

SERFF Tracking Number: QUAC-127138294 State: Arkansas
Filing Company: QualChoice Life and Health Insurance Company, State Tracking Number: 48564
Inc.
Company Tracking Number:
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.005 Plan F (Basic) 2010
Standard Plans 2010
Product Name: MediQ65 Medicare Supplement Insurance Plan F
Project Name/Number: /

Filing at a Glance

Company: QualChoice Life and Health Insurance Company, Inc.

Product Name: MediQ65 Medicare Supplement SERFF Tr Num: QUAC-127138294 State: Arkansas
Insurance Plan F

TOI: MS08I Individual Medicare Supplement - SERFF Status: Closed-Approved- State Tr Num: 48564
Standard Plans 2010 Closed

Sub-TOI: MS08I.005 Plan F (Basic) 2010 Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Stephanie Fowler

Author: Jim Couch

Date Submitted: 04/22/2011

Disposition Date: 05/18/2011

Disposition Status: Approved-Closed

Implementation Date Requested: 06/01/2011

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments: Not Applicable

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 05/18/2011

State Status Changed: 05/18/2011

Deemer Date:

Created By: Jim Couch

Submitted By: Jim Couch

Corresponding Filing Tracking Number:

Filing Description:

Filing of Plan F Medicare Supplement Insurance

Company and Contact

Filing Contact Information

Jim Couch, VP of Compliance

jim.couch@qualchoice.com

12615 Chenal Parkway, Suite 300

501-228-7111 [Phone] 5118 [Ext]

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Little Rock, AR 72211 501-707-6729 [FAX]

Filing Company Information

QualChoice Life and Health Insurance Company, Inc.	CoCode: 70998	State of Domicile: Arkansas
12615 Chenal Parkway, Suite 300	Group Code:	Company Type: Life & Health
Little Rock, AR 72211	Group Name:	State ID Number:
(501) 228-7111 ext. [Phone]	FEIN Number: 71-0386640	

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
QualChoice Life and Health Insurance Company, Inc.	\$0.00	04/22/2011	

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	05/18/2011	05/18/2011

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	05/13/2011	05/13/2011

Response Letters

Responded By	Created On	Date Submitted
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Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Rate	Rates and Factors Summary	Jim Couch	05/18/2011	05/18/2011
Form	MediQ65 Supplement Insurance Plan F	Jim Couch	05/18/2011	05/18/2011

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Disposition

Disposition Date: 05/18/2011

Implementation Date:

Status: Approved-Closed

Comment: This approval is subject to the following:

- Increases will not be given more frequently than once in a twelve-month period;
- The insured shall be notified by the insurer of its intention to increase the rate for renewal not less than thirty (30) days prior to the effective date of the renewal.

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form (revised)	MediQ65 Supplement Insurance Plan F	Approved-Closed	Yes
Form	MediQ65 Supplement Insurance Plan F	Disapproved	No
Rate	Actuarial Certificate	Approved-Closed	No
Rate	Rates and Factors Summary	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 05/13/2011
Submitted Date 05/13/2011
Respond By Date 06/13/2011

Dear Jim Couch,

This will acknowledge receipt of the captioned filing.

Objection 1

- MediQ65 Supplement Insurance Plan F, QCLHIC Medicare Supplement Plan F April 2011 (Form)

Comment: 1. Cover page - INCREASE IN PREMIUMS - please revise this paragraph to only allow the insured's rates to be increased only once per year starting on or after the anniversary date. This information also needs to be revised in any other related area of this filing.

2. Cover page - INCREASE IN PREMIUMS - please revise this paragraph to only allow the insured's rates to be increased only once per year starting on or after the anniversary date. This information also needs to be revised in any other related area of this filing.

3. Section 3 – Eligibility – Item 3 – Please add language to clarify that the medical criteria does not apply to people that are in their open enrollment or in a guaranteed issue period.

Objection 2

- Actuarial Certificate, [] (Rate)

Comment: I know that we previously discussed how to present the rates for this product, but upon further investigation I have found that the rates do need to be attached separately from the Outline of Coverage. Please also attach the rate factors for the different rating areas.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

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Amendment Letter

Submitted Date: 05/18/2011

Comments:

Adding rate and factors summary per your request.

Changed Items:

Rate/Rule Schedule Item Changes:

Document Name:	Affected Form Numbers: (Comma Separated list)	Rate Action:	Rate Action Information:	Attach Document:
Rates and Factors Summary		New		MediQ65 Rate and Rate Form Summary May 2011.pdf
MediQ65 Rate and Rate Form Summary May 2011.pdf				

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Amendment Letter

Submitted Date: 05/18/2011

Comments:

Modified Plan F Certificate per your instructions.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
QCLHIC Medicare Supplement Plan F April 2011	Policy/Contract/Fraternal Certificate	MediQ65 Supplement Insurance Plan F	Initial					MediQ65 Coverage Certificate Plan F Final Updated May 2011.pdf

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/18/2011	QCLHIC Medicare Supplement Plan F April 2011	Policy/Cont ract/Fratern Supplemental Certificate	MediQ65 Insurance Plan F	Initial			MediQ65 Coverage Certificate Plan F Final Updated May 2011.pdf



**QualChoice Life and Health Insurance Company, Inc. ° The QualChoice Building
12615 Chenal Parkway ° Suite 300 ° Little Rock, AR 72211 ° Toll Free (855) 633-4765**

MEDICARE SUPPLEMENT CERTIFICATE

PLAN F

On your payment of Premium and the issue of this Certificate, QualChoice Life and Health Insurance Company, Inc. agrees to provide the benefits described in this Certificate for Covered Services received while this Certificate is in force. All benefits are subject to the definitions, provisions, limitations, and exceptions described in this Certificate.

NOTICE TO BUYER: THIS COVERAGE MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES

YOUR RIGHTS TO CANCEL

If you are not satisfied with this Certificate for any reason, you can return it within 30 days after you receive it. This Certificate will then be void. We will refund all payments you have made on it. We can collect from you all costs for Covered Services that you received and we paid, plus our cost of recovering those Charges (including attorney's fees).

GUARANTEED RENEWABILITY

Your Coverage may be renewed annually as long as you live unless we discontinue offering such Coverage, you fail to pay required Premiums on a timely basis, you make material misrepresentations to us, or you are no longer eligible for Coverage. To renew, pay the renewal Premium when it is due. Your Certificate may be revised to comply with federal or state law. This Certificate cannot be canceled or non-renewed solely on the grounds of deterioration of health.

INCREASE IN PREMIUMS

We have the right to change the amount of your Premium on each Renewal Date of this Certificate (see Section 8(G)) with prior written notice.

PRE-EXISTING CONDITION LIMITATIONS

We will not pay for any Hospital stay or medical care you receive for a pre-existing condition during the first six (6) months after the Effective Date of this Certificate. A pre-existing condition is a condition for which medical advice was given or treatment was recommended to you by or received from a Physician within six (6) months before the Effective Date of this Certificate. However, this limitation does not apply if we receive your completed application before or during your Medicare supplement insurance open enrollment period or if by law you have other guaranteed issue rights.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

This Certificate was issued based on the answers in your application, which is made part of this Certificate, being correct and complete. If there is any information in your application that is not right or complete, you must let us know immediately. Otherwise, your Certificate may not be valid or could cause an otherwise valid claim to be denied.

If any information in your application is incorrect or incomplete, please write to us within 10 days of receiving this Certificate at:

QualChoice Life and Health Insurance Company, Inc.
P. O. Box 25626
Little Rock, AR 72221-5626

Signed by our President on the Certificate's Effective Date.

President

A handwritten signature in black ink that reads "Michael E. Stock". The signature is written in a cursive style with a large, prominent initial "M".

POLICY SCHEDULE

Subscriber's Name: [Insert]

Policy Number: [Insert]

Effective Date: [Insert]

Initial Premium: \$[Insert] per [Period]

First Renewal Date: [Insert]

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SECTION 1. About This Certificate

This Certificate has been applied for as Individual Medicare Supplement Coverage. Read this entire Certificate carefully. It sets the terms and conditions of Coverage, describes the health care services that are Covered, and describes the rights and obligations of you and QualChoice.

Words that are capitalized in this Certificate are special terms that are defined in Section 14. The terms “we,” “us,” and “our” refer to QualChoice Life and Health Insurance Company, Inc. (referred to herein as “QualChoice”). The term “you,” “your” and “yourself” refer to the Subscriber.

If you have any questions about Coverage, contact our Customer Service Department at:

QualChoice Life and Health Insurance Company, Inc.
P. O. Box 25626
Little Rock, AR 72221-5626
Toll Free (800) 235-7111

Or visit our website at qualchoice.com.

SECTION 2. Obtaining Covered Services

MediQ65 Supplement Plan F helps pay some of the costs Medicare does not pay. This plan will extend benefits beyond those that Medicare offers to you.

