QualChoice

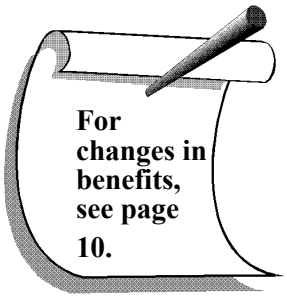
http://www.qualchoice.com

2011

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

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 7 for requirements.



Enrollment codes for this Plan:

DH1 High Option – Self Only
DH2 High Option - Self and Family
DH4 Standard Option – Self Only
DH5 Standard Option – Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

RI 73-860

Important Notice from QualChoice About Our Prescription Drug Coverage and Medicare

OPM has determined that the QualChoice Benefit Plan's prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. 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 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'll 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 (November 15th through December 31st) 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).

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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. 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 oral 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. You do not have a right to benefits that were available before January 1, 2011, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2011, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- 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 first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Operations, Program Planning & Evaluation, 1900 E Street, NW, Washington, DC 20415-3650.

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.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.

- 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

202-418-3300

OR 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.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or if you are no longer enrolled in the Plan.
- 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.

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 that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- 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 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.
- www.quic.gov/report/toc.htm. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Never Events

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 In-Network contracted providers. This new policy will help protect you from preventable medical errors and improve the quality of care you receive.

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 will encourage hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither you nor your FEHB Plan will incur cost to correct the medical error.

Section 1. Facts about this HMO Plan (High and Standard Option)

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.

This Standard Option (Codes DH4 & DH5) plan is a "grandfathered health plan" under the Affordable Care Act. A grandfathered plan must preserve basic health coverage that was already in effect when the law passed. Specifically, this plan cannot eliminate all or substantially all benefits to diagnose or treat a particular condition; it cannot increase your coinsurance (the percentage of a bill you pay); and any increases in deductibles, out-of-pocket limits, and other copayments (the fixed-dollar amount you pay) must be minimal.

As a grandfathered health plan, this plan has also decided to follow immediate reforms that apply to non-grandfathered plans.

Questions regarding what protections apply and what protections do not apply to a grandfathered health plan, and what might cause a plan to change status from grandfathered to non-grandfathered may be directed to us at QualChoice: 1-800-235-7111. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

This High Option (Codes DH1 & DH2) is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

As a non-grandfathered health plan, this plan has also decided to follow the requirements that apply to grandfathered plans.

Questions regarding what protections apply may be directed to us at QualChoice: 1-800-235-7111. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

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.

Preventive care services

Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment. First dollar coverage may be limited to a maximum dollar amount each year.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services. (See pg. 15)

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. You will no longer have to pay Coinsurance for the remainder of the calendar year after you have met the Out-of-Pocket limit during the Calendar Year. The Out-of-Pocket limit under the QualChoice High and Standard Option is $5,000. The Out-of-Network Out-of-Pocket limit under the QualChoice High Option is $6,000 for self enrollment and $18,000 for Family enrollment.

Co-Insurance is the only amount that will apply towards the Enrollee's Out-of-Pocket Limit. Co-payments, Deductibles, or charges in excess of the Maximum Allowable Payment are the patient's responsibility and do not count toward meeting the Out-of-Pocket Limit.

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 Web site (www.opm.gov/insure) 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 Web site 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 800-235-7111.

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. How we change for 2011

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

- Several provisions of the Affordable Care Act (ACA) affect eligibility and benefits under the FEHB Program and FSAFEDS beginning January 1, 2011. For instance, children up to age 26 will be covered under a Self and Family enrollment. Please read the information in Sections 11 and 12 carefully.
- We have reorganized organ and tissue transplant benefit information to clarify coverage.
- We have reorganized Mental health and substance abuse benefits to clarify coverage.

