

State: Arkansas **Filing Company:** QualChoice Life and Health Insurance Company, Inc.

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO

Product Name: QualChoice Life and Health Insurance Company PPO

Project Name/Number: /

Filing at a Glance

Company: QualChoice Life and Health Insurance Company, Inc.

Product Name: QualChoice Life and Health Insurance Company PPO

State: Arkansas

TOI: H16G Group Health - Major Medical

Sub-TOI: H16G.001A Any Size Group - PPO

Filing Type: Form

Date Submitted: 09/06/2012

SERFF Tr Num: QUAC-128671774

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: 11/13/2012

Disposition Status: Approved-Closed

Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** QualChoice Life and Health Insurance Company, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: QualChoice Life and Health Insurance Company PPO
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: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 11/13/2012	
State Status Changed: 11/13/2012	Deemer Date:
Created By: Jim Couch	Submitted By: Jim Couch
Corresponding Filing Tracking Number:	

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

Medical benefit summaries and prescription drug benefit summaries reflecting changes to contraceptive coverage as required under the Affordable Care Act.

Company and Contact

Filing Contact Information

Jim Couch, VP of Compliance	jim.couch@qualchoice.com
12615 Chenal Parkway, Suite 300	501-228-7111 [Phone] 5118 [Ext]
Little Rock, AR 72211	501-707-6729 [FAX]

Filing Company Information

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

Filing Fees

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

State: Arkansas **Filing Company:** QualChoice Life and Health Insurance Company, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: QualChoice Life and Health Insurance Company PPO
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Company	Amount	Date Processed	Transaction #
QualChoice Life and Health Insurance Company, Inc.	\$50.00	09/06/2012	62341926
QualChoice Life and Health Insurance Company, Inc.	\$200.00	09/11/2012	62590880

SERFF Tracking #:

QUAC-128671774

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Company Tracking #:

State: Arkansas **Filing Company:** QualChoice Life and Health Insurance Company, Inc.
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/13/2012	11/13/2012

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	10/17/2012	10/17/2012
Pending Industry Response	Rosalind Minor	09/13/2012	09/13/2012
Pending Industry Response	Rosalind Minor	09/07/2012	09/07/2012

Response Letters

Responded By	Created On	Date Submitted
Jim Couch	11/03/2012	11/06/2012
Jim Couch	10/16/2012	10/16/2012
Jim Couch	09/11/2012	09/12/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Objection Letter of 9/13/12	Note To Filer	Rosalind Minor	10/15/2012	10/15/2012
QualChoice Life and Health Replacement Benefit Summaries	Note To Reviewer	Jim Couch	09/06/2012	09/06/2012

SERFF Tracking #:

QUAC-128671774

State Tracking #:

Company Tracking #:

State: Arkansas **Filing Company:** QualChoice Life and Health Insurance Company, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: QualChoice Life and Health Insurance Company PPO
Project Name/Number: /

Disposition

Disposition Date: 11/13/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Supporting Actuarial Documentation	Approved-Closed	Yes
Form (revised)	QualChoice PPO Complete Benefit Summary	Approved-Closed	Yes
Form (revised)	PPO Select Benefit Summary	Approved-Closed	Yes
Form (revised)	PPO Performance Benefit Summary	Approved-Closed	Yes
Form (revised)	QualChoice Outpatient Prescription Drug Plan	Approved-Closed	Yes
Form (revised)	QualChoice Outpatient Prescription Drug Plan	Approved-Closed	Yes
Form	QualChoice PPO Complete Benefit Summary	Replaced	Yes
Form	PPO Select Benefit Summary	Replaced	Yes
Form	PPO Performance Benefit Summary	Replaced	Yes
Form	QualChoice Outpatient Prescription Drug Plan	Replaced	Yes
Form	QualChoice Outpatient Prescription Drug Plan	Replaced	Yes

State: Arkansas **Filing Company:** QualChoice Life and Health Insurance Company, Inc.

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO

Product Name: QualChoice Life and Health Insurance Company PPO

Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/17/2012
Submitted Date	10/17/2012
Respond By Date	

Dear Jim Couch,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- PPO Performance Benefit Summary, QCLHIC PPOP (08-1-12) (Form)

Comments:

The out-of-pocket limit for In-Network is \$2,000 for Individual and \$4,000 for Family while the Out-of-Network is \$8,000 for Individual and \$16,000 for Family. Please explain/certify actuarially that this is in compliance with our Bulletin 9-85.

Thank you for your continued cooperation in this matter.

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:** QualChoice Life and Health Insurance Company, Inc.

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO

Product Name: QualChoice Life and Health Insurance Company PPO

Project Name/Number: /

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/13/2012
Submitted Date	09/13/2012
Respond By Date	

Dear Jim Couch,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- QualChoice PPO Complete Benefit Summary, QCLHIC PPOC (08-1-12) (Form)
- PPO Select Benefit Summary, QCLHIC PPOS (08-1-12) (Form)
- PPO Performance Benefit Summary, QCLHIC PPOP (08-1-12) (Form)

Comments:

The above schedules indicate a benefit In Network but no coverage out of network. Our Bulletin 9-85, item 2, states that..."The difference in benefit levels, i.e., deductibles and co-payment provisions, etc., offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person. The Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers.

Also, immunizations for children, in and out of network, must be paid at 100% as required by ACA 23-79-141(f)(2)(A).

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:** QualChoice Life and Health Insurance Company, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: QualChoice Life and Health Insurance Company PPO
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

- QualChoice PPO Complete Benefit Summary, QCLHIC PPOC (08-1-12) (Form)
- PPO Select Benefit Summary, QCLHIC PPOS (08-1-12) (Form)
- PPO Performance Benefit Summary, QCLHIC PPOP (08-1-12) (Form)
- QualChoice Outpatient Prescription Drug Plan, QCLHIC PPORx[X or Y or Z] (8-1-12) (Form)
- QualChoice Outpatient Prescription Drug Plan, QCLHIC PPORx[X or Y or Z] (8-1-12) (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 \$250.00. Please submit an additional \$200.00 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

SERFF Tracking #:

QUAC-128671774

State Tracking #:

Company Tracking #:

State: Arkansas **Filing Company:** QualChoice Life and Health Insurance Company, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: QualChoice Life and Health Insurance Company PPO
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/03/2012
Submitted Date	11/06/2012

Dear Rosalind Minor,

Introduction:

I am attaching in the Supporting Documentation tab a letter of explanation and an analysis from QualChoice's in-house actuary addressing your objection. If we need to discuss, please let me know.

Response 1

Comments:

Please see attached letter of explanation and analysis.

Related Objection 1

Applies To:

- PPO Performance Benefit Summary, QCLHIC PPOP (08-1-12) (Form)

Comments:

The out-of-pocket limit for In-Network is \$2,000 for Individual and \$4,000 for Family while the Out-of-Network is \$8,000 for Individual and \$16,000 for Family. Please explain/certify actuarially that this is in compliance with our Bulletin 9-85.

Thank you for your continued cooperation in this matter.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Supporting Actuarial Documentation
Comments:	
Attachment(s):	
QCLHIC Actuary Cover Letter Re PPO Benefit Differential Oct 2012.pdf QCLHIC Ark Stat Ann 66-3703 Compliance Summary.pdf	

SERFF Tracking #:

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State: Arkansas

Filing Company:

QualChoice Life and Health Insurance Company, Inc.

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO

Product Name: QualChoice Life and Health Insurance Company PPO

Project Name/Number: /

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	QualChoice Outpatient Prescription Drug Plan	QCLHIC PPORx[X or Y or Z] (8-1-12)	CERA	Initial			8.2012 PPO Prescription Benefit Summary for AID Filing (2).pdf	Date Submitted: 11/06/2012 By: Jim Couch
<i>Previous Version</i>								
1	<i>QualChoice Outpatient Prescription Drug Plan</i>	<i>QCLHIC PPORx[X or Y or Z] (8-1-12)</i>	<i>CERA</i>	<i>Initial</i>			<i>8.2012 PPO Prescription Benefit Summary for AID Filing (2).pdf</i>	<i>Date Submitted: 09/06/2012 By: Jim Couch</i>
2	QualChoice Outpatient Prescription Drug Plan	QCLHIC PPORx[X or Y or Z] (8-1-12)	CERA	Initial			8.2012 PPO HDHP Prescription Benefit Summary for AID Filing.pdf	Date Submitted: 11/06/2012 By: Jim Couch
<i>Previous Version</i>								
2	<i>QualChoice Outpatient Prescription Drug Plan</i>	<i>QCLHIC PPORx[X or Y or Z] (8-1-12)</i>	<i>CERA</i>	<i>Initial</i>			<i>8.2012 PPO HDHP Prescription Benefit Summary for AID Filing.pdf</i>	<i>Date Submitted: 09/06/2012 By: Jim Couch</i>

No Rate/Rule Schedule items changed.

Conclusion:Sincerely,
Jim Couch

State: Arkansas **Filing Company:** QualChoice Life and Health Insurance Company, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: QualChoice Life and Health Insurance Company PPO
Project Name/Number: /

Response Letter

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

Dear Rosalind Minor,

Introduction:

Modified benefit summaries have been attached to replace the previously submitted summaries. The summaries show a range, but QCLHIC administers the OON benefit level for these services at a difference not exceeding 25%. We have also changed the OON immunizations for children to reflect payment at 100%.

Response 1

Comments:

Modified benefit summaries have been attached to replace the previously submitted summaries. The summaries show a range, but QCLHIC administers the OON benefit level for these services at a difference not exceeding 25%. We have also changed the OON immunizations for children to reflect payment at 100%.

Related Objection 1

Applies To:

- QualChoice PPO Complete Benefit Summary, QCLHIC PPOC (08-1-12) (Form)
- PPO Select Benefit Summary, QCLHIC PPOS (08-1-12) (Form)
- PPO Performance Benefit Summary, QCLHIC PPOP (08-1-12) (Form)

Comments:

The above schedules indicate a benefit In Network but no coverage out of network. Our Bulletin 9-85, item 2, states that..."The difference in benefit levels, i.e., deductibles and co-payment provisions, etc., offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person. The Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers.

Also, immunizations for children, in and out of network, must be paid at 100% as required by ACA 23-79-141(f)(2)(A).

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:

QUAC-128671774

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

QualChoice Life and Health Insurance Company, Inc.

TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO

Product Name: QualChoice Life and Health Insurance Company PPO

Project Name/Number: /

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	QualChoice PPO Complete Benefit Summary	QCLHIC PPOC (08-1-12)	CERA	Initial			PPO Complete 8.2012 Womens Health for Filing.pdf	Date Submitted: 10/16/2012 By: Jim Couch
<i>Previous Version</i>								
1	QualChoice PPO Complete Benefit Summary	QCLHIC PPOC (08-1-12)	CERA	Initial			8.2012 PPO Complete Medical Benefit Summary for filing.pdf	Date Submitted: 09/06/2012 By: Jim Couch
2	PPO Select Benefit Summary	QCLHIC PPOS (08-1-12)	CERA	Initial			PPO Select 8.2012 Womens Health for Filing.pdf	Date Submitted: 10/16/2012 By: Jim Couch
<i>Previous Version</i>								
2	PPO Select Benefit Summary	QCLHIC PPOS (08-1-12)	CERA	Initial			8.2012 PPO Select Medical Benefit Summary for filing.pdf	Date Submitted: 09/06/2012 By: Jim Couch
3	PPO Performance Benefit Summary	QCLHIC PPOP (08-1-12)	CERA	Initial			PPO Performance HDHP 8.2012 Womens Health for Filing.pdf	Date Submitted: 10/16/2012 By: Jim Couch
<i>Previous Version</i>								
3	PPO Performance Benefit Summary	QCLHIC PPOP (08-1-12)	CERA	Initial			8.2012 PPO Performance HDHP Medical Benefit Summary for filing.pdf	Date Submitted: 09/06/2012 By: Jim Couch

No Rate/Rule Schedule items changed.