By choosing to enroll as a MediQ65 Subscriber, you agree to abide by the rules as stated in this Certificate. This Certificate will be issued to Eligible Subscribers in exchange for Premium paid to us. You need to use both your red, white and blue Medicare card and your MediQ65 ID Card for health care services. Your Medicare provider must first bill Medicare for Medicare Covered Services. For services that are Covered by Medicare, we will pay your Medicare Coinsurance, Copayment or Deductible amount as specified in this Certificate only.

If Medicare changes benefits, Coinsurance, Copayments or Deductibles, this Certificate will automatically adjust to include those changes.

Any changes must be in writing and approved by us and the Arkansas Insurance Department.

SECTION 3. Eligibility

A. Medicare Supplement Eligibility

- (1) You must be enrolled in Medicare Part A and Part B to have Medicare Supplement Plan F Coverage. Medicare enrollment in both Part A and Part B is subject to being verified.
- (2) You must be a permanent resident of the State of Arkansas.
- (3) You must be 65 years or older and, unless you are in your Medicare supplement insurance open enrollment period or if by law you have other guaranteed issue rights, meet our medical criteria.

- (4) You must not continue to be enrolled in any other group or non-group Medicare Supplement program or Medicare Advantage plan if you are Covered under this Certificate.
- (5) You must not enroll in any other group or non-group Medicare Advantage or Medicare Supplement program if you want to remain Covered under this Certificate.

B. Change in Eligibility Status

You agree to notify us in writing or by calling our Customer Service Department within 30 days of any change in eligibility status. If you are no longer eligible for Coverage, you are responsible for payment for any services or benefits.

C. Suspension of Coverage

Coverage may be suspended under the following circumstances:

- (1) If you have applied for and are entitled to benefits under Medicaid, you have the right to suspend coverage of your Certificate for a period of up to 24 months. You must request suspension within 90 days of becoming entitled to Medicaid. If you suspend coverage, the benefits and Premiums will be suspended during your entitlement to benefits under Medicaid. You can apply for reinstatement within 90 days after the date you lose entitlement to Medicaid benefits, and coverage will be unconditionally reinstated. Your coverage will be reinstated, effective as of the date of termination of such entitlement, at the then current rate. We will return to you that portion of the Premium attributable to the period of suspension subject to adjustment for paid claims.
- (2) If you were eligible for and purchased this Certificate by reason of Disability, you may request that the benefits and Premiums under this Certificate be suspended for the period provided for under federal regulation if you are entitled to benefits under 42 U.S.C. Section 426(b) and you are covered under a group health plan (as defined in 42 U.S.C. Section 1395y(b)(1)(A)(v)). If this Certificate is suspended and you lose coverage under the group health plan, this Certificate will be automatically reinstated as of the date of the loss of your coverage under the group health plan. However, you must notify us of the loss of coverage within 90 days after the date of the loss and pay us the Premium for this Certificate attributable to the period from the date of the loss of coverage.
- (3) Reinstatement of coverage pursuant to (1) and (2) above:
 - a. Will not be subject to any waiting period for pre-existing conditions;
 - b. Will provide Coverage that is substantially equivalent to the Coverage in effect before the date of suspension; and
 - c. Will provide for Premiums that are at least as favorable as the Premiums that would have applied had coverage not been suspended.

SECTION 4. Effective Date of Coverage

The Effective Date of Coverage is 12:01 a.m. Standard Time where you live on the first of the month following receipt of your completed and accepted application.

Services obtained prior to the Effective Date of Coverage are not Covered.

SECTION 5. Covered Services

We will pay the Charges for Covered Services provided to you as described in this Section subject to all of the terms, conditions and provisions of this Certificate. The Covered Services you get must be reasonable and Medically Necessary for admission as an Inpatient, or for diagnosis and treatment of, an Illness, and must be provided while coverage under this Certificate is in force. Medicare Benefits will not be duplicated.

The benefits of this Certificate will automatically change to coincide with any changes in applicable Medicare Deductible or Copayment amounts and Coinsurance percentage factors. When benefits change, your Premium may change.

A. Hospital Inpatient Benefits:

We will pay the following amount for Inpatient services you are eligible for from a Hospital participating with Medicare:

- (1) One hundred percent (100%) of the Medicare Part A Inpatient hospital deductible (in effect at the time of admission to the Hospital) per Benefit Period;
- (2) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day of your Confinement;
- (3) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare for each Medicare lifetime Inpatient reserve day used from the 91st day through the 150th day of your Confinement;
- (4) Upon exhaustion of the Medicare hospital Inpatient coverage, including the lifetime Inpatient reserve days, coverage of the Part A Medicare Eligible Expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days;
- (5) The Part A Medicare Eligible Expenses for the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
- (6) The Coinsurance (in effect under Medicare at the time service is rendered) for Medicare Part A Eligible Expenses for the 21st through the 100th day at a Skilled Nursing Facility if (i) you were Inpatient at a Hospital for at least three (3) days, (2) the Hospital treated you for an Illness, and

(3) you were then admitted to a Skilled Nursing Facility participating in Medicare within thirty (30) days after being discharged from the Hospital; and

(7) Coverage of Part A Medicare Eligible Expenses incurred for hospice care and respite care expenses.

B. Medicare Part B Services:

We will pay the following amount for services, limited to the reasonable charges as determined by Medicare:

- (1) One hundred percent (100%) of the Medicare Part B Deductible (in effect at the time the service was rendered);
- (2) Your Coinsurance (in effect at the time the service is rendered) of Part B Medicare Eligible Expenses within the limits of this Certificate;
- (3) The Part B Medicare Eligible Expenses for the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations; and
- (4) One hundred percent (100%) of the Medicare Part B excess Charges which is the difference between the actual Medicare Part B Charge as billed, not to exceed any Charge limitation established by the Medicare program or state law, and the Medicare approved Part B Charge.

C. Additional Services and Supplies:

We will pay coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare Eligible Expenses for Medically Necessary emergency hospital, physician and medical care received outside the United States which is within the scope of Medicare coverage when provided in the United States, during the first sixty (60) consecutive days of each trip outside of the United States. This benefit is subject to a Calendar Year deductible of \$250.00 and a lifetime maximum benefit of \$50,000.00. For purposes of this benefit, "emergency care" means care needed immediately because of an illness or an injury of sudden or unexpected onset.

SECTION 6. Exclusions

The following are not Covered under this Certificate:

- A. Treatment, services or supplies Medicare does not cover, unless this Certificate specifically provides for them.
- B. Treatment, services or supplies to the extent that they are paid for by Medicare; treatment, services or supplies to the extent that they are paid for by another government entity or program, directly or indirectly; this does not apply, though, to health benefits or insurance plans for employees of such entities.

- C. Treatment, services or supplies you need as a result of war, or an act of war, occurring on or after the Effective Date of this Certificate.
- D. Personal comfort and convenience items.
- E. Routine physical exams, eye exams, hearing exams and directly related tests, eye glasses, or for the preparation or fitting of such things as eyeglasses or hearing aids, except for those services covered by Medicare.
- F. Orthopedic shoes or other supporting devices for the feet or routine foot care not covered by Medicare.
- G. Skilled Nursing Facility care, private duty nursing, long term care, Custodial Care, including Maintenance Care and Supportive Care.
- H. Cosmetic surgery. We do Cover such surgery if it is for repair of accidental Injury or for improving the functioning of a malformed body part.
- I. Domestic help or services provided by members of your Immediate Family or anyone else living in your household.
- J. Care, treatment, filling, removal or replacement of teeth, or for dental x-rays, root canal therapy, surgery for impacted teeth, or for other surgical procedures involving the teeth or structures directly supporting them, unless the service is a Medicare Eligible Expense. For example, we would pay your Medicare Part B Coinsurance for the extraction of teeth to prepare for radiation treatment.
- K. Treatment, services or supplies to the extent that a worker's compensation law or other U.S. or state plan covers them.
- L. Over the counter and Medicare Part D drugs you buy with or without a Physician's prescription, except for outpatient drugs prescribed as part of Medicare approved Hospice Care.
- M. Treatment, services or supplies for Confinement, surgery or care before your insurance becomes effective, or after Coverage ends except as stated in Section 8.E.
- N. Services not provided by a Health Professional.
- O. Treatment, services or supplies that are deemed unreasonable and unnecessary by Medicare. This includes but is not limited to the following: drugs or devices that have not been approved by the Food and Drug Administration (FDA), medical procedures and services performed using drugs or devices not approved by FDA, and services including drugs or devices, not considered safe and effective because they are experimental or investigational.
- P. Treatment, services or supplies received outside the United States, except as stated in Section 5.C.

- Q. Physician charges exceeding the Medicare Eligible Expense for treatment, services or supplies.
- R. Routine immunizations, except if eligible under Medicare.
- S. Treatment of service related conditions for members or ex-members of the armed forces by any military or veterans Hospital or soldier home or any Hospital contracted for or operated by any national government or agency.
- T. Medicare Part A Deductible.
- U. Medicare Part B Deductible.
- V. Services that you could get free if you did not have health care Coverage or that you are not otherwise legally obligated to pay.
- W. Services covered by any group health care contract.
- X. Transportation and travel.

