



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** Please read the FEHB Plan brochure (73-860) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can get the FEHB Plan brochure at www.qualchoice.com, and view the Glossary at www.cciio.cms.gov. You can call 1-800-235-7111 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	Calendar year accumulative <u>deductible</u> In-Network: Self \$500/Self + One or Self + Family \$1,000 Out-of-network: Self \$1,000/Self + One or Self + Family \$3,000	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. [Preventive care]	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In-Network: Self \$5,000/Self + One or Self + Family \$10,000 Out-of-network: Self \$13,200/Self + One or Self + Family \$26,400	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premium</u> , balance-billed charges (unless balanced billing is	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

	prohibited), and health care this <u>plan</u> doesn't cover.	
Will you pay less if you use a <u>network provider</u>?	Yes. See www.qualchoice.com or call 1-800-235-7111 for a list of <u>network providers</u> .	The plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider (only available under the Point-of-Service/POS benefit if enrolled in the High Option) and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 Copayment / visit	40% Coinsurance	None
	<u>Specialist</u> visit	\$35 Copayment / visit	40% Coinsurance	None
	<u>Preventive care/screening/immunization</u>	Nothing	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>Coinsurance after deductible</u>	40% <u>Coinsurance after deductible</u>	If you use out-of-network providers, the plan will pay nothing unless a <u>preauthorization</u> is obtained by you
	Imaging (CT/PET scans, MRIs)	20% <u>Coinsurance after deductible</u>	40% <u>Coinsurance after deductible</u>	If you use out-of-network providers, the plan will pay nothing unless a <u>preauthorization</u> is obtained by you

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.qualchoice.com	Generic drugs	\$10 <u>Copayment</u> / prescription at retail, \$0 <u>Copayment</u> / prescription at mail	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription) You pay three monthly copayment amounts for each 90 day mail order drug Mail order is not available for Specialty medications
	Preferred brand drugs	\$40 <u>Copayment</u> / prescription at retail, \$120 <u>Copayment</u> / prescription at mail	Not Covered	
	Non-preferred brand drugs	\$60 <u>Copayment</u> / prescription at retail, \$180 <u>Copayment</u> / prescription at mail	Not Covered	
	<u>Specialty drugs</u>	\$100 <u>Copayment</u> / prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <u>Copayment</u> / visit, No deductible	40% Coinsurance	If you use out-of-network providers, the plan will pay nothing unless a <u>preauthorization</u> is obtained by you
	Physician/surgeon fees	\$100 <u>Copayment</u> / visit	Nothing	None
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>Copayment</u> / visit	\$150 <u>Copayment</u> / visit	None
	<u>Emergency medical transportation</u>	\$100 <u>Copayment</u> / trip for ground and \$150 <u>Copayment</u> / trip for air/sea	\$100 <u>Copayment</u> / trip for ground and \$150 <u>Copayment</u> / trip for air/sea	Coverage is limited to \$10,000 per trip for air/sea ambulance
	<u>Urgent care</u>	\$35 <u>Copayment</u> / visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <u>Copayment</u> / day	40% <u>Coinsurance</u>	[Inpatient Hospital] Requires <u>preauthorization</u> ; In network \$500 <u>Copayment</u> maximum per admission
	Physician/surgeon fees	\$100 Copayment / No Deductible	40% <u>Coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$100 <u>Copayment</u> / visit	40% <u>Coinsurance</u>	[Outpatient Hospital]
	Inpatient services	\$100 <u>Copayment</u> / visit	40% <u>Coinsurance</u>	[Inpatient Hospital] Requires <u>preauthorization</u> ; In network \$500 <u>Copayment</u> maximum per admission
If you are pregnant	Office visits	Nothing	40% <u>Coinsurance</u>	\$20 <u>Copayment</u> per office visit for all postnatal care after initial visit
	Childbirth/delivery professional services	Nothing	40% <u>Coinsurance</u>	None
	Childbirth/delivery facility services	Nothing	40% <u>Coinsurance</u>	Requires <u>preauthorization</u>
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coinsurance after deductible</u>	40% <u>Coinsurance after deductible</u>	Requires <u>preauthorization</u> ; Coverage is limited to 40 visits per year
	<u>Rehabilitation services</u>	\$20 <u>Copayment</u> / visit	40% <u>Coinsurance</u>	Coverage is limited to 60 visits or two consecutive months, per condition for physical, or occupational, or a combination of both.
	<u>Habilitation services</u>	\$20 <u>Copayment</u> / visit	40% <u>Coinsurance</u>	Coverage is limited to 60 visits or two consecutive months, per condition for physical, or occupational, or a combination of both.
	<u>Skilled nursing care</u>	\$100 <u>Copayment</u> / day	40% <u>Coinsurance</u>	Requires <u>preauthorization</u> ; In network \$500 <u>Copayment</u> maximum per admission for Inpatient <u>Rehabilitation Services/Skilled Nursing Care</u>
	<u>Durable medical equipment</u>	20% <u>Coinsurance after deductible</u>	40% <u>Coinsurance after deductible</u>	Call QualChoice at 1-800-235-7111 for assistance with rental or purchase
	<u>Hospice services</u>	Nothing	40% <u>Coinsurance</u>	
If your child needs dental or eye care	Children's eye exam	Nothing	40% <u>Coinsurance</u>	Covers a screening vision exam to determine the need for vision correction
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none">• Acupuncture• Cosmetic• Dental care (Adult)	<ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside the U.S.	<ul style="list-style-type: none">• Private-duty nursing• Routine foot care• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan brochure.)		
<ul style="list-style-type: none">• Bariatric surgery• Chiropractic care	<ul style="list-style-type: none">• Hearing aids, \$1400/ear every 3 years• Infertility treatment	<ul style="list-style-type: none">• Routine eye care (Adult)