Conclusion:

SERFF Tracking #:

QUAC-128671774

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

QualChoice Life and Health Insurance Company, Inc.

TOI/Sub-TOI:

H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO

Product Name:

QualChoice Life and Health Insurance Company PPO

Project Name/Number:

/

Sincerely,
Jim Couch

State: Arkansas **Filing Company:** QualChoice Life and Health Insurance Company, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: QualChoice Life and Health Insurance Company PPO
Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 09/11/2012
Submitted Date 09/12/2012

Dear Rosalind Minor,

Introduction:

The additional fee has been sent via EFT.

Thanks.

Jim

Response 1

Comments:

Additional fee paid.

Related Objection 1

Applies To:

- QualChoice PPO Complete Benefit Summary, QCLHIC PPOC (08-1-12) (Form)
- PPO Select Benefit Summary, QCLHIC PPOS (08-1-12) (Form)
- PPO Performance Benefit Summary, QCLHIC PPOP (08-1-12) (Form)
- QualChoice Outpatient Prescription Drug Plan, QCLHIC PPORx[X or Y or Z] (8-1-12) (Form)
- QualChoice Outpatient Prescription Drug Plan, QCLHIC PPORx[X or Y or Z] (8-1-12) (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 \$250.00. Please submit an additional \$200.00 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:** QualChoice Life and Health Insurance Company, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: QualChoice Life and Health Insurance Company PPO
Project Name/Number: /

Note To Filer

Created By:

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

Last Edited By:

Rosalind Minor

Submitted On:

11/13/2012 09:33 AM

Subject:

Objection Letter of 9/13/12

Comments:

I have not had a response to my Objection Letter of 9/13/12. Do you need additional time to respond?

State: Arkansas **Filing Company:** QualChoice Life and Health Insurance Company, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: QualChoice Life and Health Insurance Company PPO
Project Name/Number: /

Note To Reviewer

Created By:

Jim Couch on 09/06/2012 03:51 PM

Last Edited By:

Rosalind Minor

Submitted On:

11/13/2012 09:33 AM

Subject:

QualChoice Life and Health Replacement Benefit Summaries

Comments:

This filing is necessary in order to have the company's medical benefit summaries and prescription drug benefit summaries modified in order to reflect the requirement under PPACA for certain contraceptive coverage without member cost share.

SERFF Tracking #:

QUAC-128671774

State Tracking #:

Company Tracking #:

State:

Arkansas

Filing Company:

QualChoice Life and Health Insurance Company, Inc.

TOI/Sub-TOI:

H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO

Product Name:

QualChoice Life and Health Insurance Company PPO

Project Name/Number:

/

Form Schedule

Lead Form Number:								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/13/2012	QualChoice PPO Complete Benefit Summary	QCLHIC PPOC (08-1-12)	CERA	Initial			PPO Complete 8.2012 Womens Health for Filing.pdf
2	Approved-Closed 11/13/2012	PPO Select Benefit Summary	QCLHIC PPOS (08-1-12)	CERA	Initial			PPO Select 8.2012 Womens Health for Filing.pdf
3	Approved-Closed 11/13/2012	PPO Performance Benefit Summary	QCLHIC PPOP (08-1-12)	CERA	Initial			PPO Performance HDHP 8.2012 Womens Health for Filing.pdf
4	Approved-Closed 11/13/2012	QualChoice Outpatient Prescription Drug Plan	QCLHIC PPORx[X or Y or Z] (8-1-12)	CERA	Initial			8.2012 PPO Prescription Benefit Summary for AID Filing (2).pdf
5	Approved-Closed 11/13/2012	QualChoice Outpatient Prescription Drug Plan	QCLHIC PPORx[X or Y or Z] (8-1-12)	CERA	Initial			8.2012 PPO HDHP Prescription Benefit Summary for AID Filing.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
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SERFF Tracking #:

QUAC-128671774

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

Arkansas

Filing Company:

QualChoice Life and Health Insurance Company, Inc.

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Product Name:

QualChoice Life and Health Insurance Company PPO

Project Name/Number:

/

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
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

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

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

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

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible <ul style="list-style-type: none"> If applicable, Co-payments are not included in the Deductible In-Network and Out-of-Network Deductibles apply separately Family Deductible is not considered satisfied until [two to three] family members satisfy their Individual Deductible Deductible amounts applied in the last quarter of a Calendar Year [will or will not] carry over to the next Calendar Year The Deductible is calculated on a Calendar Year basis 	Individual: [\$0-\$200,000] Family: [\$0-\$200,000]	Individual: [\$0-\$200,000] Family: [\$0-\$200,000]
Annual Out-of-Pocket Limit <ul style="list-style-type: none"> Applicable coinsurance will apply for families until [two or three] family members satisfy the individual Out-of-Pocket Limit Benefits will be paid at 100% of the Maximum Allowable Charge once the family Coinsurance limit is satisfied Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits If applicable, Co-payments do not apply toward your Out-of-Pocket Limit. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached Deductibles do not apply toward your Out-of-Pocket Limit Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis 	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]	Individual: [\$0-unlimited] Family: [\$0-unlimited]
Coinsurance	[0%-100%] after Deductible	[0%-100%] after Deductible
Preventive Care Services (Performed in the Office):		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical policies. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines Child Immunizations (age 0-18) Adult Immunizations (-age 18+) <ul style="list-style-type: none"> Diphtheria and Tetanus toxoid for ages over 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 Evidence of Coverage (EOC).</i>	No Cost to You	
Routine vision exam (limit 1 every 24 months)	[\$0-\$100] Co-payment	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> Well baby care, birth to age 2 Well child care, ages 2-18 	No Cost to You	[0%-100%] after Deductible or [Not Covered]
Other preventive services <ul style="list-style-type: none"> Physical Pap smear Screening mammogram (including breast exam) age 40 and over Prostate screenings for men age 40 and over 	No Cost to You	[0%-100%] after Deductible or [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 once every 5 years; OR Preventive colonoscopy age 50 and older, once every 10 years 	No Cost to You	[0%-100%] after Deductible or [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	[0%-100%] after Deductible or [Not Covered]
Smoking cessation <ul style="list-style-type: none"> Kick the Nic: smoking cessation; 12 week program <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	[0%-100%] after Deductible or [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-\$500] Co-payment] OR [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-\$500] Co-payment] OR [0%-100% after Deductible]	[0%-100%] after Deductible
Professional services that are subject to Deductible and Coinsurance (in addition to the office Co-payment, if applicable) <ul style="list-style-type: none"> Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests, lab & x-ray Other procedures, such as chemotherapy, radiation and infusion therapy Complex Injectable Prescription Medications which include: All specialty medications such as 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 - Facility		
<ul style="list-style-type: none"> Inpatient care - hospital Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per Calendar Year) 	[[\$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 (20 visits per Calendar Year) 	[0%-100%] after Deductible [and/or] [\$0-\$2,000] [Co-payment]	
<ul style="list-style-type: none"> Emergency Room, Urgent Care or ER Observation Services 	[0%-100%] [after Deductible] [and/or] [\$0-\$2,000] [Co-payment]	[0%-100%] [after Deductible] [and/or] [\$0-\$2,000] [Co-payment]
Transportation Services		
<ul style="list-style-type: none"> Ambulance - (\$1,000 maximum benefit per Calendar Year) <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%]	[0%-100%]
Therapy Services		
<ul style="list-style-type: none"> Physical Therapy Occupational Therapy Speech Therapy and Audiology Testing Chiropractic Care (12 visits per Calendar Year) Cardiac Rehabilitation (36 visits per Calendar Year) <i>Note: Therapy services are limited to a combined maximum of 30 visits per Calendar Year. This does not include Cardiac Rehabilitation or Chiropractic Care.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Maternity Services		
<ul style="list-style-type: none"> Prenatal Lab Professional Services (Office) Professional Services (Inpatient/Outpatient Facility) <i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient charges, see Inpatient sections on page 2.</i>	In-Network (You Pay) [PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment] or [0%-100% after Deductible]	Out-of-Network (You Pay) [0%-100%] after Deductible
In Vitro Fertilization and Infertility <ul style="list-style-type: none"> Infertility Diagnostic Services Invitro Fertilization <i>Note: Infertility treatment and services are subject to a \$15,000 lifetime benefit maximum. See the "In Vitro Fertilization and Infertility" section of the Evidence of Coverage (EOC).</i>	[0%-100%] after Deductible	[0%-100%] after Deductible

Mental Health and Substance Use Disorder Services		
<ul style="list-style-type: none"> Inpatient Hospital Services [10 day limit per calendar year] 	[\$0-\$500 Co-payment] [and/or] [0%-100%] after Deductible	[[0%-100%] after Deductible] or [Not Covered]
<ul style="list-style-type: none"> Professional Services (Office/Outpatient Visits) [10 visit limit per calendar year] 	[[PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment]] or [0%-100% after Deductible]	
<ul style="list-style-type: none"> Professional Services (Inpatient/Outpatient Facility) 	[0%-100%] after Deductible	
Allergy Services		
<ul style="list-style-type: none"> Office Visit and Allergy Testing 	[PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment] or [0%-100% after Deductible]	[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"> \$2,000 maximum benefit per Calendar Year 	[0%-100%] after Deductible	[0%-100%] after Deductible
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
Prosthetics 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 Evidence of Coverage for more information.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Reconstructive Surgery <ul style="list-style-type: none"> Breast reconstruction following mastectomy Restoration due to acute trauma, infection or cancer <i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient charges, see Inpatient sections on page 2.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Transplantation Services <ul style="list-style-type: none"> Physician/Professional charges 	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> Inpatient and Outpatient Charges <i>Note: Lifetime maximum of two transplants</i>	[\$0-\$500 Co-payment] [and/or] [0%-100%] after Deductible	
Diabetes Management Services <ul style="list-style-type: none"> Insulin Pumps (\$5,500 benefit maximum per Calendar Year) Supplies and equipment (Subject to \$2,000 DME limit) Diabetic Education (1 training per lifetime) 	[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	No benefits if not pre-authorized
Hearing Aids and Hearing Instruments <i>Note: Not to exceed \$1,400 per ear for each 3 year period.</i>	[Not Covered] or [Charges in Excess of the benefit limit]	[Not Covered] or [Charges in Excess of the benefit limit]
Temporomandibular Joint Disorder (TMJ) <ul style="list-style-type: none"> Surgical Treatment (limit \$15,000 per lifetime) <i>Note: These benefits are for physician/professional charges. For benefits related to these services for Outpatient, Inpatient, Office, Physical Therapy and DME charges, see respective sections, pg.1 & 2.</i>	[Not Covered] or [[0%-100%] after Deductible]	[Not Covered] or [[0%-100%] after Deductible]