SECTION 7. Claim Reimbursement

We pay your Coinsurance, Copayment or Deductible amount as specified in Section 5. Our payments are based on Medicare's approved amount for Covered Services. All claims are subject to review of availability of benefits at the time the claim is processed as well as the exclusions and maximums under this Certificate.

Your health care providers will usually submit claims to Medicare for any medical or hospital expenses you incur. Medicare then processes the benefits for expenses eligible for payment by Medicare under Part A and/or Part B. Your providers will then file a claim with QualChoice with the Explanation of Medicare Benefits showing the eligible expenses and the amount approved and paid by Medicare.

If your provider does not assist you in the filing of claims, you may submit the Explanation of Medicare Benefits you receive from Medicare directly to QualChoice for consideration.

We will process any reimbursement based on the following:

- If your provider accepts Medicare assignment, we will pay directly to the Physician, Hospital or other Health Professional that furnished the services, care, item or facility.
- If your provider does not accept Medicare assignment, solely at our option we may pay benefits directly to you instead of to the provider.
- Any payment made by us as described here discharges our liability for the amounts paid.

Claims should be submitted to QualChoice within 90 days of the initial Medicare reimbursement. If it was not reasonably possible for you to submit the documentation in the time required, we will not

reduce or deny the claim for failure to submit in the 90 days if the claim is filed as soon as possible. *In any event, the claim must be received by us no later than one year from the date of Medicare reimbursement unless you were legally unable to act.*

SECTION 8. Termination, Renewal and Reinstatement of Coverage

A. Termination of Certificate

As the Subscriber, you may terminate the Certificate to be effective at the end of any month by giving 30 days written notice of such termination. All Coverage through this Policy will terminate at 11:59 p.m. on the effective date of the termination of this Certificate.

If you lose your Coverage, we can collect from you all costs for Covered Services you received and we paid for after your Coverage terminated, plus our cost of recovering those charges (including attorney's fees).

If this Certificate terminates midterm because of your death, we will issue a pro rata refund to your estate.

B. Termination for Nonpayment of Premium

If you fail to pay the Premium by the due date, you are in default. If the default continues, your Coverage will be terminated as of the last date through which the Premium was paid. If your Coverage is terminated, any benefits incurred by you and paid by us after the termination will be charged to you.

C. Grace Period and Reinstatement

A grace period of 30 days will be granted for the payment of each Premium falling due after the first Premium. During the grace period the Certificate shall continue in force.

D. Termination for Other Reasons

Subject to reasonable notice, your Coverage may also be terminated for any of the following reasons:

- (1) You are no longer eligible for Medicare coverage.
- (2) You no longer meet eligibility requirements under this Certificate.
- (3) You provide false or misleading information or withhold material information.
- (4) We no longer offer this Coverage.

Your Certificate will end the last day Covered by your last payment.

E. Extension of Benefits

Termination of this Certificate shall be without prejudice to a continuous loss which began while the Certificate was in force. Any such extension of benefits shall only be available for such loss while you are continuously totally Disabled and shall continue to be subject to all the maximum benefit amounts

and duration limitations of the Certificate. Receipt of Medicare Part D shall not be considered in determining a continuous loss.

For the purpose of this subsection, “totally Disabled” means a Physician says:

- (1) You are Confined in a hospital or Medicare certified Skilled Nursing Facility; or
- (2) You are unable to perform the substantial duties of any job or occupation for which you are qualified and in fact you are not working for any salary or profit; or
- (3) You are substantially unable to engage in the normal activities of an individual in good health of the same age and/or sex.

F. Immediate Termination

We can terminate your Coverage for cause immediately if we find out you have committed or attempted to commit fraud against us or you have been dishonest with us about some important or material matter. For example, we may terminate your Coverage if we find out you gave us wrong or misleading information or you let someone else use your MediQ65 ID Card or receive benefits in your place. If we choose, termination can be effective the day you committed the fraud or were dishonest with us. Also, we can collect from you the costs for Covered Services that you received after the effective date of termination and we paid for, plus our cost of recovering those Charges (including attorney’s fee).

If we tell you we have terminated or will terminate your Coverage, we will terminate your Coverage on the date stated in the notice. If we terminate your Coverage retroactively, we will refund any Premiums you paid for the period after the termination date, offset by the amount of any Covered Services you received during that period. Also, we are entitled to reimbursement for any payments made for Covered Services you received after your termination date not offset by Premiums you paid.

NOTE: If you are still eligible for Coverage under Section 3 of this Certificate, we will not terminate your Coverage based on your health or your health care needs.

G. Renewal Terms

The initial term of this Certificate is from 12:00 a.m. of the day Coverage becomes effective through 11:59 p.m. on December 31st of that Calendar Year. Following the initial term, this Certificate will renew automatically every January 1st (the “Renewal Date”) for an additional 12 months, subject to all terms and provisions of this Certificate, unless otherwise terminated as provided for in this Certificate. We will give you advance written notice of any change in the Premium, material changes in Covered Services, or other provisions of this Certificate that will be effective on the Renewal Date.

Unless terminated for reasons stated in Section 8.D, this Certificate is guaranteed renewable for life subject to timely payment of Premium. We will neither cancel nor non-renew your Certificate for any reason other than nonpayment of Premium, material misrepresentation, fraud or the reasons stated in Section 8.D. If you permanently move outside the State of Arkansas after you have enrolled with us, you may still choose to renew your Coverage if all other eligibility requirements continue to be satisfied. Your Certificate may be revised to comply with federal or state law. This Certificate cannot be canceled or non-renewed solely on the grounds of deterioration of health. This Certificate automatically

terminates on the date you die. No refusal or renewal will affect an existing valid claim for Medicare Eligible Expenses Covered under this Certificate and incurred prior to the date on which this Certificate ends.

We are not responsible for notifying you when Premiums are due for Coverage provided during renewal periods under this Certificate.

H. Reinstatement

Reinstatement is subject to our right to change or terminate this Certificate (see Renewal Terms). If you end the contract by not paying your Premium, it may be reinstated. The following rules all apply:

- (1) (a) Your Coverage must be lapsed due to nonpayment of Premium; (b) you must apply for reinstatement within 1 year of the lapsed date by completing a new application including all updated health information; and (c) you want to reinstate the same Coverage you had.
- (2) We must approve your application to reinstate and determine the applicable Premium. We can approve or decline it.
- (3) If we reinstate you, losses resulting from accidents occurring or Illness beginning between the lapse date and the Effective Date of the new Certificate are not Covered.
- (4) Claims that occur in the lapse period are not Covered.
- (5) If your application is approved, the new Certificate will be effective on the first day of the month following approval. Any Premium received shall be applied to Coverage under the new Certificate.

I. Time Limit on Certain Defenses

After two (2) years from this Certificate's original Effective Date, no misstatements in the application will be used to void this Certificate or deny a claim beginning after the two (2) year period expires. This does not apply to fraudulent misstatements made in the application.

J. Certificate of Creditable Coverage

After we are notified of your termination of Coverage, you will receive a Certificate of Creditable Coverage that will provide proof of the coverage you had under the Certificate. In addition, you have the right to receive a Certificate of Creditable Coverage if you request one for yourself within 24 months after Coverage terminates. If you become covered by other health insurance, a Certificate of Creditable Coverage may help you receive the new coverage without a pre-existing condition exclusion or with a shorter exclusion period.

You may request a Certificate of Creditable Coverage by writing or calling our Customer Service Department at:

QualChoice Life and Health Insurance Company, Inc.
P. O. Box 25626
Little Rock, AR 72221-5626
Toll Free (800) 235-7111

You can also use our secure e-mail on our website at qualchoice.com.

SECTION 9. Subrogation

If you have an Injury or Illness caused by a third party, we will provide Coverage for Charges related to such Injury or Illness. Acceptance of such Coverage constitutes consent to the provisions of this section. This is a prerequisite to recovery by us against any third party for the cost of Covered Services. Our recovery rights under this section extend to worker's compensation and uninsured and underinsured motorist coverage.

You agree to protect our lien rights if you have an Injury or Illness caused by a third party. You may be due money from a third party for the cost of Covered Services. If so, our liability for your Charges will be subrogated to any such recoveries. We have the right to sue any third party in your name, as permitted by applicable state law. If you receive payment from a third party or any other insurer for the cost of Covered Services, you are obligated to reimburse us. You may reduce such reimbursement by our pro rata share of reasonable attorney's fees and costs you incurred in obtaining such recovery.

You agree to cooperate fully to facilitate enforcement of our rights under this section. This may include executing, delivering and filing further documents and instruments. You also agree to furnish such information and assistance as we may reasonably require to fully enforcing the terms of this section. You agree to take no action prejudicing our rights and interests under this section.

SECTION 10. Recovery of Excess Payment

We might pay more than we owe under this Certificate, make a payment for something that is not a Covered Services, or make a payment to you when payment should have gone directly to the Health Professional. In the event of such an erroneous or mistaken payment, you agree to refund the full amount of such payment to us promptly on our request. If we do not receive the full amount of the refund due from you, we have the right to offset future payments made to you or your Health Professional under this Certificate or under any other policy or certificate you have with us now or in the future.

