process your prescription in accordance with the governing contract, requesting the appropriate copayment. You may learn which pharmacies are In-Network by visiting our website at www.qualchoice.com.
  - A Out-of-Network pharmacy will have no information about our contracted payment rates or your copayment amounts. You will therefore have to pay the full cost for the prescription and submit a claim within 30 days to QualChoice for reimbursement. You will be reimbursed the High QualChoice contracted payment for the drug, less your copayment. This may leave you also paying the difference between the amount you were charged by the pharmacy and the amount allowed as payment for your prescription drug. It is less expensive for you if you use a In-Network pharmacy.
  - We have a contracted mail-order pharmacy that will fill up to a 90-day supply of your maintenance medications. One copayment will be charged for each 31-day supply and 3 copayments for a 90-day supply.
- **We use a formulary.** Drugs are placed on the formulary in a way that reflects their therapeutic value and their cost. We have an open formulary. This means that, with the exception of medications which are excluded from coverage (see below), brand name medications not listed in the formulary document are predominantly covered at Tier III.

Tier I: Includes generic drugs

Tier II: Includes formulary or preferred brand-name drugs, may include some generics not included in Tier I.

Tier III: Includes non-formulary or non-preferred brand-name drugs

Many generic medications are covered at Tier I, even though they may not be listed; generic medications covered at Tier II or Tier III are generally listed as such. You will pay less for your medication if you and your physician can select medications from Tier I or Tier II. To order a prescription drug brochure, call (800) 235-7111.

- **These are the dispensing limitations.** Your prescriptions will be filled for a 31-day supply for a single copayment. If your prescription is for more than a 31-day supply, more than one copayment will be charged. We also have dispensing limits in other situations:
  - **When a medication comes in multiple dose sizes,** we may limit the number of pills available at the lower dose to 31 per fill. If you require more medication, it is more appropriate in these situations for you to have the higher dose pill and continue to take only one pill a day.
  - **When a medication may be over-used** resulting in adverse effects, we may limit the total dose to be taken on a monthly or semi-monthly basis. This is true of a number of medications for migraine headaches, which, when taken in excessive dose, actually can cause more migraine headaches, rather than help. It may also be true for other medications, such as some sleeping medications which are licensed by the FDA for use only every second day.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. 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 licensed by the FDA as generic versions of a branded medication when the patent protection rights on the branded medication run out. Generic medications are required to have the same strength, consistency and effectiveness as the brand name medication, however, they are much less expensive. For this reason, you plan encourages you to use generic medications whenever you can – they work just as well and they cost you less in copayments; and because they also cost the plan less, it helps to keep your premium costs down.
- **When you do have to file a claim.** You may obtain a claim form by downloading it from our website at www.qualchoice.com or by requesting one from our Customer Service Department (800) 235-7111. Complete the form, attach the documentation, and mail it to our pharmacy administrator at the address on the form. Reimbursement generally takes 4-6 weeks.

Benefits Description	You Pay After the calendar year deductible...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
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: • 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.* • Insulin • Diabetic supplies including a glucose meter and test strips for it • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (limited to a maximum of six doses per month) Preauthorization required • Vitamin D for adults age 65 and older	**Retail Pharmacy** $10 Tier I $40 Tier II $60 Tier III **Self-Administered *Specialty* Drugs** $100 per fill Tier IV **Mail Order (90-day supply Maintenance medications only)** $0 Tier I $120 Tier II	**Retail Pharmacy** $10 Tier I $40 Tier II $60 Tier III **Self-Administered *Specialty* Drugs** $100 per fill Tier IV **Mail Order (90-day supply Maintenance medications only)** $15 Tier I $120 Tier II

