

State: Arkansas **Filing Company:** QCA Health Plan, Inc.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)
Product Name: IQChoice, Including IQChoice Select and Child Only Version
Project Name/Number: /

Filing at a Glance

Company: QCA Health Plan, Inc.
Product Name: IQChoice, Including IQChoice Select and Child Only Version
State: Arkansas
TOI: H16I Individual Health - Major Medical
Sub-TOI: H16I.005B Individual - Point-of-Service (POS)
Filing Type: Form
Date Submitted: 09/06/2012
SERFF Tr Num: QUAC-128675101
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num:

Implementation: On Approval
Date Requested:
Author(s): Jim Couch, Liz Hubbard
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 10/17/2012
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** QCA Health Plan, Inc.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)
Product Name: IQChoice, Including IQChoice Select and Child Only Version
Project Name/Number: /

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type: Individual
Overall Rate Impact:	Filing Status Changed: 10/17/2012
	State Status Changed: 10/17/2012
Deemer Date:	Created By: Jim Couch
Submitted By: Jim Couch	Corresponding Filing Tracking Number:
	PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Filing Description:

Modification to medical benefit summaries and prescription drug benefit summaries for IQChoice, IQChoice Select, and child only IQChoice to reflect no member cost share for certain contraceptive coverage per PPACA.

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

QCA Health Plan, Inc.	CoCode: 95448	State of Domicile: Arkansas
12615 Chenal Parkway, Suite 300	Group Code:	Company Type: Health
Little Rock, AR 72211	Group Name:	Maintenance Organization
(501) 228-7111 ext. [Phone]	FEIN Number: 71-0794605	State ID Number:

Filing Fees

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

Company	Amount	Date Processed	Transaction #
QCA Health Plan, Inc.	\$50.00	09/06/2012	62343379
QCA Health Plan, Inc.	\$500.00	09/10/2012	62550639

SERFF Tracking #:

QUAC-128675101

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

QCA Health Plan, Inc.

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)

Product Name: IQChoice, Including IQChoice Select and Child Only Version

Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/17/2012	10/17/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	09/12/2012	09/12/2012
Pending Industry Response	Rosalind Minor	09/07/2012	09/07/2012

Response Letters

Responded By	Created On	Date Submitted
Jim Couch	10/13/2012	10/16/2012
Jim Couch	09/10/2012	09/12/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Objection Letter of 9/12/12	Note To Filer	Rosalind Minor	10/15/2012	10/15/2012
IQChoice Products Modifications to Medical and Prescription Drug Benefit Summaries	Note To Reviewer	Jim Couch	09/06/2012	09/06/2012

SERFF Tracking #:

QUAC-128675101

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

QCA Health Plan, Inc.

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)

Product Name:

IQChoice, Including IQChoice Select and Child Only Version

Project Name/Number:

/

Disposition

Disposition Date: 10/17/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking #:

QUAC-128675101

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

QCA Health Plan, Inc.

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)

Product Name:

IQChoice, Including IQChoice Select and Child Only Version

Project Name/Number:

/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form (revised)	IQChoice Benefit Summary	Approved-Closed	Yes
Form	IQChoice Benefit Summary	Replaced	Yes
Form (revised)	IQChoice Benefit Summary	Approved-Closed	Yes
Form	IQChoice Benefit Summary	Replaced	Yes
Form	QualChoice Outpatient Prescription Drug Benefit Summary	Approved-Closed	Yes
Form (revised)	IQChoice Select Benefit Summary	Approved-Closed	Yes
Form	IQChoice Select Benefit Summary	Approved-Closed	Yes
Form (revised)	IQChoice Select Benefit Summary	Approved-Closed	Yes
Form	IQChoice Select Benefit Summary	Replaced	Yes
Form	QualChoice Outpatient Prescription Drug Benefit Summary	Approved-Closed	Yes
Form	QualChoice Outpatient Prescription Drug Benefit Summary	Approved-Closed	Yes
Form (revised)	IQChoice Select Benefit Summary	Approved-Closed	Yes
Form	IQChoice Select Benefit Summary	Replaced	Yes
Form (revised)	IQChoice Select Benefit Summary	Approved-Closed	Yes
Form	IQChoice Select Benefit Summary	Replaced	Yes

SERFF Tracking #:

QUAC-128675101

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

QCA Health Plan, Inc.

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)

Product Name:

IQChoice, Including IQChoice Select and Child Only Version

Project Name/Number:

/

Schedule	Schedule Item	Schedule Item Status	Public Access
Form	QualChoice Outpatient Prescription Drug Benefit Summary	Approved-Closed	Yes
Form	QualChoice Outpatient Prescription Drug Benefit Summary	Approved-Closed	Yes

State: Arkansas **Filing Company:** QCA Health Plan, Inc.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)
Product Name: IQChoice, Including IQChoice Select and Child Only Version
Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 09/12/2012
Submitted Date 09/12/2012
Respond By Date

Dear Jim Couch,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- IQChoice Benefit Summary, QC POSIQ NG (08-1-12) (Form)
- IQChoice Benefit Summary, QC HDHPIQ NG (08-1-12) (Form)
- IQChoice Select Benefit Summary, QC POSIQCSelect (08-1-12) (Form)
- IQChoice Select Benefit Summary, IQCSelect HDHP (08-1-2012) (Form)
- IQChoice Select Benefit Summary, QC POSIQCSelect CO (08-1-12) (Form)
- IQChoice Select Benefit Summary, IQCSelect HDHP CO (08-1-12) (Form)

Comments:

The benefit summaries has no coverage for children immunizations out-of-network. ACA 23-79-141 (f)(2)(A) states that..."benefits for recommended immunization services shall be exempt from any copayment, coinsurance, deductible, or dollar limit provision in the health insurance policy. This exemption shall be explicitly stated in the policy....". Immunizations should be paid at 100% in and out of network.

Thank you for your understanding and cooperation.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

State:	Arkansas	Filing Company:	QCA Health Plan, Inc.
TOI/Sub-TOI:	H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)		
Product Name:	IQChoice, Including IQChoice Select and Child Only Version		
Project Name/Number:	/		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/13/2012
Submitted Date	10/16/2012

Dear Rosalind Minor,

Introduction:

We have made the necessary changes to reflect no member cost for childrens immunizations out of network.

Response 1

Comments:

We have made the necessary changes to reflect no member cost for childrens immunizations out of network.

Related Objection 1

Applies To:

- IQChoice Benefit Summary, QC HDHPIQ NG (08-1-12) (Form)
- IQChoice Benefit Summary, QC POSIQ NG (08-1-12) (Form)
- IQChoice Select Benefit Summary, QC POSIQCSelect (08-1-12) (Form)
- IQChoice Select Benefit Summary, IQCSelect HDHP (08-1-2012) (Form)
- IQChoice Select Benefit Summary, QC POSIQCSelect CO (08-1-12) (Form)
- IQChoice Select Benefit Summary, IQCSelect HDHP CO (08-1-12) (Form)

Comments:

The benefit summaries has no coverage for children immunizations out-of-network. ACA 23-79-141 (f)(2)(A) states that..."benefits for recommended immunization services shall be exempt from any copayment, coinsurance, deductible, or dollar limit provision in the health insurance policy. This exemption shall be explicitly stated in the policy....". Immunizations should be paid at 100% in and out of network.

Thank you for your understanding and cooperation.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:

QUAC-128675101

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

QCA Health Plan, Inc.

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)

Product Name: IQChoice, Including IQChoice Select and Child Only Version

Project Name/Number: /

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	QC POSIQ NG (08-1-12)	CERA	IQChoice Benefit Summary	Initial		IQChoice POS 8.2012 Womens Health for Filing.pdf	Date Submitted: 10/16/2012 By: Jim Couch
<i>Previous Version</i>							
1	QC POSIQ NG (08-1-12)	CERA	IQChoice Benefit Summary	Initial		8.2012 IQChoice POS Medical Benefit Summary for AID filing.pdf	Date Submitted: 10/16/2012 By: Jim Couch
2	QC HDHPIQ NG (08-1-12)	CERA	IQChoice Benefit Summary	Initial		IQChoice HDHP 8.2012 Womens Health for Filing.pdf	Date Submitted: 10/16/2012 By: Jim Couch
<i>Previous Version</i>							
2	QC HDHPIQ NG (08-1-12)	CERA	IQChoice Benefit Summary	Initial		8.2012 IQChoice HDHP Medical Benefit Summary for AID filing.pdf	Date Submitted: 10/16/2012 By: Jim Couch

State: Arkansas

Filing Company:

QCA Health Plan, Inc.

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)

Product Name: IQChoice, Including IQChoice Select and Child Only Version

Project Name/Number: /

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	QC POSIQ NG (08-1-12)	CERA	IQChoice Benefit Summary	Initial		IQChoice POS 8.2012 Womens Health for Filing.pdf	Date Submitted: 10/16/2012 By: Jim Couch
3	QC POSIQCSelect (08-1-12)	CERA	IQChoice Select Benefit Summary	Initial		QCSelect POS 8.2012 Womens Health for Filing.pdf	Date Submitted: 10/16/2012 By: Jim Couch

Previous Version

3	<i>QC POSIQCSelect (08-1-12)</i>	<i>CERA</i>	<i>IQChoice Select Benefit Summary</i>	<i>Initial</i>		<i>8.2012 IQCSelect POS Medical Benefit Summaries for AID Filing.pdf</i>	<i>Date Submitted: 10/16/2012 By: Jim Couch</i>
4	IQCSelect HDHP (08-1-2012)	CERA	IQChoice Select Benefit Summary	Initial		IQCSelect HDHP 8.2012 Womens Health for Filing.pdf	Date Submitted: 10/16/2012 By: Jim Couch

Previous Version

SERFF Tracking #:

QUAC-128675101

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

QCA Health Plan, Inc.

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)

Product Name: IQChoice, Including IQChoice Select and Child Only Version

Project Name/Number: /

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	QC POSIQ NG (08-1-12)	CERA	IQChoice Benefit Summary	Initial		IQChoice POS 8.2012 Womens Health for Filing.pdf	Date Submitted: 10/16/2012 By: Jim Couch
4	<i>IQCSelect HDHP (08-1-2012)</i>	<i>CERA</i>	<i>IQChoice Select Benefit Summary</i>	<i>Initial</i>		<i>8.2012 IQCSelect HDHP Medical Benefit Summaries for AID Filing.pdf</i>	<i>Date Submitted: 10/16/2012 By: Jim Couch</i>
5	QC POSIQCSelect CO (08-1-12)	CERA	IQChoice Select Benefit Summary	Initial		8.2012 IQCSelect Child Only POS Medical Benefit Summary for Filing.pdf	Date Submitted: 10/16/2012 By: Jim Couch
<i>Previous Version</i>							
5	<i>QC POSIQCSelect CO (08-1-12)</i>	<i>CERA</i>	<i>IQChoice Select Benefit Summary</i>	<i>Initial</i>		<i>8.2012 IQCSelect POS Medical Benefit Summaries for AID Filing.pdf</i>	<i>Date Submitted: 10/16/2012 By: Jim Couch</i>

State: Arkansas

Filing Company:

QCA Health Plan, Inc.

