

This health insurance issuer believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to QualChoice at 501-228-7111. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.



This benefit summary is part of the Evidence of Coverage (EOC), Form QC POS/HDHP (10/1/10) and subject to all benefit terms and conditions, limitations and exclusions included in the Evidence of Coverage. This benefit summary is intended only to highlight your benefits and should not be relied upon solely to determine coverage. Please refer to the Evidence of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Evidence of Coverage is different than this benefit summary, the Evidence of Coverage prevails.

For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit our website at www.qualchoice.com

All benefit payments are based on the QualChoice Maximum Allowable Charge. Use of an Out-of-Network Provider may result in you being balance billed and higher out-of-pocket costs. Amounts in excess of the QualChoice Maximum Allowable Charge do not count toward annual Deductible or Coinsurance limits. See the "Member Financial Responsibility Comparison" section in the Evidence of Coverage.

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)		
Annual Deductible <ul style="list-style-type: none"> ▫ Co-payments are not included in the annual Deductible ▫ In-Network and Out-of-Network Deductibles apply separately ▫ Family Deductible is not considered satisfied until at least 3 separate family members have satisfied their individual Deductibles ▫ Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year ▫ The annual Deductible is calculated on a Calendar Year basis 	Individual: \$750 Family: \$2,250	Individual: \$1,500 Family: \$4,500		
Annual Out-of-Pocket Limit <ul style="list-style-type: none"> ▫ Applicable Coinsurance will apply until 3 separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit ▫ Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied ▫ Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits ▫ Co-payments do not apply toward your Out-of-Pocket Limit. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached ▫ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis 	Individual: \$4,000 Family: \$12,000	Individual: \$5,000 Family: \$15,000		
Coinsurance	20% after Deductible	40% after Deductible		
Preventive Care Services (Performed in the Office) : QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical policies. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.				
Immunizations, including flu and pneumonia vaccines Child Immunizations (age 0-18) Adult Immunizations (age 18+): <ul style="list-style-type: none"> ▫ Diphtheria and Tetanus toxoid for ages over 7 (Td), every 10 years ▫ Hepatitis B (Hep B) - once per lifetime ▫ Influenza, annually ▫ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▫ Zoster, adult 60 and older ▫ HPV (covered age 9-18, females only) <i>Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Evidence of Coverage (EOC).</i>			No Cost to You	
Routine vision exam (limit one (1) every 24 months)	\$25 Co-payment	Not Covered		
Well baby care, birth - to age 2	\$25 Co-payment	40% after Deductible		
Well child care, ages 2-18	\$25 Co-payment	40% after Deductible		
Other preventive services <ul style="list-style-type: none"> ▫ Annual physical ▫ Pap smear ▫ Screening mammogram (including breast exam) age 40 and over ▫ Prostate screenings for men age 40 and over ▫ Bone density screening tests, preventive for women age 65+ ▫ Fecal occult blood test annually 	PCP: \$25 Co-payment Specialist: \$45 Co-payment	40% after Deductible		
<ul style="list-style-type: none"> ▫ Flexible sigmoidoscopy once every 5 years; OR ▫ Double contrast barium enema once every 5 years; OR ▫ Preventive colonoscopy age 50 and older, once every 10 years 	20% after Deductible	40% after Deductible		
Smoking cessation <ul style="list-style-type: none"> ▫ Kick the Nic: smoking cessation; 12 week program <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	Not Covered		