Changes to this Plan

Changes to our High Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. See page 85.
- We now provide Preventive care for children and adults at no cost to you. Previously, the cost was $20 copayment for PCP and $30 copayment for Specialist.
- Your copayment for Mental Health office visits is now $20 per visit. Previously, you paid $30 for visits to specialists for Mental Health visits.
- You now pay 20% of the cost of diagnostic tests ordered and billed by a physician such as a CAT scan or blood test. Previously, you paid nothing.

Changes to Standard Option only

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. See page 85.
- Your copayment for Tier 1/Prescription Drugs is now $5. Previously, you paid Nothing for Tier 1/Prescription Drugs.
- We now provide Preventive care for children and adults at no cost to you. Previously, the cost was $20 copayment for PCP and $40 copayment for Specialist.
- Your copayment for Mental Health office visits is now $20 per visit. Previously, you paid $40 for visits to specialists for Mental Health visits.

Changes to both our Standard and Basic Options

- We now provide expanded vision benefits. Previously we provided benefits for one pair of replacement lenses following cataract surgery. You will now have benefits for the nonsurgical treatment for amblyopia and strabismus and one pair of replacement lenses for each incident described in *Vision services*. (See pg. 26)
- We now provide benefits for speech-generating devices, limited to $1,000 per calendar year. (See pg. 28)
- We now provide benefits for over-the-counter and prescription smoking cessation drugs. (See pg. 30)

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 Web site: 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.

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) OB/GYN, d) Pediatrician, e) 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 1-800-235-7111 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; or
- 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; or
- Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
- Reduce our service area and you enroll in another FEHB Plan,

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

If you are in the second or third trimester of pregnancy and you lose access to your 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; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

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

How to get approval for:

- **Your hospital stay and Services requiring our prior approval**

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 web site at www.qualchoice.com on the Member Home Page. You may also contact our Customer Service Department to obtain a copy of the listing.

- **Maternity Care**

Your OB/GYN or your contracted Medical Group will pre-arrange your hospital stay.

- **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.

Services requiring our Prior approval

Your primary care and specialty care providers have authority to refer you for most services. For certain services, however, your provider must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process Pre-authorization. Your physician must obtain pre-authorization for some services such as those listed below:

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

You may request a pre-review of coverage for any service by calling our Customer Service department at 800-235-7111; a full listing of those items requiring prior approval can also be located at www.qualchoice.com

You may appeal any of our pre-authorization decisions by following the procedures in Section 8. In addition, your provider may request an Expedited Appeal of a denial of a pre-authorization by calling the number on your QualChoice identification card if your provider believes the services are urgent due to your medical condition.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered services.

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 or 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.

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.

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($1,000 per family). The calendar year deductible for Out-of-Network Providers is $1000 per person($3,000 per 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 doesn't begin until you meet your 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. 12 for the exceptions to this requirement.

Your catastrophic protection out-of-pocket maximum

After your (copayments and deductible and coinsurance) total $5,000 in any calendar year, you do not have to pay any more for covered services under the High and Standard Option. The Out-of-Network Out-of-Pocket limit under the QualChoice High Option is $6,000 for self enrollment and $18,000 for Family enrollment.

Please note that copayments for prescription drugs do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services.

Carryover

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

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

When Government facilities bill us

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

Section 5. High and Standard Option Benefits

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.

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High and Standard Option 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 because 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 501-228-7111 or 800-235-7111 or at our Web site at www.qualchoice.com.

Each option offers unique features.

• **High Option**	When you have the 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 PCP copayment for office visits and a $30 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 providers and $40 for specialists). 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 family). The calendar year deductible for Out-of-Network Providers is $1000 per person ($3,000 per family). 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 Option**	**Standard Option**
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) $30 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.*

Benefit Description	You Pay	
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
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
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 Option**	**Standard Option**
Routine physical 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 - Double contrast barium enema - every five years starting at age 50 - Colonoscopy screening - every ten years starting at age 50	Nothing	Nothing

• Routine Prostate Specific Antigen (PSA) test - one annually for men age 40 and older
• Routine PapTest
• 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 calendar years
	Nothing	Nothing

Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You Pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
• Tetanus • Tetanus-diphtheria • Tetanus-diphtheria-acellular pertussis • Influenza Immunization • Pneumococcal polysaccharide vaccine • Zoster vaccine: (only for enrollees over age 60)	Nothing	Nothing
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 Option**	**Standard Option**
• 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: • 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
Maternity care	**High Option**	**Standard Option**
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) • Delivery - Postpartum care	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 Option**	**Standard Option**
- 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. 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.
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 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 Option**	**Standard Option**
• 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)	$20 copayment for a primary care physician (No deductible) $30 copayment for a specialist physician (No deductible)	$20 copayment for a primary care physician $40 copayment for a specialist physician

Family Planning - continued on next page

Benefit Description	You Pay	
Family Planning (cont.)	**High Option**	**Standard Option**
- Diaphragms **Note:** *We cover oral contraceptives under the prescription drug benefit.*	$20 copayment for a primary care physician (No deductible) $30 copayment for a specialist physician (No deductible)	$20 copayment for a primary care physician $40 copayment for a specialist physician
Not covered: • *Reversal of voluntary surgical sterilization*	*All Charges.*	*All Charges.*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility is covered except for services in the Not Covered section of this document • Intravaginal insemination (IVI) ***Note:*** All infertility and related services require preauthorization	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 Option**	**Standard Option**
• 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) $30 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 Option**	**Standard Option**
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. 34. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis	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 Option**	**Standard Option**
• Intravenous (IV)/infusion therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) ***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; otherwise, we will only cover GHT services from the date you submit the inforamtion. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	20% of the Plan allowance after deductible	30% of the Plan allowance
Physical and Occupational therapies	**High Option**	**Standard Option**
The following therapies are covered: • Physical therapy • Occupational therapy • Cardiac rehabilitation ***Note:*** We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. The therapy must be provided by a licensed therapist or qualified physician. Benefits are limited to 60 visits or two consecutive months per person, per calendar year for physical, or occupational, or a combination of both. ***Note:***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).	$30 copayment for a specialist physician (No deductible)	$40 copayment for a specialist physician
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*

Benefit Description	You Pay	
Speech Therapy	**High Option**	**Standard Option**
Benefits are limited to 60 visits or two consecutive months per person, per calendar year.	$30 copayment for a specialist physician (No deductible)	$40 copayment for a specialist physician
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Hearing testing for children through age 22, as shown in *Preventive care, children;* • Hearing aids, as shown in *Orthopedic and prosthetic devices.*		
Not covered:	*All Charges*	*All Charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Routine vision exam covered 1 every 24 months • Bi-annual eye refractions	$20 copayment for a primary care physician (No deductible)	$20 copayment for a primary care physician
• Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 18	$30 copayment for a specialist physician (No deductible)	$40 copayment for a specialist physician
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% of the Plan allowance	30% of the Plan allowance
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 Option**	**Standard Option**
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 Option**	**Standard Option**
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 placed 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 • Surgically implanted penile prostheses to treat erectile dysfunction • Hearing aids and testing to fit them ***Note:***We provide benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b). ***Note:***Hearing aids are not subject to deductible and coinsurance ***Note:*** 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 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:	*All Charges*	*All Charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• *Shoes and over-the-counter orthotics* • *Arch supports* • *Heel pads and heel cups* • *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 Option**	**Standard Option**
Durable medical equipment (DME) is equipment and supplies that: • Are prescribed by your attending physician (i.e., the physician who is treatment 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, limited to $1,000 per calendar year.	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*	*All Charges*	*All Charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
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 Option**	**Standard Option**
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*
Chiropractic	**High Option**	**Standard Option**
• 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	$30 copayment for a specialist physician (No deductible)	$40 copayment for a specialist physician

Benefit Description	You Pay	
Alternative treatments	**High Option**	**Standard Option**
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 Option**	**Standard Option**
Coverage is provided for: • Smoking 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.
• Diabetes self management for one educational course • Childhood obesity education ***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*	*All charges*	*All charges*