Covered medications and supplies - continued on next page

Benefits Description	You Pay After the calendar year deductible...	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Note: If there is no generic equivalent available, you will pay the copayment for the brand name drug prescribed. ***Note:*** When a therapeutically equivalent generic product becomes available, we may classify the formulary brand name product as a Tier III brand-name drug in determining how much you pay for the drug *Refer to Section 10 Definitions for more information regarding Specialty Drugs and Maintenance Medications.*	**Retail Pharmacy** $10 Tier I $40 Tier II $60 Tier III **Self-Administered *Specialty* Drugs** $100 per fill Tier IV **Mail Order (90-day supply Maintenance medications only)** $0 Tier I $120 Tier II $180 Tier III	**Retail Pharmacy** $10 Tier I $40 Tier II $60 Tier III **Self-Administered *Specialty* Drugs** $100 per fill Tier IV **Mail Order (90-day supply Maintenance medications only)** $15 Tier I $120 Tier II $180 Tier III
Contraceptive drugs and devices NOTE: The "morning after pill" is considered preventive service under contraceptives with no cost to the member if prescribed by a physician and purchased at a network pharmacy.	Nothing	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes, including appetite suppressant medications* • *Drugs to enhance athletic performance* • *Fertility drugs, which includes any medications used to treat infertility or to enhance fertility.* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them*, except, Vitamin D for adults 65 and over • *Non prescription medications* ***Note:*** *Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit.* *(See page 30.)*	*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.

- **Under Standard Option,** there is no calendar year deductible.
- **Under High Option,** the calendar year deductible is $500 per person ($1,000 per Self Plus One or $1000 for Self and Family). The calendar year deductible applies to almost all benefits in this Section. The phrase "(No deductible)" is used to show when the calendar year deductible does not apply.

Dental benefits are limited to accidental injury to sound, natural teeth when services are received within 72 hours of the initial injury as described in the 'Accidental Injury Benefit' section.

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.

Accidental injury benefit	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
We will provide coverage if an Enrollee has an Accidental Injury that damages a sound, natural tooth. Treatment must be pre-authorized. Benefits are subject to a maximum limit ($2,000) per Enrollee per accident. Dental services must be received from a Doctor of Dental Surgery ("D.D.S.") or a Doctor of Medical Dentistry ("D.M.D."). The damage must be severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident. The physician or dentist must certify that the injured tooth was: • A virgin or un-restored tooth; or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with any bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be started within three months of the original accident date and completed within 12 months of the original accident date.	$35 copayment for a specialist physician (No deductible)	$40 copayment for a specialist physician

Accidental injury benefit - continued on next page

Accidental injury benefit	You Pay	
Accidental injury benefit (cont.)	**High Option**	**Standard Option**
Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities. The following limitations for treatments also apply to repair of damaged teeth: • Only the sound and natural tooth or teeth avulsed or extracted as a direct result of the Accidental Injury will be considered for replacement; • Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position; reimbursement for this service will be based upon a Plan allowance per tooth; • Double abutments are not covered; • Any health intervention related to dental caries or tooth decay is not covered; • Removal of teeth is not covered; and • Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.	$35 copayment for a specialist physician (No deductible)	$40 copayment for a specialist physician
Dental Benefits	**High Option**	**Standard Option**
We have no other dental benefits.		

Section 5(h). Special features

Feature	Description
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call and talk with a registered nurse who will discuss treatment options and answer your health questions. Contact Ask A Nurse toll free at 866-232-0447.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
QCARE	The QCARE program is designed to give members the tools and information needed to help them better understand and manage their health. Services include: • Access to a 24 hour Nurse Line which includes an Audio Library covering many health related topics • Education and information on diet, exercise and other topics that are important for your health • Contact with your Care Manager at regular intervals to discuss your medication and other health needs or concerns • The assurance that your health information will be kept confidential, and will not be shared with anyone other than those you request *Care Coach* This QualChoice representative serves as a support system to you and your family, providing information and guidance concerning your medical condition, treatment plans and available options. *Better Health Advisor* Got questions? Get answers. This tool lets you compare hospitals, learn about costs and find out more about procedures, chronic diseases and pharmaceuticals. *Ask A Nurse*