Professional Services		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> ▫ Evaluation and management services ▫ Routine diagnostic services - lab & x-ray ▫ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▫ Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections 	\$25 Co-payment	40% after Deductible
Specialist Office Visit <ul style="list-style-type: none"> ▫ Evaluation and management services ▫ Routine diagnostic services - lab & x-ray ▫ Routine procedures, such as skin biopsy, shaving benign lesions and closures 	\$45 Co-payment	40% after Deductible
Professional services that are subject to Deductible and Coinsurance <ul style="list-style-type: none"> ▫ Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▫ Other procedures - chemotherapy, radiation therapy and infusion therapy ▫ Complex Injectable Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see "Outpatient Prescription Drug Benefit Summary") ▫ Complex procedures such as cystoscopy, colposcopy and invasive biopsies ▫ Services and procedures provided by a physician in a facility 	PCP: \$25 Co-payment or Specialist: \$45 Co-payment and 20% after Deductible	40% after Deductible
Inpatient Care - Room and Board		
<ul style="list-style-type: none"> ▫ Inpatient care - room and board ▫ Skilled Nursing and Inpatient Rehabilitation Services (combined 30 day limit per Calendar Year) 	20% after Deductible	40% after Deductible
Outpatient Care and Ambulatory Care Centers		
<ul style="list-style-type: none"> ▫ Outpatient Care and Ambulatory Care Centers ▫ Observation Services ▫ Diagnostic Services - Advanced imaging, Lab & X-Ray ▫ Hospice services (limited to a lifetime maximum of 180 days) ▫ Home Health Care (40 visits per Calendar Year) 	20% after Deductible	40% after Deductible
<ul style="list-style-type: none"> ▫ Outpatient Surgical Services 	20% after Deductible	40% after Deductible
Emergency Services		
<ul style="list-style-type: none"> ▫ Emergency Room, Urgent Care or ER Observation Services 	20% and \$200 Co-payment	20% and \$200 Co-payment
Transportation Services		
<ul style="list-style-type: none"> ▫ Ambulance - Ground or Air (\$1,000 maximum benefit per Calendar Year) 	20%	20%
<i>Note: Facility to facility ambulance transfer requires pre-authorization</i>		
Therapy Services		
<ul style="list-style-type: none"> ▫ Physical Therapy ▫ Occupational Therapy ▫ Speech Therapy and Audiology Testing ▫ Chiropractic Care ▫ Cardiac Rehabilitation (36 visits per Calendar Year) 	\$45 Co-payment	40% after Deductible
<i>Note: Therapy services are limited to a combined maximum of 30 visits per Calendar Year. This does not include Cardiac Rehabilitation</i>		



Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services		
▫ Routine Prenatal Lab	No Cost to You	40% after Deductible
▫ Initial Office Visit	\$25 Co-payment	40% after Deductible
▫ All other services	20% after Deductible	40% after Deductible
Facility Services	20% after Deductible	40% after Deductible
Infertility Diagnostic Services Only <i>Note: Treatment of infertility is not covered</i>	20% after Deductible	Not Covered
Mental Health and Substance Use Disorder Services		
▫ Inpatient Hospital Services	20% after Deductible	40% after Deductible
▫ Professional Services (Office/Outpatient Visits)	\$25 Co-payment	40% after Deductible
▫ Professional Services (Inpatient/Outpatient Facility)	20% after Deductible	40% after Deductible
Allergy Services		
▫ Office visit and Allergy Testing	PCP: \$25 Co-payment or Specialist: \$45 Co-payment	40% after Deductible
▫ Allergy Shots	No Cost to You	40% after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) ▫ \$2,000 maximum benefit per Calendar Year	20% after Deductible	Not Covered
Medical Supplies		
▫ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.	20% after Deductible	40% after Deductible
▫ Provided in connection with home infusion therapy		
▫ Provided in connection with Durable Medical Equipment	20% after Deductible	Not Covered
Prosthetic and Orthotic Services and Devices		
▫ Prosthetic Services and Prosthetic Devices	20% after Deductible	40% after Deductible
▫ Orthotic Services and Orthotic Devices		
<i>Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Evidence of Coverage for more information.</i>		
Reconstructive Surgery		
▫ Breast reconstruction following mastectomy	20% after Deductible	40% after Deductible
▫ Restoration due to acute trauma, infection or cancer		
<i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient or Outpatient charges, see Inpatient or Outpatient sections on page 2.</i>		
Transplantation Services		
▫ Physician/Professional charges	20% after Deductible	Not Covered
▫ Inpatient Charges	20% after Deductible	Not Covered
▫ Outpatient Charges	20% after Deductible	Not Covered
<i>Note: Lifetime maximum of two transplants</i>		
Diabetes Management Services		
▫ Insulin Pumps (\$5,500 benefit maximum per Calendar Year)	20% after Deductible	Not Covered
▫ Supplies and equipment (Subject to \$2,000 DME limit)	20% after Deductible	Not Covered
▫ Diabetic Education (1 training per lifetime)	\$45 Co-payment	40% after Deductible
Dental Care		
▫ Accidental injury to sound and natural teeth	20% after Deductible	40% after Deductible
▫ \$2,000 maximum benefit per accident		
Medical Foods for Phenylketonuria		
▫ Benefits available after member has paid \$2,400 per year	20% after Deductible	40% after Deductible
Genetic Counseling and Testing	20% after Deductible	40% after Deductible
<i>Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.</i>	No benefits if not pre-authorized	No benefits if not pre-authorized



This benefit summary is part of the Evidence of Coverage (EOC), Form QC POS (10/1/10) as amended by FIRST AMENDMENT with Autism to QCA POS (10-1-10) EOC (8-1-2011) and subject to all benefit terms and conditions, limitations and exclusions included in the Evidence of Coverage. This benefit summary is intended only to highlight your benefits and should not be relied upon solely to determine coverage. Please refer to the Evidence of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Evidence of Coverage is different than this benefit summary, the Evidence of Coverage prevails.

