Filing at a Glance

Company: QCA Health Plan, Inc.

Product Name: IQChoice Select Child Only Policy	SERFF Tr Num: QUAC-127618022	State: Arkansas
TOI: H16I Individual Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 49739
Sub-TOI: H16I.005C Individual - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor, Donna Lambert
	Authors: Jim Couch, Niki Thomas	Disposition Date: 03/28/2012
	Date Submitted: 09/08/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date: 03/28/2012

State Filing Description:

General Information

Project Name: IQChoice Select Child Only Policy
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Niki Thomas
PPACA: Not PPACA-Related
PPACA Notes: null
Healthcare.gov ID:
Filing Description:
IQChoice Select Child Only Policy
State Narrative:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 03/28/2012
State Status Changed: 03/28/2012
Created By: Niki Thomas
Corresponding Filing Tracking Number:

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

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

Filing Fees

Fee Required?	Yes
Fee Amount:	$350.00
Retaliatory?	No
Fee Explanation:	7 forms at $50 each.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
QCA Health Plan, Inc.	$350.00	09/08/2011	51374229
QCA Health Plan, Inc.	$100.00	09/28/2011	52221064

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/28/2012	03/28/2012
Approved-Closed	Rosalind Minor	09/30/2011	09/30/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	09/28/2011	09/28/2011	Niki Thomas	09/29/2011	09/29/2011
Pending Industry Response	Rosalind Minor	09/26/2011	09/26/2011	Niki Thomas	09/28/2011	09/28/2011
Pending Industry Response	Rosalind Minor	09/19/2011	09/19/2011	Niki Thomas	09/23/2011	09/23/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Health - Actuarial Justification	Niki Thomas	03/28/2012	03/28/2012
Rate	Rate Sheet	Niki Thomas	03/27/2012	03/27/2012

Form	Child Only (2011)	Niki Thomas	09/30/2011	09/30/2011
Form	Child Only (2011)	Niki Thomas	09/29/2011	09/29/2011
Form	IQCSelect Child Only Benefit Summaries	Niki Thomas	09/28/2011	09/28/2011
Form	IQC Select HDHP Benefit Summary	Niki Thomas	09/28/2011	09/28/2011
Form	IQC Select HDHP Prescription Summary	Niki Thomas	09/28/2011	09/28/2011
Rate	Rate Sheet	Niki Thomas	09/28/2011	09/28/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Actuarial Memorandum	Note To Reviewer	Niki Thomas	03/28/2012	03/28/2012
Extended Rates	Note To Filer	Rosalind Minor	03/27/2012	03/27/2012
Termination Provisions	Note To Filer	Rosalind Minor	09/29/2011	09/29/2011
Rates	Note To Filer	Rosalind Minor	09/28/2011	09/28/2011
Filing Letter	Note To Reviewer	Niki Thomas	09/08/2011	09/08/2011

Disposition

Disposition Date: 03/28/2012
Implementation Date: 03/28/2012
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed by Actuary
Comment:
This submission was re-opened in order for you to submit extended rates to age 64.

The extended rates are approved effective on this date.

Company Name:	**Overall % Indicated Change:**	**Overall % Rate Impact:**	**Written Premium Change for this Program:**	**# of Policy Holders Affected for this Program:**	**Written Premium for this Program:**	**Maximum % Change (where required):**	**Minimum % Change (where required):**
QCA Health Plan, Inc.	0.000%	0.000%	$0	0	$2,059	0.000%	0.000%
	Percent Change Approved:						
	Minimum:	0.0%	**Maximum:**	0.0%	**Weighted Average:**		0.0%

SERFF Tracking Number:	*QUAC-127618022*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49739*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005C Individual - Other*
Product Name:	*IQChoice Select Child Only Policy*		
Project Name/Number:	*IQChoice Select Child Only Policy/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document *(revised)*	Health - Actuarial Justification		No
Supporting Document	Health - Actuarial Justification	Replaced	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form *(revised)*	Child Only (2011)	Approved-Closed	Yes
Form *(revised)*	IQCSelect Child Only Benefit Summaries	Approved-Closed	Yes
Form	IQCSelect Prescription Child Only Summaries	Approved-Closed	Yes
Form	Child Only Maternity Rider	Approved-Closed	Yes
Form	Child Only Mental Health Parity Rider	Approved-Closed	Yes
Form	Child Only Prescription Drug Rider	Approved-Closed	Yes
Form	Child Only TMJ Rider	Approved-Closed	Yes
Form	IQC Select HDHP Benefit Summary	Approved-Closed	Yes
Form	IQC Select HDHP Prescription Summary	Approved-Closed	Yes
Form	Child Only (2011)	Replaced	Yes
Form	Child Only (2011)	Replaced	Yes
Form	Child Only (2011)	Replaced	Yes
Form	IQCSelect Child Only Benefit Summaries	Replaced	Yes
Rate *(revised)*	Rate Sheet	Approved-Closed	Yes
Rate	Rate Sheet	Replaced	No

Disposition

Disposition Date: 09/30/2011

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*QUAC-127618022*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49739*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005C Individual - Other*
Product Name:	*IQChoice Select Child Only Policy*		
Project Name/Number:	*IQChoice Select Child Only Policy/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document *(revised)*	Health - Actuarial Justification		No
Supporting Document	Health - Actuarial Justification	Replaced	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form *(revised)*	Child Only (2011)	Approved-Closed	Yes
Form *(revised)*	IQCSelect Child Only Benefit Summaries	Approved-Closed	Yes
Form	IQCSelect Prescription Child Only Summaries	Approved-Closed	Yes
Form	Child Only Maternity Rider	Approved-Closed	Yes
Form	Child Only Mental Health Parity Rider	Approved-Closed	Yes
Form	Child Only Prescription Drug Rider	Approved-Closed	Yes
Form	Child Only TMJ Rider	Approved-Closed	Yes
Form	IQC Select HDHP Benefit Summary	Approved-Closed	Yes
Form	IQC Select HDHP Prescription Summary	Approved-Closed	Yes
Form	Child Only (2011)	Replaced	Yes
Form	Child Only (2011)	Replaced	Yes
Form	Child Only (2011)	Replaced	Yes
Form	IQCSelect Child Only Benefit Summaries	Replaced	Yes
Rate *(revised)*	Rate Sheet	Approved-Closed	Yes
Rate	Rate Sheet	Replaced	No

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/28/2011
Submitted Date	09/28/2011
Respond By Date	

Dear Jim Couch,

This will acknowledge receipt of the captioned filing.

Objection 1

- Child Only (2011), Child Only (2011) (Form)

Comment: In my first objections on this submission, under Objection 6, I requested that you refer to the Termination Provisions under the Policy.

I also called to your attention that under ACA 23-79-119(c)(2), a health insurance issuer may nonrenew or discontinue health insurance coverage providing major medical benefits for an individual in the individual market based only on one (1) or more of the following: A. Nonpayment of Premium; (B) Fraud, (C) Termination of the Plan, (D) Movement Outside the Services Area and (E) Association Membership Ceases.

Please change the language under your Termination Provisions to comply with the above law.

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

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/29/2011
Submitted Date	09/29/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: It is QCA's understanding that the following subsections of 5.5(4) are in question: B, C, F, and H. Please see the individual responses:

B - We may terminate an Enrollee's coverage upon 30 days advance written notice to an Enrollee if he or she persistently fails to cooperate in good faith with the administration of coverage under this Policy or persistently refuses to comply with treatment plans prescribed by a physician and approved by us;

QCA contends that this language complies with ACA 23-79-119(c)(2)(B) by providing termination for Fraud. "B" would only allow a termination if the member fails to cooperate "in good faith". The very definition of "good faith" is "absence of intent to defraud". Therefore, if a member is not acting in good faith, they are attempting to defraud and may be terminated under the statute.

C - We may terminate an Enrollee's coverage for failure to pay any applicable Cost Sharing Amount required under this Policy upon 30 days advance written notice to such Enrollee unless you cure such default in payment within such 30-day period;

ACA 23-79-119(c)(2)(A) provides that an individual may be terminated if they have "failed to pay premiums or CONTRIBUTIONS under the terms of the health insurance coverage". Failure to pay a Cost Sharing Amount would be considered a "contribution" under the terms of the statute and would be grounds for termination of the policy.

F - Failure to respond to a request for recovery of overpayment in accordance with the provisions of Section 9.7;

QCA should be able to terminate any member who does not respond to requests for recovery. TIt is our opinion that this action would constitute fraud under the Statute because the member is keeping money that they are not legally entitled to.

H - An Enrollee's coverage under this Policy terminates as of the date that Enrollee is no longer eligible to be an

Enrollee under this Policy;

While H is not specifically stated in the statute, if an individual is no longer eligible for the coverage, then teh policy can be terminated. We belive that from a consumer's perspective it is helpful to have all reasons that the policy could be termianted reflected in a single place in the policy.

Related Objection 1

Applies To:

- Child Only (2011), Child Only (2011) (Form)

Comment:

In my first objections on this submission, under Objection 6, I requested that you refer to the Termination Provisions under the Policy.

I also called to your attention that under ACA 23-79-119(c)(2), a health insurance issuer may nonrenew or discontinue health insurance coverage providing major medical benefits for an individual in the individual market based only on one (1) or more of the following: A. Nonpayment of Premium; (B) Fraud, (C) Termination of the Plan, (D) Movement Outside the Services Area and (E) Association Membership Ceases.

Please change the language under your Termination Provisions to comply with the above law.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Jim Couch, Niki Thomas

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/26/2011
Submitted Date	09/26/2011
Respond By Date	

Dear Jim Couch,

This will acknowledge receipt of the captioned filing.

Objection 1

- Child Only (2011), Child Only (2011) (Form)

Comment:

Mr. Dan Honey has reviewed your responses to my objections. With respect to your response to Objection 5, nothing in Act 269 or Rule 102 takes child only coverage out of the definition of an individual major medical/comprehensive iinsurance policy. The individual comprehensive/major medical policy is subject to ACA 23-79-119(c)(1) et seq. and therefore will need to include language as specified therein. The fact the you will only be marketing/selling the product to individuals under the age of 19 does not exempt you from having to comply with all individual major medical policy requirements.

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

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/28/2011
Submitted Date	09/28/2011

Dear Rosalind Minor,

Comments:
I have updated the EOC to make the policy guaranteed renewable. I have also updated the Benefit Summary to include out of network child immunizations at no cost to the member. I have also added 2 forms: the HDHP Benefit Summary, and HDHP Prescription Summary that I previously had left out.

Thank you,
Niki Thomas

Response 1

Comments: EOC updated in response.

Related Objection 1

Applies To:

- Child Only (2011), Child Only (2011) (Form)

Comment:

Mr. Dan Honey has reviewed your responses to my objections. With respect to your response to Objection 5, nothing in Act 269 or Rule 102 takes child only coverage out of the definition of an individual major medical/comprehensive iinsurance policy. The individual comprehensive/major medical policy is subject to ACA 23-79-119(c)(1) et seq. and therefore will need to include language as specified therein. The fact the you will only be marketing/selling the product to individuals under the age of 19 does not exempt you from having to comply with all individual major medical policy requirements.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

SERFF Tracking Number:	*QUAC-127618022*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49739*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005C Individual - Other*
Product Name:	*IQChoice Select Child Only Policy*		
Project Name/Number:	*IQChoice Select Child Only Policy/*		

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Child Only (2011)	*Child Only (2011)*		*Policy/Contract/Fraternal Certificate*	*Revised*			Child Only Policy Final.pdf
Previous Version							
Child Only (2011)	*Child Only (2011)*		*Policy/Contract/Fraternal Certificate*	*Initial*			Child Only Policy.pdf

No Rate/Rule Schedule items changed.

Sincerely,
Jim Couch, Niki Thomas

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/19/2011
Submitted Date	09/19/2011
Respond By Date	

Dear Jim Couch,

This will acknowledge receipt of the captioned filing.

Objection 1

- Child Only (2011), Child Only (2011) (Form)

Comment: Under Diabetes Management on Page 14 and 15, it is requested that you expand on the coverage as outlined under ACA 23-79-603 (a) and (b).

Objection 2

- Child Only (2011), Child Only (2011) (Form)

Comment:

Please refer to Section 3.24, Preventative and Wellness Health Services. It is requested that you expand the language for children's wellness as outlined under ACA 23-79-141 (e)(1). The policyholders need to see these intervals outlined in the policy.

Also, as discussed last week, benefits for recommended immunizations shall be exempt from any copayment, coinsurance, deductible, or dollar limit and this exemption shall be explicitly stated in the policy. Immunizations must be paid at 100% for In-Network and Out-of-Network Providers. Refer to ACA 23-79-141 (f)(2)(A).

Objection 3

- Child Only (2011), Child Only (2011) (Form)

Comment:

Coverage for Autism Spectrum Disorders needs additional language. Please refer to ACA 23-99-418 (HB 1315).

Objection 4

- Child Only (2011), Child Only (2011) (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Objection 5

- Child Only (2011), Child Only (2011) (Form)

Comment:

Section 9.1, Amendment, states that...."QualChoice reserves the right to change the benefits, conditions and premiums covered under the Policy, including the terms of this Policy....". Rule and Regulation 18, Section 7 A (3) states that "the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.....". Section 9.1 is not in compliance with the above rule.

Objection 6

- Child Only (2011), Child Only (2011) (Form)

Comment:

Please refer to the Termination Provisions under the policy.

ACA 23-79-119(c)(2) states that a health insurance issuer may nonreview or discontinue health insurance coverage providing major medical benefits for an individual in the individual market based only on one (1) or more of the following: (A) Nonpayment of the Premium, (B) Fraud, (C) Termination of the Plan and (D) Movement Outside the Service Area.

Objection 7

- Child Only (2011), Child Only (2011) (Form)

Comment:

Ssection ACA 23-76-104(A)(13) outline the Sections of Chapter 85 that needs to be included in the policy. My review indicated that the policy did have the provisions outlined under ACA 23-85-107, 23-85-119, 23-85-110 and 23-85-116, but many provisions are not listed.

Also, please refer to ACA 23-85-127, the order of certain provisions.

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

Please feel free to contact me if you have questions.

SERFF Tracking Number:	*QUAC-127618022*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49739*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005C Individual - Other*
Product Name:	*IQChoice Select Child Only Policy*		
Project Name/Number:	*IQChoice Select Child Only Policy/*		

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/23/2011
Submitted Date	09/23/2011

Dear Rosalind Minor,

Comments:
I have responded to your objections in accordance with our discussion. I have included the changes in the comment sections below, but will refile the entire Child Only Policy as one document to decrease the number of replacement pages.
Thank you again,
Niki Thomas

Response 1

Comments: I have updated the language as follows:
3.8. Diabetes Management
Coverage is provided for medically necessary equipment, supplies, and services for diabetes when prescribed by a physician. Diabetes self-management training is limited to one program per lifetime per Enrollee. If there is a significant change in the Enrollee's symptoms or condition making it necessary to change the Enrollee's diabetic management process, we may authorize additional training if prescribed by a physician. Covered Services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education developed by the American Diabetes Association (ADA). A licensed provider certified by the ADA must provide the training.

Related Objection 1

Applies To:

- Child Only (2011), Child Only (2011) (Form)

Comment:
Under Diabetes Management on Page 14 and 15, it is requested that you expand on the coverage as outlined under ACA 23-79-603 (a) and (b).

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments: I have updated the language as follows:

3.24. Preventive and Wellness Health Services

We cover those services that are recognized and defined by QualChoice's Medical Policies as being preventive and/or wellness in nature. Subject to changes QualChoice may make to its Medical Policies, a partial listing of those services QualChoice considers to be preventive and/or wellness health services is included with your Benefits Summary. The most complete list of those services QualChoice considers being preventive and/or wellness health services are available on our website www.qualchoice.com (Preventive Health Benefit) or you may contact our Customer Service Department to obtain specific coverage guidelines.

Related Objection 1

Applies To:

- Child Only (2011), Child Only (2011) (Form)

Comment:

Please refer to Section 3.24, Preventative and Wellness Health Services. It is requested that you expand the language for children's wellness as outlined under ACA 23-79-141 (e)(1). The policyholders need to see these intervals outlined in the policy.

Also, as discussed last week, benefits for recommended immunizations shall be exempt from any copayment, coinsurance, deductible, or dollar limit and this exemption shall be explicitly stated in the policy. Immunizations must be paid at 100% for In-Network and Out-of-Network Providers. Refer to ACA 23-79-141 (f)(2)(A).

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments: Coverage for Autism Spectrum Disorders does not apply to individual polciies, therefore no update has been made.

Related Objection 1

Applies To:

- Child Only (2011), Child Only (2011) (Form)

Comment:

Coverage for Autism Spectrum Disorders needs additional language. Please refer to ACA 23-99-418 (HB 1315).

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 4

Comments: This language is in the Policy at Section 5.5(3)

Related Objection 1

Applies To:

- Child Only (2011), Child Only (2011) (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 5

Comments: It is our understanding that it is the Department's position that "child-only policies" mandated by Act 269 of 2011 are required to be guaranteed renewable even beyond the age of 18.

We agree that QCA's Child Only Policy is not "guaranteed renewable" because the Policy will terminate automatically on the Policy Holder's 19th birthday. For this reason, QCA will change all references from "guaranteed renewable" to "renewable" to comply with the requirements of Arkansas Act 269, AID Emergency Rule 102, and AID Rule and Regulation 18.

The Patient Protections and Affordability Act (PPACA) prohibited the application of pre-existing conditions to children under the age of 19. In response to this, many insurers stopped offering child only plans and only offered individual plans for adults. In order to ensure there would be a health insurance market for children under the age of 19, the Arkansas legislature passed Act 269. So the focus of the legislature with this legislation was on children under the age of 19, not individuals 19 or older where there is an existing health insurance market. The Act states that a, "'Child Only Policy' means renewable individual health insurance for a qualified individual" (emphasis added). The Act continues to define a "qualified individual" as "a resident of this state under nineteen years of age."

This language is repeated in Rule 102. The Rule states, "'child only individual policies' or 'child only individual policy' shall mean renewable individual health insurance coverage issued with an effective date on or after September 23, 2010, which provides coverage to an individual under the age of Nineteen".

Both the Act and the Rule emphasize that coverage under a Child Only Policy is available only for children under 19 years of age. The fact that that the policy must be "renewable" and not "guaranteed renewable" furthers the point that the Child Only Policy will be renewable until the child is no longer a "qualified individual" by reaching the age of 19.

It has been stated that A.C.A. 23-79-119 does not allow for a major medical policy to terminate as a result of reaching a certain age. However, Rule and Regulation 18 allows "guaranteed renewable" plans to be terminated at the age of 65 or eligibility for Medicare.

In addition, Rule and Regulation 18 notes that there are many different types of policies that can be offered, and that all major medical policies do not have to be "guaranteed renewable". For example, section 8(A)(1) of the rule states, "Each Policy shall include a renewal, continuation, or nonrenewal provision. The language or specification of such provision must be consistent with the type of contract to be issued. Such provision shall be appropriately captioned and clearly state the duration, where limited of renewability and the duration of the term of coverage for which the Policy is issued and for which it may be renewed".

Therefore, it is our opinion that after QCA changes all references to "guaranteed renewable" in the Policy to just "renewable" it will be in compliance with the all applicable rules and statutes. We believe that the Policy complies with

the Act and Rule 102 by stating that coverage will be provided until the Policy Holder reaches the age of 19. At that time, the Policy Holder is no longer eligible under the terms of the Policy and the Act.

Related Objection 1

Applies To:

- Child Only (2011), Child Only (2011) (Form)

Comment:

Section 9.1, Amendment, states that...."QualChoice reserves the right to change the benefits, conditions and premiums covered under the Policy, including the terms of this Policy....". Rule and Regulation 18, Section 7 A (3) states that "the term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums until the age of sixty-five (65) or to eligibility for Medicare, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.....". Section 9.1 is not in compliance with the above rule.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 6

Comments: See response to Objection #5.

Related Objection 1

Applies To:

- Child Only (2011), Child Only (2011) (Form)

Comment:

Please refer to the Termination Provisions under the policy.

ACA 23-79-119(c)(2) states that a health insurance issuer may nonreview or discontinue health insurance coverage providing major medical benefits for an individual in the individual market based only on one (1) or more of the following: (A) Nonpayment of the Premium, (B) Fraud, (C) Termination of the Plan and (D) Movement

Outside the Service Area.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 7

Comments: As per our discussion, the current Policy has most of the applicable language. I have added the following:
9.6. Claim Forms
If you notify us about a claim for service, we will provide you with a Claim Form within 15 day of your request. The forms are also available on our website www.qualchoice.com.
9.7. Processing of Claims
We will pay or deny a claim for which we have all the information we require, within 30 days after we receive the claim if it was submitted electronically, or within 45 days after receipt if it was submitted through other means. We will notify you within 30 days after receipt of the claim if we determined we require additional information.

Related Objection 1

Applies To:

- Child Only (2011), Child Only (2011) (Form)

Comment:

Ssection ACA 23-76-104(A)(13) outline the Sections of Chapter 85 that needs to be included in the policy. My review indicated that the policy did have the provisions outlined under ACA 23-85-107, 23-85-119, 23-85-110 and 23-85-116, but many provisions are not listed.

Also, please refer to ACA 23-85-127, the order of certain provisions.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Please contact me if you have any further questions.

Sincerely,
Jim Couch, Niki Thomas

Amendment Letter

Submitted Date: 03/28/2012

Comments:

Actuarial Memo

Changed Items:

Supporting Document Schedule Item Changes:

Satisfied -Name: Health - Actuarial Justification

Comment:

Actuarial Memorandum 2011.pdf

Note To Reviewer

Created By:

Niki Thomas on 03/28/2012 01:26 PM

Last Edited By:

Niki Thomas

Submitted On:

03/28/2012 01:26 PM

Subject:

Actuarial Memorandum

Comments:

Ms. Minor:

The Actuarial Memorandum has been attached under the Supporting Documentation tab.

Thank you,

Niki Thomas

Note To Filer

Created By:

Rosalind Minor on 03/27/2012 09:57 AM

Last Edited By:

Rosalind Minor

Submitted On:

03/27/2012 09:58 AM

Subject:

Extended Rates

Comments:

Please submit the actuarial memorandum for the extended rates.

Thank you.

Amendment Letter

Submitted Date: 03/27/2012

Comments:

I am hoping the Child Only Rate extension goes through.

Changed Items:

Rate/Rule Schedule Item Changes:

Document Name:	Affected Form Numbers: (Comma Separated list)	Rate Action:	Rate Action Information:	Attach Document:
Rate Sheet		Revised	Previous State Filing Number:	IQChoice Select Rate Sheet and Actuarial Memorandum including Child Only Rates up to 64.pdf
IQChoice Select Rate Sheet and Actuarial Memorandum including Child Only Rates up to 64.pdf				

Amendment Letter

Submitted Date: 09/30/2011

Comments:

Updated termination to correct for typo.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
Child Only (2011)	Policy/Contract/Fraternal Certificate	Child Only (2011)	Revised					Child Only Policy Final.pdf

Amendment Letter

Submitted Date: 09/29/2011

Comments:

Updated Policy with changes to termiantion section.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
Child Only (2011)	Policy/Contract/Fraternal Certificate	Child Only (2011)	Revised					Child Only Policy Final.pdf

Note To Filer

Created By:
Rosalind Minor on 09/29/2011 01:06 PM
Last Edited By:
Rosalind Minor
Submitted On:
09/30/2011 10:51 AM
Subject:
Termination Provisions
Comments:

I shared your response with Dan Honey and he stated that even though some of your terminations could fall under Fraud, we request that the termination language in the contract state the specific reasons that are in the statute.

Amendment Letter

Submitted Date: 09/28/2011

Comments:

I forgot to attach the updated POS Benefit Summary as well that has immunizations covered. That was also showing up as a draft item.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
QC POSIQCSelect CO (2011)	Outline of Coverage	IQCSelect Child Only Benefit Summaries	Revised					Child Only POS Benefit Summary.pdf

Amendment Letter

Submitted Date: 09/28/2011

Comments:

Roz:

I hope this will go through. It is the HDHP Benefit Summary, HDHP Prescription Summary, and the Rate sheet that you requested.

Thank you,
Niki

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
IQCSelct HDHP CO (2011)	Outline of Coverage	IQC Select HDHP Benefit Summary	Initial					Child Only HDHP Benefit Summary.pdf
QC RX IQCSelect CO (2011)	Outline of Coverage	IQC Select HDHP Prescription Summary	Initial					Child Only HDHP Prescription Summary.pdf

Rate/Rule Schedule Item Changes:

Document Name:	Affected Form Numbers: (Comma Separated list)	Rate Action:	Rate Action Information:	Attach Document:
Rate Sheet		New		Child Only Rate Sheet (1).pdf
Child Only Rate Sheet (1).pdf				

Note To Filer

Created By:
Rosalind Minor on 09/28/2011 12:20 PM
Last Edited By:
Rosalind Minor
Submitted On:
09/30/2011 10:51 AM
Subject:
Rates
Comments:

It is requested that you attached the rates that were approved under the IQ Choice select that will be used with this product.

Thank you for your cooperation.

Note To Reviewer

Created By:

Niki Thomas on 09/08/2011 12:20 PM

Last Edited By:

Rosalind Minor

Submitted On:

09/30/2011 10:51 AM

Subject:

Filing Letter

Comments:

See attached.

QualChoice

VIA SERFF

September 8, 2011

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

RE: IQChoice® Select Child Only Policy Form #: Child Only (2011)

Dear Ms. Minor:

QCA Health Plan, Inc. ("QualChoice") is submitting the documents accompanying this filing for your review and approval for the Child Only portion of the IQChoice Select product.

Included with this filing are:

- QualChoice's "Comprehensive Health Expense Coverage Policy for Individual Minor"(Form #: Child Only (2011));
- The following available riders to the product:
  - TMJ Rider
  - Maternity Rider
  - Outpatient Prescription Drug Rider; and
  - Mental Health and Substance Use Disorder Rider
- Medical benefit summaries
- Pharmacy benefit summaries

As discussed, this filing is an extension of the IQChoice Select filing approved July 20, 2011 (SERFF Tracking Number QUAC-127151023). Certain elements in the documents listed above have been modified to remove references to "your child" or "your dependent", but it is being viewed as a part of the previously submitted and approved IQChoice Select Product.

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

Sincerely yours,

/s/ J. Nicole Thomas
Associate Corporate Counsel
Nicole.Thomas@qualchoice.com
(501) 219-5129

Post Submission Update Request Processed On 03/28/2012

Status:	Allowed
Created By:	Niki Thomas
Processed By:	Rosalind Minor
Comments:	

Rate Information:

Field Name	**Requested Change**	**Prior Value**
Rate Data Applies	Yes	No
Rate Change Type	Neutral	

Company Rate Information:

Company Name:QCA Health Plan, Inc.

Field Name	**Requested Change**	**Prior Value**
Company Rate Change	Neutral	
Overall % Indicated Change	0.000%	
Overall % Rate Impact	0.000%	
Written Premium Change for this Program	$0	
# of Policy Holders Affected for this Program	0	
Written Premium for this Program	$2059	
Maximum %Change (where required)	0.000%	
Minimum %Change (where required)	0.000%	
HHS Issuer ID:	00000	
Product Names:	IQChoice Select Child Only	

FORMS:

New Policy Forms:	No new policy forms
Affected Forms for Closed Blocks:	No closed blocks
Other Affected forms:	No other affected forms

REQUESTED RATE CHANGE INFORMATION:

Change Period:	Other
Member Months:	0
Benefit Change:	None
Min:	0.000
Max:	0.000
Wighted Avg.:	0.000

PRIOR RATE:

Total Earned Premium::	0.000
Total Incurred Claims:	0.000
Min:	0.000
Max:	0.000
Wighted Avg.:	0.000

REQUESTED RATE:

Projected Earned Premium:	0.000
Projected Incurred Claims:	0.000
Min:	0.000
Max:	0.000
Weighted Avg.:	0.000

POS - Covered Lives	28
POS - Policy Holders	28

Form Schedule

Lead Form Number: Child Only (2011)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/30/2011	Child Only (2011)	Policy/Contract/Fraternal Certificate	Child Only (2011)	Revised	Replaced Form #: Previous Filing #:		Child Only Policy Final.pdf
Approved-Closed 09/30/2011	QC POSIQCSelect CO (2011)	Outline of Coverage	IQCSelect Child Only Benefit Summaries	Revised	Replaced Form #: Previous Filing #:		Child Only POS Benefit Summary.pdf
Approved-Closed 09/30/2011	QC RXIQCSelect CO (2011)	Outline of Coverage	IQCSelect Prescription Child Only Summaries	Initial			2011 IQCSelect Prescription Child Only Summaries.pdf
Approved-Closed 09/30/2011	Child Only Maternity Rider (2011)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Child Only Maternity Rider	Initial			Child Only Maternity Rider.pdf
Approved-Closed 09/30/2011	Child Only Mental Health and Substance Abuse Disorder Rider (2011)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorseme	Child Only Mental Health Parity Rider	Initial			Child Only Mental Health Parity Rider.pdf

Approved-Closed 09/30/2011	Child Only Outpatient Prescription Drug Rider (2011)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Child Only Prescription Drug Rider	Initial	Child Only Prescription Drug Rider.pdf
Approved-Closed 09/30/2011	Child Only TMJ Rider (2011)	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Child Only TMJ Rider	Initial	Child Only TMJ Rider.pdf
Approved-Closed 09/30/2011	IQCSelct HDHP CO (2011)	Outline of Coverage	IQC Select HDHP Benefit Summary	Initial	Child Only HDHP Benefit Summary.pdf
Approved-Closed 09/30/2011	QC RX IQCSelect CO (2011)	Outline of Coverage	IQC Select HDHP Prescription Summary	Initial	Child Only HDHP Prescription Summary.pdf

COMPREHENSIVE HEALTH EXPENSE COVERAGE POLICY FOR INDIVIDUAL MINOR

IMPORTANT NOTICE

COVERED BENEFITS RECEIVED FROM AN OUT-OF-NETWORK PROVIDER, EXCEPT IN CERTAIN CIRCUMSTANCES (SEE SECTION 2), ARE PAID AT A RATE LESS THAN THE SAME COVERED SERVICES RECEIVED FROM A NETWORK PROVIDER. SEE YOUR BENEFIT SUMMARY.

OTHER INSURANCE REDUCES BENEFITS – READ CAREFULLY

Attached is the Benefit Summary, showing the name of Policyholder, Policy Number, premiums and Effective Date of this Policy ("Effective Date").