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)

Product Name: IQChoice, Including IQChoice Select and Child Only Version

Project Name/Number: /

Form Schedule Item Changes

Item No.	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments	Submitted
1	QC POSIQ NG (08-1-12)	CERA	IQChoice Benefit Summary	Initial		IQChoice POS 8.2012 Womens Health for Filing.pdf	Date Submitted: 10/16/2012 By: Jim Couch
6	IQCSelect HDHP CO (08-1-12)	CERA	IQChoice Select Benefit Summary	Initial		8.2012 IQCSelect Child Only HDHP Medical Benefit Summary for Filing.pdf	Date Submitted: 10/16/2012 By: Jim Couch

Previous Version

6	<i>IQCSelect HDHP CO (08-1-12)</i>	<i>CERA</i>	<i>IQChoice Select Benefit Summary</i>	<i>Initial</i>		<i>8.2012 IQCSelect HDHP Medical Benefit Summaries for AID Filing.pdf</i>	<i>Date Submitted: 10/16/2012 By: Jim Couch</i>
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No Rate/Rule Schedule items changed.

Conclusion:Sincerely,
Jim Couch

State: Arkansas **Filing Company:** QCA Health Plan, Inc.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)
Product Name: IQChoice, Including IQChoice Select and Child Only Version
Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/07/2012
Submitted Date	09/07/2012
Respond By Date	10/07/2012

Dear Jim Couch,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- IQChoice Benefit Summary, QC POSIQ NG (08-1-12) (Form)
- IQChoice Benefit Summary, QC HDHPIQ NG (08-1-12) (Form)
- QualChoice Outpatient Prescription Drug Benefit Summary, QC RXIQ [POS or HDHP] (08-1-12) (Form)
- IQChoice Select Benefit Summary, QC POSIQCSelect (08-1-12) (Form)
- IQChoice Select Benefit Summary, IQCSelect HDHP (08-1-2012) (Form)
- QualChoice Outpatient Prescription Drug Benefit Summary, QC RXIQCSelect POS (08-1-12) (Form)
- QualChoice Outpatient Prescription Drug Benefit Summary, QC RXIQCSelectHDHP (08-1-12) (Form)
- IQChoice Select Benefit Summary, QC POSIQCSelect CO (08-1-12) (Form)
- IQChoice Select Benefit Summary, IQCSelect HDHP CO (08-1-12) (Form)
- QualChoice Outpatient Prescription Drug Benefit Summary, QC RXIQCSelect POS CO (08-1-2012) (Form)
- QualChoice Outpatient Prescription Drug Benefit Summary, QC RXIQCSelect HDHP CO (08-1-2012) (Form)

Comments:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$550.00. Please submit an additional \$500.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

State: Arkansas **Filing Company:** QCA Health Plan, Inc.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)
Product Name: IQChoice, Including IQChoice Select and Child Only Version
Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 09/10/2012
Submitted Date 09/12/2012

Dear Rosalind Minor,

Introduction:

The additional amount has been submitte via EFT. Thanks.

Jim

Response 1

Comments:

Additional fee paid.

Related Objection 1

Applies To:

- IQChoice Benefit Summary, QC HDHPIQ NG (08-1-12) (Form)
- IQChoice Benefit Summary, QC POSIQ NG (08-1-12) (Form)
- QualChoice Outpatient Prescription Drug Benefit Summary, QC RXIQ [POS or HDHP] (08-1-12) (Form)
- IQChoice Select Benefit Summary, QC POSIQCSelect (08-1-12) (Form)
- QualChoice Outpatient Prescription Drug Benefit Summary, QC RXIQCSelect POS (08-1-12) (Form)
- QualChoice Outpatient Prescription Drug Benefit Summary, QC RXIQCSelectHDHP (08-1-12) (Form)
- IQChoice Select Benefit Summary, IQCSelect HDHP (08-1-2012) (Form)
- IQChoice Select Benefit Summary, QC POSIQCSelect CO (08-1-12) (Form)
- IQChoice Select Benefit Summary, IQCSelect HDHP CO (08-1-12) (Form)
- QualChoice Outpatient Prescription Drug Benefit Summary, QC RXIQCSelect POS CO (08-1-2012) (Form)
- QualChoice Outpatient Prescription Drug Benefit Summary, QC RXIQCSelect HDHP CO (08-1-2012) (Form)

Comments:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$550.00. Please submit an additional \$500.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,

Jim Couch

State: Arkansas **Filing Company:** QCA Health Plan, Inc.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)
Product Name: IQChoice, Including IQChoice Select and Child Only Version
Project Name/Number: /

Note To Filer

Created By:

Rosalind Minor on 10/15/2012 01:11 PM

Last Edited By:

Rosalind Minor

Submitted On:

10/17/2012 08:44 AM

Subject:

Objection Letter of 9/12/12

Comments:

I have not received a response to my Objection Letter of 9/12/12. Do you need additional time to respond?

State: Arkansas **Filing Company:** QCA Health Plan, Inc.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)
Product Name: IQChoice, Including IQChoice Select and Child Only Version
Project Name/Number: /

Note To Reviewer

Created By:

Jim Couch on 09/06/2012 04:10 PM

Last Edited By:

Rosalind Minor

Submitted On:

10/17/2012 08:44 AM

Subject:

IQChoice Products Modifications to Medical and Prescription Drug Benefit Summaries

Comments:

This filing is necessary in order to update the existing IQChoice, IQChoice Select, and child only IQChoice product medical benefit summaries and prescription drug summaries in order to reflect the PPACA requirement to provide certain contraceptive coverage without member cost share.

State: Arkansas

Filing Company:

QCA Health Plan, Inc.

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)

Product Name: IQChoice, Including IQChoice Select and Child Only Version

Project Name/Number: /

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 10/17/2012	QC POSIQ NG (08-1-12)	CERA	IQChoice Benefit Summary	Initial:		IQChoice POS 8.2012 Womens Health for Filing.pdf
2	Approved-Closed 10/17/2012	QC HDHPIQ NG (08-1-12)	CERA	IQChoice Benefit Summary	Initial:		IQChoice HDHP 8.2012 Womens Health for Filing.pdf
3	Approved-Closed 10/17/2012	QC RXIQ [POS or HDHP] (08- 1-12)	CERA	QualChoice Outpatient Prescription Drug Benefit Summary	Initial:		8.2012 IQChoice Prescription Benefit Summary for AID Filing.pdf
4	Approved-Closed 10/17/2012	QC POSIQCSelect (08-1-12)	CERA	IQChoice Select Benefit Summary	Initial:		IQCSelect POS 8.2012 Womens Health for Filing.pdf
5	Approved-Closed 10/17/2012	IQCSelect HDHP (08-1- 2012)	CERA	IQChoice Select Benefit Summary	Initial:		IQCSelect HDHP 8.2012 Womens Health for Filing.pdf
6	Approved-Closed 10/17/2012	QC RXIQCSelect POS (08-1-12)	CERA	QualChoice Outpatient Prescription Drug Benefit Summary	Initial:		08.2012 IQCSelect POS Prescription Benefit Summaries for AID Filing.pdf
7	Approved-Closed 10/17/2012	QC RXIQCSelectH DHP (08-1-12)	CERA	QualChoice Outpatient Prescription Drug Benefit Summary	Initial:		08.2012 IQCSelect HDHP Prescription Benefit Summaries for AID Filing.pdf

State: Arkansas

Filing Company:

QCA Health Plan, Inc.

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)

Product Name: IQChoice, Including IQChoice Select and Child Only Version

Project Name/Number: /

Lead Form Number:

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
8	Approved-Closed 10/17/2012	QC POSIQCSelect CO (08-1-12)	CERA	IQChoice Select Benefit Summary	Initial:		8.2012 IQCSelect Child Only POS Medical Benefit Summary for Filing.pdf
9	Approved-Closed 10/17/2012	IQCSelect HDHP CO (08-1-12)	CERA	IQChoice Select Benefit Summary	Initial:		8.2012 IQCSelect Child Only HDHP Medical Benefit Summary for Filing.pdf
10	Approved-Closed 10/17/2012	QC RXIQCSelect POS CO (08-1-2012)	CERA	QualChoice Outpatient Prescription Drug Benefit Summary	Initial:		08.2012 IQCSelect POS Prescription Benefit Summaries for AID Filing.pdf
11	Approved-Closed 10/17/2012	QC RXIQCSelect HDHP CO (08-1-2012)	CERA	QualChoice Outpatient Prescription Drug Benefit Summary	Initial:		08.2012 IQCSelect HDHP Prescription Benefit Summaries for AID Filing.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate

SERFF Tracking #:

QUAC-128675101

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

QCA Health Plan, Inc.

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)

Product Name:

IQChoice, Including IQChoice Select and Child Only Version

Project Name/Number:

/

POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages
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This benefit summary is part of the Certificate of Coverage, Form QC_Indiv_Prod_1 (10-10) as **amended by AMENDMENT to IQC (10-10) (8-1-2011)** and subject to all benefit terms and conditions, limitations and exclusions included in the Certificate of Coverage. This benefit summary is intended only to highlight your benefits and should not be relied upon solely to determine coverage. Please refer to the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Certificate of Coverage is different than this benefit summary, the Certificate of Coverage prevails.

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

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

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible <ul style="list-style-type: none"> ▪ Co-payments are not included in the annual Deductible ▪ In-Network and Out-of-Network Deductibles apply separately ▪ Family Deductible is not considered satisfied until at least two (2) separate family members have satisfied their individual Deductibles ▪ The annual Deductible is calculated on a Calendar Year basis ▪ Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year 	Individual: [\$0-\$35,000] Family: [\$0-\$70,000]	Individual: [\$0-\$70,000] Family: [\$0-\$140,000]
Annual Out-of-Pocket Limit <ul style="list-style-type: none"> ▪ Applicable Coinsurance will apply until two separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit ▪ Benefit will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied ▪ Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits ▪ Co-payments do not apply toward your Out-of-Pocket Limits. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis 	Individual: [\$0-\$40,000] Family: [\$0-\$80,000]	Individual: [\$0-\$40,000] Family: [\$0-\$80,000]
Coinsurance	[0%-100%] after Deductible	[0%-100%] after Deductible
Preventive Care Services:		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical policies. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines Child Immunizations (age 0-18) Adult Immunizations (age 18+) <ul style="list-style-type: none"> ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) <i>Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Certificate of Coverage. Flu shots will be reimbursed at a fixed fee regardless of where they are obtained.</i>	No Cost to You	
Routine vision exam (limit one every 24 months)	[\$0-\$500 Co-payment]	Not Covered
Well baby care, birth - to age 2	No Cost to You	Not Covered
Well child care, ages 2-18	No Cost to You	Not Covered
Other preventive services <ul style="list-style-type: none"> ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over 	No Cost to You	Not Covered