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

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

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

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Deductible		
<ul style="list-style-type: none"> If applicable, Co-payments are not included in the Deductible In-Network and Out-of-Network Deductibles apply separately Family Deductible is not considered satisfied until [two or three] family members satisfy their Individual Deductible Deductible amounts applied in the last quarter of a Calendar Year [will or will not] carry over to the next Calendar Year The Deductible is calculated on a Calendar Year basis 	Individual: [\$0-\$200,000] Family: [\$0-\$200,000]	Individual: [\$0-\$200,000] Family: [\$0-\$200,000]
Out-of-Pocket Limit		
<ul style="list-style-type: none"> Applicable coinsurance will apply for families until [two or three] family members satisfy the individual Out-of-Pocket Limit Benefits will be paid at 100% of the Maximum Allowable Charge once the family Coinsurance limit is satisfied Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits If applicable, Co-payments do not apply toward your Out-of-Pocket Limit. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached Deductibles do not apply toward your Out-of-Pocket Limit Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis 	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]	Individual: [\$0-unlimited] Family: [\$0-unlimited]
Coinsurance	[0%-100%] after Deductible	[0%-100%] after Deductible
Preventive Care Services (Performed in the Office):		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical policies. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines		
Child Immunizations (age 0-18) Adult Immunizations (-age 18+) <ul style="list-style-type: none"> Diphtheria and Tetanus toxoid for ages over 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 Evidence of Coverage (EOC).</i>	No Cost to You	
Routine vision exam (limit 1 every 24 months)	[\$0-\$100] Co-payment	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> Well baby care, birth to age 2 Well child care, ages 2-18 	No Cost to You	[0%-100%] after Deductible or [Not Covered]
Other preventive services <ul style="list-style-type: none"> Physical Pap smear Screening mammogram (including breast exam) age 40 and over Prostate screenings for men age 40 and over 	No Cost to You	[0%-100%] after Deductible or [Not Covered]
Preventive Care Services, continued		
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 once every 5 years; OR Preventive colonoscopy age 50 and older, once every 10 years 	No Cost to You	[0%-100%] after Deductible or [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	[0%-100%] after Deductible or [Not Covered]
Smoking cessation <ul style="list-style-type: none"> Kick the Nic: smoking cessation; 12 week program <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	[0%-100%] after Deductible or [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
Professional services that are subject to Deductible and Coinsurance <ul style="list-style-type: none"> Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests, lab & x-ray Other procedures, such as chemotherapy, radiation and infusion therapy Complex Injectable Prescription Medications which include: All specialty medications such as 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 - Facility		
<ul style="list-style-type: none"> Inpatient care - hospital Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per Calendar Year) 	[\$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%-100%] after [Deductible] [and/or] [\$0-\$2,000] [Co-payment]	
<ul style="list-style-type: none"> Home Health (20 visits per Calendar Year) 	[0%-100%]	
Emergency Services		
<ul style="list-style-type: none"> Emergency Room, Urgent Care or ER Observation Services 	[0%-100%] after [Deductible] [and/or] [\$0-\$2,000] [Co-payment]	[0%-100%] after [Deductible] [and/or] [\$0-\$2,000] [Co-payment]
Transportation Services		
<ul style="list-style-type: none"> Ambulance - (\$1,000 maximum benefit per per Calendar Year) <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%]	[0%-100%]
Therapy Services		
<ul style="list-style-type: none"> Physical Therapy Occupational Therapy Speech Therapy and Audiology Testing Chiropractic Care (12 visits per Calendar Year) Cardiac Rehabilitation (36 visits per Calendar Year) <i>Note: Therapy services are limited to a combined maximum of 30 visits per Calendar Year. This does not include Cardiac Rehabilitation or Chiropractic Care.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Maternity Services		
<ul style="list-style-type: none"> Prenatal Lab Professional Services (Office) Professional Services (Inpatient/Outpatient Facility) <i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient charges, see Inpatient sections on page 2.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
	[0%-100%] after Deductible	
In Vitro Fertilization and Infertility <ul style="list-style-type: none"> Infertility Diagnostic Services In Vitro Fertilization <i>Note: Infertility treatment and services are subject to a \$15,000 lifetime benefit maximum. See the "In Vitro Fertilization and Infertility" section of the Evidence of Coverage (EOC).</i>	[0%-100%] after Deductible	[0%-100%] after Deductible

Mental Health and Substance Use Disorder Services		
<ul style="list-style-type: none"> Inpatient Hospital Services [10 day limit per calendar year] Professional Services (Office/Outpatient Visits) [10 visit limit per calendar year] Professional Services (Inpatient/Outpatient Facility) 	[\$0-\$500 Co-payment] [and/or] [0%-100% after Deductible] [0%-100%] after Deductible	[0%-100%] after Deductible
Allergy Services		
<ul style="list-style-type: none"> Office Visit and Allergy Testing Allergy Shots 	[0%-100%] after Deductible No Cost to You	[0%-100%] after Deductible [0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) <ul style="list-style-type: none"> \$2,000 maximum benefit per Calendar Year 	[0%-100%] after Deductible	[0%-100%] after Deductible
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
Prosthetics 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 Evidence of Coverage for more information.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Reconstructive Surgery <ul style="list-style-type: none"> Breast reconstruction following mastectomy Restoration due to acute trauma, infection or cancer <i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient charges, see Inpatient sections on page 2.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Transplantation Services <ul style="list-style-type: none"> Physician/Professional charges Inpatient and Outpatient Charges <i>Note: Lifetime maximum of two transplants</i>	[0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible
Diabetes Management Services <ul style="list-style-type: none"> Insulin Pumps (\$5,500 benefit maximum per Calendar Year) Supplies and equipment (Subject to \$2,000 DME limit) 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 [\$0-\$5,000] 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
Hearing Aids and Hearing Instruments <i>Note: Not to exceed \$1,400 per ear for each 3 year period.</i>	[Not Covered] or [Charges in Excess of the benefit limit]	[Not Covered] or [Charges in Excess of the benefit limit]
Temporomandibular Joint Disorder (TMJ) <ul style="list-style-type: none"> Surgical Treatment (limit \$15,000 per lifetime) <i>Note: These benefits are for physician/professional charges. For benefits related to these services for Outpatient, Inpatient, Office, Physical Therapy and DME charges, see respective sections, pg.1 & 2.</i>	[Not Covered] or [[0%-100%] after Deductible]	[Not Covered] or [[0%-100%] after Deductible]

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

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

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

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Deductible <ul style="list-style-type: none"> In-Network and Out-of-Network Deductibles apply separately Family Deductible is not considered satisfied until the entire family deductible amount is satisfied. Deductible amounts applied in the last quarter of a Calendar Year will not carry over to the next Calendar Year The Deductible is calculated on a Calendar Year basis 	Individual: \$1,200 Family: \$2,400	
Out-of-Pocket Limit <ul style="list-style-type: none"> Applicable coinsurance will apply for families until [two or three] family members satisfy the individual Out-of-Pocket Limit Benefits will be paid at 100% of the Maximum Allowable Charge once the family Coinsurance limit is satisfied Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits Deductibles do not apply toward your Out-of-Pocket Limit Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis 	Individual: \$2,000 Family: \$4,000	Individual: \$8,000 Family: \$16,000
Coinsurance	[0%-100%] after Deductible	[0%-100%] after Deductible
Preventive Care Services (Performed in the Office): QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical policies. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines Child Immunizations (age 0-18) Adult Immunizations (-age 18+) <ul style="list-style-type: none"> Diphtheria and Tetanus toxoid for ages over 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 Evidence of Coverage (EOC).</i>	No Cost to You	
Routine vision exam (limit 1 every 24 months)	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> Well baby care, birth to age 2 Well child care, ages 2-18 	No Cost to You	[0%-100%] after Deductible or [Not Covered]
Other preventive services <ul style="list-style-type: none"> Physical Pap smear Screening mammogram (including breast exam) age 40 and over Prostate screenings for men age 40 and over 	No Cost to You	[0%-100%] after Deductible or [Not Covered]
Preventive Care Services, continued		
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 once every 5 years; OR Preventive colonoscopy age 50 and older, once every 10 years 	No Cost to You	[0%-100%] after Deductible or [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	[0%-100%] after Deductible or [Not Covered]
Smoking cessation <ul style="list-style-type: none"> Kick the Nic: smoking cessation; 12 week program <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	[0%-100%] after Deductible or [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: <ul style="list-style-type: none"> 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
Professional services that are subject to Deductible and Coinsurance <ul style="list-style-type: none"> Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests, lab & x-ray Other procedures, such as chemotherapy, radiation and infusion therapy Complex Injectable Prescription Medications which include: <ul style="list-style-type: none"> All specialty medications such as 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 - Facility		
<ul style="list-style-type: none"> Inpatient care - hospital Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per Calendar Year) 	[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 Home Health 20 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 - (\$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 and Audiology Testing Chiropractic Care (12 visits per Calendar Year) Cardiac Rehabilitation (36 visits per Calendar Year) <i>Note: Therapy services are limited to a combined maximum of 30 visits per Calendar Year. This does not include Cardiac Rehabilitation or Chiropractic Care.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Maternity Services		
<ul style="list-style-type: none"> Prenatal Lab Professional Services (Office) Professional Services (Inpatient/Outpatient Facility) <i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient charges, see Inpatient sections on page 2.</i>	In-Network (You Pay) [0%-100%] after Deductible [0%-100%] after Deductible	Out-of-Network (You Pay) [0%-100%] after Deductible
In Vitro Fertilization and Infertility <ul style="list-style-type: none"> Infertility Diagnostic Services In vitro Fertilization <i>Note: Infertility treatment and services are subject to a \$15,000 lifetime benefit maximum. See the "In Vitro Fertilization and Infertility" section of the Evidence of Coverage (EOC).</i>	[0%-100%] after Deductible	[0%-100%] after Deductible

Mental Health and Substance Use Disorder Benefits		
<ul style="list-style-type: none"> Inpatient Hospital Services [10 day limit per calendar year] 		
<ul style="list-style-type: none"> Professional Services (Inpatient/Outpatient Facility) [10 visit limit per calendar year] Professional Services (Office/Outpatient Visits) 	[0%-100%] after Deductible	[0%-100%] after Deductible
Allergy Services		
<ul style="list-style-type: none"> Office Visit and Allergy Testing Allergy Shots 	[0%-100%] after Deductible	[0%-100%] after Deductible
	[0%-100%] after Deductible	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) <ul style="list-style-type: none"> \$2,000 maximum benefit per Calendar Year 	[0%-100%] after Deductible	[0%-100%] after Deductible
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
Prosthetics 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 Evidence of Coverage for more information.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Reconstructive Surgery <ul style="list-style-type: none"> Breast reconstruction following mastectomy Restoration due to acute trauma, infection or cancer <i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient charges, see Inpatient sections on page 2.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
Transplantation Services <ul style="list-style-type: none"> Physician/Professional charges Inpatient and Outpatient Charges <i>Note: Lifetime maximum of two transplants</i>	[0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible
Diabetes Management Services <ul style="list-style-type: none"> Insulin Pumps (\$5,500 benefit maximum per Calendar Year) Supplies and equipment (Subject to \$2,000 DME limit) 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 [\$0-\$5,000] 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
Hearing Aids and Hearing Instruments <i>Note: Not to exceed \$1,400 per ear for each 3 year period.</i>	[Not Covered] or [Charges in Excess of the benefit limit]	[Not Covered] or [Charges in Excess of the benefit limit]
Temporomandibular Joint Disorder (TMJ) <ul style="list-style-type: none"> Surgical Treatment (limit \$15,000 lifetime) <i>Note: These benefits are for physician/professional charges. For benefits related to these services for Outpatient, Inpatient, Office, Physical Therapy and DME charges, see respective sections, pg.1 & 2.</i>	[Not Covered] or [[0%-100%] after Deductible]	[Not Covered] or [[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 Evidence of Coverage, Form QCLHIC PPO (10-01-10) and Outpatient Prescription Drug Rider and is subject to all benefit terms and conditions, limitations and exclusions contained therein. 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 Evidence of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this benefit summary conflicts in any way with the Outpatient Prescription Drug Rider, the Outpatient Prescription Drug Rider and Evidence of Coverage will prevail.

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

[NOTE: If a covered brand-name product is chosen by the member when a generic equivalent is available, you will pay the Tier 3 co-payment plus the difference in cost of the brand name product and the generic product.]

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.

Tier 5 medications are generally classified as specialty medications and are generally only available through a specialty pharmacy, when not dispensed or administered by your physician in his/her office.

(See QC website for list of specialty meds covered under pharmacy benefit.) All else, see medical benefit.

Many Tier 5 medications require prior-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.

