

SERFF Tracking Number: QUAC-128078700 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  
Project Name/Number: /

## Filing at a Glance

Company: QCA Health Plan, Inc.

Product Name: POS

TOI: H16G Group Health - Major Medical

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

Filing Type: Form

SERFF Tr Num: QUAC-128078700 State: Arkansas

SERFF Status: Closed-Approved State Tr Num:

Co Tr Num:

State Status: Approved-Closed

Reviewer(s): Donna Lambert

Authors: Jim Couch, Niki Thomas Disposition Date: 02/10/2012

Date Submitted: 02/07/2012

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date: 03/12/2012

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type:

Filing Status Changed: 02/10/2012

State Status Changed: 02/10/2012

Created By: Niki Thomas

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:

POS Benefit Summaries and Prescription Drug Benefit Summaries

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

Jim Couch, VP of Compliance

12615 Chenal Parkway, Suite 300

Little Rock, AR 72211

jim.couch@qualchoice.com

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

501-707-6729 [FAX]

### Filing Company Information

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 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  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$300.00  
 Retaliatory? No  
 Fee Explanation: 6 forms at \$50 a form.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
QCA Health Plan, Inc.	\$300.00	02/07/2012	56164483

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	02/10/2012	02/10/2012

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Highlighted Excel Documents	Note To Reviewer	Niki Thomas	02/09/2012	02/09/2012
Highlighted Excel Docs	Note To Filer	Donna Lambert	02/09/2012	02/09/2012
Filing Letter	Note To Reviewer	Niki Thomas	02/07/2012	02/07/2012

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## Disposition

Disposition Date: 02/10/2012

Implementation Date: 03/12/2012

Status: Approved

HHS Status: HHS Approved

State Review: Not Reviewed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved	Yes
<b>Supporting Document</b>	Application	Approved	Yes
<b>Supporting Document</b>	PPACA Uniform Compliance Summary	Approved	Yes
<b>Form</b>	Preferred Choice NG	Approved	Yes
<b>Form</b>	Flex Choice NG	Approved	Yes
<b>Form</b>	Flex Choice GF	Approved	Yes
<b>Form</b>	Preferred Choice GF	Approved	Yes
<b>Form</b>	Right Choice	Approved	Yes
<b>Form</b>	Flex Choice	Approved	Yes



## GROUP MASTER CONTRACT

This Group Master Contract is entered into by and between QCA Health Plan, Inc. (hereinafter “QualChoice”) and the entity identified in the Group Application for Coverage as the Plan Sponsor (hereinafter “Plan Sponsor”) with an effective date as reflected in the Group Application for Coverage (the “Effective Date”).

WHEREAS, this Group Master Contract is made in consideration of the Group Application for Coverage and Product Selection & Sold Rate Form completed by the Plan Sponsor and individual enrollment forms which are incorporated herein by reference, the payment of premiums by Plan Sponsor, when due, and is subject to the terms and conditions of Explanation(s) of Coverage, schedules of benefits, riders, amendments and addenda, which are also incorporated in and made part of this Group Master Contract by reference; and

WHEREAS, Plan Sponsor desires to enter into this Group Master Contract with QualChoice to provide certain health care services and benefits as described in the Agreement (as that term is defined below).

THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is acknowledged by the parties, the parties agree as follows:

### I. Definitions

Unless stated otherwise herein, the capitalized words or terms used in this Group Master Contract shall have the same definition as those same capitalized words or terms used in the Evidence of Coverage issued by QualChoice to Plan Sponsor’s Certificate Holders. With regard to this Group Master Contract, the following definitions shall apply:

1. “Agreement” means (i) this Group Master Contract and all addenda, amendments, endorsements, and riders thereto, (ii) the Group Application for Coverage and any subsequent notice from Plan Sponsor modifying the Group Application accepted by QualChoice, (iii) the Product Selection & Sold Rate Form for Initial Term and any subsequent rate renewal confirmations accepted by QualChoice, (iv) individual enrollment forms, (v) the Evidence of Coverage (“Certificate” or “EOC”) and all addenda, amendments, endorsements, and riders thereto, (vi) the summary of benefits, and (vii) the policies and procedures adopted by QualChoice to administer the benefits under this Agreement.

2. “**Evidence of Coverage**” or “**EOC**” means the certificate that describes the Covered Services and any terms, conditions, exclusions and limitations thereto. The EOC is not intended to be a Plan Document or Summary Plan Document as defined by ERISA. QualChoice will provide Plan Sponsor with access to Enrollees’ EOC in an electronic format. It will be Plan Sponsor’s responsibility to distribute the EOC’s to Enrollees in accordance with applicable laws.

### II. Terms of EOC

All of the terms, limitations and exclusions set forth in the EOC are incorporated herein by reference, including, but not limited to, each of the party’s and each Enrollee’s rights, duties and responsibilities with regard to: An individual’s eligibility for coverage and enrollment, pre-existing condition limitations, Covered Services and conditions and limitations thereto, cost sharing requirements, exclusions from coverage, termination of an Enrollee’s coverage, an Enrollee’s potential ability to continue coverage under COBRA, coordination of benefits with other health plans, utilization management requirements, process for filing of claims and appealing claim denials, and subrogation.



### III. Eligibility

1. An individual's eligibility for benefits set forth in the EOC issued by QualChoice shall be governed under the terms of the EOC, including an individual's potential ability to continue coverage pursuant to the Consolidation Omnibus Budget Reconciliation Act of 1985 ("COBRA") or applicable state law.

2. Plan Sponsor will cooperate with QualChoice to provide all information required by QualChoice to determine an individual's eligibility for benefits under the EOC. All employees of Plan Sponsor and their dependents, including newly hired employees and their dependents, must complete an individual application in order to be enrolled by QualChoice and QualChoice reserves the right to further require such individuals to complete a medical history questionnaire. In addition to any other requirements set forth in the EOC, an individual's eligibility is conditioned on QualChoice's receipt of all information required by QualChoice to determine the individual's eligibility.

3. Subject to Plan Sponsor's payment of the applicable monthly premium and all other terms, conditions and limitations set forth in the EOC, coverage for Plan Sponsor's employees and their dependents will become effective as follows:

- A. An employee and any dependents who enroll with QualChoice during the initial group enrollment begins coverage on the Effective Date;
- B. An employee and any dependents who enroll with QualChoice during the annual enrollment period determined by QualChoice and Plan Sponsor begins coverage as of the anniversary of the Effective Date;
- C. Newly hired employees of Plan Sponsor and their dependents first become eligible for coverage the first day of the month following the waiting period for new hires reflected in the Group Application for Coverage or any subsequent notice from Plan Sponsor accepted by QualChoice.

4. Persons ineligible under the Agreement include, without limitation, full-time employees working less than the number of hours reflected in the Group Application for Coverage or any subsequent notice from Plan Sponsor accepted by QualChoice, part-time employees working less than the number of hours reflected in the Group Application for Coverage or any subsequent notice from Plan Sponsor accepted by QualChoice, independent contractors, temporary employees, seasonal employees, employees who are laid off, retirees (unless otherwise indicated on the Group Application for Coverage or any subsequent notice from Plan Sponsor accepted by QualChoice), and any individuals who do not meet the requirements for eligibility according to the EOC and any schedule of benefits, riders or amendments thereto.

5. Plan Sponsor will give QualChoice written notice of any new enrollees and/or changes in an individual's eligibility for benefits under the EOC no later than sixty (60) days following the change. Plan Sponsor accepts the full amount of any liability from its failure to provide QualChoice with correct information including, but not limited to, new eligibility, termination, or family status change information and is responsible to QualChoice for any medical or drug benefit overpayments made due to its failure to maintain current eligibility. In the event Plan Sponsor does not provide QualChoice with timely notice of an individual's termination, QualChoice will give Plan Sponsor a credit for the premiums paid on that individual for the months following the month of the individual's termination, not to exceed an amount equal to three (3) months of premium paid.



6. Plan Sponsor agrees at least 50% of its eligible employees and 75% of all of its full-time employees will enroll in the Plan. Plan Sponsor further agrees that no more than 20% of Plan Sponsor's employees will live out of the Service Area. In the event that the number of Plan Sponsor employees living out of the Service Area exceeds 20%, QualChoice reserves the right to modify the monthly premiums and have such revised premiums go into effect upon 30 days notice.

7. Plan Sponsor agrees to indemnify and hold QualChoice harmless for any claims QualChoice pays in error due to Plan Sponsor's failure to provide timely and accurate information to QualChoice on an individual's initial eligibility for benefits under the Agreement, changes in an individual's eligibility for benefits under the Agreement, or as otherwise required under the Agreement to verify an individual's eligibility status.

8. If COBRA applies to the Agreement, Plan Sponsor must provide its Enrollees notice of COBRA rights at the time their coverage begins and their right to elect continuation coverage under COBRA following a COBRA qualifying event. Plan Sponsor shall notify QualChoice of all Enrollee COBRA elections not less than 30 days following receipt of such elections from the Enrollee. QualChoice does not assume Plan Sponsor's obligation to provide benefits under COBRA if Plan Sponsor fails to timely provide these notices, nor is QualChoice responsible for providing any COBRA notices to Enrollees.

9. Plan Sponsor is legally obligated to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Plan Sponsor will cooperate with QualChoice to provide QualChoice information concerning an individual's prior healthcare coverage when such individual is enrolled. QualChoice will provide Enrollees HIPAA certificates of creditable coverage with respect to their QualChoice coverage when their eligibility terminates under the Agreement.

#### **IV. Identification Cards**

QualChoice will provide identification cards for Certificate Holders. The receipt and/or possession of an identification card does not automatically entitle an individual to benefits. The identification cards are the property of QualChoice and must be returned to QualChoice upon request.

#### **V. Premium Payments**

1. The monthly premiums for coverage of Enrollees shall be remitted by Plan Sponsor to QualChoice on or before the Effective Date and on or before the first day of each succeeding calendar month, at the location specified by QualChoice on the monthly billing statement. The payment of premium will maintain in force coverage under the Agreement through the date when the next premium becomes payable. Failure to remit monthly premiums by their due date can at the sole discretion of QualChoice result in termination of coverage to the end of the last month for which premiums were received. Reinstatement of Plan Sponsor coverage following termination for non-payment of premiums shall be at the sole discretion of QualChoice and shall require payment of the current month and the following month premiums in full, plus a reinstatement administrative charge of \$250.00.

2. Full premium for the first month, or partial month, of an individual Enrollee's coverage is payable if the effective date of coverage for the Certificate Holder is before the 16<sup>th</sup> of the month. Full premium for the last partial month of an individual Enrollee's coverage is payable if the Certificate Holder's termination date is on or after the 15<sup>th</sup> of the month.

3. The monthly premium rates for the Initial Term (as defined below) are as set forth in the final Product Selection & Sold Rate Form for Initial Term (or renewal confirmation effective as of



the Effective Date) approved by QualChoice as set forth in Exhibit A attached hereto, subject to any modifications as provided herein.

5. QualChoice reserves the right to establish new premium rates for each contract period following the Initial Term which will become effective on the anniversary of the Effective Date. The new premium rates will be provided by QualChoice to the Plan Sponsor or the Plan Sponsor's agent of record when present, at least thirty (30) days prior to the new rates going into effect. Plan Sponsor will be deemed to have accepted the premium adjustment by signing and returning to QualChoice a renewal confirmation. QualChoice also reserves the right to establish new premium rates if Plan Sponsor's enrollment changes by more than ten percent (10%) during the contract period.

6. It is Plan Sponsor's duty to collect any premium required of the Certificate Holder.

7. In the event Plan Sponsor voluntarily files or has filed involuntarily against it a petition in bankruptcy and a court of competent jurisdiction determines that Section VI(3)(ii) is unenforceable, as a condition of QualChoice continuing to provide coverage pursuant to the Agreement, Plan Sponsor agrees to pay QualChoice as adequate assurance a security deposit in an amount equal to one and one-half (1 ½) times the highest monthly premium amount billed by QualChoice in the prior twelve (12) month period.

## **VI. Term and Termination**

1. The Agreement shall be in effect as of the Effective Date and shall remain in effect for one (1) year (the "Initial Term"). Unless either party terminates the Agreement as provided herein, the Agreement, as amended or modified, will renew on each anniversary of the Effective Date for an additional one (1) year term subject to Plan Sponsor returning a renewal confirmation that has been presented by QualChoice along with any other documents required by QualChoice as part of a renewal. Renewal of the Agreement will be subject to changes in premiums and any other changes to the Agreement as provided for herein.

2. Plan Sponsor may terminate the Agreement:

- (i) At the end of a contract period upon giving QualChoice written notice prior to the end of the contract period, by failing to return a renewal confirmation presented by QualChoice, or by failing to provide any other documents required by QualChoice as part of a renewal;
- (ii) On any premium due date by giving QualChoice written notice of termination prior to the premium due date;
- (iii) Immediately upon written notice to QualChoice in the event QualChoice files a petition in bankruptcy, dissolves, ceases to exist, is liquidated, or becomes insolvent;
- (iv) Immediately upon written notice to QualChoice in the event QualChoice's certificate of authority or license is revoked; or
- (v) For QualChoice's failure to cure a material breach of the Agreement within thirty (30) days of Plan Sponsor's written notice of the breach.