We can also recover from another insurance company or service plan, or from any other person or entity that has received any excess payment from us for up to one year.

SECTION 11. Non-Duplication of Benefits

- A. We provide each Subscriber with health care services within the limits of this Certificate.
- B. QualChoice's Coverage does not duplicate benefits or pay more for Covered Services than the actual fees.

SECTION 12. Premiums

Premiums are due in full at QualChoice on or before the first day of each month for that month's Coverage unless arrangements have been made with us to make payments on other than a monthly basis. The method you will use to pay your Premium will be as reflected in your application for coverage

unless later changed by you in a written note that we accept. We reserve the right to deduct any Premium due and unpaid from a claim payment.

Excluding your first Premium payment, all Premium payments to QualChoice are subject to a 30-day grace period. During this time Premiums may be made to us without lapse of Coverage. If the Premium is not paid within that grace period, your Coverage will be terminated as of last Premium paid to date.

We have the right to change the amount of your Premium on each Renewal Date of this Certificate (see Section 8(G)) with prior written notice. You may terminate this Certificate as of the date that the revised Premium would become effective, by providing written notice of termination not less than 10 days prior to such effective date.

SECTION 13. Claim Inquiries and Appeals

- A. If a claim for is denied either in whole or in part, you will receive a notice explaining the reason(s) for the denial. You may request a review of a denial by sending a written request to:

QualChoice
Attention: Appeals and Grievance Coordinator
P.O. Box 25610
Little Rock, AR 72221-5610

Your request must be made within sixty (60) days after you have been notified of the denial of benefits.

- B. In preparing your request for review, you have the right to examine documents relevant to your claim. You may submit with your request for review any additional information relevant to your claim. A complete review will be made by us of all information relating to your claim. You will receive a final decision in writing within sixty (60) days after the receipt of your review request, except where special circumstances require additional review. A final decision will be sent to you no later than one hundred twenty (120) days after you originally submit it for review.

SECTION 14. Definitions

- A. **Amendment.** The Certificate may be changed at any time. These changes would be reflected in an additional document called an Amendment which will be provided to you.
- B. **Benefit Period.** A Benefit Period starts with the first full day that you are in a Hospital. It ends when you have not been in a Hospital or Skilled Nursing Facility or Rehabilitative facility for at least 60 consecutive days. There is no limit to the number of Benefit Periods you can have.
- C. **Calendar Year.** The period that starts with the Effective Date of your Certificate and ends on December 31st of such year. Each following Calendar Year shall start on January 1st of any year and end on December 31st of that year.
- D. **Centers for Medicare and Medicaid Services (CMS).** The federal agency that regulates Medicare and Medicaid.
- E. **Certificate.** The document that describes your and our rights and duties. It includes the application and any Amendments to this document.

- F. **Certificate of Creditable Coverage.** A Certificate issued to you upon termination of Coverage under this Certificate.
- G. **Charges.** The reasonable Charges for items or services set by Medicare. We treat Charges for stays in a Hospital or Skilled Nursing Facility as incurred on the date of admission. We treat all other Charges as incurred on the date you get the service or item. We pay only up to the reasonable Charges set by Medicare; no agreement between you (or someone acting for you) and any other person, group or provider of services will cause us to pay more.
- H. **Coinsurance or Copayment.** The portion of Covered health care costs for which the Covered person has a financial responsibility. Coinsurance is usually a fixed percentage which applies after first meeting a Deductible. A Copayment is usually a flat dollar amount rather than a percentage.
- I. **Confinement.** A reasonable and necessary admission as an Inpatient in a Hospital or Skilled Nursing Facility.
- J. **Covered Service, Coverage, Cover or Covered.** Those service and supplies that you are entitled to under this Certificate, if they are Medically Necessary and you have met all other requirements of this Certificate. This Certificate limits what we will pay for some services and supplies. When we say we will "Cover" a service or supply, it means we will treat the service or supply as a Covered Service.
- K. **Custodial Care.** Care given to you if: (1) you do not require the technical skills of a registered nurse at all times; (2) you need services for activities of daily living including, but not limited to, dressing, bathing, eating, walking, taking medications and maintaining continence; and (3) the services you require are not likely to improve your condition. Custodial Care includes Maintenance Care and Supportive Care as defined in this Certificate. Care may still be considered Custodial Care as determined by us, even if: (1) you are under the care of a Physician; (2) the Physician prescribes services to support and maintain your condition; or (3) health care services are being provided by a registered or licensed practical nurse.
- L. **Deductible.** The Medicare Part A Deductible is the amount you are responsible to pay the first time you are admitted to a Hospital in each Benefit Period. The Medicare Part B Deductible is the amount you are responsible to pay for each calendar year toward Part B Medicare Eligible Expenses.
- M. **Disabled or Disability.** Under the Social Security Act, you are Disabled or have a Disability if, taking into account your age, education and past work experience, you are unable to perform any substantial gainful activity by reason of a medically determinable physical or mental impairment, or combination of impairments, which can be expected to result in death or which has lasted or can be expected to last at least 12 consecutive months.
- N. **Effective Date.** The first of the month following receipt and acceptance of your completed application or a date specified in your application. The date must be a date in the future. We may verify your enrollment in Medicare Part A and Part B.
- O. **Health Professional.** An individual licensed, certified or authorized under state law to practice a health profession and who is practicing within the scope of that license, certification or authorization.
- P. **Home Health Care.** Care you received while confined to your home. A specific plan for your care and treatment must be made by a licensed agency or organization and approved in writing by your Physician. S/he must review the plan at least every 2 months unless s/he decides less frequent reviews are enough.

- Q. **Home Health Care Agency.** An agency or organization that is licensed to provide skilled nursing services and other therapeutic services in an outpatient setting.
- R. **Hospice Care.** Services for the terminally ill and their families including pain management and other supportive services.
- S. **Hospital.** An appropriately licensed acute care institution (including a long term acute care facility) that provides Inpatient medical care and treatment for ill and injured persons through medical, diagnostic, and major surgical facilities. All services must be provided on its premises under the supervision of a staff of Physicians and with 24 hour-a-day nursing and Physician services.
- T. **ID Card.** The Subscriber Identification Card you receive from us as evidence of your enrollment with us.
- U. **Ill or Illness.** A sickness or a disease.
- V. **Immediate Family.** Your spouse, children, parents, grandparents, brothers and sisters and their spouses.
- W. **Injury or Injured.** Accidental bodily Injury.
- X. **Inpatient.** Admission as a bed patient to a Hospital or Skilled Nursing Facility.
- Y. **Maintenance Care.** Health care services delivered after the acute phase of an illness has passed and maximum therapeutic benefit has occurred. Such care promotes optimal function in the absence of significant symptoms.
- Z. **Medicaid.** The state governmental program that helps with the medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help you pay for your Medicare premiums and other costs, if you qualify.
- AA. **Medical Emergency.** The sudden onset of a medical condition with signs and symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.
- BB. **Medically Necessary.** The services or supplies needed to diagnose, care for or treat your physical or mental condition as determined by the Centers for Medicare and Medicaid Services (CMS).
- CC. **Medicare.** Title XVIII of the Social Security Act, as amended.
- DD. **Medicare Advantage Plan.** A plan of coverage for health benefits under Medicare Part C as defined in 42 United States Code Section 13951-28(b)(1), as amended, and includes any of the following: (1) coordinated care plans that provide health care services, including but not limited to health maintenance organization plans (with or without point-of-service option), plans offered by provider-sponsored organizations, and preferred provider plans; (2) medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and (3) Medicare Advantage private fee-for-service plans.
- EE. **Medicare Eligible Expenses.** Health care expenses which are covered by Medicare Parts A and B, recognized as medically necessary and reasonable by Medicare, and that may or may not be fully reimbursed by Medicare. Medicare Eligible Expenses may also be referred to as the cost of Covered Services.
- FF. **Medicare Supplement Coverage.** Coverage that conforms to Rule 27 of the Arkansas Insurance Code. "Medicare Supplement Coverage" includes Medicare Supplement and Medicare Select plans but does not include coverage under Medicare Advantage plans as established under Medicare Part C or Outpatient Prescription Drug plans established under Medicare Part D.

- GG. **Physician.** An appropriately licensed medical or osteopathic doctor practicing within the scope of their license.
- HH. **Premium.** The total payment from Subscriber to us for Coverage.
- II. **QualChoice.** QualChoice Life and Health Insurance Company, Inc. which is the Arkansas corporation licensed as a life and health insurance company providing benefits under this Certificate. II.
- JJ. **Respite Care.** Temporary or periodic care you receive in a Medicare-approved nursing home, assisted living facility or other type of long-term care program so that a family member or friend who is your usual caregiver can rest while you are receiving Hospice Care.
- KK. **Skilled Nursing Facility.** A facility that is appropriately licensed to provide services in lieu of hospitalization including skilled nursing care and related services on an Inpatient basis.
- LL. **Subscriber.** A person who: (a) meets all applicable eligibility requirements of the Certificate; (2) has enrolled for Coverage; and (3) has paid us any applicable Premium payments under this Certificate.
- MM. **Supportive Care.** Health care services for a patient whose recovery has slowed or ceased entirely, and only minimal rehabilitative gains can be demonstrated with continued care.
- NN. **We, us or our.** QualChoice.
- OO. **You, your or yourself.** The Subscriber.