	A registered nurse is on call all day and all night to provide assistance. Call 1-866-232-0447. *Ask A Doc* The doctor is always in for you. Use this tool to have direct access to physician advice.
Health Promotion	• Extensive online services provided to encourage healthy behavior at www.qualchoice.com • Take our personal health assessment and identify your health risks • We offer both eFitness and eDietitian to answer online diet and exercise questions • Our health coaches can assist you in developing an action plan to make positive lifestyle choices • We offer online journals so you can track your progress
Childhood Health and Activity	• Learn about ways to keep your children healthy and active through material our health coaches can provide • We also utilize material through www.MyPyramid.gov that promotes healthy nutrition for children and preschoolers including interactive online games and coloring sheets encouraging healthy food selection • Our health coaches will work with parents to plan healthy menus and build a healthy recipe selection
Special Additions Maternity Program	Special Additions Maternity Program is especially designed to provide you with guidance and information during your pregnancy. When you enroll in the program you will receive informative education material that will keep you up to date on what to expect during your pregnancy.
Travel benefit/services overseas	See Section 5(j)

Section 5(i) - 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 responsbility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at, (800) 235-7111 or visit their website at www.qualchoice.com.

Vision Discount Program	All FEHB members who enroll in a QualChoice plan will be issued a card from Superior Vision which allows FEHB members to access Superiors' national network of providers and obtain vision services for discounted costs.

Section 5(j). Point of Service benefits

Facts about this Plan's POS option (Out-of-Network)

NOTE: The Standard Option does not have point-of-service benefits.

Under the point-of-service option, you may choose to obtain covered health services from Out-of-Network providers and hospitals whenever you need care. When you obtain covered non-emergency medical treatment from an Out-of-Network provider, you are subject to the deductible, coinsurance and out-of-pocket maximum stated below.

What is covered

Under the point-of-service benefit, you are covered for medically necessary, covered health services when you self-refer to an Out-of-Network provider. You may receive the medically necessary covered health services listed below, except for the services listed under "What is not covered". If you choose to use the point-of-service benefit, you will receive a lower allowance than when the High Option In-Network benefit is utilized. In addition, the Out-of-Network provider may bill you for any amounts not paid by the Plan.

- Medical Office visits
- Preventive Health Services, including Well Baby and Well Child Care, routine periodic preventive health examinations, immunizations, allergy testing and treatment, and allergy serum.
- Emergency services
- X-ray and Laboratory services
- Acute Inpatient Hospital Services
- Maternity , Pregnancy and Newborn Care
- Inpatient Physician Services and Consultations
- Outpatient Hospital services
- Outpatient Surgery
- Home Health Care
- Skilled Nursing Facility Services
- Mental Health Services
- Inpatient Chemical Dependency Services
- Inpatient Alcohol Treatment
- Durable Medical Equipment and Prosthetic Devices
- Orthopedic Appliances
- Outpatient Rehabilitative Therapy
- Oral Surgery

Plan Precertification

When utilizing the POS benefit, we continue to require that you obtain prior medical review for the same services for which prior medical review is required under the High Option In-Network benefit. When utilizing Out-of-Network providers, it is recommended that you advise the provider to contact the Plan for prior medical review before services are provided. If services are deemed not medically necessary, you will be responsible for the cost of services rendered.

Deductible

When the point-of-service benefit is utilized, you pay a $1,000 deductible per member per calendar year or a $3,000 deductible per family per calendar year for all covered health services received from Out-of-Network providers. This deductible is separate from the deductible that applies under the High Option In-Network benefit, and will apply even if you have met your In-Network benefit deductible. Coinsurance and copayments you pay under either the Out-of-Network benefit or the In-Network benefit cannot be used to meet your calendar year deductible under the point-of-service benefit.

Coinsurance

If you use a provider who has not contracted with us, you will be responsible for the point-of-service deductible (described above), 40% coinsurance, and the remaining balance of the Out-of-Network provider's charges, if they are greater than the fee schedule or allowance amount. Copayments do not apply to point-of-service benefits.