3. QualChoice may terminate the Agreement:

- (i) Except as may be prohibited under applicable law, at the end of a contract period upon giving Plan Sponsor at least thirty (30) days written notice prior to the end of the contract period;
- (ii) Immediately upon written notice to Plan Sponsor in the event Plan Sponsor voluntarily files or has filed involuntarily against it a petition in bankruptcy, dissolves, ceases to exist, is liquidated, or becomes insolvent;



- (iii) By giving thirty (30) days prior written notice to the Plan Sponsor in the event of fraud, misrepresentation, omission or concealment of any material fact by Plan Sponsor on which QualChoice relied in providing coverage to Plan Sponsor;
- (iv) Immediately upon written notice to Plan Sponsor, if Plan Sponsor fails to remit to QualChoice monthly premiums by their due date; the effective date of the termination shall be the end of the last month for which premiums were received by QualChoice from Plan Sponsor; Plan Sponsor's financial institution's return of or refusal to honor a check or draft constitutes nonpayment of premium;
- (v) By giving thirty (30) days prior written notice to the Plan Sponsor if the Plan Sponsor fails to maintain the levels of employee participation in the health plan as provided under QualChoice's standard guidelines;
- (vi) By giving thirty (30) days prior written notice to the Plan Sponsor if the Plan Sponsor offers a health plan option(s) to its employees other than the QualChoice option(s) (which includes offering without QualChoice's prior written consent a benefit plan, product, or service that can reduce an Enrollee's cost sharing (e.g., a deductible) under the QualChoice health benefit plan);
- (vii) By giving thirty (30) days prior written notice to the Plan Sponsor if the Plan Sponsor fails to make the Plan Sponsor contributions as set forth in the Group Application for Coverage or any subsequent notice from Plan Sponsor accepted by QualChoice;
- (viii) Immediately in the case where the Agreement is available to Plan Sponsor only through an association, the membership of the Plan Sponsor in the association (on the basis of which the coverage of the Agreement is provided) ceases, but only if the coverage is terminated under this paragraph uniformly without regard to any health status-related factor relating to any Enrollee;
- (ix) By giving ninety (90) days prior written notice if QualChoice elects not to renew all of its health benefit plans delivered or issued for delivery in the State of Arkansas;
- (x) Immediately upon written notice to Plan Sponsor if Plan Sponsor or its principal place of business relocates to a location outside of the Service Area; or
- (xi) For Plan Sponsor's failure to cure a material breach of the Agreement within thirty (30) days of QualChoice's written notice of the breach (unless a shorter timeframe for termination is otherwise provided hereunder).

4. Regardless of which party initiates the termination or the reason for termination, Plan Sponsor will be liable for all premiums due and owing to QualChoice for the period prior to termination of the Agreement.

5. When the Agreement terminates, Plan Sponsor shall promptly notify all affected Enrollees of such termination in writing.

6. QualChoice will have no liability for expenses incurred or treatment received by an Enrollee after the termination of the Agreement except as set forth in the applicable EOC.

**VII. COBRA/HIPAA Administrative Services [NOTE: THIS SECTION APPLIES ONLY IF REQUESTED BY PLAN SPONSOR AS REFLECTED IN THE PRODUCT SELECTION AND SOLD RATE FORM]**

1. QualChoice has made arrangements for an unrelated, third-party entity to provide COBRA and HIPAA administrative services (hereinafter the "COBRA/HIPAA Administrator") to employers and group health plans that are clients of QualChoice. These services are optional; there is no requirement that Plan Sponsor obtain COBRA and HIPAA administrative services from the COBRA/HIPAA Administrator.



2. Plan Sponsor has conducted its own due diligence and has elected to obtain COBRA and HIPAA administrative services from the COBRA/HIPAA Administrator. Plan Sponsor will enter into a direct services contract with the COBRA/HIPAA Administrator that will set out the rights, duties and obligations of Plan Sponsor and the COBRA/HIPAA Administrator.

3. QualChoice will at Plan Sponsor's request implement and coordinate an exchange of information regarding new Enrollees and changes in Enrollee eligibility status under Plan Sponsor's medical benefit plan necessary for the COBRA/HIPAA Administrator to provide its services to Plan Sponsor. The information provided by QualChoice to the COBRA/HIPAA Administrator will be based on the information provided to it by Plan Sponsor or the applicable Enrollee.

4. QualChoice makes no representations, warranties, or recommendations regarding the COBRA/HIPAA Administrator. QualChoice shall have no responsibility or liability to Plan Sponsor or any other person or entity for the COBRA/HIPAA Administrator's actions or failure to act or for Plan Sponsor's decision to enter into a contract with the COBRA/HIPAA Administrator. Plan Sponsor hereby waives any and all claims against QualChoice for costs, expenses, judgments, damages, liabilities, legal fees, or other costs of litigation or defense of any claim, including reasonable attorneys' fees and costs ("Costs or Liabilities") to the extent such Costs or Liabilities are caused by or arise out of the COBRA/HIPAA Administrator's actions or failure to act or for Plan Sponsor's decision to enter into a contract with the COBRA/HIPAA Administrator.

5. The fee charged by the COBRA/HIPAA Administrator to Plan Sponsor for its COBRA and HIPAA administrative fees will be as reflected in the direct services contract between Plan Sponsor and the COBRA/HIPAA Administrator. Plan Sponsor has the option in its sole discretion, to remit its COBRA and HIPAA administrative fees to the COBRA/HIPAA Administrator through QualChoice. Upon its receipt of Plan Sponsor's COBRA and HIPAA administrative fee, QualChoice will promptly forward the payment to the COBRA/HIPAA Administrator on behalf of Plan Sponsor. QualChoice shall have no responsibility or liability to advance funds to the COBRA/HIPAA Administrator on behalf of Plan Sponsor; payment of the COBRA and HIPAA administrative fee is solely the responsibility and liability of Plan Sponsor.

6. Plan Sponsor shall pay QualChoice the prevailing fee as set forth in the final Product Selection & Sold Rate Form for the Initial Term form approved by QualChoice for coordination of COBRA and HIPAA services as described herein between Plan Sponsor and the COBRA/HIPAA Administrator. QualChoice's fee is subject to being modified by QualChoice in the same manner as new premium rates may be modified pursuant to the Group Master Contract. Modified QualChoice fees for coordination of COBRA and HIPAA services will be as reflected in any subsequent writing signed by Plan Sponsor.

## **VIII. General Terms**

1. QualChoice accesses contracts with network healthcare providers to obtain services from such providers for Enrollees. Network healthcare providers shall not be considered an agent of QualChoice nor is QualChoice an agent of any network provider. Network providers maintain the provider-patient relationship with Enrollees and are solely responsible to Enrollees for any act or omission of the network provider in providing their services.

2. QualChoice is not an administrator, plan sponsor, or named or unnamed fiduciary as those terms are defined under ERISA. If Plan Sponsor's plan is an ERISA plan, in performing its duties and obligations set forth in the Agreement, QualChoice is a fiduciary as defined under ERISA only for the purpose of processing claims. It is the responsibility of Plan Sponsor to notify Enrollees of their ERISA rights and to comply with any other ERISA mandated responsibilities, obligations or duties, including providing a Summary Plan Document.



3. Plan Sponsor agrees and represents that no other healthcare plan will be offered or available to its employees other than those offered by QualChoice or its affiliates. Plan Sponsor further agrees that if more than one QualChoice plan is offered to its employees, a minimum premium difference of 12% is required for each step up or down in benefit level.

4. QualChoice may amend the terms and conditions of this Group Master Contract at any time on at least sixty (60) days prior written notice to Plan Sponsor. Any amendment will be deemed to be accepted by Plan Sponsor if Plan Sponsor pays the monthly premium due following the notice. Plan Sponsor's failure to pay the monthly premium due following the notice shall be deemed an election by Plan Sponsor to terminate the Agreement as of the effective date of the amendment. QualChoice will be responsible for notifying the Certificate Holders of any changes in Covered Services.

5. No change in the Agreement will be effective unless approved by an authorized officer of QualChoice. No agent, employee or representative of QualChoice, other than an authorized officer, may change the Agreement or waive any of its provisions.

6. QualChoice has the exclusive right to interpret the terms of the EOC and any schedule of benefits, riders or amendments thereto. QualChoice's decision with regard to whether to pay a claim is within its sole discretion and will be conclusive.

7. Plan Sponsor will allow its payroll records to be audited by QualChoice at QualChoice's expense for the purpose of verifying eligibility, participation levels and Plan Sponsor contributions. Plan Sponsor agrees to cooperate as reasonably necessary with QualChoice, its agents and employees in such audit.

8. **Plan Sponsor agrees to promptly notify QualChoice in accordance with Section VIII(9) below in the event Plan Sponsor changes at any time during the plan year its rate of contribution towards the cost of coverage for its employees.**

9. Any notice required under the Agreement must be in writing. Notice from one party to the other party must be by first class mail with proper postage to the individual whose signature is set forth below at the party's address set forth in the Group Application for Coverage. Notice shall be deemed effectively received on the date of delivery or three (3) business days after the date of the post mark, which ever is earlier. Either party may by written notice to the other party change the address to which notices should be sent.

10. The Agreement shall be governed by and construed in accordance with Arkansas law except to the extent pre-empted by federal law. The parties agree that all legal proceedings between the parties arising out of the Agreement shall be filed in the applicable state or federal court situated in Pulaski County, Arkansas.

11. If any provision or any part of the Agreement is for any reason held to be illegal or invalid, such illegality shall not affect or impair any other provision or right or remedy of QualChoice pursuant to the Agreement.

12. The Agreement nor any rights therein shall be assigned, transferred or otherwise conveyed by QualChoice, Plan Sponsor, or any Enrollee. QualChoice may, however, transfer any or all of its rights and/or obligations under the Agreement to any parent, subsidiary, other affiliate, or successor-in-interest to QualChoice's business without permission from Plan Sponsor or any Enrollee.

13. Failure by either party to insist on or enforce any of its rights under the Agreement shall not constitute a waiver of those rights by such party, and nothing shall constitute a waiver of that party's rights to insist on the other party's strict compliance with the provisions of the Agreement.

14. In the event of a national disaster, war, riot, civil insurrection, or the occurrence of any other circumstances that are beyond the control of QualChoice which results in the loss of availability of facilities, personnel or financial resources of QualChoice, QualChoice will not be considered to have breached the Agreement.

15. The Agreement constitutes and embodies the entire agreement between QualChoice and Plan Sponsor with respect to the subject matter hereof. The Agreement supersedes and



replaces all previous agreements and certificates between the parties with respect to the subject matter hereof. In the event of any conflict between the terms of this Group Master Agreement, the Group Application for Coverage, and/or the Product Selection & Sold Rate Form, the Group Master Contract will control. Plan Sponsor acknowledges that it has not entered into the Agreement based upon representations by any person, entity or organization other than QualChoice.

16. The Agreement is a contract solely between QualChoice and Plan Sponsor.

17. The Agreement does not provide for workers' compensation benefits.

18. If any provision of the Agreement does not comply with any law of the State of Arkansas, the Agreement shall be deemed amended to meet the minimum requirements of the law, unless such law is pre-empted by federal law or if otherwise found to be void by a court of competent jurisdiction, in which case any amendment to the Agreement required by the pre-empted or voided law shall be deemed rescinded.

**Plan Sponsor indicates its acceptance of the terms of the Agreement, including this Group Master Contract, by submitting to QualChoice a Group Application for Coverage and Product Selection & Sold Rate Form that is approved by QualChoice. Plan Sponsor agrees that its signature on a Group Application for Coverage and/or Product Selection & Sold Rate form constitutes a signature on this Group Master Contract.**

QualChoice indicates its acceptance of the terms of the Agreement, including this Group Master Contract, by causing its duly authorized officer to execute this Group Master Contract below and submitting it to the Plan Sponsor following QualChoice's final approval of the Plan Sponsor's Group Application for Coverage and Product Selection & Sold Rate Form.

**QCA Health Plan, Inc.  
12615 Chenal Parkway  
Suite 300  
Little Rock, AR 72211**

By: \_\_\_\_\_

Name: \_\_\_\_\_  
(Printed)

Title: \_\_\_\_\_

SERFF Tracking Number: QUAC-128078700 State: Arkansas  
Filing Company: QCA Health Plan, Inc. State Tracking Number:  
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TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001B Any Size Group - POS  
Product Name: POS  
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**Note To Reviewer**

**Created By:**

Niki Thomas on 02/09/2012 10:36 AM

**Last Edited By:**

Donna Lambert

**Submitted On:**

02/10/2012 08:27 AM

**Subject:**

Highlighted Excel Documents

**Comments:**

Ms. Lambert:

I am going to attempt to attach the pdf version of the redlines to this note. If this does not go through I have also emailed you the excel documents.