GUARANTEED RENEWABLE CONDITIONED
UPON RESIDENCE IN ARKANSAS
PREMIUMS SUBJECT TO CHANGE

THIS POLICY HAS SEVERAL SPECIFIC EXCLUSIONS. (SEE SECTION 4)

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* available from www.medicare.gov or 800-633-4227.

OUTLINE OF COVERAGE

If you are not satisfied with any of the terms or conditions of this Policy, you may return it to us within ten (10) days of its delivery to you and receive a full refund of all premiums you have paid.

READ YOUR POLICY CAREFULLY. This Outline of Coverage provides a brief description of the important features of this Policy. This Outline is not the Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and us. ***It is, therefore, important that you read your Policy carefully***.

POINT OF SERVICE COVERAGE. Policies of this type are designed to provide coverage for hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any applicable Cost Sharing Amounts as referenced in the Benefit Summary or other limitations set forth in the Policy.

BENEFITS

Deductible: As shown on the Benefit Summary per Calendar Year per Enrollee.

Out-of-Network Providers: Covered Services received from an Out-of-Network Provider, except in certain circumstances (see Section 2), are allowed at a rate less than the same Covered Services received from a Network Provider. (See the Benefit Summary.)

Covered Services: Subject to payment of your Coinsurance and Deductible at the amount reflected in the Benefit Summary:

- Daily hospital room and board
- Miscellaneous hospital services
- Surgical services
- Anesthesia services
- In-hospital medical visits
- Out-of-hospital care

Medicare Eligibility: If you are eligible for Medicare, you are not eligible to begin or continue coverage under this Policy.

Calendar Year Coinsurance Maximum: Please check the Benefit Summary to determine the amount of the Calendar Year Coinsurance maximum Benefits.

Special Limitations:

Durable Medical Equipment:	A maximum payment of $5,000 per Calendar Year per Enrollee. Please see the Benefits Summary for Cost Sharing Amount
Ambulance:	See the Benefit Summary
Home Health Services:	A maximum of 40 visits per Calendar Year per Enrollee please see the Benefits Summary for Cost Sharing Amount

Physical, Occupational, Speech Therapy, Chiropractic & Audiology Care:	A maximum of a total combined 45 visits per Calendar Year per Enrollee please see the Benefits Summary for Cost Sharing Amount
Skilled Nursing Facilities:	Thirty (30) days per Calendar Year per Enrollee

Benefits and Services Are *Not* Included For:

- Routine Maternity Care and Obstetrical Care, unless covered by a Maternity Rider;
- Psychiatric conditions and substance abuse services, unless covered by a Mental Health and Substance Abuse Rider;
- Injuries or disease caused by war;
- Dentistry, except for Accidental Injury (See Section 3.4), anesthesia (See Section 3.5) and oral surgery (See Section 3.6);
- Dental x-rays;
- Eye refractions, unless needed because of Accidental Injury;
- Eyeglasses or hearing aids, unless needed because of Accidental Injury;
- Cosmetic surgery, unless needed because of Accidental Injury or breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998;
- Health services and supplies not meeting Medical Necessity criteria or that are not associated with a Covered Service;
- Prescription drugs for outpatient use filled by a prescription order or refill and non-injectable medications given in a physician's office except in an Emergency are not covered, unless covered by a prescription drug rider;
- Medical or hospital services collectible under Workers' Compensation or any law providing benefits for dependents of military personnel;
- Services rendered in government hospitals (unless otherwise required by applicable law);
- Intentional self-inflicted injuries;
- In-patient services, including electrocardiograms, x-rays, and laboratory examinations, if they could have been performed safely and adequately on an out-patient basis; and
- Services and supplies that are experimental or investigational in nature.

Guaranteed Renewable/Conditioned On Residence in Arkansas

This Policy and riders are guaranteed renewable as long as your permanent residence is in Arkansas. At any time after the first twelve (12) month period of your coverage under this Policy we can change your premium rate, but only if the rate is changed for all policies and riders of the same form number and premium classification as this Policy. Your premium rate will also change in any month that you attain an age that moves you into a different premium classification established by QualChoice.

Table of Contents

1. INTRODUCTION TO YOUR POLICY 7
   1.1. Who Is QualChoice? 7
   1.2. Changes to This Policy 7
   1.3. Key Information 7
2. HOW THIS POLICY WORKS 7
   2.1. In-Network Benefits 7
   2.2. Out-of-Network Benefits 8
   2.3. Provider Network 9
   2.4. Cost Sharing Requirements 9
   2.5. Member Financial Responsibility Comparison 10
   2.6. Medically Necessary Services 10
   2.7. Exclusion and Limitations 11
   2.8. Coverage While Traveling Out of the Service Area 11
   2.9. General Conditions for Payment 11
   2.10. Administration and Interpretation of this Policy 11
   2.11. Pre-Authorization of Services 12
   2.12. Utilization Management 12
   2.13. Case Management 12
3. COVERED MEDICAL BENEFITS 12
   3.1. Advanced Diagnostic Imaging 13
   3.2. Ambulance Services – Transportation 13
   3.3. Complications of Pregnancy 13
   3.4. Dental – Accidental Injury 13
   3.5. Dental – Anesthesia 14
   3.6. Dental – Oral Surgery 14
   3.7. Dental – Other 14
   3.8. Diabetes Management 14
   3.9. Durable Medical Equipment 15
   3.10. Emergency Health Services 15
   3.11. Eye Examinations 16
   3.12. Family Planning Services 16
   3.13. Home Health Services 16
   3.14. Home Infusion Therapy 16
   3.15. Hospice Care Services 16
   3.16. Facility – Inpatient Care 17
   3.17. Injectable Prescription Medications 18
   3.18. Infertility 18
   3.19. Medical Foods 18
   3.20. Medical Supplies 18
   3.21. Orthotic Services and Orthotic Devices 18
   3.22. Outpatient Services 19
   3.23. Physician Office Services 19
   3.24. Preventive and Wellness Health Services 20
   3.25. Professional Services for Complex Surgery 20
   3.26. Prosthetic Services and Prosthetic Devices 20
   3.27. Reconstructive Surgery 21
   3.28. Skilled Nursing Facility and Inpatient Rehabilitation Services 21
   3.29. Therapeutic and Rehabilitation Services 22
   3.30. Transplantation Services 22
4. NON-COVERED SERVICES, EXCLUSIONS AND LIMITATIONS 23
   4.1. Exclusions From Coverage 23

4.2. Limitations to Benefits 32
5. ELIGIBILITY CRITERIA 34
5.1. Hospitalization When Coverage Begins 34
5.2. Eligibility for Medicare 34
5.3. Who is Eligible for Coverage and When Does Coverage Begin 34
5.4. Maternity Coverage 34
5.5. Termination of Coverage 34
6. COORDINATION OF BENEFITS 36
6.1. How COB Works 36
6.2. Rules to Determine Primary and Secondary Plans 36
6.3. Allowable Expense 37
6.4. Reduction of Benefits 37
6.5. Enforcement of Provisions 38
6.6. Facility of Payment 38
6.7. Right of Recovery 38
6.8. Hospitalization When Coverage Begins 38
7. COMPLAINTS AND APPEALS 38
7.1. Initial Communication and Resolution of a Problem or Dispute 39
7.2. Types of Requests and Claims 39
7.3. Appeal Process 40
7.4. Documentation 41
7.5. Conduct of Appeals 42
7.6. Legal Actions 42
7.7. Authorized Representative 42
7.8. External Medical Review 43
8. SUBROGATION 44
9. GENERAL PROVISIONS 44
9.1. Amendment 44
9.2. Assignment 44
9.3. Notice 45
9.4. Medical Records 45
9.5. Notice of Claim 45
9.6. Claim Forms 45
9.7. Processing of Claims 45
9.8 Who Receives Payment Under This Policy 45
9.9 Recovery of Overpayments 45
9.10. Confidentiality 45
9.11. Complaint and Appeals 46
9.12. Right to Develop Guidelines 46
9.13. Limitation on Benefit of This Policy 46
9.14. Misstatement of Age 46
9.15. Applicable Law 46
9.16. Headings 46
9.17. Pronouns 46
9.18 Recission 46
9.19 Severability 46
9.20 Legal Actions 46
9.21 Time Limit on Certain Defenses 47
10. DEFINITIONS 47

1. INTRODUCTION TO YOUR POLICY

1.1. Who Is QualChoice?

QCA Health Plan, Inc. ("QualChoice", also referred to in this Policy as "us", "we" or "our") is a Health Maintenance Organization. QualChoice has a Certificate of authority from the Commissioner of Insurance of the State of Arkansas. We are located at 12615 Chenal Parkway, Suite 300, Little Rock, Arkansas 72211. Our telephone number is (501) 228-7111.

This is your Comprehensive Individual Major Medical Policy (the "Policy") for health care Benefits with us.

1.2. Changes to This Policy

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Policy. When that happens we will send you a new Policy, Rider or Amendment pages thirty (30) days prior to the change going into effect.

1.3. Key Information

For purposes of this Policy and each section of the Policy, "you" or "your" means the Policy Holder.

We have capitalized certain words in this Policy. Those words have special meanings and are defined in Section 10, "Definitions".

Only we have the right to change, interpret, modify, withdraw or add Benefits, as permitted by law, without your approval.

On its Effective Date this Policy replaces and overrules any Policy that we may have previously issued to you. This Policy will in turn be overruled by any policy we may issue to you in the future.

Your coverage under this Policy begins at 12:01 a.m. on the Effective Date as reflected in the Benefit Summary. Coverage will end on the date this Policy is terminated for any of the reasons described in this Policy. We determine your eligibility for Benefits as described in this Policy. This Policy and the Benefit Summary describe the covered Benefits, conditions, limitations, exclusions and Cost Sharing Amounts. The attached Benefit Summary is an integral part of this Policy. In the event this Policy and the Benefit Summary conflict, the Benefit Summary will control. You should locate and familiarize yourself with the Benefit Summary. This Policy describes some special procedures with which you must comply.

The laws of the State of Arkansas shall be the laws that govern this Policy.

If you have questions about your Benefits, payments, or cost sharing, please call us during business hours at (501) 228-7111.

2. HOW THIS POLICY WORKS

This Policy provides flexible choices in obtaining health care services. Care can be sought from any Network Provider under this Policy without a Referral from a Network Primary Care Physician. There is freedom to select either In-Network or Out-of-Network Benefits each time care is sought. Consult the Benefit Summary to identify Covered Services and Cost Sharing amounts for each choice.

2.1. In-Network Benefits

In-Network Benefits are generally paid at a higher level than Out-of-Network Benefits. In-Network Benefits are Covered Services which are either:

1. Provided by or under the direct supervision of a Network Provider in a physician's office or at a Network Facility, or
2. Emergency health services meeting the QualChoice payment guidelines.

Please note that certain Covered Services may only be obtained from a Network Provider. Such Covered Services are identified in the Benefit Summary.

Covered Services may be sought from any Network Physicians without a Referral. Coverage for services in the office is at the primary care physician benefit level when Covered Services are sought directly from any Network Primary Care Physician. Coverage for services in the office is at the

specialist benefit level when Covered Services are sought from any other Network Physician. You should validate the status of a Network Provider by calling our Customer Service unit or accessing the on-line provider directory at www.qualchoice.com or calling our Customer Service unit at 800-235-7111. Please refer to the Benefit Summary for details.

2.2. Out-of-Network Benefits

You may seek Covered Services directly from a physician or other provider who is not a Network Provider. Services provided by an Out-of-Network Provider will be covered and reimbursed under your Out-of-Network Benefits unless:

1. **Policy Provision:** The Benefits Summary or this Policy specifically provides a different Deductible, Coinsurance or Out-of-Pocket Limit for the particular service or supply that is the subject of the Claim;
2. **Emergency Services:** The intervention is for an Emergency in which case the In-Network Benefit Deductible, Coinsurance and Out-of-Pocket Limit apply;
3. **Continuity of Care, Prior to Coverage:** You notify QualChoice that prior to the effective date of your coverage, you were scheduled with an Out-of-Network Provider for a procedure or ongoing treatment covered under the terms of this Plan, that such procedure or treatment is for a condition requiring immediate care, and that you request In-Network Benefits for such scheduled procedure or ongoing treatment. If QualChoice approves In-Network Benefits for the scheduled procedure or ongoing treatment, In-Network Benefit Deductible, Coinsurance, and Out-of-Pocket Limit will apply to Claims for services and supplies rendered by the Out-of-Network Provider for such condition after QualChoice's approval until the procedure or treatment ends or until the end of ninety (90) days, whichever occurs first;
4. **Provider Leaves Network:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when your ongoing treatment for an acute condition began and that you request In-Network Benefits for the continuation of such ongoing treatment. If QualChoice approves In-Network Benefits for the requested ongoing treatment, In-Network Deductible, Coinsurance and Out-of Pocket Maximum will apply to Claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to Claims for services and supplies rendered by the Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first;
6. **Provider Leaves Network, Pregnancy:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when you began receiving obstetrical care for a pregnancy covered under the terms of the Plan, that you were in the third trimester of your pregnancy on the date that the Provider left the POS, and that you request In-Network Benefits for continuation of such obstetrical care from this Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested obstetrical care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to Claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to Claims for services and supplies rendered by the Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits; or
7. **Prior Authorization:** You notify QualChoice prior to seeking services of the absence of or the exhaustion of all In-Network resources for a Covered Service resulting in the need to seek care from an Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to Claims for services and supplies received from this Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first.

The amounts allowed for Covered Services accessed under your Out-of-Network Benefits will be subject to the Maximum Allowable Charge. You will be responsible for the applicable Cost Sharing Amounts related to such Covered Services and the difference between the charges billed by the Out-of-Network Provider and the Maximum Allowable Charge. Please refer to your Benefits Summary for details:

Note: Notification to QualChoice of requests for payment of an Out-of-Network Provider services or supplies at In-Network Benefit level must be made by writing to QCA Health Plan, Inc. Attn: Care Management, P.O. Box 25610, Little Rock, AR 72221 or by faxing the request to (501) 228-9413, and must be received at least five (5) working days prior to your receipt of such services or supplies.

2.3. Provider Network

We publish an online directory listing of physicians, facilities, and other healthcare providers who have contractually agreed to provide Covered Services to Enrollees and have them reimbursed at In-Network Benefit level. You may search the directory on our website at www.qualchoice.com. Because contractual agreements can change, you may wish to verify a physician or provider is participating in our Network before care is sought.

We do not practice medicine or provide medical supplies. We are not responsible for any action or inaction of any healthcare provider. We provide no express or implied warranties or guarantees with respect to any Network Provider or the professional services provided by such provider. The utilization of a Network Provider or any other provider and the decision to receive or decline to receive health care services is your responsibility.

If you have a medical condition that we believe needs special services, we may direct you to an appropriate facility or other provider chosen by us. If you require certain complex Covered Services for which expertise is limited, we may direct you to an Out-of-Network Provider. **In both cases, In-Network Benefits will only be paid if Covered Services for that condition are approved by us.** We will not cover any services not specifically authorized by us in the written statement of authorization. The following do not constitute approval for Benefits:

1. A Referral, whether written or oral, by a Network Physician to an Out-of-Network Provider; or
2. An order or prescription for services to an Out-of-Network Provider.

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, availability to Network Providers may be limited. If this happens, we may require you to utilize a single Network Physician to provide and coordinate all future Covered Services. If you do not make a change to a single Network Physician within 31 days of the date we notify you, we will assign a single Network Physician to you. If you fail to use the assigned Network Physician, Covered Services will be paid as Out-of-Network Benefits.

2.4. Cost Sharing Requirements

You must share in the cost of Covered Services through Co-payments, Coinsurance, and Deductibles, or combinations of these Cost Sharing Amounts. Consult the Benefit Summary to determine the amounts of your payments under the Cost Sharing Amounts. A Network Provider may bill you directly for Co-payments, Coinsurance and Deductible amounts, but may not bill for the difference between his or her customary charge and the Maximum Allowable Charge. An Out-of-Network Provider may bill you directly for all applicable Co-payments, Coinsurance and Deductible amounts plus any difference between the total amount of billed charges for services and the Maximum Allowable Charge. **These additional charges could amount to thousands of dollars in additional out-of-pocket expense for which you are responsible.**

1. **Deductible:** The Deductible is a certain dollar amount per Calendar Year, as set forth in the Benefit Summary. You must satisfy the Deductible before we begin to pay for Covered Services to which the Deductible applies.
2. **Co-payment:** A Co-payment is a fixed dollar amount you must pay each time a Covered Service is received to which a Co-payment applies. Co-payment amounts do not apply to the satisfaction of the Deductible amounts or Out-of-Pocket limits for each Enrollee. Please see the Benefit Summary for a list of those Benefits to which Co-payments apply.
3. **Coinsurance:** Coinsurance is a fixed percentage of Maximum Allowable Charges for the cost of Covered Services you must pay per Calendar Year. Coinsurance payments are in addition to Deductibles or Co-payments. The Benefit Summary contains the Coinsurance percentage applicable to specific Benefits. You are responsible for paying the amount of the applicable Coinsurance for the Covered Services provided.

4. **Limits on Out-of-Pocket Payments:** The Enrollee will no longer have to pay Coinsurance for the remainder of the Calendar Year after the Enrollee has met the out-of-pocket limit during the Calendar Year. The Benefit Summary lists the limit on out-of-pocket payments for Coinsurance. Co-payments, Deductibles, or charges in excess of the Maximum Allowable Charge are the patient's responsibility and do not count toward meeting the Limit on Out-of-Pocket Payments. Once your Out-of-Pocket Limits have been satisfied, you will still be responsible for charges in excess of our Maximum Allowable Charge for services provided by an Out-of-Network Provider.

2.5. Member Financial Responsibility Comparison

The following table provides an example of the cost you will pay for a typical inpatient hospital stay utilizing the In-Network Benefits compared to the Out-of-Network Benefits. The amount you will pay may be different based on the benefit plan you select.

	In-Network	Out-of-Network
Facility Billed Charges	$50,000	$50,000
Maximum Allowable Charge	25,000	20,000
Deductible Paid by You	-500	-1,000
Coinsurance Paid by You	-1,000	-2,000
QualChoice Total Payment	$23,500	$17,000
Your Total Financial Responsibility:		
Deductible	500	1,000
Coinsurance	1,000	2,000
Difference Between Maximum Allowable Charge and Billed Charges	0	30,000
Your Total Financial Responsibility	$1,500	$33,000

2.6. Medically Necessary Services

"Medically Necessary" or "Medical Necessity" means a Covered Service which in the opinion of our medical personnel:

1. Provides for the diagnosis or treatment of the Enrollee's covered medical conditions;
2. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's specific illness, injury or medical condition in relation to any overall medical/health conditions;
3. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
4. Is not primarily for the convenience of the Enrollee, his or her physician, or other provider; and
5. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

Regardless of anything else in this Policy, and regardless of any other communications or materials you may receive in connection with this Policy, you will not have coverage for any service, any medication, any treatment, any procedure or any equipment, supplies or associated costs if QualChoice finds it to be not Medically Necessary. All determinations of Medical Necessity for Covered Services are made in accordance with the above definition at the sole discretion of QualChoice.

We reimburse only for Medically Necessary Covered Services as defined in Section 10. This standard applies to all sections of this Policy.

If we determine a service is not Medically Necessary before or after a Network Provider renders it, we prohibit the Network Provider who rendered the service from billing you for the service unless you agreed in writing to be responsible for payment before the service was provided.

If we determine a service is not Medically Necessary before or after an Out-of-Network Provider has rendered it, you will be responsible for the charges for services which are determined not to be Medically Necessary.

We make a determination of Medical Necessity after considering the advice of trained medical professionals, including physicians, who may use medically recognized standards and criteria. In making the determination, we will examine the circumstances of your condition and the care provided, including the reason your provider prescribed or provided the care, and any unusual circumstances, which necessitate attention. However, the fact your physician prescribed the care or service does not automatically mean the care is Medically Necessary or it qualifies for payment under this Policy. A medical treatment that meets the criteria for Medical Necessity will still not be reimbursed if the condition being treated is excluded from coverage as set forth in Section 4.

2.7. Exclusion and Limitations

Some services have specific limitations. Exclusion of other services from coverage is in full or in part. Consult the Benefit Summary and Section 4 for information on benefit limitations and exclusions.

This Policy refers to Medical Policies we have developed that may limit or exclude coverage for a particular service, treatment or drug. You may contact our Customer Service Department to request a copy of our Medical Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Medical Policies on our web site at www.qualchoice.com.

2.8. Coverage While Traveling Out of the Service Area

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

We will deny coverage for routine and follow-up care after Emergency care unless a Network Provider in Arkansas performs the services.

If care is accessed by an Enrollee from providers not participating in the QCNN for an unforeseen illness, reimbursement for Covered Services will be at the Out-of-Network Benefit level.

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

2.9. General Conditions for Payment

Payment for Covered Services is subject to the Enrollee's eligibility on the date such services are rendered, and to all conditions, limitations, and exclusions of the Policy. A final determination of eligibility is made at the time the Claim is received by us. Determination of non-eligibility subsequent to the payment of services as a result of error or fraud will result in recovery of such payments made by us. Benefits are provided only if services provided were ordered by a health care provider, provided within the scope of that health care provider's license, and rendered in accordance with professionally recognized standards of care.

2.10. Administration and Interpretation of this Policy

We have sole and exclusive discretion to interpret the Benefits provided under this Policy as well as all other provisions, terms, conditions, limitations and exclusions in the Policy and to make factual determinations related to the Policy and its Benefits. We may delegate this authority to other persons or entities to provide administrative or Benefit services with regard to this Policy. Subject to applicable law or regulation, we reserve the right to change, interpret, modify, withdraw or add Benefits or

terminate the Policy, in our sole discretion, without prior approval by you. Changes to this Policy will be valid or binding only if in writing and agreed to by an officer of QualChoice.

2.11. Pre-Authorization of Services

Pre-authorization is a determination made prior to services or supplies being provided of whether the services or supplies are Medically Necessary. We must receive sufficient clinical information to establish Medical Necessity. The Medical Necessity for an Out-of-Network Referral will include the absence of or the exhaustion of all In-Network resources. Pre-authorizations are all time-limited.

QualChoice requires that certain Covered Services be pre-authorized. The specific procedures requiring pre-authorization can change based upon new or changing medical technology. We reserve the right to modify the official listing of services requiring pre-authorization as deemed necessary. A listing of the services requiring pre-authorization is maintained on our web site at www.qualchoice.com on the Member Home Page. You may also contact our Customer Service Department to obtain a copy of the listing.

The responsibility for obtaining pre-authorization varies depending on whether you use a Network Provider or an Out-of-Network Provider. Network Providers (not including QCNN providers) are responsible for obtaining the necessary pre-authorizations. Enrollees living outside of the Service Area will be responsible for obtaining pre-authorization to receive Benefits at the In-Network level when accessing care from the QCNN. QCNN providers are not responsible for obtaining a pre-authorization for services. Out-of-Network Providers have no contractual relationship to QualChoice, and therefore are not primarily responsible for obtaining required pre-authorizations. When care is being sought from Out-of-Network Providers, you are responsible for making sure all the providers obtain the required pre-authorizations. The Out-of-Network Providers must supply the clinical information necessary for us to determine Medical Necessity. We will give no pre-authorization without the necessary clinical information.

Pre-authorization is not a guarantee of payment. Even though pre-authorized, payment may not be rendered for any service if the clinical status changed sufficiently such that the service is no longer medically appropriate. Your coverage with QualChoice must be in force on the date of service or no payment will be made. You may request a pre-review of coverage for any service by calling our Customer Service Department. Any of our pre-authorization decisions may be appealed by following the procedures in Section 7. Your physician may request an Expedited Appeal of a denial of a pre-authorization by calling the number on your QualChoice identification card if your physician believes the services are urgent due to your medical condition.

2.12. Utilization Management

We cover Medically Necessary services as described in Section 2.6. Determinations of Medical Necessity are made using QualChoice's Medical Policies. We make decisions regarding whether a particular service is or was Medically Necessary based on information provided by your Network Provider(s). When we review services after care has already been provided, we may review your medical records. A Network Provider may request the criteria or guidelines used by QualChoice in making any decision.

2.13. Case Management

We provide a Case Management program. Case Management assists Enrollees to achieve the best clinical outcomes, making the best use of the Benefits. Case Management helps with an individual's specific health care needs. Case Management involves the timely coordination of health care services. We review clinical information before we include any Enrollee in the Case Management program. We stay involved in the case until the need is resolved. Enrollees may participate in Case Management programs including programs for diabetes mellitus, transplants, oncology, and neonatology.

3. COVERED MEDICAL BENEFITS

Coverage is available for medical services or care as specified in this Section subject to the General Conditions for Payment specified in Section 2.9, Pre-Authorization of Services described in Section 2.11,

and to all other applicable conditions, limitations and exclusions of this Policy. **Consult the Benefit Summary for applicable Cost Sharing Amounts.**

3.1. Advanced Diagnostic Imaging

Advanced Diagnostic Imaging consists of the following studies (though others may be added as new studies are developed):

1. All imaging using Computerized Axial Tomography (CAT) technology;
2. All imaging using Magnetic Resonance Imaging (MRI) technology;
3. All imaging using Positron Emission Tomography (PET) technology;
4. All imaging using nuclear medicine techniques (in which a radioactive substance is administered to the patient to permit or enhance imaging, which is done at least in part with detection techniques to assess the locations at which the radioactive substance is concentrated in the body).

The following rules apply to these imaging procedures:

1. Regardless of where they are performed, they always fall under the required Cost Sharing Amounts of this Policy as set forth in the Benefit Summary; and
2. Pre-authorization may be required for any or all of these tests. The requirements for pre-authorization detailed in Section 2.11 should be referred to and followed when receiving any of the Advanced Diagnostic Imaging studies.

3.2. Ambulance Services – Transportation

We cover licensed ambulance transportation subject to all terms, conditions, exclusions and limitations as set forth in this Policy. This benefit is subject to the Cost Sharing Amounts and benefit limitations specified in the Benefit Summary, and the following criteria:

1. When an accident or other medical emergency occurs, we cover transport to the nearest hospital when Emergency care is required;
2. We cover ambulance transportation from one hospital to another hospital for one of the reasons identified below; when transportation for these listed reasons is required, it must be coordinated through the QualChoice Care Management department:
   A. To access equipment or expertise necessary for proper care;
   B. To receive a test or service which is not available at the hospital where you have been admitted and you return after the test or service is completed;
   C. To transport you from an Out-of-Network Facility to a Network Facility;
   D. To transport you directly from an acute care setting to an alternate level of care.

3.3. Complications of Pregnancy

Subject to all terms, conditions, and limitations of this Policy and subject to applicable Coinsurance and Deductible, coverage is provided for treatment of Complications of Pregnancy (as defined in Section 10) when provided by a physician.

3.4. Dental – Accidental Injury

We will provide coverage if an Enrollee has an Accidental Injury that damages a sound, natural tooth. Treatment must be authorized by QualChoice. Benefits are subject to a maximum limit per Enrollee per accident. See the Benefit Summary for the limitation. Dental services must be received from a Doctor of Dental Surgery, “D.D.S.” or a Doctor of Medical Dentistry, “D.M.D.” The damage must be severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. The Physician or dentist must certify that the injured tooth was:

1. A virgin or un-restored tooth, or
2. A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with any bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be started within three months of the original accident date and completed within 12 months of the original accident date.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities. The following limitations for treatments also apply to repair of damaged teeth:

1. Only the sound and natural tooth or teeth avulsed or extracted as a direct result of the Accidental Injury will be considered for replacement;
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based upon a Maximum Allowable Charge per tooth;
3. Double abutments are not covered;
4. Any health intervention related to dental caries or tooth decay is not covered;
5. Removal of teeth is not covered; and
6. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

3.5. Dental – Anesthesia

QualChoice will provide Benefits for anesthesia and facilities for dental procedures which would ordinarily be done under local anesthesia provided:

1. The procedure is performed in a Network Facility or a network ambulatory surgery facility; and
2. The situation meets Medical Necessity criteria, and the patient is:
    a. A child under 7 years of age who is determined by two network dentists to be unable to undergo the procedure without general anesthesia and who cannot wait until an older age for the procedure, when undergoing the procedure without general anesthesia would be possible; or
    b. A person with a serious mental health condition that prevents use of local anesthesia for the procedure; or
    c. A person with a serious physical condition making hospital care necessary for the safe performance of dental work; or
    d. A person with a significant behavioral problem (as certified by a Network Physician) which precludes safe performance of the dental work under local anesthesia.

All network requirements, Medical Necessity determinations, and such other limitations as are applied to other Covered Services will apply. Pre-authorization is required, see Section 2.11.

3.6. Dental – Oral Surgery

QualChoice will pay only for the following non-dental oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required;
2. Surgical procedures required to treat an Accidental Injury to jaws, cheeks, lips, tongue, roof and floor of the mouth. Injury to a tooth or teeth while eating is not considered an Accidental Injury; treatment of such injury will not be covered;
3. Excision of exostoses of jaws and hard palate;
4. Extraction of teeth is required because of the results from radiation or chemotherapy;
5. Frenectomy;
6. External incision and drainage of cellulitis;
7. Incision of accessory sinuses, salivary glands or ducts;
8. Certain dental services, as reflected in the Medical Policies, performed in conjunction with Medically Necessary reconstructive surgery; and
9. Dental services integral to medical services covered by the Plan.

3.7. Dental – Other

No other dental care and orthodontic services are covered.

3.8. Diabetes Management

Coverage is provided for medically necessary equipment, supplies, and services for diabetes when prescribed by a physician. Diabetes self-management training is limited to one program per lifetime

per Enrollee. If there is a significant change in the Enrollee's symptoms or condition making it necessary to change the Enrollee's diabetic management process, we may authorize additional training if prescribed by a physician. Covered Services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education developed by the American Diabetes Association (ADA). A licensed provider certified by the ADA must provide the training.

3.9. Durable Medical Equipment

Durable Medical Equipment (DME) is subject to Medical Necessity and appropriateness review. We will not cover DME if primarily used for the convenience of the Enrollee or any other person. DME is equipment serving a medical purpose, is non-disposable, can withstand repeated use, is appropriate for use in the home, and is generally not useful in the absence of the illness or injury for which it is used.

All DME services must be obtained through a Network Provider. All DME remains the property of QualChoice or a Network Provider. When it is more cost effective, we will purchase rather than lease equipment. The amount paid for leasing a DME item will not exceed the Maximum Allowable Charge for purchase. We retain the right to recover any equipment purchased by us for the use of the Enrollee upon cancellation or termination of coverage for the Enrollee. Delivery or set up charges are included in the Maximum Allowable Charge for the DME.

Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Enrollee.

The definition and description of coverage for orthotics and prosthetic devices and services are in Sections 3.21 and 3.26 below.

Important Note: DME dispensed by a physician in an office setting and billed by a DME provider must be provided through a DME Network Provider. It is your responsibility to confirm this with the physician. If DME dispensed by the physician is not from a DME Network Provider, a prescription may be obtained from the physician for the DME followed by contact with us to assist in obtaining the equipment. Failure to insure all DME is obtained from a DME Network Provider will result in denial of Benefits.

3.10. Emergency Health Services

We cover emergency room services that meet the definition of "Emergency" as set out in Section 10.

1. **Emergency Care within the Service Area:** An Enrollee is encouraged to seek care from a Network Provider in the event of an Emergency (as defined in Section 10) whenever possible. However, if in an Emergency an Enrollee is unable to access a Network Provider, the Enrollee should go to the nearest urgent or emergent care facility. Services provided in an Emergency are paid as shown in your Benefits Summary.
2. **Emergency Care outside of the Service Area:** Services provided in an Emergency when you are outside of the Service Area, but within the United Sates are paid as shown in your Benefits Summary. Your QualChoice identification card provides a toll-free telephone number to call for a listing of healthcare providers in the QualChoice National Network (QCNN). QualChoice encourages you to seek treatment whenever possible from a healthcare provider in the QCNN.

If an Enrollee obtains services in an emergency room when the circumstances were not an Emergency, it will result in a denial of Benefits for the services provided. You have access to our "Ask a Nurse" assistance line at any time by calling (866) 232-0447.

IMPORTANT IN THE EVENT OF AN ADMISSION AT AN OUT-OF-NETWORK FACILITY: If treatment of an Emergency is sought at an Out-of-Network Emergency Room, *you, a family member or the hospital must notify our Care Management Department once you are stabilized, but in no event more than forty-eight (48) hours after initial treatment, if further care or inpatient admission is needed*. Failure to notify us within the specified 48 hour time requirement may result in a denial of benefits. Upon receipt of such notification we may either authorize the admission to, or further treatment at, the

Out-of-Network Facility, or coordinate appropriate transfer to a Network Facility through communication with the Out-of-Network Facility, the admitting physician, and the Enrollee's Network Provider. If you stay at the Out-of-Network Facility beyond the period for which we have determined further treatment is considered Medically Necessary, you will be responsible for all charges billed by the hospital and other providers providing the care.

3.11. Eye Examinations

Eye Examinations for active illness or injury that are received from a health care provider in the provider's office are a Covered Service.

3.12. Family Planning Services

Coverage is provided for the following family planning services:

1. Oral contraceptives and prescription barrier methods are only covered when a prescription drug rider has been purchased through QualChoice; coverage is subject to all of the terms, conditions, limitations, and exclusions of the prescription drug rider;
2. Voluntary sterilizations (vasectomies and tubal ligations) are covered except as excluded in Section 4; and
3. Long acting reversible contraceptives, including hormonal implantable systems and intrauterine contraceptives, are covered as a medical benefit.

Reversal of a voluntary sterilization is a specific exclusion.

3.13. Home Health Services

Coverage is available for the following services provided in the home when the medical condition supports the need for such services, the services are ordered by a Physician, and the services are pre-authorized by QualChoice.

We count each visit by a member of a home care team as one home care visit. We count up to four hours of home health nurse/aide service as one home care visit. (See the Benefit Summary for visit limitation details.)

The following services provided by a licensed home health agency in the home are Covered Services:

1. Intermittent skilled nursing care by a registered nurse or a licensed practical nurse. A service will not be determined to be "skilled" simply because there is not an available caregiver in the Enrollee's home; skilled nursing care provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse is not Custodial Care;
2. Physical, occupational and speech therapy services; and
3. Medical supplies provided by a home health agency during the course of approved care.

3.14. Home Infusion Therapy

The benefit for medications received from licensed specialty pharmacy or a licensed retail pharmacy designated by QualChoice as a home infusion therapy provider is covered based upon obtaining pre-authorization and upon the Maximum Allowable Charge for the medication.

1. Covered Medication: A home infusion therapy medication is covered as a medical benefit (as opposed to a prescription drug benefit) and is subject to Co-payment (if applicable) and/or Deductible and Coinsurance.
2. FDA approved medications that exist as separate components are intended for reconstitution prior to administration are covered. Examples include, but are not limited to, total parental, intravenous antibiotics, and hydration therapy and specialty infusions.
3. Medical supplies used in conjunction with home infusion therapy are covered if the home infusion is approved.

When home infusion therapy services are provided separately from home health services, then the home infusion therapy service does not apply to the home health benefit.

3.15. Hospice Care Services

Hospice care must be pre-authorized and arranged by a QualChoice Case Manager. Consult the Benefit Summary for applicable Cost Sharing Amount. In addition, coverage is available for an

Enrollee with a life expectancy of six months or less. Care must be provided by a hospice possessing all licenses, certifications, permits and approvals required by applicable federal, state and local law.

The following services, when ordered by a physician, are covered during the period when the hospice has admitted an Enrollee to its program:

1. Inpatient care in a freestanding hospice, a hospice unit within a hospital or skilled nursing facility or in an acute care hospital bed;
2. Home care services provided by the hospice either directly or under arrangements with other licensed providers, including but not limited to, the following:
   A. Intermittent nursing care by registered nurses, licensed practical nurses, or home health aides;
   B. Respiratory therapy;
   C. Social services;
   D. Nutritional services;
   E. Laboratory examinations;
   F. Chemotherapy and radiation therapy when required for control of symptoms;
   G. Medical supplies; and
   H. Medical care provided by a physician.

3.16. Facility – Inpatient Care

Inpatient hospital care Benefits are available for services and supplies received during the hospital stay and room and board in a semi-private room (a room with two or more beds). We will not pay for any hospital services unless the service is provided by an employee of the hospital, the hospital bills for the service, the service is not primarily for convenience and the hospital retains the payment collected for the service.

Facility inpatient care is also subject to the following conditions:

1. We cover Medically Necessary acute inpatient hospital care for the care or treatment of your condition, illness, or injury;
2. The services of social workers and discharge planners shall be included in the basic daily room and board allowance;
3. Coverage is provided for a minimum of forty-eight (48) hours for an in-patient stay related to a mastectomy;
4. We do not provide Benefits while you are waiting for Custodial Care;
5. We do not provide Benefits while waiting for a preferred bed, room, or facility;
6. The following applies when an Enrollee is waiting for transfer from an acute facility to another facility for continuing care (e.g., nursing home, rehabilitation facility, skilled nursing facility, and long term acute care facility):
   A. The acute facility that the Enrollee is in awaiting a transfer should provide care equivalent to the care provided by the facility to which the Enrollee is waiting to be transferred;
   B. The days an Enrollee spends in the acute facility waiting for a transfer may count toward the limits for sub-acute and rehabilitation Benefits;
   C. We will pay the acute facility the Enrollee is in awaiting a transfer the lesser of that acute facility's rate or the rate at the facility to which the Enrollee is being transferred; as demonstrated in Section 2.5 above, this could have a significant financial impact on you if the acute facility the Enrollee is in while waiting to be transferred is an Out-of-Network Facility;
   D. If the acute facility the Enrollee is in awaiting a transfer is not providing the care we expect, we will deny those days and make no payment; as demonstrated in Section 2.5 above, this could have a significant financial impact on you if the acute facility the Enrollee is in while waiting to be transferred is an Out-of-Network Provider.
7. Services rendered in a facility in a country outside of the United States of America shall not be paid except at the sole discretion of QualChoice.
8. Services to Out-of-Network Facilities are subject to pre-admission notification as described in Section 2.11. Please call the number listed on your identification card to notify us of the admission.

3.17. Injectable Prescription Medications

Benefits are available for Injectable Prescription Medication(s) received in a physician's office based upon the Maximum Allowable Charge for the Injectable Prescription Medication and subject to the applicable Cost Sharing Amounts specified in the Benefit Summary for other services provided in the physician's office. Benefits are available for Injectable Prescription Medications for self-administration through a prescription drug rider available from QualChoice. Injectable Prescription Medications that an Enrollee has the ability to self-administer may be obtained with direct delivery to the Enrollee's home. Our Care Management staff will assist Enrollees in coordinating this service.

3.18. Infertility

Limited diagnostic work-up for infertility is covered. This is designed to screen for basic problems that might cause infertility. Any other services required for the diagnosis or treatment of infertility or of any associated disease whose primary manifestation is infertility are not covered. You may contact us to obtain specific coverage guidelines.

3.19. Medical Foods

Medical foods and low protein modified food products for the therapeutic treatment of a person inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism are covered if:

1. The medical food or low protein modified food products are prescribed by a physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Network Physician; and
3. The cost of the medical food or low protein modified food products for an individual exceeds $2,400 per year per person, that is to say, the covered amount will be the incurred cost of medical food or low protein modified food products that is in excess of the $2,400 per year per person.

3.20. Medical Supplies

Subject to all terms, conditions, exclusions and limitations of this Policy, Medical Supplies, other than Medical Supplies that can be purchased without a prescription, are covered when prescribed by a physician and when Medically Necessary. The following conditions will also apply to coverage for Medical Supplies:

1. Coverage for Medical Supplies provided in a physician's office is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used;
2. Coverage for Medical Supplies is limited to a 31-day supply per month;
3. Coverage for Medical Supplies used in connection with Durable Medical Supplies is subject to the Cost Sharing Amounts and DME benefit limitations specified in the Benefit Summary; and
4. Coverage for Medical Supplies provided in connection with home infusion therapy is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used.

3.21. Orthotic Services and Orthotic Devices

Orthotic services and orthotic devices (as defined in this Section) are covered as described below.

All "orthotic devices" and "orthotic services", including the fitting and/or repair of orthotic devices, require pre-authorization as described in Section 2.11.

An "orthotic service" is an evaluation and treatment of a condition that requires the use of an "orthotic device".

In order for a device to be an "orthotic device" under this Policy, the device must meet all three (3) of the following requirements:

1. The external device is (i) Intended to restore physiological function or cosmesis to a patient; and (ii) Custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

An orthotic device does *not* include a/an (i) cane, (ii) crutch, (iii) corset, (iv) dental appliance, (v) elastic hose, (vi) elastic support, (vii) fabric support, (viii) generic arch support, (ix) low-temperature plastic splint, (x) soft cervical collar, (xi) truss, or (xii) any similar device meeting both of the following requirements:

1. It is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
2. It has no significant impact on the neuromuscular, musculoskeletal or neuromusculoskeletal functions of the body.

An orthotic device also does *not* include foot orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain. This applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, are mainly protective in nature, and/or combine functional control and protection. This also applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.

Coverage for orthotic devices and orthotic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of an orthotic device or associated orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Policy. However, QualChoice will replace or repair an orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.22. Outpatient Services

1. **Outpatient Facility Services:** Covered outpatient services shall include the following services provided in a licensed outpatient facility or at a hospital outpatient department: diagnostic services, radiation therapy, chemotherapy, x-ray services, laboratory services, surgical services, physical, occupational and speech therapy services, audiology services and renal dialysis. We also cover up to 24 hours of outpatient observation for the purpose of extended recovery from a surgical or invasive procedure or for evaluation of the possible need for inpatient admission.

2. **Outpatient Surgery:** Coverage is provided for outpatient surgical services received from an ambulatory surgery center or in an outpatient hospital setting when performed or prescribed by a physician. Covered Services include diagnostic imaging and laboratory services required to augment surgical services and performed on the same day as such surgical service. If an Out-of-Network Facility or ambulatory surgery center not contracted with QualChoice is used, payment will be limited to the Maximum Allowable Charge for the service.

3.23. Physician Office Services

The diagnosis and treatment of an illness or Accidental Injury is a Covered Service when provided in a medical office, subject to the Cost Sharing Amounts set forth in your Benefits Summary.

3.24. Preventive and Wellness Health Services

We cover those services that are recognized and defined by QualChoice's Medical Policies as being preventive and/or wellness in nature. Subject to changes QualChoice may make to its Medical Policies, a partial listing of those services QualChoice considers to be preventive and/or wellness health services is included with your Benefits Summary. The most complete list of those services QualChoice considers being preventive and/or wellness health services are available on our website www.qualchoice.com (Preventive Health Benefit) or you may contact our Customer Service Department to obtain specific coverage guidelines.

3.25. Professional Services for Complex Surgery

We cover complex surgeries subject to the limitations described below including application of all Cost Sharing Amounts and other limitations as set forth in this Policy and related Benefits Summary.

The Benefit amount payable for a complex surgery includes payment for related or follow-up care by the surgeon before and after the operation. In other words, the one payment covers the operation and the surgeon's care after the operation. Payment for surgery is subject to the following limitations:

1. When multiple or bilateral surgical procedures are performed in the same operative session, whether through one or more incisions, we will cover the major or first procedure and, in addition, we will cover one-half of the Maximum Allowable Charge of the lesser or subsequent procedure(s).
2. When an incidental procedure, including, but not limited to, incidental appendectomy, treatment of adhesions, excision of previous scar, or puncture of ovarian cyst, is performed through the same incision, we will only pay for the major procedure;
3. When the physician performs an operative procedure in two or more stages, the total payment for the combination of steps or stages making up the entire procedure will be limited to the Maximum Allowable Charge that we would have paid if the physician had not performed it in multiple steps or stages;
4. Not all surgeries require an assistant surgeon; we will pay for one assistant surgeon who is a physician qualified to act as an assistant for the surgical procedure when Medically Necessary;
5. We will cover a standby physician only if that physician is required to assist with certain high-risk deliveries identified by us and only if that physician is in the immediate proximity to the Enrollee during the standby period.

3.26. Prosthetic Services and Prosthetic Devices

Prosthetic services and prosthetic devices (as defined in this Section) are covered as described below.

All "prosthetic devices" and "prosthetic services", including the fitting and/or repair of prosthetic devices, require pre-authorization as described in Section 2.11.

A "prosthetic service" is an evaluation and treatment of a condition that requires the use of a "prosthetic device".

In order for a device to be a "prosthetic device" under this Policy, the device must meet all three (3) of the following requirements:

1. The device is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

A prosthetic device includes a breast prosthesis to the extent required pursuant to the Women's Health and Cancer Rights Act of 1998.

A prosthetic device does *not* include a/an (i) artificial eye, (ii) artificial ear, (iii) dental appliance (which would include corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome), (iv) cosmetic device such as artificial eyelashes or wigs, (v) device used exclusively for athletic purposes, (vi) artificial facial device, or (vii) any other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

Coverage for prosthetic devices and prosthetic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of a prosthetic device or associated prosthetic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Policy. However, QualChoice will replace or repair a prosthetic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.27. Reconstructive Surgery

We cover services in connection with reconstructive surgery if necessary to restore the part of the body injured or deformed by acute trauma, infection or cancer subject to the following:

1. Restoration must be aimed at restoration of function, not just restoration of appearance;
2. Restoration is intended to achieve an average person's normal function (for example, restoration aimed at athletic performance is *not* covered);
3. The reconstructive surgery is necessary to correct congenital malformations or anomalies resulting in a severe functional impairment of a Child covered under this Policy.

Coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by a physician:

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

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

3.28. Skilled Nursing Facility and Inpatient Rehabilitation Services

Coverage is available for Medically Necessary care in a skilled nursing facility or acute inpatient rehabilitation facility when provided immediately after hospitalization in an acute care general hospital for a covered illness or injury. Care will be limited to the number of covered days provided by the Policy and must meet the Medically Necessary criteria of continued improvement. See the Benefit Summary for details.

3.29. Therapeutic and Rehabilitation Services

Services for outpatient physical, occupational or speech therapy and chiropractic, audiology or pulmonary rehabilitation are covered. This includes services performed in the office of a physician, chiropractor or therapist, outpatient therapy center, or in the outpatient department of a hospital. Refer to the Benefit Summary and Section 4 for specific limits. Cardiac rehabilitation services are covered separately and are not subject to this limitation. Please note that Benefits are available only for services that are expected to result in a significant improvement in the Enrollee's condition within two months of the start of the treatment.

3.30. Transplantation Services

Transplant Benefits are available subject to the general conditions for payment specified in Section 4, and to all other applicable conditions, limitations and exclusions of this Policy. Consult the Benefit Summary for applicable Cost Sharing Amounts and other limitation amounts.

1. **Pre-Authorization Required:** ***You or an authorized representative must call the number on your ID card to obtain pre-authorization before the evaluation for transplant and placement on any transplant list.*** Once the evaluation is complete, an additional pre-authorization must be obtained for the transplant procedure. We will coordinate all transplant services, including evaluation and transplant. Failure to coordinate all transplant related services with us, or failure to comply with pre-authorization procedures, may result in non-payment of these services.
2. **Transplant Standards:** We cover transplant procedures under the standards set out by the Policy and are as follows:
   A. **General Description of Transplant Covered Services:** We will cover any hospital, medical, surgical, and other service related to the transplant, including blood and blood plasma. **We only cover transplants and transplant related services performed at a transplant center approved by us.**
   B. **Facility Care:** We cover all inpatient and outpatient care at a designated transplant center. When we authorize the transplant to occur at an Out-of-Network facility, we may require Network Physicians at a Network Facility to provide some follow-up care.
   C. **Organ Procurement:** We will pay for services directly related to organ procurement including tissue typing, surgical extraction and storage and transportation costs of the organ or other human tissue used in a covered transplant procedure. (If the donor has other insurance, we must receive an explanation of benefits from the donor's health policy indicating coverage or denial for the donation.) Please refer to the Benefit Summary for Cost Sharing Amounts and lifetime maximums.
3. **Bone Marrow Transplantation:** Bone marrow transplantation is only covered for specific indications listed below. This limitation applies to the bone marrow transplantation and any related procedure including High Dose Chemotherapy. The limitation applies to transplants of bone marrow or of peripheral blood cells intended to reconstitute the marrow. Covered diseases are:
   A. Aplastic anemia
   B. Wiscott-Aldrich syndrome
   C. Albers-Schonberg syndrome
   D. Thalassemia major
   E. Myelodysplastic syndromes – primary and acquired
   F. Immunodeficiency syndrome
   G. Non-Hodgkin's lymphoma, intermediate or high grade, stage III or IV
   H. Hodgkin's disease, stage IIIA or IIIB, or stage IVA or IVB
   I. Neuroblastoma, stage III or IV
   J. Chronic myelogenous blast leukemia in blast crisis or chronic phase
   K. Chronic myelogenous leukemia in the chronic phase

L. Multiple myeloma
M. Acute lymphocytic or myelocytic leukemia in patients who are in remission but at high risk for relapse

4. **Cornea Transplantation:** Cornea transplantation is covered subject to all terms, limitations and exclusions as set forth in this Policy. Cornea transplantation does not require pre-authorization.

This Policy requires specific donor matches for certain procedures.

4. NON-COVERED SERVICES, EXCLUSIONS AND LIMITATIONS

Some services, treatments, medications and supplies are not covered. Others have limitations on coverage. This Section describes those exclusions and limitations. QualChoice may choose to eliminate an exclusion or limitation if advances in medical care warrant making such a change. One or more of our optional coverage riders may cover some of these items. If you purchase any riders, they are included as part of this Policy. Please refer to the Benefit Summary for additional exclusions and limitations on Covered Services. QualChoice may provide very limited coverage for some services that are otherwise excluded or limited by this Section 4 strictly for preventive health purposes; where applicable, these limited coverages are identified and described in QualChoice's Preventive Health Benefit Medical Policy.

4.1. Exclusions From Coverage

1. **Acupuncture:** Acupuncture services for pain therapy are not covered.
2. **Admission to a Facility before Becoming Covered under This Policy:** We will not cover an inpatient admission commencing before the Effective Date of this Policy. We will not cover any portion of the facility or medical services related to the stay. This applies to admissions to an acute hospital, sub-acute hospital, skilled nursing facility, rehabilitation unit, or any other inpatient facility.
3. **Abortion:** We do not cover elective abortion. We do not cover medical services, supplies or treatment the primary purpose of which is to cause an elective abortion. We do not cover any services, supplies or treatment provided as a result of such an abortion.
4. **Adoption and Surrogate Parenting:** We will not cover services, supplies, treatment, or other costs relating to the care of the biological mother of an adopted child. Maternity charges incurred by an Enrollee acting as a surrogate mother are not covered charges.
5. **After Hours or Weekend Charges:** We will not cover any extra charges related to the time of day or day of the week on which services were rendered.
6. **Against Medical Advice:** We will not cover any services related to an inpatient admission, observation admission, or emergency room visit resulting in the Enrollee's discharge against medical advice. We will not cover any services required for complications resulting from the Enrollee's discharge against medical advice.
7. **Alternative or Complementary Medicine:** We will not cover devices or services relating to alternative systems of medical practice such as, but not limited to, the following:
   A. Acupuncture
   B. Homeopathy or Naturopathy;
   C. Bioelectromagnetic care;
   D. Herbal medicine;
   E. Hippo therapy (equine therapy);
   F. Hypnotherapy (see mental health coverage);
   G. Aromatherapy;
   H. Reflexology;
   I. Mind/body control such as dance or prayer therapies;
   J. Pharmacological and biological therapy not accepted by mainstream medical practitioners such as chelation therapy or metabolic therapy.

8. **Blood:** We do not provide Benefits for blood, blood plasma or blood derivatives. We do not cover fees for voluntary blood donation or storage of blood products. We do cover the charges for the administration of blood or blood products.

9. **Blood Donation:** We do not cover directed blood donations. We do not cover donations for specified recipients, you or another, regardless of donor or anticipated date of use. We do not pay for procurement, storage, or administration of such donated blood. We do not pay for any extra charges associated with designated blood donation.
10. **Blood Typing:** Blood typing or DNA analysis for paternity testing is not covered.
11. **Care Plan Oversight:** Multi-disciplinary team conferences as well as any other kind of team conferences are not covered.
12. **Care Provided By a Relative by Blood or Marriage:** We will not cover care provided by an individual who normally resides in your household. We also will not cover care provided by you or by your parents, siblings, spouses, children, grandparents, aunts, uncles, nieces and nephews or other relatives by blood or marriage.
13. **Care Rendered in Certain Non-Facility Institutions:** We will not pay for care in hospitals or other facilities not licensed as short-term acute care general hospitals or skilled nursing facilities. Examples are:
    A. Convalescent homes or similar institutions;
    B. An institution primarily for Custodial Care, rest or domicile;
    C. Residential care or treatment facilities;
    D. Health resorts, camps, safe houses, spas, sanitariums, schools, or tuberculosis hospitals;
    E. Infirmaries at camps or schools;
    F. Facilities for treatment of mental illness and substance abuse;
    G. Rehabilitation facilities and rehabilitation units in other facilities (except as covered under Section 3.29);
    H. Skilled nursing facilities and places primarily for nursing care (except as covered under Section 3.28);
    I. Freestanding cardiac care facilities;
    J. Sleep study centers;
    K. Extended care, chronic care, or transitional hospitals or facilities (except as covered under Section 3.29 and 3.30); or
    L. Other facilities and institutions, which do not meet our criteria for short-term acute care general hospitals or skilled nursing facilities
14. **Cerebellar Stimulator or Pacemaker:** Cerebellar stimulator or pacemaker for the treatment of neurological disease is not covered.
15. **Cervicography:** Cervicography is not covered.
16. **Charges In Excess Of Calendar Year or Lifetime Maximums:** We will not cover any service, supply or treatment in excess of the Calendar Year or lifetime maximum as shown on the Benefit Summary.
17. **Charges for Missed/Canceled Appointments:** We will not pay for charges resulting from the Enrollee's failure to keep scheduled appointments.
18. **Chelation Therapy:** Services or supplies provided as, or in conjunction with, chelation therapy are not covered, except for treatment of acute heavy metal poisoning.
19. **Cognitive Rehabilitation:** Services and supplies provided as part of cognitive rehabilitation are not covered.
20. **Complications:** We will not cover medical or surgical complications resulting from a non-Covered Service. We will not cover medical or surgical complications as a direct or closely related result of the Enrollee's refusal to accept treatment, medicines, or a course of treatment recommended by a provider.
21. **Contraceptive Devices or Supplies:** Contraceptive devices or supplies available over-the–counter (without a prescription) are not covered.
22. **Convenience Items or Services:** We will not cover items or services utilized primarily for an Enrollee's convenience or the convenience of a family member, caregiver or provider. Such items include, but are not limited to: cot, telephone, television rental charges in a hospital, whirlpool baths, automobile or van conversions, motor scooters, air purifiers, exercise equipment, machines used for communication and speech, lifts, and home modifications.
23. **Cosmetic or Reconstructive Surgery:** We will not pay for any procedures, services, equipment or supplies provided in connection with elective cosmetic surgery or complications arising from a cosmetic surgery even if coverage was provided by another health plan.

Cosmetic surgery is intended primarily to improve appearance or have a psychological benefit.

24. **Cranial Electrotherapy Stimulation Devices**: Cranial electrotherapy stimulation devices are not covered.
25. **Current Perception Threshold Testing**: Current perception threshold testing is not covered.
26. **Custodial Care:** We do not cover any service which is custodial in nature. We consider care custodial in nature when it is primarily for meeting personal needs. Persons without professional skills or training can provide Custodial Care. For example, Custodial Care includes assistance in activities of daily living (walking, getting in and out of bed, bathing, dressing, eating and taking medication). Custodial care also includes medical services not seeking to cure or improve the patient. They may be provided during periods when the medical condition of the patient is not changing. They generally do not require continued administration by trained medical personnel. Examples include long-term maintenance activities such as dressing changes, tube feeding or range of motion exercises. Non-covered Custodial Care may be rendered in a hospital, domiciliary facility, nursing home, skilled nursing facility, or home. Non-covered Custodial Care may be residential care, respite care, private duty nursing, or any other service custodial in nature.
27. **Dental Care:** This Policy does not provide Benefits for dental care. Except as otherwise stated in this Policy, we do not cover:
    A. Treatment of cavities;
    B. Tooth extractions;
    C. Care of the gums;
    D. Care of the bones supporting the teeth;
    E. Treatment of periodontal disease;
    F. Treatment of dental abscess;
    G. Treatment of dentigerous cysts;
    H. Removal of soft tissue supporting or surrounding teeth;
    I. Orthodontia (including braces);
    J. False teeth;
    K. Orthognathic surgery; or
    L. Any other dental services you may receive.
28. **Dental Implants:** Dental implants of titanium osseointegrated fixtures or of any other material are not covered.
29. **Dermatomal Somatosensory Evoked Potentials:** Dermatomal somatosensory evoked potential testing is not covered.
30. **Developmental Delay:** Services or supplies provided for developmental delay, including learning disabilities, communication delay, perceptual disorder, sensory deficit and motor dysfunctions are not covered.
31. **Dexamethasone Infusion:** Dexamethasone infusion is not covered.
32. **Dietary and Nutritional Services:** Unless such dietary supplies are the sole source of nutrition for the Enrollee, any services or supplies provided for dietary or nutritional services, including but not limited to medical nutrition therapy, are not covered. Baby formulas or thickening agents, whether prescribed by a Physician or acquired over the counter, are not a covered benefit.
33. **Donor Expenses For Transplant:** Services and supplies associated with an organ and tissue transplant where the Enrollee is the donor are not covered.
34. **Dynamic Orthotic Cranioplasty:** Dynamic orthotic cranioplasty is not covered.
35. **Electrogastrography:** Electrogastrography is not covered.
36. **Electron Beam Computed Tomography:** Electron beam computed tomography is not covered.
37. **Environmental Intervention:** Services or supplies used in adjusting an Enrollee's home, place of employment or other environment so that it meets the Enrollee's physical or psychological condition are not covered.

38. **Enteral Feedings:** Enteral feedings are not covered except when approved by us and documented to be the Enrollee's sole source of nutrition, subject to all other terms, conditions, and limitations of this Policy.
39. **Excessive Use:** Excessive use of medications is not covered. For purposes of this exclusion, each Enrollee agrees that QualChoice shall be entitled to deny coverage of medications under a prescription drug rider or this Policy, on grounds of excessive use when our medical director, in his sole discretion, determines (1) that an Enrollee has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard reference compendia or by the Pharmacy & Therapeutics Committee; or (2) that an Enrollee has obtained or attempted to obtain the same medication from more than one Physician for the same or overlapping periods of time; or (3) that the pattern of prescription medication purchases, changes of Physicians or pharmacy or other information indicates that an Enrollee has obtained or sought to obtain excessive quantities of medications. Each Enrollee hereby authorizes QualChoice to communicate with any physician, health care provider or pharmacy for the purpose of reviewing and discussing the Enrollee's prescription history, use or activity to evaluate for excessive use.
40. **Exercise Programs:** Exercise programs for treatment of any condition are not covered. Examples would be gym memberships, personal trainers, and home exercise equipment, even if recommended or prescribed by a Physician.
41. **Experimental or Investigational Procedures and Related Equipment and Supplies:** We will not cover any procedure or service we consider to be experimental or investigational. We also will not pay for equipment or supplies related to such procedures. We base decisions on what is experimental or investigational on unbiased technology reviews and national scientific, peer-reviewed medical literature. Any therapy subject to government agency approval must have received final approval before we consider it for coverage. A new treatment with no outcome advantage over existing treatments may be considered investigational while studies are in progress to determine if any treatment advantage exists in any subpopulation of the affected group.
42. **Extracorporeal Shock Wave Therapy:** Extracorporeal shock wave therapy (ESWT) for any musculoskeletal condition, including but not limited to plantar fasciitis or tennis elbow, is not covered.
43. **Eyeglasses:** Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contacts except for the initial acquisition following cataract surgery as specified in Section 4.1.
44. **First Aid Supplies:** We will not cover over the counter first aid supplies.
45. **Foot Care:** Services or supplies for palliative or cosmetic foot care or for flat foot conditions are not covered. This includes but is not limited to supporting devices for the foot such as shoe inserts, elastic stockings, Jobst stockings, the treatment of subluxations of the foot, arthroeresis for flat feet, care of corns, bunions, calluses, routine trimming of toe nails, fallen arches, weak feet and chronic foot strain. However, subject to all terms, conditions, exclusions and limitations as set forth in this Policy, foot care is provided when required for prevention of complications associated with diabetes mellitus or other peripheral sensory neuropathy.
46. **Formula:** Baby formula and thickening agents, even if prescribed by a physician or acquired over-the-counter are not covered.
47. **Fraud or Misrepresentation:** Health interventions or health services, including but not limited to medications obtained by unauthorized or fraudulent use of an Enrollee's identification card or by material misrepresentation as part of the enrollment process or at other times, are not covered.
48. **Free Care:** We will not cover any care if there was no charge for the care. This applies even if you, or your provider thought the services were not covered by insurance when the provider chose not to charge for the care.