SECTION 15. General Provisions

A. Your Relationship With Your Doctor or Hospital

This Certificate will not alter the usual, customary relationship you have with your doctor, hospital, service or facility. We do not contract with you to choose or provide a doctor, hospital, service or facilities. Nor do we assure their availability. We are not responsible to you for the acts of any health care provider or for any services or facilities. We are obligated only to provide the benefits stated in this Certificate.

B. Entire Agreement

This Certificate, including the application and any Amendments or attachments, is the entire agreement between Subscriber and us. Beginning on the Effective Date of Coverage, the Certificate supersedes all other agreements for health care services and benefits between you and us. No change in the Certificate is valid until approved by an executive officer of QualChoice and unless such approval is endorsed or attached. No agent has authority to change the Certificate or to waive any of its provisions.

C. Limit on Assignability of Benefits

This is your personal Certificate. You cannot assign any benefit to anyone other than a Physician, Hospital or other provider entitled to receive a specific benefit for you. We may require that the original or a copy of your assignment to a health care provider be provided to us for our files.

D. Conformity with State and Federal Law

We will apply this Certificate in accordance with state and federal laws and regulations. If any part of this Certificate does not conform with state or federal laws or regulations, it is amended to conform to the minimum requirements of such laws and regulations.

E. Clerical Errors

Clerical errors, such as incorrect transcriptions of Effective Dates, termination dates, or erroneous mailings, will not change the rights or obligations of you or us under this Certificate. Clerical errors will not operate to grant additional benefits to you, terminate Coverage otherwise in force or continue Coverage beyond the date it would otherwise terminate.

F. Governing Law and Severability

This Certificate will be governed by Arkansas law and any applicable federal law. If any provision of this Certificate is held to be invalid or unenforceable, the remaining provisions of this Certificate will remain in full force and effect.

G. Notices

Any notice required or permitted under this Certificate shall be in writing and shall be considered to have been given on the date when delivered in person or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address in your application or to any more recent address of which the sending party has received written notice.

H. Third Parties

This Certificate shall not confer any rights, remedies, claims or obligations on third parties except as specifically provided in this Certificate.

I. Waiver

In the event a party waives any provision of this Certificate, that party will not be considered to have waived that provision at any other time or to have waived any other provision. The failure to exercise any right under this Certificate shall not operate as a waiver of such right.

J. Legal Action

No legal action may be brought to recover on this Certificate within 60 days after a written claim for payment of health care services has been given to us as required by this Certificate. No such action may be brought after three (3) years after the time a written claim for payment of health care expenses is required to be given.

K. Other insurance with QualChoice

You may have coverage under only one of our MediQ65 policies at any one time. If through error we issue more than one such policy to you, you can select the one policy that is to remain in effect. In the event of death, this selection will be made by your estate. We will return the money you paid, less any claim benefits that we paid, for any policy that does not remain in effect.

SECTION 16. Confidentiality of Health Care Records

You agree to permit providers to release information to QualChoice. This can include medical record and claims information related to services you may receive or have received. We agree to keep this information confidential and to require its contractors to do the same. Consistent with our Notice of Privacy Practices, information will be used and disclosed only as authorized or required by law.

It is your responsibility to cooperate with us by providing health history information and helping to obtain prior medical records at the request of QualChoice.

You may request a copy of our Notice of Privacy Practices by writing or calling our Customer Service Department at:

QualChoice Life and Health Insurance Company, Inc.
P. O. Box 25626
Little Rock, AR 72221-5626
Toll Free (800) 235-7111

Or visit our website at qualchoice.com.

SERFF Tracking Number: QUAC-127138294 State: Arkansas
 Filing Company: QualChoice Life and Health Insurance Company, State Tracking Number: 48564
 Inc.
 Company Tracking Number:
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.005 Plan F (Basic) 2010
 Standard Plans 2010
 Product Name: MediQ65 Medicare Supplement Insurance Plan F
 Project Name/Number: /

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 05/18/2011	Rates and Factors Summary		New		MediQ65 Rate and Rate Form Summary May 2011.pdf

VIA SERFF

May 17, 2011

Ms. Stephanie Fowler
 Arkansas Department of Insurance
 Life and Health Division
 1200 West Third Street
 Little Rock, AR 72201-1904

RE: QualChoice Life and Health Insurance Company, Inc. Medicare Supplement Policy Filings; Rates and Factors Summary

Dear Ms. Fowler:

This letter will summarize the rates and rate factors for the "MediQ65" Medicare supplement insurance product currently under your review.

Plan Type:	A	F	G	N
Form #: QCLHIC Medicare Supplement	Plan A April 2011	Plan F April 2011	Plan G April 2011	Plan N April 2011
Monthly Rate Eff. 5-1-2011	\$111.00	\$146.00	\$132.00	\$108.00

Area	Factor	Family Composition	Factor
720 – 722	1.000	Single	1.000
All Others	0.930	Couple	0.930

Underwriting	Factor
Standard	1.000
Preferred	0.900

Please feel free to contact me at any time should you need additional information or have any questions or comments.

Sincerely yours,



James W. Couch, J.D.
 Vice President of Compliance
 (501) 219-5118
jim.couch@qualchoice.com

SERFF Tracking Number: QUAC-127138294 State: Arkansas
 Filing Company: QualChoice Life and Health Insurance Company, State Tracking Number: 48564
 Inc.
 Company Tracking Number:
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.005 Plan F (Basic) 2010
 Standard Plans 2010
 Product Name: MediQ65 Medicare Supplement Insurance Plan F
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	05/18/2011
Comments:		
Attachment: Letter to S Fowler Re Flesch Score April 2011.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	05/18/2011
Comments:		
Attachment: APPLICATION PACKET_0419_to AID.pdf		

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage	Approved-Closed	05/18/2011
Comments:		
Attachment: MediQ65 Outline of Coverage_to AID.pdf		

VIA SERFF

April 22, 2011

Ms. Stephanie Fowler
Arkansas Department of Insurance
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

RE: QualChoice Life and Health Insurance Company, Inc. Medicare Supplement
Policy Filings

Dear Ms. Fowler:

This certifies that the following Medigap policies do not meet the minimum score of forty (40) on the Flesch reading ease test as specified in Ark. Stat. Ann. §23-80-206:

Coverage document for Plan A (Form # QCLHIC Medicare Supplement Plan A April 2011)

Coverage document for Plan F (Form # QCLHIC Medicare Supplement Plan F April 2011)

Coverage document for Plan G (Form # QCLHIC Medicare Supplement Plan G April 2011)

Coverage document for Plan N (Form # QCLHIC Medicare Supplement Plan N April 2011)

Although the score is lower than the minimum required, it should be approved in accordance with Ark. Stat. Ann. §23-80-207 and warranted due to the nature of the policy form and necessary inclusion of medical terminology and language drafted to conform to state and federal law.

Please feel free to contact me at any time should you need additional information or have any questions or comments.

Sincerely yours,



James W. Couch, J.D.
Vice President of Compliance
jim.couch@qualchoice.com
(501) 219-5118



APPLICATION PACKET

- Open Enrollment Period
- Application for Coverage
- Important Information for Applicant
- Authorization to Disclose Protected Health Information (PHI)
- Payment Authorization Form
- Fair Credit Reporting Act Notice

QUICK CHECKLIST

Complete, sign and return the following forms in the enclosed postage-paid return envelope.

- Application for Coverage
- Important Information for Applicant
- Authorization to Disclose PHI
- Payment Authorization Form (attach check marked VOID if selecting Bank Draft)



MediQ65™ Medicare supplement Insurance is underwritten by QualChoice Life and Health Insurance Company, Inc. 'QualChoice' is the registered name used for products and services provided by one or more of the QualChoice group of subsidiary companies.

OPEN ENROLLMENT PERIOD

IMPORTANT INFORMATION!

Please read carefully before beginning the application process.

Do You Qualify For A Medigap Policy?

You may apply for a Medicare Supplement policy at any time. However, there is an important enrollment period to take advantage of called the Medigap **Open Enrollment Period** (OEP).

- State and federal laws guarantee that for a period of six months from the date you become enrolled in Medicare Part B **and** you are age 65 or older you have a right to buy a Medicare supplement policy of your choice, regardless of medical history, health status, or prior claims.
- The six-month period begins the first day of the month you are enrolled in Medicare Part B **and** are age 65 or older.
- If your birthday falls on the first day of the month, your Medicare coverage will begin the first day of the previous month, while you are age 64. Your Open Enrollment Period will also begin at that time.

MEDICARE PART B COVERAGE DEFERRED

If you are age 65 or older and have deferred your Medicare Part B coverage, your Open Enrollment Period begins with the date your Medicare Part B coverage becomes effective and continues for six months.