Thank you for all your trouble,

Niki Thomas

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](http://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 Benefit Maximum (for Essential Benefits*)]	[\$750,000-Unlimited]	
<b>Annual Deductible</b> <ul style="list-style-type: none"> <li>Co-payments are not included in the annual Deductible</li> <li>In-Network and Out-of-Network Deductibles apply separately</li> <li>Family Deductible is not considered satisfied until at least [2 to 5] separate family members have satisfied their individual Deductibles</li> <li>[Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year] OR [Deductible amounts applied in the last quarter of a Calendar Year will not carry over to the next Calendar Year]</li> <li>The annual Deductible is calculated on a Calendar Year basis</li> </ul>	Individual: [\$0-[\$0-\$2,000],000] Family: [\$0-[\$0-\$2,000],000]	Individual: [\$0-[\$0-\$2,000],000] Family: [\$0-[\$0-\$2,000],000]
<b>Annual Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>Applicable Coinsurance will apply until [2 to 5] separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit</li> <li>Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied</li> <li>Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits</li> <li>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</li> <li>Out-of-Pocket Limit &amp; benefit limits are calculated on a Calendar Year basis</li> </ul>	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]
<b>Coinsurance</b>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Preventive Care Services (Performed in the Office):</b>		
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.		
<b>Immunizations, including flu and pneumonia vaccines</b> <b>Child Immunizations (age 0-18)</b> <b>Adult Immunizations (age 18+)</b> <ul style="list-style-type: none"> <li>Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years</li> <li>Hepatitis B (Hep B) - once per lifetime</li> <li>Influenza, annually</li> <li>Pneumococcal Conjugate, adult over 55 or immunosuppressed</li> <li>Zoster, adult 60 and older</li> <li>HPV (covered age 9-18, females only)</li> </ul> <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>	Paid in Full	
Routine vision exam (limit 1 every 24 months)	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	Not Covered
Well baby care, birth - to age 2	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Well child care, ages 2-18	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Other preventive services <ul style="list-style-type: none"> <li>Annual physical</li> <li>Pap smear</li> </ul>	PCP: [\$0-\$500] Co-payment or	[0%-100%] after Deductible



- Screening mammogram (including breast exam) age 40 and over
- Prostate screenings for men age 40 and over

Specialist: [\$0-\$500] Co-payment or [[0%-100%] 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"> <li>Bone density screening tests, preventive for women age 65+</li> <li>Fecal occult blood test annually</li> </ul>	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"> <li>Flexible sigmoidoscopy once every 5 years; OR</li> <li>Double contrast barium enema once every 5 years; OR</li> <li>Preventive colonoscopy age 50 and older, once every 10 years</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
Smoking cessation <ul style="list-style-type: none"> <li>Kick the Nic: smoking cessation; 12 week program</li> </ul> <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	Not Covered
<b>Professional Services</b>		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> <li>Evaluation and management services</li> <li>Routine diagnostic services - lab &amp; x-ray</li> <li>Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> <li>Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Specialist Office Visit <ul style="list-style-type: none"> <li>Evaluation and management services</li> <li>Routine diagnostic services - lab &amp; x-ray</li> <li>Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> </ul>	[\$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) <ul style="list-style-type: none"> <li>Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests</li> <li>Other procedures, such as chemotherapy, radiation and infusion therapy</li> <li>Complex Injectable Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see "Outpatient Prescription Drug Benefit Summary")</li> <li>Complex procedures such as cystoscopy, colposcopy and invasive biopsies</li> <li>Services and procedures provided by a physician in a facility</li> </ul>	PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment and/or [[0%-100%] after Deductible]	[0%-100%] after Deductible
<b>Inpatient Care - Room and Board</b>		
<ul style="list-style-type: none"> <li>Inpatient care - room and board</li> <li>Skilled Nursing Facility and Inpatient Rehabilitation Services (combined [0 to 365] day limit per Calendar Year)</li> </ul>	[[0%-100%] after Deductible] and/or [[0-\$2,000] Co-payment]	[0%-100%] after Deductible
<b>Outpatient Care and Ambulatory Care Centers</b>		
<ul style="list-style-type: none"> <li>Outpatient Care and Ambulatory Care Centers</li> <li>Observation Services</li> <li>Diagnostic Services - Advanced imaging, Lab &amp; X-Ray</li> <li>Hospice services (limited to a lifetime maximum of [0 to 365] days)</li> <li>Home Health Care ([0 to 400] visits per Calendar Year)</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Outpatient Surgical Services</li> </ul>	[[0%-100%] after Deductible] and/or [[0-\$2,000] Co-payment]	
<b>Emergency Services</b>		
<ul style="list-style-type: none"> <li>Emergency Room, Urgent Care or ER Observation Services</li> </ul>	[0%-100%] after [Deductible] or [\$0-\$2,000] [Co-payment]	[0%-100%] after [Deductible] or [\$0-\$2,000] [Co-payment]
<b>Transportation Services</b>		
<ul style="list-style-type: none"> <li>Ambulance - Ground or Air ([\$0-\$100,000] maximum benefit per Calendar Year)</li> </ul> <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%]	[0%-100%]

Therapy Services		
<ul style="list-style-type: none"> <li>Physical Therapy</li> <li>Occupational Therapy</li> <li>Speech Therapy and Audiology Testing</li> <li>Chiropractic Care</li> <li>Cardiac Rehabilitation ([0 to 300] visits per Calendar Year)</li> </ul> <p><i>Note: Therapy services are limited to a combined maximum of [0-300] visits per Calendar Year. This does not include Cardiac Rehabilitation.</i></p>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Maternity Services		
Physician Services	In-Network (You Pay)	Out-of-Network (You Pay)
<ul style="list-style-type: none"> <li>Routine Prenatal Lab</li> </ul>	[Paid in full] or [0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Initial Office Visit</li> <li>All other services</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible] [0%-100%] after Deductible	
Facility Services	[0%-100%] after Deductible	
Infertility Diagnostic Services Only	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<i>Note: Treatment of infertility is not covered.</i>		
Mental Health and Substance Use Disorder Services		
<ul style="list-style-type: none"> <li>Inpatient Hospital Services - [10 day limit per calendar year]</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>Professional Services (Office/Outpatient Visits) - [10 visit limit per calendar year]</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	
<ul style="list-style-type: none"> <li>Professional Services (Inpatient/Outpatient Facility)</li> </ul>	[0%-100%] after Deductible	
Allergy Services		
<ul style="list-style-type: none"> <li>Office Visit and Allergy Testing</li> </ul>	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"> <li>Allergy Shots</li> </ul>	Paid in Full	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME)	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>[\$0-20,000] maximum benefit per Calendar Year</li> </ul>		
Medical Supplies	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.</li> </ul>		
<ul style="list-style-type: none"> <li>Provided in connection with home infusion therapy</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Provided in connection with Durable Medical Equipment</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
Prosthetic and Orthotic Services and Devices	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Prosthetic Services and Prosthetic Devices</li> <li>Orthotic Services and Orthotic Devices</li> </ul> <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>		
Reconstructive Surgery	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Breast reconstruction following mastectomy</li> <li>Restoration due to acute trauma, infection or cancer</li> </ul> <p><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></p>		
Transplantation Services	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>Physician/Professional charges</li> <li>Inpatient and Outpatient Charges</li> </ul> <p><i>Note: Lifetime maximum of two transplants</i></p>	[0%-100%] after Deductible	



Diabetes Management Services <ul style="list-style-type: none"> <li>▪ Insulin Pumps ([0-\$50,000] benefit maximum per Calendar Year)</li> <li>▪ Supplies and equipment (Subject to [\$0-\$200,000] DME limit)</li> </ul>	[0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>▪ Diabetic Education ([0 to 100] training per lifetime)</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Dental Care <ul style="list-style-type: none"> <li>▪ Accidental injury to sound and natural teeth            [\$0-\$20,000] maximum benefit per accident</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria <ul style="list-style-type: none"> <li>▪ Benefits available after member has paid [\$0-\$5,000] per year</li> </ul>	[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

[\*Essential Benefits are services that QualChoice has determined fall within the following categories or services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescriptive drugs
- Rehabilitation and habilitative services and devices
- Lab services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care]



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](http://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 Benefit Maximum (for Essential Benefits*)]	[\$750,000-Unlimited]	
<b>Annual Deductible</b> <ul style="list-style-type: none"> <li>Co-payments are not included in the annual Deductible</li> <li>In-Network and Out-of-Network Deductibles apply separately</li> <li>Family Deductible is not considered satisfied until at least <b>[2 to 5]</b> separate family members have satisfied their individual Deductibles</li> <li>[Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year] OR [Deductible amounts applied in the last quarter of a Calendar Year will not carry over to the next Calendar Year]</li> <li>The annual Deductible is calculated on a Calendar Year basis</li> </ul>	Individual: [\$0-[\$0-\$2,000],000] Family: [\$0-[\$0-\$2,000],000]	Individual: [\$0-[\$0-\$2,000],000] Family: [\$0-[\$0-\$2,000],000]
<b>Annual Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>Applicable Coinsurance will apply until <b>[2 to 5]</b> separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit</li> <li>Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied</li> <li>Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits</li> <li>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</li> <li>Out-of-Pocket Limit &amp; benefit limits are calculated on a Calendar Year basis</li> </ul>	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]
<b>Coinsurance</b>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Preventive Care Services (Performed in the Office):</b>		
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.		
<b>Immunizations, including flu and pneumonia vaccines</b> <b>Child Immunizations (age 0-18)</b> <b>Adult Immunizations (age 18+)</b> <ul style="list-style-type: none"> <li>Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years</li> <li>Hepatitis B (Hep B) - once per lifetime</li> <li>Influenza, annually</li> <li>Pneumococcal Conjugate, adult over 55 or immunosuppressed</li> <li>Zoster, adult 60 and older</li> <li>HPV (covered age 9-18, females only)</li> </ul> <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>	Paid in Full	
Routine vision exam (limit 1 every 24 months)	No Cost to You	Not Covered
Well baby care, birth - to age 2	No Cost to You	Not Covered
Well child care, ages 2-18	No Cost to You	Not Covered

Other preventive services <ul style="list-style-type: none"> <li>Annual physical</li> <li>Pap smear</li> <li>Screening mammogram (including breast exam) age 40 and over</li> <li>Prostate screenings for men age 40 and over</li> </ul>	No Cost to You	Not Covered
<b>Preventive Care Services, continued</b>	<b>In-Network (You Pay)</b>	<b>Out-of-Network (You Pay)</b>
Other preventive services, continued <ul style="list-style-type: none"> <li>Bone density screening tests, preventive for women age 65+</li> <li>Fecal occult blood test annually</li> </ul>	No Cost to You	Not Covered
<ul style="list-style-type: none"> <li>Flexible sigmoidoscopy once every 5 years; OR</li> <li>Double contrast barium enema once every 5 years; OR</li> <li>Preventive colonoscopy age 50 and older, once every 10 years</li> </ul>	No Cost to You	Not Covered
Smoking cessation <ul style="list-style-type: none"> <li>Kick the Nic: smoking cessation; 12 week program</li> </ul> <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	Not Covered
<b>Professional Services</b>		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> <li>Evaluation and management services</li> <li>Routine diagnostic services - lab &amp; x-ray</li> <li>Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> <li>Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Specialist Office Visit <ul style="list-style-type: none"> <li>Evaluation and management services</li> <li>Routine diagnostic services - lab &amp; x-ray</li> <li>Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> </ul>	[\$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) <ul style="list-style-type: none"> <li>Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests</li> <li>Other procedures, such as chemotherapy, radiation and infusion therapy</li> <li>Complex Injectable Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see "Outpatient Prescription Drug Benefit Summary"</li> <li>Complex procedures such as cystoscopy, colposcopy and invasive biopsies</li> <li>Services and procedures provided by a physician in a facility</li> </ul>	PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment and/or [0%-100%] after Deductible	[0%-100%] after Deductible
<b>Inpatient Care - Room and Board</b>		
<ul style="list-style-type: none"> <li>Inpatient care - room and board</li> <li>Skilled Nursing Facility and Inpatient Rehabilitation Services (combined [0 to 365] day limit per Calendar Year)</li> </ul>	[0%-100%] after Deductible [and/or] [\$0-\$2,000] Co-payment	[0%-100%] after Deductible
<b>Outpatient Care and Ambulatory Care Centers</b>		
<ul style="list-style-type: none"> <li>Outpatient Care and Ambulatory Care Centers</li> <li>Observation Services</li> <li>Diagnostic Services - Advanced imaging, Lab &amp; X-Ray</li> <li>Hospice services (limited to a lifetime maximum of [0 to 365] days)</li> <li>Home Health Care ([0 to 400] visits per Calendar Year)</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Outpatient Surgical Services</li> </ul>	[0%-100%] after Deductible [and/or] [\$0-\$2,000] Co-payment	
<b>Emergency Services</b>		
<ul style="list-style-type: none"> <li>Emergency Room, Urgent Care or ER Observation Services</li> </ul>	[0%-100%] after [Deductible] or [\$0-\$2,000] [Co-payment]	[0%-100%] after [Deductible] or [\$0-\$2,000] [Co-payment]
<b>Transportation Services</b>		
<ul style="list-style-type: none"> <li>Ambulance - Ground or Air ([\$0-\$100,000] maximum benefit per Calendar</li> </ul> <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%]	[0%-100%]