For Out-of-Network health care professionals, laboratories, urgent care facilities, ambulatory surgical centers and durable medical equipment, your 40% coinsurance amount is determined from our fee schedule for Out-of-Network providers. Our fee schedule for Out-of-Network providers is based on the In-Network maximum allowable payment. For Out-of-Network hospitals and other inpatient facilities, your 40% coinsurance is based on our allowance, which is determined by the nature of the services provided, the type of facility in which they were provided, and maximum allowable payment determination.

Please note that hospital charges, sometimes called facility charges, do not include any charges for doctors ' services.

Out-of-Pocket Maximum

After your point-of-service deductible and coinsurance total $13,200 per person per calendar year or $26,400 per family per calendar year, you do not have to pay any more for covered services under the POS benefit. Charges over the fee allowance are not applied to the out-of-pocket maximum and you may be billed for these amounts.

Emergency Benefits

Medically necessary emergency care (even if received from an Out-of-Network provider) is always covered as an In-Network benefit.

What is Not Covered

Read Sections 5 and 6 about services that are not covered under the Plan.

Prescriptions are covered under the normal High Option benefit, see section 5(f).

NOTE: Charges in excess of our Plan Allowance are not covered under the High Option Out-of-Network benefit.

How to Obtain Benefits

If you receive services from an Out-of-Network provider , the provider may file a claim directly with us. If the provider files a claim, payment generally will be made directly to the provider. However , we may pay you , even if the provider filed the claim. In that case, you are responsible for paying the provider. If the provider requires you to pay up front and will not submit a claim for you, you should submit a claim to us for reimbursement. See pg. 68 for instructions on how to file a claim. You must submit a complete claim form by December 31st of the year after the year you received the service. Either OPM or we can extend this deadline if you show that Government administrative operations or legal incapacity prevented you from filing on time.

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 Out-of-Network Point of Service benefits and 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.
- Extra care costs or research costs associated with clinical trials.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, borthers or sisters by blood, marriage or adoption.

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 or seek Out-of-network services through the High Option Point of Service Plan. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at (800) 235-7111 or at our website at www.qualchoice.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.

Prescription Drugs

Submit your claims to: QualChoiceP.O. Box 25610, Little Rock, AR 72221,Little Rock, AR 72211

Other supplies or services

Submit your claims to: QualChoiceP.O. Box 25610, Little Rock, AR 72221, Little Rock, AR 72211

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. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a five year limitation on the reissuance of uncashed checks.

Post-service claims procedures

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

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

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

Authorized Representative

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

Notice Requirements

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

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

Section 8. The disputed claims process

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

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 claims, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing QualChoice ATTN: Appeals Department P. O. Box 25610, Little Rock, AR 72221 or calling (800) 235-7111.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claims, 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 judgement (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement 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 claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

1 Ask us in writing to reconsider our initial decision. You must:

a) Write to us within 6 months from the date of our decision; and

b) Send your request to us at: QualChoice, PO Box 25610, Little Rock, AR 72221; and

c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; and

e) Include 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.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim or

b) Write to you and maintain our denial or

c) Ask you or your provider for more information

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

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

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

You must write to OPM within:

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

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

Send OPM the following information:

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

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

Note: You are the only person who has 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 health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions 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 (800) 235-7111. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time.

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions 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 (800) 235-7111. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0755 between 8 a.m. and 5 p.m. Eastern Time.

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

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

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

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

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

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

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an 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.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When You have Medicare

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age

- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (TTY: 1-800-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY: 1-800-325-0778).

Should I enroll in Medicare?

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

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

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

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

The Original Medicare Plan (Part A or Part B)

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

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

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

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at (800) 235-7111 or see our website at www.qualchoice.com

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

When Medicare Part A is primary -

- Under **High Option**, we will waive our:
  - Inpatient hospital per-day copayments; an
  - Inpatient Non-member hospital coinsurance.
- Under **Standard Option**, we will waive our:
  - Inpatient hospital per-day copayments.