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued <ul style="list-style-type: none"> ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually 	No Cost to You	Not Covered
<ul style="list-style-type: none"> ▪ Flexible sigmoidoscopy once every 5 years; OR ▪ Double contrast barium enema once every 5 years; OR ▪ Preventive colonoscopy, age 50 and older, once every 10 years 		
Family Planning <ul style="list-style-type: none"> ▪ Tubal ligation and associated services (reversal of sterilization is not a covered benefit) ▪ Insertion or implantation of birth control pellets, capsules or IUDs ▪ Fitting and insertion of diaphragms, rings or caps ▪ Injection of long acting contraceptives 	No Cost to You	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections 	[\$20-\$100] Co-payment	[0%-100%] after Deductible
Specialist Office Visit <ul style="list-style-type: none"> ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures 	[\$20-\$100] Co-payment	[0%-100%] after Deductible
The following professional services are subject to Deductible and Coinsurance: <ul style="list-style-type: none"> ▪ Complex diagnostic services - advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures - chemotherapy, radiation therapy and infusion therapy ▪ Complex Injectable Prescription Medications which include: All specialty medications such as, enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see "Outpatient Prescription Drug Benefit Summary") ▪ Complex procedures, such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility 	[0%-100%] after Deductible	[0%-100%] after Deductible
Inpatient Care - Room and Board		
<ul style="list-style-type: none"> ▪ Inpatient care - room and board (semi-private only) ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (30 day limit per Calendar Year for each) 	[0%-100%] after Deductible	[0%-100%] after Deductible
Outpatient Care and Ambulatory Care Centers		
<ul style="list-style-type: none"> ▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice services (limited to a lifetime maximum of 180 days) ▪ Outpatient Surgical Services 	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> ▪ Home Health Care (40 visits per Calendar Year) 	[0%-100%] after Deductible	[0%-100%] after Deductible
Emergency Services		
<ul style="list-style-type: none"> ▪ Emergency Room, Urgent Care or ER Observation Services 	[\$0-\$1,000] Co-payment	[\$0-\$1,000] Co-payment
Transportation Services		
<ul style="list-style-type: none"> ▪ Ambulance - Ground or Air (\$1,000 maximum benefit per Calendar Year) <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Therapy Services		
<ul style="list-style-type: none"> ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy ▪ Chiropractic Care 	[0%-100%] after Deductible	Not Covered
<ul style="list-style-type: none"> ▪ Cardiac Rehabilitation (36 visits per Calendar Year) <i>Note: Therapy and chiropractic services are limited to a combined maximum of 45 visits per Calendar Year. This does not include Cardiac Rehabilitation.</i>	[\$0-\$1,000] Co-payment	[0%-100%] after Deductible

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services: <ul style="list-style-type: none"> Routine Prenatal Lab Initial Office Visit All other services 	Not Covered	Not Covered
Facility Services Infertility Diagnostic Services Only <i>Note: Treatment of infertility is not covered.</i>	Not Covered	Not Covered
	Not Covered	Not Covered
Mental Health and Substance Use Disorder Services		
<ul style="list-style-type: none"> Professional Services (Office visit) 	Not Covered	Not Covered
<ul style="list-style-type: none"> Inpatient Hospital Services Professional Services (Inpatient Facility) 	Not Covered	
Allergy Services		
<ul style="list-style-type: none"> Allergy Testing and Allergy Shots 	PCP: [\$0-\$100] Co-payment OR Specialist: [\$0-\$100] Co-payment	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) <ul style="list-style-type: none"> \$5,000 maximum benefit per Calendar Year 	[0%-100%] after Deductible	Not Covered
Medical Supplies <ul style="list-style-type: none"> Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately. Provided in connection with home infusion therapy Provided in connection with Durable Medical Equipment 	PCP: [\$0-\$100] Co-payment or Specialist: [\$0-\$100] Co-payment [0%-100%] after Deductible	[0%-100%] after Deductible
	[0%-100%] after Deductible	Not Covered
Prosthetic and Orthotic Services and Devices <ul style="list-style-type: none"> Prosthetic Services and Prosthetic Devices Orthotic Services and Orthotic Devices <i>Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Certificate of Coverage for more information.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Reconstructive Surgery <ul style="list-style-type: none"> Breast reconstruction (48 hour minimum hospital stay) Restoration due to acute trauma, infection or cancer 	[0%-100%] after Deductible	[0%-100%] after Deductible
Transplantation Services <ul style="list-style-type: none"> Lifetime maximum of two transplants 	[0%-100%] after Deductible	Not Covered
Diabetes Management Services <ul style="list-style-type: none"> Supplies and equipment Diabetic Education (1 training per lifetime) 	[0%-100%] after Deductible [\$0-\$100] Co-payment	[0%-100%] after Deductible [0%-100%] after Deductible
Dental Care <ul style="list-style-type: none"> Accidental injury to sound and natural teeth \$2,000 maximum benefit per accident 	[\$0-\$100] Co-payment and 0% after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria <ul style="list-style-type: none"> Benefits available after member has paid \$2,400 per year 	[0%-100%] after Deductible	[0%-100%] after Deductible
Genetic Counseling and Testing <i>Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.</i>	No benefits if not pre-authorized	No benefits if not pre-authorized
	[0%-100%] after Deductible	[0%-100%] after Deductible

This benefit summary is part of the Certificate of Coverage, Form QC_Indiv_Prod_1 (10-10) **as amended by AMENDMENT to IQC (10-10) (8-1-2011)** and subject to all benefit terms and conditions, limitations and exclusions included in the Certificate of Coverage. This benefit summary is intended only to highlight your benefits and should not be relied upon solely to determine coverage. Please refer to the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Certificate of Coverage is different than this benefit summary, the Certificate of Coverage prevails.

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

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

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible <ul style="list-style-type: none"> ▪ Family deductible is not considered satisfied until the entire family deductible amount is satisfied ▪ The annual Deductible is calculated on a Calendar Year basis ▪ Deductible amounts applied in the last quarter of a Calendar Year will NOT carry over to the next Calendar Year 	Individual: [\$2,500 - \$5,000] Family: [\$5,000-\$10,000]	
Annual Out-of-Pocket Limit <ul style="list-style-type: none"> ▪ Applicable Coinsurance will apply until the family Out-of-Pocket Limit is satisfied ▪ Benefits will be paid at 100% of the Maximum Allowable Payment once the family annual Coinsurance Limit is satisfied ▪ Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits. ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis ▪ Annual Coinsurance Limit does not include Deductible amounts 	Individual: \$0 Family: \$0	Individual: \$5,000 Family: \$10,000
Coinsurance	0% after Deductible	50% after Deductible
Preventive Care Services:		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical policies. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Routine vision exam (limit one every 24 months)	Paid in full	Not Covered
Immunizations, including flu and pneumonia vaccines Child Immunizations (age 0-18) Adult Immunizations (age 18+) <ul style="list-style-type: none"> ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) <i>Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Certificate of Coverage. Flu shots will be reimbursed at a fixed fee regardless of where they are obtained.</i>	No Cost to You	
Well baby care, birth - to age 2 Well child care, ages 2-18 Other preventive services <ul style="list-style-type: none"> ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over 	No Cost to You	Not Covered

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued <ul style="list-style-type: none"> ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually ▪ Flexible sigmoidoscopy once every 5 years, OR ▪ Double contrast barium enema, OR ▪ Preventive colonoscopy age 50 and older, once every 10 years 	No Cost to You	Not Covered
Family Planning <ul style="list-style-type: none"> ▪ Tubal ligation and associated services (reversal of sterilization is not a covered benefit) ▪ Insertion or implantation of birth control pellets, capsules or IUDs ▪ Fitting and insertion of diaphragms, rings or caps ▪ Injection of long acting contraceptives 	No Cost to You	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections 	0% after Deductible	50% after Deductible
Specialist Office Visit <ul style="list-style-type: none"> ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures 	0% after Deductible	50% after Deductible
Other Professional services <ul style="list-style-type: none"> ▪ Complex diagnostic services - advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures, such as chemotherapy, radiation therapy and infusion therapy ▪ Complex Injectable Prescription Medications which include: All specialty medications such as, enbrel, humira, IV antibiotics and high potency antibiotics. (when obtained at a pharmacy, see "Outpatient Prescription Drug Benefit Summary" .) ▪ Complex procedures, such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility 	0% after Deductible	50% after Deductible
Inpatient Care - Room and Board		
<ul style="list-style-type: none"> ▪ Inpatient care - room and board ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (30 day limit per Calendar Year for each) 	0% after Deductible	50% after Deductible
Outpatient Care and Ambulatory Care Centers		
<ul style="list-style-type: none"> ▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice (limited to a lifetime maximum of 180 days) ▪ Outpatient Surgical Services ▪ Home Health Services (40 visits per Calendar Year) 	0% after Deductible	50% after Deductible
Emergency Services		
<ul style="list-style-type: none"> ▪ Emergency Room, Urgent Care or ER Observation Services 	0% after Deductible	50% after Deductible
Transportation Services		
<ul style="list-style-type: none"> ▪ Ambulance - Ground or Air (\$1,000 maximum benefit per Calendar Year) <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	0% after Deductible	50% after Deductible
Therapy Services		
<ul style="list-style-type: none"> ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy ▪ Chiropractic Care ▪ Audiology Care ▪ Cardiac Rehabilitation (36 visits per Calendar Year) <i>Note: Therapy and chiropractic services are limited to a combined maximum of 45 visits per Calendar Year. This does not include Cardiac Rehabilitation.</i>	0% after Deductible	50% Not Covered

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services: <ul style="list-style-type: none"> ▪ Routine Prenatal Lab ▪ Initial Office Visit ▪ All other services 	Not Covered	Not Covered
Facility Services	Not Covered	Not Covered
Infertility Diagnostic Services Only <i>Note: Treatment of infertility is not covered.</i>	Not Covered	Not Covered
Mental Health and Substance Use Disorder Services		
Professional Services (Office Visits) Inpatient Hospital Services Professional Services (Inpatient Facility)	Not Covered	Not Covered
Allergy Services		
Allergy Testing and shots	0% after Deductible	50% after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) <ul style="list-style-type: none"> ▪ \$5,000 maximum benefit per Calendar Year 	0% after Deductible	Not Covered
Medical Supplies <ul style="list-style-type: none"> ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately ▪ Provided in connection with home infusion therapy ▪ Provided in connection with Durable Medical Equipment 	0% after Deductible	50% after Deductible
Prosthetic and Orthotic Services and Devices <ul style="list-style-type: none"> ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices <i>Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Certificate of Coverage for more information.</i>	0% after Deductible	50% after Deductible
Reconstructive Surgery <ul style="list-style-type: none"> ▪ Breast reconstruction (48 hour minimum hospital stay) ▪ Restoration due to acute trauma, infection or cancer 	0% after Deductible	50% after Deductible
Transplantation Services <ul style="list-style-type: none"> ▪ Lifetime maximum of two transplants 	0% after Deductible	Not Covered
Diabetes Management Services <ul style="list-style-type: none"> ▪ Supplies and equipment ▪ Diabetic Education (1 training per lifetime) 	0% after Deductible	Not Covered
Dental Care <ul style="list-style-type: none"> ▪ Accidental injury to sound and natural teeth ▪ \$2,000 maximum benefit per accident 	0% after Deductible	50% after Deductible
Medical Foods for Phenylketonuria <ul style="list-style-type: none"> ▪ Benefits available after member has paid \$2,400 per year 	0% after Deductible	50% after Deductible
Genetic Counseling and Testing <i>Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.</i>	No benefits if not pre-authorized 0% after Deductible	No benefits if not pre-authorized 50% after Deductible

NOTE: This High Deductible Health Plan is qualified for use with a Health Savings Account.

This benefit summary is part of the Certificate of Coverage, Form IQC (10-10) as amended by Amendment to IQC (10-10) (8-1-2011) and Outpatient Prescription Drug Rider and is subject to all benefit terms and conditions, limitations and exclusions included in the Certificate of Coverage. This benefit summary is intended only to highlight your benefits for Outpatient Prescription Drugs and should not be relied upon solely to determine coverage. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Outpatient Prescription Drug Rider and/or Certificate of Coverage are different than this benefit summary, the Outpatient Prescription Drug Rider and the Certificate of Coverage prevail.

Some medications may require pre-authorization by QualChoice. For details and to access the most current listing of specific medications, including those requiring pre-authorization, visit our website at www.qualchoice.com.

