

SERFF Tracking Number: QUAC-128068218 State: Arkansas
Filing Company: QCA Health Plan, Inc. State Tracking Number:
Company Tracking Number:
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001B Any Size Group - POS
Product Name: POS (CAW Amendment)
Project Name/Number: CAW Amendment/

Filing at a Glance

Company: QCA Health Plan, Inc.

Product Name: POS (CAW Amendment)

TOI: H16G Group Health - Major Medical

Sub-TOI: H16G.001B Any Size Group - POS

Filing Type: Form

SERFF Tr Num: QUAC-128068218 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num:

Co Tr Num:

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Authors: Jim Couch, Niki Thomas

Disposition Date: 02/06/2012

Date Submitted: 02/03/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: CAW Amendment

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type:

Filing Status Changed: 02/06/2012

State Status Changed: 02/06/2012

Created By: Niki Thomas

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

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Filing Description:

CAW Amendment

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Niki Thomas

Company and Contact

Filing Contact Information

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

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$200.00
 Retaliatory? No
 Fee Explanation: 4 Forms at \$50 a form.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
QCA Health Plan, Inc.	\$200.00	02/03/2012	56067768

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/06/2012	02/06/2012

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Disposition

Disposition Date: 02/06/2012

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Status: Approved-Closed

HHS Status: HHS Approved

State Review:

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Prescription Drug Rider	Approved-Closed	Yes
Form	Prescription Drug Plan	Approved-Closed	Yes
Form	Benefit Summary	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/06/2012	Form # QC POS/HDHP (10-1-10)	Policy/Cont al	Amendment CAW Certificate Amendment #1 January 2012	Initial			CAW Amendment.pdf
Approved-Closed 02/06/2012	Form # QC POS (10-1-10)	Policy/Cont t, Insert	Amendment Prescription Drug Rider	Initial			CAW Outpatient Prescription Drug Rider.pdf
Approved-Closed 02/06/2012	Form # QCRx POS/HDHP (10-1-10)	Policy/Cont al	Prescription Drug Plan Certificate CAW);	Initial			Central Arkansas Water - Pharmacy Benefit Summary.pdf
Approved-Closed 02/06/2012	Form # CQ POSPC GF (10-1-10)	Policy/Cont al	Benefit Summary Certificate	Initial			Central Arkansas Water - Benefit Summary.pdf

**AMENDMENT TO QCA HEALTH PLAN, INC.
EVIDENCE OF COVERAGE**

The QCA Health Plan, Inc. (d/b/a QualChoice) Evidence of Coverage identified as QC POS/HDHP (10-1-10) approved by the Arkansas Department of Insurance on November 6, 2009; and The First Amendment to the Evidence of Coverage as identified as FIRST AMENDMENT [with Autism] to QCA POS [HDHP] (10-1-10) EOC (8-1-2011) is hereby amended for *Central Arkansas Water* **ONLY** effective January 1, 2012 as follows:

Section 2.10 Coverage While Traveling Out of the Service Area shall be replaced in its entirety with the following:

We cover the cost of Emergency health services an Enrollee incurs while traveling outside of the Service Area, including outside of the United States. An Enrollee is encouraged to seek services for Emergency health services from health care providers participating in the QualChoice National Network (QCNN) when the Enrollee is out of the Service Area. An Enrollee may limit out-of-pocket expenses for Emergency health services while outside of the Service Area to applicable Cost Sharing Amounts by accessing such care from a QCNN provider.

If care is accessed within the United States by an Enrollee from providers not participating in the QCNN, reimbursement for Covered Services will be at the Out-of-Network Benefit level. We will deny coverage for routine and follow up care after Emergency health services unless a Network Provider in Arkansas performs the services.

The QualChoice identification card contains contact information for the QCNN. QCNN providers may be identified by calling the number on the identification card. The Enrollee must present their QualChoice identification card to the servicing provider indicating participation in the QCNN in order to receive this benefit. Submit a Claim for Benefits directly to us for processing. Provisions for Emergency health services as set forth in [Section 3.10](#) must also be followed to receive maximum Benefits.

Dependents who have notified QualChoice that they reside outside the Service Area may access the QCNN providers and facilities for Covered Services at the In-Network benefit level upon prior approval by QualChoice.

The following Subparagraph 3 shall be added to Section 3.10 Emergency Health Services:

3. **Emergency Care Outside of the United States:** Services provided in an Emergency when you are outside of the United States, are paid at the In-Network benefit level. You will need to submit a claim form with your receipt for services.