MEDICARE DISABLED

Federal law does not require that people under the age of 65 with Medicare Part B as a result of disability or permanent kidney failure be given an Open Enrollment Period. However, when you turn 65, you will have an Open Enrollment Period opportunity. Your Open Enrollment Period begins with the first day of the month in which you turn age 65 and continues for six months.

FOR MORE INFORMATION ABOUT MEDICARE AND MEDIGAP

MediQ65 Medicare Supplement Plan ♦ Weekdays 8am to 5pm Central Time

Toll Free **1.855.MEDIQ65 (1.855.633.4765)**

www.qualchoice.com

Senior Health Insurance Information Program (SHIIP – State of Arkansas) is a health insurance information program that provides free one-on-one counseling, education, and information to individuals with Medicare of all ages.

Toll Free **1.800.224.6330 or 501.371.2782**

www.insurance.arkansas.gov

Medicare / 24 hours a day, 7 days a week

Medicare Hotline **1.800.633.4227 (1.800.MEDICARE)** or TTY/TDD users call **877.486.2048**

“Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare” available at www.medicare.gov

Thank you for selecting QualChoice MediQ65™ for your Medicare supplement insurance coverage. You must have both Medicare Parts A and B to apply for these plans.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY to assure prompt processing of your application. A MediQ65™ application form is also available at www.qualchoice.com.

1. This application is a legal document. If you are approved for coverage, it will become part of your contract. Therefore, it is very important that you provide all requested information and that it is accurate and legible.
2. You must reside in Arkansas to apply for a MediQ65™ Medicare Supplement plan.
3. This form can be completed by an agent/broker authorized to sell QualChoice MediQ65™ policies, or you can fill it in yourself.
4. Answer each required question completely using dark blue or black ink. No pencil please.
5. Do not use liquid paper, correction tape or "white out" to correct any mistakes.
6. If you make a mistake, mark through the incorrect information, initial it and then provide the correct information.
7. All required sections must be completed to avoid delays in processing.
8. Any attached sheets must be **signed** and **dated**.
9. Be sure to make a photocopy of this completed application for your records.
10. The information provided here will be used and disclosed only as permitted by our *Notice of Privacy Practices* which can be viewed at www.qualchoice.com.
11. You must **sign** and **date** the application.
12. **DO NOT** send money with this application. You will be billed later.
13. Return this entire application and any attachments in the postage-paid return envelope provided.

POLICY EFFECTIVE DATES

The policy effective date will be the *1st of the month after* your completed application is approved and processed.

RULES FOR EFFECTIVE DATES

- You cannot have an effective date prior to your Medicare Part A and Part B effective dates.
- You cannot have an effective date prior to your termination from a Medicare Advantage plan.
- You cannot have an effective date prior to your application submission date.

Questions or Need Assistance?

1.855.MEDIQ65 (1.855.633.4765)

Monday-Friday 8am to 5pm

SECTION I. WHO IS APPLYING

First Name		MI	Last Name		
Social Security No.	Date of Birth		Age	Gender	County of Residence
	MM	DD	YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female	
CONTACT INFORMATION					
Primary Phone Number		Secondary Phone Number			Best Time to Call
					AM PM
RESIDENTIAL ADDRESS (No P.O. Box, please)			City	State	Zip
				AR	
MAILING ADDRESS (Complete only if different from residential address)			City	State	Zip
				AR	
BILLING ADDRESS (Complete only if different from residential address)			City	State	Zip
				AR	
EMAIL ADDRESS					
Please check (✓) one. <input type="checkbox"/> Yes <input type="checkbox"/> No					
<p>IMPORTANT DECISION: <i>I want to do my part for the environment and reduce waste. By checking "Yes", I agree that QualChoice can deliver all documents, notices and any other communications with respect to my MediQ65™ coverage electronically to my email address below. This includes, but is not limited to, my insurance certificate of coverage, all explanation of benefits describing how my claims have been adjudicated, billing invoices, renewal notices, and any other communications. I understand I can change my mind at any time and revoke my decision to have these documents and communications sent to me electronically simply by contacting QualChoice at 1.855.MEDIQ65 (1.855.633.4765). I also understand that I can ask QualChoice at any time to provide me with any of these documents in paper form by regular mail. I agree to contact QualChoice if my email address changes so that these important documents, notices and communications will come to my new email address.</i></p>					
PLEASE PRINT YOUR EMAIL ADDRESS BELOW.					

SECTION II. BILLING PREFERENCE. Check Only One.

Please check (✓) your preferred billing option **and** complete **Section XII: PAYMENT AUTHORIZATION FORM** If billing option is left blank, your policy will automatically default to Monthly Invoice Billing (a \$2.00 monthly service fee will apply).

Monthly Bank Draft
 Monthly Invoice Billing (\$2.00 monthly service fee)
 Quarterly Billing

SECTION III. CHOOSE YOUR PLAN

Please enroll me in the following MediQ65™ Plan: (Check only one)	MediQ65™ Plan A <input type="checkbox"/>	MediQ65™ Plan F <input type="checkbox"/>	MediQ65™ Plan G <input type="checkbox"/>	MediQ65™ Plan N <input type="checkbox"/>
Do you currently have QualChoice health coverage?	<input type="checkbox"/> NO <input type="checkbox"/> YES If YES , please include your QualChoice ID No. below. YOUR QUALCHOICE ID No. _____			

SECTION IV: EFFECTIVE DATE

Your effective date will be the *1st of the month after* your completed application is approved and processed. Effective date of coverage cannot be prior to your Medicare Part B effective date.

SECTION V. YOUR MEDICARE INSURANCE INFORMATION

You **must** have both Medicare Hospital (Part A) and Medical (Part B) coverage to apply for MediQ65™.

Please FILL IN THE BLANKS below to match your red, white and blue Medicare Health Insurance card.

Medicare Claim Number										Hospital (Part A) Effective Date			Medical (Part B) Effective Date			
			-			-					MM	DD	YYYY	MM	DD	YYYY

(sample Medicare Card inserted here)

SECTION VI. ELIGIBILITY INFORMATION

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with this application.

Please mark YES or NO with '✓' in box

1.	Did you turn age 65 in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
2.	Did you enroll in Medicare Part B in the last 6 months? a. If YES , what is the effective date? <table border="1" data-bbox="248 1375 716 1455"> <tr> <td>MM</td> <td>DD</td> <td>YYYY</td> </tr> </table>	MM	DD	YYYY	<input type="checkbox"/> Yes <input type="checkbox"/> No
MM	DD	YYYY			
3.	Are you covered for medical assistance through the state Medicaid program? NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your 'Share Of Cost', please respond NO to this question a. If YES , will Medicaid pay your premiums for this Medicare supplement policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No			
4.	Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

5. If you had coverage from any Medicare plan, other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO, PPO or PFFS), fill in your START DATE and END DATE below. If you are still covered under this plan, leave the “END DATE” blank.

START DATE			END DATE		
MM	DD	YYYY	MM	DD	YYYY

a. If you are still covered under the other Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes No

b. Was this your first time in this type of Medicare plan? Yes No

c. Did you drop a **Medicare supplement policy** to enroll in the Medicare plan? Yes No

6. Do you have another **Medicare supplement** policy in force? Yes No

a. If **YES**, what is the name of the company? And what plan do you have?

Name of Company	Name of Plan

b. If **YES**, do you plan to replace your current Medicare supplement policy with this MediQ65™ policy? Yes No

7. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan?) Yes No

a. What are your dates of coverage under the other policy? If you are still covered under the other policy, leave the “END DATE” blank.

START DATE			END DATE		
MM	DD	YYYY	MM	DD	YYYY



IMPORTANT INFORMATION!

Please read carefully before continuing the application process.

➤ OPEN ENROLLMENT PERIOD

Under the Open Enrollment Period health questions are **not** required to be answered. You are **NOT** required to complete **Sections VII-IX** if you are applying during the Medicare Supplement Open Enrollment Period. You may continue your application process at **Section X**.

➤ If you are NOT in the OPEN ENROLLMENT PERIOD

Please answer **ALL** of the following health questions. Acceptance or rejection of your application is subject to your enrollment in Medicare Hospital (Part A) and Medical (Part B) coverage and our review of your answers to the medical questions. Application cannot be processed unless all questions are answered.

SECTION VII. MEDICAL QUESTIONS. If this section applies to you, please answer all questions.