Tier Definitions:

Tier 1 medications are the lowest cost share option, as shown below. For the lowest out-of-pocket expense, you should always consider Tier 1 if you and your doctor decide they are appropriate for your treatment.

Tier 2 medications require a tier 2 cost share, as shown below. Consider Tier 2 medications if you and your doctor decide that a Tier 2 medication is the most appropriate to treat your condition.

Tier 3 medications require a Tier 3 cost share, as shown below. If your medication is in Tier 3, ask your doctor whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.

Tier 4 medications are not included on the formulary. Almost all new prescription medications that are not listed in the formulary are included in Tier 4.

[Applicable Discount: (Individual Core or Basic) "Member pays 100% of the QualChoice discounted rate."]

Tier 5 medications are generally classified as specialty medications and are generally only available through mail-order when not dispensed or administered by your physician in his/her office. Many Tier 5 medications require pre-authorization and are at the highest level of cost share.

Payment Procedures

Network Pharmacy

- You must pay the applicable cost sharing amount to the network pharmacy at the time the prescription is filled.
- The pharmacy will then submit the claim for reimbursement.

Out-of-Network Pharmacy

- You must pay the full amount of the prescription to the out-of-network pharmacy.
- You can then request reimbursement from QualChoice by submitting your receipt from the pharmacy, along with a QualChoice claim form.
- Reimbursement to you will be based on the contract rate for the drug dispensed, less a \$2.00 processing fee.
- Reimbursement may take up to 6 weeks.

Prescription Benefits In-Network	Retail (You Pay)	Mail Order (You Pay)
[Co-payment/Coinsurance] Amounts		
• Tier 1	[\$0-\$100 Co-payment] or [Nothing after Deductible]	[\$0-\$100 Co-payment] or [Nothing after Deductible]
• Tier 2	[\$0-\$500 Co-payment] or [Nothing after Deductible]	[\$0-\$500 Co-payment] or [Nothing after Deductible]
• Tier 3	[\$0-\$1,000 Co-payment] or [Nothing after Deductible]	[\$0-\$1,000 Co-payment] or [Nothing after Deductible]
• Tier 4	100%	100%
• Tier 5	\$200	\$200*
Coinsurance Amounts		
• Tier 1	[Nothing] or [0%-100% after Deductible]	[Nothing] or [0%-100% after Deductible]
• Tier 2	[Nothing] or [0%-100% after Deductible]	[Nothing] or [0%-100% after Deductible]
• Tier 3	[Nothing] or [0%-100% after Deductible]	[Nothing] or [0%-100% after Deductible]
• Tier 4	100%	100%
• Tier 5	\$200	\$200
Deductible	[\$2,500-\$10,000]	[\$2,500-\$10,000]

Contraceptive Coverage

- All oral contraceptives in either formulary Tiers 1 or 2 (all formulary options) - No Cost to You. (No coverage Out-of-Network)
 - Oral contraceptives in Tier 3 - Normal cost sharing, see Tier 3 above
- Ortho Evra patch, Nuvaring, Caps and Diaphragms - No Cost to You (No coverage Out-of-Network)
- Emergency contraceptives, e.g. Plan B, Ella - no cost sharing with a prescription, otherwise, not a covered benefit
- Over-the-counter birth control methods, e.g. gels, creams, condoms, etc. - not a covered benefit
- Abortion or abortifacient drugs - not a covered benefit

Limitations

- Retail pharmacy - One monthly cost sharing amount per **[30 or 31]** day supply
- Mail order pharmacy - **[1 to 5]** monthly cost sharing amounts per 90-day supply

Note:

- All new prescriptions are limited to a **[30 or 31]** day supply. Refills of maintenance medication are limited to a 90-day supply at certain contracted pharmacies and through mail order.
- Insulin and syringes will be covered with one monthly cost sharing amount for each **[30 or 31]** day supply, if filled at the same time.
- Test strips and lancets will be covered with one monthly cost sharing amount for each **[30 or 31]** day supply, if filled at the same time.
- Contact a Health Coach at 1-888-795-6810, if you need assistance obtaining a new glucometer.

Step Therapy

Certain medications may be required to be used before another medication is covered. Step therapy is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other and more costly therapy if the first line medication fails. **Examples** of step therapy under this plan include certain antihypertensive medications and Attention Deficit Disorder (ADD) medication.

Contact Customer Service at 1-501-228-7111 or 1-800-235-7111 for more details.

Benefit Details

- Benefit details are subject to all benefit terms, conditions, limitations and exclusions.
- Benefits are provided for formulary prescription drugs when prescribed by a physician or by a licensed health care provider within the scope of their license.
- Benefits are available through a network pharmacy, a network mail order pharmacy or an out-of-network pharmacy, provided that the drug is a Covered Prescription Drug.
- Benefits include compound prescriptions when the compound contains at least one prescription drug.
- Coverage is provided for contraceptives ("Birth Control") including oral, injectable and hormonal contraceptives.

Exclusions

Examples of drugs that we will not pay for are listed below. A complete listing is in the Outpatient Prescription Drug Rider.

- Experimental or investigational drugs or research drugs;
- Over-the-counter medications;
- Cosmetic agents, including, but not limited to, Retin-A for enrollees over age 25;
- Erectile dysfunction drugs, including but not limited to, impotency;
- Drugs for which there is a therapeutically equivalent over-the-counter drug;
- Oral or topical medication for hair loss;
- Smoking cessation medications, except for persons enrolled in the QualChoice "Kick the Nic" program;
- Smoking cessation devices;
- Drugs prescribed to treat infertility;
- Weight loss medication; appetite suppressants; anti-obesity drugs; anorexiant;
- General vitamins;
- Drugs whose primary purpose is the removal, destruction, or interference with the implantation of a fertilized ovum, embryo, or fetus;
- A drug prescribed as part of treatment to change an Enrollee's gender; and
- Over-the-counter birth control items

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

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

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

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued <ul style="list-style-type: none"> ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually 	No Cost to You	Not Covered
<ul style="list-style-type: none"> ▪ Flexible sigmoidoscopy once every 5 years; OR ▪ Double contrast barium enema once every 5 years; OR ▪ Preventive colonoscopy, age 50 and older, once every 10 years 		
Family Planning <ul style="list-style-type: none"> ▪ Tubal ligation and associated services (reversal of sterilization is not a covered benefit) ▪ Insertion or implantation of birth control pellets, capsules or IUDs ▪ Fitting and insertion of diaphragms, rings or caps ▪ Injection of long acting contraceptives 	No Cost to You	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections 	[\$0-\$100] Co-payment	[0%-100%] after Deductible
Specialist Office Visit <ul style="list-style-type: none"> ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures 	[0%-100%] [after [\$0-\$350] Co- [0%-100%] after Deductible	[0%-100%] after Deductible
The following professional services are subject to Deductible and Coinsurance: <ul style="list-style-type: none"> ▪ Complex diagnostic services - advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures - chemotherapy, radiation therapy and infusion therapy ▪ Complex Injectable Prescription Medications which include: All specialty medications such as, enbrel, humira, IV medications and high potency antibiotics ▪ Complex procedures, such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility 	[0%-100%] after Deductible	[0%-100%] after Deductible
Inpatient Care - Room and Board		
<ul style="list-style-type: none"> ▪ Inpatient care - room and board (semi-private only) ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (30 day limit per Calendar Year for each) 	[\$0-\$500 Co-payment] and/or [0%-100%] after Deductible	[0%-100%] after Deductible
Outpatient Care and Ambulatory Care Centers		
<ul style="list-style-type: none"> ▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice services (limited to a lifetime maximum of 180 days) 	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> ▪ Outpatient Surgical Services ▪ Home Health Care (40 visits per Calendar Year) 	[\$0-\$500 Co-payment] and/or [0%-100%] after Deductible	[0%-100%] after Deductible
Emergency Services		
<ul style="list-style-type: none"> ▪ Emergency Room, Urgent Care or ER Observation Services 	[\$0-\$1,000] Co-payment or [[0%-100%] after Deductible]	[\$0-\$1,000] Co-payment or [[0%-100%] after Deductible]
Transportation Services		
<ul style="list-style-type: none"> ▪ Ambulance - Ground or Air (\$1,000 maximum benefit per Calendar Year) <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Therapy Services		
<ul style="list-style-type: none"> ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy ▪ Chiropractic Care 	[0%-100%] after Deductible	Not Covered
<ul style="list-style-type: none"> ▪ Cardiac Rehabilitation (36 visits per Calendar Year) <i>Note: Therapy and chiropractic services are limited to a combined maximum of 45 visits per Calendar Year. This does not include Cardiac Rehabilitation.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services: <ul style="list-style-type: none"> Routine Prenatal Lab Initial Office Visit All other services 	Not Covered	Not Covered
Facility Services	Not Covered	Not Covered
Infertility Diagnostic Services Only <i>Note: Treatment of infertility is not covered.</i>	Not Covered	Not Covered
Mental Health and Substance Use Disorder Services		
<ul style="list-style-type: none"> Professional Services (Office visit) <i>Note: If the Mental Health and Substance Use Disorder Rider is purchased refer to the Primary Care Physician (PCP) Office Visit Benefit in the Professional Services Category of this summary for applicable benefits.</i>	Not Covered	Not Covered
<ul style="list-style-type: none"> Inpatient Hospital Services Professional Services (Inpatient Facility) <i>Note: If the Mental Health and Substance Use Disorder Rider is purchased refer to the "Inpatient Care - Room and Board" Category of this summary for applicable benefits.</i>	Not Covered	
Allergy Services		
<ul style="list-style-type: none"> Office Visit and Allergy Testing 	PCP: [\$0-\$100] Co-payment OR Specialist: [0%-100%] [and/or] [\$0-\$350 Co-payment]	[0%-100%] after Deductible
<ul style="list-style-type: none"> Allergy Shots 	No Cost to You	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) <ul style="list-style-type: none"> \$5,000 maximum benefit per Calendar Year 	[0%-10%] after Deductible	Not Covered
Medical Supplies <ul style="list-style-type: none"> Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately. Provided in connection with home infusion therapy Provided in connection with Durable Medical Equipment 	PCP: [\$0-\$100] Co-payment or Specialist: [0%-100%] [0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible Not Covered
Prosthetic and Orthotic Services and Devices <ul style="list-style-type: none"> Prosthetic Services and Prosthetic Devices Orthotic Services and Orthotic Devices <i>Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Certificate of Coverage for more information.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Reconstructive Surgery <ul style="list-style-type: none"> Breast reconstruction (48 hour minimum hospital stay) Restoration due to acute trauma, infection or cancer 	[0%-100%] after Deductible	[0%-100%] after Deductible
Transplantation Services <ul style="list-style-type: none"> Lifetime maximum of two transplants 	[0%-100%] after Deductible	Not Covered
Diabetes Management Services <ul style="list-style-type: none"> Supplies and equipment Diabetic Education (1 training per lifetime) 	[0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible [0%-100%] after Deductible
Dental Care <ul style="list-style-type: none"> Accidental injury to sound and natural teeth \$2,000 maximum benefit per accident 	[0%-100%] after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria <ul style="list-style-type: none"> Benefits available after member has paid \$2,400 per year 	[0%-100%] after Deductible	[0%-100%] after Deductible
Genetic Counseling and Testing <i>Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.</i>	No benefits if not pre-authorized [0%-100%] after Deductible	No benefits if not pre-authorized [0%-100%] after Deductible

This benefit summary is part of the Certificate of Coverage, Form IQCSelect_Indiv_Prod_1 (2011) **as amended by Amendment (2) to IQCSelect (2011)** and subject to all benefit terms and conditions, limitations and exclusions included in the Certificate of Coverage. This benefit summary is intended only to highlight your benefits and should not be relied upon solely to determine coverage. Please refer to the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Certificate of Coverage is different than this benefit summary, the Certificate of Coverage prevails.