Subparagraph 4 of Section 4.2 Limitations to Benefits shall be replaced in its entirety with the following:

4. Cochlear Implants: Coverage for cochlear implants is subject to a maximum lifetime benefit of \$35,000 per Enrollee. Coverage is limited to one cochlear implant device, the surgical procedure, and one speech processor. Reimplantation of the same device is not covered. Pre-authorization is required.

Section 3.28 Reconstructive Surgery shall be replaced in its entirety with the following:

3.28 Reconstructive Surgery:

Cosmetic Services are not covered. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Certificate, and subject to the Deductible and Coinsurance specified in the Summary of Benefits, coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by an In-Network Physician:

1. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Enrollee;
2. Surgery performed on a child for the correction of a cleft palate or cleft lip, removal of a port-wine stain (only on the face), or correction of a congenital abnormality. In order to be covered, such corrective surgery for a congenital defect must be performed when the child is twelve (12) years or younger, unless, in its sole discretion, QualChoice determines that due to the complexity of the procedure, such surgery could not be performed prior to a child's twelfth (12th) birthday. Dental care to correct congenital defects is not a covered benefit.
3. Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery;
4. In connection with a mastectomy eligible for coverage under this Certificate, services for (a) reconstruction of the breast on which the surgery was performed; (b) surgery to reconstruct the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphademas; or
5. Reduction Mammoplasty that meets our criteria for coverage (which you may request to obtain a copy from us) is a Covered Service subject to Deductible and 50% Coinsurance. Pre-authorization is required.
6. Reconstructive or restorative surgery aimed at enhancement beyond normal function is not covered (for example, restoration aimed at athletic performance is not covered).

Cosmetic services are intended primarily to improve your appearance or for your psychological benefit. As further explained in Section 4.1 we do not pay for any procedures, surgeries, services, equipment or supplies provided in connection with elective cosmetic surgeries.

Subparagraph 20 of Section 4.1 Non-Covered Services and Exclusions from Coverage shall be replaced in its entirety with the following:

20. Cosmetic or Reconstructive Services: Cosmetic services are intended primarily to improve your appearance or for your psychological benefit. We will not pay for any procedures, surgeries, services, equipment or supplies provided in connection with elective cosmetic services.

Subparagraph 3 of Section 5.4 Termination of Coverage shall be replaced in its entirety with the following:

3. If You Are No Longer A Member Of The Employer Group: If your employment or membership in the Employer Group terminates or you no longer meet the eligibility requirements as set forth in Section 2.8, your coverage under this Plan will automatically terminate on the last day of the month through which your Employer Group premium has been paid on your behalf. You have the right to continue coverage. See Section 8 for a description of how you, your covered spouse, and your dependents may elect to continue coverage under certain circumstances.

Subparagraph 4 of Section 5.4 Termination of Coverage shall be replaced in its entirety with the following:

4. Certificate Holder's Death: Coverage for Covered Dependents under this Plan will automatically terminate on the last day of the month of the Certificate Holder's death. For a description of how Covered Dependents can elect to continue coverage following the death of the Certificate Holder, please refer to Section 8.

Subparagraph 5 of Section 5.4 Termination of Coverage shall be replaced in its entirety with the following:

5. Termination of Your Marriage: If you divorce, legally separate, or annul your marriage, the coverage of the Certificate Holder's spouse will automatically terminate on the last day of the month the divorce, legal separation, or annulment occurred. A court order requiring the Certificate Holder to provide coverage for the former spouse does not change the termination of coverage. However, see Section 8 for information about how a Certificate Holder's spouse can elect to continue coverage.

Subparagraph 6 of Section 5.4 Termination of Coverage shall be replaced in its entirety with the following:

6. Termination of Coverage of a Dependent Child: The coverage of a Child under this Certificate will terminate automatically on the last day of the month of the earliest the Child either:

- A. No longer meets the limiting age eligibility requirements; or
- B. For a Child incapable of self-support (an incapacitated Child), on the date the Child becomes capable of self-support; termination of coverage based

upon age limitation(s) does not apply to a Child who qualifies as an incapacitated Child.

This Amendment becomes a part of the QCA Health Plan, Inc. Evidence of Coverage identified as QC POS/HDHP (10-1-2010) and The First Amendment to the Evidence of Coverage as identified as FIRST AMENDMENT [with Autism] to QCA POS [HDHP] (10-1-10) EOC (8-1-2011) for Central Arkansas Water ONLY. All provisions of the Evidence of Coverage that are not contrary to the provisions of this Amendment remain in full force and effect.

A handwritten signature in black ink that reads "Michael E. Stock".