Prescription Benefits In-Network	Retail (You Pay)	Mail Order (You Pay)
Co-payment Amounts		
▪ Tier 1	[\$0-\$500] [Co-payment]	[\$0-\$500] [Co-payment]
▪ Tier 2	[\$0-\$500] [Co-payment]	[\$0-\$500] [Co-payment]
▪ Tier 3[* (see Tier 3 Note above)]	[\$0-\$500] [Co-payment]	[\$0-\$500] [Co-payment]
▪ Tier 4	100%	100%
▪ Tier 5	[See Medical Benefits] and/or [\$0-\$500] [Co-payment]	[See Medical Benefits] and/or [\$0-\$500] [Co-payment]
NOTE: If dispensed in your physician office or at a facility - see medical benefits		
Coinsurance Amounts		
▪ Tier 1	[0%-100%] [after Deductible]	[0%-100%] [after Deductible]
▪ Tier 2	[0%-100%] [after Deductible]	[0%-100%] [after Deductible]
▪ Tier 3	[0%-100%] [after Deductible]	[0%-100%] [after Deductible]
▪ Tier 4	100%	100%
▪ Tier 5	[See Medical Benefits] and/or [0% to 100%] [after Deductible]	[See Medical Benefits] and/or [0% to 100%] [after Deductible]
Deductible	[\$0-\$200,000]	[\$0-\$200,000]

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 [30-31]-day supply
- Mail order pharmacy - [1-5] monthly cost sharing amounts per 90-day supply

Note: All new prescriptions are limited to a [30-31]-day supply. Refills of maintenance medications are limited to a 90-day supply at [30-31]-day supply, if filled at the same time.

Insulin and syringes will be covered with one monthly cost sharing amount for each [30-31]-day supply, if filled at the same time.

Test strips and lancets will be covered with one monthly cost sharing amount for each [30-31]-day supply, if filled at the same time.

Contact a Health Coach if you need assistance obtaining a new glucometer. 1-888-795-6810

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 1-800-235-7111 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;
- 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 sex from one gender to another; and
Over-the-counter birth control items

This benefit summary is part of the Evidence of Coverage, Form QCLHC PPO HDHP (10-01-10) and Outpatient Prescription Drug Rider and is subject to all benefit terms and conditions, limitations and exclusions contained therein. 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 Evidence of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. If this benefit summary conflicts in any way with the Outpatient Prescription Drug Rider, the Outpatient Prescription Drug Rider and Evidence of Coverage will prevail.

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Prescription Benefits In-Network	Retail (You Pay)	Mail Order (You Pay)
Co-payment Amounts		
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▪ Tier 2	Not Applicable	Not Applicable
▪ Tier 3	Not Applicable	Not Applicable
▪ Tier 4	100%	100%
▪ Tier 5	[See Medical Benefits] and/or [\$0-\$500] [Co-payment]	[See Medical Benefits] and/or [\$0-\$500] [Co-payment]
NOTE: If dispensed in your physician office or at a facility - see medical benefits		
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▪ Tier 1	[0%-100%] [after Deductible]	[0%-100%] [after Deductible]
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▪ Tier 4	100%	100%
▪ Tier 5	[See Medical Benefits] and/or [0% to 100%] [after Deductible]	[See Medical Benefits] and/or [0% to 100%] [after Deductible]
Deductible	[\$0-\$200,000]	[\$0-\$200,000]

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- 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;
- 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 sex from one gender to another; and Over-the-counter birth control items

SERFF Tracking #:

QUAC-128671774

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

Arkansas

Filing Company:

QualChoice Life and Health Insurance Company, Inc.

TOI/Sub-TOI:

H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO

Product Name:

QualChoice Life and Health Insurance Company PPO

Project Name/Number:

/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/13/2012
Comments:	Please see attached.		
Attachment(s):	PPO Benefit Summary Changes Flesch Letter Sept 2012.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	11/13/2012
Comments:	Not applicable to this filing.		

		Item Status:	Status Date:
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	11/13/2012
Comments:	Not applicable to this filing, even though the changes reflected in the filing are required by the change requiring certain contraceptive coverage without member cost share.		

		Item Status:	Status Date:
Satisfied - Item:	Supporting Actuarial Documentation	Approved-Closed	11/13/2012
Comments:			
Attachment(s):	QCLHIC Actuary Cover Letter Re PPO Benefit Differential Oct 2012.pdf QCLHIC Ark Stat Ann 66-3703 Compliance Summary.pdf		



September 6, 2012

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

RE: QualChoice Life and Health PPO 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 # QCLHIC PPOC (08-1-12);
2. Form # QCLHIC PPOS (08-1-12);
3. Form # QCLHIC PPOP (08-1-12);
4. Form # QCLHIC PPORx[X or Y or Z] (08-1-12) for the standard plan; and
5. Form # QCLHIC PPORx[X or Y or Z] (08-1-12) for the high deductible plan.

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

October 26, 2012

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

Subject: QualChoice Life and Health Insurance Company, Inc. PPO Benefit Differentials

Dear Ms. Minor:

Enclosed please find the demonstration that the in and out of network cost sharing is within 25% of total charges for each of QualChoice's PPO plans.

In performing the test, 25% of total charges should be the appropriate measure. This can be understood by comparing an in-network plan that pays for everything. The minimum out-of-network plan could require a 25% coinsurance. This is equivalent to 25% of total allowed charges.

The QualChoice actuarial department has created a pricing model based on calendar year 2011 data. The model pulls all allowed charges for the year and sorts them by member and subscriber. Then, given a deductible, coinsurance, and out-of-pocket maximum, the model calculates the financial impact for each member.

In the model, there is the capacity to include or exclude prescription drugs. The member pays on the average 25% of his prescription drug costs if he has a plan where the deductible and coinsurance do not apply.

A comparison is made between the in-network member cost sharing plus 25% of allowed charges and the out-of-network cost sharing. If the former is greater than the latter, the set of benefits is in compliance.

I can certainly understand where some of benefits appear to not meet the mandated benefit differential. However, statistically, all of our options fall within the necessary 25% corridor.

If you have any questions, please feel free to contact me.

Sincerely,

Edgar J. Goral
Director of Actuarial Services
(501) 219-5149



QualChoice Life and Health Insurance Company, Inc.

**PPO Product
Ark. Stat. Ann. 66-3703
Compliance Summary**

QualChoice[®] is the brand name used for products and services provided by one or more of the QualChoice subsidiary companies. The QualChoice companies that offer, underwrite or administer benefits coverage include QCA Health Plan, Inc. and QualChoice Life and Health Insurance Company, Inc.

Methodology

Plans with Copayments for Pharmacy Claims

Allowed charges incurred in calendar year 2011 were used in determining whether Qualchoice's PPO plans were in compliance with Arkansas Statute 66-3703.

For plans PF1200C, PF1200E, PF2000C, PF2000E, PF3000B, PF3000E, PF5000E, and PF1250 the variables in the QC L&H PPO Product Compliance Summary are defined as followed:

Allowed- the allowed medical charges incurred in calendar year 2011

Paid- the aggregate medical charges paid by QualChoice in calendar year 2011 if we assume all members have the in and out of network benefits described in the plan

Payer's Value- the aggregate medical charges paid by QualChoice members in calendar year 2011 if we assume all members have the in and out of network benefits described in the plan

25% of Rx- the aggregate pharmacy charges paid by QualChoice members in calendar year 2011

25% of Allowed Charges(25AC)- 25% of the total allowed charges in calendar year 2011

Payers Total Value (PTV)- the total allowed charges paid by QCA members in calendar year 2011 if we assume all members have the in and out of network benefits described in the plan

PTV+25AC- the sum of the "Payers Total Value" variable and the 25% of "Allowed Charges" variable

In determining whether a plan is in compliance with Arkansas Statute 66-3703, we compared the in network PTV+25AC variable with the out of network's PTV variable. If the out of network's PTV variable is less than the in network's PTV+25AC variable then the plan is in compliance. If the out of network's PTV variable is greater than the in network's PTV+25AC variable then the plan is out of compliance.

Plans with Ded/Coin for Pharmacy Claims

Allowed charges incurred in calendar year 2011 were used in determining whether Qualchoice's PPO plans were in compliance with Arkansas Statute 66-3703.

For plans S500B, S750C, S1000B, S1000C, S1500C, S2000B, S2500D, S5000D, S500M, S750N, S1000M, S1000N, S1500N, S2000M, S2500P, S5000P, C500F, C750G, C1000F, C1000G, C1500G, C2000F, C2500H, C5000H, C500I, C750J, C1000I, C1000J, C1500J, C2000I, C2500K, C5000K, C500K, C750K, C1000K, C1500K, C2000K, C500L, C750L, C1000L, C1500L, C2000L, C2500L, and C5000L the variables in the QC L&H PPO Product Compliance Summary are defined as followed:

Allowed- the total medical charges incurred in calendar year 2011

Paid- the total charges paid by QualChoice in calendar year 2011 if we assume all members have the in and out of network benefits described in the plan

Payer's Value- the total charges paid by QualChoice members in calendar year 2011 if we assume all members have the in and out of network benefits described in the plan

25% of Allowed Charges(25AC)- 25% of the total allowed charges in calendar year 2011

Payers Total Value (PTV)- the total allowed charges paid by QualChoice members in calendar year 2011 if we assume all members have the in and out of network benefits described in the plan

PTV+25AC- the sum of the "Payers Total Value" variable and the "25% of Allowed Charges" variable

In determining whether a plan is in compliance with Arkansas Statute 66-3703, we compared the in network PTV+25AC variable with the out of network's PTV variable. If the out of network's PTV variable is less than the in network's PTV+25AC variable then the plan is in compliance. If the out of network's PTV variable is greater than the in network's PTV+25AC variable then the plan is out of compliance.

QC L&H PPO Product Compliance Summary

C500F	In	Out	In Compliance?	C750G	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 208,823,167.93	\$ 156,185,614.69		Paid	\$ 195,841,829.15	\$ 144,569,778.82	
Payers Value	\$ 58,920,040.28	\$ 111,557,593.52		Payers Value	\$ 71,901,379.06	\$ 123,173,429.39	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07		25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12		25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 77,252,565.35	\$ 129,890,118.59		Payers Total Value (PTV)	\$ 90,233,904.13	\$ 141,505,954.46	
PTV+25AC	\$ 162,520,892.47			PTV+25AC	\$ 175,502,231.25		

C500I	In	Out	In Compliance?	C750J	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 208,823,167.93	\$ 156,185,614.69		Paid	\$ 195,841,829.15	\$ 144,569,778.82	
Payers Value	\$ 58,920,040.28	\$ 111,557,593.52		Payers Value	\$ 71,901,379.06	\$ 123,173,429.39	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07		25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12		25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 77,252,565.35	\$ 129,890,118.59		Payers Total Value (PTV)	\$ 90,233,904.13	\$ 141,505,954.46	
PTV+25AC	\$ 162,520,892.47			PTV+25AC	\$ 175,502,231.25		

C500K	In	Out	In Compliance?	C750K	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 200,948,349.57	\$ 147,157,191.49		Paid	\$ 191,751,434.44	\$ 137,540,703.75	
Payers Value	\$ 66,794,858.64	\$ 120,586,016.72		Payers Value	\$ 75,991,773.77	\$ 130,202,504.46	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07		25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12		25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 85,127,383.71	\$ 138,918,541.79		Payers Total Value (PTV)	\$ 94,324,298.83	\$ 148,535,029.53	
PTV+25AC	\$ 170,395,710.83			PTV+25AC	\$ 179,592,625.95		

C1500L	In	Out	In Compliance?	C2000L	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 163,888,457.52	\$ 110,175,202.56		Paid	\$ 153,559,771.90	\$ 155,775,945.20	
Payers Value	\$ 103,854,750.69	\$ 157,568,005.65		Payers Value	\$ 114,183,436.31	\$ 111,967,263.01	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07		25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12		25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 122,187,275.75	\$ 175,900,530.72		Payers Total Value (PTV)	\$ 132,515,961.37	\$ 130,299,788.08	
PTV+25AC	\$ 207,455,602.87			PTV+25AC	\$ 217,784,288.49		