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Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible <ul style="list-style-type: none"> ▫ Co-payments are not included in the annual Deductible ▫ In-Network and Out-of-Network Deductibles apply separately ▫ Family Deductible is not considered satisfied until at least 3 separate family members have satisfied their individual Deductibles ▫ Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year ▫ The annual Deductible is calculated on a Calendar Year basis 	Individual: \$1,000 Family: \$3,000	Individual: \$2,000 Family: \$6,000
Annual Out-of-Pocket Limit <ul style="list-style-type: none"> ▫ Applicable Coinsurance will apply until 3 separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit ▫ Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied ▫ Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits ▫ Co-payments do not apply toward your Out-of-Pocket Limit. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached ▫ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis 	Individual: \$4,000 Family: \$12,000	Individual: \$8,000 Family: \$24,000
Coinsurance	20% after Deductible	40% after Deductible
Preventive Care Services (Performed in the Office) :		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical policies. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines Child Immunizations (age 0-18) Adult Immunizations (age 18+): <ul style="list-style-type: none"> ▫ Diphtheria and Tetanus toxoid for ages over 7 (Td), every 10 years ▫ Hepatitis B (Hep B) - once per lifetime ▫ Influenza, annually ▫ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▫ Zoster, adult 60 and older ▫ HPV (covered age 9-18, females only) <i>Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Evidence of Coverage (EOC).</i>	No Cost to You	
Routine vision exam (limit one (1) every 24 months)	\$25 Co-payment	Not Covered
Well baby care, birth - to age 2	No Cost to You	Not Covered
Well child care, ages 2-18	No Cost to You	Not Covered
Other preventive services <ul style="list-style-type: none"> ▫ Annual physical ▫ Pap smear ▫ Screening mammogram (including breast exam) age 40 and over ▫ Prostate screenings for men age 40 and over ▫ Bone density screening tests, preventive for women age 65+ ▫ Fecal occult blood test annually 	No Cost to You	Not Covered
<ul style="list-style-type: none"> ▫ Flexible sigmoidoscopy once every 5 years; OR ▫ Double contrast barium enema once every 5 years; OR ▫ Preventive colonoscopy age 50 and older, once every 10 years 	No Cost to You	Not Covered

Preventive Care Services, continued		
Family Planning <ul style="list-style-type: none"> ▫ Tubal ligation and associated services (reversal of sterilization is not a covered benefit) ▫ Insertion or implantation of birth control pellets, capsules or IUDs ▫ Fitting and insertion of diaphragms, rings or caps ▫ Injection of long acting contraceptives 	No Cost to You	Not Covered
Smoking cessation <ul style="list-style-type: none"> ▫ Kick the Nic: smoking cessation; 12 week program <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> ▫ Evaluation and management services ▫ Routine diagnostic services - lab & x-ray ▫ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▫ Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections 	\$25 Co-payment	40% after Deductible
Specialist Office Visit <ul style="list-style-type: none"> ▫ Evaluation and management services ▫ Routine diagnostic services - lab & x-ray ▫ Routine procedures, such as skin biopsy, shaving benign lesions and closures 	\$45 Co-payment	40% after Deductible
Professional services that are subject to Deductible and Coinsurance <ul style="list-style-type: none"> ▫ Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▫ Other procedures - chemotherapy, radiation therapy and infusion therapy ▫ Complex Injectable Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see "Outpatient Prescription Drug Benefit Summary") ▫ Complex procedures such as cystoscopy, colposcopy and invasive biopsies ▫ Services and procedures provided by a physician in a facility 	PCP: \$25 Co-payment or Specialist: \$45 Co-payment and 20% after Deductible	40% after Deductible
Inpatient Care - Room and Board		
<ul style="list-style-type: none"> ▫ Inpatient care - room and board ▫ Skilled Nursing and Inpatient Rehabilitation Services (combined 30 day limit per Plan Year) 	20% after Deductible	40% after Deductible
Outpatient Care and Ambulatory Care Centers		
<ul style="list-style-type: none"> ▫ Outpatient Care and Ambulatory Care Centers ▫ Observation Services ▫ Diagnostic Services - Advanced imaging, Lab & X-Ray ▫ Hospice services (limited to a lifetime maximum of 180 days) ▫ Home Health Care (40 visits per Plan Year) 	20% after Deductible	40% after Deductible
<ul style="list-style-type: none"> ▫ Outpatient Surgical Services 	20% after Deductible	40% after Deductible
Emergency Services		
<ul style="list-style-type: none"> ▫ Emergency Room, Urgent Care or ER Observation Services 	\$200 Co-payment	\$200 Co-payment
Transportation Services		
<ul style="list-style-type: none"> ▫ Ambulance - Ground or Air (\$1,000 maximum benefit per Plan Year) <i>Note: Facility to facility ambulance transfer requires pre-authorization</i>	20%	20%
Therapy Services		
<ul style="list-style-type: none"> ▫ Physical Therapy ▫ Occupational Therapy ▫ Speech Therapy and Audiology Testing ▫ Chiropractic Care ▫ Cardiac Rehabilitation (36 visits per Plan Year) <i>Note: Therapy services are limited to a combined maximum of 30 visits per Plan Year. This does not include Cardiac Rehabilitation</i>	\$45 Co-payment	40% after Deductible



Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services		
▫ Routine Prenatal Lab	No Cost to You	40% after Deductible
▫ Initial Office Visit	\$25 Co-payment	40% after Deductible
▫ All other services	20% after Deductible	40% after Deductible
Facility Services	20% after Deductible	40% after Deductible
Infertility Diagnostic Services Only <i>Note: Treatment of infertility is not covered</i>	20% after Deductible	Not Covered
Mental Health and Substance Use Disorder Services		
▫ Inpatient Hospital Services	20% after Deductible	40% after Deductible
▫ Professional Services (Office/Outpatient Visits)	\$25 Co-payment	40% after Deductible
▫ Professional Services (Inpatient/Outpatient Facility)	20% after Deductible	40% after Deductible
Allergy Services		
▫ Office visit and Allergy Testing	PCP: \$25 Co-payment or Specialist: \$45 Co-payment	40% after Deductible
▫ Allergy Shots	No Cost to You	40% after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) ▫ \$2,000 maximum benefit per Calendar Year	20% after Deductible	Not Covered
Medical Supplies ▫ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately. ▫ Provided in connection with home infusion therapy ▫ Provided in connection with Durable Medical Equipment	20% after Deductible	40% after Deductible
Prosthetic and Orthotic Services and Devices ▫ Prosthetic Services and Prosthetic Devices ▫ Orthotic Services and Orthotic Devices <i>Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Evidence of Coverage for more information.</i>	20% after Deductible	40% after Deductible
Reconstructive Surgery ▫ Breast reconstruction following mastectomy ▫ Restoration due to acute trauma, infection or cancer <i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient or Outpatient charges, see Inpatient or Outpatient sections on page 2.</i>	20% after Deductible	40% after Deductible
Transplantation Services ▫ Physician/Professional charges	20% after Deductible	Not Covered
▫ Inpatient Charges	20% after Deductible	Not Covered
▫ Outpatient Charges	20% after Deductible	Not Covered
<i>Note: Lifetime maximum of two transplants</i>		
Diabetes Management Services ▫ Insulin Pumps (\$5,500 benefit maximum per Calendar Year) ▫ Supplies and equipment (Subject to \$2,000 DME limit) ▫ Diabetic Education (1 training per lifetime)	20% after Deductible 20% after Deductible \$45 Co-payment	Not Covered Not Covered 40% after Deductible
Dental Care ▫ Accidental injury to sound and natural teeth ▫ \$2,000 maximum benefit per accident	20% after Deductible	40% after Deductible
Medical Foods for Phenylketonuria ▫ Benefits available after member has paid \$2,400 per year	20% after Deductible	40% after Deductible
Genetic Counseling and Testing <i>Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.</i>	20% after Deductible No benefits if not pre-authorized	40% after Deductible No benefits if not pre-authorized