**Michael E. Stock, President & CEO
QCA Health Plan, Inc.
The QualChoice Building
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211**

RIDER TO QUALCHOICE EVIDENCE OF COVERAGE (FORM # QCA POS (10-1-10)) FOR OUTPATIENT PRESCRIPTION DRUGS

This rider (the "Outpatient Prescription Drug Rider") amends the QCA Health Plan, Inc. Evidence of Coverage (Form # QCA POS (10-1-10)) (the "Certificate") and the Benefits Summary issued to the Enrollee and is therefore part of the Group Master Contract that is a legal document between QCA Health Plan, Inc. and your Employer Group. Unless otherwise stated herein, this Outpatient Prescription Drug Rider is subject to all terms, conditions, exclusions and limitations set forth in the Certificate, the Benefits Summary, and the Group Master Contract.

We have capitalized certain words in this Outpatient Prescription Drug Rider. Those words have special meanings and, unless defined otherwise in this Outpatient Prescription Drug Rider, are defined in Section 13 of the Certificate.

For purposes of this Outpatient Prescription Drug Rider and each section of this Outpatient Prescription Drug Rider, QCA Health Plan, Inc. ("QualChoice") is referred to as "us", "we" or "our", and "you" or "your" means the Certificate Holder, i.e., the Employee.

1.0 Prescription Drug Benefits

Benefits are available for those outpatient prescription drugs as specified in this Outpatient Prescription Drug Rider, subject to the Cost Sharing Amounts and Exclusions and Limitations described in this Outpatient Prescription Drug Rider, in addition to all other applicable conditions, limitations and exclusions of the Certificate and Benefits Summary. Under this prescription drug benefit, you will pay one or more of the following as reflected in the Benefits Summary: a fixed copayment amount, a prescription drug deductible, and/or pre-defined coinsurance percentage for each prescription drug obtained. **Consult the Benefits Summary for your applicable Cost Sharing Amounts by Tier and the specific Formulary purchased by your Employer Group.**

1.1 Covered Prescription Drugs

A "Covered Prescription Drug" is one that is (1) an injectable or non-injectable medication, (2) approved by the Food and Drug Administration (FDA), (3) is obtainable only with a physician's written prescription, (4) not excluded or limited in Section 1.13 of this Outpatient Prescription Drug Rider, and (5) has been placed by QualChoice on a Formulary as described in Section 1.2 below.

There may be limitations on coverage for Covered Prescription Drugs. Those limitations are set out in Section 1.14 of this Outpatient Prescription Drug Rider.

1.2 Formulary and Tiers

The list of Covered Prescription Drugs approved for coverage is called the "Formulary". The Formulary is subject to periodic review and modification by us (see Sections 1.7, 1.8, and 1.11, below). QualChoice offers various formularies for prescription drug coverage. **Consult the Benefits Summary for the specific Formulary purchased by your Employer Group.**

All Covered Prescription Drugs placed on a specific Formulary will be assigned to a "Tier". The Tiers defined for Covered Prescription Drugs are described in your Benefits Summary. The Formulary is subject to periodic review and modification by us in our sole discretion and without notice, including the placement of prescription drugs in certain Tiers.

You can find out whether a medication is on the Formulary and, if so, in what Tier it has been placed by logging onto our website at www.qualchoice.com and selecting the drug formulary link on your member home page. The Tier determines the Enrollee Cost Sharing Amount (see [Section 1.12](#) below and your Benefits Summary for details regarding Enrollee cost sharing for different Tiers).

1.3 Purchase From Retail Pharmacy

An Enrollee must show his/her QualChoice identification card when purchasing a prescription at a participating network retail pharmacy, otherwise the pharmacy may require the Enrollee to pay the full cost of the medication and our discounted rates will not be available. The Enrollee may remit the Claim for Benefits by contacting our Customer Service department or going to our website www.qualchoice.com to obtain a prescription drug claim form. This form includes instructions and mailing address to submit Claims. The Claim for Benefits must be submitted within sixty (60) days of the medication being dispensed for reimbursement. The Claim for Benefits will be subject to all terms, conditions, exclusions and limitations set forth in this Outpatient Prescription Drug Rider, the Certificate and the Benefits Summary. Reimbursement to the Enrollee will not exceed what would have been paid if the Enrollee had presented his/her QualChoice identification card at the time the prescription was filled, less the Enrollee's appropriate Cost Sharing Amount.

All participating network retail pharmacies can fill a 34 day prescription. A select group of participating network retail pharmacies is allowed to fill a 100 day prescription for a maintenance medication. You can identify these select pharmacies by logging onto our website at www.qualchoice.com.