Therapy Services		
<ul style="list-style-type: none"> <li>Physical Therapy</li> <li>Occupational Therapy</li> <li>Speech Therapy and Audiology Testing</li> <li>Chiropractic Care</li> <li>Cardiac Rehabilitation ([0 to 300] visits per Calendar Year)</li> </ul> <p><i>Note: Therapy services are limited to a combined maximum of [0-300] visits per Calendar Year. This does not include Cardiac Rehabilitation.</i></p>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Maternity Services		
Physician Services	In-Network (You Pay)	Out-of-Network (You Pay)
<ul style="list-style-type: none"> <li>Routine Prenatal Lab</li> </ul>	[Paid in full] or [0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Initial Office Visit</li> <li>All other services</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	
	[0%-100%] after Deductible	
Facility Services	[0%-100%] after Deductible	[0%-100%] after Deductible
Infertility Diagnostic Services Only	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<i>Note: Treatment of infertility is not covered.</i>		
Mental Health and Substance Use Disorder Services		
<ul style="list-style-type: none"> <li>Inpatient Hospital Services - [10 day limit per calendar year]</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>Professional Services (Office/Outpatient Visits) - [10 visit limit per calendar year]</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	
<ul style="list-style-type: none"> <li>Professional Services (Inpatient/Outpatient Facility)</li> </ul>	[0%-100%] after Deductible	
Allergy Services		
<ul style="list-style-type: none"> <li>Office Visit and Allergy Testing</li> </ul>	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"> <li>Allergy Shots</li> </ul>	Paid in Full	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME)	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>[\$0-20,000] maximum benefit per Calendar Year</li> </ul>		
Medical Supplies	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.</li> </ul>		
<ul style="list-style-type: none"> <li>Provided in connection with home infusion therapy</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Provided in connection with Durable Medical Equipment</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
Prosthetic and Orthotic Services and Devices	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Prosthetic Services and Prosthetic Devices</li> <li>Orthotic Services and Orthotic Devices</li> </ul> <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>		
Reconstructive Surgery	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Breast reconstruction following mastectomy</li> <li>Restoration due to acute trauma, infection or cancer</li> </ul> <p><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></p>		
Transplantation Services	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>Physician/Professional charges</li> <li>Inpatient and Outpatient Charges</li> </ul> <p><i>Note: Lifetime maximum of two transplants</i></p>	[0%-100%] after Deductible	

Diabetes Management Services <ul style="list-style-type: none"> <li>▪ Insulin Pumps ([0-\$50,000] benefit maximum per Calendar Year)</li> <li>▪ Supplies and equipment (Subject to [0-\$200,000] DME limit)</li> </ul>	[0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>▪ Diabetic Education ([0 to 100] training per lifetime)</li> </ul>	[\$0-\$500] Co-payment or [0%-100%] after Deductible	[0%-100%] after Deductible
Dental Care <ul style="list-style-type: none"> <li>▪ Accidental injury to sound and natural teeth [0-\$20,000] maximum benefit per accident</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria <ul style="list-style-type: none"> <li>▪ Benefits available after member has paid [0-\$5,000] per year</li> </ul>	[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

[\*Essential Benefits are services that QualChoice has determined fall within the following categories or services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescriptive drugs
- Rehabilitation and habilitative services and devices
- Lab services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care]



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**For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit our website at [www.qualchoice.com](http://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 Benefit Maximum (for Essential Benefits*)]	[\$750,000-Unlimited]	
<b>Annual Deductible</b> <ul style="list-style-type: none"> <li>Co-payments are not included in the annual Deductible</li> <li>In-Network and Out-of-Network Deductibles apply separately</li> <li>Family Deductible is not considered satisfied until at least [2 to 5] separate family members have satisfied their individual Deductibles</li> <li>[Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year] OR [Deductible amounts applied in the last quarter of a Calendar Year will not carry over to the next Calendar Year]</li> <li>The annual Deductible is calculated on a Calendar Year basis</li> </ul>	Individual: [\$0-[\$0-\$2,000],000] Family: [\$0-[\$0-\$2,000],000]	Individual: [\$0-[\$0-\$2,000],000] Family: [\$0-[\$0-\$2,000],000]
<b>Annual Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>Applicable Coinsurance will apply until [2 to 5] separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit</li> <li>Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied</li> <li>Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits</li> <li>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</li> <li>Out-of-Pocket Limit &amp; benefit limits are calculated on a Calendar Year basis</li> </ul>	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]
<b>Coinsurance</b>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Preventive Care Services (Performed in the Office):</b>		
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.		
<b>Immunizations, including flu and pneumonia vaccines</b> <b>Child Immunizations (age 0-18)</b> <b>Adult Immunizations (age 18+)</b> <ul style="list-style-type: none"> <li>Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years</li> <li>Hepatitis B (Hep B) - once per lifetime</li> <li>Influenza, annually</li> <li>Pneumococcal Conjugate, adult over 55 or immunosuppressed</li> <li>Zoster, adult 60 and older</li> <li>HPV (covered age 9-18, females only)</li> </ul> <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>	Paid in Full	
Routine vision exam (limit 1 every 24 months)	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	Not Covered
Well baby care, birth - to age 2	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Well child care, ages 2-18	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Other preventive services <ul style="list-style-type: none"> <li>Annual physical</li> <li>Pap smear</li> </ul>	PCP: [\$0-\$500] Co-payment or	[0%-100%] after Deductible



<ul style="list-style-type: none"><li>• Screening mammogram (including breast exam) age 40 and over</li><li>• Prostate screenings for men age 40 and over</li></ul>	Specialist: [\$0-\$500] Co-payment or [[0%-100%] after Deductible]	
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<b>Preventive Care Services, continued</b>	<b>In-Network (You Pay)</b>	<b>Out-of-Network (You Pay)</b>
Other preventive services, continued <ul style="list-style-type: none"> <li>Bone density screening tests, preventive for women age 65+</li> <li>Fecal occult blood test annually</li> </ul>	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"> <li>Flexible sigmoidoscopy once every 5 years; OR</li> <li>Double contrast barium enema once every 5 years; OR</li> <li>Preventive colonoscopy age 50 and older, once every 10 years</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
Smoking cessation <ul style="list-style-type: none"> <li>Kick the Nic: smoking cessation; 12 week program</li> </ul> <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	Not Covered
<b>Professional Services</b>		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> <li>Evaluation and management services</li> <li>Routine diagnostic services - lab &amp; x-ray</li> <li>Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> <li>Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Specialist Office Visit <ul style="list-style-type: none"> <li>Evaluation and management services</li> <li>Routine diagnostic services - lab &amp; x-ray</li> <li>Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> </ul>	[\$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) <ul style="list-style-type: none"> <li>Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests</li> <li>Other procedures, such as chemotherapy, radiation and infusion therapy</li> <li>Complex Injectable Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see "Outpatient Prescription Drug Benefit Summary")</li> <li>Complex procedures such as cystoscopy, colposcopy and invasive biopsies</li> <li>Services and procedures provided by a physician in a facility</li> </ul>	PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment and/or [[0%-100%] after Deductible]	[0%-100%] after Deductible
<b>Inpatient Care - Room and Board</b>		
<ul style="list-style-type: none"> <li>Inpatient care - room and board</li> <li>Skilled Nursing Facility and Inpatient Rehabilitation Services (combined [0 to 365] day limit per Calendar Year)</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Outpatient Care and Ambulatory Care Centers</b>		
<ul style="list-style-type: none"> <li>Outpatient Care and Ambulatory Care Centers</li> <li>Observation Services</li> <li>Diagnostic Services - Advanced imaging, Lab &amp; X-Ray</li> <li>Hospice services (limited to a lifetime maximum of [0 to 365] days)</li> <li>Home Health Care ([0 to 400] visits per Calendar Year)</li> <li>Outpatient Surgical Services</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Emergency Services</b>		
<ul style="list-style-type: none"> <li>Emergency Room, Urgent Care or ER Observation Services</li> </ul>	[0%-100%] after [Deductible] or [\$0-\$2,000] [Co-payment]	[0%-100%] after [Deductible] or [\$0-\$2,000] [Co-payment]
<b>Transportation Services</b>		
<ul style="list-style-type: none"> <li>Ambulance - Ground or Air ([\$0-\$100,000] maximum benefit per Calendar</li> </ul> <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%]	[0%-100%]

<b>Therapy Services</b>		
<ul style="list-style-type: none"> <li>Physical Therapy</li> <li>Occupational Therapy</li> <li>Speech Therapy and Audiology Testing</li> <li>Chiropractic Care</li> <li>Cardiac Rehabilitation ([0 to 300] visits per Calendar Year)</li> </ul> <p><i>Note: Therapy services are limited to a combined maximum of [0-300] visits per Calendar Year. This does not include Cardiac Rehabilitation.</i></p>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
<b>Maternity Services</b>		
<b>Physician Services</b> <ul style="list-style-type: none"> <li>Routine Prenatal Lab</li> </ul>	[Paid in full] or [0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Initial Office Visit</li> <li>All other services</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	
	[0%-100%] after Deductible	
<b>Facility Services</b> Infertility Diagnostic Services Only <i>Note: Treatment of infertility is not covered.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<b>Mental Health and Substance Use Disorder Services</b>		
<ul style="list-style-type: none"> <li>Inpatient Hospital Services - [10 day limit per calendar year]</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>Professional Services (Office/<b>Outpatient Visits</b>) - [10 visit limit per calendar year]</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	
<ul style="list-style-type: none"> <li>Professional Services (Inpatient/<b>Outpatient Facility</b>)</li> </ul>	[0%-100%] after Deductible	
<b>Allergy Services</b>		
<ul style="list-style-type: none"> <li>Office Visit and Allergy Testing</li> </ul>	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"> <li>Allergy Shots</li> </ul>	Paid in Full	[0%-100%] after Deductible
<b>Other Treatment, Services and Supplies</b>		
<b>Durable Medical Equipment (DME)</b> <ul style="list-style-type: none"> <li>[\$0-20,000] maximum benefit per Calendar Year</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<b>Medical Supplies</b> <ul style="list-style-type: none"> <li>Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.</li> <li>Provided in connection with home infusion therapy</li> <li>Provided in connection with Durable Medical Equipment</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
	[0%-100%] after Deductible	[0%-100%] after Deductible
	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<b>Prosthetic and Orthotic Services and Devices</b> <ul style="list-style-type: none"> <li>Prosthetic Services and Prosthetic Devices</li> <li>Orthotic Services and Orthotic Devices</li> </ul> <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
<b>Reconstructive Surgery</b> <ul style="list-style-type: none"> <li>Breast reconstruction following mastectomy</li> <li>Restoration due to acute trauma, infection or cancer</li> </ul> <p><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></p>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Transplantation Services</b> <ul style="list-style-type: none"> <li>Physician/Professional charges</li> <li>Inpatient and Outpatient Charges</li> </ul> <p><i>Note: Lifetime maximum of two transplants</i></p>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]



Diabetes Management Services <ul style="list-style-type: none"> <li>▪ Insulin Pumps ([0-\$50,000] benefit maximum per Calendar Year)</li> <li>▪ Supplies and equipment (Subject to [0-\$200,000] DME limit)</li> </ul>	[0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>▪ Diabetic Education ([0 to 100] training per lifetime)</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Dental Care <ul style="list-style-type: none"> <li>▪ Accidental injury to sound and natural teeth [0-\$20,000] maximum benefit per accident</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria <ul style="list-style-type: none"> <li>▪ Benefits available after member has paid [0-\$5,000] per year</li> </ul>	[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

[\*Essential Benefits are services that QualChoice has determined fall within the following categories or services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescriptive drugs
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- Lab services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care]