49. **Government Programs:** We will not pay for Covered Services to the extent benefits for such services are payable under Medicare or any other federal, state or local government program.
50. **Hair Loss or Growth:** Wigs, hair transplants or, unless specifically covered in a prescription drug rider issued to you by us, any medication that is taken for hair growth even if prescribed by a Physician, are not covered regardless of the cause of hair loss. Treatment of male or female pattern baldness is not covered.
51. **Health and Behavior Assessment:** Evaluation of psychosocial factors potentially impacting physical health problems and treatments are not covered. This includes health and behavior assessment procedures used to identify psychological, behavior, emotional, cognitive, and social factors affecting physical health problems.
52. **Hearing or Talking Aids:** Regardless of the reason for the hearing or speech disability, hearing aids, prosthetic devices to assist hearing, or talking devices, including special computers, are not covered. Fitting or repair of such devices is not covered. Nor are cochlear implants, or its associated speech processor, or auditory brain stem implants covered.
53. **Heat Bandage:** Treatment of a wound with a warm-up active wound therapy device or a non-contact radiant heat bandage is not covered.
54. **High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation:** High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation are not covered, except in the circumstances set forth in Section 3.30.
55. **High Frequency Chest Wall Oscillators:** High frequency chest wall oscillators that are used to provide airflow to the lungs are not covered.
56. **Home Uterine Activity Monitor:** Home uterine activity monitors or their use is not covered.
57. **Illegal Acts:** We will not cover health care services resulting from an Enrollee's participation in an illegal act or being engaged in an illegal occupation, whether or not convicted, riot or insurrection except as required by law.
58. **Illegal Uses:** Medications, drugs or substances that are illegal to dispense, possess, consume or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner, are not covered. Complications or an Accidental Injury from illegal drug use or while driving under the influence of alcohol determined to be in excess of legal limits, are not covered.
59. **Impotence or Sexual Dysfunction:** We will not cover medical, surgical, or pharmacological treatment for impotence, frigidity, or other sexual dysfunction unless such dysfunction is the result of diabetic neuropathy, spinal cord injury or prostate surgery.
60. **Immunizations**: Immunizations for travel, school, work or recreation are not covered.
61. **Insulin Pump for Diabetes Mellitus:** We do not cover insulin pumps for diabetes mellitus.
62. **Infertility Treatment:** We will cover a basic diagnostic work-up to make an initial diagnosis of infertility. We will not cover any medications (unless specifically covered in a prescription drug rider issued to you by us), procedures, or other services for treatment of infertility. It does not matter if the infertility service is therapeutic, it is still not covered. It does not matter whether the infertility service or treatment is by natural, artificial, mechanical, pharmacological, or other means, it is still not covered. Specific services that are not covered include, but are not limited to:
    A. Reversal of sterilization
    B. Pre-implantation testing and/or artificial insemination
    C. Surrogate pregnancies
    D. Medical treatment of infertility
    E. Surgical treatment of infertility
    F. In vitro fertilization

    Note: We will not pay for surgery that is done primarily for infertility treatment even when other diseases or conditions that may be the underlying medical condition causing the infertility are detected or treated during such surgery.
63. **Inotropic Agents for Congestive Heart Failure:** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. However, subject to all terms, conditions, exclusions and limitations set forth in this Policy, where the

Enrollee is on a cardiac transplant list at a hospital where there is an ongoing cardiac transplantation program, the Policy will cover infusion of inotropic agents.

64. **Instructional Programs:** We will not pay for instructional or educational testing, programs, seminars or workshops such as, but not limited to, childbirth classes, vocational training or testing, diet programs, nutritional programs, smoking cessation classes, educational or neuroeducational testing, or general or remedial education classes. Diabetic education is covered as set forth in Section 3.8.
65. **Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders:** Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.
66. **Learning Disabilities:** Services or supplies provided for learning disabilities, i.e. reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty and other learning difficulties, are not covered.
67. **Lost Medications:** Replacement of previously filled prescription medications because the initial prescription medication was lost, stolen, spilled, contaminated, etc. are not covered.
68. **Magnetic Innervation Therapy:** Extracorporeal magnetic innervation therapy for the treatment of urinary incontinence is not covered.
69. **Maintenance Therapy:** We will not cover maintenance therapy for chiropractic therapy, physical therapy, occupational therapy, recreational therapy, or speech therapy.
70. **Mammoplasty:** Except as provided in Section 3.27, we do not cover mammoplasty for reasons of augmentation, reduction or asymmetry of the breasts. We do not cover removal of breast implants placed or removed for cosmetic purposes.
71. **Mandated or Court Ordered Care:** We will not cover any medical, psychological, or psychiatric care which is the result of a court order or otherwise mandated by a third party (such as, but not limited to, an employer, licensing board, recreation council, or school).
72. **Maternity Care and Obstetrical Care:** We do not cover services or supplies for Maternity Care and Obstetrical Care.
73. **Medical Reports:** We will not cover expenses for medical report preparation and presentation. We will not pay for provider appearances at hearings and court proceedings. We will not pay for charges for the completion of insurance forms, or the preparation or copying of medical records.
74. **Medical/Surgical Services or Supplies for Control of Obesity or Morbid Obesity:** We will not cover any surgery, medical services or supplies intended for control of either obesity or morbid obesity even if the obesity or morbid obesity aggravates another condition or illness. This would include services such as dietary control, medications (unless specifically covered in a prescription drug rider issued to you by us), counseling or weight maintenance programs, gastric stapling, gastric bypass or any other service intended to control obesity. We do not cover surgical or medical procedures to treat the complications or consequences of weight loss, such as abdominoplasty or panniculectomy.
75. **Medication Therapy Management Services:** Medication therapy management services by a pharmacist, including but not limited to a review of an Enrollee's history and medical profile, an evaluation of prescription medication, over-the-counter medications and herbal medications, are not covered.
76. **Meniscal Allograft Transplantation:** Meniscal allograft transplantation is not covered.
77. **Mental Health or Substance Abuse:** Unless a Mental Health and/or Substance Abuse Rider accompanies this Policy, mental health, substance abuse, and chemical dependency treatment and related services and supplies are not covered, including, but not limited to, the following conditions and treatments:
    A. Sexual and gender identity disorders;
    B. Treatment for smoking or nicotine addiction;
    C. Services provided for treatment of adolescent behavior or conduct disorders, oppositional disorders, or neuroeducational testing;
    D. Outpatient psychotherapy or counseling for personal growth or life and social enrichment;
    E. Group therapy or group counseling at any time in any setting by any provider;
    F. Psychiatric conditions and substance abuse, including alcohol;
    G. Detoxification from abusive chemical or substance abuse;
    H. Medication supporting an addiction or substance dependency;

I. Seasonal Affective Disorder (SAD) treatment;
J. Educational services of any type for any reason;
K. Marriage and family therapy or counseling services; and
L. Services rendered by an Out-of-Network Provider.

78. **Non-Compliance with Recommended Treatment:** We will not cover services provided as the result of or related to an Enrollee's refusal to comply with a physician's or other provider's recommendations or orders, or failure to cooperate with a prescribed plan of treatment or recovery.
79. **Nurse Midwife:** Services provided by a nurse midwife are not covered.
80. **Nutritional Counseling or Nutritional Supplements:** Benefits are not available for dietary control counseling or weight maintenance programs. For Enrollees with diabetes, see Section 3.8.
81. **Oral, Implantable and Injectable Contraceptives:** Oral and prescription contraceptive methods that are not on the QualChoice formulary are not covered. Implantable and injectable contraceptives provided in a physician's office are not covered.
82. **Orthognathic Surgery:** The surgical repositioning of segments of the mandible or maxilla containing one to several teeth, or the bodily reposition of entire jaws, whether to reduce a dislocation of temporomandibular joint or for any other purpose, is not covered. For coverage of Oral Surgery or Reconstructive Surgery, see Section 3.
83. **Orthoptic or Pleoptic Therapy:** Orthoptic or pleoptic therapy is not covered.
84. **Orthotics:** Orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain are not covered. This exclusion applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, those that are mainly protective in nature, and those that combine functional control and protection. The exclusion applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.
85. **Outpatient Rehabilitation Services:** Coverage for outpatient visits for physical, occupational, and speech therapy, audiology services, pulmonary rehabilitation and chiropractic services are limited to a maximum number of visits per Enrollee per Calendar Year as set out in the Benefit Summary. Coverage for cardiac rehabilitation is limited to a maximum number of visits per Enrollee per Calendar Year as set out in the Benefit Summary. Any outpatient rehabilitation services obtained from an Out-of-Network Provider are not covered.
86. **Outside United States:** We do not cover services or supplies obtained outside of the United States except in our sole discretion.
87. **Over the Counter Medications:** Unless specifically identified in a prescription drug rider purchased from QualChoice, medications (except insulin) which do not by law require a prescription from a Physician are not covered.
88. **Pain Pump, Disposable:** Disposable pain pumps following surgery are not covered.
89. **Parkinson's Disease, Treatment with Fetal Mesencephalic Transplantation:** Fetal mesencephalic transplantation (FMT) for treatment of Parkinson's disease is not covered.
90. **Percutaneous Diskectomy:** Any method of percutaneous diskectomy, including, but not limited to, automated or manual percutaneous diskectomy, laser diskectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered.
91. **Percutaneous Sacroplasty:** Percutaneous sacroplasty is not covered.
92. **Performance Enhancement:** We will not cover medical, surgical or rehabilitation services primarily intended to improve the level of physical functioning for purposes of enhanced job, athletic or recreational performance, including but not limited to work hardening programs, back schools, programs of general physical conditioning, athletic trainers and special or specially modified surgical procedures designed to enhance performance above normal.
93. **Peripheral Nerve Stimulators:** Peripheral nerve stimulators are not covered.
94. **Peripheral Vascular Disease Rehabilitation Therapy:** Peripheral vascular disease rehabilitation therapy is not covered.
95. **Premarital Laboratory Work:** We will not cover premarital laboratory work required by any state or local law.

96. **Prescription Medications:** Unless specifically covered in a prescription drug rider issued to you by us, prescription drugs for outpatient use filled by a prescription order or refill and non-injectable medications given in a physician's office except in an Emergency are not covered.
97. **Private Duty Nurses:** We will not cover private duty nurses.
98. **Private Room:** We do not cover a private hospital room. We will pay the most common charge for semi-private accommodations. If there is a charge for a private room, you must pay the difference between the charges for a private room and our payment.
99. **Prolotherapy:** Prolotherapy or Sclerotherapy for the stimulation of tendon or ligament tissue or for pain relief in a localized area of musculoskeletal origin is not covered.
100. **Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions:** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.
101. **Required Examinations or Services:** We will not cover examinations or services required or recommended by a third party. This would include services for the purpose of:
    A. Obtaining employment;
    B. Maintaining employment;
    C. Obtaining insurance;
    D. Obtaining professional or other licenses;
    E. Engaging in travel;
    F. Athletic or recreational activities; or
    G. Attending a school, camp, or other program.
102. **Research Studies:** We will not cover any service provided in connection with research studies or clinical trials.
103. **Rest Cures:** Services or supplies for rest cures are not covered.
104. **Reversal of Sterilization:** We will not cover any procedures or related care to reverse previous sterilization.
105. **Second Surgical Opinion and Consultation with Specialist:** We will not cover a second surgical opinion and a consultation from the same physician or from two physicians who are in practice together.
106. **Self-inflicted Injuries:** Services for intentional self-inflicted injuries, including drug overdose, are not covered, except when it is determined the act causing the injury resulted from a medical condition (physical or mental).
107. **Sensory Stimulation of Coma Patients:** Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.
108. **Services Not Specified as Covered Services:** We will not cover any services not specifically described in Section 3 of this Policy.
109. **Sex-Change Treatment:** We will not cover surgical procedures or related care to alter your sex from one gender to the other.
110. **Sexual and Gender Identity Disorders:** Any services related to the treatment of sexual and identity disorders are not covered.
111. **Short Stature Syndrome:** Any services related to the treatment of short stature syndrome, except for laboratory documented growth hormone deficiency, are not covered.
112. **Smoking or Tobacco Cessation or Caffeine Addiction:** Unless a Smoking Cessation Rider is issued to you by us, treatment of caffeine or nicotine addiction, smoking cessation prescription medication products, including but not limited to, nicotine gum and nicotine patches are not covered.
113. **Snoring:** Devices, procedures or supplies to treat snoring are not covered.
114. **Sperm and Embryo Preservation and Donation:** We will not cover charges related to the donation, collection, or preservation of sperm or embryos for later use.
115. **Sterilization, Voluntary Hysterectomy:** We will not cover charges related to hysterectomy for the primary purpose of voluntary sterilization. We will not cover charges related to implantation of the Essure device or other similar devices identified at our sole discretion. You may contact us to obtain a listing of such devices.
116. **Tanning Equipment:** Tanning equipment is not covered.
117. **Telephone and Other Electronic Communication:** We do not cover communications between a provider and an Enrollee or a provider and another provider done by telephone or other electronic means such as email.

118. **Temporomandibular Joint Syndrome (TMJ):** Unless a TMJ Rider is included with this Policy, we will not cover charges related to treatment or diagnosis of TMJ, including, but not limited to, medical, surgical and dental treatment, physical therapy, joint splints, adjustments, medications, as well as any orthotic treatment. All other procedures involving the teeth or areas surrounding the teeth are not covered, including shortening of the mandible or maxillae, or correction of malocclusion.
119. **Thermography:** Thermography, the measuring of self-emanating infrared radiation that reveals temperature variation at the surface of the body, is not covered.
120. **Third Party Liability Exclusion:** We will not pay any Benefits to an Enrollee to the extent the Enrollee has received payment, in whole or in part, from a third party, or its insurer, for past or future medical or hospital or other health care charges as the result of the negligence or intentional act of a third party. If an Enrollee makes a Claim for Benefits under this Policy prior to receiving payment from a third party, or its insurer, the Enrollee (or legal representative for a minor or incompetent) agrees to repay us from any amount of money received by the Enrollee from the third party, or its insurer. Please refer to Section 8 and Section 9.7 for further information concerning repayment of Benefits.
121. **Thoracic Electrical Bioimpedance:** Thoracic electrical bioimpedance is not covered.
122. **Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae:** Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.
123. **Trans-telephonic Home Spirometry:** Tans-telephonic home or ambulatory spirometry is generally not covered. However, subject to all terms, conditions, exclusions and limitations as set forth in this Policy, trans-telephonic home or ambulatory spirometry is covered for patients who have had a lung transplant, when pre-approved by the QualChoice Care Management Department.
124. **Travel and Transportation Expenses:** We will not cover travel and transportation expenses, even if prescribed by a physician, except for emergency ambulance service or ambulance service for transfer coordinated by the QualChoice Care Management Department.
125. **Travel or Work Related Immunizations:** We will not cover immunizations to fulfill requirements for international travel or for work.
126. **Ultrasounds:** Obstetrical ultrasound is not covered.
127. **Unlicensed Provider:** Coverage is not provided for treatment, procedures or services provided by any person or entity, including but not limited to physicians, who is required to be licensed to perform the treatment, procedure or services, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of QualChoice, include within its scope the treatment, procedure or service provided.
128. **Vacuum Assisted Closure:** Vacuum assisted closure devices and services associated with it are not covered.
129. **Vision and Hearing Services:** Except as set forth in the Benefit Summary, we will not cover routine eye or hearing examinations, services or tests, eyeglasses, contact lenses, hearing aids and other vision care and hearing care services and supplies, except as required for the diagnosis and treatment of diseases of, or injury to, the eyes or ears.
130. **Vision Correction:** We will not cover eye surgery to correct refractive errors. This includes refractive keratoplasty, refractive keratomileusis, epikeratophakia procedures, Low Vision Enhancement System (LVES), Laser Assisted Insitu Keratomileusis (LASIK), eyeglass, and contact lenses, except the initial acquisition of one pair within the twelve months following cataract surgery up to a maximum of $200.00 (for frames and lenses), are not covered.
131. **Vitamins or Baby Formula:** Unless specifically covered in a prescription drug rider issued to you by us, vitamins, food or nutrient supplements are not covered. **Baby formula and thickening agents, even if prescribed by a Physician are not covered.** However, subject to all terms, conditions, exclusions and limitations set forth in this Policy, coverage is provided for medical foods and low protein modified food products for the treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism (see Section 3.19).
132. **Vocational Rehabilitation:** Vocational rehabilitation services, counseling and testing are not covered.

133. **War or Act of War:** We will not cover any services relating to any injury or sickness resulting from war or any act of war (declared or undeclared), or in the armed forces of any country if any government plan covers the injury or sickness.
134. **Weight Control:** Medications prescribed, dispensed or used for the treatment of obesity are not covered. Medications prescribed, dispensed or used in any program of weight control, weight reduction, weight loss or other dietary control are not covered. Weight loss surgical procedures, including complications relating thereto, are not covered.
135. **Whole Body Computed Tomography:** Whole body computed tomography is not covered.
136. **Workers' Compensation:** We will not cover any care or supplies for any injury, condition or disease arising from employment. We will not make any payments even if a Claim is not made for the benefits which are available under the Workers' Compensation Law.
137. **Wound Treatment:** Blood derived growth factors are not covered.

4.2. Limitations to Benefits

1. **Ambulance:** Transportation by ambulance is limited to a maximum annual benefit amount, and is subject to review for Medical Necessity. Consult the Benefit Summary for Benefit limitations.
2. **Autism Screening:** Screening for autism is limited to a maximum of once between the ages of 1 and 4. Coverage for developmental delay associated with autism spectrum disorder is excluded.
3. **Biofeedback:** Biofeedback is covered only when it is Medically Necessary for muscle re-education of specific muscle groups, or for treating the pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and when more conventional treatments (heat, cold, exercise, and support) have not been successful. Pre-authorization is required. Biofeedback is medically appropriate when applied to the conditions reflected in the QualChoice Medical Policies.
4. **Circumstances Beyond Our Control:** Services and other covered Benefits could be delayed or made impractical by circumstances not reasonably within our control, such as: complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of hospital or medical group personnel, or similar causes. If so, Network Providers will make a good faith effort to provide services and other Benefits covered hereunder. Neither any provider nor we shall have any other liability or obligation because of such delay or such failure to provide services or other Benefits.
5. **Durable Medical Equipment (DME):** Benefits for DME is limited to an annual dollar maximum and must be obtained from a Network Provider. Please refer to the Benefit Summary for this annual limit.
6. **Eating Disorders:** We cover services for eating disorders only as provided in Section 3 of this Policy. This includes treatment for anorexia, bulimia and other eating disorders.
7. **Electrotherapy and Electromagnetic Stimulators:** All treatment using electrotherapy and electromagnetic stimulators, including services and supplies used in conjunction with such stimulators, and complications resulting from such treatment, is covered only for conditions specified in our Medical Policies.
8. **Enhanced External Counterpulsation:** Enhanced external counterpulsation (EECP) is covered only for conditions specified in our Medical Policies.
9. **Genetic Counseling and Testing:** Genetic counseling, genetic testing, and chromosome analysis are covered only when there is documented evidence that a genetic anomaly or defect may be present which could threaten the life of the Enrollee. Preauthorization is required. Genetic counseling, genetic testing, and chromosome analysis may be appropriate for (i) lymphoma, (ii) multiple myeloma, (iii) suspected Down's Syndrome, and (iv) testing for BRCA genes. We will not cover genetic counseling or testing:
   A. To determine the likelihood of developing a disease or condition;
   B. To determine the likelihood of a disease or the presence of a disease in a relative;
   C. To determine the likelihood of passing an inheritable disease, e.g. cystic fibrosis, or congenital abnormality to an offspring; or
   D. For pre-implantation genetic diagnosis or treatment.

10. **Home Health Care:** Home health visits are limited to a maximum number of visits per Enrollee per Calendar Year. The Home Health Care visit limitation and the Cost Sharing Amounts are specified in the Benefit Summary.
11. **Hospice Care:** Hospice Care is limited to a maximum number of days of coverage per Enrollee. The Hospice Care day limitation and the Cost Sharing Amounts are specified in the Benefit Summary.
12. **In Vitro Chemoresistance and Chemosensitivity Assays:** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but not limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered, subject to QualChoice's Medical Policies.
13. **Insulin Pump for Diabetes Mellitus:** We will cover insulin pumps to a Maximum Allowable Charge of $5,500. Insulin pump supplies are covered under your medical benefit and are not subject to this limitation. Pre-authorization is required.
14. **Lifetime Maximum:** Consult your Benefits Summary, Medical Policies, and this Policy for various lifetime maximum Benefits per Enrollee.
15. **Major Disaster or Epidemic:** If a major disaster or epidemic occurs, Network Providers will render medical services as is practical according to their best judgment within the limitation of available facilities and personnel. Neither any Network Provider nor we has any liability or obligation for delay or failure to provide or arrange any such services to the extent the disaster or epidemic creates unavailability of facilities or personnel.
16. **Prosthetic and Orthotic Devices and Services:** QualChoice does not cover replacement of a prosthetic or orthotic device or associated prosthetic or orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Policy. However, QualChoice will replace or repair a prosthetic or orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.
17. **Refusal to Accept Treatment:** You may refuse to accept procedures or treatment recommended by Network Providers for personal reasons. In such case, neither we nor any Network Provider shall have any further responsibility to provide care for the condition under treatment, unless such refusal is later recanted and there is an agreement to follow the recommended treatment or procedure.
18. **Transplant Services:** Transplant services are subject to the following benefit maximums:
    A. Coverage for procurement (per transplant) is limited to the amount reflected in your Benefits Summary;
    B. Lifetime maximum organ transplant coverage is limited to the amount reflected in your Benefits Summary;
    C. We will not cover the transportation and/or lodging costs of the transplant donor, or individuals traveling with either the donor or the recipient. We will not pay for artificial or non-human parts or organs or any services related to transplants using artificial or non-human parts or organs. Transportation costs of the transplant recipient are covered at the sole discretion and evaluation of the QualChoice Care Management Department. Coverage is limited to no more than two (2) transplants per Enrollee per lifetime. We cover re-transplantation, subject to the transplant limit of two (2).
    D. Solid organ transplants of any kind are not covered for an Enrollee with a malignancy of any kind that is presently active, in partial remission or in complete remission less than two years. A solid organ transplant of any kind is not covered for an Enrollee that has had a malignancy removed or treated in the three (3) years prior to the proposed transplant. For purposes of this exclusion, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma, or melanoma. Exceptions to this exclusion are hepatocellular carcinoma under certain circumstances, basal or squamous cell carcinomas of the skin, absent lymphatic or distant metastasis.
    E. Organ transplants not pre-authorized by QualChoice Care Management Department are not covered.

5. ELIGIBILITY CRITERIA

5.1. Hospitalization When Coverage Begins

If an Enrollee is an inpatient in a hospital, skilled nursing facility, or other inpatient facility on the Effective Date of this Policy, coverage under this Policy will not be effective for such Enrollee until after discharge from the facility.

No person, who is a registered inpatient in a hospital, skilled nursing facility, or other inpatient facility on the date he or she would otherwise be entitled to begin coverage will be eligible under this Policy or receive such coverage for such inpatient confinement.

5.2. Eligibility for Medicare

If you are eligible for Medicare, you are not eligible to begin or continue coverage under this Policy.

5.3. Who is Eligible for Coverage and When Does Coverage Begin

Subject to the Policy Holder meeting all eligibility requirements in this Policy, the Policy Holder's coverage begins upon the Effective Date of this Policy as reflected in the Benefit Summary. You may contact us for information concerning eligibility requirements and the Effective Date.

You must list yourself on the Enrollment Application to be eligible for coverage. You must meet all eligibility requirements in this Policy. ***Only*** a person who is a resident of the State of Arkansas and is under the age of 19 is eligible for coverage under this Policy. For the purposes of this Section, an Enrollee is a "resident" of the State of Arkansas if s/he lives in Arkansas and has an intent to remain in the State for a period of time, which may include a Child who is a student at a college or university located outside of Arkansas. QualChoice reserves the right to request documentation necessary to demonstrate that an Enrollee's residency is the State of Arkansas. Except under limited circumstances described in this Policy, we are not required to provide coverage under this Policy to every applicant for coverage.

No one is eligible for coverage if that person does not meet our eligibility rules. You should contact us for further information concerning your eligibility. Nor is someone eligible to enroll if that person had previous coverage with us and was terminated for causes described in Section 5.5.4 of this Policy.

5.4. Maternity Coverage

This Policy does not include coverage for Maternity Care and Obstetrical Care unless originally issued with a maternity coverage rider. You may add a maternity coverage rider by submitting an application to us which must be approved by us prior to you conceiving a child. Our standard underwriting standards must be met in order for us to approve issuing a maternity coverage rider. As a consequence, there can be no maternity Benefits under this Policy before the end of 12 months from the date maternity coverage was issued.

5.5. Termination of Coverage

Subject to the Policy Holder meeting all eligibility requirements in this Policy, the Policy Holder's coverage begins upon the Effective Date of this Policy as reflected in the Benefit Summary and will end on the date that the Policy is terminated by its terms.

An Enrollee's coverage under this Policy will terminate in certain circumstances. We describe these circumstances below.

1. **Default in Payment of Premiums:** Premiums are due on or before the first day of each month of Coverage under this Policy by the method described in your Enrollment Application. A grace period of thirty-one (31) days from that due date (the "Grace Period") will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. Failure to make premium payments to us in accordance before the end of the Grace Period shall terminate Benefits under this Policy. Coverage under this Policy will be terminated retroactive to the last day of the month for which premium payment was received.
2. **Becoming Eligible for Medicare:** When an Enrollee becomes eligible for Medicare, that Enrollee is no longer eligible for coverage under this Policy and should notify us immediately.

3. **On Death:** Coverage for the Policy Holder under this Policy will automatically terminate on the date of the Policy Holder's death. All premiums paid for coverage beyond the date of the Policy Holder's death will be refunded following our receipt of proof of death.
4. **Our Option to Terminate This Policy:** We may terminate this Policy for any of the following reasons:
   A. We rescind an Enrollee's coverage for material misrepresentation or fraud committed by the Enrollee in connection with any Claim filed under this Policy;
   period;
   B. We may terminate an Enrollee's coverage upon 30 days advance written notice if an unauthorized person is allowed to use the Enrollee's identification card or if the Enrollee otherwise cooperates in the unauthorized use of such Enrollee's identification card or Benefits;
   C. Each Enrollee represents all statements made in his or her Enrollment Application for coverage are true to the best of his or her knowledge and belief. If an Enrollee furnishes any misleading, deceptive, incomplete, or untrue statement, which is material to the acceptance of his or her Enrollment Application, we may rescind his or her coverage under this Policy back to the original Effective Date;
   D. We will terminate an Enrollee's coverage under this Policy if the Enrollee moves permanently to another state effective as of the end of the month for which the premium for that Enrollee has been paid;
   E. We may terminate this Policy on 90 days written notice if we decide to no longer issue this particular type of health coverage; or
   F. We may terminate this Policy if you fail to pay premiums or contributions under the terms of this Policy.

   If QualChoice terminates the coverage of an Enrollee, it will notify the Enrollee in writing of the termination date and premium payments received on account of the terminated Enrollee applicable to periods after the effective date of termination shall be refunded to the Enrollee within 30 days or in the next scheduled billing cycle.

5. **You Terminate Coverage**: If the Policy Holder wishes to terminate coverage under this Policy, the Policy Holder must notify QualChoice in writing in advance of the requested termination date which will be effective no sooner than the end of the calendar month that QualChoice received the notice of termination. Premiums will only be refunded for any period already paid beyond the end of the month in which the notice of termination was received.
6. **No Further Liability.** Following termination of this Policy, we will have no further liability for Benefits except for those incurred before the date the Policy terminated.
7. **Reinstatement.** If any renewal premium is not paid within the Grace Period, a subsequent acceptance of premium by us or by any agent authorized by us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if we or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless we have previously notified you in writing of our disapproval of such application. The reinstated Policy shall cover only losses resulting from such Accidental Injury as may be sustained after the date of reinstatement and loss to such sickness as may begin more than ten (10) days after such date. In all other respects, the Enrollee and us shall have the same rights hereunder as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.
8. **Guaranteed Renewability**. This policy and riders are guaranteed renewable so long as your permanent residence is in Arkansas. At any time after the first twelve (12) month period of coverage under the Policy, we may change your premium rate, but only if the rate is changed

for all policies and riders of the same form number and premium classification as this Policy. Your premium rate will also change in any month that you attain an age that moves you into a different premium classification established by QualChoice.

6. COORDINATION OF BENEFITS

You may have coverage under more than one health policy. This Policy contains a Coordination of Benefits (COB) provision. This is to eliminate duplication of payment for services. There is no COB for prescription drugs supplied at the retail pharmacy. COB will apply for drugs covered under the medical benefit. We do not coordinate against the following kinds of coverage: hospital indemnity coverage or other fixed indemnity coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, as defined by state law, school accident type coverage, benefits for non-medical components of long-term care policies, Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

6.1. How COB Works

The order of benefit determination rules govern the order in which each health policy will pay a Claim for benefits. The health policy that pays first is called the primary policy. The primary policy must pay benefits in accordance with its policy terms without regard to the possibility that another health policy may cover some expenses. The plan that pays after the primary policy is the secondary policy. The secondary policy may reduce the benefits it pays so that payments from all health policies do not exceed 100% of the COB Allowable Expense (described in Section 6.4 below).

6.2. Rules to Determine Primary and Secondary Plans

The following rules will determine primary and secondary policy coverage:

1. If a health policy does not have a COB provision, that policy is primary.
2. The health policy covering the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is primary, and the health policy that covers the person as a dependent is secondary.
3. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one health policy the order of benefits is determined as follows:
   - A. For a child whose parents are married or are living together, whether or not they have ever been married:
     - (1) The health policy of the parent whose birthday falls earlier in the Calendar Year is primary; or
     - (2) If both parents have the same birthday, the health policy that has covered the parent the longest is primary.
   - B. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
     - (1) The plan of the parent who a court has established as being responsible for the child's health care expenses or health care coverage is primary (we must be informed of this requirement and documentation may be required);
     - (2) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage , the provisions of Subparagraph A above determines the order of benefits;
     - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of Subparagraph A above determine the order of benefits; or
     - (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
       - (a) Plan of the custodial parent;

(b) Plan of the custodial parent's new spouse (if remarried);
(c) Plan of the non-custodial parent; and then
(d) Plan of the new spouse of the non-custodial parent (if remarried).