1.	What is your height? <table border="1" style="width: 100%;"> <tr> <td style="width: 20%;"></td> <td style="width: 10%; text-align: center;">ft.</td> <td style="width: 20%;"></td> <td style="width: 10%; text-align: center;">in.</td> </tr> </table>		ft.		in.	What is your weight? <table border="1" style="width: 100%;"> <tr> <td style="width: 20%;"></td> <td style="width: 10%; text-align: center;">lbs.</td> </tr> </table>		lbs.
	ft.		in.					
	lbs.							
2.	Are you Medicare disabled? a. If YES , please indicate disability conditions below: (leave 3-4 lines)	<input type="checkbox"/> Yes <input type="checkbox"/> No						
3.	Do you have a pacemaker?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
4.	Are you now a patient in a hospital or nursing home?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
5.	Have you ever been declined or rated for the issuance of life, accident or health or long term care insurance? a. If YES , please explain: (leave 3-4 lines)	<input type="checkbox"/> Yes <input type="checkbox"/> No						
6.	Have you used any form of tobacco within the past 12 months? a. If YES , please indicate type of tobacco and amount: Type of Tobacco: _____ Amount of Use: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No						

Have you ever had any diagnosis of or been advised to have treatment for any of the following? If you respond YES, please complete Section VIII.					
7.	Disease or disorder of the heart or circulatory system, or high blood pressure or stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
8.	Disease or disorder of the lungs or respiratory system?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
9.	Disease or disorder of the kidneys, liver, gallbladder, intestines, rectum, stomach, or other vital organs?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
10.	Diabetes or high blood sugar? a. If YES , provide date of onset below: <table border="1" style="width: 100%;"> <tr> <td style="width: 20%; text-align: center;">MM</td> <td style="width: 20%; text-align: center;">DD</td> <td style="width: 20%; text-align: center;">YYYY</td> </tr> </table>	MM	DD	YYYY	<input type="checkbox"/> Yes <input type="checkbox"/> No
MM	DD	YYYY			
11.	Mental incapacitation, Alzheimer's disease, mental disease, depression or psychiatric treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
12.	Physical incapacitation, epilepsy, Parkinson's disease or disorder of the nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
13.	Cancer or malignancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
14.	Disease or disorder of the blood, glands, or skin?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
15.	Arthritis, paralysis, disease or disorder of the muscles, bones or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
16.	Have you consulted a physician or received hospital (inpatient or outpatient care) or rehabilitation services during the past five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
17.	Have you ever had or been advised to have treatment for any condition not listed above?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
18.	In the past 3 years have you taken any medications prescribed by a health care provider? a. If YES , list medications in Section IX .	<input type="checkbox"/> Yes <input type="checkbox"/> No			

SECTION X: IMPORTANT INFORMATION FOR APPLICANT. PLEASE READ CAREFULLY.

Your application cannot be processed without this form being signed and returned.

Send no money with this application. You will be billed.

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. If, after purchasing this policy you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

In signing below, I represent and acknowledge:

1. That I should not cancel any coverage I currently have until I am notified of QualChoice's decision.
2. An agent/broker involved in this insurance transaction may receive compensation from QualChoice for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent /broker.
3. If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information.
4. I agree any provider of medical services or supplies is authorized and directed to furnish QualChoice all records or copies thereof, relating to such services or supplies.
5. I authorize and release to QualChoice, Title XVIII Medicare claims information needed to coordinate benefits with this policy at any time I am eligible for Medicare benefits

6. QualChoice may phone me for additional information that may help with the timely processing of my application.
7. That the statements and answers given in this application and any signed and dated addenda to this application (both front and back) are true, complete and correctly recorded.
8. I have read and understand the “Important Information for Applicant” section above.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

- I, the applicant, certify that I signed this application in the state of Arkansas.
- I, the applicant or my authorized representative, acknowledge receipt of the following:
 - (1) “Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare” (available at www.medicare.gov)
 - (2) 2011 Outline of Medicare Supplement Coverage

✎ SIGNATURE OF APPLICANT	DATE SIGNED
X	

FOR AGENT/BROKER ONLY

If application is being made through an agent/broker, he/she must complete the following information.

I have read and understand the MediQ65™ Application for Coverage. I additionally certify that the applicant has received the “Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare” and the 2011 Outline of Medicare Supplement Coverage for the policy applied for and that the applicant has both Parts A and B of Medicare. The policy applied for will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage.

Before this form can be processed, the agent/broker’s current health and life license must be on file. In addition, the agent/broker must be appointed with QualChoice.

AGENCY FEDERAL TAX ID # (IF APPLICABLE)	AGENT/BROKER LICENSE #	TELEPHONE NO.
AGENT/BROKER PRINTED NAME	AGENT/BROKER SIGNATURE	DATE SIGNED
	X	

List below all health insurance policies you have issued to this applicant that are still in force and any other health insurance issued in the past five (5) years that are no longer in force and submit with this application as required.

NAME OF POLICY	NAME OF INSURANCE COMPANY	POLICY DATE	
		TO	FROM

SECTION XI: AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Your application cannot be processed without this form being signed and returned.

1. I authorize any medical professional, medical care institution, other provider of health care services or supplies, the Medical Information Bureau (MIB), reinsurer, health plan, prior insurance carrier, consumer reporting agency, other third party medical and/or pharmaceutical databases or other organization, institution or person, that has any records on me or my health to provide QualChoice, any third party retained by QualChoice, or its reinsurers, information with respect to any physical or mental condition, treatment or any non-medical information on me.
2. I understand that information obtained as a result of this authorization will be used for the purpose of underwriting and determining eligibility for coverage.
3. This information shall also be used by QualChoice in investigating and adjudicating claims for benefits.
4. I understand that in the course of their business operations, QualChoice may disclose this information to others as required or permitted by law and as set out in the QualChoice *Notice of Privacy Practices*.
5. I specifically authorize QualChoice to release necessary information obtained by QualChoice about me to my broker/agent.
6. This authorization permits release of information related to substance use or abuse, but does not provide for the disclosure of psychotherapy notes as defined in 45 CFR § 164.501.
7. I acknowledge that signing this authorization is a condition of my enrollment for health coverage by QualChoice.
8. I understand that I may terminate this authorization by sending a written revocation to **QualChoice, ATTN: MEDIQ65, P.O. Box 25626, Little Rock, AR 72221-5626**. However, if I revoke this authorization before I am enrolled in the MediQ65 policy, my application for coverage will be denied.
9. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims.
10. A photocopy of this authorization is as valid as the original.
11. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signature in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signature Act A.C.A §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i)
12. QualChoice may release any information obtained by it about me to MIB or any member company for purposes described in QualChoice's *Notice of Privacy Practices*.

This authorization must be signed by each proposed insured who is 18 years of age or older.

PRINT NAME OF APPLICANT		
SIGNATURE OF APPLICANT	X	DATE SIGNED

Section XII. PAYMENT AUTHORIZATION FORM

Use this form to select the type of payment method you want QualChoice to apply when billing your MediQ65™ premium. Your application cannot be processed without this form being signed and returned.

SELECT ONE OF THE PAYMENT METHODS BELOW

Bank Draft (Monthly). I authorize QualChoice and the Bank/Financial Institution indicated below, to debit my MediQ65 premium from the account indicated below. This authority is to remain in full force and effect until my Bank has received written notification from me of the Bank Draft termination in such time and such manner as to afford the Bank a reasonable opportunity to act on it, or until the Bank has sent me ten (10) days' written notice of the Bank's termination of this agreement. I understand that by revoking the Bank Draft after I have agreed to it, I will also be terminating my MediQ65 coverage, UNLESS QualChoice has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the Bank Draft withdrawal date. I understand that if my bank rejects a draft due to insufficient funds in my account, QualChoice may charge me a fee of up to \$20.00. In order to use monthly bank draft as my payment method, I understand that I must submit this form to QualChoice and staple a blank check marked VOID in the top left-hand corner of this form. Your first month's premium will be drafted upon initial acceptance of coverage. For all other premiums you may select one of two bank draft dates.

I understand and agree that my first month's premium will be drafted upon initial acceptance of coverage.

PLEASE CHECK ONE: For all other bank drafts I select the following date: 24th of the month *preceding* the coverage month 5th of the coverage month. **Example:** Premiums due in January coverage month can be drafted on Dec 24 or Jan 5.

NAME OF BANK (OR OTHER FINANCIAL INSTITUTION)	ACCOUNT TYPE (CHECK ONE) <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS
BANK ACCOUNT NUMBER	9 DIGIT BANK ROUTING NO.
ACCOUNT HOLDER NAME	ACCOUNT HOLDER ADDRESS (STREET, CITY, STATE, ZIP)
ACCOUNT HOLDER SIGNATURE X	DATE SIGNED

Monthly Invoice Billing. (\$2.00 monthly service fee applies) Your monthly invoice will be mailed to your Billing Address as listed in Section I.

Quarterly Billing. I authorize QualChoice to bill my MediQ65™ premium on a quarterly basis. This type of billing arrangement is to remain in full force and effect until QualChoice receives written notice of my desire to change my billing arrangement. I must provide QualChoice notice to change my billing arrangement twenty (20) days prior to when my next premium payment is due. In order to use quarterly billing as my payment method, I understand that I must submit this form to QualChoice. I understand that if I fail to submit my quarterly premium payment to QualChoice when it is due, I risk terminating my QualChoice MediQ65™ coverage.