1.4 Purchase From Mail Order Pharmacy

In addition to a retail pharmacy network, Enrollees may obtain their Covered Prescription Drugs through our mail order pharmacy. You can find out more about purchasing your prescription drugs through our mail order pharmacy by contacting our Customer Service department. The Enrollee Cost Sharing Amount described in [Section 1.12](#) below for mail order is the same as it is for participating retail drug stores.

1.5 Purchase From Out-of-Network Pharmacy

If you purchase a Covered Prescription Drug from a pharmacy that is *not* a participating network pharmacy, you must pay the full amount of the Covered Prescription Drug to the pharmacy. You can then request reimbursement from QualChoice by submitting your receipt from the pharmacy, along with a QualChoice pharmacy claim form. QualChoice will reimburse you up to the amount described in your Benefit Summary. You will be responsible for the difference between the pharmacy's charge and the amount reimbursed by QualChoice, plus a standard processing fee described in your Benefit Summary.

1.6 Obtaining Benefits for Covered OTC Products

Only those over-the-counter (non-prescription or OTC) medications listed on the Formulary are covered. A written prescription is necessary to obtain covered over-the-counter products. At the retail pharmacy, the Enrollee should present their over-the-counter product prescription and QualChoice identification card. The purchase will be processed in the same way as a prescription drug is processed. You can find out whether a particular over-the-counter medication is on the Formulary by logging onto our website at www.qualchoice.com and selecting the drug formulary link on your member home page or by contacting our customer service department.

1.7 Brands With Generic Available

A "Brand Drug" is one that is sold under a proprietary name. A "Generic Drug" is one that is sold under a nonproprietary name. Most Brand Drugs with a Generic Drug available are considered non-preferred products and are placed in a higher tier. When a Brand Drug becomes available as a Generic Drug, the Brand Drug may no longer be available on the Formulary or the tier may change. The new tier applies regardless of whether the Enrollee or the physician chooses the product.

1.8 New Drugs Entering the Market

New drugs entering the market and drugs in new dosage forms will not automatically be placed on the formulary. Tier placement on the formulary will be made at the discretion of QualChoice.

1.9 Maintenance Medications

Some Maintenance Medications (as defined in this paragraph) are allowed at a 100-day supply with a Co-pay for each 34 day supply. See [Section 1.3](#) – Purchase From Retail Pharmacy. For purposes of this Plan, “Maintenance Medications” are defined as follows:

A. A drug that is usually administered continuously, rather than intermittently, and for longer than 100 days, typically for the remainder of one’s life. This means the patient taking the medication on a scheduled basis year round and not as needed or seasonally.

B. A drug in which the most common use is to treat a chronic disease state when a therapeutic endpoint cannot be determined. Therapy with the drug is not considered curative.

C. A drug that has a low probability for dosage or therapy changes due to side effects, serum drug concentration monitoring, or therapeutic responses over a course of prolonged therapy.

D. While certain drugs may sometimes be used on a chronic basis, the drug will only meet the above definition if it is most commonly used in this way. The most common examples of maintenance medications are medicines used to treat high blood pressure, diabetes, high cholesterol, or hypothyroidism.

E. Drugs in the following classes are considered to be Maintenance Medications. If your medication falls in one of these categories you will be able to get a 100 days supply either from your retail pharmacy (if it participates in the 100-day network) or from the mail order pharmacy. You will need a prescription from your doctor with enough refills to allow 100 days. One Co-payment will be charged for each 34 day supply.

- i. Alzheimer Disease medication
- ii. Antipsychotic medication
- iii. Antivirals for HIV
- iv. Asthma and other respiratory medication
- v. Benign Prostatic Hyperplasia (BPH) medication
- vi. Blood pressure medication (e.g., beta blockers, calcium channel blockers, diuretics, ACE-inhibitors)
- vii. Cancer medication
- viii. Cholesterol lowering drugs
- ix. Diabetes medication
- x. Glaucoma medication
- xi. Heart medication
- xii. Organ transplant medication
- xiii. Osteoporosis medication
- xiv. Parkinson’s Disease medication
- xv. Potassium supplements
- xvi. Seizure medication
- xvii. Thyroid medication

1.10 Diabetes Supplies

The following diabetes supplies are covered under your pharmacy benefit as reflected in the Benefits Summary:

1. Glucometers
2. Diabetes supplies should be filled for a 34-day supply (if possible) to minimize Enrollee cost sharing.
 - Test strips and lancets, if filled together, will be considered to be a single prescription
 - Insulin and syringes, if filled together, will be considered to be a single prescription