Educational classes and programs - continued on next page

Benefit Description	You Pay	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
• *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 family). The calendar year deductible for Out-of-Network Providers is $1,000 per person ($3,000 per family). 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 amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in 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 Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Insertion of internal prosthetic devices. See 5(a) for *Orthopedic and prosthetic devisces* for device coverage information • Surgical treatment of severe obesity (bariatric surgery). ***Note:*** You must get prior approval for surgery for morbid obesity. For consideration for this surgery, several criteria must be met, such as:	$100 copayment (No deductible)	$200 copayment

Surgical procedures - continued on next page

Benefit Description	You Pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
- 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.qcark.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 Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance, and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are; protruding ear deformities, cleft lip, cleft palate, 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; - breast prostheses and surgical bras and replacements (see Prosthetic devices)	$100 copayment (No deductible)	$200 copayment

Reconstructive surgery - continued on next page

Benefit Description	You Pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
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 Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; 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 Option**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review. Refer to *Other services* in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- 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 reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma (Stage II or IV) - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myleogenous leukemia - Hemoglobinopathy - Marrow Failure and related Disorders (i.e. Fanconi's PNH, pure red cell aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- 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 reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (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 reoccurrence (relapsed) - Advanced non-Hodgkin's lymphona with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (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 - 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 - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Multiple myeloma • Mini-transplants (non-myeloblative autologous, reduced intensity conditioning or RIC) for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
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 Option**	**Standard Option**
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:** 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	Nothing	Nothing

Anesthesia - continued on next page

Benefit Description	You Pay	
Anesthesia (cont.)	**High Option**	**Standard Option**
• 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 family). The calendar year deductible for Out-of-Network Providers is $1,000 per person ($3,000 per family). 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 Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • 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
Not covered: • *Custodial care*	*All Charges*	*All Charges*

Inpatient hospital - continued on next page

Benefit Description	You Pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
• *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 Option**	**Standard Option**
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 (No deductible)	$200 copayment
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
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*
Hospice care	**High Option**	**Standard Option**
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	Nothing	Nothing

Hospice care - continued on next page

Benefit Description	You Pay	
Hospice care (cont.)	**High Option**	**Standard Option**
• 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 Option**	**Standard Option**
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 calendar year	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 family). The calendar year deductible for Out-of-Network Providers is $1,000 per person ($3,000 per family). 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.

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 Option**	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$20 copayment for a primary care physician (No deductible) $30 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.	$100 copayment (No deductible)	$100 copayment
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$20 copayment for a primary care physician (No deductible) $30 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.	$100 copayment (No deductible)	$100 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*

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 family). The calendar year deductible for Out-of-Network Providers is $1,000 per person ($3,000 per family). 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 PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

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 Option**	**Standard Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	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 Option**	**Standard Option**
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) $20 copayment for a specialist physician (No deductible)	$20 copayment for a primary care physician (No deductible) $20 copayment for a specialist physician (No deductible)
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner	$20 copayment for a primary care physician (No deductible) $20 copayment for a specialist physician (No deductible)	$20 copayment for a primary care physician (No deductible) $20 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 Option**	**Standard Option**
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 Option**	**Standard Option**
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

Benefit Description	You Pay After the calendar year deductible…	
Not Covered	**High Option**	**Standard Option**
• *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.
- **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**. Your prescription can be written by a licensed physician or dentist, or by another licensed health care provider, whose license includes the privilege of writing prescriptions.
- **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 2 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 1-800-235-7111.