By signing this PAYMENT AUTHORIZATION FORM, I agree to all terms and conditions expressed in the payment method I have chosen above. I understand that not properly following what has been authorized on this form may cause my MediQ65™ policy to be terminated at QualChoice's discretion

PRINT NAME OF APPLICANT		
SIGNATURE OF APPLICANT X		DATE SIGNED

Notice to Proposed Insured

Please keep for your records

In connection with your application for insurance an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to:

QualChoice MediQ65™
Underwriting Division
PO Box 25626
Little Rock, AR 72221-5626



2011
OUTLINE OF
MEDICARE SUPPLEMENT
COVERAGE

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

Benefit Chart of Medicare Supplement Plans sold with an effective Date of Coverage on or after June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in Arkansas. **QualChoice offers benefit plans A, F, G and N.** Plans E, H, I, and J are no longer available for sale.

BASIC BENEFITS

Hospitalization	Medical Expenses	Blood	Hospice
Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.	Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B coinsurance or copayments.	First three pints of blood each year.	Part A coinsurance

READING THE CHART: If the '■' mark appears in a column the Medigap policy covers 100% of the desired benefit. If a column lists a percentage, then the policy covers that percentage of the described benefit. If a column is blank, then the policy does not cover that benefit.

Note: The Medigap policy covers coinsurance only after you have paid the deductible (unless the Medigap policy also covers the deductible)

MEDIGAP BENEFITS	A	B	C	D	F ¹	G	K	L	M	N
Medicare Part A Coinsurance hospital costs up to an additional 365 days after Medicare benefits are used up (cost varies based on day)	■	■	■	■	■	■	■	■	■	■
Medicare Part B Coinsurance or Copayment (20% of Medicare Assignment)	■	■	■	■	■	■	50%	75%	■	■
Blood (First 3 Pints)	■	■	■	■	■	■	50%	75%	■	■
Part A Hospice Care Coinsurance or Copayment	■	■	■	■	■	■	50%	75%	■	■
Skilled Nursing Facility Care Coinsurance (cost varies based on day)			■	■	■	■	50%	75%	■	■
Medicare Part A Deductible (\$1,132 per benefit period in 2011)		■	■	■	■	■	50%	75%	50%	■
Medicare Part B Deductible (\$162 per year in 2011)			■		■					
Medicare Part B Excess Charges (up to 15% above Medicare-Approved amount if provider does not accept Medicare assignment)					■	■				
Foreign Travel Emergency Services (Up to Plan Limits)			■	■	■	■			■	■
Medicare Preventive Part B Coinsurance (in 2011 most preventive screenings no longer require coinsurance payment)	■	■	■	■	■	■	■	■	■	■
Out-of-pocket annual limit (will increase each year for inflation)							\$4,640	\$2,320		

¹Plan F has an option called a high deductible plan. This high deductible plan pays the same benefits as Plan F after you've paid a calendar year deductible of \$2,000. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include Medicare deductibles for Part A & Part B, but do not include the plan's separate foreign travel emergency deductible.

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

PREMIUM INFORMATION – MediQ65™ Medicare Supplement Plans

Premium rates are determined by the service area in which you reside. If you are approved for coverage and then move to a different service area, your premium rate may change. The new premium rate will be effective on the first day of the next premium billing period.

RATES EFFECTIVE JULY 1, 2011

Service Area 1 Counties

Arkansas, Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Chicot, Clay, Cleveland, Columbia, Craighead, Crawford, Crittenden, Desha, Drew, Franklin, Fulton, Grant, Greene, Jefferson, Johnson, Lafayette, Lee, Lincoln, Logan, Madison, Marion, Miller, Mississippi, Monroe, Montgomery, Newton, Phillips, Poinsett, Polk, Pope, Prairie, Randolph, Scott, Searcy, Sebastian, St. Francis, Stone, Union, Washington, White, Woodruff, and Yell

PREMIUM	Plan A	Plan F	Plan G	Plan N
Monthly Rate*	103.23	135.78	122.76	100.44
Quarterly Rate	309.69	407.34	368.28	301.32

Service Area 2 Counties

Clark, Cleburne, Conway, Cross, Dallas, Faulkner, Garland, Hempstead, Hot Spring, Howard, Independence, Izard, Jackson, Lawrence, Little River, Lonoke, Nevada, Ouachita, Perry, Pike, Pulaski, Saline, Sevier, Sharp, and Van Buren

PREMIUM	Plan A	Plan F	Plan G	Plan N
Monthly Rate*	111.00	146.00	132.00	108.00
Quarterly Rate	333.00	438.00	396.00	324.00

*If monthly invoice is selected as method of payment on **Payment Authorization Form** (see **Application Packet**), a monthly \$2.00 service charge will apply.

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

PREMIUM INFORMATION

QualChoice can only raise your premium if we raise the premium for all policies like yours in the same service area as yours.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your **MediQ65™** policy, you have the right to return any policy within 30 days of receiving that policy to:

QualChoice Life and Health Insurance Company, Inc.
P.O. Box 25626
Little Rock, AR 72221-5626

If the policy is returned to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither QualChoice Life and Health Insurance Company nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult **Medicare and You** for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded. Keep a copy for your own file.

Medicare Plan A (Part A) – Hospital Services – Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room & board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$1,132/ benefit period	\$0	\$1,132 (Part B deductible)
61 st through 90 th day	All but \$283 a day	\$283 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
<i>Once lifetime reserve days are used:</i> Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$141.50 a day	\$0	Up to \$141.50 a day
101 st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements including a doctor’s certification of terminal illness.	All but very limited coinsurance/copayment for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, QualChoice stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Medicare Plan A (Part B) – Medical Services – Per Calendar Period

*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year. Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - in or out of the hospital and outpatient hospital treatment, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$162 of Medicare-Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All costs
BLOOD			
First three pints	\$0	All costs	\$0
Next \$162 of Medicare-Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0

Parts A & B

HOME HEALTH CARE - Medicare-Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<i>Durable Medical Equipment:</i> First \$162 of Medicare-Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

Medicare Plan F (Part A) – Hospital Services – Per Benefit Period

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semi-private room & board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$1,132/ benefit period	\$1,132 (Part A deductible)	\$0
61 st through 90 th day	All but \$283 a day	\$283 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
<i>Once lifetime reserve days are used:</i> Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements including a doctor’s certification of terminal illness.	All but very limited coinsurance/copayment for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, QualChoice stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Medicare Plan F (Part B) – Medical Services – Per Calendar Year

*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year. Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - in or out of the hospital and outpatient hospital treatment, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$162 of Medicare-Approved Amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	100%	\$0
BLOOD			
First three pints	\$0	All costs	\$0
Next \$162 of Medicare-Approved Amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0

Parts A & B

HOME HEALTH CARE - Medicare-Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<i>Durable Medical Equipment:</i> First \$162 of Medicare-Approved Amounts*	\$0	\$162 (Part B deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0
OTHER BENEFITS <u>NOT</u> COVERED BY MEDICARE			
FOREIGN TRAVEL – not covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 life-time maximum

Medicare Plan G (Part A) – Hospital Services – Per Benefit Year

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room & board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$1,132/ benefit period	\$1,132 (Part A deductible)	\$0
61 st through 90 th day	All but \$283 a day	\$283 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
<i>Once lifetime reserve days are used:</i> Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements including a doctor’s certification of terminal illness.	All but very limited coinsurance/copayment for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, QualChoice stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Medicare Plan G (Part B) – Medical Services – Per Calendar Year

*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year. Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - in or out of the hospital and outpatient hospital treatment, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$162 of Medicare-Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	100%	\$0
BLOOD			
First three pints	\$0	All costs	\$0
Next \$162 of Medicare-Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0

Parts A & B

HOME HEALTH CARE - Medicare-Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<i>Durable Medical Equipment:</i> First \$162 of Medicare-Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

OTHER BENEFITS NOT COVERED BY MEDICARE

FOREIGN TRAVEL – not covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Medicare Plan N (Part A) – Hospital Services – Per Benefit Year

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room & board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$1,132/ benefit period	\$1,32 (Part A deductible)	\$0
61 st through 90 th day	All but \$283 a day	\$283 a day	\$0
91 st day and after: While using 60 lifetime reserve days	All but \$566 a day	\$566 a day	\$0
<i>Once lifetime reserve days are used:</i> Additional 365 days	\$0	100% of Medicare eligible expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First three pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
HOSPICE CARE			
You must meet Medicare’s requirements including a doctor’s certification of terminal illness.	All but very limited coinsurance/copayment for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

** NOTICE: When your Medicare Part A hospital benefits are exhausted, QualChoice stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Medicare Plan N (Part B) – Medical Services – Per Calendar Year

*Once you have been billed \$162 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year. Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - in or out of the hospital and outpatient hospital treatment, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$162 of Medicare-Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	0%	All costs
BLOOD			
First three pints	\$0	All costs	\$0
Next \$162 of Medicare-Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
Tests for diagnostic services	100%	\$0	\$0

Continued on next page.

Parts A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - Medicare-Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
<i>Durable Medical Equipment:</i> First \$162 of Medicare-Approved Amounts*	\$0	\$0	\$162 (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
OTHER BENEFITS <u>NOT</u> COVERED BY MEDICARE			
FOREIGN TRAVEL – not covered by Medicare			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 life-time maximum

DISCLAIMER

MediQ65 Medicare Supplement plans are not connected with or endorsed by the U.S. government or the federal Medicare program.



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