S1500C	In	Out	In Compliance?	S2000B	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 175,131,934.13	\$ 124,083,460.01		Paid	\$ 167,880,409.48	\$ 116,006,251.68	
Payers Value	\$ 92,611,274.08	\$ 143,659,748.20		Payers Value	\$ 99,862,798.73	\$ 151,736,956.53	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07		25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12		25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 110,943,799.15	\$ 161,992,273.26		Payers Total Value (PTV)	\$ 118,195,323.80	\$ 170,069,481.60	
PTV+25AC	\$ 196,212,126.27			PTV+25AC	\$ 203,463,650.92		

QC L&H PPO Product Compliance Summary (cont)

S1500N	In	Out	In Compliance?	S2000M	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 169,427,885.13	\$ 118,379,411.01		Paid	\$ 162,176,360.48	\$ 110,302,202.68	
Payers Value	\$ 98,315,323.08	\$ 149,363,797.20		Payers Value	\$ 105,566,847.73	\$ 157,441,005.53	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07		25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12		25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 116,647,848.15	\$ 167,696,322.26		Payers Total Value (PTV)	\$ 123,899,372.80	\$ 175,773,530.60	
PTV+25AC	\$ 201,916,175.27			PTV+25AC	\$ 209,167,699.92		

PF3000B	In	Out	In Compliance?	PF3000E	In	Out	In Compliance?
Allowed	\$ 341,073,308.48	\$ 341,073,308.48	Yes	Allowed	\$ 341,073,308.48	\$ 341,073,308.48	Yes
Paid	\$ 198,010,055.76	\$ 162,363,610.13		Paid	\$ 220,213,741.55	\$ 184,766,155.84	
Payers Value	\$ 143,063,252.72	\$ 178,709,698.35		Payers Value	\$ 120,859,566.93	\$ 156,307,152.64	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12		25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 143,063,252.72	\$ 178,709,698.35		Payers Total Value (PTV)	\$ 120,859,566.93	\$ 156,307,152.64	
PTV+25AC	\$ 228,331,579.84			PTV+25AC	\$ 206,127,894.05		

C1000F	In	Out	In Compliance?	C1000G	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 191,527,486.75	\$ 138,331,992.78		Paid	\$ 187,998,678.23	\$ 124,083,460.01	
Payers Value	\$ 76,215,721.46	\$ 129,411,215.43		Payers Value	\$ 79,744,529.98	\$ 143,659,748.20	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07		25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12		25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 94,548,246.53	\$ 147,743,740.49		Payers Total Value (PTV)	\$ 98,077,055.05	\$ 161,992,273.26	
PTV+25AC	\$ 179,816,573.65			PTV+25AC	\$ 183,345,382.17		

C1000I	In	Out	In Compliance?	C1000J	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 191,527,486.75	\$ 138,331,992.78		Paid	\$ 187,998,678.23	\$ 124,083,460.01	
Payers Value	\$ 76,215,721.46	\$ 129,411,215.43		Payers Value	\$ 79,744,529.98	\$ 143,659,748.20	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07		25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12		25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 94,548,246.53	\$ 147,743,740.49		Payers Total Value (PTV)	\$ 98,077,055.05	\$ 161,992,273.26	
PTV+25AC	\$ 179,816,573.65			PTV+25AC	\$ 183,345,382.17		

C1000K	In	Out	In Compliance?	C1500K	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 183,972,343.17	\$ 117,515,659.06		Paid	\$ 171,228,914.02	\$ 117,515,659.06	
Payers Value	\$ 83,770,865.04	\$ 150,227,549.15		Payers Value	\$ 96,514,294.19	\$ 150,227,549.15	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07		25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12		25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 102,103,390.11	\$ 168,560,074.22		Payers Total Value (PTV)	\$ 114,846,819.25	\$ 168,560,074.22	
PTV+25AC	\$ 187,371,717.23			PTV+25AC	\$ 200,115,146.37		

QC L&H PPO Product Compliance Summary (cont)

C2500L	In	Out	In Compliance?	C5000L	In	Out	In Compliance?		
Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$	144,879,655.60	\$	93,338,350.33	Paid	\$	115,281,866.91	\$	72,992,146.28
Payers Value	\$	122,863,552.61	\$	174,404,857.88	Payers Value	\$	152,461,341.30	\$	194,751,061.93
25% of Rx	\$	18,332,525.07	\$	18,332,525.07	25% of Rx	\$	18,332,525.07	\$	18,332,525.07
25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12	25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12
Payers Total Value (PTV)	\$	141,196,077.68	\$	192,737,382.95	Payers Total Value (PTV)	\$	170,793,866.37	\$	213,083,587.00
PTV+25AC	\$	226,464,404.80			PTV+25AC	\$	256,062,193.49		
S2500D	In	Out	In Compliance?	S5000D	In	Out	In Compliance?		
Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$	152,220,112.10	\$	100,678,806.83	Paid	\$	122,622,323.41	\$	76,373,595.91
Payers Value	\$	115,523,096.11	\$	167,064,401.38	Payers Value	\$	145,120,884.80	\$	191,369,612.30
25% of Rx	\$	18,332,525.07	\$	18,332,525.07	25% of Rx	\$	18,332,525.07	\$	18,332,525.07
25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12	25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12
Payers Total Value (PTV)	\$	133,855,621.18	\$	185,396,926.45	Payers Total Value (PTV)	\$	163,453,409.87	\$	209,702,137.37
PTV+25AC	\$	219,123,948.30			PTV+25AC	\$	248,721,736.99		
S2500P	In	Out	In Compliance?	S5000P	In	Out	In Compliance?		
Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$	146,516,063.10	\$	94,974,757.83	Paid	\$	116,918,274.41	\$	70,669,546.91
Payers Value	\$	121,227,145.11	\$	172,768,450.38	Payers Value	\$	150,824,933.80	\$	197,073,661.30
25% of Rx	\$	18,332,525.07	\$	18,332,525.07	25% of Rx	\$	18,332,525.07	\$	18,332,525.07
25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12	25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12
Payers Total Value (PTV)	\$	139,559,670.18	\$	191,100,975.45	Payers Total Value (PTV)	\$	169,157,458.87	\$	215,406,186.37
PTV+25AC	\$	224,827,997.30			PTV+25AC	\$	254,425,785.99		
PF5000E	In	Out	In Compliance?	PF1250D	In	Out	In Compliance?		
Allowed	\$	341,073,308.48	\$ 341,073,308.48	Yes	Allowed	\$	341,073,308.48	\$ 341,073,308.48	Yes
Paid	\$	181,027,195.36	\$	150,093,531.19	Paid	\$	274,825,845.59	\$	233,617,910.53
Payers Value	\$	160,046,113.12	\$	190,979,777.29	Payers Value	\$	66,247,462.89	\$	107,455,397.95
25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12	25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12
Payers Total Value (PTV)	\$	160,046,113.12	\$	190,979,777.29	Payers Total Value (PTV)	\$	66,247,462.89	\$	107,455,397.95
PTV+25AC	\$	245,314,440.24			PTV+25AC	\$	151,515,790.01		
C1500G	In	Out	In Compliance?	C2000F	In	Out	In Compliance?		
Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$	175,131,934.13	\$	124,083,460.01	Paid	\$	167,880,409.48	\$	116,006,251.68
Payers Value	\$	92,611,274.08	\$	143,659,748.20	Payers Value	\$	99,862,798.73	\$	151,736,956.53
25% of Rx	\$	18,332,525.07	\$	18,332,525.07	25% of Rx	\$	18,332,525.07	\$	18,332,525.07
25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12	25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12
Payers Total Value (PTV)	\$	110,943,799.15	\$	161,992,273.26	Payers Total Value (PTV)	\$	118,195,323.80	\$	170,069,481.60
PTV+25AC	\$	196,212,126.27			PTV+25AC	\$	203,463,650.92		

QC L&H PPO Product Compliance Summary (cont)

C1500J	In	Out	In Compliance?	C2000I	In	Out	In Compliance?		
Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$	175,131,934.13	\$	124,083,460.01	Paid	\$	167,880,409.48	\$	116,006,251.68
Payers Value	\$	92,611,274.08	\$	143,659,748.20	Payers Value	\$	99,862,798.73	\$	151,736,956.53
25% of Rx	\$	18,332,525.07	\$	18,332,525.07	25% of Rx	\$	18,332,525.07	\$	18,332,525.07
25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12	25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12
Payers Total Value (PTV)	\$	110,943,799.15	\$	161,992,273.26	Payers Total Value (PTV)	\$	118,195,323.80	\$	170,069,481.60
PTV+25AC	\$	196,212,126.27			PTV+25AC	\$	203,463,650.92		
C2000K	In	Out	In Compliance?	C500L	In	Out	In Compliance?		
Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$	160,900,228.40	\$	108,178,342.08	Paid	\$	193,607,893.07	\$	139,816,734.99
Payers Value	\$	106,842,979.81	\$	159,564,866.13	Payers Value	\$	74,135,315.14	\$	127,926,473.22
25% of Rx	\$	18,332,525.07	\$	18,332,525.07	25% of Rx	\$	18,332,525.07	\$	18,332,525.07
25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12	25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12
Payers Total Value (PTV)	\$	125,175,504.87	\$	177,897,391.20	Payers Total Value (PTV)	\$	92,467,840.21	\$	146,258,998.29
PTV+25AC	\$	210,443,831.99			PTV+25AC	\$	177,736,167.33		
S500B	In	Out	In Compliance?	S750C	In	Out	In Compliance?		
Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$	208,823,167.93	\$	156,185,614.69	Paid	\$	195,841,829.15	\$	144,569,778.82
Payers Value	\$	58,920,040.28	\$	111,557,593.52	Payers Value	\$	71,901,379.06	\$	123,173,429.39
25% of Rx	\$	18,332,525.07	\$	18,332,525.07	25% of Rx	\$	18,332,525.07	\$	18,332,525.07
25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12	25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12
Payers Total Value (PTV)	\$	77,252,565.35	\$	129,890,118.59	Payers Total Value (PTV)	\$	90,233,904.13	\$	141,505,954.46
PTV+25AC	\$	162,520,892.47			PTV+25AC	\$	175,502,231.25		
S500M	In	Out	In Compliance?	S750N	In	Out	In Compliance?		
Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$	267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$	203,119,118.93	\$	150,481,565.69	Paid	\$	190,137,780.15	\$	138,865,729.82
Payers Value	\$	64,624,089.28	\$	117,261,642.52	Payers Value	\$	77,605,428.06	\$	128,877,478.39
25% of Rx	\$	18,332,525.07	\$	18,332,525.07	25% of Rx	\$	18,332,525.07	\$	18,332,525.07
25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12	25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12
Payers Total Value (PTV)	\$	82,956,614.35	\$	135,594,167.59	Payers Total Value (PTV)	\$	95,937,953.13	\$	147,210,003.46
PTV+25AC	\$	168,224,941.47			PTV+25AC	\$	181,206,280.25		
PF1200C	In	Out	In Compliance?	PF1200E	In	Out	In Compliance?		
Allowed	\$	341,073,308.48	\$ 341,073,308.48	Yes	Allowed	\$	341,073,308.48	\$ 341,073,308.48	Yes
Paid	\$	240,522,541.56	\$	204,183,604.46	Paid	\$	276,861,478.65	\$	233,590,651.67
Payers Value	\$	100,550,766.92	\$	136,889,704.02	Payers Value	\$	64,211,829.83	\$	107,482,656.81
25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12	25% of Allowed Charges(25AC)	\$	85,268,327.12	\$	85,268,327.12
Payers Total Value (PTV)	\$	100,550,766.92	\$	136,889,704.02	Payers Total Value (PTV)	\$	64,211,829.83	\$	107,482,656.81
PTV+25AC	\$	185,819,094.04			PTV+25AC	\$	149,480,156.95		