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Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
[Annual Benefit Maximum (for Essential Benefits*)]	[\$750,000-Unlimited]	
<b>Annual Deductible</b> <ul style="list-style-type: none"> <li>Co-payments are not included in the annual Deductible</li> <li>In-Network and Out-of-Network Deductibles apply separately</li> <li>Family Deductible is not considered satisfied until at least <b>[2 to 5]</b> separate family members have satisfied their individual Deductibles</li> <li>[Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year] OR [Deductible amounts applied in the last quarter of a Calendar Year will not carry over to the next Calendar Year]</li> <li>The annual Deductible is calculated on a Calendar Year basis</li> </ul>	<b>Individual: [\$0-[\$0-\$2,000],000]</b> <b>Family: [\$0-[\$0-\$2,000],000]</b>	<b>Individual: [\$0-[\$0-\$2,000],000]</b> <b>Family: [\$0-[\$0-\$2,000],000]</b>
<b>Annual Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>Applicable Coinsurance will apply until <b>[2 to 5]</b> separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit</li> <li>Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied</li> <li>Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits</li> <li>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</li> <li>Out-of-Pocket Limit &amp; benefit limits are calculated on a Calendar Year basis</li> </ul>	<b>Individual: [\$0-\$500,000]</b> <b>Family: [\$0-\$1,000,000]</b>	<b>Individual: [\$0-\$500,000]</b> <b>Family: [\$0-\$1,000,000]</b>
<b>Coinsurance</b>	<b>[0%-100%] after Deductible</b>	<b>[0%-100%] after Deductible</b>
<b>Preventive Care Services (Performed in the Office):</b>		
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.		
<b>Immunizations, including flu and pneumonia vaccines</b> <b>Child Immunizations (age 0-18)</b> <b>Adult Immunizations (age 18+)</b> <ul style="list-style-type: none"> <li>Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years</li> <li>Hepatitis B (Hep B) - once per lifetime</li> <li>Influenza, annually</li> <li>Pneumococcal Conjugate, adult over 55 or immunosuppressed</li> <li>Zoster, adult 60 and older</li> <li>HPV (covered age 9-18, females only)</li> </ul> <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>	Paid in Full	
Routine vision exam (limit 1 every 24 months)	No Cost to You	Not Covered
Well baby care, birth - to age 2	No Cost to You	Not Covered
Well child care, ages 2-18	No Cost to You	Not Covered

Other preventive services <ul style="list-style-type: none"> <li>Annual physical</li> <li>Pap smear</li> <li>Screening mammogram (including breast exam) age 40 and over</li> <li>Prostate screenings for men age 40 and over</li> </ul>	No Cost to You	Not Covered
<b>Preventive Care Services, continued</b>	<b>In-Network (You Pay)</b>	<b>Out-of-Network (You Pay)</b>
Other preventive services, continued <ul style="list-style-type: none"> <li>Bone density screening tests, preventive for women age 65+</li> <li>Fecal occult blood test annually</li> </ul>	No Cost to You	Not Covered
<ul style="list-style-type: none"> <li>Flexible sigmoidoscopy once every 5 years; OR</li> <li>Double contrast barium enema once every 5 years; OR</li> <li>Preventive colonoscopy age 50 and older, once every 10 years</li> </ul>	No Cost to You	Not Covered
Smoking cessation <ul style="list-style-type: none"> <li>Kick the Nic: smoking cessation; 12 week program</li> </ul> <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	Not Covered
<b>Professional Services</b>		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> <li>Evaluation and management services</li> <li>Routine diagnostic services - lab &amp; x-ray</li> <li>Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> <li>Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Specialist Office Visit <ul style="list-style-type: none"> <li>Evaluation and management services</li> <li>Routine diagnostic services - lab &amp; x-ray</li> <li>Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> </ul>	[\$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) <ul style="list-style-type: none"> <li>Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests</li> <li>Other procedures, such as chemotherapy, radiation and infusion therapy</li> <li>Complex Injectable Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see "Outpatient Prescription Drug Benefit Summary"</li> <li>Complex procedures such as cystoscopy, colposcopy and invasive biopsies</li> <li>Services and procedures provided by a physician in a facility</li> </ul>	PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment and/or [0%-100%] after Deductible	[0%-100%] after Deductible
<b>Inpatient Care - Room and Board</b>		
<ul style="list-style-type: none"> <li>Inpatient care - room and board</li> <li>Skilled Nursing Facility and Inpatient Rehabilitation Services (combined [0 to 365] day limit per Calendar Year)</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Outpatient Care and Ambulatory Care Centers</b>		
<ul style="list-style-type: none"> <li>Outpatient Care and Ambulatory Care Centers</li> <li>Observation Services</li> <li>Diagnostic Services - Advanced imaging, Lab &amp; X-Ray</li> <li>Hospice services (limited to a lifetime maximum of [0 to 365] days)</li> <li>Home Health Care ([0 to 400] visits per Calendar Year)</li> <li>Outpatient Surgical Services</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Emergency Services</b>		
<ul style="list-style-type: none"> <li>Emergency Room, Urgent Care or ER Observation Services</li> </ul>	[0%-100%] after [Deductible] or [\$0-\$2,000] [Co-payment]	[0%-100%] after [Deductible] or [\$0-\$2,000] [Co-payment]
<b>Transportation Services</b>		
<ul style="list-style-type: none"> <li>Ambulance - Ground or Air ([\$0-\$100,000] maximum benefit per Calendar</li> </ul> <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%]	[0%-100%]

Therapy Services		
<ul style="list-style-type: none"> <li>Physical Therapy</li> <li>Occupational Therapy</li> <li>Speech Therapy and Audiology Testing</li> <li>Chiropractic Care</li> <li>Cardiac Rehabilitation ([0 to 300] visits per Calendar Year)</li> </ul> <p><i>Note: Therapy services are limited to a combined maximum of [0-300] visits per Calendar Year. This does not include Cardiac Rehabilitation.</i></p>	<b>[\$0-\$500] Co-payment</b>	<b>[0%-100%] after Deductible</b>
Maternity Services		
Physician Services	<b>In-Network (You Pay)</b>	<b>Out-of-Network (You Pay)</b>
<ul style="list-style-type: none"> <li>Routine Prenatal Lab</li> <li>Initial Office Visit</li> <li>All other services</li> </ul>	[Paid in full] or [0%-100%] after [\$0-\$500] Co-payment	[0%-100%] after Deductible
Facility Services	[0%-100%] after Deductible	[0%-100%] after Deductible
Infertility Diagnostic Services Only	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<i>Note: Treatment of infertility is not covered.</i>		
Mental Health and Substance Use Disorder Services		
<ul style="list-style-type: none"> <li>Inpatient Hospital Services - [10 day limit per calendar year]</li> </ul>	[0%-100%] after Deductible	
<ul style="list-style-type: none"> <li>Professional Services (Office/Outpatient Visits) - [10 visit limit per calendar year]</li> </ul>	[\$0-\$500] Co-payment	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>Professional Services (Inpatient/Outpatient Facility)</li> </ul>	[0%-100%] after Deductible	
Allergy Services		
<ul style="list-style-type: none"> <li>Office Visit and Allergy Testing</li> </ul>	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"> <li>Allergy Shots</li> </ul>	Paid in Full	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME)	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>[\$0-20,000] maximum benefit per Calendar Year</li> </ul>		
Medical Supplies	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.</li> </ul>		
<ul style="list-style-type: none"> <li>Provided in connection with home infusion therapy</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Provided in connection with Durable Medical Equipment</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
Prosthetic and Orthotic Services and Devices	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Prosthetic Services and Prosthetic Devices</li> <li>Orthotic Services and Orthotic Devices</li> </ul> <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>		
Reconstructive Surgery	<b>[0%-100%] after Deductible</b>	<b>[0%-100%] after Deductible</b>
<ul style="list-style-type: none"> <li>Breast reconstruction following mastectomy</li> <li>Restoration due to acute trauma, infection or cancer</li> </ul> <p><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></p>		
Transplantation Services	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>Physician/Professional charges</li> <li>Inpatient and Outpatient Charges</li> </ul> <p><i>Note: Lifetime maximum of two transplants</i></p>	[0%-100%] after Deductible	



Diabetes Management Services <ul style="list-style-type: none"> <li>▪ Insulin Pumps ([0-\$50,000] benefit maximum per Calendar Year)</li> <li>▪ Supplies and equipment (Subject to [0-\$200,000] DME limit)</li> </ul>	[0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>▪ Diabetic Education ([0 to 100] training per lifetime)</li> </ul>	[\$0-\$500] Co-payment or <b>[0%-100%] after Deductible</b>	[0%-100%] after Deductible
Dental Care <ul style="list-style-type: none"> <li>▪ Accidental injury to sound and natural teeth [0-\$20,000] maximum benefit per accident</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria <ul style="list-style-type: none"> <li>▪ Benefits available after member has paid [0-\$5,000] per year</li> </ul>	[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

*[\*Essential Benefits are services that QualChoice has determined fall within the following categories or services:*

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescriptive drugs
- Rehabilitation and habilitative services and devices
- Lab services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care]

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.

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](http://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](http://www.qualchoice.com).**

<p><b>Tier Definitions:</b></p> <p><b>Tier 1</b> 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.</p> <p><b>Tier 2</b> 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.</p> <p><b>Tier 3</b> 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.</p> <p><i>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.</i></p> <p><b>Tier 4</b> 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.</p> <p><b>Tier 5</b> 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.</p> <p>(See QC website for list of specialty meds covered under pharmacy benefit.) All else, see medical benefit.</p> <p>Many Tier 5 medications require prior-authorization and are at the highest level of cost share.</p>
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**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)
<b>Co-payment Amounts</b>		
▪ 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]
<i>NOTE: If dispensed in your physician office or at a facility - see medical benefits</i>		
<b>Coinsurance Amounts</b>		
▪ 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]
<b>Deductible</b>	[\$0-\$200,000]	[\$0-\$200,000]

**Limitations**

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

*Note: All new prescriptions are limited to a 30-day supply. Refills are limited to a 90-day supply at certain contracted pharmacies and through mail order.*

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

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

Contact a Health Coach 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 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;
- Drugs prescribed to treat infertility;
- Weight loss medication; appetite suppressants; anti-obesity drugs; anorexians;
- 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 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.

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**For information about specific medications, visit our website at [www.qualchoice.com](http://www.qualchoice.com).**

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**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, the cost difference between the brand product and the generic product will be the responsibility of the member and will not apply to the annual deductible or out-of-pocket maximum amounts.*

**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**

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Prescription Benefits In-Network	Retail (You Pay)	Mail Order (You Pay)
<b>Co-payment Amounts</b>		
▪ Tier 1	Not Applicable	Not Applicable
▪ Tier 2	Not Applicable	Not Applicable
▪ Tier 3	Not Applicable	Not Applicable
▪ 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]
<i>NOTE: If dispensed in your physician office or at a facility - see medical benefits</i>		
<b>Coinsurance Amounts</b>		
▪ Tier 1	[0%-100%]after Deductible	[0%-100%] after Deductible
▪ Tier 2	[0%-100%]after Deductible	[0%-100%] after Deductible
▪ Tier 3* (see Tier 3 Note above)	[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]
<b>Deductible</b>	[\$0-\$10,000] (Individual)/ [\$0-\$20,000] (Family)	

**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 are limited to a 90-day supply at certain contracted pharmacies and through mail order.*

*Insulin and syringes will be covered with one monthly cost sharing amount for each*



*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.*

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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.  
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### Benefit Details

- Benefit Details are subject to all benefit terms, conditions, limitations and exclusions
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- 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.**

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- 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

SERFF Tracking Number: QUAC-128078700 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  
Project Name/Number: /

**Note To Filer**

**Created By:**

Donna Lambert on 02/09/2012 07:59 AM

**Last Edited By:**

Donna Lambert

**Submitted On:**

02/10/2012 08:27 AM

**Subject:**

Highlighted Excel Docs

**Comments:**

Please send the highlighted changes for this filing. If you cannot convert the Excel docs into PDF and attach them to the filing, you may email them to me at donna.lambert@arkansas.gov.

SERFF Tracking Number: QUAC-128078700 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  
Project Name/Number: /

**Note To Reviewer**

**Created By:**

Niki Thomas on 02/07/2012 05:05 PM

**Last Edited By:**

Donna Lambert

**Submitted On:**

02/10/2012 08:27 AM

**Subject:**

Filing Letter

**Comments:**

Please see the attached filing letter. I have also highlighted the changes for this filing in excel documents. I can provide them after this filing has been assigned.