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-800-235-7111 or visit www.opm.gov/insure/health. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or temporary continuation of coverage (TCC). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your FEHB Plan brochure. If you need assistance, you can contact: the state insurance department phone number 1-800-852-5494.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-235-7111 (TTY: 711).]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-235-7111 (TTY: 711).]

[Chinese (中文): 如果需要中文的帮助 · 请拨打这个号码 800-235-7111 (TTY: 711).]

[Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-235-7111 (TTY: 711)]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist copay</u>	\$35
■ Hospital (facility) <u>copay</u>	\$100
■ Other <u>copay</u>	\$100

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$235
<u>Coinsurance</u>	\$600
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,395

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist copay</u>	\$35
■ Hospital (facility) <u>copay</u>	\$100
■ Other <u>copay</u>	\$100

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$235
<u>Coinsurance</u>	\$60
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$855

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist copay</u>	\$35
■ Hospital (facility) <u>copay</u>	\$100
■ Other <u>copay</u>	\$100

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$235
<u>Coinsurance</u>	\$90
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$825

Statement of Non-Discrimination

QualChoice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. QualChoice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

QualChoice:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact QualChoice Customer Service at 501-228-71110 (TTY: 711).

If you believe that QualChoice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: QualChoice Civil Rights Coordinator, P.O. Box 25610, Little Rock, AR 72221, 501-228-7111 (TTY: 711), Fax 501-707-6729, QCA_COE@qualchoice.com. You can file a grievance by mail, fax, or email. If you need help filing a grievance, QualChoice is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Declaración de no discriminación

QualChoice cumple con las leyes de derechos civiles federales aplicables y no discrimina basándose en la raza, color, origen nacional, edad, discapacidad, o sexo. QualChoice no excluye personas o las trata de manera diferente debido a su raza, color, origen nacional, edad, discapacidad, o sexo.

QualChoice:

- Proporciona ayuda y servicios gratuitos a las personas con discapacidad para que se comuniquen eficazmente con nosotros, tales como:
 - Intérpretes calificados de lenguaje por señas
 - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Proporciona servicios de idiomas a las personas cuyo lenguaje primario no es el inglés, tales como:
 - Intérpretes calificados
 - Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con QualChoice Customer Service a 501-228-7111 (TTY: 711).

Si considera que QualChoice no le ha proporcionado estos servicios, o en cierto modo le ha discriminado debido a su raza, color, origen nacional, edad, discapacidad o sexo, puede presentar una queja ante: QualChoice Civil Rights Coordinator, P.O. Box 25610, Little Rock, AR 72221, 501-228-7111 (TTY: 711), Fax 501-707-6729, QCA_COE@qualchoice.com. Usted puede presentar una queja por correo, fax, o correo electrónico. Si necesita ayuda para presentar una queja, QualChoice está disponible para brindarle ayuda. También puede presentar una queja de violación a sus derechos civiles ante la Oficina de derechos civiles del Departamento de Salud y Servicios Humanos de Estados Unidos (U.S. Department of Health and Human Services), en forma electrónica a través del portal de quejas de la Oficina de derechos civiles, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o por correo o vía telefónica llamando al: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Los formularios de queja están disponibles en <http://www.hhs.gov/ocr/office/file/index.html>

**QualChoice offers help for members with limited English proficiency (LEP).
The following statement is printed in the top languages used in Arkansas,
as required by the Federal government:**

***ATTENTION: Language assistance services, free of charge, are available to you.
Call 1-800-235-7111 (TTY: 711).***

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-235-7111 (TTY: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-235-7111 (TTY: 711).

Marshallese

LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jerbal in jipañ ilo kajin ñe am ejjeļok wōñāān. Kaalok 1-800-235-7111 (TTY: 711).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-235-7111 (TTY: 711)。

Lao

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-235-7111 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-235-7111 (TTY: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.
اتصل برقم 1-800-235-7111 (رقم هاتف الصم والبكم: 711).

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-235-7111 (TTY: 711).

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-235-7111 (ATS: 711).

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-235-7111 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-235-7111 (TTY: 711) 번으로 전화해 주십시오.

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-235-7111 (TTY: 711).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-800-235-7111 (TTY: 711) まで、お電話にてご連絡ください。

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-800-235-7111 (TTY: 711) पर कॉल करें।

Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-235-7111 (TTY: 711).