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Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Deductible <ul style="list-style-type: none"> ▪ Co-payments are not included in the Deductible ▪ In-Network and Out-of-Network Deductibles apply separately ▪ Family Deductible is not considered satisfied until at least 3 separate family members have satisfied their individual Deductibles ▪ Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year ▪ The Deductible is calculated on a Calendar Year basis 	Individual: \$1,000 Family: \$3,000	Individual: \$2,000 Family: \$6,000
Annual Out-of-Pocket Limit <ul style="list-style-type: none"> ▪ Annual Out-of-Pocket Limit includes Deductible ▪ Applicable Coinsurance will apply until 3 separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit ▪ Benefits will be paid at 100% of the Maximum Allowable Charge once the family Annual Out-of-Pocket Limit is satisfied ▪ Annual Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits ▪ Co-payments do not apply toward your Annual Out-of-Pocket Limit. You will continue to be responsible for Co-payments once the Annual Out-of-Pocket Limit is reached ▪ Annual Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis 	Individual: \$5,000 Family: \$18,000	Individual: \$10,000 Family: \$30,000
Maximum Out-of-Pocket Limit for Essential Health Benefits <ul style="list-style-type: none"> ▪ The Maximum Out-of-Pocket Limit is the most that you could pay for covered In-Network Essential Health Benefits in a calendar year ▪ Maximum Out-of-Pocket Limit includes Deductible, Coinsurance and medical Co-payments for Essential Health Benefits 	Individual: \$6,350 Family: \$12,700	Not applicable
Coinsurance	20% after Deductible	40% after Deductible
Preventive Care Services (Performed in the Office): QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical policies. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies. <i>Note: Refer to QualChoice Medical Policies for complete list and access rules for Immunizations.</i>		
Immunizations, including flu and pneumonia vaccines Child Immunizations (age 0-18) Adult Immunizations (age 18+) <ul style="list-style-type: none"> ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually (see Medical Policy) ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older <i>Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Evidence of Coverage (EOC).</i>	No Cost to You	
Routine vision exam (limit 1 every 24 months)	\$25 Co-payment	Not Covered
Well child care, birth through age 18	No Cost to You	Not Covered
Other preventive services <ul style="list-style-type: none"> ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over 	No Cost to You	Not Covered

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
<ul style="list-style-type: none"> Bone density screening tests, preventive for women age 65+ Colon Cancer screening, age 50 and older (diagnostic testing at any age, see Outpatient Care for cost sharing) <ul style="list-style-type: none"> Fecal occult blood test annually Flexible sigmoidoscopy once every 5 years; OR Double contrast barium enema once every 5 years; OR Preventive colonoscopy age 50 and older, once every 10 years 	No Cost to You	Not Covered
Family Planning <ul style="list-style-type: none"> Tubal ligation and associated services (reversal of sterilization is not a covered benefit) Insertion or implantation of birth control pellets, capsules or IUDs Fitting and insertion of diaphragms, rings or caps Injection of long acting contraceptives 	No Cost to You	Not Covered
Smoking cessation <ul style="list-style-type: none"> Kick the Nic: smoking cessation; 12 week program <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	Not Covered
Professional Services NOTE: Refer to QualChoice Medical Policies at www.qualchoice.com for a list of routine procedures.		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> Evaluation and management services Routine diagnostic services Routine procedures Routine Injectable Prescription Medications 	\$25 Co-payment	40% after Deductible
Specialist Office Visit <ul style="list-style-type: none"> Evaluation and management services Routine diagnostic services Routine procedures 	\$45 Co-payment	40% after Deductible
Professional services that are subject to Deductible and Coinsurance (in addition to the office Co-payment) <ul style="list-style-type: none"> Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests, complex labwork Other procedures, such as chemotherapy, radiation and infusion therapy Complex Injectable Prescription Medications which include: All specialty medications not covered under the pharmacy benefit, such as Enbrel®, Humira®, IV medications and high potency antibiotics Complex procedures such as cystoscopy, colposcopy and invasive biopsies Services and procedures provided by a physician in a facility 	PCP: \$25 Co-payment Specialist: \$45 Co-payment and 20% after Deductible	40% after Deductible
Inpatient Care - Room and Board		
<ul style="list-style-type: none"> Inpatient care - room and board Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per Calendar Year) 	20% after Deductible	40% after Deductible
Outpatient Care and Ambulatory Care Centers		
<ul style="list-style-type: none"> Outpatient Care and Ambulatory Care Centers Observation Services, whether in an emergency department or hospital Diagnostic Services - Advanced imaging, Lab & X-Ray Hospice services (limited to a lifetime maximum of 180 days) Home HealthCare (40 visits per Calendar Year) Outpatient Surgical Services 	20% after Deductible	40% after Deductible
Emergency Services		
<ul style="list-style-type: none"> Emergency Room or ER Observation Services Urgent Care 	\$200 Co-payment and 20% \$200 Co-payment and 20%	\$200 Co-payment and 20% 40% after Deductible
Transportation Services		
<ul style="list-style-type: none"> Ambulance - Ground - \$1,000 Benefit Maximum per trip Ambulance - Air \$5,000 Benefit Maximum per trip <i>Note: Ambulance is only covered if it is deemed Medically Necessary by QualChoice, and only to the closest appropriate facility. Travel by air ambulance will only be covered if such travel will result in quicker arrival at the closest appropriate facility and if the difference in travel time is likely to improve patient outcome. Facility to facility ambulance transfer requires pre-authorization.</i>	20% 20%	20% 20%
Rehabilitation Services		
<ul style="list-style-type: none"> Physical Therapy Occupational Therapy Speech Therapy and Audiology Testing Chiropractic Care Cardiac Rehabilitation (36 visits per Calendar Year) <i>Note: Therapy services are limited to a combined maximum of 30 visits per Calendar Year. This does not include Cardiac Rehabilitation</i>	\$45 Co-payment	40% after Deductible