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

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

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible <ul style="list-style-type: none"> ▪ Family deductible is not considered satisfied until the entire family deductible amount is satisfied ▪ The annual Deductible is calculated on a Calendar Year basis ▪ Deductible amounts applied in the last quarter of a Calendar Year will NOT carry over to the next Calendar Year 	Individual: [\$2,500-\$10,000] Family: [\$5,000-\$20,000]	
Annual Out-of-Pocket Limit <ul style="list-style-type: none"> ▪ Applicable Coinsurance will apply until the family Out-of-Pocket Limit is satisfied ▪ Benefits will be paid at 10[0%-100%] of the Maximum Allowable Payment once the family annual Coinsurance Limit is satisfied ▪ Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits. ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis ▪ Annual Coinsurance Limit does not include Deductible amounts 	Individual: \$0 Family: \$0	Individual: Unlimited Family: Unlimited
Coinsurance	[0%-100%] after Deductible	[0%-100%] after Deductible
Preventive Care Services:		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical policies. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Routine vision exam (limit one every 24 months)	No Cost to You	Not Covered
Immunizations, including flu and pneumonia vaccines Child Immunizations (age 0-18) Adult Immunizations (age 18+) <ul style="list-style-type: none"> ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) <i>Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Certificate of Coverage. Flu shots will be reimbursed at a fixed fee regardless of where they are obtained.</i>	No Cost to You	
Well baby care, birth - to age 2 Well child care, ages 2-18 Other preventive services <ul style="list-style-type: none"> ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over 	No Cost to You	Not Covered

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued <ul style="list-style-type: none"> ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually ▪ Flexible sigmoidoscopy once every 5 years, OR ▪ Double contrast barium enema, OR ▪ Preventive colonoscopy age 50 and older, once every 10 years 	No Cost to You	Not Covered
Family Planning <ul style="list-style-type: none"> ▪ Tubal ligation and associated services (reversal of sterilization is not a covered benefit) ▪ Insertion or implantation of birth control pellets, capsules or IUDs ▪ Fitting and insertion of diaphragms, rings or caps ▪ Injection of long acting contraceptives 	No Cost to You	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections 	[0%-100%] after Deductible	[0%-100%] after Deductible
Specialist Office Visit <ul style="list-style-type: none"> ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures 	[0%-100%] after Deductible	[0%-100%] after Deductible
Other Professional services <ul style="list-style-type: none"> ▪ Complex diagnostic services - advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures, such as chemotherapy, radiation therapy and infusion therapy ▪ Complex Injectable Prescription Medications which include: All specialty medications such as, enbrel, humira, IV antibiotics and high potency antibiotics ▪ Complex procedures, such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility 	[0%-100%] after Deductible	[0%-100%] after Deductible
Inpatient Care - Room and Board		
<ul style="list-style-type: none"> ▪ Inpatient care - room and board ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (30 day limit per Calendar Year for each) 	[0%-100%] after Deductible	[0%-100%] after Deductible
Outpatient Care and Ambulatory Care Centers		
<ul style="list-style-type: none"> ▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice (limited to a lifetime maximum of 180 days) ▪ Outpatient Surgical Services ▪ Home Health Services (40 visits per Calendar Year) 	[0%-100%] after Deductible	[0%-100%] after Deductible
Emergency Services		
<ul style="list-style-type: none"> ▪ Emergency Room, Urgent Care or ER Observation Services 	[0%-100%] after Deductible	[0%-100%] after Deductible
Transportation Services		
<ul style="list-style-type: none"> ▪ Ambulance - Ground or Air (\$1,000 maximum benefit per Calendar Year) <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Therapy Services		
<ul style="list-style-type: none"> ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy ▪ Chiropractic Care ▪ Audiology Care ▪ Cardiac Rehabilitation (36 visits per Calendar Year) <i>Note: Therapy and chiropractic services are limited to a combined maximum of 45 visits per Calendar Year. This does not include Cardiac Rehabilitation.</i>	[0%-100%] after Deductible	[0%-100%] Not Covered

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services: <ul style="list-style-type: none"> ▪ Routine Prenatal Lab ▪ Initial Office Visit ▪ All other services 	Not Covered	Not Covered
Facility Services	Not Covered	Not Covered
Infertility Diagnostic Services Only <i>Note: Treatment of infertility is not covered.</i>	Not Covered	Not Covered
Mental Health and Substance Use Disorder Services		
Professional Services (Office Visits) <i>Note: If the Mental Health and Substance Use Disorder Rider is purchased refer to the Primary Care Physician (PCP) Office Visit Benefit in the Professional Services Category of this summary for applicable benefits.</i>	Not Covered	Not Covered
Inpatient Hospital Services Professional Services (Inpatient Facility) <i>Note: If the Mental Health and Substance Use Disorder Rider is purchased refer to the "Inpatient Care - Room and Board" Category of this summary for applicable benefits.</i>		
Allergy Services		
Allergy Testing and shots	[0%-100%] after Deductible	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) <ul style="list-style-type: none"> ▪ \$5,000 maximum benefit per Calendar Year 	[0%-100%] after Deductible	Not Covered
Medical Supplies <ul style="list-style-type: none"> ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately ▪ Provided in connection with home infusion therapy ▪ Provided in connection with Durable Medical Equipment 	[0%-100%] after Deductible	[0%-100%] after Deductible
Prosthetic and Orthotic Services and Devices <ul style="list-style-type: none"> ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices <i>Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Certificate of Coverage for more information.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Reconstructive Surgery <ul style="list-style-type: none"> ▪ Breast reconstruction (48 hour minimum hospital stay) ▪ Restoration due to acute trauma, infection or cancer 	[0%-100%] after Deductible	[0%-100%] after Deductible
Transplantation Services <ul style="list-style-type: none"> ▪ Lifetime maximum of two transplants 	[0%-100%] after Deductible	Not Covered
Diabetes Management Services <ul style="list-style-type: none"> ▪ Supplies and equipment ▪ Diabetic Education (1 training per lifetime) 	[0%-100%] after Deductible	Not Covered
Dental Care <ul style="list-style-type: none"> ▪ Accidental injury to sound and natural teeth ▪ \$2,000 maximum benefit per accident 	[0%-100%] after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria <ul style="list-style-type: none"> ▪ Benefits available after member has paid \$2,400 per year 	[0%-100%] after Deductible	[0%-100%] after Deductible
Genetic Counseling and Testing <i>Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.</i>	No benefits if not pre-authorized [0%-100%] after Deductible	No benefits if not pre-authorized [0%-100%] after Deductible

NOTE: This High Deductible Health Plan is qualified for use with a Health Savings Account.

This benefit summary is part of the Certificate of Coverage, **Form IQCSelect_Indiv_Prod_1 (2011)** and Outpatient Prescription Drug Rider and is subject to all benefit terms and conditions, limitations and exclusions included in the Certificate of Coverage. This benefit summary is intended only to highlight your benefits for Outpatient Prescription Drugs and should not be relied upon solely to determine coverage. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Outpatient Prescription Drug Rider and/or Certificate of Coverage are different than this benefit summary, the Outpatient Prescription Drug Rider and the Certificate of Coverage prevail.

Some medications may require pre-authorization by QualChoice. For details and to access the most current listing of specific medications, including those requiring pre-authorization, visit our website at www.qualchoice.com.

Tier Definitions:

Tier 1 medications are the lowest cost share option, as shown below. For the lowest out-of-pocket expense, you should always consider Tier 1 if you and your doctor decide they are appropriate for your treatment.

Tier 2 medications require a tier 2 cost share, as shown below. Consider Tier 2 medications if you and your doctor decide that a Tier 2 medication is the most appropriate to treat your condition.

Tier 3 medications require a Tier 3 cost share, as shown below. If your medication is in Tier 3, ask your doctor whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.

Tier 4 medications are not included on the formulary. Almost all new prescription medications that are not listed in the formulary are included in Tier 4.

Member pays 100% of the QualChoice discounted rate. Member out-of-pocket will not accumulate toward any deductible or coinsurance limit.

Tier 5 medications are generally classified as specialty medications and are generally only available through mail-order when not dispensed or administered by your physician in his/her office. Many Tier 5 medications require pre-authorization, see Medical Benefit Summary for applicable cost sharing.

Payment Procedures

Network Pharmacy

- You must pay the applicable cost sharing amount to the network pharmacy at the time the prescription is filled.
- The pharmacy will then submit the claim for reimbursement.

Out-of-Network Pharmacy

- You must pay the full amount of the prescription to the out-of-network pharmacy.
- You can then request reimbursement from QualChoice by submitting your receipt from the pharmacy, along with a QualChoice claim form.
- Reimbursement to you will be based on the contract rate for the drug dispensed, less a \$2.00 processing fee.
- Reimbursement may take up to 6 weeks.

Prescription Benefits In-Network	Retail (You Pay)	Mail Order (You Pay)
Co-payment Amounts		
▪ Tier 1	\$10 Co-payment	\$30 Co-payment
▪ Tier 2	\$35 Co-payment	\$105 Co-payment
▪ Tier 3	\$70 Co-payment	\$210 Co-payment
▪ Tier 4	100%	100%
▪ Tier 5*	\$200 Co-payment	Not Applicable
<i>*NOTE: If dispensed in your physician office or at a facility - see medical benefits</i>		
Deductible	Not Applicable	

Contraceptive Coverage

- All oral contraceptives in either formulary Tiers 1 or 2 (all formulary options) - No Cost to You. (No coverage Out-of-Network)
- Oral contraceptives in Tier 3 - Normal cost sharing, see Tier 3 above
- Ortho Evra patch, Nuvaring, Caps and Diaphragms - No Cost to You (No coverage Out-of-Network)
- Emergency contraceptives, e.g. Plan B, Ella - no cost sharing with a prescription, otherwise, not a covered benefit
- Over-the-counter birth control methods, e.g. gels, creams, condoms, etc. - not a covered benefit
- Abortion or abortifacient drugs - not a covered benefit

Limitations

- Retail pharmacy - One monthly cost sharing amount per 30 day supply
- Mail order pharmacy - 3 monthly cost sharing amounts per 90-day supply

Note:

- *All new prescriptions are limited to a 30 day supply. Refills of maintenance medication are limited to a 90-day supply at certain contracted pharmacies and through mail order.*
- *Insulin and syringes will be covered with one monthly cost sharing amount for each 30 day supply, if filled at the same time.*
- *Test strips and lancets will be covered with one monthly cost sharing amount for each 30 day supply, if filled at the same time.*
- *Contact a Health Coach at 1-888-795-6810, if you need assistance obtaining a new glucometer.*

Step Therapy

Certain medications may be required to be used before another medication is covered. Step therapy is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other and more costly therapy if the first line medication fails. **Examples** of step therapy under this plan include certain antihypertensive medications and Attention Deficit Disorder (ADD) medication.

Contact Customer Service at 1-501-228-7111 or 1-800-235-7111 for more details.