- **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 (1-800-235-7111). 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 • Contraceptive drugs and devices ***Note:*** If there is no generic equivalent available, you will pay the copayment for the brand name drug prescribed.	**Retail Pharmacy** $0 Tier I $40 Tier II $60 Tier III **Self-Administered *Specialty* Drugs** $75 per formulary name brand $100 per non-formulary **Mail Order (90 day supply Maintenance medications only)** $0 Tier I $80 Tier II $120 Tier III	**Retail Pharmacy** $5 Tier I $40 Tier II $60 Tier III **Self-Administered *Specialty* Drugs** $75 per formulary name brand $100 per non-formulary **Mail Order (90 day supply Maintenance medications only)** $10 Tier I $80 Tier II $120 Tier III

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: 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 ***Note:*** Refer to pg. 25 for Specialty Drugs administered in a facility or office setting. *Refer to Section 10 Definitions for more information regarding Specialty Drugs and Maintenance Medications.*	**Retail Pharmacy** $0 Tier I $40 Tier II $60 Tier III **Self-Administered *Specialty* Drugs** $75 per formulary name brand $100 per non-formulary **Mail Order (90 day supply Maintenance medications only)** $0 Tier I $80 Tier II $120 Tier III	**Retail Pharmacy** $5 Tier I $40 Tier II $60 Tier III **Self-Administered *Specialty* Drugs** $75 per formulary name brand $100 per non-formulary **Mail Order (90 day supply Maintenance medications only)** $10 Tier I $80 Tier II $120 Tier III
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* • *Non prescription medications* ***Note:*** *Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Smoking 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 for In-Network Providers is $500 per person ($1,000 per family). The calendar year deductible for Out-of-Network Providers is $1,000 per person ($3,000 per family). 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.

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.	$30 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.	$30 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 traditional care and coordinate other benefits as a less costly alternative benefit. 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 cannot 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 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.
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.

Feature	Description
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(i)

Section 5(i). 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 $6,000 per person per calendar year or $18,000 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. 57 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 – things we don't 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 (see specifics regarding transplants).**

We do not cover the following:

- Care by non-plan providers except for Out-of-Network Point of Service benefits;
- 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 related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.
- Extra care costs or research costs associated with clinical trials.

Section 7. Filing a claim for covered services

There are four types of claims. Three of the four types - Urgent care claims, Pre-service claims, and Concurrent review claims - usually involve access to care where you need to request and receive our advance approval to receive coverage for a particular service or supply covered under this Brochure. See Section 3 for more information on these claims/requests and Section 10 for the definitions of these three types of claims.

The fourth type - Post-service claims - is the claim for payment of benefits after services or supplies have been received.

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, call us at 800-235-7111.

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 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); and
- Receipts, if you paid for your services.

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 31st of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Urgent care claims procedures

If you have an urgent care claim, please contact our Customer Service Department at QualChoice: 1-800-235-7111. Urgent care claims must meet the definition found in Section 10 of this brochure and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame from our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information, or (ii) 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 a written or electronic notification within three days of oral notification.

Concurrent care claims procedures

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 as an appealable decision. 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.

Pre-service claims procedures

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the 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 before the expiration of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

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

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department, and (2) your rquest names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we notify you before the expiration of the origianl 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.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Submit your Medical/Hospital and Prescription Drug claims to: QualChoice, PO Box 25610, Little Rock, AR 72221

Authorized Representative

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

Section 8. The disputed claims process

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3. You may be able to appeal to the U.S. Office of Personnel Management (OPM) immediately if we do not follow the particular requirements of this disputed claims process. For more information about situations in which you are entitled to immediately appeal and how to do so, please visit www.qualchoice.com.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

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) 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.

2 We have 30 days from the date we receive your request to:

a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care) or precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); or

b) Write to you and maintain our denial - go to step 4; or

c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

3 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.

In the case of an appeal of an urgent care claim, we will notify you of our decision not later than 72 hours after receipt of your reconsideration request. We will hasten 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.

4 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, Insurance Operations, Health Insurance HI 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; and
- Your email address (optional) if you would like to receive OPM's decision via email. Please note that by including an 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.

5 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 sue, 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 sue 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 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 (HI)3 at (202) 606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with 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' guidelines.

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.