1.11 Specialty Pharmacy

Some Covered Prescription Drugs are designated as Specialty Pharmacy medications. These are medications generally used to treat relatively uncommon and/or potentially catastrophic illnesses. Specialty Pharmacy medications may require our pre-authorization and must be obtained through a contracted Specialty Pharmacy identified by QualChoice instead of a retail pharmacy. Some Specialty Pharmacy medications may be covered under the medical plan instead of the pharmacy Benefit and they are subject to your medical plan deductible and coinsurance. You can find out whether a particular medication is considered to be a Specialty Pharmacy medication, a particular Specialty Pharmacy medication requires pre-authorization, and if Specialty Pharmacy medication has been placed on a tier or is covered under the medical plan by logging onto our website at www.qualchoice.com and selecting the drug formulary link on your member home page or by contacting our Customer Service department.

1.12 Cost Sharing Amounts

1. The Enrollee will be responsible for paying the member Cost Sharing Amounts reflected in the Benefits Summary. The Cost Sharing Amounts will be different for drugs on different Tiers.
2. If a Brand Drug is dispensed when a Generic Drug is available and the Employer Group has selected a mandatory generic drug benefit as reflected in the Benefits Summary, the Enrollee may be required to pay the appropriate Cost Sharing Amounts for the brand name drug, plus the difference in the cost between the Brand Drug and the Generic Drug.
3. The amount an Enrollee pays towards Co-payments, Deductibles (if applicable), service charges and any non-Covered Prescription Drugs is not included in determining the amount of any Out-of-Pocket Limit stated in this Certificate and/or Benefits Summary.
4. Amounts paid by you or your dependents for prescription drugs do not accumulate toward satisfying your medical Deductible responsibility or your medical Out-of-Pocket Limit responsibility shown in your Benefit Summary.
5. All QualChoice formularies are subject to changes during the year. These changes can be caused by events such as the introduction of new medications, wholesale price changes by drug manufacturers, or review of current coverage status based on new clinical information. These changes can affect your Cost Sharing Amounts.

1.13 Exclusions From Coverage

1. Charges to administer or inject a medication are not covered under this Outpatient Prescription Drug Rider.
2. Medications dispensed when an Enrollee is in a hospital, skilled nursing facility or other healthcare facility are not covered as a prescription drug benefit. (These medications would be covered under your medical benefit.)
3. Drugs that we determine are not either safe or effective may not be covered even though not specifically excluded as described herein, and even though they may be available as a generic.
4. We do not cover medications prescribed for any injury, condition or disease arising from employment. We will not make any payments even if a claim is not made for the benefits which are available under the Workers' Compensation Law.
5. Unless specifically stated otherwise in this Outpatient Prescription Drug Rider, medical supplies, immunizations, and durable medical equipment are not covered as a prescription drug benefit.
6. Except to the extent that they are specifically listed in the Formulary, the following products or categories of drugs are not covered as a prescription drug benefit, but may be covered as a medical Benefit under the Certificate:
 - Implantable contraceptives,
 - Contraceptive devices,
 - Nutritional/dietary drugs,
 - Biologicals, and
 - Miscellaneous medical supplies.

7. The following products or categories of drugs are not covered as a Benefit under the Certificate (unless included in the Formulary selected by our Employer):
 - Cosmetic agents, including, but not limited to, Retin A for Enrollees over the age of 25 and medications for hair loss;
 - Drugs for which there is a therapeutically equivalent over-the-counter drug;
 - Erectile dysfunction drugs, including but not limited to, impotency (except in very limited circumstances described in QualChoice's medical policies);
 - Obsolete drugs;
 - Smoking cessation drugs and devices (unless a Smoking Cessation Rider is included with this Certificate);
 - Anorexiant;
 - Appetite suppressants;
 - Anti-obesity drugs;
 - Unit dose drugs;
 - H2 blocker anti-ulcer medications ;
 - Anti-histamines; and
 - Over-the-counter medications (except as discussed in Section 1.6 above).
8. The following products or categories of drugs are not covered as either a medical or prescription drug benefit:
 - Drugs not approved by the Food and Drug Administration;
 - Drugs prescribed for an unproven indication (i.e., "off-label" uses);
 - Over-the-counter drugs (unless stated elsewhere in this Outpatient Prescription Drug Rider);
 - A drug that is not Medically Necessary for the Enrollee's medical condition for which the drug has been prescribed;
 - A drug used or intended to be used in connection with or arising from a treatment, service, condition, sickness, disease, injury, or bodily malfunction that is not a Covered Service;
 - Drugs for which payment or benefits are provided by the local, state or federal government;
 - Compounded drugs that do not contain at least one ingredient that requires a prescription;
 - Drugs whose primary purpose is the removal, destruction, or interference with the implantation of a fertilized ovum, embryo, or fetus;
 - Research drugs;
 - Experimental or investigational drugs;
 - A drug prescribed as part of treatment to change an Enrollee's sex from one gender to another; and
 - General and injectable vitamins.
9. Replacement of previously filled prescription medications because the initial prescription medication was lost, stolen, spilled, contaminated, etc. are not covered.
10. Excessive use of medications is not covered. For purposes of this exclusion, each Enrollee agrees that QualChoice shall be entitled to deny coverage of medications under this Outpatient Prescription Drug Rider or the Certificate, on grounds of excessive use when it is determined that: (1) an Enrollee has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard reference compendia or by the Pharmacy & Therapeutics Committee; or (2) an Enrollee has obtained or attempted to obtain the same medication from more than one physician for the same or overlapping periods of time; or (3) the pattern of prescription medication purchases, changes of physicians or pharmacy or other information indicates that an Enrollee has obtained or sought to obtain excessive quantities of medications. Each Enrollee hereby authorizes QualChoice to communicate with any physician, health care provider or pharmacy