QC L&H PPO Product Compliance Summary (cont)

PF1250A	In	Out	In Compliance?
Paid	\$ 341,073,308.48	\$ 341,073,308.48	Yes
Allowed	\$ 238,858,541.54	\$ 202,891,237.49	
Payers Value	\$ 102,214,766.94	\$ 138,182,070.99	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 102,214,766.94	\$ 138,182,070.99	
PTV+25AC	\$ 187,483,094.06		

PF1250B	In	Out	In Compliance?
Allowed	\$ 341,073,308.48	\$ 341,073,308.48	Yes
Paid	\$ 238,858,541.54	\$ 202,891,237.49	
Payers Value	\$ 102,214,766.94	\$ 138,182,070.99	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 102,214,766.94	\$ 138,182,070.99	
PTV+25AC	\$ 187,483,094.06		

C2500H	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 152,220,112.10	\$ 100,678,806.83	
Payers Value	\$ 115,523,096.11	\$ 167,064,401.38	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 133,855,621.18	\$ 185,396,926.45	
PTV+25AC	\$ 219,123,948.30		

C5000H	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 122,622,323.41	\$ 76,373,595.91	
Payers Value	\$ 145,120,884.80	\$ 191,369,612.30	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 163,453,409.87	\$ 209,702,137.37	
PTV+25AC	\$ 248,721,736.99		

C2500K	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 152,220,112.10	\$ 100,678,806.83	
Payers Value	\$ 115,523,096.11	\$ 167,064,401.38	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 133,855,621.18	\$ 185,396,926.45	
PTV+25AC	\$ 219,123,948.30		

C5000K	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 122,622,323.41	\$ 76,373,595.91	
Payers Value	\$ 145,120,884.80	\$ 191,369,612.30	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 163,453,409.87	\$ 209,702,137.37	
PTV+25AC	\$ 248,721,736.99		

C750L	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 184,410,977.94	\$ 130,200,247.25	
Payers Value	\$ 83,332,230.27	\$ 137,542,960.96	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 101,664,755.33	\$ 155,875,486.03	
PTV+25AC	\$ 186,933,082.45		

C1000L	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 176,631,886.67	\$ 110,175,202.56	
Payers Value	\$ 91,111,321.54	\$ 157,568,005.65	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 109,443,846.61	\$ 175,900,530.72	
PTV+25AC	\$ 194,712,173.73		

S1000B	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 191,527,486.75	\$ 138,331,992.78	
Payers Value	\$ 76,215,721.46	\$ 129,411,215.43	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 94,548,246.53	\$ 147,743,740.49	
PTV+25AC	\$ 179,816,573.65		

S1000C	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 187,998,678.23	\$ 124,083,460.01	
Payers Value	\$ 79,744,529.98	\$ 143,659,748.20	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 98,077,055.05	\$ 161,992,273.26	
PTV+25AC	\$ 183,345,382.17		

QC L&H PPO Product Compliance Summary (cont)

S1000M	In	Out	In Compliance?	S1000N	In	Out	In Compliance?
Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes	Allowed	\$ 267,743,208.21	\$ 267,743,208.21	Yes
Paid	\$ 185,823,437.75	\$ 132,627,943.78		Paid	\$ 182,294,629.23	\$ 118,379,411.01	
Payers Value	\$ 81,919,770.46	\$ 135,115,264.43		Payers Value	\$ 85,448,578.98	\$ 149,363,797.20	
25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07		25% of Rx	\$ 18,332,525.07	\$ 18,332,525.07	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12		25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 100,252,295.53	\$ 153,447,789.49		Payers Total Value (PTV)	\$ 103,781,104.05	\$ 167,696,322.26	
PTV+25AC	\$ 185,520,622.65			PTV+25AC	\$ 189,049,431.17		
PF2000C	In	Out	In Compliance?	PF2000E	In	Out	In Compliance?
Allowed	\$ 341,073,308.48	\$ 341,073,308.48	Yes	Allowed	\$ 341,073,308.48	\$ 341,073,308.48	Yes
Paid	\$ 216,869,931.76	\$ 185,746,820.60		Paid	\$ 247,993,042.92	\$ 210,273,029.84	
Payers Value	\$ 124,203,376.72	\$ 155,326,487.88		Payers Value	\$ 93,080,265.56	\$ 130,800,278.64	
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12		25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12	
Payers Total Value (PTV)	\$ 124,203,376.72	\$ 155,326,487.88		Payers Total Value (PTV)	\$ 93,080,265.56	\$ 130,800,278.64	
PTV+25AC	\$ 209,471,703.84			PTV+25AC	\$ 178,348,592.68		
PF1250C	In	Out	In Compliance?				
Allowed	\$ 341,073,308.48	\$ 341,073,308.48	Yes				
Paid	\$ 274,825,845.59	\$ 233,617,910.53					
Payers Value	\$ 66,247,462.89	\$ 107,455,397.95					
25% of Allowed Charges(25AC)	\$ 85,268,327.12	\$ 85,268,327.12					
Payers Total Value (PTV)	\$ 66,247,462.89	\$ 107,455,397.95					
PTV+25AC	\$ 151,515,790.01						

Standard PPO Products

PPO Complete	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
Plan ID	C500F	C750G	C1000F	C1000G	C1500G	C2000F	C2500H	C5000H
PCP/Spec. OV Copay	\$30/Ded/Coins							
Deductible(In/Out)	\$500/1,000	\$750/1,500	\$1,000/2,000	\$1,000/3,000	\$1,500/3,000	\$2,000/4,000	\$2,500/5,000	\$5,000/10,000
Coinsurance (In/Out)	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%
Out of Pocket(In/Out)	\$2,000/8,000	\$3,000/9,000	\$2,000/8,000	\$3,000/9,000	\$3,000/9,000	\$2,000/8,000	\$5,000/15,000	\$5,000/15,000
Inpatient	Ded/Coins							
Outpatient Surg.	Ded/Coins							
ER	Ded/Coins							
Deductible Type	Fullfillment 3X							
Deductible Credit & Carryover	DC and Credit							
SAE	Excluded							

PPO Complete	Option 9	Option 10	Option 11	Option 12	Option 13	Option 14	Option 15	Option 16
Plan ID	C500I	C750J	C1000I	C1000J	C1500J	C2000I	C2500K	C5000K
PCP/Spec. OV Copay	\$30/50	\$30/50	\$30/50	\$30/50	\$30/50	\$30/50	\$30/50	\$30/50
Deductible(In/Out)	\$500/1,000	\$750/1,500	\$1,000/2,000	\$1,000/3,000	\$1,500/3,000	\$2,000/4,000	\$2,500/5,000	\$5,000/10,000
Coinsurance (In/Out)	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%
Out of Pocket(In/Out)	\$2,000/8,000	\$3,000/9,000	\$2,000/8,000	\$3,000/9,000	\$3,000/9,000	\$2,000/8,000	\$5,000/15,000	\$5,000/10,000
Inpatient	Ded/Coins							
Outpatient Surg.	Ded/Coins							
ER	Ded/Coins							
Deductible Type	Fullfillment 3X							
Deductible Credit & Carryover	DC and Credit							
SAE	Excluded							

PPO Complete	Option 17	Option 18	Option 19	Option 20	Option 21	Option 22	Option 23	Option 24
Plan ID	C500K	C750K	C1000K	C1500K	C2000K	C500L	C750L	C1000L
PCP/Spec. OV Copay	\$30/50	\$30/50	\$30/50	\$30/50	\$30/50	\$30/50	\$30/50	\$30/50
Deductible(In/Out)	\$500/1,000	\$750/1,500	\$1,000/3,000	\$1,500/3,000	\$2,000/4,000	\$500/1,000	\$750/1,500	\$1,000/3,000
Coinsurance (In/Out)	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%
Out of Pocket(In/Out)	\$5,000/15,000	\$5,000/15,000	\$5,000/15,000	\$5,000/15,000	\$5,000/15,000	\$5,000/15,000	\$5,000/15,000	\$5,000/15,000
Inpatient	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	\$500+Ded/Coins	\$500+Ded/Coins	\$500+Ded/Coins
Outpatient Surg.	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	\$150+Ded/Coins	\$150+Ded/Coins	\$150+Ded/Coins
ER	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	\$100+Coins	\$100+Coins	\$100+Coins
Deductible Type	Fullfillment 3X							
Deductible Credit & Carryover	DC and Credit							
SAE	Excluded							

PPO Complete	Option 25	Option 26	Option 27	Option 28
Plan ID	C1500L	C2000L	C2500L	C5000L
PCP/Spec. OV Copay	\$30/50	\$30/50	\$30/50	\$30/50
Deductible(In/Out)	\$1,500/3,000	\$2,000/4,000	\$2,500/5,000	\$5,000/10,000
Coinsurance (In/Out)	80%/60%	80%/60%	80%/60%	80%/60%
Out of Pocket(In/Out)	\$5,000/15,000	\$5,000/15,000	\$5,000/15,000	\$5,000/10,000
Inpatient	\$500+Ded/Coins	\$500+Ded/Coins	\$500+Ded/Coins	\$500+Ded/Coins
Outpatient Surg.	\$150+Ded/Coins	\$150+Ded/Coins	\$150+Ded/Coins	\$150+Ded/Coins
ER	\$100+Coins	\$100+Coins	\$100+Coins	\$100+Coins
Deductible Type	Fullfillment 3X	Fullfillment 3X	Fullfillment 3X	Fullfillment 3X
Deductible Credit & Carryover	DC and Credit	DC and Credit	DC and Credit	DC and Credit
SAE	Excluded	Excluded	Excluded	Excluded

Standard PPO Products

PPO Select	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7	Option 8
Plan ID	S500B	S750C	S1000B	S1000C	S1500C	S2000B	S2500D	S5000D
PCP/Spec. OV Copay	Ded/Coins							
Deductible(In/Out)	\$500/1,000	\$750/1,500	\$1,000/2,000	\$1,000/3,000	\$1,500/3,000	\$2,000/4,000	\$2,500/5,000	\$5,000/10,000
Coinsurance (In/Out)	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%
Out of Pocket(In/Out)	\$2,000/8,000	\$3,000/9,000	\$2,000/8,000	\$3,000/9,000	\$3,000/9,000	\$2,000/8,000	\$5,000/15,000	\$5,000/15,000
Inpatient	Ded/Coins							
Outpatient Surg.	Ded/Coins							
ER	Ded/Coins							
Deductible Type	Fullfillment 3X							
Deductible Credit & Carryover	DC and Credit							
SAE	Excluded							

PPO Select	Option 9	Option 10	Option 11	Option 12	Option 13	Option 14	Option 15	Option 16
Plan ID	S500M	S750N	S1000M	S1000N	S1500N	S2000M	S2500P	S5000P
PCP/Spec. OV Copay	Ded/Coins							
Deductible(In/Out)	\$500/1,000	\$750/1,500	\$1,000/2,000	\$1,000/3,000	\$1,500/3,000	\$2,000/4,000	\$2,500/5,000	\$5,000/10,000
Coinsurance (In/Out)	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%	80%/60%
Out of Pocket(In/Out)	\$2,000/8,000	\$3,000/9,000	\$2,000/8,000	\$3,000/9,000	\$3,000/9,000	\$2,000/8,000	\$5,000/15,000	\$5,000/15,000
Inpatient	\$250+Ded/Coins							
Outpatient Surg.	\$150+Ded/Coins							
ER	\$100+Coins							
Deductible Type	Fullfillment 3X							
Deductible Credit & Carryover	DC and Credit							
SAE	Excluded							