C. For a dependent child covered under more than one health policy of individuals who are the parents of the child, the provisions of Subparagraph A or B above determine the order of benefits as if those individuals were the parents of the child.

4. The health policy that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is primary. The same rule applies to a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. Note that this rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.
5. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another health policy, the health policy covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is primary and the COBRA or state or other federal continuation coverage is secondary. If the other health policy does not have this rule, and as a result, the health policy or policies do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.
6. The health policy that covered the person as an employee, member, policyholder, subscriber or retiree longer is primary and the health policy that covered the person the shorter period of time is secondary.
7. If the preceding rules do not determine the order of benefits, the COB Allowable Expense shall be shared equally between the health policies or policies. In addition, this Policy will not pay more than it would have paid had it been primary.

6.3. Allowable Expense

For the purposes of this Section 6, "Allowable Expense" is a health care expense (including Deductible, Coinsurance or Co-payments) covered in full or in part by any health care plan or policy covering the Enrollee. This means an expense or service not covered by any plan or policy covering the Enrollee is not an Allowable Expense. Also, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Enrollee is not an Allowable Expense.

If two (2) or more plans or policies cover you and compute their benefit payments based on that plan's maximum allowable charge, any amount in excess of the Allowable Expense of the primary payor for a specified benefit is not an Allowable Expense.

If two (2) or more plans or policies cover you and provide benefits or services based on negotiated fees, any amount in excess of the negotiated fees of the primary payor is not an Allowable Expense.

If you are covered under multiple plans or policies and the Allowable Expense is determined by more than one method, the primary policy's payment arrangement shall be the Allowable Expense for all plans or policies.

6.4. Reduction of Benefits

When this Policy is secondary, we will reduce our benefits so that the total benefits paid or provided by all plan or policies are not more than one hundred percent (100%) of the total Allowable Expense of the primary policy.

A. In determining the amount to be paid for any Claim, QualChoice will calculate the Benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense that is unpaid by the primary policy. QualChoice will then reduce its payment by the amount so that, when combined with the amount paid by the primary policy, the total Benefits paid or provided by all health policy

or policies for the Claim do not exceed the total Allowable Expense of the primary policy for that Claim.

B. QualChoice will credit to Enrollee's Deductible any amounts it would have credited to the Deductible in the absence of other health care coverage.

C. If an Enrollee is enrolled in two or more closed panel plans (that is, a plan or policy that provides benefits primarily through a panel of contracted health care providers and excludes coverage for services provided by other health care providers) and if, for any reason, including the provision of service by an Out-of Network Provider, benefits are not payable by one closed panel plan, COB shall not apply between that closed panel plan and other closed panel plans.

6.5. Enforcement of Provisions

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the Plan and other health policy or policies. For the purposes of COB administration, QualChoice will get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under the Plan and other health policy or policies covering the person Claiming benefits. QualChoice is not required to tell, or get the consent of, any person, including the Enrollee, to do this. You must give QualChoice any facts we needs to apply those rules and determine Benefits payable. If you fail to provide this information, we may delay Benefit payments.

6.6. Facility of Payment

A payment made under another health policy may include an amount that should have been paid under this Plan. If it does, QualChoice may pay that amount to the other plan or policy that made that payment. That amount will then be treated as though it were a benefit paid by QualChoice under this Certificate. QualChoice will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.7. Right of Recovery

If we pay more for Covered Services than this provision allows, we have the right to recover the excess payment. You agree to do whatever is necessary to secure our right to recover excess payments.

6.8. Hospitalization When Coverage Begins

Consistent with applicable law, if an eligible Enrollee is inpatient in a hospital on the effective date of this Certificate and immediately prior to such effective date was covered by another group health policy that provides coverage for hospital or medical services or expenses, coverage for benefits under that other policy, contract, or certificate will continue and it will be the primary policy for those services and expenses associated with that hospital admission. As the primary policy, that group health policy will be responsible for those services and expenses until the end of that hospital admission or until the expiration of any applicable extension of benefits provided under such group health policy, whichever occurs first.

7. COMPLAINTS AND APPEALS

We have authority and full discretion to determine all questions, problems or disputes, arising in connection with Benefits, including but not limited to eligibility, interpretation of Policy language and findings of fact about such questions. Our actions, determinations and interpretations with respect to all such matters, and with respect to any matter within the scope of our authority, shall be conclusive and binding on the Enrollee. Any problem or Claims dispute between an Enrollee and us must go through our complaint and appeals process. If the problem or dispute is over a determination of Medical Necessity, classification of treatment as Experimental or Investigational or involves an Expedited Appeal, the appeal process is controlling.

7.1. Initial Communication and Resolution of a Problem or Dispute

We welcome and encourage (but do not require) discussion of any inquiry, complaint or dispute concerning interpretation of the provisions of this Policy. A Customer Service representative will make every effort to resolve the issue. If we are unable to resolve the issue to the satisfaction of the Enrollee, the Enrollee has the right to request an Internal Review.

1. **Definition:** A complaint is an expression of dissatisfaction about us. A complaint, however, is not and will ***not*** be considered to be or handled as an "appeal" as described in Section 7.3 below. An "appeal" must be initiated and conducted as described in Section 7.3 below.
2. **Oral Complaints:** An Enrollee having a complaint regarding anything about us may contact a Customer Service Representative at 501-228-7111 or 1-800-235-7111 to assist in resolving the matter informally. The Enrollee may submit a written complaint if not satisfied with the resolution. An Enrollee is not required to make an oral complaint prior to submitting a written complaint.
3. **Written Complaints:** The Enrollee may submit a written complaint to us at the following address:

   QualChoice
   Attention: Appeals and Grievance Coordinator
   P. O. Box 25610
   Little Rock, Arkansas 72221

4. **Complaint Resolution.** We will acknowledge receipt of a written complaint within 5 working days. We will investigate the complaint and send the Enrollee a response with resolution. If we are unable to resolve the written complaint within 30 calendar days due to circumstances beyond our control, we will provide notice of the reason for the delay before the 30th calendar day.

7.2. Types of Requests and Claims

1. **Pre-Service Request:** A Pre-Service Request is a request for a service that requires prior notification and approval of the benefit prior to receiving the service. These are services, for example, that are subject to pre-certification as set forth in the Pre-Authorization of Services section of this Policy.
2. **Post-Service Claims:** Post-Service Claims are those Claims for services that have already been received by the Enrollee.
3. **Urgent Care Request:** An Urgent Care Request is a request for a service that a physician with knowledge of the Enrollee's medical condition has determined that without the service the Enrollee's:

   A. Medical condition would subject the Enrollee to severe pain that cannot be adequately managed; or

   B. Life, health or ability to regain maximum function could be seriously jeopardized.

4. **Concurrent Care Request**: A Concurrent Care Request is a request for a service that arises when Medical Necessity of an on-going course of treatment to be provided over a period of time has been approved.
5. **Administrative Issues**: We consider issues such as those regarding eligibility, coverage, level of coverage, rescission of coverage (that is, cancellation or discontinuance of coverage retroactively (unless due to lack of timely premium payment)), and adherence to prescribed procedures as Administrative Issues.
6. **Medical Issues**: We consider issues such as a determination of Medical Necessity, the definition of a medical treatment as Experimental or Investigational, or the sufficiency of clinical information to make a coverage determination, to be a Medical Issue.

7.3. Appeal Process

1. **Initiating a Pre-Service, Concurrent Care, or Post-Service Internal Appeal:** The Enrollee (or the Enrollee's healthcare provider with regard to a Pre-Service Request, Concurrent Care Request or Urgent Care Request) has 180 calendar days from the date of receipt of the initial determination was made to file a formal written appeal, under this Section 7. To initiate an appeal, an Enrollee (or the Enrollee's healthcare provider) must write to our complaint and appeals coordinator at the following address:

   Appeals and Grievance Coordinator
   QualChoice
   P.O. Box 25610
   Little Rock, AR 72221-5610

   This appeal may also be faxed to:

   Appeals and Grievance Coordinator
   QualChoice
   Fax #: 501-228-9413

2. **Appeal of Pre-Service Request and Concurrent Care Request**

   A. **Internal Appeal of Administrative Issues.** After receipt of the written appeal, the Internal Appeal Reviewer will conduct an investigation of the appeal. The Internal Appeal Committee meeting at our office will hear an Internal Appeal of an Administrative Issue. The Enrollee and/or the treating healthcare provider has the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Internal Appeal Committee's questions. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

   B. **Internal Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Internal Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Internal Appeal to a medical director for review and we will notify the Enrollee of a decision within fifteen (15) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

   C. **Expedited Appeals**. A request for an expedited appeal for a Pre-Service Request or Concurrent Care Request will be treated as an appeal of an Urgent Care Request as described in Section 7.3(4) below subject to the request meeting the criteria for an Urgent Care Request.

3. **Appeal of Post-Service Claims**

   A. **Internal Appeal of Administrative Issues.** After receipt of the written appeal, the Internal Appeal Reviewer will conduct an investigation of the appeal. The Internal Appeal Committee meeting at our office will hear a Internal Appeal of an Administrative Issue. The Enrollee has the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Internal Appeal Committee's questions. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the

reasons for the findings and will include the contract language and or policy supporting the decision.

B. **Internal Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Internal Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Internal Appeal to a medical director for review and we will notify the Enrollee of a decision within thirty (30) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

C. **No Expedited Appeals**. There are no expedited appeals for Post-Service Claims.

4. **Appeal of Urgent Care Request**

A. **Initiating an Internal Appeal.** If the Enrollee requests an expedited review and a health care professional with knowledge of the Enrollee's medical condition certifies the determination as a general pre-service request that would seriously jeopardize the Enrollee's life or health or the Enrollee's ability to regain maximum function, the Enrollee or their health care professional may submit an appeal to the Appeals and Grievance Coordinator by facsimile to 501-228-9413.

An expedited appeal may be submitted by telephone, 501-228-7111 or 1-800-235-7111 followed by a written confirmation.

B. **Internal Appeal.** An appeal of an Urgent Care Request will be handled by us as a Medical Issue. A medical director will make the determination on review at both levels of appeal in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Appeals Coordinator initially receives the request for review.

7.4. Documentation

1. **Written Appeals:** All appeals must be submitted in writing and include the Enrollee's name, identification number, and reference to the specific appealed Claim. However, an appeal related to an Urgent Care Request as defined in Section 7.2(3) above can initially be submitted orally so we can immediately commence consideration. We require written confirmation of such Urgent Care Request appeal even though investigation will have begun.

2. **Right to Information of Enrollee:** We will provide the Enrollee, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information that:

A. Were relied upon in making the benefit determination;
B. Were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
C. Demonstrate compliance with the terms of the Policy; and
D. Constitute a statement of policy or guidance with respect to the Policy concerning the denied treatment option or benefit for the Enrollee's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In addition, we will provide the Enrollee, free of charge, with any new or additional rationale and/or evidence we consider, rely on, or is generated in connection with the appeal. We will provide this rationale and/or evidence as soon as possible and sufficiently in advance to allow the Enrollee a reasonable opportunity to respond prior to the date of a determination on the appeal being made by us.

3. **Right of Enrollee to Submit Information:** The Enrollee may submit with the request for an appeal any additional written comments, issues, documents, records and other information relating to the request or Claim. The Enrollee and the treating health care provider(s) are required to provide individual(s) reviewing the appeal, upon request, access to information necessary to determine the appeal. Such information should be provided not later than 5 days after the date on which the Appeals Reviewer's request for information is received, or, in the case of an Urgent Care Request or Concurrent Care Request, at such earlier time as may be necessary to comply with the applicable timelines. The Enrollee's failure to provide access to such information shall not remove the obligation of the Appeals Reviewer to make a determination on the appeal, but not providing the requested information may affect the Appeals Reviewer's determination. When adequate medical records for consideration of the appeal do not accompany the appeal of a medical issue, there are only two options: denial of the appeal or delay of the decision until we receive the records. We will inform the Enrollee of the process of obtaining the medical records, an effort in which the Enrollee may assist. At any point, the Enrollee may insist we make a determination based on the records then available, in which case we will render the decision within thirty (30) days.

7.5. Conduct of Appeals

An appeal is conducted following the procedures below.

1. **Scope of Review**: The Appeals Reviewer(s) shall conduct a complete review of all information relating to the request or Claim and shall not afford deference to the initial determination or previous appeal review in conducting the review.
2. **Qualifications of Appeals Reviewer**: The Appeals Reviewer is an individual or committee of individuals selected by us with appropriate expertise and who did not deny the request or Claim that is the subject of the appeal.
3. **Review of Medical Judgment**: When reviewing a request or Claim in which the determination was based in whole or in part on medical judgment, including determination with regard to whether a particular treatment is experimental, investigational, or not Medically Necessary or appropriate, we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual consulted in the initial determination, nor the subordinate of such individual. Upon request of the Enrollee, the identity of the health care professional(s) consulted in conducting the review who are our employees will be provided, without regard to whether we relied upon the advice of the health care professional in making the benefit determination.

7.6. Legal Actions

Prior to initiating legal action, the Enrollee must complete the appeal process in accordance with this Section. No one may bring legal action after the expiration of 3 years from the required submission time of the request or Claim.

7.7. Authorized Representative

1. **One Authorized Representative:** An Enrollee may have one representative and only one representative at a time, to assist in making a complaint, submitting a request or Claim, or appealing an unfavorable determination.
2. **Authority of Authorized Representative:** An Authorized Representative shall have the authority to represent the Enrollee in all matters in connection with the Enrollee's complaint, request, Claim or appeal of a determination. If the Enrollee has an Authorized Representative, references to the terms "The Enrollee" or "Enrollee" in this document refer to the Authorized Representative.

3. **Designation of Authorized Representative:** One of the following persons may act as an Enrollee's Authorized Representative:

   A. An individual designated by the Enrollee in writing in a form approved by us;
   B. The treating provider, if it is a Pre-Service Request, a Concurrent Care Request, or an Urgent Care Request, or if the Enrollee has designated the provider in writing in a form approved by us (Note: An assignment of benefits to a provider will not constitute appointment of that provider as an authorized representative);
   C. A person holding the Enrollee's durable power of attorney;
   D. If the Enrollee is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Enrollee by a court of competent jurisdiction; or
   E. If the Enrollee is a minor, the Enrollee's parent or legal guardian, unless we are notified the Enrollee's request or Claim involves health care services where the consent of the Enrollee's parent or legal guardian is or was not required by law and the Enrollee shall represent himself or herself.

4. **Term of the Authorized Representative:** The authority of an Authorized Representative shall continue for the period specified in the Enrollee's appointment of the Authorized Representative or until the Enrollee is legally competent to represent him or herself and notifies us in writing the Authorized Representative is no longer required or authorized.

5. **Communication with Authorized Representative:** If the Authorized Representative represents the Enrollee because the Authorized Representative is the Enrollee's parent or legal guardian or attorney in fact under a durable power of attorney, we shall send all correspondence, notices and benefit determinations to the Authorized Representative.

   If the Authorized Representative represents the Enrollee in connection with the submission of a Pre-Service Request or Concurrent Care Request, including a Claim involving Urgent Care, or in connection with an appeal, we shall send all correspondence, notices and benefit determinations to the Authorized Representative. If the Authorized Representative represents the Enrollee in connection with a Post-Service Claim, we will send all correspondence, notices, and benefit determinations in connection with the Enrollee's Claim to the Enrollee, but we will provide copies of such correspondence to the Authorized Representative upon request. The Enrollee understands it will take us a reasonable period, approximately 30 days, to notify all its personnel about the termination of the Enrollee's Authorized Representative and we may communicate information about the Enrollee to the Authorized Representative during the notification period.

7.8. External Medical Review

After you have exhausted your Internal Appeal rights with QualChoice and QualChoice has made its final determination with regard to your appeal, a voluntary external review process may be available to you. To find out more about this external review process, including an external expedited review in the event of an Urgent Care Request, please contact QualChoice's Appeals and Grievance Coordinator at 501-228-7111 or 1-800-235-7111.

The external review process is only available if the determination you appealed was based on whether the healthcare service was Medically Necessary or experimental/investigational and the adverse determination by QualChoice will cause you to have medical expenses in excess of $500.00.

An external review is not available for such things as a denial based on an express exclusion in this Policy, an express limitation in this Policy, dollar limits under this Policy, fraud or misrepresentation, or failure to follow procedures in obtaining healthcare provider access.

Your request for an external medical review must be made within sixty (60) days of your receipt of QualChoice's denial and in writing to:

Appeals and Grievance Coordinator

QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

The written communication must be marked and identified as a "*Request for External Review*".

The medical review would be conducted by an independent, external medical review organization selected by QualChoice from a list of approved organizations maintained by the Arkansas Department of Insurance. You would be required to pay a $25.00 fee to file the request for the external review which would be refunded to you in the event QualChoice's determination is reversed by the independent medical review organization.

As part of the external review process, you have the opportunity to submit additional information to QualChoice related to your Claim for consideration by the external review organization for consideration. You will be required to authorize the release of any medical records necessary for the external review organization to reach a decision.

The determination by the external review organization is binding and final on you, and QualChoice, unless other remedies are available under applicable state or federal law.

You may contact the Arkansas Insurance Commissioner for assistance at any time. The mailing address is: Arkansas Insurance Department, Attn: External Review Assistance, 1200 West Third Street, Little Rock, AR 72201. Their telephone number is 501-371-2640 or toll free 800-852-5494. Their email address is insurance.consumers@arkansas.gov.

8. SUBROGATION

If you have an injury or illness caused by a third party, we will provide Covered Services for such injury or illness. Acceptance of such Covered Services constitutes consent to the provisions of this Section. We will require a recovery authorization signed by you. This is a prerequisite to recovery by us against any third party for the cost of Covered Services. Our recovery rights under this Section 8 extend to worker's compensation and uninsured and underinsured motorist coverage.

You agree to protect our lien rights if an injury or illness is suffered and caused by a third party. You may be due money from a third party for the cost of Covered Services. If so, our liability for Benefits will be subrogated to any such recoveries. We have the right to sue any third party in your name, as permitted by applicable state law. If payment is received from a third party for the cost of Covered Services, you are obligated to reimburse us. Reimbursement to us may be reduced by our pro rata share of reasonable attorney's fees and costs incurred in obtaining such recovery.

You agree to cooperate fully to facilitate enforcement of our rights under this Section 8. This may include executing, delivering and filing further documents and instruments. You also agree to furnish such information and assistance, as we may reasonably require to fully enforce the terms of this Section 8. You agree to take no action prejudicing our rights and interests under this Section 8.

9. GENERAL PROVISIONS

9.1. Amendment

QualChoice reserves the right to change the benefits, conditions and premiums covered under the Policy, including the terms of this Policy. If we do so, we will give thirty (30) days written notice to you and the change will go into effect on the date fixed in the notice.

9.2. Assignment

Benefits or monies due under this Policy cannot be assigned to any person, corporation, organization or other entity. Any assignment will be void and have no effect. Assignment means the transfer of a

right to the Benefits provided under this Policy. We reserve the right to make payment of Benefits directly to the healthcare provider that rendered the service.

9.3. Notice

Any notice we give to an Enrollee will be in writing. It will be mailed to him or her at the home address as it appears in our records. Notice to us must be in writing and mailed to our offices at:

QualChoice
12615 Chenal Parkway, Suite 300
P.O. Box 25610
Little Rock, AR 72221-5610

9.4. Medical Records

We may need to obtain copies of an Enrollee's medical records from any of the Enrollee's treating providers. This may be necessary to properly administer Benefits. The Enrollee, or the Enrollee's legal representative, agrees to sign an appropriate authorization for release of medical records upon our request. By accepting Benefits under this Policy, an Enrollee authorizes and directs any person or entity to furnish us with information and copies of records related to healthcare services provided by them to that Enrollee. If an Enrollee elects not to consent to the release of medical records, or if your provider fails to comply with a request for records, we may be unable to properly administer coverage. If this occurs, we have the right to deny payment for impacted Covered Services.

9.5. Notice of Claim

We must receive an Enrollee's Claim for Benefits within no more than 12 months from the date the Enrollee receive the service. Failure to meet this requirement will result in payment denial.

9.6. Claim Forms

If you notify us about a claim for service, we will provide you with a Claim Form within 15 day of your request. The forms are also available on our website www.qualchoice.com.

9.7. Processing of Claims

We will pay or deny a claim for which we have all the information we require, within 30 days after we receive the claim if it was submitted electronically, or within 45 days after receipt if it was submitted through other means. We will notify you within 30 days after receipt of the claim if we determined we require additional information.

9.8. Who Receives Payment Under This Policy

We will make payments under this Policy directly to the Network Providers providing care. If an Enrollee receives Covered Services from any Out-of-Network Provider, we reserve the right to pay either the Policy Holder, Enrollee or the provider.

9.9. Recovery of Overpayments

On occasion, an incorrect payment may be made to you. Reason for this may include when you are not eligible, the service is not covered, or Coordination of Benefits was omitted. When this happens, we will explain the problem in writing. The amount of the mistaken payment must return to us within 60 days. Alternatively, you must provide us with written notice stating the reasons why you may be entitled to such payment. In accordance with applicable law, we may reduce future payments to you in order to recover any mistaken payment. We will recover overpayments and mistaken payments made to providers directly from them.

9.10. Confidentiality

Medical records and other information concerning an Enrollee's care we receive from providers are confidential. We will use such information only to administer the Enrollee's coverage. We will only disclose such information as required or permitted by law and as set out in the QualChoice Notice of Privacy Practices at www.qualchoice.com.

9.11. Complaint and Appeals

An Enrollee is entitled to have any complaints heard by us. We are obligated to hear such complaints, including complaints against Network Providers, in an equitable fashion. The rules and procedures set forth in Section 7 will be followed.

9.12. Right to Develop Guidelines

We reserve the right to develop or adopt guidelines for the administration of Benefits under this Policy. These criteria will be interpretive only and will not be contrary to any terms of this Policy. If you have a question about the criteria used to apply to a particular Benefit, you may contact us or visit our website at www.qualchoice.com for further information.

9.13. Limitation on Benefit of This Policy

No person or entity other than our Enrollees and us shall be entitled to bring any action to enforce any provision of this Policy. The covenants, undertakings, and agreements set forth in this Policy shall be solely for the benefit of our Enrollees and us.

9.14. Misstatement of Age

If the age of the insured has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

9.15. Applicable Law

This Policy, the rights and obligations of our employees and us under this Policy, and any Claims or disputes relating thereto, shall be governed by and construed in accordance with Arkansas law. If any provision of this Policy that, on its Effective Date, is in conflict with Arkansas law, then that provision is automatically changed to conform to the least minimum requirements of the law.

9.16. Headings

Section and subsection headings contained in this Policy are inserted for convenience of reference only. They shall not be deemed to be part of this Policy for any purpose. They shall not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

9.17. Pronouns

All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

9.18 Recission

Subject to the time limits set out in Section 9.19, we may rescind coverage under this Policy if an Enrollee performs an act, practice, or omission that constitutes fraud, or the Enrollee makes an intentional misrepresentation of material fact. In the event we rescind coverage, we have the right to demand that you pay back all the Benefits we paid to you or on your behalf during the period of time that you should not have been covered under this Policy. In these circumstances, we may also obtain refunds from providers that rendered services to you when coverage should not have been provided, in which case that provider may seek to obtain reimbursement from you for the amount obtained by us from that provider.

9.19 Severability

If any part of any provision of this Policy or any document or writing given pursuant to or in connection with this Policy shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity or unenforceability only. Such invalidity or unenforceability will in no way affect the remaining parts of such provision or the remaining provisions of this Policy.

9.20 Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this

Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

9.21 Time Limit on Certain Defenses

After three (3) years from the date of issuance of this Policy, no misstatements, except fraudulent misstatements, made by the applicant for the Policy shall be used to void the Policy or to deny a Claim for loss incurred after the expiration of such three (3) year period. No Claim for loss incurred, as defined in this Policy, commencing after three (3) year from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of this Policy.

9.22 Waiver

The waiver by us or any Enrollee hereunder of a breach of or a default under any of the provisions of this Policy shall not be construed as a waiver of any subsequent breach or default of a similar nature. The failure of any of such parties, on one or more occasions, to enforce any of the provisions of this Policy or to exercise any right or privilege hereunder, shall not be a waiver of any of such provisions, rights or privileges hereunder.

9.23 Entire Policy; Changes

This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

10. DEFINITIONS

There are other definitions, usually capitalized, contained in various Sections throughout this Policy. The capitalized words or terms used in this Policy and are not otherwise defined have the meanings set forth below:

10.1 **"Accidental Injury"** means a bodily injury happening unexpectedly and taking place not according to the usual course of events (for example an automobile accident), and which is the direct cause of the loss, independent of disease or bodily infirmity. Accidental injury to teeth does not include any damage caused by chewing or biting any object.

10.2 **"Advanced Diagnostic Imaging"** includes but is not limited to Computerized Tomography (CT), Computerized Tomography Angiography (CTA), Coronary CT & CTA, CT Bone Density (QCT), Diagnostic CT Colonography, Functional MRI Brain (fMRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Magnetic Resonance Spectroscopy (MRS), Nuclear Cardiology, Positron Emission Tomography scanning (PET), Screening CT Colonography, and SPECT.

10.3 **"Benefits"** means reimbursement or payments for health care available to the Enrollee covered under this Policy.

10.4 **"Benefit Summary"** means a document containing specific information relating to coverage and Cost Sharing Amounts under this Policy. The information may include amounts for Deductibles, Co-payments, Coinsurance, Out-of-Pocket Limits and lifetime maximum Benefits as well as visit and day maximums for limited services.

10.5 **"Calendar Year"** means the period of one year beginning January 1 and ending on December 31 as identified in your Benefits Summary.

10.6 **"Claim for Benefits" or "Claim"** means (i) a request for payment or prior approval (when required under the Policy) for a service, supply, medication, equipment or treatment covered by the Policy, (ii) that is submitted to us by an Enrollee, a healthcare provider with an assignment of benefits from the Enrollee, or an Enrollee's authorized representative, and (iii)

is submitted consistent with QualChoice's standard Claim filing policies and procedures (copies of which are available on request).

10.7 **"Coinsurance"** means a fixed percentage of the Maximum Allowable Charge the Enrollee must pay toward the cost of certain Covered Services for each Calendar Year. Those Covered Services subject to the application of Coinsurance are identified in the Benefit Summary. Coinsurance is subject to an annual maximum limit.

10.8 **"Complications of Pregnancy"** means hospital confinement required to treat conditions, such as the following, in a pregnant female: acute nephritis, nephrosis, cardiac decompensation, HELLP syndrome, uterine rupture, amniotic fluid embolism, chorioamnionitis, fatty liver in pregnancy, septic abortion, placenta accrete, gestational hypertension, puerperal sepsis, peripartum cardiomyopathy, cholestasis in pregnancy, thrombocytopenia in pregnancy, placenta previa, placental abruption, acute cholecystitis and pancreatitis in pregnancy, postpartum hemorrhage, septic pelvic thromboplebitis, retained placenta, venous air embolus associated with pregnancy, miscarriage, or an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of descent or dilitation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a c-section delivery is not considered to be an Emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section. "Complications of Pregnancy" also means treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism, hepatitis B or C, HIV, Human papilloma virus, abnormal PAP syphilis, chlamydia, herpes, urinary tract infections, thromboembolism, appendicitis, hypothyroidism, pulmonary embolism, sickle cell disease, tuberculosis, migraine headaches, depression, acute myocarditis, asthma, maternal cytomegalovirus, urolithiasis, DVT prophylaxis, ovarian dermoid tumors, biliary atresia and/or cirrhosis, first trimester adnexal mass, hyditidiform mole or ectopic pregnancy. Management of a difficult pregnancy is not considered to be a "Complication of Pregnancy".

10.9 **"Co-payment"** means a fixed dollar amount the Enrollee must pay each time the Enrollee receive a particular Covered Service to which a Co-payment applies.

10.10 **"Cost Sharing Amount"** means an amount the Enrollee is required to pay each time the Enrollee receives a particular service to which Deductibles, Co-payments, Coinsurance or benefit limitations apply. These requirements are set forth in the Benefit Summary.

10.11 **"Covered Services"** means services or supplies for which Benefits are available (i.e., payments may be made) as described in this Policy. Covered Services do not include services or supplies and care excluded pursuant to Section 4 or which do not meet the definition of "Medically Necessary" in this Section and the other qualifications set forth in Section 3.

10.12 **"Custodial Care"** means provision of routine care, including assistance with activities of daily living, to a person who is disabled mentally or physically and that disability is expected to continue for an extended length of time. "Custodial Care" can include services and supplies ordered by the Enrollee's physician and services and supplies provided by a registered nurse, a licensed practical nurse, or licensed visiting nurse. Even if "Custodial Care" is needed by an Enrollee, it is not care that is covered under this Policy.

10.13 **"Deductible"** means a certain fixed dollar amount you or the Enrollee must incur before we begin to pay for the cost of Covered Services provided to the Enrollee during each Calendar Year.

10.14 **"Emergency"** means those health care services provided on a 24 hour/365 days a year basis to evaluate and treat medical conditions of a recent onset and severity, leading a prudent lay person, possessing an average knowledge of medicine and health, to believe his

or her condition, sickness, or injury is of such a nature where failure to seek immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

10.15 **"Enrollee"** means a Policy Holder.

10.16 **"Enrollment Application"** means the form to be accurately completed by a prospective Policy Holder to apply for coverage.

10.17 **"Injectable Prescription Medications"** means any injectable pharmaceutical that has been approved by the Food and Drug Administration and can be obtained only through a prescription. QualChoice has classified selected medications, primarily immunizations and allergy and antibiotic injections, as "Office Services-Minor" or "Office Services-Other".

10.18 **"Maternity Care and Obstetrical Care"** means services associated with premature rupture of membranes, false labor, occasional spotting in pregnancy, pre-term labor, pre-term birth, physician directed rest during pregnancy, morning sickness, hyperemesis gravidarum, celphalopelvic disproportion, intrauterine growth retardation, analysis for fetal down syndrome, trisomey 18 or neural tube defect, congenital diaphragmatic hernia, hydrops fatalis, group B strep prophylaxis in pregnancy, isoimmunization in pregnancy, antepartum fetal surveillance, management of hyperemesis, cervical incompetence, fetal urethral obstruction, twin or greater gestation with prior uterine atony, macrosomia, incompetent cervix, forceps delivery, fetal fibronectin, cytotec for induction of labor, sudden onset of polyhydramnios, prophylactic cesarean delivery of HIV positive mother, Klippel-Trenaunay Syndrome, caudal regression syndrome, hospitalization to postpone delivery until the fetus is further developed, biophysical profiles, fetal monitoring, non-routine ultrasounds, vaginal delivery, antepartum and postpartum care, or services related to c-sections scheduled because of (i) multiple gestation, (ii) previous c-section delivery, (iii) patient or physician convenience, (iv) cephalopelvic disproportion, or (v) abnormal presentations such as breech, shoulder dystonia, transverse and compound.