for the purpose of reviewing and discussing the Enrollee's prescription history, use or activity to evaluate for excessive use.

1.14 Limitations Of Coverage

Coverage for Covered Prescription Drugs are subject to the following limitations:

1. Covered Prescription Drugs filled at most retail pharmacies are subject to a 34-day supply.
2. Covered Prescription Drugs at a limited number of select contracted retail and mail order pharmacies are subject to a 90-day supply. You may also contact our Customer Service Department to obtain a copy of the listing.
NOTE: Prescriptions filled at a non-participating retail pharmacy must be paid for by the Enrollee who may seek reimbursement by remitting the Claim for Benefits directly to us within sixty (60) days of the medication being dispensed, subject to all terms, conditions, exclusions and limitations set forth in this Certificate and the Benefits Summary. In such a case, reimbursement to the Enrollee from QualChoice will be the amount that would have been paid to a participating retail network pharmacy.
3. We may limit the number of doses of a particular medication that will be covered for a single prescription or the number of doses that will be covered if dispensed over a particular span of time. Examples of these dosage limitations include, but are not limited to:
 - i. Anti-nausea medications used for the treatment of nausea and vomiting associated with chemotherapy, radiation therapy, and surgery are limited to a 5-day supply per prescription and must be pre-authorized by QualChoice;
 - ii. COX-2 inhibitor anti-inflammatory drugs are covered subject to FDA-approved indications and dosing recommendations and quantity limits per prescription;
 - iii. Coverage for sedative and hypnotic products is limited to a maximum of 34 tablets per 30 day supply, with a maximum quantity of 360 tablets per Enrollee per calendar year; and
 - iv. Anti-migraine medications are covered subject to limitations of the number of doses per month, based on the recommended maximum number of episodes to treat per month.
5. We do not cover a prescription that is in excess of what has been prescribed by the prescribing physician or that is being refilled more than one year following the prescribing physician writing the initial prescription.
6. If it is determined an Enrollee is using prescription drugs in a harmful or abusive manner or with harmful frequency, the Enrollee may be limited to specific participating network pharmacies to obtain medication. The Enrollee will be notified of this determination. The Enrollee's failure to use the identified participating pharmacy will result in that Enrollee's prescription drugs not being covered.

1.15 Step-Therapy Program

In the step-therapy program, a certain medication may be required to be used before another medication will be covered. Unless an exception is made, the second drug will not be covered unless the first drug has been tried first. You may obtain a description of the specific medications subject to the step-therapy program by contacting our customer service department.

1.16 Pre-Authorization May Be Required

Prior to certain prescription drugs being covered, your physician must obtain pre-authorization from us as described in the Certificate. The list of prescription drugs requiring pre-authorization is subject to review and change. For a current list of those prescription drugs requiring pre-authorization, access our website at www.qualchoice.com or contact our customer service department.

1.17 Rebates

We may receive rebates for certain Brand Drugs that are on the Formulary. We do not take these rebates into account when determining any percentage Co-insurance. This does not affect your cost-sharing amounts.

This benefit summary is part of the Evidence of Coverage, Form QC POS/HDHP(10-01-10) and Outpatient Prescription Drug Rider and is subject to all benefit terms and conditions, limitations and exclusions contained therein. The 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 in your Evidence of Coverage for a complete listing of services, limitations, exclusions and a description of all terms and conditions of coverages, 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 to treat your condition.