When Medicare Part B is primary -

- Under **High Option**, we will waive our:
  - Calendar year deductible
  - Coinsurance for services and supplies provided provided by physicians and other covered health care professionals (inpatient and outpatient, including mental conditions and substance abuse care);
  - Copayments for office visits to In-network physicians and other health care professionals;
  - Outpatient facility coinsurance for medical, surgical, preventive, and mental conditions and substance abuse care; and
  - Copayments for professional care provided in an emergency room
- Under **Standard Option**, we will waive our:
  - Copayments and coinsurance for care received from covered professional and facility providers.

Note: We do not waive benefit limitations, such as the the 40-visit limit for home health visits. In addition, we do not waive any copayments for prescription drugs.

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 without Medicare**	**Member Cost with Medicare Part A and** B	**Member Cost with Medicare Part A and** B
Benefit Description	**High Option**	**Standard Option**	**High Option**	**Standard Option**
Deductible	$500 Self Only/ $1,000 Self Plus One or Self and Family	N/A	$500 Self Only/ $1,000 Self Plus One or Self and Family	N/A
Out-of- Pocket Maximum	$5,000 Self Only/ $10,000 Self Plus One or Self and Family	$5,500 Self Only/ $11,000 Self Plus One or Self and Family	$5,000 Self Only/ $10,000 Self Plus One or Self and Family	$5,500 Self Only/ $11,000 Self Plus One or Self and Family
Primary Care Physician	$20	$20	$0	$0
Specialist	$35	$40	$0	$0
Inpatient Hospital	$100 copay per day with a maximum of $500	$200 copay per day with a maximum of $1,000	$0	$0
Outpatient Hospital	$100	$200	$0	$0
Rx	Level 1 -$10 Level 2 -$40 Level 3 - $60 Level 4 –$100 Specialty (30 day supply)	Level 1 -$10 Level 2 -$40 Level 3 - $60 Level 4 – $100 Specialty (30 day supply)	Level 1 -$10 Level 2 -$40 Level 3 - $60 Level 4 – $100 Specialty (30 day supply)	Level 1 -$10 Level 2 -$40 Level 3 - $60 Level 4 – $100 Specialty (30 day supply)
Rx – Mail Order (90-day supply)	Tier 1-$0, Tier 2 and 3-3x retail copay	Tier 1-$15, Tier 2 and 3-3x retail copay	Tier 1-$0, Tier 2 and 3-3x retail copay	Tier 1-$15, Tier 2 and 3-3x retail copay

You can find more information about how our plan coordinates benefits with Medicare at www.qualchoice.com

Tell us about your Medicare coverage

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

Medicare Advantage (Part C)

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY: 1-800-486-2048) 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:

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

Accidental Injury

Means a bodily injury happening unexpectedly and taking place not according to the usual course of events (for example an automobile accident), and which is the direct cause of the loss, independent of disease or bodily infirmity. Accidental Injury to teeth does not include any damage caused by chewing or biting any object.

Admission

The period from entry (admission) as an inpatient into a hospital (or other covered facility) until discharge. In counting days of inpatient care, the date of entry and the date of discharge count as the same day.

Benefits

Means reimbursement or payments for health care available to Enrollees covered under this Plan.

Benefits Summary

Means a document containing specific information relating to your coverage and Cost-Sharing Amounts under this Plan. The information may include amounts for deductible, co-payments, coinsurance, out-of-pocket limits and lifetime maximum benefits as well as visit and day limit maximums for limited services.

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 (FDA); 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
- 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

Means a fixed percentage of the maximum allowable payment you must pay toward the cost of certain covered services for each calendar year. Those covered services subject to the application of coinsurance are identified in your benefits summary. Coinsurance is subject to an annual maximum limit. You may also be responsible for additional amounts. See page 22.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See pg 22.