PPO PERFORMANCE	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6	Option 7
Plan ID	PF1200C	PF1200E	PF2000C	PF2000E	PF3000B	PF3000E	PF5000E
PCP/Spec. OV Copay	Ded/Coins						
Deductible(In/Out)	\$1,200 in&out	\$1,200 in&out	\$2,000 in&out	\$2,000 in&out	\$3,000 in&out	\$3,000 in&out	\$5,000 in&out
Coinsurance (In/Out)	80%/60%	100%/80%	80%/60%	100%/80%	80%/60%	100%/80%	100%/80%
Out of Pocket(In/Out)	\$3,000/6,000	\$0/6,000	\$3,000/6,000	\$0/6,000	\$2,000/8,000	\$0/9,000	\$0/15,000
Inpatient	Ded/Coins						
Outpatient Surg.	Ded/Coins						
ER	Ded/Coins						
Deductible Type	HDHP 2X						
Deductible Credit & Carryover	No DC or Credit						
SAE	Excluded						
Prescription Drug	Ded/Coins						

PPO PERFORMANCE	Option 1	Option 2	Option 3	Option 4
Plan ID	PF1250A*	PF1250B*	PF1250C*	PF1250D*
PCP/Spec. OV Copay	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Deductible(In/Out)	\$1,250 in&out	\$1,250 in&out	\$1,250 in&out	\$1,250 in&out
Coinsurance (In/Out)	80%/60%	100%/80%	100%/80%	100%/80%
Out of Pocket(In/Out)	\$3,000/6,000	\$3,000/6,000	\$0/5,000	\$0/5,000
Inpatient	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Outpatient Surg.	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
ER	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Deductible Type	HDHP 2X	HDHP 2X	HDHP 2X	HDHP 2X
Deductible Credit & Carryover	No DC or Credit			
SAE	Excluded	Excluded	Excluded	Excluded
Prescription Drug	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins

* New high deductible plans

State: Arkansas **Filing Company:** QualChoice Life and Health Insurance Company, Inc.
TOI/Sub-TOI: H16G Group Health - Major Medical/H16G.001A Any Size Group - PPO
Product Name: QualChoice Life and Health Insurance Company PPO
Project Name/Number: /

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/06/2012	Replaced 11/13/2012	Form	QualChoice PPO Complete Benefit Summary	09/11/2012	8.2012 PPO Complete Medical Benefit Summary for filing.pdf (Superseded)
09/06/2012	Replaced 11/13/2012	Form	PPO Select Benefit Summary	09/11/2012	8.2012 PPO Select Medical Benefit Summary for filing.pdf (Superseded)
09/06/2012	Replaced 11/13/2012	Form	PPO Performance Benefit Summary	09/11/2012	8.2012 PPO Performance HDHP Medical Benefit Summary for filing.pdf (Superseded)
09/06/2012	Replaced 11/13/2012	Form	QualChoice Outpatient Prescription Drug Plan	09/11/2012	8.2012 PPO Prescription Benefit Summary for AID Filing (2).pdf
09/06/2012	Replaced 11/13/2012	Form	QualChoice Outpatient Prescription Drug Plan	09/11/2012	8.2012 PPO HDHP Prescription Benefit Summary for AID Filing.pdf

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

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

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

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible <ul style="list-style-type: none"> If applicable, Co-payments are not included in the Deductible In-Network and Out-of-Network Deductibles apply separately Family Deductible is not considered satisfied until [two to three] family members satisfy their Individual Deductible Deductible amounts applied in the last quarter of a Calendar Year [will or will not] carry over to the next Calendar Year The Deductible is calculated on a Calendar Year basis 	Individual: [\$0-\$200,000] Family: [\$0-\$200,000]	Individual: [\$0-\$200,000] Family: [\$0-\$200,000]
Annual Out-of-Pocket Limit <ul style="list-style-type: none"> Applicable coinsurance will apply for families until [two or three] family members satisfy the individual Out-of-Pocket Limit Benefits will be paid at 100% of the Maximum Allowable Charge once the family Coinsurance limit is satisfied Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits If applicable, Co-payments do not apply toward your Out-of-Pocket Limit. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached Deductibles do not apply toward your Out-of-Pocket Limit Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis 	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]	Individual: [\$0-unlimited] Family: [\$0-unlimited]
Coinsurance	[0%-100%] after Deductible	[0%-100%] after Deductible
Preventive Care Services (Performed in the Office): QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical policies. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines Child Immunizations (age 0-18) Adult Immunizations (-age 18+) <ul style="list-style-type: none"> Diphtheria and Tetanus toxoid for ages over 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 Evidence of Coverage (EOC).</i>	No Cost to You	Not Covered
Routine vision exam (limit 1 every 24 months)	[\$0-\$100] Co-payment	Not Covered
<ul style="list-style-type: none"> Well baby care, birth to age 2 Well child care, ages 2-18 	No Cost to You	Not Covered
Other preventive services <ul style="list-style-type: none"> 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 once every 5 years; OR Preventive colonoscopy age 50 and older, once every 10 years 	No Cost to You	Not Covered
Family Planning <ul style="list-style-type: none"> Tubal ligation and associated services (reversal of sterilization is not a covered benefit) Insertion or implantation of birth control pellets, capsules or IUDs Fitting and insertion of diaphragms, rings or caps Injection of long acting contraceptives 	No Cost to You	Not Covered
Smoking cessation <ul style="list-style-type: none"> Kick the Nic: smoking cessation; 12 week program <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	Not Covered
Professional Services		
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-\$500] Co-payment] OR [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-\$500] Co-payment] OR [0%-100% after Deductible]	[0%-100%] after Deductible
Professional services that are subject to Deductible and Coinsurance (in addition to the office Co-payment, if applicable) <ul style="list-style-type: none"> Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests, lab & x-ray Other procedures, such as chemotherapy, radiation and infusion therapy Complex Injectable Prescription Medications which include: All specialty medications such as 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 - Facility		
<ul style="list-style-type: none"> Inpatient care - hospital Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per Calendar Year) 	[[[\$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%-100%] after Deductible [and/or] [\$0-\$2,000] [Co-payment]	
<ul style="list-style-type: none"> Home Health (20 visits per Calendar Year) 	[0%-100%]	
Emergency Services		
<ul style="list-style-type: none"> Emergency Room, Urgent Care or ER Observation Services 	[0%-100%] [after Deductible] [and/or] [\$0-\$2,000] [Co-payment]	[0%-100%] [after Deductible] [and/or] [\$0-\$2,000] [Co-payment]
Transportation Services		
<ul style="list-style-type: none"> Ambulance - (\$1,000 maximum benefit per Calendar Year) <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%]	[0%-100%]
Therapy Services		
<ul style="list-style-type: none"> Physical Therapy Occupational Therapy Speech Therapy and Audiology Testing Chiropractic Care (12 visits per Calendar Year) Cardiac Rehabilitation (36 visits per Calendar Year) <i>Note: Therapy services are limited to a combined maximum of 30 visits per Calendar Year. This does not include Cardiac Rehabilitation or Chiropractic Care.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
<ul style="list-style-type: none"> Prenatal Lab Professional Services (Office) Professional Services (Inpatient/Outpatient Facility) <p><i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient charges, see Inpatient sections on page 2.</i></p>	<p>[PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment] or [0%-100% after Deductible]</p> <p>[0%-100% after Deductible]</p>	[0%-100%] after Deductible
<p>In Vitro Fertilization and Infertility</p> <ul style="list-style-type: none"> Infertility Diagnostic Services Invitro Fertilization <p><i>Note: Infertility treatment and services are subject to a \$15,000 lifetime benefit maximum. See the "In Vitro Fertilization and Infertility" section of the Evidence of Coverage (EOC).</i></p>	[0%-100%] after Deductible	[0%-100%] after Deductible
Mental Health and Substance Use Disorder Services		
<ul style="list-style-type: none"> Inpatient Hospital Services [10 day limit per calendar year] Professional Services (Office/Outpatient Visits) [10 visit limit per calendar year] Professional Services (Inpatient/Outpatient Facility) 	<p>[\$0-\$500 Co-payment] [and/or] [0%-100%] after Deductible</p> <p>[[PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment]] or [0%-100% after Deductible]</p> <p>[0%-100%] after Deductible</p>	[[0%-100%] after Deductible] or [Not Covered]
Allergy Services		
<ul style="list-style-type: none"> Office Visit and Allergy Testing Allergy Shots 	<p>[PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment] or [0%-100% after Deductible]</p> <p>No Cost to You</p>	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
<p>Durable Medical Equipment (DME)</p> <ul style="list-style-type: none"> \$2,000 maximum benefit per Calendar Year 	[0%-100%] after Deductible	[0%-100%] after Deductible
<p>Medical Supplies</p> <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
<p>Prosthetics and Orthotic Services and Devices</p> <ul style="list-style-type: none"> Prosthetic Services and Prosthetic Devices Orthotic Services and Orthotic Devices <p><i>Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Evidence of Coverage for more information.</i></p>	[0%-100%] after Deductible	[0%-100%] after Deductible
<p>Reconstructive Surgery</p> <ul style="list-style-type: none"> Breast reconstruction following mastectomy Restoration due to acute trauma, infection or cancer <p><i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient charges, see Inpatient sections on page 2.</i></p>	[0%-100%] after Deductible	[0%-100%] after Deductible

Transplantation Services		
<ul style="list-style-type: none"> Physician/Professional charges 	[0%-100%] after Deductible	
<ul style="list-style-type: none"> Inpatient and Outpatient Charges <i>Note: Lifetime maximum of two transplants</i>	[\$0-\$500 Co-payment] [and/or] [0%-100%] after Deductible	[0%-100%] after Deductible
Diabetes Management Services		
<ul style="list-style-type: none"> Insulin Pumps (\$5,500 benefit maximum per Calendar Year) Supplies and equipment (Subject to \$2,000 DME limit) 	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> Diabetic Education (1 training per lifetime) 	[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	No benefits if not pre-authorized
	[0%-100%] after Deductible	[0%-100%] after Deductible
Hearing Aids and Hearing Instruments		
<i>Note: Not to exceed \$1,400 per ear for each 3 year period.</i>	[Not Covered] or [Charges in Excess of the benefit limit]	[Not Covered] or [Charges in Excess of the benefit limit]
Temporomandibular Joint Disorder (TMJ)		
<ul style="list-style-type: none"> Surgical Treatment (limit \$15,000 per lifetime) <i>Note: These benefits are for physician/professional charges. For benefits related to these services for Outpatient, Inpatient, Office, Physical Therapy and DME charges, see respective sections, pg.1 & 2.</i>	[Not Covered] or [[0%-100%] after Deductible]	[Not Covered] or [[0%-100%] after Deductible]

