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 deductible?	Calendar year accumulative deductible 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 deductible amount before this plan 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. [Preventive care]	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.].
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	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 out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges (unless balanced billing is	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

	prohibited), and health care this plan doesn't cover.	
Will you pay less if you use a network provider?	Yes. See www.qualchoice.com or call 1-800-235-7111 for a list of network providers.	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 provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 Copayment / visit	40% Coinsurance	None
	Specialist visit	$35 Copayment / visit	40% Coinsurance	None
	Preventive care/screening/ immunization	Nothing	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance after deductible	40% Coinsurance after deductible	If you use out-of-network providers, the plan will pay nothing unless a preauthorization is obtained by you
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after deductible	40% Coinsurance after deductible	If you use out-of-network providers, the plan will pay nothing unless a preauthorization 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 prescription drug coverage is available at www.qualchoice.com	Generic drugs	$10 Copayment / prescription at retail, $0 Copayment / 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 Copayment / prescription at retail, $120 Copayment / prescription at mail	Not Covered	
	Non-preferred brand drugs	$60 Copayment / prescription at retail, $180 Copayment / prescription at mail	Not Covered	
	Specialty drugs	$100 Copayment / prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 Copayment / visit, No deductible	40% Coinsurance	If you use out-of-network providers, the plan will pay nothing unless a preauthorization is obtained by you
	Physician/surgeon fees	$100 Copayment / visit	Nothing	None
If you need immediate medical attention	Emergency room care	$150 Copayment / visit	$150 Copayment / visit	None
	Emergency medical transportation	$100 Copayment / trip for ground and $150 Copayment / trip for air/sea	$100 Copayment / trip for ground and $150 Copayment / trip for air/sea	Coverage is limited to $10,000 per trip for air/sea ambulance
	Urgent care	$35 Copayment / visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 Copayment / day	40% Coinsurance	[Inpatient Hospital] Requires preauthorization; In network $500 Copayment maximum per admission
	Physician/surgeon fees	$100 Copayment / No Deductible	40% Coinsurance	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 Copayment / visit	40% Coinsurance	[Outpatient Hospital]
	Inpatient services	$100 Copayment / visit	40% Coinsurance	[Inpatient Hospital] Requires preauthorization; In network $500 Copayment maximum per admission
If you are pregnant	Office visits	Nothing	40% Coinsurance	$20 Copayment per office visit for all postnatal care after initial visit
	Childbirth/delivery professional services	Nothing	40% Coinsurance	None
	Childbirth/delivery facility services	Nothing	40% Coinsurance	Requires preauthorization
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after deductible	40% Coinsurance after deductible	Requires preauthorization; Coverage is limited to 40 visits per year
	Rehabilitation services	$20 Copayment / visit	40% Coinsurance	Coverage is limited to 60 visits or two consecutive months, per condition for physical, or occupational, or a combination of both.
	Habilitation services	$20 Copayment / visit	40% Coinsurance	Coverage is limited to 60 visits or two consecutive months, per condition for physical, or occupational, or a combination of both.
	Skilled nursing care	$100 Copayment / day	40% Coinsurance	Requires preauthorization; In network $500 Copayment maximum per admission for Inpatient Rehabilitation Services/Skilled Nursing Care
	Durable medical equipment	20% Coinsurance after deductible	40% Coinsurance after deductible	Call QualChoice at 1-800-235-7111 for assistance with rental or purchase
	Hospice services	Nothing	40% Coinsurance	
If your child needs dental or eye care	Children's eye exam	Nothing	40% Coinsurance	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 Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids, $1400/ear every 3 years
- Infertility treatment
- 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 ( ): Ă 800-235-7111 (TTY: 711).]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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 deductible	$500
Specialist *copay*	$35
Hospital (facility) *copay*	$100
Other *copay*	$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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$235
Coinsurance	$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 deductible	$500
Specialist *copay*	$35
Hospital (facility) *copay*	$100
Other *copay*	$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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$235
Coinsurance	$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 deductible	$500
Specialist *copay*	$35
Hospital (facility) *copay*	$100
Other *copay*	$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**

In this example, Mia would pay:

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

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

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 Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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 (رقمهاتف 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 નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-235-7111 (TTY: 711).