February 7, 2012

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

RE: Prescription Drug Benefit Summary and Benefit Summary Filing

To Whom it May Concern:

Please find attached to this filing, the following QCA Health Plan, Inc. documents:

1. Preferred Choice NG – Form # QC POSPC NG (10-1-10)
2. Flex Choice NG – Form # QC POSFC NG (10-1-10)
3. Flex Choice GF – Form # QC POSFC GF (10-1-10)
4. Preferred Choice GF – Form # QC POSPC GF (10-1-10)
5. Right Choice – Form # QCRxG POS/HDHP Right (4-1-12)
6. Flex Choice – Form # QCRxG POS/HDHP Flex (4-1-12)

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  
(501) 219-5129

SERFF Tracking Number: QUAC-128078700

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

Project Name/Number: /

## Form Schedule

### Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 02/10/2012	Form # POSPC (10-1-10)	QC Outline of NGCoverage	Preferred Choice NG	Initial			Preferred Choice_NG (POS).pdf
Approved 02/10/2012	Form # POSFC (10-1-10)	QC Outline of NGCoverage	Flex Choice NG	Initial			FlexChoice_N G (POS).pdf
Approved 02/10/2012	Form # POSFC (10-1-10)	QC Outline of GF Coverage	Flex Choice GF	Initial			FlexChoice_G F (POS).pdf
Approved 02/10/2012	Form # POSPC (10-1-10)	QC Outline of GF Coverage	Preferred Choice GF	Initial			Preferred Choice_GF.p df
Approved 02/10/2012	Form # QCRxG POS/HDHP Right (4-1- 12)	Outline of Coverage	Right Choice	Initial			RightChoice (POS).pdf
Approved 02/10/2012	Form # QCRxG POS/HDHP Flex (4-1- 12)	Outline of Coverage	Flex Choice	Initial			Preferred_Fle xChoice (POS).pdf



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](http://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 Benefit Maximum (for Essential Benefits*)]	[\$750,000-Unlimited]	
<b>Annual Deductible</b> <ul style="list-style-type: none"> <li>Co-payments are not included in the annual Deductible</li> <li>In-Network and Out-of-Network Deductibles apply separately</li> <li>Family Deductible is not considered satisfied until at least <b>[2 to 5]</b> separate family members have satisfied their individual Deductibles</li> <li>[Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year] OR [Deductible amounts applied in the last quarter of a Calendar Year will not carry over to the next Calendar Year]</li> <li>The annual Deductible is calculated on a Calendar Year basis</li> </ul>	<b>Individual: [\$0-[\$0-\$2,000],000]</b> <b>Family: [\$0-[\$0-\$2,000],000]</b>	<b>Individual: [\$0-[\$0-\$2,000],000]</b> <b>Family: [\$0-[\$0-\$2,000],000]</b>
<b>Annual Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>Applicable Coinsurance will apply until <b>[2 to 5]</b> separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit</li> <li>Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied</li> <li>Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits</li> <li>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</li> <li>Out-of-Pocket Limit &amp; benefit limits are calculated on a Calendar Year basis</li> </ul>	<b>Individual: [\$0-\$500,000]</b> <b>Family: [\$0-\$1,000,000]</b>	<b>Individual: [\$0-\$500,000]</b> <b>Family: [\$0-\$1,000,000]</b>
<b>Coinsurance</b>	<b>[0%-100%] after Deductible</b>	<b>[0%-100%] after Deductible</b>
<b>Preventive Care Services (Performed in the Office):</b>		
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.		
<b>Immunizations, including flu and pneumonia vaccines</b> <b>Child Immunizations (age 0-18)</b> <b>Adult Immunizations (age 18+)</b> <ul style="list-style-type: none"> <li>Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years</li> <li>Hepatitis B (Hep B) - once per lifetime</li> <li>Influenza, annually</li> <li>Pneumococcal Conjugate, adult over 55 or immunosuppressed</li> <li>Zoster, adult 60 and older</li> <li>HPV (covered age 9-18, females only)</li> </ul> <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>	Paid in Full	
Routine vision exam (limit 1 every 24 months)	No Cost to You	Not Covered
Well baby care, birth - to age 2	No Cost to You	Not Covered
Well child care, ages 2-18	No Cost to You	Not Covered

Other preventive services <ul style="list-style-type: none"> <li>Annual physical</li> <li>Pap smear</li> <li>Screening mammogram (including breast exam) age 40 and over</li> <li>Prostate screenings for men age 40 and over</li> </ul>	No Cost to You	Not Covered
<b>Preventive Care Services, continued</b>	<b>In-Network (You Pay)</b>	<b>Out-of-Network (You Pay)</b>
Other preventive services, continued <ul style="list-style-type: none"> <li>Bone density screening tests, preventive for women age 65+</li> <li>Fecal occult blood test annually</li> </ul>	No Cost to You	Not Covered
<ul style="list-style-type: none"> <li>Flexible sigmoidoscopy once every 5 years; OR</li> <li>Double contrast barium enema once every 5 years; OR</li> <li>Preventive colonoscopy age 50 and older, once every 10 years</li> </ul>	No Cost to You	Not Covered
Smoking cessation <ul style="list-style-type: none"> <li>Kick the Nic: smoking cessation; 12 week program</li> </ul> <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	Not Covered
<b>Professional Services</b>		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> <li>Evaluation and management services</li> <li>Routine diagnostic services - lab &amp; x-ray</li> <li>Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> <li>Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Specialist Office Visit <ul style="list-style-type: none"> <li>Evaluation and management services</li> <li>Routine diagnostic services - lab &amp; x-ray</li> <li>Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> </ul>	[\$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) <ul style="list-style-type: none"> <li>Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests</li> <li>Other procedures, such as chemotherapy, radiation and infusion therapy</li> <li>Complex Injectable Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see "Outpatient Prescription Drug Benefit Summary")</li> <li>Complex procedures such as cystoscopy, colposcopy and invasive biopsies</li> <li>Services and procedures provided by a physician in a facility</li> </ul>	PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment and/or [0%-100%] after Deductible	[0%-100%] after Deductible
<b>Inpatient Care - Room and Board</b>		
<ul style="list-style-type: none"> <li>Inpatient care - room and board</li> <li>Skilled Nursing Facility and Inpatient Rehabilitation Services (combined [0 to 365] day limit per Calendar Year)</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Outpatient Care and Ambulatory Care Centers</b>		
<ul style="list-style-type: none"> <li>Outpatient Care and Ambulatory Care Centers</li> <li>Observation Services</li> <li>Diagnostic Services - Advanced imaging, Lab &amp; X-Ray</li> <li>Hospice services (limited to a lifetime maximum of [0 to 365] days)</li> <li>Home Health Care ([0 to 400] visits per Calendar Year)</li> <li>Outpatient Surgical Services</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Emergency Services</b>		
<ul style="list-style-type: none"> <li>Emergency Room, Urgent Care or ER Observation Services</li> </ul>	[0%-100%] after [Deductible] or [\$0-\$2,000] [Co-payment]	[0%-100%] after [Deductible] or [\$0-\$2,000] [Co-payment]
<b>Transportation Services</b>		
<ul style="list-style-type: none"> <li>Ambulance - Ground or Air ([\$0-\$100,000] maximum benefit per Calendar Year)</li> </ul> <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%]	[0%-100%]

Therapy Services		
<ul style="list-style-type: none"> <li>Physical Therapy</li> <li>Occupational Therapy</li> <li>Speech Therapy and Audiology Testing</li> <li>Chiropractic Care</li> <li>Cardiac Rehabilitation ([0 to 300] visits per Calendar Year)</li> </ul> <p><i>Note: Therapy services are limited to a combined maximum of [0-300] visits per Calendar Year. This does not include Cardiac Rehabilitation.</i></p>	<b>[\$0-\$500] Co-payment</b>	<b>[0%-100%] after Deductible</b>
Maternity Services		
Physician Services	<b>In-Network (You Pay)</b>	<b>Out-of-Network (You Pay)</b>
<ul style="list-style-type: none"> <li>Routine Prenatal Lab</li> <li>Initial Office Visit</li> <li>All other services</li> </ul>	[Paid in full] or [0%-100%] after [\$0-\$500] Co-payment	[0%-100%] after Deductible
Facility Services	[0%-100%] after Deductible	[0%-100%] after Deductible
Infertility Diagnostic Services Only	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<i>Note: Treatment of infertility is not covered.</i>		
Mental Health and Substance Use Disorder Services		
<ul style="list-style-type: none"> <li>Inpatient Hospital Services - [10 day limit per calendar year]</li> </ul>	[0%-100%] after Deductible	
<ul style="list-style-type: none"> <li>Professional Services (Office/Outpatient Visits) - [10 visit limit per calendar year]</li> </ul>	[\$0-\$500] Co-payment	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>Professional Services (Inpatient/Outpatient Facility)</li> </ul>	[0%-100%] after Deductible	
Allergy Services		
<ul style="list-style-type: none"> <li>Office Visit and Allergy Testing</li> </ul>	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"> <li>Allergy Shots</li> </ul>	Paid in Full	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME)	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>[\$0-20,000] maximum benefit per Calendar Year</li> </ul>		
Medical Supplies	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.</li> </ul>		
<ul style="list-style-type: none"> <li>Provided in connection with home infusion therapy</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Provided in connection with Durable Medical Equipment</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
Prosthetic and Orthotic Services and Devices	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Prosthetic Services and Prosthetic Devices</li> <li>Orthotic Services and Orthotic Devices</li> </ul> <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>		
Reconstructive Surgery	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Breast reconstruction following mastectomy</li> <li>Restoration due to acute trauma, infection or cancer</li> </ul> <p><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></p>		
Transplantation Services	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>Physician/Professional charges</li> <li>Inpatient and Outpatient Charges</li> </ul> <p><i>Note: Lifetime maximum of two transplants</i></p>	[0%-100%] after Deductible	



Diabetes Management Services <ul style="list-style-type: none"> <li>▪ Insulin Pumps ([0-\$50,000] benefit maximum per Calendar Year)</li> <li>▪ Supplies and equipment (Subject to [0-\$200,000] DME limit)</li> </ul>	[0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>▪ Diabetic Education ([0 to 100] training per lifetime)</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Dental Care <ul style="list-style-type: none"> <li>▪ Accidental injury to sound and natural teeth [0-\$20,000] maximum benefit per accident</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria <ul style="list-style-type: none"> <li>▪ Benefits available after member has paid [0-\$5,000] per year</li> </ul>	[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

*[\*Essential Benefits are services that QualChoice has determined fall within the following categories or services:*

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescriptive drugs
- Rehabilitation and habilitative services and devices
- Lab services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care]



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](http://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 Benefit Maximum (for Essential Benefits*)]	[\$750,000-Unlimited]	
<b>Annual Deductible</b> <ul style="list-style-type: none"> <li>Co-payments are not included in the annual Deductible</li> <li>In-Network and Out-of-Network Deductibles apply separately</li> <li>Family Deductible is not considered satisfied until at least <b>[2 to 5]</b> separate family members have satisfied their individual Deductibles</li> <li>[Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year] OR [Deductible amounts applied in the last quarter of a Calendar Year will not carry over to the next Calendar Year]</li> <li>The annual Deductible is calculated on a Calendar Year basis</li> </ul>	Individual: [\$0-[\$0-\$2,000],000] Family: [\$0-[\$0-\$2,000],000]	Individual: [\$0-[\$0-\$2,000],000] Family: [\$0-[\$0-\$2,000],000]
<b>Annual Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>Applicable Coinsurance will apply until <b>[2 to 5]</b> separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit</li> <li>Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied</li> <li>Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits</li> <li>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</li> <li>Out-of-Pocket Limit &amp; benefit limits are calculated on a Calendar Year basis</li> </ul>	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]
<b>Coinsurance</b>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Preventive Care Services (Performed in the Office):</b>		
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.		
<b>Immunizations, including flu and pneumonia vaccines</b> <b>Child Immunizations (age 0-18)</b> <b>Adult Immunizations (age 18+)</b> <ul style="list-style-type: none"> <li>Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years</li> <li>Hepatitis B (Hep B) - once per lifetime</li> <li>Influenza, annually</li> <li>Pneumococcal Conjugate, adult over 55 or immunosuppressed</li> <li>Zoster, adult 60 and older</li> <li>HPV (covered age 9-18, females only)</li> </ul> <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>	Paid in Full	
Routine vision exam (limit 1 every 24 months)	No Cost to You	Not Covered
Well baby care, birth - to age 2	No Cost to You	Not Covered
Well child care, ages 2-18	No Cost to You	Not Covered

Other preventive services <ul style="list-style-type: none"> <li>Annual physical</li> <li>Pap smear</li> <li>Screening mammogram (including breast exam) age 40 and over</li> <li>Prostate screenings for men age 40 and over</li> </ul>	No Cost to You	Not Covered
<b>Preventive Care Services, continued</b>	<b>In-Network (You Pay)</b>	<b>Out-of-Network (You Pay)</b>
Other preventive services, continued <ul style="list-style-type: none"> <li>Bone density screening tests, preventive for women age 65+</li> <li>Fecal occult blood test annually</li> </ul>	No Cost to You	Not Covered
<ul style="list-style-type: none"> <li>Flexible sigmoidoscopy once every 5 years; OR</li> <li>Double contrast barium enema once every 5 years; OR</li> <li>Preventive colonoscopy age 50 and older, once every 10 years</li> </ul>	No Cost to You	Not Covered
Smoking cessation <ul style="list-style-type: none"> <li>Kick the Nic: smoking cessation; 12 week program</li> </ul> <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	Not Covered
<b>Professional Services</b>		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> <li>Evaluation and management services</li> <li>Routine diagnostic services - lab &amp; x-ray</li> <li>Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> <li>Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Specialist Office Visit <ul style="list-style-type: none"> <li>Evaluation and management services</li> <li>Routine diagnostic services - lab &amp; x-ray</li> <li>Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> </ul>	[\$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) <ul style="list-style-type: none"> <li>Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests</li> <li>Other procedures, such as chemotherapy, radiation and infusion therapy</li> <li>Complex Injectable Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see "Outpatient Prescription Drug Benefit Summary"</li> <li>Complex procedures such as cystoscopy, colposcopy and invasive biopsies</li> <li>Services and procedures provided by a physician in a facility</li> </ul>	PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment and/or [0%-100%] after Deductible	[0%-100%] after Deductible
<b>Inpatient Care - Room and Board</b>		
<ul style="list-style-type: none"> <li>Inpatient care - room and board</li> <li>Skilled Nursing Facility and Inpatient Rehabilitation Services (combined [0 to 365] day limit per Calendar Year)</li> </ul>	[0%-100%] after Deductible [and/or] [\$0-\$2,000] Co-payment	[0%-100%] after Deductible
<b>Outpatient Care and Ambulatory Care Centers</b>		
<ul style="list-style-type: none"> <li>Outpatient Care and Ambulatory Care Centers</li> <li>Observation Services</li> <li>Diagnostic Services - Advanced imaging, Lab &amp; X-Ray</li> <li>Hospice services (limited to a lifetime maximum of [0 to 365] days)</li> <li>Home Health Care ([0 to 400] visits per Calendar Year)</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Outpatient Surgical Services</li> </ul>	[0%-100%] after Deductible [and/or] [\$0-\$2,000] Co-payment	
<b>Emergency Services</b>		
<ul style="list-style-type: none"> <li>Emergency Room, Urgent Care or ER Observation Services</li> </ul>	[0%-100%] after [Deductible] or [\$0-\$2,000] [Co-payment]	[0%-100%] after [Deductible] or [\$0-\$2,000] [Co-payment]
<b>Transportation Services</b>		
<ul style="list-style-type: none"> <li>Ambulance - Ground or Air ([\$0-\$100,000] maximum benefit per Calendar</li> </ul> <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%]	[0%-100%]