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; and
- 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. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). 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. The notice will give you guidance on enrolling in Medicare Part D.

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 web site 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; and
- 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.

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), but 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.

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

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settelement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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, 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

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. These costs are covered by this plan.

- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan does not cover these costs.
- 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.

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

- 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.

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 15.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See pg 15.

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. 15.

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.

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

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 1-800-235-7111. 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. 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.

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 who 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 a *Guide to Federal Benefits,* 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; and
- 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

Several provisions of the Affordable Care Act (ACA) affect the eligibility of family members under the FEHB Program effective January 1, 2011.

Children	Coverage
Between ages 22 and 26	Children between the ages of 22 and 26 are covered under their parent's Self and Family enrollment up to age 26.
Married Children	Married children (but NOT their spouse or their own children) are covered up to age 26. This is true even if the child is currently under age 22.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.
Stepchildren	Stepchildren do not need to live with the enrollee in a parent–child relationship to be eligible for coverage up to age 26.
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.
Foster Children	Foster children are eligible for coverage up to age 26.

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

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children or stepchildren your employing or retirement office authorizes coverage for. 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 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 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 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 when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 26 turns 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.

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 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 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 and Family coverage 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 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 and Family 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. 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 2011 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 2010 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), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

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.

If you leave Federal 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.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of 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. The result can be a discount of 20% to more than 40% on services/products you 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 $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, 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) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **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 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) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) 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), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

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

Dental plans provide a comprehensive range of services, including all the following:

- 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 24-month waiting period

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and 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/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

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

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

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Summary of benefits for the High Option 2011

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
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $30 specialist	20
Services provided by a hospital:		
• Inpatient	$100 copayment per day up to a maximum of $500 per admission	40 - 41
• Outpatient	$100 copayment	40
Emergency benefits:		
• Medical emergency	$100 per Emergency Room visit	42-43
• Ambulance Services:	Ground: $100 copayment per trip; Air/Sea: $150 copayment per trip	41
Mental health and substance abuse treatment: (Pre-authorization required for all services)	Regular cost-sharing	44-46
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after $5,000 per contract per year; some costs do not count towards this protection	16
Prescription drugs:		
• Retail pharmacy	$0 Tier I, $40 Tier II, $60 Tier III	48
• Self-administered Specialty drugs	$75 Tier II, $100 Tier III	48
• Mail order	$0 Tier I, $80 Tier II, $120 Tier III	48

Summary of benefits for the Standard Option 2011

- 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
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $40 specialist	20
Services provided by a hospital:		
• Inpatient	$200 copayment per day up to a maximum of $1,000 per admission	39-40
• Outpatient	$200 copayment	40
Emergency benefits:		
• Medical emergency	$100 per Emergency Room visit	42-43
• Ambulance Services:	Ground: $100 copayment per trip; Air/Sea: $150 copayment per trip	41
Mental health and substance abuse treatment:	Regular cost-sharing	44-46
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after $5,000 per contract per year; some costs do not count toward this protection	16
Prescription drugs:		
• Retail pharmacy	$5 Tier I, $40 Tier II, $60 Tier III	48
• Self-administered Specialty drugs	$75 Tier II, $100 Tier III	48
• Mail order	$10 Tier I, $80 Tier II, $120 Tier III	48

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2011 Rate Information for QualChoice

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

Postal rates apply to career Postal Service employees. Most employees should refer to the Guide to Benefits *for Career* United States Postal Service Employees, RI 70-2, and to the rates shown below.

The rates shown below do not apply to *Post*al Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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. Refer to the applicable Guide to Federal Benefits.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	DH1	180.66	67.62	391.43	146.51	203.24	45.04
High Option Self and Family	DH2	403.98	177.45	875.29	384.48	454.48	126.95
Standard Option Self Only	DH4	145.24	48.41	314.69	104.89	163.63	30.02
Standard Option Self and Family	DH5	340.11	113.37	736.91	245.63	383.19	70.29