10.19 **"Maximum Allowable Charge"** means the schedule of fees established by us for payments to providers for Covered Services and which may be less than actual charges billed by Network Providers or Out-of-Network Providers. **Please Note:** All Benefits under this Policy are subject to and shall be paid only by reference to the Maximum Allowable Charge as determined at the discretion of QualChoice. This means that regardless of how much a health care provider may bill for a given service, the Benefits under this Policy will be limited by the Maximum Allowable Charge we establish. If a Network Provider is used, that provider is obligated to accept our established rate as the Maximum Allowable Charge, and may only bill you for your Cost Sharing Amounts and any non-Covered Services; however, if an Out-of-Network Provider is used, you will be responsible for all amounts billed in excess of the Maximum Allowable Charge.

10.20. **"Medically Necessary" or "Medical Necessity"** means a Covered Service which in the opinion of our medical personnel:

1. Provides for the diagnosis or treatment of the Enrollee's covered medical conditions;
2. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's specific illness, injury or medical condition in relation to any overall medical/health conditions;
3. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
4. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and
5. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

10.21. "Medical Policy" or "Medical Policies" means a statement developed by QualChoice that sets forth the medical criteria for coverage under QualChoice's benefit Policy or insurance policy. Limitations of benefits related to coverage of a medication, treatment, service, equipment or supply are also outlined in the Medical Policies. Medical Policies are or are based on nationally accepted guidelines and peer reviewed medical literature. Our Medical Advisory Committee reviews and approves all internally developed Medical Policies. Medical Policies are available from QualChoice, at no cost, upon request, or the Medical Policies can be reviewed on QualChoice's web site at www.qualchoice.com.

10.22 "Medical Supplies" means a device or equipment that is of such a nature that it is not generally used repeatedly and is usually used by a person for a medical purpose.

10.23 "Mental Health or Substance Use Disorder" means any psychiatric disorder or disorder of emotion or thought, appropriately classified as an Axis I diagnosis in accordance with the current edition of the Diagnosis & statistical Manual of Mental Diseases of the American Psychiatric Association (DMS) classification.

10.24 "Network Facility" means a hospital that has entered into an agreement with us to make Covered Services available to Enrollees.

10.25 "Network Primary Care Physician" means a physician who has entered into an agreement with us retarding, among other things, willingness to provide primary care Covered Services to Enrollees and who may be utilitized by an Enrollee as his or her primary care physician.

10.26 "Network Physician" means a physician who has entered into an agreement with us regarding, among other things, providing and arranging for the provision of Covered Services to Enrollees.

10.27 "Network Provider" means a Network Physician, Network Specialist, Network Facility or other provider having an agreement with us to make Covered Services available to Enrollees.

10.28 "Network Specialist" means a medical or surgical specialist who has entered into an agreement with us to make Covered Services available to Enrollees.

10.29 "Out-of-Network Provider" or "Out-of-Network Facility" means a physician, hospital or other provider that has not entered into an agreement with us to make Covered Services available to Enrollees.

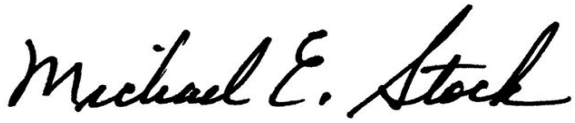
10.30 "Out-of-Network Service" means a Covered Service provided to an Enrollee by an Out-of-Network Provider.

10.31 "Out-of-Pocked Limit" means the maximum amount you pay every Calendar Year as set out in your Benefits Summary.

10.32 "Policy Holder" means you, the individual to whom this Policy is issued.

10.33 "Referral" means a specific written approval an Enrollee seeks additional evaluation or treatment from an Out-of-Network Provider. A general statement by a Network Provider stating a patient should seek a particular type of service or provider does not constitute a Referral under this Policy. We issue referrals for a specific period as determined by us. It is your responsibility to ensure all services provided to you are completed during the appropriate period. If services are rendered outside the approved period, Benefits will be allowed at Out-of-Network reimbursement levels.

10.34 "Service Area" means the geographical area in which we are licensed by the State of Arkansas to conduct business**.**



Michael E. Stock, President & CEO
QCA Health Plan, Inc. ("QualChoice")
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211

ARKANSAS CONSUMER INFORMATION NOTICE

If you need additional information about this Policy, please contact us at:

QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211
(501) 228-7111

If QualChoice is unable to respond to your questions, you should contact:

Arkansas Insurance Department
Consumer Services Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

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

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

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

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible ▪ Co-payments are not included in the annual Deductible ▪ In-Network and Out-of-Network Deductibles apply separately ▪ The annual Deductible is calculated on a Calendar Year basis ▪ Deductible amounts applied in the last quarter of a Calendar Year will NOT carry over to the next Calendar Year	Individual: [$0-$20,000]	Individual: [$0-Unlimited]
Annual Out-of-Pocket Limit ▪ Benefit will be paid at 100% of the Maximum Allowable Charge once the family annual Coinsurance limit is satisfied ▪ Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits ▪ Co-payments do not apply toward your Out-of-Pocket Limits. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis	Individual: [$0-$10,000]	Individual: [$0-Unlimited]
Coinsurance	[0%-100%] after Deductible	[0%-100%] after Deductible
Preventive Care Services:		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines **Child Immunizations (age 0-18)** **Adult Immunizations (age 18+)** ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) *Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Certificate of Coverage. Flu shots will be reimbursed at a fixed fee regardless of where they are obtained.*	No Cost to You	
Routine vision exam (limit one every 24 months)	No Cost to You	Not Covered
Well baby care, birth - to age 2	No Cost to You	Not Covered
Well child care, ages 2-18	No Cost to You	Not Covered
Other preventive services ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over	No Cost to You	Not Covered

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually	No Cost to You	Not Covered
▪ Flexible sigmoidoscopy once every 5 years; OR ▪ Double contrast barium enema once every 5 years; OR ▪ Preventive colonoscopy, age 50 and older, once every 10 years		
Professional Services		
Primary Care Physician (PCP) Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectible Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections	[$0-$100] Co-payment	[0%-100%] after Deductible
Specialist Office Visit ▪ Evaluation and management services	[0%-100%] [after [$0-$350] Co-payment]	[0%-100%] after Deductible
▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures	[0%-100%] after Deductible	
The following professional services are subject to Deductible and Coinsurance: ▪ Complex diagnostic services - advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures - chemotherapy, radiation therapy and infusion therapy ▪ Complex Injectible Prescription Medications which include: All specialty medications such as, enbrel, humira, IV medications and high potency antibiotics ▪ Complex procedures, such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility	[0%-100%] after Deductible	[0%-100%] after Deductible
Inpatient Care - Room and Board		
▪ Inpatient care - room and board (semi-private only) ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (30 day limit per Calendar Year for each)	[$0-$500 Co-payment] and/or [0%-100%] after Deductible	[0%-100%] after Deductible
Outpatient Care and Ambulatory Care Centers		
▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice services (limited to a lifetime maximum of 180 days)	[0%-100%] after Deductible	[0%-100%] after Deductible
▪ Outpatient Surgical Services	[$0-$500 Co-payment] and/or [0%-100%] after Deductible	
▪ Home Health Care (40 visits per Calendar Year)	[0%-100%] after Deductible	[0%-100%] after Deductible
Emergency Services		
▪ Emergency Room, Urgent Care or ER Observation Services	[$0-$1,000] Co-payment or [[0%-100%] after Deductible]	[$0-$1,000] Co-payment or [[0%-100%] after Deductible]
Transportation Services		
▪ Ambulance - Ground or Air ($1,000 maximum benefit per Calendar Year) *Note: Facility to facility ambulance transfer requires pre-authorization.*	[0%-100%] after Deductible	[0%-100%] after Deductible
Therapy Services		
▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy ▪ Chiropractic Care	[0%-100%] after Deductible	Not Covered
▪ Cardiac Rehabilitation (36 visits per Calendar Year) *Note: Therapy and chiropractic services are limited to a combined maximum of 45 visits per Calendar Year. This does not include Cardiac Rehabilitation.*	[0%-100%] after Deductible	[0%-100%] after Deductible

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services: ▪ Routine Prenatal Lab ▪ Initial Office Visit ▪ All other services	Not Covered	Not Covered
Facility Services	Not Covered	Not Covered
Infertility Diagnostic Services Only *Note: Treatment of infertility is not covered.*	Not Covered	Not Covered
Mental Health and SubstanceUse Disorder Services		
▪ Professional Services (Office visit) *Note: If the Mental Health and Substance Use Disorder Rider is purchased refer to the Primary Care Physician (PCP) Office Visit Benefit in the Professional Services Category of this summary for applicable benefits.*	Not Covered	Not Covered
▪ Inpatient Hospital Services ▪ Professional Services (Inpatient Facility) *Note: If the Mental Health and Substance Use Disorder Rider is purchased refer to the "Inpatient Care - Room and Board" Category of this summary for applicable benefits.*	Not Covered	
Allergy Services		
▪ Office Visit and Allergy Testing	PCP: [$0-$100] Co-payment OR Specialist: [0%-100%] [and/or] [$0-$350 Co-payment]	[0%-100%] after Deductible
▪ Allergy Shots	No Cost to You	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) ▪ $5,000 maximum benefit per Calendar Year	[0%-10%] after Deductible	Not Covered
Medical Supplies ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.	PCP: [$0-$100] Co-payment or Specialist: [0%-100%]	[0%-100%] after Deductible
▪ Provided in connection with home infusion therapy	[0%-100%] after Deductible	
▪ Provided in connection with Durable Medical Equipment	[0%-100%] after Deductible	Not Covered
Prosthetic and Orthotic Services and Devices ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices *Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Certificate of Coverage for more information.*	[0%-100%] after Deductible	[0%-100%] after Deductible
Reconstructive Surgery ▪ Breast reconstruction (48 hour minimum hospital stay) ▪ Restoration due to acute trauma, infection or cancer	[0%-100%] after Deductible	[0%-100%] after Deductible
Transplantation Services ▪ Lifetime maximum of two transplants	[0%-100%] after Deductible	Not Covered
Diabetes Management Services ▪ Supplies and equipment ▪ Diabetic Education (1 training per lifetime)	[0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible [0%-100%] after Deductible
Dental Care ▪ Accidental injury to sound and natural teeth ▪ $2,000 maximum benefit per accident	[0%-100%] after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria ▪ Benefits available after member has paid $2,400 per year	[0%-100%] after Deductible	[0%-100%] after Deductible
Genetic Counseling and Testing *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.*	No benefits if not pre-authorized [0%-100%] after Deductible	No benefits if not pre-authorized [0%-100%] after Deductible

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

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

Tier Definitions:

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

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

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

Tier 4 medications are not included on the formulary. Almost all new prescription medications that are not listed in the formulary are included in Tier 4. Member pays 100% of the QualChoice discounted rate. Member out-of-pocket will not accumulate toward any deductible or coinsurance limit.

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

Payment Procedures

Network Pharmacy

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

Out-of-Network Pharmacy

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

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

Limitations

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

Note:

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

Step Therapy

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

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

Benefit Details

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

Exclusions

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

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

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RIDER TO QUALCHOICE COMPREHENSIVE HEALTH EXPENSE COVERAGE POLICY FOR Individual Minor (FORM # Child Only (2011)) FOR

MATERNITY HEALTH SERVICES

This rider (the "Maternity Rider") amends the QualChoice Comprehensive Health Expense Coverage Policy for Individual Minor (Form # Child Only (2011)) (the "Policy") and the Benefits Summary issued to the Policy Holder. Unless otherwise stated in herein, this Maternity Rider is subject to all terms, conditions, exclusions and limitations set forth in the Policy and the Benefits Summary.

We have capitalized certain words in this Maternity Rider. Those words have special meanings and, unless defined otherwise in this Maternity Rider, are defined in Section 10, "Definitions", of the Policy.

For purposes of this Maternity Rider and each section of this Maternity Rider, QCA Health Plan, Inc. ("QualChoice") is referred to as "us", "we" or "our", and "you" or "your" means the Policy Holder.

1.0 Covered Services

Benefits are available through this Maternity Rider for those medical services or care specified in this Section 1.0, subject to the Cost Sharing Amounts and Exclusions and Limitation described in this Maternity Rider, in addition to all other applicable conditions, limitations and exclusions of the Policy and Benefits Summary. **Consult the Benefits Summary for applicable Cost Sharing Amounts.**

1.1 **Maternity and Obstetrical Care:** Coverage is provided for Maternity Care and Obstetrical Care (other than for a Dependent child) like any other conditions, including routine prenatal care, postnatal care, use of delivery room and any related complications). Routine prenatal care includes coverage of only one routine ultrasound. We provide special prenatal programs designed to benefit the Enrollee and the Enrollee's baby during pregnancy. These are available at no additional cost and are voluntary. To sign up, contact us as early as possible during the pregnancy.

1.2 **Inpatient Hospital Stays:** We will pay for an inpatient hospital stay of at least 48 hours for the mother following a normal vaginal delivery. We will pay for an inpatient hospital stay of at least 96 hours for the mother following a cesarean section delivery.

1.3 **Fetal Testing:** Amniocentesis or chorionic villus sampling are covered when performed in accordance with recognized standards of care based on the mother's age or, under certain circumstances, with our prior approval.

1.4 **Midwives:** Coverage is provided for services received from a certified nurse midwife, but only if employed by a Network Physician (we do not cover charges for home deliveries).

2.0 Cost Sharing Amounts

2.1 The Enrollee shall be required to pay the same Coinsurance and Co-payment with respect to Maternity Care and Obstetrical Care described in this Rider as that Enrollee would be required to pay under the Policy and Benefits Summary for services that are Medically Necessary and performed for the treatment of an illness or injury, including, but not limited to, the Coinsurance and Co-payment generally applicable to inpatient hospital, out patient hospital services, and office visits. The Coinsurance and Co-payment described in this Maternity Rider will be counted against the applicable annual maximum Out-of-Pocket Limit set out in the Policy and Benefits Summary.

3.0 Exclusions and Limitations

3.1 12 Month Waiting Period: There is a twelve (12) month waiting period applied to Maternity Care and Obstetrical Care. That means there can be no maternity Benefits under this Policy before the end of 12 months from the date coverage under this Maternity Rider was issued

3.2 Infertility Treatment: We do not cover services or supplies for in vitro fertilization, artificial insemination or any other treatment for infertility.

3.3 Ultrasounds: More than one obstetrical ultrasound during Routine Prenatal Care is not covered. We may cover additional ultrasound examinations only if they are required based on medical indications and the result of the ultrasound will affect the management of the pregnancy. All ultra-sounds must be pre-authorized as described in the Policy.

3.4 Benefit Limit: Total Benefits payable under this Maternity Rider are limited to $5,000 per pregnancy.

3.5 Re-Issuance: We will not issue a maternity rider covering any Enrollee covered by this Maternity Rider after this Maternity Rider terminates.

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Michael E. Stock

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

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QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211
(501) 228-7111

If QualChoice is unable to respond to your questions, you should contact:

Arkansas Insurance Department
Consumer Services Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

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RIDER TO QUALCHOICE COMPREHENSIVE HEALTH EXPENSE COVERAGE POLICY FOR Individual Minor (FORM # Child Only (2011)) FOR

MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

For Those Plans Electing Mental Health and Substance Use Disorder Benefits

This rider (the "Mental Health and Substance Use Disorder Benefits Rider") amends the QualChoice Comprehensive Health Expense Coverage Policy for Individual Minor (Form # Child Only (2011)) (the "Policy") and the Benefits Summary issued to the Policy Holder. Unless otherwise stated herein, this Mental Health and Substance Use Disorder Benefits Rider is subject to all terms, conditions, exclusions and limitations set forth in the Policy and the Benefits Summary.

We have capitalized certain words in this Mental Health and Substance Use Disorder Benefits Rider. Those words have special meanings and, unless defined otherwise in this Mental Health and Substance Use Disorder Benefits Rider, are defined in Section 10, "Definitions", of the Policy.

For purposes of this Mental Health and Substance Use Disorder Benefits Rider, QCA Health Plan, Inc. ("QualChoice") is referred to as "us", "we" or "our", and "you" or "your" means the Policy Holder.

The following will be added to Section 3.0 ("Covered Medical Benefits") of the Policy:

Mental Health and Substance Use Disorder:

Subject to all of the terms, conditions, limitations and exclusions of this Policy, services for treatment of a Mental Health or Substance Abuse Disorder (as defined in Section 10 of the Policy) that are covered are as follows:

1. **Professional Services**. Services for treatment of a Mental Health or Substance Abuse will be covered for crisis resolution or symptom relief;
2. **Hospital Care**. We cover short-term in-patient hospitalization or partial hospitalization for treatment of a Mental Health or Substance Abuse. Services for treatment of a Mental Health or Substance Abuse are only covered when provided in a psychiatric hospital or substance abuse disorder unit of a general acute care hospital. Services for treatment of a Mental Health or Substance Abuse are not covered when provided by a facility that is not licensed as a hospital.

Refer to your Benefits Summary for cost sharing requirements and any benefit limitations.

Treatment Plan - Services for treatment of Mental Health or Substance Use Disorder require submission by the treating healthcare provider of a treatment plan after the initial visit. QualChoice reviews the treatment plan to evaluate the Medical Necessity of the services and it must include at a minimum (i) a detailed diagnosis, (ii) an outline of the intended therapeutic process, (iii) an expected course of treatment, and (iv) the anticipated frequency and duration of treatment.

Exclusions – In addition to all other terms, conditions, and limitations set out in the Policy, coverage for treatment of a Mental Health or Substance Use Disorder under this Treatment of Mental Health and Substance Use Disorder Benefits Rider is subject to the following exclusions:

A. A service performed in connection with treatment of a condition not classified as being an Axis I diagnosis in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association by the diagnosing or treating provider is not covered;
B. Outpatient psychotherapy or counseling for personal growth or life and social enrichment is not covered;
C. A service that is not scientifically supported for the treatment of the Axis I diagnosis recorded is not covered;
D. Residential treatment is not covered; and
E. A service not provided by a psychiatrist, licensed clinical psychologist, licensed clinical social worker, licensed professional counselor, advanced practice nurse, or licensed psychological examiner is not covered.

Definitions - "Mental Health or Substance Use Disorder" means any psychiatric disorder or disorder of emotion or thought, appropriately classified as an Axis I diagnosis in accordance with the current edition of the Diagnosis & Statistical Manual of Mental Diseases of the American Psychiatric Association (DSM) classification.

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Michael E. Stock

Michael E. Stock
QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, Arkansas 72211
(501) 228-7111

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If you need additional information about this Mental Health and Substance Use Disorder Rider, please contact us at:

QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211
(501) 228-7111

If QualChoice is unable to respond to your questions, you should contact:

Arkansas Insurance Department
Consumer Services Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

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RIDER TO QUALCHOICE COMPREHENSIVE HEALTH EXPENSE COVERAGE POLICY FOR Individual Minor (FORM # Child Only (2011)) FOR

OUTPATIENT PRESCRIPTION DRUGS

This rider (the "Outpatient Prescription Drug Rider") amends the QCA Health Plan, Inc. Certificate of Coverage for Individual Minor Plans (Form # Child Only (2011)) (the "Policy") and the Benefits Summary issued to you that are legal documents between QCA Health Plan, Inc. and you. Unless otherwise stated herein, this Outpatient Prescription Drug Rider is subject to all terms, conditions, exclusions and limitations set forth in the Policy and Benefits Summary.

We have capitalized certain words in this Outpatient Prescription Drug Rider. Those words have special meanings and, unless defined otherwise in this Outpatient Prescription Drug Rider, are defined in Section 10 of the Policy.

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

1.0 Prescription Drug Benefits

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

1.1 Covered Prescription Drugs

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

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

1.2 Formulary and Tiers

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

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

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

1.3 Purchase from Retail Pharmacy

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

All participating network retail pharmacies can fill a 30 day prescription. A select group of participating network retail pharmacies is allowed to fill a 90 day prescription for a maintenance medication. You can identify these select pharmacies by logging onto our website at www.qualchoice.com.

1.4 Purchase from Mail Order Pharmacy

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

1.5 Purchase from Out-of-Network Pharmacy

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

1.6 Obtaining Benefits for Covered OTC Products

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

1.7 Brands with Generic Available

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

1.8 New Drugs Entering the Market

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

1.9 Maintenance Medications

Some Maintenance Medications (as defined in this paragraph) are allowed at a 90-day supply with a Co-pay for each 30 day supply. See Section 1.3 – Purchase from Retail Pharmacy. For purposes of this Plan, "Maintenance Medications" are defined as follows:

A. A drug that is usually administered continuously, rather than intermittently, and for longer than 90 days, typically for the remainder of one's life. This means the patient taking the medication on a scheduled basis year round and not as needed or seasonally.

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

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

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

E. Drugs in the following classes are considered to be Maintenance Medications. If your medication falls in one of these categories you will be able to get a 90 days supply either from your retail pharmacy (if it participates in the 90-day network) or from the mail order pharmacy. You will need a prescription from your doctor with enough refills to allow 90 days. One Co-payment will be charged for each 30 day supply.

i. Alzheimer Disease medication
ii. Antipsychotic medication
iii. Asthma and other respiratory medication
iv. Benign Prostatic Hyperplasia (BPH) medication
v. Blood pressure medication (e.g., beta blockers, calcium channel blockers, diuretics, ACE-inhibitors)
vi. Certain cancer medication (other cancer medications may be a Specialty Pharmacy medication (see Section 1.11))
vii. Cholesterol lowering drugs
viii. Diabetes medication
ix. Glaucoma medication
x. Heart medication
xi. Organ transplant medication
xii. Osteoporosis medication
xiii. Parkinson's Disease medication
xiv. Potassium supplements
xv. Seizure medication
xvi. Thyroid medication
xvii. Antidepressants
xviii. Contraceptives
xix. Gout medication
xx. Estrogens

1.10 Diabetes Supplies

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

1. Glucometers

2. Diabetes supplies should be filled for a 30-day supply (if possible) to minimize Enrollee cost sharing.
    - Test strips and lancets, if filled together, will be considered to be a single prescription
    - Insulin and syringes, if filled together, will be considered to be a single prescription

1.11 Specialty Pharmacy

Some Covered Prescription Drugs are designated as Specialty Pharmacy medications. These are medications generally used to treat relatively uncommon and/or potentially catastrophic illnesses. Specialty Pharmacy medications may require our pre-authorization and must be obtained through a contracted Specialty Pharmacy identified by QualChoice instead of a retail pharmacy. You will be able to get a 30-day supply of Specialty Pharmacy medication. Some Specialty Pharmacy medications may be covered under the medical plan instead of the pharmacy Benefit and they are subject to your medical plan deductible and coinsurance. You can find out whether a particular medication is considered to be a Specialty Pharmacy medication, a particular Specialty Pharmacy medication requires pre-authorization, and if Specialty Pharmacy medication has been placed on a tier or is covered under the medical plan by logging onto our website at www.qualchoice.com and selecting the drug formulary link on your member home page or by contacting our Customer Service department.

1.12 Cost Sharing Amounts

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

1.13 Exclusions From Coverage

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

- Contraceptive devices,
- Nutritional/dietary drugs,
- Biologicals, and
- Miscellaneous medical supplies.

7. The following products or categories of drugs are not covered as a Benefit under the Policy (unless included in the Formulary selected by our Employer):
    - Cosmetic agents, including, but not limited to, Retin A for Enrollees over the age of 25 and medications for hair loss;
    - Drugs for which there is a therapeutically equivalent over-the-counter drug;
    - Erectile dysfunction drugs, including but not limited to, impotency (except in very limited circumstances described in QualChoice's medical policies);
    - Obsolete drugs;
    - Smoking cessation drugs and devices (unless a Smoking Cessation Rider is included with this Policy);
    - Anorexiants;
    - Appetite suppressants;
    - Anti-obesity drugs;
    - Unit dose drugs;
    - H2 blocker anti-ulcer medications;
    - PPI anti-ulcer medications;
    - Anabolic steroids;
    - Anti-histamines; and
    - Over-the-counter medications (except as discussed in Section 1.6 above).
8. The following products or categories of drugs are not covered as either a medical or prescription drug benefit:
    - Drugs not approved by the Food and Drug Administration;
    - Drugs prescribed for an unproven indication (i.e., "off-label" uses);
    - Over-the-counter drugs (unless stated elsewhere in this Outpatient Prescription Drug Rider);
    - A drug that is not Medically Necessary for the Enrollee's medical condition for which the drug has been prescribed;
    - A drug used or intended to be used in connection with or arising from a treatment, service, condition, sickness, disease, injury, or bodily malfunction that is not a Covered Service;
    - Drugs for which payment or benefits are provided by the local, state or federal government;
    - Compounded drugs that do not contain at least one ingredient that requires a prescription;
    - Drugs whose primary purpose is the removal, destruction, or interference with the implantation of a fertilized ovum, embryo, or fetus;
    - Drugs prescribed to treat infertility;
    - Research drugs;
    - Experimental or investigational drugs;
    - A drug prescribed as part of treatment to change an Enrollee's sex from one gender to another; and
    - General and injectable vitamins.
9. Replacement of previously filled prescription medications because the initial prescription medication was lost, stolen, spilled, contaminated, etc. are not covered.
10. Excessive use of medications is not covered. For purposes of this exclusion, each Enrollee agrees that QualChoice shall be entitled to deny coverage of medications under this Outpatient Prescription Drug Rider or the Policy, on grounds of excessive use when it is determined that: (1) an Enrollee has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section

1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard reference compendia or by the Pharmacy & Therapeutics Committee; or (2) an Enrollee has obtained or attempted to obtain the same medication from more than one physician for the same or overlapping periods of time; or (3) the pattern of prescription medication purchases, changes of physicians or pharmacy or other information indicates that an Enrollee has obtained or sought to obtain excessive quantities of medications. Each Enrollee hereby authorizes QualChoice to communicate with any physician, health care provider or pharmacy for the purpose of reviewing and discussing the Enrollee's prescription history, use or activity to evaluate for excessive use.

1.14 Limitations of Coverage

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

1. Covered Prescription Drugs filled at most retail pharmacies are subject to a 30-day supply.
2. Covered Prescription Drugs at a limited number of select contracted retail and mail order pharmacies are subject to a 90-day supply. You may also contact our Customer Service Department to obtain a copy of the listing.

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

1.15 Step-Therapy Program

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

1.16 Pre-Authorization May Be Required

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

1.17 Rebates

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

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

ARKANSAS CONSUMER INFORMATION NOTICE

If you need additional information about this Outpatient Prescription Drug Rider, please contact us at:

QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211
(501) 228-7111

If QualChoice is unable to respond to your questions, you should contact:

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Consumer Services Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

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RIDER TO QUALCHOICE COMPREHENSIVE HEALTH EXPENSE COVERAGE POLICY FOR Individual Minor (FORM # Child Only (2011)) FOR

TEMPOROMANDIBULAR JOINT DISORDER (TMJ)

This rider (the "TMJ Rider") amends the QualChoice Comprehensive Health Expense Coverage Policy for Individual Minor (Form # Child Only (2011)) (the "Policy") and the Benefit Summary issued to the Policy Holder. Unless otherwise stated in herein, this TMJ Rider is subject to all terms, conditions, exclusions and limitations set forth in the Policy and the Benefit Summary.

We have capitalized certain words in this TMJ Rider. Those words have special meanings and, unless defined otherwise in this TMJ Rider, are defined in Section 10, "Definitions", of the Policy.

For purposes of this TMJ Rider and each section of this TMJ Rider, QCA Health Plan, Inc. ("QualChoice") is referred to as "us", "we" or "our", and "you" or "your" means the Policy Holder.

The following will be added to Section 3.0 ("Covered Medical Benefits") of the Policy:

Benefits are available through this TMJ Rider for those medical services or care specified in this TMJ Rider and subject to the Cost Sharing Amounts and Exclusions and Limitation described in this TMJ Rider, in addition to all other applicable conditions, limitations and exclusions of the Policy and Benefit Summary. **Consult the Benefit Summary for applicable Cost Sharing Amounts.**

Coverage is provided under this TMJ Rider for non-surgical care consisting of an initial exam, a removable appliance, splints and adult retainers, physical therapy, medications and muscle tests that are connected with the detection or correction of jaw joint problems, including temporomandibular joint and craniomandibular disorders, or conditions of the joints linking the jawbone and skull. This also includes the complex of muscles, nerves, and other tissues related to that joint. TMJ and related care does not include dental work, such as, but not limited to, orthodontics, fixed or removable bridgework/dentures, inlays, onlays, crowns or surgery, whether done for dental or medical reasons. Benefits are provided for surgical treatment of temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex of muscles, nerves, and other tissues related to that joint.

Cost Sharing Amounts

The Enrollee shall be required to pay the same Coinsurance and Co-payment with respect to treatment covered by this TMJ Rider as that Enrollee would be required to pay under the Policy and Benefit Summary for services that are Medically Necessary and performed for the treatment of an illness or injury, including, but not limited to, the Coinsurance and Co-payment generally applicable to inpatient hospital, out patient hospital services, and office visits. The Coinsurance and Co-payment described in this TMJ Rider will be counted against the applicable annual maximum out-of-pocket limitation set out in the Policy and Benefit Summary. **Consult the Benefit Summary for applicable Cost Sharing Amounts.**

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Exclusions and Limitations

Pre-Authorization Required: TMJ services must be pre-authorized by us. For details regarding the pre-authorization process, refer to the "Pre-authorization for Services" section of the Policy. Failure to meet the pre-authorization requirements will result in a reduction or denial of benefits.

Michael E. Stock

Michael E. Stock, President & CEO

QCA Health Plan, Inc.