Therapy Services		
<ul style="list-style-type: none"> <li>Physical Therapy</li> <li>Occupational Therapy</li> <li>Speech Therapy and Audiology Testing</li> <li>Chiropractic Care</li> <li>Cardiac Rehabilitation ([0 to 300] visits per Calendar Year)</li> </ul> <p><i>Note: Therapy services are limited to a combined maximum of [0-300] visits per Calendar Year. This does not include Cardiac Rehabilitation.</i></p>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Maternity Services		
Physician Services	In-Network (You Pay)	Out-of-Network (You Pay)
<ul style="list-style-type: none"> <li>Routine Prenatal Lab</li> </ul>	[Paid in full] or [0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Initial Office Visit</li> <li>All other services</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	
	[0%-100%] after Deductible	
Facility Services	[0%-100%] after Deductible	[0%-100%] after Deductible
Infertility Diagnostic Services Only	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<i>Note: Treatment of infertility is not covered.</i>		
Mental Health and Substance Use Disorder Services		
<ul style="list-style-type: none"> <li>Inpatient Hospital Services - [10 day limit per calendar year]</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>Professional Services (Office/Outpatient Visits) - [10 visit limit per calendar year]</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	
<ul style="list-style-type: none"> <li>Professional Services (Inpatient/Outpatient Facility)</li> </ul>	[0%-100%] after Deductible	
Allergy Services		
<ul style="list-style-type: none"> <li>Office Visit and Allergy Testing</li> </ul>	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"> <li>Allergy Shots</li> </ul>	Paid in Full	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME)	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>[\$0-20,000] maximum benefit per Calendar Year</li> </ul>		
Medical Supplies	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.</li> </ul>		
<ul style="list-style-type: none"> <li>Provided in connection with home infusion therapy</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Provided in connection with Durable Medical Equipment</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
Prosthetic and Orthotic Services and Devices	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Prosthetic Services and Prosthetic Devices</li> <li>Orthotic Services and Orthotic Devices</li> </ul> <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>		
Reconstructive Surgery	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Breast reconstruction following mastectomy</li> <li>Restoration due to acute trauma, infection or cancer</li> </ul> <p><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></p>		
Transplantation Services	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>Physician/Professional charges</li> <li>Inpatient and Outpatient Charges</li> </ul> <p><i>Note: Lifetime maximum of two transplants</i></p>	[0%-100%] after Deductible	

Diabetes Management Services <ul style="list-style-type: none"> <li>▪ Insulin Pumps ([0-\$50,000] benefit maximum per Calendar Year)</li> <li>▪ Supplies and equipment (Subject to [0-\$200,000] DME limit)</li> </ul>	[0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>▪ Diabetic Education ([0 to 100] training per lifetime)</li> </ul>	[\$0-\$500] Co-payment or <b>[[0%-100%] after Deductible]</b>	[0%-100%] after Deductible
Dental Care <ul style="list-style-type: none"> <li>▪ Accidental injury to sound and natural teeth            [\$0-\$20,000] maximum benefit per accident</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria <ul style="list-style-type: none"> <li>▪ Benefits available after member has paid [0-\$5,000] per year</li> </ul>	[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

[\*Essential Benefits are services that QualChoice has determined fall within the following categories or services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescriptive drugs
- Rehabilitation and habilitative services and devices
- Lab services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care]



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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 Benefit Maximum (for Essential Benefits*)]	[\$750,000-Unlimited]	
<b>Annual Deductible</b> <ul style="list-style-type: none"> <li>Co-payments are not included in the annual Deductible</li> <li>In-Network and Out-of-Network Deductibles apply separately</li> <li>Family Deductible is not considered satisfied until at least <b>[2 to 5]</b> separate family members have satisfied their individual Deductibles</li> <li>[Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year] OR [Deductible amounts applied in the last quarter of a Calendar Year will not carry over to the next Calendar Year]</li> <li>The annual Deductible is calculated on a Calendar Year basis</li> </ul>	Individual: [\$0-[\$0-\$2,000],000] Family: [\$0-[\$0-\$2,000],000]	Individual: [\$0-[\$0-\$2,000],000] Family: [\$0-[\$0-\$2,000],000]
<b>Annual Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>Applicable Coinsurance will apply until <b>[2 to 5]</b> separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit</li> <li>Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied</li> <li>Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits</li> <li>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</li> <li>Out-of-Pocket Limit &amp; benefit limits are calculated on a Calendar Year basis</li> </ul>	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]
<b>Coinsurance</b>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Preventive Care Services (Performed in the Office):</b>		
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.		
<b>Immunizations, including flu and pneumonia vaccines</b> <b>Child Immunizations (age 0-18)</b> <b>Adult Immunizations (age 18+)</b> <ul style="list-style-type: none"> <li>Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years</li> <li>Hepatitis B (Hep B) - once per lifetime</li> <li>Influenza, annually</li> <li>Pneumococcal Conjugate, adult over 55 or immunosuppressed</li> <li>Zoster, adult 60 and older</li> <li>HPV (covered age 9-18, females only)</li> </ul> <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>	Paid in Full	
Routine vision exam (limit 1 every 24 months)	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	Not Covered
Well baby care, birth - to age 2	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Well child care, ages 2-18	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Other preventive services <ul style="list-style-type: none"> <li>Annual physical</li> <li>Pap smear</li> <li>Screening mammogram (including breast exam) age 40 and over</li> <li>Prostate screenings for men age 40 and over</li> </ul>	PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] 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"> <li>▪ Bone density screening tests, preventive for women age 65+</li> <li>▪ Fecal occult blood test annually</li> </ul>	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"> <li>▪ Flexible sigmoidoscopy once every 5 years; OR</li> <li>▪ Double contrast barium enema once every 5 years; OR</li> <li>▪ Preventive colonoscopy age 50 and older, once every 10 years</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
Smoking cessation <ul style="list-style-type: none"> <li>▪ Kick the Nic: smoking cessation; 12 week program</li> </ul> <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	Not Covered
<b>Professional Services</b>		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> <li>▪ Evaluation and management services</li> <li>▪ Routine diagnostic services - lab &amp; x-ray</li> <li>▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> <li>▪ Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Specialist Office Visit <ul style="list-style-type: none"> <li>▪ Evaluation and management services</li> <li>▪ Routine diagnostic services - lab &amp; x-ray</li> <li>▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> </ul>	[\$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) <ul style="list-style-type: none"> <li>▪ Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests</li> <li>▪ Other procedures, such as chemotherapy, radiation and infusion therapy</li> <li>▪ Complex Injectable Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see "Outpatient Prescription Drug Benefit Summary")</li> <li>▪ Complex procedures such as cystoscopy, colposcopy and invasive biopsies</li> <li>▪ Services and procedures provided by a physician in a facility</li> </ul>	PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment and/or [[0%-100%] after Deductible]	[0%-100%] after Deductible
<b>Inpatient Care - Room and Board</b>		
<ul style="list-style-type: none"> <li>▪ Inpatient care - room and board</li> <li>▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (combined [0 to 365] day limit per Calendar Year)</li> </ul>	[[0%-100%] after Deductible] and/or [[0-\$2,000] Co-payment]	[0%-100%] after Deductible
<b>Outpatient Care and Ambulatory Care Centers</b>		
<ul style="list-style-type: none"> <li>▪ Outpatient Care and Ambulatory Care Centers</li> <li>▪ Observation Services</li> <li>▪ Diagnostic Services - Advanced imaging, Lab &amp; X-Ray</li> <li>▪ Hospice services (limited to a lifetime maximum of [0 to 365] days)</li> <li>▪ Home Health Care ([0 to 400] visits per Calendar Year)</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>▪ Outpatient Surgical Services</li> </ul>	[[0%-100%] after Deductible] and/or [[0-\$2,000] Co-payment]	
<b>Emergency Services</b>		
<ul style="list-style-type: none"> <li>▪ Emergency Room, Urgent Care or ER Observation Services</li> </ul>	[0%-100%] after [Deductible] or [0-\$2,000] [Co-payment]	[0%-100%] after [Deductible] or [0-\$2,000] [Co-payment]
<b>Transportation Services</b>		
<ul style="list-style-type: none"> <li>▪ Ambulance - Ground or Air ([0-\$100,000] maximum benefit per Calendar Year)</li> </ul> <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%]	[0%-100%]

Therapy Services		
<ul style="list-style-type: none"> <li>Physical Therapy</li> <li>Occupational Therapy</li> <li>Speech Therapy and Audiology Testing</li> <li>Chiropractic Care</li> <li>Cardiac Rehabilitation ([0 to 300] visits per Calendar Year)</li> </ul> <p><i>Note: Therapy services are limited to a combined maximum of [0-300] visits per Calendar Year. This does not include Cardiac Rehabilitation.</i></p>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Maternity Services		
Physician Services	In-Network (You Pay)	Out-of-Network (You Pay)
<ul style="list-style-type: none"> <li>Routine Prenatal Lab</li> </ul>	[Paid in full] or [0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Initial Office Visit</li> <li>All other services</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	
	[0%-100%] after Deductible	
Facility Services	[0%-100%] after Deductible	[0%-100%] after Deductible
Infertility Diagnostic Services Only	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<i>Note: Treatment of infertility is not covered.</i>		
Mental Health and Substance Use Disorder Services		
<ul style="list-style-type: none"> <li>Inpatient Hospital Services - [10 day limit per calendar year]</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>Professional Services (Office/Outpatient Visits) - [10 visit limit per calendar year]</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	
<ul style="list-style-type: none"> <li>Professional Services (Inpatient/Outpatient Facility)</li> </ul>	[0%-100%] after Deductible	
Allergy Services		
<ul style="list-style-type: none"> <li>Office Visit and Allergy Testing</li> </ul>	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"> <li>Allergy Shots</li> </ul>	Paid in Full	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME)	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>[\$0-20,000] maximum benefit per Calendar Year</li> </ul>		
Medical Supplies	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.</li> </ul>		
<ul style="list-style-type: none"> <li>Provided in connection with home infusion therapy</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Provided in connection with Durable Medical Equipment</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
Prosthetic and Orthotic Services and Devices	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Prosthetic Services and Prosthetic Devices</li> <li>Orthotic Services and Orthotic Devices</li> </ul> <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>		
Reconstructive Surgery	[0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Breast reconstruction following mastectomy</li> <li>Restoration due to acute trauma, infection or cancer</li> </ul> <p><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></p>		
Transplantation Services	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>Physician/Professional charges</li> <li>Inpatient and Outpatient Charges</li> </ul> <p><i>Note: Lifetime maximum of two transplants</i></p>	[0%-100%] after Deductible	



Diabetes Management Services <ul style="list-style-type: none"> <li>▪ Insulin Pumps ([0-\$50,000] benefit maximum per Calendar Year)</li> <li>▪ Supplies and equipment (Subject to [0-\$200,000] DME limit)</li> </ul>	[0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>▪ Diabetic Education ([0 to 100] training per lifetime)</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Dental Care <ul style="list-style-type: none"> <li>▪ Accidental injury to sound and natural teeth [0-\$20,000] maximum benefit per accident</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria <ul style="list-style-type: none"> <li>▪ Benefits available after member has paid [0-\$5,000] per year</li> </ul>	[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

[\*Essential Benefits are services that QualChoice has determined fall within the following categories or services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescriptive drugs
- Rehabilitation and habilitative services and devices
- Lab services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care]