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. Services or supplies for which benefits are available (i.e., payments may be made) as described in this brochure. Covered services do not include services or supplies and care excluded or which do not meet the definition of "medically necessary" in this section.

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that a person not medically skilled could perform safely and reasonably, or that mainly assist the patient with daily living activities, such as: 1. Personal care, including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or dressing; 2. Homemaking, such as preparing meals or special diets; 3. Moving the patient; 4. Acting as companion or sitter; 5. Supervising medication that can usually be self-administered; or known as Long Term Care. We, our medical staff, and/or an independent medical review determine which services are custodial 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 pg. 22.

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.

Experimental or investigational services

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); and, approval for marketing has not been given at the time it is furnished. **Note:** Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product, is experimental or investigational if:

1. Reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
2. Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only:

- Published reports and articles in the authoritative medical and scientific literature;
- The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or
- The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or biological product or medical treatment or procedure.

QualChoice has a Medical Review department that determines whether a claimed service is experimental or investigational after consulting with internal or external experts or nationally recognized guidelines in a particular field or specialty.

For more detailed information, contact QualChoice customer service at (800) 235-7111.

Health care professional

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

Maintenance Medications

“Maintenance Medications” are defined as follows:

A. A drug that is usually administered continuously, rather than intermittently, and for longer than 90 days, typically for the remainder of one's life. This means the patient taking the medication on a scheduled basis year round and not as needed or seasonally.

B. A drug in which the most common use is to treat a chronic disease state when a therapeutic endpoint cannot be determined. Therapy with the drug is not considered curative.

C. A drug that has a low probability for dosage or therapy changes due to side effects, serum drug concentration monitoring, or therapeutic responses over a course of prolonged therapy.

D. While certain drugs may sometimes be used on a chronic basis, the drug will only meet the above definition if it is most commonly used in this way. The most common examples of maintenance medications are medicines used to treat high blood pressure, diabetes, high cholesterol, or hypothyroidism.

E. Drugs in the following classes are considered to be Maintenance Medications. If your medication falls in one of these categories you will be able to get a 90 days supply either from your retail pharmacy (if it participates in the 90-day network) or from the mail order pharmacy. You will need a prescription from your doctor with enough refills to allow 90 days. One Co-payment will be charged for each 31 day supply.

i. Alzheimer Disease medication

ii. Antipsychotic medication

iii. Antivirals for HIV

iv. Asthma and other respiratory medication

v. Benign Prostatic Hyperplasia (BPH) medication

vi. Blood pressure medication (e.g., beta blockers, calcium channel blockers, diuretics, ACE-inhibitors)

vii. Cancer medication

viii. Cholesterol lowering drugs

ix. Diabetes medication

x. Glaucoma medication

xi. Heart medication

xii. Organ transplant medication

xiii. Osteoporosis medication

xiv. Parkinson's Disease medication

xv. Potassium supplements

xvi. Seizure medication

xvii. Thyroid medication

Medical necessity

We determine whether services, drugs, supplies, or equipment provided by a hospital or other covered provider are:

1. Appropriate to prevent, diagnose, or treat your condition, illness, or injury;
2. Consistent with standards of good medical practice in the United States;

3. Not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4. Not part of or associated with scholastic education or vocational training of the patient; and
5. In the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance or deductible (if applicable) for covered services. Plans determine their allowances in different ways. We determine our allowance by our contracted rate with In-Network providers.

You may seek Covered Services directly from a physician or other provider who is not in the Network. Services provided by an Out-of-Network Provider will be covered and reimbursed under your Out-of-Network Benefits unless prior authorization for coverage as an In-Network Benefit is received from us. The amounts allowed for Covered Services accessed under your Out-of-Network Benefits will be subject to the Maximum Allowable Payment. You will be responsible for the applicable Cost-Sharing Amounts related to such Covered Services and the difference between the charges billed by the Out-of-Network Provider and the Maximum Allowable Payment.