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services <ul style="list-style-type: none"> Routine Prenatal Lab Initial Office Visit All other services 	No Cost to You \$25 Co-payment 20% after Deductible	40% after Deductible
Facility Services	20% after Deductible	40% after Deductible
Infertility Diagnostic Services Only <i>Note: Treatment of infertility is not covered.</i>	20% after Deductible	Not Covered
Mental Health and Substance Use Disorder Services		
<ul style="list-style-type: none"> Inpatient Hospital Services Professional Services (Office/Outpatient Visits) Professional Services (Inpatient/Outpatient Facility) 	20% after Deductible \$45 Co-payment 20% after Deductible	40% after Deductible
Allergy Services		
<ul style="list-style-type: none"> Office Visit and Allergy Testing Allergy Shots Serum 	\$45 Co-payment No Cost to You 20% after Deductible	40% after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) <ul style="list-style-type: none"> \$2,000 Benefit Maximum per Calendar Year for non Essential Health Benefit DME <i>Note: There are some DME items that are excluded from the Maximum Out-of-Pocket for Essential Health Benefits. Refer to QualChoice Medical Policies for a list of items and coverage limits at www.qualchoice.com.</i>	20% after Deductible	Not Covered
Medical Supplies <ul style="list-style-type: none"> Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately. Provided in connection with home infusion therapy Provided in connection with Durable Medical Equipment 	20% after Deductible 20% after Deductible	40% after Deductible Not Covered
Prosthetic and Orthotic Services and Devices <ul style="list-style-type: none"> Prosthetic Services and Prosthetic Devices Orthotic Services and Orthotic Devices <i>Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. Refer to QualChoice Medical Policies for more information: qualchoice.com</i>	20% after Deductible	40% after Deductible
Reconstructive Surgery <ul style="list-style-type: none"> Breast reconstruction following mastectomy Restoration due to acute trauma, infection or cancer <i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient or Outpatient charges, see Inpatient or Outpatient sections on page 2.</i>	20% after Deductible	40% after Deductible
Transplantation Services <ul style="list-style-type: none"> Physician/Professional charges Inpatient and Outpatient Charges <i>Note: Lifetime maximum of two transplants</i>	20% after Deductible	Not Covered
Diabetes Management Services <ul style="list-style-type: none"> Insulin Pumps (\$5,500 Benefit Maximum per pump) Supplies and equipment-(Subject to \$2,000 DME limit) Diabetic Education (1 training per lifetime) 	20% after Deductible \$45 Co-payment	Not Covered 40% after Deductible
Dental Care <ul style="list-style-type: none"> Accidental injury to sound and natural teeth \$2,000 Benefit Maximum per accident <i>NOTE: See Evidence of Coverage for terms, conditions and limits.</i>	20% after Deductible	40% after Deductible
Medical Foods for Inborn Diseases of Metabolism <ul style="list-style-type: none"> Benefits available after member has paid \$2,400 per year 	20% after Deductible	40% after Deductible
Genetic Counseling and Testing <i>Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.</i>	No benefits if not pre-authorized 20% after Deductible	No benefits if not pre-authorized 40% after Deductible