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

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

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

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Deductible <ul style="list-style-type: none"> If applicable, Co-payments are not included in the Deductible In-Network and Out-of-Network Deductibles apply separately Family Deductible is not considered satisfied until [two or three] family members satisfy their Individual Deductible Deductible amounts applied in the last quarter of a Calendar Year [will or will not] carry over to the next Calendar Year The Deductible is calculated on a Calendar Year basis 	Individual: [\$0-\$200,000] Family: [\$0-\$200,000]	Individual: [\$0-\$200,000] Family: [\$0-\$200,000]
Out-of-Pocket Limit <ul style="list-style-type: none"> Applicable coinsurance will apply for families until [two or three] family members satisfy the individual Out-of-Pocket Limit Benefits will be paid at 100% of the Maximum Allowable Charge once the family Coinsurance limit is satisfied Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits If applicable, Co-payments do not apply toward your Out-of-Pocket Limit. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached Deductibles do not apply toward your Out-of-Pocket Limit Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis 	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]	Individual: [\$0-unlimited] Family: [\$0-unlimited]
Coinsurance	[0%-100%] after Deductible	[0%-100%] after Deductible
Preventive Care Services (Performed in the Office):		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical policies. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines Child Immunizations (age 0-18) Adult Immunizations (-age 18+) <ul style="list-style-type: none"> Diphtheria and Tetanus toxoid for ages over 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 Evidence of Coverage (EOC).</i>	No Cost to You	Not Covered
Routine vision exam (limit 1 every 24 months)	[\$0-\$100] Co-payment	Not Covered
<ul style="list-style-type: none"> Well baby care, birth to age 2 Well child care, ages 2-18 	No Cost to You	Not Covered
Other preventive services <ul style="list-style-type: none"> 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 once every 5 years; OR Preventive colonoscopy age 50 and older, once every 10 years 	No Cost to You	Not Covered
Family Planning <ul style="list-style-type: none"> Tubal ligation and associated services (reversal of sterilization is not a covered benefit) Insertion or implantation of birth control pellets, capsules or IUDs Fitting and insertion of diaphragms, rings or caps Injection of long acting contraceptives 	No Cost to You	Not Covered
Smoking cessation <ul style="list-style-type: none"> Kick the Nic: smoking cessation; 12 week program <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	Not Covered
Professional Services		
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: <ul style="list-style-type: none"> 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
Professional services that are subject to Deductible and Coinsurance <ul style="list-style-type: none"> Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests, lab & x-ray Other procedures, such as chemotherapy, radiation and infusion therapy Complex Injectable Prescription Medications which include: <ul style="list-style-type: none"> All specialty medications such as 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 - Facility		
<ul style="list-style-type: none"> Inpatient care - hospital Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per Calendar Year) 	[\$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%-100%] after [Deductible] [and/or] [\$0-\$2,000] [Co-payment]	
<ul style="list-style-type: none"> Home Health (20 visits per Calendar Year) 	[0%-100%]	
Emergency Services		
<ul style="list-style-type: none"> Emergency Room, Urgent Care or ER Observation Services 	[0%-100%] after [Deductible] [and/or] [\$0-\$2,000] [Co-payment]	[0%-100%] after [Deductible] [and/or] [\$0-\$2,000] [Co-payment]
Transportation Services		
<ul style="list-style-type: none"> Ambulance - (\$1,000 maximum benefit per per Calendar Year) <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%]	[0%-100%]
Therapy Services		
<ul style="list-style-type: none"> Physical Therapy Occupational Therapy Speech Therapy and Audiology Testing Chiropractic Care (12 visits per Calendar Year) Cardiac Rehabilitation (36 visits per Calendar Year) <i>Note: Therapy services are limited to a combined maximum of 30 visits per Calendar Year. This does not include Cardiac Rehabilitation or Chiropractic Care.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
<ul style="list-style-type: none"> Prenatal Lab Professional Services (Office) 	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> Professional Services (Inpatient/Outpatient Facility) <p><i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient charges, see Inpatient sections on page 2.</i></p>	[0%-100%] after Deductible	
In Vitro Fertilization and Infertility <ul style="list-style-type: none"> Infertility Diagnostic Services In Vitro Fertilization <p><i>Note: Infertility treatment and services are subject to a \$15,000 lifetime benefit maximum. See the "In Vitro Fertilization and Infertility" section of the Evidence of Coverage (EOC).</i></p>	[0%-100%] after Deductible	[0%-100%] after Deductible
Mental Health and Substance Use Disorder Services		
<ul style="list-style-type: none"> Inpatient Hospital Services [10 day limit per calendar year] 	[\$0-\$500 Co-payment] [and/or] [0%-100% after Deductible]	
<ul style="list-style-type: none"> Professional Services (Office/Outpatient Visits) [10 visit limit per calendar year] 	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> Professional Services (Inpatient/Outpatient Facility) 		
Allergy Services		
<ul style="list-style-type: none"> Office Visit and Allergy Testing 	[0%-100%] after Deductible	[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"> \$2,000 maximum benefit per Calendar Year 	[0%-100%] after Deductible	[0%-100%] after Deductible
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
Prosthetics and Orthotic Services and Devices <ul style="list-style-type: none"> Prosthetic Services and Prosthetic Devices Orthotic Services and Orthotic Devices <p><i>Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Evidence of Coverage for more information.</i></p>	[0%-100%] after Deductible	[0%-100%] after Deductible
Reconstructive Surgery <ul style="list-style-type: none"> Breast reconstruction following mastectomy Restoration due to acute trauma, infection or cancer <p><i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient charges, see Inpatient sections on page 2.</i></p>	[0%-100%] after Deductible	[0%-100%] after Deductible

Transplantation Services		
<ul style="list-style-type: none"> Physician/Professional charges Inpatient and Outpatient Charges 	[0%-100%] after Deductible	[0%-100%] after Deductible
<i>Note: Lifetime maximum of two transplants</i>	[0%-100%] after Deductible	
Diabetes Management Services		
<ul style="list-style-type: none"> Insulin Pumps (\$5,500 benefit maximum per Calendar Year) Supplies and equipment (Subject to \$2,000 DME limit) 	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> Diabetic Education (1 training per lifetime) 	[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 [\$0-\$5,000] per year 	[0%-100%] after Deductible	[0%-100%] after Deductible
Genetic Counseling and Testing	No benefits if not pre-authorized	No benefits if not pre-authorized
<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>	[0%-100%] after Deductible	[0%-100%] after Deductible
Hearing Aids and Hearing Instruments		
<i>Note: Not to exceed \$1,400 per ear for each 3 year period.</i>	[Not Covered] or [Charges in Excess of the benefit limit]	[Not Covered] or [Charges in Excess of the benefit limit]
Temporomandibular Joint Disorder (TMJ)		
<ul style="list-style-type: none"> Surgical Treatment (limit \$15,000 per lifetime) 	[Not Covered] or [[0%-100%] after Deductible]	[Not Covered] or [[0%-100%] after Deductible]
<i>Note: These benefits are for physician/professional charges. For benefits related to these services for Outpatient, Inpatient, Office, Physical Therapy and DME charges, see respective sections, pg.1 & 2.</i>		

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

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

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

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Deductible <ul style="list-style-type: none"> In-Network and Out-of-Network Deductibles apply separately Family Deductible is not considered satisfied until the entire family deductible amount is satisfied. Deductible amounts applied in the last quarter of a Calendar Year will not carry over to the next Calendar Year The Deductible is calculated on a Calendar Year basis 	Individual: \$1,200 Family: \$2,400	
Out-of-Pocket Limit <ul style="list-style-type: none"> Applicable coinsurance will apply for families until [two or three] family members satisfy the individual Out-of-Pocket Limit Benefits will be paid at 100% of the Maximum Allowable Charge once the family Coinsurance limit is satisfied Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits Deductibles do not apply toward your Out-of-Pocket Limit Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis 	Individual: \$2,000 Family: \$4,000	Individual: \$8,000 Family: \$16,000
Coinsurance	[0%-100%] after Deductible	[0%-100%] after Deductible
Preventive Care Services (Performed in the Office):		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical policies. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines Child Immunizations (age 0-18) Adult Immunizations (-age 18+) <ul style="list-style-type: none"> Diphtheria and Tetanus toxoid for ages over 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 Evidence of Coverage (EOC).</i>	No Cost to You	Not Covered
Routine vision exam (limit 1 every 24 months)	[0%-100%] after Deductible	Not Covered
<ul style="list-style-type: none"> Well baby care, birth to age 2 Well child care, ages 2-18 	No Cost to You	Not Covered
Other preventive services <ul style="list-style-type: none"> 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 once every 5 years; OR • Preventive colonoscopy age 50 and older, once every 10 years 	No Cost to You	Not Covered
Family Planning <ul style="list-style-type: none"> • Tubal ligation and associated services (reversal of sterilization is not a covered benefit) • Insertion or implantation of birth control pellets, capsules or IUDs • Fitting and insertion of diaphragms, rings or caps • Injection of long acting contraceptives 	No Cost to You	Not Covered
Smoking cessation <ul style="list-style-type: none"> • Kick the Nic: smoking cessation; 12 week program <i>Note: Contact QCare 1-888-795-6810</i>	No Cost to You	Not Covered
Professional Services		
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
Professional services that are subject to Deductible and Coinsurance <ul style="list-style-type: none"> • Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests, lab & x-ray • Other procedures, such as chemotherapy, radiation and infusion therapy • Complex Injectable Prescription Medications which include: All specialty medications such as 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 - Facility		
<ul style="list-style-type: none"> • Inpatient care - hospital • Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per Calendar Year) 	[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 • Home Health 20 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 - (\$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 and Audiology Testing • Chiropractic Care (12 visits per Calendar Year) • Cardiac Rehabilitation (36 visits per Calendar Year) <i>Note: Therapy services are limited to a combined maximum of 30 visits per Calendar Year. This does not include Cardiac Rehabilitation or Chiropractic Care.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
<ul style="list-style-type: none"> Prenatal Lab Professional Services (Office) Professional Services (Inpatient/Outpatient Facility) <p><i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient charges, see Inpatient sections on page 2.</i></p>	[0%-100%] after Deductible	[0%-100%] after Deductible
In Vitro Fertilization and Infertility <ul style="list-style-type: none"> Infertility Diagnostic Services In Vitro Fertilization <p><i>Note: Infertility treatment and services are subject to a \$15,000 lifetime benefit maximum. See the "In Vitro Fertilization and Infertility" section of the Evidence of Coverage (EOC).</i></p>	[0%-100%] after Deductible	[0%-100%] after Deductible
Mental Health and Substance Use Disorder Benefits		
<ul style="list-style-type: none"> Inpatient Hospital Services [10 day limit per calendar year] Professional Services (Inpatient/Outpatient Facility) [10 visit limit per calendar year] Professional Services (Office/Outpatient Visits) 	[0%-100%] after Deductible	[0%-100%] after Deductible
Allergy Services		
<ul style="list-style-type: none"> Office Visit and Allergy Testing Allergy Shots 	[0%-100%] after Deductible	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) <ul style="list-style-type: none"> \$2,000 maximum benefit per Calendar Year 	[0%-100%] after Deductible	[0%-100%] after Deductible
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
Prosthetics and Orthotic Services and Devices <ul style="list-style-type: none"> Prosthetic Services and Prosthetic Devices Orthotic Services and Orthotic Devices <p><i>Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Evidence of Coverage for more information.</i></p>	[0%-100%] after Deductible	[0%-100%] after Deductible
Reconstructive Surgery <ul style="list-style-type: none"> Breast reconstruction following mastectomy Restoration due to acute trauma, infection or cancer <p><i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient charges, see Inpatient sections on page 2.</i></p>	[0%-100%] after Deductible	[0%-100%] after Deductible
Transplantation Services <ul style="list-style-type: none"> Physician/Professional charges Inpatient and Outpatient Charges <p><i>Note: Lifetime maximum of two transplants</i></p>	[0%-100%] after Deductible	[0%-100%] after Deductible
Diabetes Management Services <ul style="list-style-type: none"> Insulin Pumps (\$5,500 benefit maximum per Calendar Year) Supplies and equipment (Subject to \$2,000 DME limit) Diabetic Education (1 training per lifetime) 	[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 ▪ Benefits available after member has paid [\$0-\$5,000] 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
Hearing Aids and Hearing Instruments <i>Note: Not to exceed \$1,400 per ear for each 3 year period.</i>	[Not Covered] or [Charges in Excess of the benefit limit]	[Not Covered] or [Charges in Excess of the benefit limit]
Temporomandibular Joint Disorder (TMJ) ▪ Surgical Treatment (limit \$15,000 lifetime) <i>Note: These benefits are for physician/professional charges. For benefits related to these services for Outpatient, Inpatient, Office, Physical Therapy and DME charges, see respective sections, pg.1 & 2.</i>	[Not Covered] or [[0%-100%] after Deductible]	[Not Covered] or [[0%-100%] after Deductible]

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