This Benefit Summary is part of the Evidence of Coverage Certificate (Certificate), Form QCLHIC PPO LG NGF EOC (1-2021). It is subject to all Benefit terms and conditions, limitations and exclusions included in the Certificate. It is meant only to highlight your Benefits and should not be relied upon solely to determine coverage. Please refer to the Certificate 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 Certificate is different than that in this Benefit Summary, the Certificate 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 Covered Services are subject to the Deductible and Coinsurance, unless otherwise specified in this Benefit Summary or Certificate.

All Benefit payments are based on the QualChoice Maximum Allowable Charge. Use of an Out-of-Network Provider may result in balance billing costs to you as well as higher out-of-pocket costs. Amounts in excess of the QualChoice Maximum Allowable Charge do not count toward the Deductible or Out-of- Pocket limits. See the "Member Financial Responsibility Comparison" section in the Certificate.

Medical Benefits and Covered Services	**In-Network** (You Pay)	**Out-of-Network** (You Pay)
Annual Deductible		
• The Deductible is calculated on a Calendar Year basis. • In-Network and Out-of-Network Deductibles apply separately. • The Deductible amounts applied in the last quarter of a Calendar Year will carryover to the next Calendar Year. • Coinsurance and Copayments are not included in the Deductible. • All Individual Deductible amounts will count toward the satisfaction of the family Deductible, but an individual will not have to pay more than the Individual Deductible amount.	Individual: $5,000 Family: $10,000	Individual: $7,500 Family: $15,000
Maximum Out-of-Pocket Limit		
• The Out-of-Pocket Limit is calculated on a Calendar Year basis. • Applicable Coinsurance will apply until the Maximum Out-of-Pocket is met. • Out-Of-Pocket Limit includes Deductible, Coinsurance and Copayments. • Benefits will be paid at 100% of the Maximum Allowable Charge once the Individual or Family Out-of-Pocket Limit is satisfied, whichever applies. • All individual Out-of-Pocket amounts will count toward the satisfaction of the Family Out-of-Pocket Limit, but an Individual will not have to pay more than the Individual Out-of-Pocket Limit for covered charges. • Maximum Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits.	Individual: $6,350 Family: $12,700	Individual: $12,700 Family: $25,400

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Immunizations[1] (see QualChoice Medical Coverage Policies for covered immunizations)		
Adult (age 19 and older)	No Cost to You	Not Covered
Child (age 0-19)	No Cost to You	Not Covered
Preventive Services[2]		
Annual Physical	No Cost to You	Not Covered
Pap Smear (1 per 3 years)	No Cost to You	Not Covered
Screening Mammogram (including breast exam) for women age 40 and older	No Cost to You	Not Covered
Prostate Screening for men age 40 and older	No Cost to You	Not Covered
Bone Density Sreening for women age 65 and older	No Cost to You	Not Covered
Colon Cancer Screening, age 50 and older	No Cost to You	Not Covered
Family Planning		
Tubal Ligation and Associated Services	No Cost to You	Not Covered
Insertion or Implantation, or Removal of Birth Control Pellets, Capsules or IUDs	No Cost to You	Not Covered
Fitting and Insertion of Diaphragms, Rings or Caps	No Cost to You	Not Covered
Injection of Long Acting Contraceptives	No Cost to You	Not Covered
Primary Care Provider Office Visit		
Evaluation/Management/Telemedicine	$35 Copayment	50% after Deductible
Routine Care	No Cost to You	50% after Deductible
Complex Care	30%	50% after Deductible
Advanced Care	30% after Deductible	50% after Deductible
Specialist Provider Office Visit		
Evaluation/Management	$50 Copayment	50% after Deductible
Routine Care	No Cost to You	50% after Deductible
Complex Care	30%	50% after Deductible
Advanced Care	30% after Deductible	50% after Deductible
Inpatient Care		
Physician Services	30% after Deductible	50% after Deductible
Room and Board	30% after Deductible	50% after Deductible
Skilled Nursing and Inpatient Rehabilitation (30 days per member per Calendar Year)	30% after Deductible	50% after Deductible
Neurological Rehabilitation Facility Services (60 days lifetime maximum)	30% after Deductible	50% after Deductible
Outpatient Care		
Physician Services	30% after Deductible	50% after Deductible
Facility Services	30% after Deductible	50% after Deductible
Observation Services	30% after Deductible	50% after Deductible
Diagnostic Services[3]	30% after Deductible	50% after Deductible
Hospice Services	30% after Deductible	50% after Deductible
Surgical Services	30% after Deductible	50% after Deductible
Home Health Care - 40 visit limit per Calendar Year	30% after Deductible	50% after Deductible
Emergency Services		
Emergency Room	$100 Copayment	$100 Copayment
Urgent Care	$50 Copayment	50% after Deductible
Transportation Services[5]		
Ground and Water Ambulance - $1,000 per trip	30%	30%
Air Ambulance - $5,000 per trip	30%	30%