12615 Chenal Parkway, Suite 300

Little Rock, AR 72211

ARKANSAS CONSUMER INFORMATION NOTICE

If you need additional information about this TMJ Rider, please contact us at:

QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211
(501) 228-7111

If QualChoice is unable to respond to your questions, you should contact:

Arkansas Insurance Department
Consumer Services Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

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

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

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

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible ▪ The annual Deductible is calculated on a Calendar Year basis ▪ Deductible amounts applied in the last quarter of a Calendar Year will NOT carry over to the next Calendar Year	Individual: [$2,500-$10,000]	
Annual Out-of-Pocket Limit ▪ Benefits will be paid at 10[0%-100%] of the Maximum Allowable Payment once the family annual Coinsurance Limit is satisfied ▪ Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits. ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis ▪ Annual Coinsurance Limit does not include Deductible amounts	Individual: $0 Family: $0	Individual: Unlimited
Coinsurance	[0%-100%] after Deductible	[0%-100%] after Deductible
Preventive Care Services:		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Routine vision exam (limit one every 24 months)	No Cost to You	Not Covered
Immunizations, including flu and pneumonia vaccines **Child Immunizations (age 0-18)** **Adult Immunizations (age 18+)** ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) *Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Certificate of Coverage. Flu shots will be reimbursed at a fixed fee regardless of where they are obtained.*	No Cost to You	
Well baby care, birth - to age 2 Well child care, ages 2-18 Other preventive services ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over	No Cost to You	Not Covered

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually ▪ Flexible sigmoidoscopy once every 5 years, OR ▪ Double contrast barium enema, OR ▪ Preventive colonoscopy age 50 and older, once every 10 years	No Cost to You	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectible Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections	[0%-100%] after Deductible	[0%-100%] after Deductible
Specialist Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures	[0%-100%] after Deductible	[0%-100%] after Deductible
Other Professional services ▪ Complex diagnostic services - advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures, such as chemotherapy, radiation therapy and infusion therapy ▪ Complex Injectible Prescription Medications which include: All specialty medications such as, enbrel, humira, IV antibiotics and high potency antibiotics ▪ Complex procedures, such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility	[0%-100%] after Deductible	[0%-100%] after Deductible
Inpatient Care - Room and Board		
▪ Inpatient care - room and board ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (30 day limit per Calendar Year for each)	[0%-100%] after Deductible	[0%-100%] after Deductible
Outpatient Care and Ambulatory Care Centers		
▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice (limited to a lifetime maximum of 180 days) ▪ Outpatient Surgical Services ▪ Home Health Services (40 visits per Calendar Year)	[0%-100%] after Deductible	[0%-100%] after Deductible
Emergency Services		
▪ Emergency Room, Urgent Care or ER Observation Services	[0%-100%] after Deductible	[0%-100%] after Deductible
Transportation Services		
▪ Ambulance - Ground or Air ($1,000 maximum benefit per Calendar Year) *Note: Facility to facility ambulance transfer requires pre-authorization.*	[0%-100%] after Deductible	[0%-100%] after Deductible
Therapy Services		
▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy ▪ Chiropractic Care ▪ Audiology Care ▪ Cardiac Rehabilitation (36 visits per Calendar Year) *Note: Therapy and chiropractic services are limited to a combined maximum of 45 visits per Calendar Year. This does not include Cardiac Rehabilitation.*	[0%-100%] after Deductible	[0%-100%] Not Covered

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services: ▪ Routine Prenatal Lab ▪ Initial Office Visit ▪ All other services	Not Covered	Not Covered
Facility Services	Not Covered	Not Covered
Infertility Diagnostic Services Only *Note: Treatment of infertility is not covered.*	Not Covered	Not Covered
Mental Health and Substance Use Disorder Services		
Professional Services (Office Visits) *Note: If the Mental Health and Substance Use Disorder Rider is purchased refer to the Primary Care Physician (PCP) Office Visit Benefit in the Professional Services Category of this summary for applicable benefits.* Inpatient Hospital Services Professional Services (Inpatient Facility) *Note: If the Mental Health and Substance Use Disorder Rider is purchased refer to the "Inpatient Care - Room and Board" Category of this summary for applicable benefits.*	Not Covered	Not Covered
Allergy Services		
Allergy Testing and shots	[0%-100%] after Deductible	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) ▪ $5,000 maximum benefit per Calendar Year	[0%-100%] after Deductible	Not Covered
Medical Supplies ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately ▪ Provided in connection with home infusion therapy	[0%-100%] after Deductible	[0%-100%] after Deductible
▪ Provided in connection with Durable Medical Equipment	[0%-100%] after Deductible	Not Covered
Prosthetic and Orthotic Services and Devices ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices *Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Certificate of Coverage for more information.*	[0%-100%] after Deductible	[0%-100%] after Deductible
Reconstructive Surgery ▪ Breast reconstruction (48 hour minimum hospital stay) ▪ Restoration due to acute trauma, infection or cancer	[0%-100%] after Deductible	[0%-100%] after Deductible
Transplantation Services ▪ Lifetime maximum of two transplants	[0%-100%] after Deductible	Not Covered
Diabetes Management Services ▪ Supplies and equipment ▪ Diabetic Education (1 training per lifetime)	[0%-100%] after Deductible	Not Covered
Dental Care ▪ Accidental injury to sound and natural teeth ▪ $2,000 maximum benefit per accident	[0%-100%] after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria ▪ Benefits available after member has paid $2,400 per year	[0%-100%] after Deductible	[0%-100%] after Deductible
Genetic Counseling and Testing *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.*	No benefits if not pre-authorized [0%-100%] after Deductible	No benefits if not pre-authorized [0%-100%] after Deductible

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

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

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

Tier Definitions:

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

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

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

Tier 4 medications are not included on the formulary. Almost all new prescription medications that are not listed in the formulary are included in Tier 4. Member pays 100% of the QualChoice discounted rate. Member out-of-pocket will not accumulate toward any deductible or coinsurance limit.

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

Payment Procedures

Network Pharmacy

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

Out-of-Network Pharmacy

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

Prescription Benefits In-Network	Retail (You Pay)	Mail Order (You Pay)
[Co-payment/Coinsurance] Amounts		
▪ 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 Benefit Summary	
Coinsurance Amounts		
▪ Tier 1	**[0%-100% after Deductible]**	**[0%-100% after Deductible]**
▪ Tier 2	**[0%-100% after Deductible]**	**[0%-100% after Deductible]**
▪ Tier 3	**[0%-100% after Deductible]**	**[0%-100% after Deductible]**
▪ Tier 4	**100%**	**100%**
▪ Tier 5	[0%-100% after Deductible]	[0%-100% after Deductible]
Deductible	**[$2,500-$10,000]**	

Limitations

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

Note:

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

Step Therapy

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

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

Benefit Details

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

Exclusions

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

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

Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type: Neutral

Overall Percentage of Last Rate Revision: %

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
QCA Health Plan, Inc.	Neutral	0.000%	0.000%	$0	0	$2,059	0.000%	0.000%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:				28				
Policy Holders:				28				

Rate Review Details

COMPANY:

Company Name:	QCA Health Plan, Inc.
HHS Issuer Id:	00000
Product Names:	IQChoice Select Child Only
Trend Factors:	

FORMS:

New Policy Forms:	No new policy forms
Affected Forms:	No closed blocks
Other Affected Forms:	No other affected forms

REQUESTED RATE CHANGE INFORMATION:

Change Period:	Other
Member Months:	0
Benefit Change:	None
Percent Change Requested:	Min: 0.0 Max: 0.0 Avg: 0.0

PRIOR RATE:

Total Earned Premium:	0.00
Total Incurred Claims:	0.00
Annual $:	Min: 0.00 Max: 0.00 Avg: 0.00

REQUESTED RATE:

Projected Earned Premium:	0.00
Projected Incurred Claims:	0.00
Annual $:	Min: 0.00 Max: 0.00 Avg: 0.00

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved-Closed 03/28/2012	Rate Sheet		Revised	Previous State Filing Number: Percent Rate Change Request:	IQChoice Select Rate Sheet and Actuarial Memorandum including Child Only Rates up to 64.pdf

March 1, 2012

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

Subject: Refiling QualChoice Individual Product Actuarial Memorandum (Form # IQCSelect (2011)) to include Child Only Policies with ages up to 64

Dear Ms. Minor:

Enclosed please find the Actuarial Memorandum in connection with QualChoice's proposed individual health product (Form # IQCSelect(2011)). This filing is to replace select Exhibits, those containing child only rates, from the filing for the same form dated June 23rd, 2011. This filing's rates are the same where there is overlap, but includes rates for individuals on a Child Only Policy extended to age 64. The exhibits replaced are: A-1, A-3, A-5, A-7, A-9, A-11, A-13, C-1, and C2.

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

Sincerely yours,

Graham R. Sutherlin

Graham R. Sutherlin
Director of Actuarial Services
(501) 219-5149

Enclosures

Exhibit A: QualChoice IQChoice Select
Exhibit C: QualChoice IQChoice Select – Out of Arkansas Rates for Child Only Policies

Exhibit A- 1 - Child Only Rates

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Plan Identification	I08000750A		I08001000A		I08001500A	
Deductible (In/Out network)	$750/$1,500		$1,000/$2,000		$1,500/$3,000	
Coinsurance (In/Out network)	80%/60%		80%/60%		80%/60%	
Coinsurance Max (In/Out network)	$2,000/$4,000		$2,000/$4,000		$2,000/$4,000	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 20% other		$50 Copay on E&M 20% other		$50 Copay on E&M 20% other	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
Age	Male	Female	Male	Female	Male	Female
0	328.39	328.39	320.27	320.27	303.16	303.16
1	186.58	186.58	181.97	181.97	172.24	172.24
2	93.87	93.87	91.55	91.55	86.66	86.66
3	53.64	53.64	52.32	52.32	49.52	49.52
4	50.96	50.96	49.70	49.70	47.04	47.04
5	40.23	40.23	39.24	39.24	37.14	37.14
6	30.63	30.63	29.87	29.87	28.27	28.27
7	48.47	48.47	47.27	47.27	44.74	44.74
8	43.96	43.96	42.87	42.87	40.58	40.58
9	39.45	39.45	38.48	38.48	36.42	36.42
10	42.82	42.82	41.76	41.76	39.53	39.53
11	47.32	47.32	46.16	46.16	43.69	43.69
12	51.83	51.83	50.55	50.55	47.85	47.85
13	50.42	62.25	49.18	60.71	46.55	57.47
14	54.45	67.23	53.11	65.57	50.27	62.06
15	58.49	72.20	57.04	70.42	53.99	66.66
16	62.52	77.18	60.97	75.28	57.72	71.25
17	66.55	82.16	64.91	80.13	61.44	75.85
18	69.52	85.82	67.80	83.70	64.17	79.23
19	104.27	128.73	101.70	125.55	96.26	118.84
20	215.58	275.45	210.25	268.64	198.96	254.64
21	222.60	285.69	217.10	278.63	205.36	263.97
22	229.56	295.93	223.89	288.62	211.76	273.23
23	236.59	306.18	230.75	298.61	218.20	282.56
24	243.62	316.45	237.60	308.63	224.64	291.89
25	253.45	335.69	247.19	327.40	233.90	310.05
26	259.06	338.56	252.66	330.19	239.31	312.65
27	264.60	341.39	258.06	332.96	244.72	315.28
28	270.14	344.23	263.46	335.72	250.06	317.84
29	275.71	347.09	268.90	338.52	255.47	320.47
30	281.32	357.40	274.37	348.57	260.88	330.43
31	287.67	371.33	280.56	362.15	266.72	343.07

Exhibit A- 1 - Child Only Rates

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Plan Identification	I08000750A		I08001000A		I08001500A	
Deductible (In/Out network)	$750/$1,500		$1,000/$2,000		$1,500/$3,000	
Coinsurance (In/Out network)	80%/60%		80%/60%		80%/60%	
Coinsurance Max (In/Out network)	$2,000/$4,000		$2,000/$4,000		$2,000/$4,000	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 20% other		$50 Copay on E&M 20% other		$50 Copay on E&M 20% other	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
Age	Male	Female	Male	Female	Male	Female
32	294.10	385.26	286.83	375.74	272.59	355.75
33	300.49	399.25	293.06	389.39	278.43	368.43
34	306.84	413.19	299.26	402.98	284.26	381.07
35	322.53	430.75	314.56	420.10	299.36	397.31
36	331.40	442.06	323.22	431.14	307.50	407.60
37	340.24	453.34	331.84	442.14	315.56	417.86
38	349.12	464.68	340.49	453.20	323.66	428.12
39	357.96	475.99	349.11	464.23	331.76	438.42
40	366.83	487.27	357.77	475.23	339.85	448.68
41	378.76	499.65	369.40	487.30	350.78	459.91
42	390.72	512.02	381.07	499.37	361.71	471.13
43	402.61	524.37	392.67	511.42	372.60	482.36
44	414.58	536.75	404.33	523.49	383.49	493.59
45	432.04	550.71	421.37	537.11	399.94	506.39
46	458.73	553.55	447.40	539.87	424.76	508.98
47	485.43	556.41	473.43	542.67	449.63	511.58
48	510.84	560.38	498.22	546.53	473.18	515.29
49	536.23	564.28	522.98	550.34	496.70	518.94
50	597.10	598.73	582.35	583.94	555.61	552.80
51	651.49	619.09	635.39	603.80	605.58	571.40
52	704.59	638.33	687.18	622.56	654.32	588.87
53	758.05	666.07	739.32	649.62	703.40	614.71
54	808.03	690.77	788.07	673.70	748.99	637.58
55	857.94	715.46	836.74	697.79	794.50	660.46
56	893.69	743.30	871.60	724.93	827.14	686.15
57	934.26	775.31	911.18	756.15	864.56	716.00
58	974.94	800.61	950.85	780.83	902.08	739.18
59	1,015.55	825.86	990.46	805.45	939.53	762.35
60	1,056.19	851.16	1,030.10	830.13	977.05	785.53
61	1,114.98	885.98	1,087.43	864.08	1,031.13	817.35
62	1,173.87	920.79	1,144.86	898.04	1,085.23	849.16
63	1,236.98	957.50	1,206.42	933.84	1,143.58	882.84
64	1,300.06	994.17	1,267.94	969.61	1,201.94	916.52

Exhibit A- 3 - Child Only Rates

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Plan Identification	I08002500A		I08005000A		I10007500A	
Deductible (In/Out network)	$2,500/$5,000		$5,000/$10,000		$7,500/$15,000	
Coinsurance (In/Out network)	80%/60%		80%/60%		100%/80%	
Coinsurance Max (In/Out network)	$2,000/$4,000		$2,000/$4,000		$0/unlimited	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 20% other		Ded/Coins		Ded/Coins	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
Age	Male	Female	Male	Female	Male	Female
0	272.98	272.98	215.13	215.13	203.45	203.45
1	155.10	155.10	122.23	122.23	115.59	115.59
2	78.03	78.03	61.50	61.50	58.16	58.16
3	44.59	44.59	35.14	35.14	33.23	33.23
4	42.36	42.36	33.38	33.38	31.57	31.57
5	33.44	33.44	26.36	26.36	24.92	24.92
6	25.46	25.46	20.06	20.06	18.97	18.97
7	40.29	40.29	31.75	31.75	30.03	30.03
8	36.54	36.54	28.80	28.80	27.24	27.24
9	32.80	32.80	25.85	25.85	24.44	24.44
10	35.60	35.60	28.05	28.05	26.53	26.53
11	39.34	39.34	31.00	31.00	29.32	29.32
12	43.09	43.09	33.95	33.95	32.11	32.11
13	41.92	51.75	33.03	40.78	31.24	38.57
14	45.27	55.88	35.67	44.04	33.74	41.65
15	48.62	60.02	38.32	47.30	36.24	44.73
16	51.97	64.16	40.96	50.56	38.73	47.82
17	55.32	68.30	43.60	53.83	41.23	50.90
18	57.79	71.34	45.54	56.22	43.07	53.17
19	86.68	107.01	68.31	84.33	64.60	79.76
20	179.05	229.91	140.96	182.04	133.25	172.42
21	184.74	238.05	145.34	188.08	137.33	178.04
22	190.39	246.13	149.64	194.12	141.37	183.60
23	196.07	254.27	153.98	200.16	145.45	189.22
24	201.80	262.38	158.36	206.22	149.50	194.84
25	210.51	279.43	165.71	220.58	156.64	208.73
26	215.83	281.74	170.51	222.35	161.39	210.35
27	221.11	284.04	175.30	224.08	166.13	211.96
28	226.40	286.32	180.06	225.78	170.81	213.57
29	231.69	288.59	184.86	227.52	175.56	215.19
30	237.01	298.39	189.65	236.33	180.31	223.86
31	242.18	309.42	193.61	244.51	183.96	231.44

Exhibit A- 3 - Child Only Rates

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Plan Identification	I08002500A		I08005000A		I10007500A	
Deductible (In/Out network)	$2,500/$5,000		$5,000/$10,000		$7,500/$15,000	
Coinsurance (In/Out network)	80%/60%		80%/60%		100%/80%	
Coinsurance Max (In/Out network)	$2,000/$4,000		$2,000/$4,000		$0/unlimited	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 20% other		Ded/Coins		Ded/Coins	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
Age	Male	Female	Male	Female	Male	Female
32	247.40	320.45	197.57	252.71	187.69	239.05
33	252.57	331.51	201.56	260.94	191.42	246.66
34	257.71	342.51	205.48	269.12	195.11	254.24
35	272.44	357.17	218.60	280.73	208.02	265.25
36	279.62	366.14	224.10	287.41	213.12	271.44
37	286.76	375.08	229.52	294.05	218.22	277.58
38	293.91	384.02	234.99	300.73	223.32	283.78
39	301.09	392.99	240.45	307.40	228.42	289.97
40	308.23	401.93	245.91	314.05	233.51	296.11
41	317.86	411.73	253.22	321.33	240.37	302.88
42	327.52	421.50	260.57	328.61	247.23	309.63
43	337.14	431.27	267.89	335.89	254.05	316.34
44	346.76	441.07	275.21	343.17	260.87	323.11
45	362.11	452.47	288.02	351.95	273.22	331.36
46	384.78	454.75	306.36	353.68	290.73	332.97
47	407.49	457.02	324.74	355.42	308.25	334.58
48	428.89	460.43	341.82	358.19	324.49	337.26
49	450.25	463.81	358.90	360.94	340.74	339.89
50	508.10	497.91	410.99	392.63	392.16	371.36
51	552.71	514.26	445.64	404.97	424.76	382.85
52	596.05	529.47	479.07	416.26	456.09	393.32
53	639.76	553.19	512.85	435.56	487.81	411.79
54	679.86	573.89	543.17	452.03	516.05	427.41
55	719.92	594.60	573.41	468.47	544.26	443.00
56	748.60	617.77	595.11	486.76	564.44	460.29
57	782.25	645.11	621.54	508.97	589.45	481.50
58	816.00	665.70	648.07	524.84	614.49	496.40
59	849.68	686.28	674.57	540.67	639.53	511.24
60	883.40	706.87	701.07	556.53	664.57	526.11
61	931.70	734.95	738.60	577.94	699.87	546.11
62	980.03	763.06	776.16	599.32	735.22	566.11
63	1,032.74	793.05	817.92	622.52	774.78	587.93
64	1,085.45	823.04	859.68	645.72	814.35	609.71

Exhibit A- 5 - Child Only Rates

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Plan Identification	I10010000A		I10020000A		IHSA02500B	
Deductible (In/Out network)	$10,000/$20,000		$20,000/$40,000		$2,500/$5,000	
Coinsurance (In/Out network)	100%/80%		100%/80%		100%/80%	
Coinsurance Max (In/Out network)	$0/unlimited		$0/unlimited		$0/unlimited	
PCP Office Visit	$30 Copay		$30 Copay		Ded/Coins	
Specialist Office Visit	Ded/Coins		Ded/Coins		Ded/Coins	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		Ded/Coins	
Inpatient/Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		Ded/Coins	
Age	Male	Female	Male	Female	Male	Female
0	187.37	187.37	153.64	153.64	218.96	218.96
1	106.46	106.46	87.29	87.29	124.41	124.41
2	53.56	53.56	43.92	43.92	62.59	62.59
3	30.61	30.61	25.10	25.10	35.77	35.77
4	29.08	29.08	23.84	23.84	33.98	33.98
5	22.95	22.95	18.82	18.82	26.82	26.82
6	17.47	17.47	14.33	14.33	20.42	20.42
7	27.65	27.65	22.68	22.68	32.32	32.32
8	25.08	25.08	20.57	20.57	29.31	29.31
9	22.51	22.51	18.46	18.46	26.31	26.31
10	24.43	24.43	20.03	20.03	28.55	28.55
11	27.00	27.00	22.14	22.14	31.56	31.56
12	29.57	29.57	24.25	24.25	34.56	34.56
13	28.77	35.52	23.59	29.12	33.62	41.51
14	31.07	38.36	25.48	31.45	36.31	44.83
15	33.37	41.20	27.36	33.78	39.00	48.14
16	35.67	44.04	29.25	36.11	41.69	51.46
17	37.97	46.88	31.14	38.44	44.38	54.78
18	39.66	48.97	32.52	40.15	46.35	57.22
19	59.50	73.45	48.79	60.23	69.53	85.83
20	122.67	159.15	100.46	131.37	139.06	178.29
21	126.36	164.16	103.32	135.11	139.06	182.49
22	130.00	169.15	106.17	138.82	139.06	186.69
23	133.68	174.17	109.02	142.57	139.06	190.89
24	137.36	179.16	111.91	146.34	139.06	198.66
25	144.19	192.38	118.06	158.10	147.62	220.05
26	148.83	193.84	122.57	159.23	150.81	223.18
27	153.50	195.31	127.05	160.36	150.81	226.28
28	158.10	196.74	131.53	161.47	150.81	229.40
29	162.74	198.20	136.05	162.60	150.81	232.50
30	167.41	206.69	140.56	170.65	179.88	251.43
31	170.74	213.43	143.16	175.70	183.49	258.28

Exhibit A- 5 - Child Only Rates

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Plan Identification	I10010000A		I10020000A		IHSA02500B	
Deductible (In/Out network)	$10,000/$20,000		$20,000/$40,000		$2,500/$5,000	
Coinsurance (In/Out network)	100%/80%		100%/80%		100%/80%	
Coinsurance Max (In/Out network)	$0/unlimited		$0/unlimited		$0/unlimited	
PCP Office Visit	$30 Copay		$30 Copay		Ded/Coins	
Specialist Office Visit	Ded/Coins		Ded/Coins		Ded/Coins	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		Ded/Coins	
Inpatient/Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		Ded/Coins	
Age	Male	Female	Male	Female	Male	Female
32	174.14	220.22	145.80	180.74	190.52	265.13
33	177.50	226.99	148.40	185.79	196.36	270.41
34	180.83	233.76	151.00	190.83	202.05	275.55
35	193.43	243.91	163.07	199.22	219.40	285.19
36	198.06	249.44	166.68	203.33	225.28	290.33
37	202.66	254.92	170.22	207.44	231.31	295.14
38	207.27	260.46	173.80	211.55	239.11	300.91
39	211.90	265.96	177.37	215.69	246.84	306.66
40	216.50	271.47	180.95	219.77	254.63	312.41
41	222.66	277.49	185.72	224.28	262.39	318.16
42	228.86	283.51	190.49	228.76	270.35	337.62
43	235.01	289.50	195.22	233.23	282.46	345.57
44	241.21	295.53	199.99	237.74	294.40	353.66
45	252.89	303.04	210.43	243.69	313.25	363.69
46	269.28	304.47	224.37	244.80	332.32	371.77
47	285.63	305.93	238.32	245.93	351.43	379.54
48	300.71	308.46	250.96	248.09	374.14	391.20
49	315.75	310.92	263.57	250.21	397.07	402.88
50	366.22	342.09	312.34	280.71	419.79	416.59
51	396.02	352.45	336.18	288.65	442.50	430.42
52	424.55	361.76	358.76	295.59	465.21	444.44
53	453.43	379.03	381.69	310.38	495.98	470.22
54	478.81	393.48	401.06	322.37	538.65	496.19
55	504.15	407.90	420.38	334.33	582.80	521.97
56	522.34	423.85	434.22	347.43	628.51	547.75
57	545.31	443.69	452.97	364.38	676.08	573.50
58	568.35	457.22	471.83	375.09	721.03	595.00
59	591.36	470.73	490.61	385.78	766.52	616.37
60	614.40	484.24	509.43	396.49	812.61	637.90
61	646.68	502.33	535.30	410.55	859.41	659.22
62	678.96	520.42	561.20	424.61	906.37	680.43
63	715.52	540.30	591.40	440.45	963.71	713.41
64	752.05	560.14	621.64	456.27	1,021.18	746.25

Exhibit A- 7 - Child Only Rates

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Plan Identification	IHSA05000B		I07000750A		I07001000A	
Deductible (In/Out network)	$5,000/$10,000		$750/$1,500		$1,000/$2,000	
Coinsurance (In/Out network)	100%/80%		70%/50%		70%/50%	
Coinsurance Max (In/Out network)	$0/unlimited		$3,000/$6,000		$3,000/$6,000	
PCP Office Visit	Ded/Coins		$30 Copay		$30 Copay	
Specialist Office Visit	Ded/Coins		$50 Copay on E&M 30% other		$50 Copay on E&M 30% other	
Preventive	100%		100%		100%	
Emergency Room	Ded/Coins		$250 Copay		$250 Copay	
Inpatient/Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	Ded/Coins		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
Age	Male	Female	Male	Female	Male	Female
0	169.97	169.97	316.52	316.52	308.91	308.91
1	96.57	96.57	179.83	179.83	175.51	175.51
2	48.59	48.59	90.48	90.48	88.30	88.30
3	27.76	27.76	51.70	51.70	50.46	50.46
4	26.38	26.38	49.12	49.12	47.94	47.94
5	20.82	20.82	38.78	38.78	37.84	37.84
6	15.85	15.85	29.52	29.52	28.81	28.81
7	25.08	25.08	46.71	46.71	45.59	45.59
8	22.75	22.75	42.37	42.37	41.35	41.35
9	20.42	20.42	38.03	38.03	37.11	37.11
10	22.16	22.16	41.27	41.27	40.28	40.28
11	24.49	24.49	45.61	45.61	44.52	44.52
12	26.83	26.83	49.96	49.96	48.76	48.76
13	26.10	32.22	48.60	60.00	47.43	58.56
14	28.19	34.80	52.49	64.80	51.23	63.24
15	30.27	37.37	56.37	69.60	55.02	67.92
16	32.36	39.95	60.26	74.39	58.81	72.61
17	34.45	42.53	64.15	79.19	62.61	77.29
18	35.98	44.42	67.00	82.72	65.39	80.73
19	53.97	66.63	100.51	124.08	98.09	121.10
20	107.94	138.41	207.79	265.49	202.79	259.11
21	107.94	141.66	214.56	275.37	209.40	268.75
22	107.94	144.92	221.27	285.24	215.95	278.39
23	107.94	148.18	228.04	295.11	222.56	288.02
24	107.94	154.22	234.82	305.02	229.17	297.69
25	114.55	170.84	244.29	323.56	238.42	315.78
26	117.05	173.26	249.70	326.32	243.70	318.48
27	117.05	175.65	255.04	329.05	248.91	321.15
28	117.05	178.09	260.37	331.79	254.12	323.81
29	117.05	180.51	265.75	334.55	259.36	326.51
30	139.60	195.21	271.15	344.48	264.64	336.20
31	142.41	200.52	277.28	357.91	270.61	349.31

Exhibit A- 7 - Child Only Rates

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Plan Identification	IHSA05000B		I07000750A		I07001000A	
Deductible (In/Out network)	$5,000/$10,000		$750/$1,500		$1,000/$2,000	
Coinsurance (In/Out network)	100%/80%		70%/50%		70%/50%	
Coinsurance Max (In/Out network)	$0/unlimited		$3,000/$6,000		$3,000/$6,000	
PCP Office Visit	Ded/Coins		$30 Copay		$30 Copay	
Specialist Office Visit	Ded/Coins		$50 Copay on E&M 30% other		$50 Copay on E&M 30% other	
Preventive	100%		100%		100%	
Emergency Room	Ded/Coins		$250 Copay		$250 Copay	
Inpatient/Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	Ded/Coins		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
Age	Male	Female	Male	Female	Male	Female
32	147.84	205.85	283.47	371.34	276.66	362.42
33	152.41	209.95	289.63	384.83	282.67	375.58
34	156.82	213.94	295.75	398.26	288.65	388.69
35	170.27	221.40	310.88	415.18	303.40	405.20
36	174.80	225.39	319.43	426.08	311.75	415.84
37	179.50	229.14	327.95	436.96	320.07	426.46
38	185.54	233.61	336.50	447.89	328.42	437.12
39	191.57	238.10	345.02	458.79	336.73	447.76
40	197.61	242.56	353.58	469.66	345.08	458.38
41	203.62	247.03	365.07	481.59	356.30	470.02
42	209.78	262.13	376.60	493.52	367.55	481.66
43	219.21	268.28	388.06	505.42	378.74	493.28
44	228.47	274.58	399.59	517.35	389.99	504.92
45	243.10	282.33	416.43	530.81	406.42	518.06
46	257.89	288.60	442.16	533.55	431.53	520.72
47	272.71	294.64	467.89	536.31	456.64	523.42
48	290.35	303.70	492.39	540.13	480.55	527.15
49	308.14	312.77	516.85	543.89	504.43	530.82
50	325.81	323.43	575.53	577.09	561.70	563.23
51	343.44	334.17	627.94	596.72	612.85	582.38
52	361.07	345.04	679.13	615.27	662.81	600.48
53	384.90	365.05	730.66	642.01	713.10	626.58
54	418.00	385.20	778.83	665.81	760.11	649.81
55	452.31	405.24	826.94	689.61	807.06	673.04
56	487.77	425.25	861.39	716.44	840.69	699.22
57	524.66	445.24	900.50	747.29	878.86	729.33
58	559.55	461.97	939.71	771.68	917.13	753.14
59	594.85	478.54	978.85	796.01	955.33	776.88
60	630.62	495.24	1,018.03	820.40	993.56	800.69
61	666.94	511.79	1,074.69	853.96	1,048.86	833.44
62	703.43	528.28	1,131.45	887.52	1,104.26	866.19
63	747.89	553.86	1,192.28	922.90	1,163.63	900.72
64	792.52	579.33	1,253.08	958.25	1,222.97	935.22

Exhibit A- 9 - Child Only Rates
IQChoice Select - Individual Comprehensive Major Medical and Rx Plan
Form No. IQCSelect (2011)
Summary of Benefit Design and Rates