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

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

Member pays 100% of the QualChoice discounted rate.

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 medications 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	\$10 Co-payment	\$30 Co-payment
▪ Tier 2	\$30 Co-payment	\$90 Co-payment
▪ Tier 3	\$50 Co-payment	\$150 Co-payment
▪ Tier 4	100%	100%
▪ Tier 5	\$50 Co-payment	Not Applicable

NOTE: If dispensed in your physician office or at a facility - see medical benefits

Generic Incentive

If a Brand Name Medication is dispensed when a Generic Medication is available, and the physician has **NOT** indicated "dispensed as written" the Co-payment required is the Brand (2nd or 3rd tier) medication Co-payment plus the difference in cost between the Brand name medication and Generic Medication, or the cost of the medication, whichever is less.

Limitations

- Retail pharmacy - One monthly cost sharing amount per 34-day supply
- Mail order pharmacy - 3 monthly cost sharing amounts per 100-day supply

Note: All new prescriptions are limited to a 34-day supply. Refills are limited to a 100-day supply at certain contracted pharmacies and through mail order.

Diabetic Supplies are covered at 20% of the members cost share.

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 drugs under this plan include anti-hypertensive and Attention Deficit Disorder (ADD) medications. Contact Customer Service 1-800-235-7111 for more details.

Benefit Details

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

Exclusions

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

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

This benefit summary is part of the Evidence of Coverage (EOC), Form QC POS/HDHP (10/1/10) 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 annual 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"> Co-payments are not included in the annual Deductible In-Network and Out-of-Network Deductibles apply separately Family Deductible is not considered satisfied until at least 3 separate family members have satisfied their individual Deductibles Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year The annual Deductible is calculated on a Calendar Year basis 	Individual: \$500 Family: \$1,500	Individual: \$1,500 Family: \$4,500
Annual Out-of-Pocket Limit <ul style="list-style-type: none"> Once 3 separate family members meet their individual Out of Pocket the family out-of-pocket limit is satisfied. Benefits will be paid at 100% of the Maximum Allowable Charge once the applicable annual Out-of-Pocket limit is satisfied Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits Co-payments do not apply toward your Out-of-Pocket Limit. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis 	Individual: \$2,000 Family: \$6,000	Individual: \$8,000 Family: \$24,000
Coinsurance	20% after Deductible	40% 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)	\$25 Co-payment	40% after Deductible
Well baby care, birth - to age 2	\$25 Co-payment	40% after Deductible
Well child care, ages 2-18	\$25 Co-payment	40% after Deductible
Other preventive services <ul style="list-style-type: none"> Annual physical Pap smear Screening mammogram (including breast exam) age 40 and over Prostate screenings for men age 40 and over 	PCP: \$25 Co-payment or Specialist: \$40 Co-payment No Cost to You	40% after Deductible

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued <ul style="list-style-type: none"> Bone density screening tests, preventive for women age 65+ Fecal occult blood test annually 	No Cost to You	40% after Deductible
<ul style="list-style-type: none"> Flexible sigmoidoscopy once every 5 years; OR Double contrast barium enema once every 5 years; OR Preventive colonoscopy age 50 and older, once every 10 years 	20% after Deductible	40% after Deductible
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 	\$25 Co-payment	40% 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 	\$40 Co-payment	40% after Deductible
Professional services that are subject to Deductible and Coinsurance (in addition to the office Co-payment) <ul style="list-style-type: none"> Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests - Subject to Prior Authorization 	PCP: \$25 Co-payment or Specialist: \$40 Co-payment and 20% after Deductible	40% after Deductible
<ul style="list-style-type: none"> Other procedures, such as chemotherapy, radiation and infusion therapy Complex procedures such as cystoscopy, colposcopy and invasive biopsies Services and procedures provided by a physician in a facility 	20% after Deductible	40% after Deductible
<ul style="list-style-type: none"> Complex Injectable Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics 	20%	
Inpatient Care - Room and Board		
<ul style="list-style-type: none"> Inpatient care - room and board Inpatient Rehabilitation Service (limited to 60 days per Calendar Year) Skilled Nursing Facility (limited to 60 days per Calendar Year) 	20% after Deductible and \$200 Co-payment	40% after Deductible
	20% after Deductible	
<i>Co-payment per admission/Maximum 2 admission Co-payments per Member and 4 admission co-payments per family per Contract Year.</i>		
Outpatient Care and Ambulatory Care Centers		
<ul style="list-style-type: none"> Outpatient Care and Ambulatory Care Centers Observation Services Hospice services Home Health Care (50 visits per Calendar Year) Diagnostic Services - Advanced imaging, Lab & X-Ray 	20% after Deductible	40% after Deductible
<ul style="list-style-type: none"> Outpatient Surgical Services 	20% after Deductible and \$100 Co-payment	
Emergency Services		
<ul style="list-style-type: none"> Emergency Room, Urgent Care or ER Observation Services 	\$100 Co-payment plus 20%	
Transportation Services		
<ul style="list-style-type: none"> Ambulance - Ground is limited to \$1,000 maximum; Air is limited to \$5,000 per trip. One trip per contract year. <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	50%	50%
Therapy Services		
<ul style="list-style-type: none"> Physical Therapy Occupational Therapy Speech Therapy and Audiology Testing Chiropractic Care 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.</i>	20% after \$40 Co-payment	Not Covered