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Rehabilitation Services (Combined 30 visits per Calendar Year excluding cardiac rehab) Therapy services provided and billed by a licensed Physical, Occupational or Speech Therapist is a PCP Copayment.		
Physical therapy	$50 Copayment	50% after Deductible
Occupational therapy	$50 Copayment	50% after Deductible
Speech therapy and Audiology testing	$50 Copayment	50% after Deductible
Chiropractic care	$50 Copayment	50% after Deductible
Cardiac rehab (36 visits per Calendar Year)	$50 Copayment	50% after Deductible
Maternity Services		
Initial Office Visit All other services are subject to your inpatient and outpatient Benefits	$35 Copayment	50% after Deductible
Infertility Diagnostic Services only	30% after Deductible	50% after Deductible
Infertility Treatment (limited to 1 cycle of in vitro fertilization treatment per lifetime)	30% after Deductible	50% after Deductible
Mental Health and Substance Abuse Disorder[3]		
Office Visit - Consultation, Evaluation and Psychotherapy	$50 Copayment	50% after Deductible
Outpatient (other services and procedures provided in office or outpatient facility)	30% after Deductible	50% after Deductible
Partial Hospitalization	30% after Deductible	50% after Deductible
Inpatient Physician Services	30% after Deductible	50% after Deductible
Inpatient Facility Services	30% after Deductible	50% after Deductible
Allergy Services		
Office Visit	$50 Copayment	50% after Deductible
Allergy Testing	No Cost to You	50% after Deductible
Allergy Shots	No Cost to You	50% after Deductible
Allergy Serum	30% after Deductible	50% after Deductible
Medical Supplies		
Provided in a Physician's Office	30% after Deductible	50% after Deductible
Home Infusion Therapy Supplies	30% after Deductible	50% after Deductible
Transplantation Services[7] Lifetime maximum of 2 transplants		
Inpatient Physician Services	30% after Deductible	Not Covered
Inpatient Facility Services	30% after Deductible	Not Covered
Outpatient Care	30% after Deductible	Not Covered
Diabetes Management Services		
Supplies[6] and Equipment	30% after Deductible	Not Covered
Insulin Pump	30% after Deductible	Not Covered
Diabetic Education (1 training per lifetime)	$50 Copayment	50% after Deductible
Other Medical Services		
Durable Medical Equipment and Related Supplies	30% after Deductible	Not Covered
Home Phototherapy Devices	$100 Copayment	Not Covered
Genetic Counseling	30% after Deductible	50% after Deductible
Genetic Testing	30% after Deductible	Not Covered
Prosthetic and Orthotic Devices (1 per 3 years unless medically necessary)	30% after Deductible	50% after Deductible

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Other Medical Services		
Hearing Aids ($1,400 per ear)[4]	Not Covered	Not Covered
Temporomandibular Joint Disorder	Not Covered	Not Covered
Smoking Cessation (two 12-week programs per Calendar Year)	No Cost to You	Not Covered
Vision		
Routine Vision Exam (1 per 24 months, age 19 and older)	$35 Copayment	Not Covered
Routine Pediatric Vision Exam (1 per 24 months, up to age 19)	$35 Copayment	Not Covered
Glasses (lenses and frames) (1 per 24 months, up to age 19)	Not Covered	Not Covered
Dental		
Accidental Injury ($2,000 per accident)[4]	30% after Deductible	30% after Deductible
Cleaning (1 per 6 months, up to age 19)	Not Covered	Not Covered
Exam (1 per 6 months, up to age 19)	Not Covered	Not Covered
Basic Services (up to age 19)	Not Covered	Not Covered
Major Services (up to age 19)	Not Covered	Not Covered
Orthodontic Services	Not Covered	Not Covered
Prescription Drugs[8]		
Deductible	Not Applicable	Not Applicable
Tier 1	$10 Copayment	Not Covered
Tier 2	$35 Copayment	Not Covered
Tier 3	$60 Copayment	Not Covered
Tier 5	$100 Copayment	Not Covered

[1]If not Medically Necessary, not a Covered Service, or in excess of the Benefits otherwise provided by your Certificate, immunizations for travel, school, work, or recreation are not covered. Refer to QualChoice Medical Coverage Policies for complete list and access rules for immunizations.

[2]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 Coverage 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 Coverage Policies.

[3]Out-of-Network drug testing is not covered.

[4]This Benefit is limited to the Maximum Allowable Charge or the applicable limit in this Benefit Summary, whichever is less, and is subject to member Cost Sharing Amounts.

[5]This Benefit is limited to the Maximum Allowable Charge or the applicable limit in this Benefit Summary, whichever is less, and is subject to member Cost Sharing Amounts.

Ambulance is only covered if it is deemed Medical 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 outcome.

[6]Combinations of either test strips and lancets or insulin and syringes are covered under the pharmacy Benefit and treated as a single prescription with a single pharmacy Copayment.

[7]All transplants and transplant-related services must be coordinated by QualChoice, performed at a facility approved by QualChoice, and will be paid at the in-network Benefit level.

[8]Prescription Benefit Limitations

· Retail Pharmacy - One (1) monthly cost sharing amount per 30 day supply
· Mail Order Pharmacy - Three (3) monthly cost sharing amount per 90 day supply

Additional Information regarding your Prescription Benefit:

· Non-maintenance medications are limited to a 30 day supply. Maintenance medications, retail or mail order, available up to a 90 day supply.
· Insulin and syringes will be covered with one (1) monthly cost sharing amount for each 30 day supply, if filled at the same time.
· Test strips and lancets will be covered with one (1) monthly cost sharing amount for each 30 day supply, if filled at the same time.
· Contact a Health Coach at 1-888-795-6810, if you need assistance obtaining a new glucometer.
· Step Therapy - Certain medication may be required to be used before another medication is covered. Step therapy is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other therapy is the first line medication fails. Contact Customer Service at 1-800-235-7111 for more details.