Benefit Details

- Benefit details are subject to all benefit terms, conditions, limitations and exclusions.
- Benefits are provided for formulary prescription drugs when prescribed by a physician or by a licensed health care provider within the scope of their license.
- Benefits are available through a network pharmacy, a network mail order pharmacy or an out-of-network pharmacy, provided that the drug is a Covered Prescription Drug.
- Benefits include compound prescriptions when the compound contains at least one prescription drug.
- Coverage is provided for contraceptives ("Birth Control") including oral, injectable and hormonal contraceptives.

Exclusions

Examples of drugs that we will not pay for are listed below. A complete listing is in the Outpatient Prescription Drug Rider.

- Experimental or investigational drugs or research drugs;
- Over-the-counter medications;
- Cosmetic agents, including, but not limited to, Retin-A for enrollees over age 25;
- Erectile dysfunction drugs, including but not limited to, impotency;
- Drugs for which there is a therapeutically equivalent over-the-counter drug;
- Oral or topical medication for hair loss;
- Smoking cessation medications, except for persons enrolled in the QualChoice "Kick the Nic" program;
- Smoking cessation devices;
- Drugs prescribed to treat infertility;
- Weight loss medication; appetite suppressants; anti-obesity drugs; anorexiant;
- General vitamins;
- Drugs whose primary purpose is the removal, destruction, or interference with the implantation of a fertilized ovum, embryo, or fetus;
- A drug prescribed as part of treatment to change an Enrollee's gender; and
- Over-the-counter birth control items

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Some medications may require pre-authorization by QualChoice. For details and to access the most current listing of specific medications, including those requiring pre-authorization, visit our website at www.qualchoice.com.

Tier Definitions:

Tier 1 medications are the lowest cost share option, as shown below. For the lowest out-of-pocket expense, you should always consider Tier 1 if you and your doctor decide they are appropriate for your treatment.

Tier 2 medications require a tier 2 cost share, as shown below. Consider Tier 2 medications if you and your doctor decide that a Tier 2 medication is the most appropriate to treat your condition.

Tier 3 medications require a Tier 3 cost share, as shown below. If your medication is in Tier 3, ask your doctor whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.

Tier 4 medications are not included on the formulary. Almost all new prescription medications that are not listed in the formulary are included in Tier 4.

Member pays 100% of the QualChoice discounted rate. Member out-of-pocket will not accumulate toward any deductible or coinsurance limit.

Tier 5 medications are generally classified as specialty medications and are generally only available through mail-order when not dispensed or administered by your physician in his/her office. Many Tier 5 medications require pre-authorization, see Medical Benefit Summary for applicable cost sharing.

Payment Procedures

Network Pharmacy

- You must pay the applicable cost sharing amount to the network pharmacy at the time the prescription is filled.
- The pharmacy will then submit the claim for reimbursement.

Out-of-Network Pharmacy

- You must pay the full amount of the prescription to the out-of-network pharmacy.
- You can then request reimbursement from QualChoice by submitting your receipt from the pharmacy, along with a QualChoice claim form.
- Reimbursement to you will be based on the contract rate for the drug dispensed, less a \$2.00 processing fee.
- Reimbursement may take up to 6 weeks.

Prescription Benefits In-Network	Retail (You Pay)	Mail Order (You Pay)
Coinsurance Amounts		
▪ Tier 1	0% after Deductible	0% after Deductible
▪ Tier 2	0% after Deductible	0% after Deductible
▪ Tier 3	0% after Deductible	0% after Deductible
▪ Tier 4	100%	100%
▪ Tier 5	0% after Deductible	0% after Deductible
Deductible	Individual: [\$2,500-\$5,000]/Family: [\$5,000-\$10,000]	

Contraceptive Coverage

- All oral contraceptives in either formulary Tiers 1 or 2 (all formulary options) - No Cost to You. (No coverage Out-of-Network)
- Oral contraceptives in Tier 3 - Normal cost sharing, see Tier 3 above
- Ortho Evra patch, Nuvaring, Caps and Diaphragms - No Cost to You (No coverage Out-of-Network)
- Emergency contraceptives, e.g. Plan B, Ella - no cost sharing with a prescription, otherwise, not a covered benefit
- Over-the-counter birth control methods, e.g. gels, creams, condoms, etc. - not a covered benefit
- Abortion or abortifacient drugs - not a covered benefit

Limitations

- Retail pharmacy - One monthly cost sharing amount per 30 day supply
- Mail order pharmacy - 3 monthly cost sharing amounts per 90-day supply

Note:

- *All new prescriptions are limited to a 30 day supply. Refills of maintenance medication are limited to a 90-day supply at certain contracted pharmacies and through mail order.*
- *Insulin and syringes will be covered with one monthly cost sharing amount for each 30 day supply, if filled at the same time.*
- *Test strips and lancets will be covered with one monthly cost sharing amount for each 30 day supply, if filled at the same time.*
- *Contact a Health Coach at 1-888-795-6810, if you need assistance obtaining a new glucometer.*

Step Therapy

Certain medications may be required to be used before another medication is covered. Step therapy is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other and more costly therapy if the first line medication fails. **Examples** of step therapy under this plan include certain antihypertensive medications and Attention Deficit Disorder (ADD) medication.

Contact Customer Service at 1-501-228-7111 or 1-800-235-7111 for more details.

Benefit Details

- Benefit details are subject to all benefit terms, conditions, limitations and exclusions.
- Benefits are provided for formulary prescription drugs when prescribed by a physician or by a licensed health care provider within the scope of their license.
- Benefits are available through a network pharmacy, a network mail order pharmacy or an out-of-network pharmacy, provided that the drug is a Covered Prescription Drug.
- Benefits include compound prescriptions when the compound contains at least one prescription drug.
- Coverage is provided for contraceptives ("Birth Control") including oral, injectable and hormonal contraceptives.

Exclusions

Examples of drugs that we will not pay for are listed below. A complete listing is in the Outpatient Prescription Drug Rider.

- Experimental or investigational drugs or research drugs;
- Over-the-counter medications;
- Cosmetic agents, including, but not limited to, Retin-A for enrollees over age 25;
- Erectile dysfunction drugs, including but not limited to, impotency;
- Drugs for which there is a therapeutically equivalent over-the-counter drug;
- Oral or topical medication for hair loss;
- Smoking cessation medications, except for persons enrolled in the QualChoice "Kick the Nic" program;
- Smoking cessation devices;
- Drugs prescribed to treat infertility;
- Weight loss medication; appetite suppressants; anti-obesity drugs; anorexiant;
- General vitamins;
- Drugs whose primary purpose is the removal, destruction, or interference with the implantation of a fertilized ovum, embryo, or fetus;
- A drug prescribed as part of treatment to change an Enrollee's gender; and
- Over-the-counter birth control items

This benefit summary is part of the Certificate of Coverage, Form Child Only (2011) **as amended by AMENDMENT(2) to IQCSelect (2011)** and subject to all benefit terms and conditions, limitations and exclusions included in the Certificate of Coverage. This benefit summary is intended only to highlight your benefits and should not be relied upon solely to determine coverage. Please refer to the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Certificate of Coverage is different than this benefit summary, the Certificate of Coverage prevails.

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

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

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible <ul style="list-style-type: none"> ▪ Co-payments are not included in the annual Deductible ▪ In-Network and Out-of-Network Deductibles apply separately ▪ The annual Deductible is calculated on a Calendar Year basis ▪ Deductible amounts applied in the last quarter of a Calendar Year will NOT carry over to the next Calendar Year 	Individual: [\$0-\$20,000]	Individual: [\$0-Unlimited]
Annual Out-of-Pocket Limit <ul style="list-style-type: none"> ▪ Benefit will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied ▪ Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits ▪ Co-payments do not apply toward your Out-of-Pocket Limits. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis 	Individual: [\$0-\$10,000]	Individual: [\$0-Unlimited]
Coinsurance	[0%-100%] after Deductible	[0%-100%] after Deductible
Preventive Care Services:		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical policies. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines Child Immunizations (age 0-18) Adult Immunizations (age 18+) <ul style="list-style-type: none"> ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) <i>Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Certificate of Coverage. Flu shots will be reimbursed at a fixed fee regardless of where they are obtained.</i>	No Cost to You	
Routine vision exam (limit one every 24 months)	No Cost to You	Not Covered
Well baby care, birth - to age 2	No Cost to You	Not Covered
Well child care, ages 2-18	No Cost to You	Not Covered
Other preventive services <ul style="list-style-type: none"> ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over 	No Cost to You	Not Covered

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued <ul style="list-style-type: none"> ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually 	No Cost to You	Not Covered
<ul style="list-style-type: none"> ▪ Flexible sigmoidoscopy once every 5 years; OR ▪ Double contrast barium enema once every 5 years; OR ▪ Preventive colonoscopy, age 50 and older, once every 10 years 		
Family Planning <ul style="list-style-type: none"> ▪ Tubal ligation and associated services (reversal of sterilization is not a ▪ Insertion or implantation of birth control pellets, capsules or IUDs ▪ Fitting and insertion of diaphragms, rings or caps ▪ Injection of long acting contraceptives 	No Cost to You	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections 	[\$0-\$100] Co-payment	[0%-100%] after Deductible
Specialist Office Visit <ul style="list-style-type: none"> ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures 	[0%-100%] [after [\$0-\$350] Co-payment] [0%-100%] after Deductible	[0%-100%] after Deductible
The following professional services are subject to Deductible and Coinsurance: <ul style="list-style-type: none"> ▪ Complex diagnostic services - advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures - chemotherapy, radiation therapy and infusion therapy ▪ Complex Injectable Prescription Medications which include: All specialty medications such as, enbrel, humira, IV medications and high potency antibiotics ▪ Complex procedures, such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility 	[0%-100%] after Deductible	[0%-100%] after Deductible
Inpatient Care - Room and Board		
<ul style="list-style-type: none"> ▪ Inpatient care - room and board (semi-private only) ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (30 day limit per Calendar Year for each) 	[\$0-\$500 Co-payment] and/or [0%-100%] after Deductible	[0%-100%] after Deductible
Outpatient Care and Ambulatory Care Centers		
<ul style="list-style-type: none"> ▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice services (limited to a lifetime maximum of 180 days) 	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> ▪ Outpatient Surgical Services 	[\$0-\$500 Co-payment] and/or [0%-100%] after Deductible	
<ul style="list-style-type: none"> ▪ Home Health Care (40 visits per Calendar Year) 	[0%-100%] after Deductible	[0%-100%] after Deductible
Emergency Services		
<ul style="list-style-type: none"> ▪ Emergency Room, Urgent Care or ER Observation Services 	[\$0-\$1,000] Co-payment or [[0%-100%] after Deductible]	[\$0-\$1,000] Co-payment or [[0%-100%] after Deductible]
Transportation Services		
<ul style="list-style-type: none"> ▪ Ambulance - Ground or Air (\$1,000 maximum benefit per Calendar Year) <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Therapy Services		
<ul style="list-style-type: none"> ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy ▪ Chiropractic Care 	[0%-100%] after Deductible	Not Covered
<ul style="list-style-type: none"> ▪ Cardiac Rehabilitation (36 visits per Calendar Year) <i>Note: Therapy and chiropractic services are limited to a combined maximum of 45 visits per Calendar Year. This does not include Cardiac Rehabilitation.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services: <ul style="list-style-type: none"> ▪ Routine Prenatal Lab ▪ Initial Office Visit ▪ All other services 	Not Covered	Not Covered
Facility Services	Not Covered	Not Covered
Infertility Diagnostic Services Only <i>Note: Treatment of infertility is not covered.</i>	Not Covered	Not Covered
Mental Health and Substance Use Disorder Services		
<ul style="list-style-type: none"> ▪ Professional Services (Office visit) <i>Note: If the Mental Health and Substance Use Disorder Rider is purchased refer to the Primary Care Physician (PCP) Office Visit Benefit in the Professional Services Category of this summary for applicable benefits.</i>	Not Covered	Not Covered
<ul style="list-style-type: none"> ▪ Inpatient Hospital Services ▪ Professional Services (Inpatient Facility) <i>Note: If the Mental Health and Substance Use Disorder Rider is purchased refer to the "Inpatient Care - Room and Board" Category of this summary for applicable benefits.</i>	Not Covered	
Allergy Services		
<ul style="list-style-type: none"> ▪ Office Visit and Allergy Testing 	PCP: [\$0-\$100] Co-payment OR Specialist: [0%-100%] [and/or] [\$0-\$350 Co-payment]	[0%-100%] after Deductible
<ul style="list-style-type: none"> ▪ Allergy Shots 	No Cost to You	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) <ul style="list-style-type: none"> ▪ \$5,000 maximum benefit per Calendar Year 	[0%-10%] after Deductible	Not Covered
Medical Supplies <ul style="list-style-type: none"> ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately. ▪ Provided in connection with home infusion therapy ▪ Provided in connection with Durable Medical Equipment 	PCP: [\$0-\$100] Co-payment or Specialist: [0%-100%] [0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible
Prosthetic and Orthotic Services and Devices <ul style="list-style-type: none"> ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices <i>Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Certificate of Coverage for more information.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Reconstructive Surgery <ul style="list-style-type: none"> ▪ Breast reconstruction (48 hour minimum hospital stay) ▪ Restoration due to acute trauma, infection or cancer 	[0%-100%] after Deductible	[0%-100%] after Deductible
Transplantation Services <ul style="list-style-type: none"> ▪ Lifetime maximum of two transplants 	[0%-100%] after Deductible	Not Covered
Diabetes Management Services <ul style="list-style-type: none"> ▪ Supplies and equipment ▪ Diabetic Education (1 training per lifetime) 	[0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible [0%-100%] after Deductible
Dental Care <ul style="list-style-type: none"> ▪ Accidental injury to sound and natural teeth ▪ \$2,000 maximum benefit per accident 	[0%-100%] after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria <ul style="list-style-type: none"> ▪ Benefits available after member has paid \$2,400 per year 	[0%-100%] after Deductible	[0%-100%] after Deductible
Genetic Counseling and Testing <i>Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.</i>	No benefits if not pre-authorized [0%-100%] after Deductible	No benefits if not pre-authorized [0%-100%] after Deductible