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services		
<ul style="list-style-type: none"> Routine Prenatal Lab Initial Office Visit 	Paid in full \$25 Co-payment	40% after Deductible
<ul style="list-style-type: none"> All other services 	20% after Deductible and \$200 per inpatient admission	
Facility Services	20% after Deductible and \$200 per inpatient admission	40% after Deductible
Infertility Diagnostic Services Only <i>Note: Treatment of infertility is not covered.</i>	50%	Not Covered
Mental Health and Substance Use Disorder Services		
<ul style="list-style-type: none"> Inpatient Hospital Services <i>Co-payment per admission/Maximum 2 admission Co-payments per Member and 4 admission co-payments per family per Contract Year.</i>	20% after Deductible and \$200 Co-payment	40% after Deductible
<ul style="list-style-type: none"> Professional Services (Office/Outpatient Visits - Evaluation Only) 	\$25 Co-payment	
<ul style="list-style-type: none"> Professional Services - Services and procedures provided in the Specialists office other than consultation and evaluation. 	20%	
<ul style="list-style-type: none"> Professional Services (Inpatient/Outpatient Facility) 	20% after Deductible	
Allergy Services		
<ul style="list-style-type: none"> Office Visit and Allergy Testing 	20%	40% after Deductible
<ul style="list-style-type: none"> Allergy Shots 	20%	40% after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME)	50%	50% 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. 	50%	50% after Deductible
<ul style="list-style-type: none"> Provided in connection with home infusion therapy 	50%	50% after Deductible
<ul style="list-style-type: none"> Provided in connection with Durable Medical Equipment 	50%	50% after Deductible
Prosthetic and Orthotic-Services and Devices		
<ul style="list-style-type: none"> Prosthetic Services and Prosthetic Devices Orthotic Services and Orthotic Devices <i>Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Evidence of Coverage for more information.</i>	20% after Deductible	40% after Deductible
Reconstructive Surgery		
<ul style="list-style-type: none"> Breast reconstruction following mastectomy Restoration due to acute trauma, infection, cancer or surgery <i>Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient or Outpatient charges, see Inpatient or Outpatient sections on page 2.</i>	50%	Not Covered
Transplant Services (physician charges only, see also Inpatient/Outpatient)	20% after Deductible	Not Covered
Diabetes Management Services		
<ul style="list-style-type: none"> Insulin Pumps (Durable Medical Equipment) 	50%	40% after Deductible
<ul style="list-style-type: none"> Supplies and equipment 	20%	
<ul style="list-style-type: none"> Diabetic Education (1 training per lifetime) 	\$25 Co-payment	
Dental Care		
<ul style="list-style-type: none"> Accidental injury to sound and natural teeth \$2,000 maximum benefit per accident 	PCP: \$25 Co-payment or Specialist: \$40 Co-payment and 20% after Deductible	40% after Deductible
Medical Foods for Phenylketonuria		
	PCP: \$25 Co-payment or Specialist: \$40 Co-payment and 20% after Deductible	40% 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
	20% after Deductible	40% after Deductible

SERFF Tracking Number: QUAC-128068218 State: Arkansas
 Filing Company: QCA Health Plan, Inc. State Tracking Number:
 Company Tracking Number:
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001B Any Size Group - POS
 Product Name: POS (CAW Amendment)
 Project Name/Number: CAW Amendment/

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	02/06/2012
Comments:			
Attachment:			
Flesch Letter.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	02/06/2012
Bypass Reason:	The application for this product has been previously filed and approved.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	02/06/2012
Bypass Reason:	The PPACA Uniform Compliance summary for this product has previously been filed and approved.		
Comments:			



February 3, 2012

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

RE:

To Whom it May Concern:

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. 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,

J. Nicole Thomas
Associate Corporate Counsel
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(501) 219-5129