Filing at a Glance

Company: QualChoice Life and Health Insurance Company, Inc.
Product Name: MediQ65 Medicare Supplement Plan G
SERFF Tr Num: QUAC-127190891
State: Arkansas
TOI: MS05I Individual Medicare Supplement - Standard Plans
SERFF Status: Closed-Approved-Closed
State Tr Num: 48932
Sub-TOI: MS05I.008 Plan G
Co Tr Num:
State Status: Approved-Closed
Filing Type: Form
Reviewer(s): Stephanie Fowler
Author: Jim Couch
Disposition Date: 06/22/2011
Date Submitted: 05/27/2011
Disposition Status: Approved-Closed
Implementation Date Requested: On Approval
Implementation Date:
State Filing Description:

General Information

Project Name:
Status of Filing in Domicile: Not Filed
Project Number:
Date Approved in Domicile:
Requested Filing Mode:
Domicile Status Comments:
Explanation for Combination/Other:
Market Type: Individual
Submission Type:
Individual Market Type:
Overall Rate Impact:
Filing Status Changed: 06/22/2011
State Status Changed: 06/22/2011
Deemer Date:
Created By: Jim Couch
Submitted By: Jim Couch
Corresponding Filing Tracking Number:
Filing Description:
We found errors in the exclusion section of the previously filed and approved Plan G certificate. This filing corrects those errors.

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]
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	05/27/2011	

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	06/22/2011	06/22/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Replacement of previously filed Plan G Certificate to correct errors in exclusions section.	Note To Reviewer	Jim Couch	05/27/2011	05/27/2011

SERFF Tracking Number:	*QUAC-127190891*	*State:*	*Arkansas*
Filing Company:	*QualChoice Life and Health Insurance Company, Inc.*	*State Tracking Number:*	*48932*
Company Tracking Number:			
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.008 Plan G*
Product Name:	*MediQ65 Medicare Supplement Plan G*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 06/22/2011
Implementation Date:
Status: Approved-Closed
Comment: The revisions to the attached forms are approved. 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.

SERFF Tracking Number:	*QUAC-127190891*	*State:*	*Arkansas*
Filing Company:	*QualChoice Life and Health Insurance Company, Inc.*	*State Tracking Number:*	*48932*
Company Tracking Number:			
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.008 Plan G*
Product Name:	*MediQ65 Medicare Supplement Plan G*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	MediQ65 Medicare Supplement Certificate Plan G	Approved-Closed	Yes

Note To Reviewer

Created By:
Jim Couch on 05/27/2011 03:44 PM
Last Edited By:
Stephanie Fowler
Submitted On:
06/22/2011 02:14 PM
Subject:
Replacement of previously filed Plan G Certificate to correct errors in exclusions section.
Comments:
Sec. 4. Changed "completed and accepted" to "approved and processed" to make consistent with language in application.

Sec. 6. Exclusions:

> 6(G): Struck exclusion for skilled nursing

> 6(Q): Struck exclusion for physician charges exceeding Medicare eligible expense

> 6(T): Struck exclusion for Part A Deductible

Attaching red-lined copy reflecting changes for your information.

MediQ65™

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 G

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-exisiting 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

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 G 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 G 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 reinstitution within 90 days after the date you lose entitlement to Medicaid benefits, and coverage will be unconditionally reinstituted. Your coverage will be reinstituted, 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 reinstituted 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) Reinstitution 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~~approved and processed 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) Your Coinsurance (in effect at the time the service is rendered) of Part B Medicare Eligible Expenses within the limits of this Certificate;

(2) The Part B Medicare Eligible Expenses 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

(3) 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, p~~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.~~Q. Routine immunizations, except if eligible under Medicare.

~~S.~~R. 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.~~S. Medicare Part B Deductible.

~~V.~~T. 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.~~U. Services covered by any group health care contract.

~~X.~~V. 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 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 notice 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.

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.

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/22/2011	QCLHIC Medicare Supplement Plan G April 2011	Policy/Contract/Fraternal Certificate	MediQ65 Medicare Supplement Certificate Plan G	Revised	Replaced Form #: QCLHIC Medicare Supplement Plan G April 2011 Previous Filing #: QCLHIC Medicare Supplement Plan G April 2011		MediQ65 Coverage Certificate Plan G Final Updated May 2011 #2.pdf

MediQ65™

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 G

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-exisiting 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

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 G 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 G 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 reinstitution within 90 days after the date you lose entitlement to Medicaid benefits, and coverage will be unconditionally reinstituted. Your coverage will be reinstituted, 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 reinstituted 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) Reinstitution 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 approved and processed 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) Your Coinsurance (in effect at the time the service is rendered) of Part B Medicare Eligible Expenses within the limits of this Certificate;

(2) The Part B Medicare Eligible Expenses 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

(3) 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. 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. Routine immunizations, except if eligible under Medicare.

R. 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.

S. Medicare Part B Deductible.

T. Services that you could get free if you did not have health care Coverage or that you are not otherwise legally obligated to pay.

U. Services covered by any group health care contract.

V. 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 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 notice 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.

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.

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification		
Bypass Reason:	Please rely on previously filed letter dated April 22, 2011.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application		
Bypass Reason:	Please rely on previously filed and approved application. No changes to application required due to corrections in certificate.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification		
Bypass Reason:	Please rely on previously filed and approved actuarial certification.		
Comments:			

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	06/22/2011

Comments:

We found 2 typos in the previously submitted Outline of Coverage which are corrected in the attached

Page 5: Hospitalization
First 60 days “YOU PAY” column $1,132 (Part A deductible)

Page 11: Hospitalization
First 60 days “PLANS PAYS” column $1,132 (Part A deductible)

SERFF Tracking Number:	*QUAC-127190891*	*State:*	*Arkansas*
Filing Company:	*QualChoice Life and Health Insurance Company, Inc.*	*State Tracking Number:*	*48932*
Company Tracking Number:			
TOI:	*MS05I Individual Medicare Supplement - Standard Plans*	*Sub-TOI:*	*MS05I.008 Plan G*
Product Name:	*MediQ65 Medicare Supplement Plan G*		
Project Name/Number:	*/*		

Attachment:

MediQ65 Outline of Coverage_to AID.pdf

2011
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

52511

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	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		

[1]Plan 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.

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.

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 A deductible)
61st through 90th day	All but $283 a day	$283 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
Once lifetime reserve days are used: 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
21st through 100th day	All but $141.50 a day	$0	Up to $141.50 a day
101st 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/copay-ment 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
Durable Medical Equipment: 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
61st through 90th day	All but $283 a day	$283 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
Once lifetime reserve days are used: 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
21st through 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st 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/copay-ment 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
Durable Medical Equipment: First $162 of Medicare-Approved Amounts*	$0	$162 (Part B deductible)	$0
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 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
61st through 90th day	All but $283 a day	$283 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
Once lifetime reserve days are used: 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
21st through 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st 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/copay-ment 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
Durable Medical Equipment: 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	$1,132 (Part A deductible)	$0
61st through 90th day	All but $283 a day	$283 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
Once lifetime reserve days are used: 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
21st through 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st 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/copay-ment 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
Durable Medical Equipment: 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 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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