This benefit summary is part of the Certificate of Coverage, Form Child Only (2011) **as amended by AMENDMENT(2) to IQCSelect (2011)** and subject to all benefit terms and conditions, limitations and exclusions included in the Certificate of Coverage. This benefit summary is intended only to highlight your benefits and should not be relied upon solely to determine coverage. Please refer to the Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Certificate of Coverage is different than this benefit summary, the Certificate of Coverage prevails.

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

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

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible <ul style="list-style-type: none"> ▪ The annual Deductible is calculated on a Calendar Year basis ▪ Deductible amounts applied in the last quarter of a Calendar Year will NOT carry over to the next Calendar Year 	Individual: [\$2,500-\$10,000]	
Annual Out-of-Pocket Limit <ul style="list-style-type: none"> ▪ Benefits will be paid at 10[0%-100%] of the Maximum Allowable Payment once the family annual Coinsurance Limit is satisfied ▪ Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits. ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis ▪ Annual Coinsurance Limit does not include Deductible amounts 	Individual: \$0 Family: \$0	Individual: Unlimited
Coinsurance	[0%-100%] after Deductible	[0%-100%] after Deductible
Preventive Care Services:		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical policies. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Routine vision exam (limit one every 24 months)	No Cost to You	Not Covered
Immunizations, including flu and pneumonia vaccines Child Immunizations (age 0-18) Adult Immunizations (age 18+) <ul style="list-style-type: none"> ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) <p><i>Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Certificate of Coverage. Flu shots will be reimbursed at a fixed fee regardless of where they are obtained.</i></p>	No Cost to You	
Well baby care, birth - to age 2 Well child care, ages 2-18 Other preventive services <ul style="list-style-type: none"> ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over 	No Cost to You	Not Covered

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued <ul style="list-style-type: none"> ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually ▪ Flexible sigmoidoscopy once every 5 years, OR ▪ Double contrast barium enema, OR ▪ Preventive colonoscopy age 50 and older, once every 10 years 	No Cost to You	Not Covered
Family Planning <ul style="list-style-type: none"> ▪ Tubal ligation and associated services (reversal of sterilization is not a covered) ▪ Insertion or implantation of birth control pellets, capsules or IUDs ▪ Fitting and insertion of diaphragms, rings or caps ▪ Injection of long acting contraceptives 	No Cost to You	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections 	[0%-100%] after Deductible	[0%-100%] after Deductible
Specialist Office Visit <ul style="list-style-type: none"> ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures 	[0%-100%] after Deductible	[0%-100%] after Deductible
Other Professional services <ul style="list-style-type: none"> ▪ Complex diagnostic services - advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures, such as chemotherapy, radiation therapy and infusion therapy ▪ Complex Injectable Prescription Medications which include: All specialty medications such as, enbrel, humira, IV antibiotics and high potency antibiotics ▪ Complex procedures, such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility 	[0%-100%] after Deductible	[0%-100%] after Deductible
Inpatient Care - Room and Board		
<ul style="list-style-type: none"> ▪ Inpatient care - room and board ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (30 day limit per Calendar Year for each) 	[0%-100%] after Deductible	[0%-100%] after Deductible
Outpatient Care and Ambulatory Care Centers		
<ul style="list-style-type: none"> ▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice (limited to a lifetime maximum of 180 days) ▪ Outpatient Surgical Services ▪ Home Health Services (40 visits per Calendar Year) 	[0%-100%] after Deductible	[0%-100%] after Deductible
Emergency Services		
<ul style="list-style-type: none"> ▪ Emergency Room, Urgent Care or ER Observation Services 	[0%-100%] after Deductible	[0%-100%] after Deductible
Transportation Services		
<ul style="list-style-type: none"> ▪ Ambulance - Ground or Air (\$1,000 maximum benefit per Calendar Year) <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Therapy Services		
<ul style="list-style-type: none"> ▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy ▪ Chiropractic Care ▪ Audiology Care ▪ Cardiac Rehabilitation (36 visits per Calendar Year) <i>Note: Therapy and chiropractic services are limited to a combined maximum of 45 visits per Calendar Year. This does not include Cardiac Rehabilitation.</i>	[0%-100%] after Deductible	[0%-100%] Not Covered

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services: <ul style="list-style-type: none"> ▪ Routine Prenatal Lab ▪ Initial Office Visit ▪ All other services 	Not Covered	Not Covered
Facility Services	Not Covered	Not Covered
Infertility Diagnostic Services Only <i>Note: Treatment of infertility is not covered.</i>	Not Covered	Not Covered
Mental Health and Substance Use Disorder Services		
Professional Services (Office Visits) <i>Note: If the Mental Health and Substance Use Disorder Rider is purchased refer to the Primary Care Physician (PCP) Office Visit Benefit in the Professional Services Category of this summary for applicable benefits.</i>	Not Covered	Not Covered
Inpatient Hospital Services Professional Services (Inpatient Facility) <i>Note: If the Mental Health and Substance Use Disorder Rider is purchased refer to the "Inpatient Care - Room and Board" Category of this summary for applicable benefits.</i>		
Allergy Services		
Allergy Testing and shots	[0%-100%] after Deductible	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) <ul style="list-style-type: none"> ▪ \$5,000 maximum benefit per Calendar Year 	[0%-100%] after Deductible	Not Covered
Medical Supplies <ul style="list-style-type: none"> ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately ▪ Provided in connection with home infusion therapy ▪ Provided in connection with Durable Medical Equipment 	[0%-100%] after Deductible	[0%-100%] after Deductible
Prosthetic and Orthotic Services and Devices <ul style="list-style-type: none"> ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices <i>Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Certificate of Coverage for more information.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Reconstructive Surgery <ul style="list-style-type: none"> ▪ Breast reconstruction (48 hour minimum hospital stay) ▪ Restoration due to acute trauma, infection or cancer 	[0%-100%] after Deductible	[0%-100%] after Deductible
Transplantation Services <ul style="list-style-type: none"> ▪ Lifetime maximum of two transplants 	[0%-100%] after Deductible	Not Covered
Diabetes Management Services <ul style="list-style-type: none"> ▪ Supplies and equipment ▪ Diabetic Education (1 training per lifetime) 	[0%-100%] after Deductible	Not Covered
Dental Care <ul style="list-style-type: none"> ▪ Accidental injury to sound and natural teeth ▪ \$2,000 maximum benefit per accident 	[0%-100%] after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria <ul style="list-style-type: none"> ▪ Benefits available after member has paid \$2,400 per year 	[0%-100%] after Deductible	[0%-100%] after Deductible
Genetic Counseling and Testing <i>Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.</i>	No benefits if not pre-authorized [0%-100%] after Deductible	No benefits if not pre-authorized [0%-100%] after Deductible

NOTE: This High Deductible Health Plan is qualified for use with a Health Savings Account.

This benefit summary is part of the Certificate of Coverage, **Form IQCSelect_Indiv_Prod_1 (2011)** and Outpatient Prescription Drug Rider and is subject to all benefit terms and conditions, limitations and exclusions included in the Certificate of Coverage. This benefit summary is intended only to highlight your benefits for Outpatient Prescription Drugs and should not be relied upon solely to determine coverage. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Outpatient Prescription Drug Rider and/or Certificate of Coverage are different than this benefit summary, the Outpatient Prescription Drug Rider and the Certificate of Coverage prevail.

Some medications may require pre-authorization by QualChoice. For details and to access the most current listing of specific medications, including those requiring pre-authorization, visit our website at www.qualchoice.com.

Tier Definitions:

Tier 1 medications are the lowest cost share option, as shown below. For the lowest out-of-pocket expense, you should always consider Tier 1 if you and your doctor decide they are appropriate for your treatment.

Tier 2 medications require a tier 2 cost share, as shown below. Consider Tier 2 medications if you and your doctor decide that a Tier 2 medication is the most appropriate to treat your condition.

Tier 3 medications require a Tier 3 cost share, as shown below. If your medication is in Tier 3, ask your doctor whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.

Tier 4 medications are not included on the formulary. Almost all new prescription medications that are not listed in the formulary are included in Tier 4.

Member pays 100% of the QualChoice discounted rate. Member out-of-pocket will not accumulate toward any deductible or coinsurance limit.

Tier 5 medications are generally classified as specialty medications and are generally only available through mail-order when not dispensed or administered by your physician in his/her office. Many Tier 5 medications require pre-authorization, see Medical Benefit Summary for applicable cost sharing.

Payment Procedures

Network Pharmacy

- You must pay the applicable cost sharing amount to the network pharmacy at the time the prescription is filled.
- The pharmacy will then submit the claim for reimbursement.