Post-service claims

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

Pre-service claims

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

- **Reimbursement**

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

Specialty Drugs

Specialty Drugs are defined as specialized therapies developed for chronic, complex illnesses and:

- may have special handling, storage, shipping requirements
- may require nursing services or special programs to support patient compliance
- require disease-specific treatment programs
- may have limited distribution requirements
- may be injections, infusions, or oral products
- are high cost, typically > $500 per treatment episode

- **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 th rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Us/We

Us and We refer to QualChoice.

You

You refers to the enrollee and each covered family member.

Urgent care claims

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

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

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

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at (800) 235-7111. 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.

Section 11. Other Federal Programs

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

Important information about three Federal programs that complement the FEHB Program

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

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **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 a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), (TTY: 1-800-952-0450), 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.

Dental Insurance

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

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan 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: 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

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

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 2016

Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions , limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

See Section 5(i) for Out-of-Network benefits related to this High Option Point-of-Service Plan.

Below, an asterisk (*) means the item is subject to the $500 calendar year deductible.

High Option Benefits	You pay	Page
Deductible	Self Only deductible is $500. Self Plus One and Self and Family deductible is $1,000.	22
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $35 specialist	28
Services provided by a hospital:		
• Inpatient	$100 copayment per day up to a maximum of $500 per admission	49
• Outpatient	$100 copayment	50
Emergency benefits:		
• Medical emergency	$150 per Emergency Room visit	52
• Ambulance Services:	Ground: $100 copayment per trip; Air/Sea: $150 copayment per trip; $10,000 limit per trip	52
Mental health and substance abuse treatment: (Pre-authorization required for all services)	Regular cost-sharing	54
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after $5,000 for Self Only. Nothing after $10,000 for Self Plus One and Self and Family. Out-of-Network: $13,200 for Self Only. Nothing after $26,400 for Self Plus One and Self and Family.	22
Prescription drugs:		
• Retail pharmacy	$10 Tier I, $40 Tier II, $60 Tier III	58
• Self-administered Specialty drugs	$100 per fill Tier IV	58
• Mail order	$0 Tier I, $120 Tier II, $180 Tier III	58

Summary of benefits for the Standard Option 2016

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

Standard Option Benefits	You Pay	Page
Deductible	N/A	
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $40 specialist	28
Services provided by a hospital:		
• Inpatient	$200 copayment per day up to a maximum of $1,000 per admission	49
• Outpatient	$200 copayment	50
Emergency benefits:		
• Medical emergency	$150 per Emergency Room visit	52
• Ambulance Services:	Ground: $100 copayment per trip; Air/Sea: $150 copayment per trip; $10,000 limit per trip	52
Mental health and substance abuse treatment:	Regular cost-sharing	54
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after $5,500 for Self Only. Nothing after $11,100 for Self Plus One and Self and Family.	22
Prescription drugs:		
• Retail pharmacy	$10 Tier I, $40 Tier II, $60 Tier III	58
• Self-administered Specialty drugs	$100 per fill Tier IV	58
• Mail order	$15 Tier I, $120 Tier II, $180 Tier III	58

2016 Rate Information for QualChoice

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

Postal rates apply to United States Postal Service employees.

Postal Category 1 rates apply to career bargaining unit employees.

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

For further assistance, Postal Service employees should call:

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

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

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	DH1	$213.37	$99.44	$462.30	$215.46	$87.58	$99.44
High Option Self Plus One	DH3	$455.73	$151.91	$987.41	$329.14	$126.09	$151.91
High Option Self and Family	DH2	$488.50	$327.40	$1,058.42	$709.36	$300.26	$327.40
Standard Option Self Only	DH4	$182.99	$60.99	$396.47	$132.15	$50.63	$60.99
Standard Option Self Plus One	DH6	$355.45	$118.48	$770.14	$256.71	$98.34	$118.48
Standard Option Self and Family	DH5	$477.28	$159.09	$1,034.10	$344.70	$132.05	$159.09