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](http://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 Benefit Maximum (for Essential Benefits*)]	[\$750,000-Unlimited]	
<b>Annual Deductible</b> <ul style="list-style-type: none"> <li>Co-payments are not included in the annual Deductible</li> <li>In-Network and Out-of-Network Deductibles apply separately</li> <li>Family Deductible is not considered satisfied until at least [2 to 5] separate family members have satisfied their individual Deductibles</li> <li>[Deductible amounts applied in the last quarter of a Calendar Year will carry over to the next Calendar Year] OR [Deductible amounts applied in the last quarter of a Calendar Year will not carry over to the next Calendar Year]</li> <li>The annual Deductible is calculated on a Calendar Year basis</li> </ul>	Individual: [\$0-[\$0-\$2,000],000] Family: [\$0-[\$0-\$2,000],000]	Individual: [\$0-[\$0-\$2,000],000] Family: [\$0-[\$0-\$2,000],000]
<b>Annual Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>Applicable Coinsurance will apply until [2 to 5] separate family members meet their individual Out-of-Pocket Limits satisfying the family out-of-pocket limit</li> <li>Benefits will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied</li> <li>Out-of-Pocket limits apply separately to In-Network and Out-of-Network Benefits</li> <li>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</li> <li>Out-of-Pocket Limit &amp; benefit limits are calculated on a Calendar Year basis</li> </ul>	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]	Individual: [\$0-\$500,000] Family: [\$0-\$1,000,000]
<b>Coinsurance</b>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Preventive Care Services (Performed in the Office):</b>		
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.		
<b>Immunizations, including flu and pneumonia vaccines</b> <b>Child Immunizations (age 0-18)</b> <b>Adult Immunizations (age 18+)</b> <ul style="list-style-type: none"> <li>Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years</li> <li>Hepatitis B (Hep B) - once per lifetime</li> <li>Influenza, annually</li> <li>Pneumococcal Conjugate, adult over 55 or immunosuppressed</li> <li>Zoster, adult 60 and older</li> <li>HPV (covered age 9-18, females only)</li> </ul> <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>	Paid in Full	
Routine vision exam (limit 1 every 24 months)	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	Not Covered
Well baby care, birth - to age 2	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Well child care, ages 2-18	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
<b>Other preventive services</b> <ul style="list-style-type: none"> <li>Annual physical</li> <li>Pap smear</li> <li>Screening mammogram (including breast exam) age 40 and over</li> <li>Prostate screenings for men age 40 and over</li> </ul>	PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] 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"> <li>Bone density screening tests, preventive for women age 65+</li> <li>Fecal occult blood test annually</li> </ul>	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"> <li>Flexible sigmoidoscopy once every 5 years; OR</li> <li>Double contrast barium enema once every 5 years; OR</li> <li>Preventive colonoscopy age 50 and older, once every 10 years</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
Smoking cessation <ul style="list-style-type: none"> <li>Kick the Nic: smoking cessation; 12 week program</li> </ul> <i>Note: Contact QCARE 1-888-795-6810</i>	No Cost to You	Not Covered
<b>Professional Services</b>		
Primary Care Physician (PCP) Office Visit <ul style="list-style-type: none"> <li>Evaluation and management services</li> <li>Routine diagnostic services - lab &amp; x-ray</li> <li>Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> <li>Routine Injectable Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Specialist Office Visit <ul style="list-style-type: none"> <li>Evaluation and management services</li> <li>Routine diagnostic services - lab &amp; x-ray</li> <li>Routine procedures, such as skin biopsy, shaving benign lesions and closures</li> </ul>	[\$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) <ul style="list-style-type: none"> <li>Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests</li> <li>Other procedures, such as chemotherapy, radiation and infusion therapy</li> <li>Complex Injectable Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics (when obtained at a pharmacy, see "Outpatient Prescription Drug Benefit Summary")</li> <li>Complex procedures such as cystoscopy, colposcopy and invasive biopsies</li> <li>Services and procedures provided by a physician in a facility</li> </ul>	PCP: [\$0-\$500] Co-payment or Specialist: [\$0-\$500] Co-payment and/or [[0%-100%] after Deductible]	[0%-100%] after Deductible
<b>Inpatient Care - Room and Board</b>		
<ul style="list-style-type: none"> <li>Inpatient care - room and board</li> <li>Skilled Nursing Facility and Inpatient Rehabilitation Services (combined [0 to 365] day limit per Calendar Year)</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Outpatient Care and Ambulatory Care Centers</b>		
<ul style="list-style-type: none"> <li>Outpatient Care and Ambulatory Care Centers</li> <li>Observation Services</li> <li>Diagnostic Services - Advanced imaging, Lab &amp; X-Ray</li> <li>Hospice services (limited to a lifetime maximum of [0 to 365] days)</li> <li>Home Health Care ([0 to 400] visits per Calendar Year)</li> <li>Outpatient Surgical Services</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Emergency Services</b>		
<ul style="list-style-type: none"> <li>Emergency Room, Urgent Care or ER Observation Services</li> </ul>	[0%-100%] after [Deductible] or [\$0-\$2,000] [Co-payment]	[0%-100%] after [Deductible] or [\$0-\$2,000] [Co-payment]
<b>Transportation Services</b>		
<ul style="list-style-type: none"> <li>Ambulance - Ground or Air ([\$0-\$100,000] maximum benefit per Calendar</li> </ul> <i>Note: Facility to facility ambulance transfer requires pre-authorization.</i>	[0%-100%]	[0%-100%]

<b>Therapy Services</b>		
<ul style="list-style-type: none"> <li>Physical Therapy</li> <li>Occupational Therapy</li> <li>Speech Therapy and Audiology Testing</li> <li>Chiropractic Care</li> <li>Cardiac Rehabilitation ([0 to 300] visits per Calendar Year)</li> </ul> <p><i>Note: Therapy services are limited to a combined maximum of [0-300] visits per Calendar Year. This does not include Cardiac Rehabilitation.</i></p>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
<b>Maternity Services</b>		
<b>Physician Services</b>	<b>In-Network (You Pay)</b>	<b>Out-of-Network (You Pay)</b>
<ul style="list-style-type: none"> <li>Routine Prenatal Lab</li> </ul>	[Paid in full] or [0%-100%] after Deductible	[0%-100%] after Deductible
<ul style="list-style-type: none"> <li>Initial Office Visit</li> <li>All other services</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	
	[0%-100%] after Deductible	
<b>Facility Services</b> <b>Infertility Diagnostic Services Only</b> <i>Note: Treatment of infertility is not covered.</i>	[0%-100%] after Deductible	[0%-100%] after Deductible
	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<b>Mental Health and Substance Use Disorder Services</b>		
<ul style="list-style-type: none"> <li>Inpatient Hospital Services - [10 day limit per calendar year]</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>Professional Services (Office/<b>Outpatient Visits</b>) - [10 visit limit per calendar year]</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	
<ul style="list-style-type: none"> <li>Professional Services (Inpatient/<b>Outpatient Facility</b>)</li> </ul>	[0%-100%] after Deductible	
<b>Allergy Services</b>		
<ul style="list-style-type: none"> <li>Office Visit and Allergy Testing</li> </ul>	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"> <li>Allergy Shots</li> </ul>	Paid in Full	[0%-100%] after Deductible
<b>Other Treatment, Services and Supplies</b>		
<b>Durable Medical Equipment (DME)</b> <ul style="list-style-type: none"> <li>[\$0-20,000] maximum benefit per Calendar Year</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<b>Medical Supplies</b> <ul style="list-style-type: none"> <li>Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.</li> <li>Provided in connection with home infusion therapy</li> <li>Provided in connection with Durable Medical Equipment</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
	[0%-100%] after Deductible	[0%-100%] after Deductible
	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<b>Prosthetic and Orthotic Services and Devices</b> <ul style="list-style-type: none"> <li>Prosthetic Services and Prosthetic Devices</li> <li>Orthotic Services and Orthotic Devices</li> </ul> <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
<b>Reconstructive Surgery</b> <ul style="list-style-type: none"> <li>Breast reconstruction following mastectomy</li> <li>Restoration due to acute trauma, infection or cancer</li> </ul> <p><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></p>	[0%-100%] after Deductible	[0%-100%] after Deductible
<b>Transplantation Services</b> <ul style="list-style-type: none"> <li>Physician/Professional charges</li> <li>Inpatient and Outpatient Charges</li> </ul> <p><i>Note: Lifetime maximum of two transplants</i></p>	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
	[0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]



Diabetes Management Services <ul style="list-style-type: none"> <li>▪ Insulin Pumps ([0-\$50,000] benefit maximum per Calendar Year)</li> <li>▪ Supplies and equipment (Subject to [0-\$200,000] DME limit)</li> </ul>	[0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible or [Not Covered]
<ul style="list-style-type: none"> <li>▪ Diabetic Education ([0 to 100] training per lifetime)</li> </ul>	[\$0-\$500] Co-payment or [[0%-100%] after Deductible]	[0%-100%] after Deductible
Dental Care <ul style="list-style-type: none"> <li>▪ Accidental injury to sound and natural teeth [0-\$20,000] maximum benefit per accident</li> </ul>	[0%-100%] after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria <ul style="list-style-type: none"> <li>▪ Benefits available after member has paid [0-\$5,000] per year</li> </ul>	[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

[\*Essential Benefits are services that QualChoice has determined fall within the following categories or services:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescriptive drugs
- Rehabilitation and habilitative services and devices
- Lab services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care]

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.

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](http://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](http://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, the cost difference between the brand product and the generic product will be the responsibility of the member and will not apply to the annual deductible or out-of-pocket maximum amounts.*

**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)
<b>Co-payment Amounts</b>		
▪ Tier 1	Not Applicable	Not Applicable
▪ Tier 2	Not Applicable	Not Applicable
▪ Tier 3	Not Applicable	Not Applicable
▪ 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]
<i>NOTE: If dispensed in your physician office or at a facility - see medical benefits</i>		
<b>Coinsurance Amounts</b>		
▪ Tier 1	[0%-100%]after Deductible	[0%-100%] after Deductible
▪ Tier 2	[0%-100%]after Deductible	[0%-100%] after Deductible
▪ Tier 3* (see Tier 3 Note above)	[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]
<b>Deductible</b>	[\$0-\$10,000] (Individual)/ [\$0-\$20,000] (Family)	

**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 are limited to a 90-day supply at certain contracted pharmacies and through mail order.*

*Insulin and syringes will be covered with one monthly cost sharing amount for each [30-31]-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

**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, 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.

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**For information about specific medications, visit our website at [www.qualchoice.com](http://www.qualchoice.com).**

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<p><b>Tier Definitions:</b></p> <p><b>Tier 1</b> 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.</p> <p><b>Tier 2</b> 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.</p> <p><b>Tier 3</b> 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.</p> <p><i>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.</i></p> <p><b>Tier 4</b> 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.</p> <p><b>Tier 5</b> 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.</p> <p>(See QC website for list of specialty meds covered under pharmacy benefit.) All else, see medical benefit.</p> <p>Many Tier 5 medications require prior-authorization and are at the highest level of cost share.</p>
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- 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)
<b>Co-payment Amounts</b>		
▪ 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]
<i>NOTE: If dispensed in your physician office or at a facility - see medical benefits</i>		
<b>Coinsurance Amounts</b>		
▪ 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]
<b>Deductible</b>	[\$0-\$200,000]	[\$0-\$200,000]

### Limitations

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

*Note: All new prescriptions are limited to a 30-day supply. Refills are limited to a 90-day supply at certain contracted pharmacies and through mail order.*

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

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

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

### Benefit Details

- Benefit Details are subject to all benefit terms, conditions, limitations and exclusions
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- 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.**

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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;
- 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

SERFF Tracking Number: QUAC-128078700

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

Project Name/Number: /

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved	02/10/2012
<b>Comments:</b>		
<b>Attachment:</b> POS Flesch Letter.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application	Approved	02/10/2012
<b>Bypass Reason:</b> The application for this product has been previously submitted and approved.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> PPACA Uniform Compliance Summary	Approved	02/10/2012
<b>Bypass Reason:</b> Any applicable PPACA Uniform Compliance Summary for this product has been previously submitted and approved.		
<b>Comments:</b>		



February 7, 2012

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

RE: Prescription Drug Benefit Summary and Benefit Summary Filing

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.

1. Preferred Choice NG – Form # QC POSPC NG (10-1-10)
2. Flex Choice NG – Form # QC POSFC NG (10-1-10)
3. Flex Choice GF – Form # QC POSFC GF (10-1-10)
4. Preferred Choice GF – Form # QC POSPC GF (10-1-10)
5. Right Choice – Form # QCRxG POS/HDHP Right (4-1-12)
6. Flex Choice – Form # QCRxG POS/HDHP Flex (4-1-12)

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

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

Sincerely,

J. Nicole Thomas  
Associate Corporate Counsel  
[Nicole.Thomas@qualchoice.com](mailto:Nicole.Thomas@qualchoice.com)  
(501) 219-5129