Out-of-Network Pharmacy

- You must pay the full amount of the prescription to the out-of-network pharmacy.
- You can then request reimbursement from QualChoice by submitting your receipt from the pharmacy, along with a QualChoice claim form.
- Reimbursement to you will be based on the contract rate for the drug dispensed, less a \$2.00 processing fee.
- Reimbursement may take up to 6 weeks.

Prescription Benefits In-Network	Retail (You Pay)	Mail Order (You Pay)
Co-payment Amounts		
▪ Tier 1	\$10 Co-payment	\$30 Co-payment
▪ Tier 2	\$35 Co-payment	\$105 Co-payment
▪ Tier 3	\$70 Co-payment	\$210 Co-payment
▪ Tier 4	100%	100%
▪ Tier 5*	\$200 Co-payment	Not Applicable
<i>*NOTE: If dispensed in your physician office or at a facility - see medical benefits</i>		
Deductible	Not Applicable	

Contraceptive Coverage

- All oral contraceptives in either formulary Tiers 1 or 2 (all formulary options) - No Cost to You. (No coverage Out-of-Network)
- Oral contraceptives in Tier 3 - Normal cost sharing, see Tier 3 above
- Ortho Evra patch, Nuvaring, Caps and Diaphragms - No Cost to You (No coverage Out-of-Network)
- Emergency contraceptives, e.g. Plan B, Ella - no cost sharing with a prescription, otherwise, not a covered benefit
- Over-the-counter birth control methods, e.g. gels, creams, condoms, etc. - not a covered benefit
- Abortion or abortifacient drugs - not a covered benefit

Limitations

- Retail pharmacy - One monthly cost sharing amount per 30 day supply
- Mail order pharmacy - 3 monthly cost sharing amounts per 90-day supply

Note:

- *All new prescriptions are limited to a 30 day supply. Refills of maintenance medication are limited to a 90-day supply at certain contracted pharmacies and through mail order.*
- *Insulin and syringes will be covered with one monthly cost sharing amount for each 30 day supply, if filled at the same time.*
- *Test strips and lancets will be covered with one monthly cost sharing amount for each 30 day supply, if filled at the same time.*
- *Contact a Health Coach at 1-888-795-6810, if you need assistance obtaining a new glucometer.*

Step Therapy

Certain medications may be required to be used before another medication is covered. Step therapy is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other and more costly therapy if the first line medication fails. **Examples** of step therapy under this plan include certain antihypertensive medications and Attention Deficit Disorder (ADD) medication.

Contact Customer Service at 1-501-228-7111 or 1-800-235-7111 for more details.

Benefit Details

- Benefit details are subject to all benefit terms, conditions, limitations and exclusions.
- Benefits are provided for formulary prescription drugs when prescribed by a physician or by a licensed health care provider within the scope of their license.
- Benefits are available through a network pharmacy, a network mail order pharmacy or an out-of-network pharmacy, provided that the drug is a Covered Prescription Drug.
- Benefits include compound prescriptions when the compound contains at least one prescription drug.
- Coverage is provided for contraceptives ("Birth Control") including oral, injectable and hormonal contraceptives.

Exclusions

Examples of drugs that we will not pay for are listed below. A complete listing is in the Outpatient Prescription Drug Rider.

- Experimental or investigational drugs or research drugs;
- Over-the-counter medications;
- Cosmetic agents, including, but not limited to, Retin-A for enrollees over age 25;
- Erectile dysfunction drugs, including but not limited to, impotency;
- Drugs for which there is a therapeutically equivalent over-the-counter drug;
- Oral or topical medication for hair loss;
- Smoking cessation medications, except for persons enrolled in the QualChoice "Kick the Nic" program;
- Smoking cessation devices;
- Drugs prescribed to treat infertility;
- Weight loss medication; appetite suppressants; anti-obesity drugs; anorexiant;
- General vitamins;
- Drugs whose primary purpose is the removal, destruction, or interference with the implantation of a fertilized ovum, embryo, or fetus;
- A drug prescribed as part of treatment to change an Enrollee's gender; and
- Over-the-counter birth control items

This benefit summary is part of the Certificate of Coverage, [Form IQCSelect_Indiv_Prod_1 \(2011\)](#) and Outpatient Prescription Drug Rider and is subject to all benefit terms and conditions, limitations and exclusions included in the Certificate of Coverage. This benefit summary is intended only to highlight your benefits for Outpatient Prescription Drugs and should not be relied upon solely to determine coverage. Please refer to your Outpatient Prescription Drug Rider and Certificate of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Outpatient Prescription Drug Rider and/or Certificate of Coverage are different than this benefit summary, the Outpatient Prescription Drug Rider and the Certificate of Coverage prevail.

Some medications may require pre-authorization by QualChoice. For details and to access the most current listing of specific medications, including those requiring pre-authorization, visit our website at www.qualchoice.com.

Tier Definitions:

Tier 1 medications are the lowest cost share option, as shown below. For the lowest out-of-pocket expense, you should always consider Tier 1 if you and your doctor decide they are appropriate for your treatment.

Tier 2 medications require a tier 2 cost share, as shown below. Consider Tier 2 medications if you and your doctor decide that a Tier 2 medication is the most appropriate to treat your condition.

Tier 3 medications require a Tier 3 cost share, as shown below. If your medication is in Tier 3, ask your doctor whether there are Tier 1 or Tier 2 alternatives that may be appropriate for your treatment.

Tier 4 medications are not included on the formulary. Almost all new prescription medications that are not listed in the formulary are included in Tier 4.

Member pays 100% of the QualChoice discounted rate. Member out-of-pocket will not accumulate toward any deductible or coinsurance limit.

Tier 5 medications are generally classified as specialty medications and are generally only available through mail-order when not dispensed or administered by your physician in his/her office. Many Tier 5 medications require pre-authorization, see Medical Benefit Summary for applicable cost sharing.

Payment Procedures

Network Pharmacy

- You must pay the applicable cost sharing amount to the network pharmacy at the time the prescription is filled.
- The pharmacy will then submit the claim for reimbursement.

Out-of-Network Pharmacy

- You must pay the full amount of the prescription to the out-of-network pharmacy.
- You can then request reimbursement from QualChoice by submitting your receipt from the pharmacy, along with a QualChoice claim form.
- Reimbursement to you will be based on the contract rate for the drug dispensed, less a \$2.00 processing fee.
- Reimbursement may take up to 6 weeks.

Prescription Benefits In-Network	Retail (You Pay)	Mail Order (You Pay)
Coinsurance Amounts		
▪ Tier 1	0% after Deductible	0% after Deductible
▪ Tier 2	0% after Deductible	0% after Deductible
▪ Tier 3	0% after Deductible	0% after Deductible
▪ Tier 4	100%	100%
▪ Tier 5	0% after Deductible	0% after Deductible
Deductible	Individual: [\$2,500-\$5,000]/Family: [\$5,000-\$10,000]	

Contraceptive Coverage

- All oral contraceptives in either formulary Tiers 1 or 2 (all formulary options) - No Cost to You. (No coverage Out-of-Network)
- Oral contraceptives in Tier 3 - Normal cost sharing, see Tier 3 above
- Ortho Evra patch, Nuvaring, Caps and Diaphragms - No Cost to You (No coverage Out-of-Network)
- Emergency contraceptives, e.g. Plan B, Ella - no cost sharing with a prescription, otherwise, not a covered benefit
- Over-the-counter birth control methods, e.g. gels, creams, condoms, etc. - not a covered benefit
- Abortion or abortifacient drugs - not a covered benefit

Limitations

- Retail pharmacy - One monthly cost sharing amount per 30 day supply
- Mail order pharmacy - 3 monthly cost sharing amounts per 90-day supply

Note:

- *All new prescriptions are limited to a 30 day supply. Refills of maintenance medication are limited to a 90-day supply at certain contracted pharmacies and through mail order.*
- *Insulin and syringes will be covered with one monthly cost sharing amount for each 30 day supply, if filled at the same time.*
- *Test strips and lancets will be covered with one monthly cost sharing amount for each 30 day supply, if filled at the same time.*
- *Contact a Health Coach at 1-888-795-6810, if you need assistance obtaining a new glucometer.*

Step Therapy

Certain medications may be required to be used before another medication is covered. Step therapy is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other and more costly therapy if the first line medication fails. **Examples** of step therapy under this plan include certain antihypertensive medications and Attention Deficit Disorder (ADD) medication.

Contact Customer Service at 1-501-228-7111 or 1-800-235-7111 for more details.

Benefit Details

- Benefit details are subject to all benefit terms, conditions, limitations and exclusions.
- Benefits are provided for formulary prescription drugs when prescribed by a physician or by a licensed health care provider within the scope of their license.
- Benefits are available through a network pharmacy, a network mail order pharmacy or an out-of-network pharmacy, provided that the drug is a Covered Prescription Drug.
- Benefits include compound prescriptions when the compound contains at least one prescription drug.
- Coverage is provided for contraceptives ("Birth Control") including oral, injectable and hormonal contraceptives.

Exclusions

Examples of drugs that we will not pay for are listed below. A complete listing is in the Outpatient Prescription Drug Rider.

- Experimental or investigational drugs or research drugs;
- Over-the-counter medications;
- Cosmetic agents, including, but not limited to, Retin-A for enrollees over age 25;
- Erectile dysfunction drugs, including but not limited to, impotency;
- Drugs for which there is a therapeutically equivalent over-the-counter drug;
- Oral or topical medication for hair loss;
- Smoking cessation medications, except for persons enrolled in the QualChoice "Kick the Nic" program;
- Smoking cessation devices;
- Drugs prescribed to treat infertility;
- Weight loss medication; appetite suppressants; anti-obesity drugs; anorexiant;
- General vitamins;
- Drugs whose primary purpose is the removal, destruction, or interference with the implantation of a fertilized ovum, embryo, or fetus;
- A drug prescribed as part of treatment to change an Enrollee's gender; and
- Over-the-counter birth control items

SERFF Tracking #:

QUAC-128675101

State Tracking #:**Company Tracking #:****State:**

Arkansas

Filing Company:

QCA Health Plan, Inc.

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)

Product Name:

IQChoice, Including IQChoice Select and Child Only Version

Project Name/Number:

/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	10/17/2012
Comments:	Please see attached.		
Attachment(s):	IQChoice Benefit Summary Changes Flesch Letter Sept 2012.pdf		
		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	10/17/2012
Comments:	Not applicable to this filing.		
		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	10/17/2012
Comments:	See Form Schedule Tab		
		Item Status:	Status Date:
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	10/17/2012
Comments:	Not applicable to thsi filing, though the purpose of the filing is to modify existing benefit summaries to reflect the PPACA requirement to provide certain contraceptive coverage without member cost share.		



September 6, 2012

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

RE: IQChoice and IQChoice Select Medical and Prescription Drug Benefit Summary
Filing To Reflect Changes In Contraceptive Coverage

Dear Ms. Minor:

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

1. Form # QC POSIQ NG (08-1-12);
2. Form # QC HDHPIQ NG (08-1-12);
3. Form # QC RXIQ [POS or HDHP] (08-1-12);
4. Form # QC POSIQCSelect (08-1-12);
5. Form # IQCSelect HDHP (08-1-12);
6. Form # QC RXIQCSelect POS (08-1-12);
7. Form # QC RXIQCSelectHDHP (08-1-12);
8. Form # QC POSIQCSelect CO (08-1-12);
9. Form # IQCSelect HDHP CO (08-1-12);
10. Form # QC RXIQCSelect POS CO (08-1-12); and
11. Form # QC RXIQCSelect HDHP CO (08-1-12).

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

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

Sincerely,

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