Plan Identification	I07001500A		I07002500A		I07005000A	
Deductible (In/Out network)	$1,500/$3,000		$2,500/$5,000		$5,000/$10,000	
Coinsurance (In/Out network)	70%/50%		70%/50%		70%/50%	
Coinsurance Max (In/Out network)	$3,000/$6,000		$3,000/$6,000		$3,000/$6,000	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 30% other		$50 Copay on E&M 30% other		Ded/Coins	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
Age	Male	Female	Male	Female	Male	Female
0	292.88	292.88	263.08	263.08	210.46	210.46
1	166.40	166.40	149.47	149.47	119.57	119.57
2	83.72	83.72	75.20	75.20	60.16	60.16
3	47.84	47.84	42.97	42.97	34.38	34.38
4	45.45	45.45	40.82	40.82	32.66	32.66
5	35.88	35.88	32.23	32.23	25.78	25.78
6	27.31	27.31	24.54	24.54	19.63	19.63
7	43.23	43.23	38.83	38.83	31.06	31.06
8	39.21	39.21	35.22	35.22	28.17	28.17
9	35.19	35.19	31.61	31.61	25.29	25.29
10	38.19	38.19	34.30	34.30	27.44	27.44
11	42.21	42.21	37.91	37.91	30.33	30.33
12	46.23	46.23	41.52	41.52	33.22	33.22
13	44.97	55.52	40.39	49.87	32.31	39.89
14	48.57	59.96	43.62	53.86	34.90	43.08
15	52.16	64.40	46.86	57.84	37.48	46.27
16	55.76	68.84	50.09	61.83	40.07	49.46
17	59.36	73.28	53.32	65.82	42.65	52.66
18	62.00	76.54	55.69	68.75	44.55	55.00
19	93.00	114.81	83.54	103.13	66.83	82.50
20	192.22	246.01	172.55	221.56	137.90	178.09
21	198.40	255.02	178.03	229.41	142.18	183.99
22	204.59	263.97	183.48	237.20	146.39	189.90
23	210.80	272.98	188.96	245.04	150.64	195.81
24	217.02	281.99	194.47	252.86	154.92	201.74
25	225.97	299.55	202.87	269.29	162.11	215.79
26	231.20	302.05	208.00	271.51	166.80	217.51
27	236.43	304.59	213.09	273.73	171.49	219.21
28	241.59	307.07	218.18	275.93	176.15	220.88
29	246.82	309.61	223.28	278.12	180.84	222.57
30	252.04	319.23	228.41	287.56	185.53	231.19
31	257.68	331.45	233.39	298.19	189.40	239.19

Exhibit A- 9 - Child Only Rates
IQChoice Select - Individual Comprehensive Major Medical and Rx Plan
Form No. IQCSelect (2011)
Summary of Benefit Design and Rates

Plan Identification	I07001500A		I07002500A		I07005000A	
Deductible (In/Out network)	$1,500/$3,000		$2,500/$5,000		$5,000/$10,000	
Coinsurance (In/Out network)	70%/50%		70%/50%		70%/50%	
Coinsurance Max (In/Out network)	$3,000/$6,000		$3,000/$6,000		$3,000/$6,000	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 30% other		$50 Copay on E&M 30% other		Ded/Coins	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
Age	Male	Female	Male	Female	Male	Female
32	263.35	343.69	238.42	308.82	193.27	247.22
33	268.99	355.94	243.41	319.48	197.18	255.27
34	274.63	368.16	248.36	330.08	201.01	263.27
35	289.22	383.85	262.55	344.20	213.85	274.63
36	297.07	393.79	269.47	352.85	219.23	281.16
37	304.86	403.70	276.36	361.47	224.54	287.66
38	312.69	413.62	283.24	370.08	229.88	294.19
39	320.51	423.56	290.16	378.73	235.22	300.72
40	328.34	433.47	297.05	387.34	240.56	307.22
41	338.89	444.32	306.32	396.79	247.72	314.34
42	349.45	455.17	315.63	406.20	254.91	321.47
43	359.97	466.01	324.90	415.62	262.07	328.59
44	370.50	476.86	334.18	425.07	269.23	335.71
45	386.38	489.22	348.97	436.05	281.76	344.30
46	410.37	491.73	370.82	438.24	299.70	346.00
47	434.39	494.24	392.70	440.43	317.68	347.69
48	457.14	497.83	413.32	443.72	334.39	350.41
49	479.86	501.35	433.91	446.98	351.10	353.09
50	536.78	534.07	489.66	479.84	402.06	384.10
51	585.06	552.03	532.65	495.59	435.96	396.17
52	632.14	568.92	574.42	510.25	468.66	407.22
53	679.56	593.88	616.54	533.11	501.71	426.10
54	723.60	615.98	655.18	553.07	531.36	442.21
55	767.58	638.08	693.79	573.02	560.95	458.29
56	799.11	662.89	721.43	595.35	582.18	476.18
57	835.26	691.73	753.86	621.70	608.03	497.91
58	871.51	714.13	786.39	641.54	633.99	513.43
59	907.69	736.52	818.84	661.37	659.91	528.92
60	943.94	758.91	851.34	681.21	685.84	544.43
61	996.18	789.65	897.88	708.28	722.55	565.38
62	1,048.46	820.38	944.46	735.37	759.29	586.29
63	1,104.83	852.92	995.26	764.27	800.14	608.99
64	1,161.20	885.46	1,046.06	793.16	840.99	631.68

Exhibit A- 11 - Child Only Rates

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Plan Identification	I07000750B		I07001000B		I07001500B	
Deductible (In/Out network)	$750/$1,500		$1,000/$2,000		$1,500/$3,000	
Coinsurance (In/Out network)	70%/50%		70%/50%		70%/50%	
Coinsurance Max (In/Out network)	$3,000/$6,000		$3,000/$6,000		$3,000/$6,000	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 30% other		$50 Copay on E&M 30% other		$50 Copay on E&M 30% other	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/Outpatient Surgery	$250 Copay + Ded/Coins		$250 Copay + Ded/Coins		$250 Copay + Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
Age	Male	Female	Male	Female	Male	Female
0	310.23	310.23	302.93	302.93	287.74	287.74
1	176.26	176.26	172.11	172.11	163.49	163.49
2	88.68	88.68	86.59	86.59	82.25	82.25
3	50.68	50.68	49.48	49.48	47.00	47.00
4	48.14	48.14	47.01	47.01	44.65	44.65
5	38.01	38.01	37.11	37.11	35.25	35.25
6	28.93	28.93	28.25	28.25	26.84	26.84
7	45.79	45.79	44.71	44.71	42.47	42.47
8	41.53	41.53	40.55	40.55	38.52	38.52
9	37.27	37.27	36.40	36.40	34.57	34.57
10	40.45	40.45	39.50	39.50	37.52	37.52
11	44.71	44.71	43.66	43.66	41.47	41.47
12	48.96	48.96	47.81	47.81	45.42	45.42
13	47.63	58.81	46.51	57.42	44.18	54.54
14	51.44	63.51	50.23	62.02	47.72	58.91
15	55.25	68.21	53.95	66.61	51.25	63.27
16	59.06	72.92	57.67	71.20	54.78	67.63
17	62.87	77.62	61.39	75.79	58.32	71.99
18	65.67	81.08	64.13	79.17	60.91	75.20
19	98.51	121.61	96.19	118.75	91.37	112.80
20	203.66	260.22	198.86	254.09	188.85	241.70
21	210.30	269.90	205.35	263.54	194.92	250.55
22	216.87	279.57	211.77	272.99	201.00	259.34
23	223.51	289.25	218.25	282.44	207.11	268.20
24	230.15	298.96	224.73	291.92	213.22	277.05
25	239.44	317.13	233.80	309.67	222.01	294.29
26	244.74	319.84	238.98	312.31	227.15	296.76
27	249.97	322.52	244.09	314.93	232.28	299.25
28	255.20	325.20	249.19	317.54	237.35	301.68
29	260.47	327.90	254.34	320.18	242.49	304.18
30	265.77	337.64	259.51	329.69	247.62	313.63
31	271.77	350.80	265.37	342.54	253.16	325.63

Exhibit A- 11 - Child Only Rates

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Plan Identification	I07000750B		I07001000B		I07001500B	
Deductible (In/Out network)	$750/$1,500		$1,000/$2,000		$1,500/$3,000	
Coinsurance (In/Out network)	70%/50%		70%/50%		70%/50%	
Coinsurance Max (In/Out network)	$3,000/$6,000		$3,000/$6,000		$3,000/$6,000	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 30% other		$50 Copay on E&M 30% other		$50 Copay on E&M 30% other	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/Outpatient Surgery	$250 Copay + Ded/Coins		$250 Copay + Ded/Coins		$250 Copay + Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
Age	Male	Female	Male	Female	Male	Female
32	277.84	363.96	271.30	355.40	258.73	337.67
33	283.87	377.18	277.19	368.30	264.27	349.70
34	289.88	390.34	283.05	381.16	269.81	361.70
35	304.70	406.93	297.53	397.36	284.14	377.11
36	313.08	417.62	305.71	407.79	291.86	386.88
37	321.43	428.28	313.87	418.19	299.52	396.62
38	329.82	438.99	322.05	428.66	307.20	406.36
39	338.17	449.68	330.21	439.09	314.89	416.13
40	346.55	460.33	338.39	449.50	322.58	425.87
41	357.82	472.02	349.40	460.91	332.95	436.53
42	369.12	483.72	360.43	472.33	343.32	447.18
43	380.35	495.38	371.40	483.72	353.66	457.84
44	391.66	507.08	382.44	495.14	364.00	468.50
45	408.16	520.27	398.55	508.02	379.61	480.64
46	433.37	522.95	423.17	510.64	403.17	483.11
47	458.59	525.65	447.80	513.28	426.77	485.57
48	482.60	529.40	471.24	516.94	449.12	489.10
49	506.58	533.08	494.66	520.54	471.45	492.56
50	564.09	565.63	550.82	552.32	527.37	524.70
51	615.47	584.87	600.98	571.10	574.80	542.35
52	665.64	603.04	649.97	588.85	621.05	558.94
53	716.14	629.25	699.28	614.44	667.65	583.46
54	763.36	652.58	745.39	637.22	710.91	605.17
55	810.51	675.91	791.43	660.00	754.11	626.89
56	844.28	702.20	824.41	685.68	785.10	651.27
57	882.61	732.45	861.83	715.21	820.61	679.60
58	921.04	756.35	899.36	738.55	856.22	701.60
59	959.40	780.20	936.82	761.83	891.77	723.60
60	997.80	804.10	974.32	785.18	927.39	745.60
61	1,053.34	837.00	1,028.54	817.29	978.71	775.80
62	1,108.97	869.89	1,082.87	849.41	1,030.07	805.99
63	1,168.60	904.56	1,141.09	883.27	1,085.45	837.96
64	1,228.19	939.21	1,199.28	917.10	1,140.84	869.93

Exhibit A- 13 - Child Only Rates

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Plan Identification	I07002500B		I07005000B	
Deductible (In/Out network)	$2,500/$5,000		$5,000/$10,000	
Coinsurance (In/Out network)	70%/50%		70%/50%	
Coinsurance Max (In/Out network)	$3,000/$6,000		$3,000/$6,000	
PCP Office Visit	$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 30% other		Ded/Coins	
Preventive	100%		100%	
Emergency Room	$250 Copay		$250 Copay	
Inpatient/Outpatient Surgery	$250 Copay + Ded/Coins		$250 Copay + Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
Age	Male	Female	Male	Female
0	259.05	259.05	207.77	207.77
1	147.18	147.18	118.05	118.05
2	74.05	74.05	59.39	59.39
3	42.32	42.32	33.94	33.94
4	40.20	40.20	32.24	32.24
5	31.74	31.74	25.45	25.45
6	24.16	24.16	19.38	19.38
7	38.23	38.23	30.66	30.66
8	34.68	34.68	27.81	27.81
9	31.12	31.12	24.96	24.96
10	33.78	33.78	27.09	27.09
11	37.33	37.33	29.94	29.94
12	40.89	40.89	32.79	32.79
13	39.78	49.11	31.90	39.38
14	42.96	53.03	34.45	42.53
15	46.14	56.96	37.00	45.68
16	49.32	60.89	39.56	48.83
17	52.50	64.81	42.11	51.98
18	54.84	67.70	43.98	54.30
19	82.26	101.55	65.97	81.45
20	169.91	218.18	136.14	175.81
21	175.31	225.90	140.37	181.65
22	180.67	233.57	144.52	187.48
23	186.07	241.30	148.72	193.31
24	191.50	248.99	152.94	199.17
25	199.77	265.18	160.04	213.04
26	204.82	267.36	164.67	214.74
27	209.83	269.55	169.30	216.41
28	214.85	271.71	173.90	218.06
29	219.86	273.86	178.53	219.73
30	224.91	283.17	183.17	228.24
31	229.83	293.63	186.99	236.14

Exhibit A- 13 - Child Only Rates

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Plan Identification	I07002500B		I07005000B	
Deductible (In/Out network)	$2,500/$5,000		$5,000/$10,000	
Coinsurance (In/Out network)	70%/50%		70%/50%	
Coinsurance Max (In/Out network)	$3,000/$6,000		$3,000/$6,000	
PCP Office Visit	$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 30% other		Ded/Coins	
Preventive	100%		100%	
Emergency Room	$250 Copay		$250 Copay	
Inpatient/Outpatient Surgery	$250 Copay + Ded/Coins		$250 Copay + Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
Age	Male	Female	Male	Female
32	234.77	304.10	190.81	244.06
33	239.68	314.60	194.66	252.02
34	244.56	325.03	198.45	259.91
35	258.54	338.94	211.12	271.13
36	265.35	347.46	216.43	277.57
37	272.13	355.94	221.67	283.99
38	278.91	364.42	226.95	290.44
39	285.73	372.94	232.22	296.88
40	292.51	381.42	237.49	303.30
41	301.64	390.72	244.56	310.33
42	310.80	399.99	251.66	317.36
43	319.94	409.27	258.72	324.40
44	329.07	418.57	265.79	331.43
45	343.63	429.38	278.16	339.91
46	365.15	431.54	295.88	341.58
47	386.70	433.70	313.63	343.26
48	407.00	436.94	330.12	345.94
49	427.27	440.14	346.62	348.59
50	482.17	472.51	396.93	379.20
51	524.51	488.02	430.40	391.11
52	565.64	502.45	462.68	402.02
53	607.11	524.96	495.30	420.66
54	645.16	544.61	524.58	436.56
55	683.18	564.26	553.79	452.44
56	710.40	586.24	574.75	470.10
57	742.33	612.19	600.27	491.56
58	774.36	631.73	625.90	506.88
59	806.33	651.26	651.49	522.17
60	838.32	670.80	677.08	537.49
61	884.16	697.45	713.33	558.16
62	930.03	724.12	749.60	578.81
63	980.04	752.58	789.93	601.22
64	1,030.06	781.04	830.26	623.62

Exhibit C-1 <Revised>

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Child Only Out of AR Rates

Plan Identification	I08000750A		I08001000A		I08001500A	
Deductible (In/Out network)	$750/$1,500		$1,000/$2,000		$1,500/$3,000	
Coinsurance (In/Out network)	80%/60%		80%/60%		80%/60%	
Coinsurance Max (In/Out network)	$2,000/$4,000		$2,000/$4,000		$2,000/$4,000	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 20% other		$50 Copay on E&M 20% other		$50 Copay on E&M 20% other	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/ Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
	Male	Female	Male	Female	Male	Female
0	385.62	385.62	376.09	376.09	355.99	355.99
1	219.09	219.09	213.68	213.68	202.26	202.26
2	110.23	110.23	107.51	107.51	101.76	101.76
3	62.99	62.99	61.43	61.43	58.15	58.15
4	59.84	59.84	58.36	58.36	55.24	55.24
5	47.24	47.24	46.07	46.07	43.61	43.61
6	35.96	35.96	35.08	35.08	33.20	33.20
7	56.91	56.91	55.51	55.51	52.54	52.54
8	51.62	51.62	50.35	50.35	47.66	47.66
9	46.33	46.33	45.19	45.19	42.77	42.77
10	50.28	50.28	49.04	49.04	46.42	46.42
11	55.57	55.57	54.20	54.20	51.30	51.30
12	60.86	60.86	59.36	59.36	56.19	56.19
13	59.21	73.10	57.75	71.29	54.66	67.48
14	63.95	78.94	62.37	76.99	59.03	72.88
15	68.68	84.79	66.98	82.69	63.40	78.27
16	73.42	90.64	71.60	88.40	67.78	83.67
17	78.15	96.48	76.22	94.10	72.15	89.07
18	81.63	100.78	79.62	98.29	75.36	93.03
19	122.45	151.17	119.42	147.43	113.04	139.55
20	253.15	323.46	246.89	315.46	233.64	299.02
21	261.40	335.48	254.94	327.20	241.15	309.97
22	269.57	347.51	262.91	338.93	248.67	320.86
23	277.83	359.54	270.96	350.66	256.23	331.81
24	286.08	371.61	279.01	362.43	263.79	342.76
25	297.63	394.20	290.27	384.46	274.67	364.09
26	304.21	397.56	296.70	387.74	281.02	367.14
27	310.72	400.89	303.04	390.99	287.38	370.23
28	317.22	404.22	309.38	394.23	293.65	373.24
29	323.76	407.59	315.76	397.52	300.00	376.32
30	330.35	419.69	322.19	409.32	306.35	388.02
31	337.81	436.05	329.46	425.27	313.21	402.87

Exhibit C-1 <Revised>

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Child Only Out of AR Rates

Plan Identification	I08000750A		I08001000A		I08001500A	
Deductible (In/Out network)	$750/$1,500		$1,000/$2,000		$1,500/$3,000	
Coinsurance (In/Out network)	80%/60%		80%/60%		80%/60%	
Coinsurance Max (In/Out network)	$2,000/$4,000		$2,000/$4,000		$2,000/$4,000	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 20% other		$50 Copay on E&M 20% other		$50 Copay on E&M 20% other	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/ Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
	Male	Female	Male	Female	Male	Female
32	345.36	452.41	336.82	441.23	320.10	417.75
33	352.86	468.84	344.14	457.26	326.95	432.64
34	360.32	485.20	351.42	473.21	333.80	447.49
35	378.74	505.82	369.39	493.32	351.54	466.56
36	389.17	519.10	379.55	506.28	361.09	478.64
37	399.55	532.35	389.67	519.20	370.56	490.69
38	409.97	545.67	399.84	532.19	380.07	502.74
39	420.35	558.95	409.96	545.14	389.58	514.83
40	430.77	572.20	420.12	558.06	399.09	526.88
41	444.77	586.73	433.78	572.23	411.92	540.06
42	458.82	601.27	447.48	586.41	424.75	553.25
43	472.78	615.77	461.10	600.55	437.54	566.43
44	486.83	630.30	474.80	614.73	450.33	579.62
45	507.34	646.70	494.81	630.72	469.64	594.64
46	538.69	650.03	525.38	633.97	498.80	597.69
47	570.03	653.39	555.95	637.25	527.99	600.74
48	599.88	658.05	585.06	641.79	555.65	605.10
49	629.68	662.63	614.13	646.26	583.27	609.39
50	701.17	703.08	683.85	685.71	652.45	649.15
51	765.03	727.00	746.13	709.03	711.13	670.99
52	827.39	749.59	806.95	731.07	768.36	691.51
53	890.17	782.17	868.18	762.84	826.00	721.84
54	948.86	811.16	925.42	791.12	879.53	748.71
55	1,007.47	840.16	982.58	819.40	932.98	775.57
56	1,049.45	872.85	1,023.52	851.28	971.31	805.74
57	1,097.09	910.44	1,069.99	887.94	1,015.24	840.79
58	1,144.86	940.15	1,116.58	916.92	1,059.30	868.01
59	1,192.55	969.79	1,163.08	945.83	1,103.28	895.23
60	1,240.28	999.51	1,209.63	974.81	1,147.34	922.45
61	1,309.31	1,040.39	1,276.96	1,014.69	1,210.84	959.80
62	1,378.46	1,081.28	1,344.40	1,054.56	1,274.38	997.16
63	1,452.58	1,124.38	1,416.69	1,096.60	1,342.90	1,036.71
64	1,526.65	1,167.45	1,488.93	1,138.60	1,411.42	1,076.26

Exhibit C-1 <Revised>

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Child Only Out of AR Rates

Plan Identification	I08002500A		I08005000A		I10007500A	
Deductible (In/Out network)	$2,500/$5,000		$5,000/$10,000		$7,500/$15,000	
Coinsurance (In/Out network)	80%/60%		80%/60%		100%/80%	
Coinsurance Max (In/Out network)	$2,000/$4,000		$2,000/$4,000		$0/unlimited	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 20% other		Ded/Coins		Ded/Coins	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/ Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
	Male	Female	Male	Female	Male	Female
0	320.56	320.56	252.63	252.63	238.91	238.91
1	182.13	182.13	143.53	143.53	135.74	135.74
2	91.63	91.63	72.21	72.21	68.29	68.29
3	52.36	52.36	41.27	41.27	39.03	39.03
4	49.74	49.74	39.20	39.20	37.07	37.07
5	39.27	39.27	30.95	30.95	29.27	29.27
6	29.90	29.90	23.56	23.56	22.28	22.28
7	47.31	47.31	37.28	37.28	35.26	35.26
8	42.91	42.91	33.82	33.82	31.98	31.98
9	38.51	38.51	30.35	30.35	28.70	28.70
10	41.80	41.80	32.94	32.94	31.15	31.15
11	46.20	46.20	36.41	36.41	34.43	34.43
12	50.60	50.60	39.87	39.87	37.71	37.71
13	49.22	60.77	38.79	47.89	36.68	45.29
14	53.16	65.62	41.89	51.72	39.62	48.91
15	57.09	70.48	44.99	55.55	42.55	52.53
16	61.03	75.34	48.10	59.38	45.49	56.15
17	64.97	80.20	51.20	63.21	48.42	59.78
18	67.86	83.78	53.48	66.02	50.58	62.44
19	101.79	125.66	80.22	99.03	75.86	93.66
20	210.26	269.98	165.53	213.77	156.48	202.47
21	216.93	279.54	170.67	220.86	161.27	209.07
22	223.57	289.03	175.73	227.95	166.01	215.60
23	230.25	298.59	180.82	235.04	170.81	222.20
24	236.97	308.11	185.96	242.17	175.55	228.80
25	247.20	328.14	194.59	259.03	183.94	245.11
26	253.45	330.84	200.22	261.10	189.51	247.01
27	259.65	333.55	205.86	263.13	195.09	248.90
28	265.86	336.22	211.45	265.14	200.58	250.80
29	272.07	338.89	217.08	267.17	206.16	252.69
30	278.32	350.40	222.71	277.52	211.73	262.88
31	284.39	363.35	227.35	287.12	216.03	271.78

Exhibit C-1 <Revised>
IQChoice Select - Individual Comprehensive Major Medical and Rx Plan
Form No. IQCSelect (2011)
Summary of Benefit Design and Rates
Child Only Out of AR Rates

Plan Identification	I08002500A		I08005000A		I10007500A	
Deductible (In/Out network)	$2,500/$5,000		$5,000/$10,000		$7,500/$15,000	
Coinsurance (In/Out network)	80%/60%		80%/60%		100%/80%	
Coinsurance Max (In/Out network)	$2,000/$4,000		$2,000/$4,000		$0/unlimited	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 20% other		Ded/Coins		Ded/Coins	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/ Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
	Male	Female	Male	Female	Male	Female
32	290.51	376.30	232.00	296.76	220.40	280.71
33	296.59	389.29	236.69	306.42	224.78	289.65
34	302.63	402.21	241.29	316.03	229.12	298.55
35	319.92	419.42	256.70	329.66	244.27	311.48
36	328.35	429.95	263.16	337.50	250.26	318.75
37	336.74	440.45	269.53	345.30	256.25	325.96
38	345.13	450.95	275.94	353.14	262.24	333.24
39	353.57	461.49	282.35	360.98	268.23	340.51
40	361.96	471.98	288.77	368.78	274.21	347.72
41	373.26	483.49	297.36	377.33	282.27	355.67
42	384.60	494.97	305.99	385.88	290.32	363.59
43	395.90	506.44	314.58	394.43	298.33	371.48
44	407.20	517.95	323.17	402.98	306.34	379.43
45	425.22	531.33	338.22	413.29	320.84	389.11
46	451.85	534.00	359.76	415.33	341.40	391.00
47	478.51	536.67	381.34	417.36	361.97	392.90
48	503.64	540.68	401.40	420.62	381.05	396.05
49	528.72	544.65	421.45	423.84	400.13	399.12
50	596.65	584.70	482.62	461.06	460.51	436.08
51	649.05	603.89	523.31	475.55	498.79	449.58
52	699.94	621.75	562.57	488.81	535.58	461.87
53	751.26	649.60	602.24	511.48	572.83	483.56
54	798.35	673.92	637.83	530.81	606.00	501.90
55	845.39	698.24	673.35	550.12	639.12	520.21
56	879.08	725.44	698.83	571.59	662.82	540.51
57	918.59	757.55	729.87	597.68	692.18	565.42
58	958.22	781.72	761.03	616.31	721.59	582.92
59	997.78	805.90	792.14	634.90	750.99	600.35
60	1,037.37	830.07	823.26	653.53	780.39	617.81
61	1,094.09	863.04	867.33	678.67	821.86	641.29
62	1,150.84	896.06	911.43	703.77	863.36	664.78
63	1,212.74	931.27	960.47	731.01	909.82	690.40
64	1,274.64	966.48	1,009.51	758.26	956.28	715.98

Exhibit C-1 <Revised>

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Child Only Out of AR Rates

Plan Identification	I10010000A		I10020000A		IHSA02500B	
Deductible (In/Out network)	$10,000/$20,000		$20,000/$40,000		$2,500/$5,000	
Coinsurance (In/Out network)	100%/80%		100%/80%		100%/80%	
Coinsurance Max (In/Out network)	$0/unlimited		$0/unlimited		$0/unlimited	
PCP Office Visit	$30 Copay		$30 Copay		Ded/Coins	
Specialist Office Visit	Ded/Coins		Ded/Coins		Ded/Coins	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		Ded/Coins	
Inpatient/ Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		Ded/Coins	
	Male	Female	Male	Female	Male	Female
0	220.03	220.03	180.42	180.42	257.12	257.12
1	125.01	125.01	102.51	102.51	146.09	146.09
2	62.90	62.90	51.57	51.57	73.50	73.50
3	35.94	35.94	29.47	29.47	42.00	42.00
4	34.14	34.14	28.00	28.00	39.90	39.90
5	26.96	26.96	22.10	22.10	31.50	31.50
6	20.52	20.52	16.83	16.83	23.98	23.98
7	32.47	32.47	26.63	26.63	37.95	37.95
8	29.45	29.45	24.15	24.15	34.42	34.42
9	26.44	26.44	21.68	21.68	30.89	30.89
10	28.69	28.69	23.53	23.53	33.53	33.53
11	31.71	31.71	26.00	26.00	37.06	37.06
12	34.73	34.73	28.48	28.48	40.58	40.58
13	33.78	41.71	27.70	34.20	39.48	48.74
14	36.49	45.04	29.92	36.94	42.64	52.64
15	39.19	48.38	32.13	39.67	45.80	56.54
16	41.89	51.71	34.35	42.41	48.95	60.43
17	44.59	55.05	36.56	45.14	52.11	64.33
18	46.58	57.50	38.19	47.15	54.43	67.20
19	69.87	86.25	57.29	70.73	81.65	100.80
20	144.06	186.88	117.97	154.27	163.29	209.36
21	148.38	192.78	121.32	158.66	163.29	214.29
22	152.66	198.64	124.68	163.02	163.29	219.22
23	156.98	204.53	128.03	167.41	163.29	224.16
24	161.30	210.39	131.42	171.84	163.29	233.28
25	169.33	225.91	138.63	185.65	173.35	258.41
26	174.77	227.63	143.93	186.98	177.10	262.08
27	180.26	229.35	149.19	188.31	177.10	265.71
28	185.66	231.03	154.46	189.61	177.10	269.38
29	191.10	232.75	159.76	190.94	177.10	273.02
30	196.59	242.71	165.06	200.40	211.23	295.25
31	200.50	250.63	168.11	206.32	215.47	303.30

Exhibit C-1 <Revised>
IQChoice Select - Individual Comprehensive Major Medical and Rx Plan
Form No. IQCSelect (2011)
Summary of Benefit Design and Rates
Child Only Out of AR Rates

Plan Identification	I10010000A		I10020000A		IHSA02500B	
Deductible (In/Out network)	$10,000/$20,000		$20,000/$40,000		$2,500/$5,000	
Coinsurance (In/Out network)	100%/80%		100%/80%		100%/80%	
Coinsurance Max (In/Out network)	$0/unlimited		$0/unlimited		$0/unlimited	
PCP Office Visit	$30 Copay		$30 Copay		Ded/Coins	
Specialist Office Visit	Ded/Coins		Ded/Coins		Ded/Coins	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		Ded/Coins	
Inpatient/ Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		Ded/Coins	
	Male	Female	Male	Female	Male	Female
32	204.49	258.61	171.21	212.25	223.72	311.34
33	208.44	266.55	174.27	218.17	230.59	317.54
34	212.34	274.50	177.32	224.09	237.27	323.58
35	227.14	286.42	191.49	233.95	257.64	334.89
36	232.58	292.92	195.73	238.77	264.54	340.94
37	237.99	299.35	199.89	243.60	271.63	346.58
38	243.39	305.85	204.09	248.42	280.78	353.36
39	248.83	312.32	208.29	253.28	289.86	360.11
40	254.24	318.78	212.49	258.08	299.01	366.86
41	261.47	325.85	218.09	263.37	308.13	373.62
42	268.74	332.92	223.69	268.63	317.47	396.46
43	275.98	339.96	229.24	273.89	331.69	405.80
44	283.25	347.03	234.84	279.18	345.72	415.30
45	296.96	355.86	247.10	286.17	367.85	427.07
46	316.21	357.54	263.48	287.46	390.24	436.57
47	335.41	359.26	279.85	288.80	412.68	445.69
48	353.12	362.22	294.70	291.33	439.35	459.38
49	370.78	365.12	309.50	293.82	466.28	473.10
50	430.05	401.72	366.77	329.63	492.95	489.19
51	465.04	413.87	394.77	338.95	519.62	505.44
52	498.54	424.82	421.28	347.11	546.30	521.90
53	532.46	445.09	448.22	364.48	582.42	552.18
54	562.26	462.06	470.96	378.56	632.54	582.67
55	592.02	479.00	493.65	392.61	684.38	612.94
56	613.38	497.72	509.90	407.98	738.06	643.22
57	640.35	521.02	531.92	427.89	793.92	673.46
58	667.41	536.91	554.06	440.47	846.70	698.71
59	694.43	552.77	576.12	453.01	900.11	723.80
60	721.48	568.63	598.22	465.60	954.24	749.08
61	759.39	589.88	628.60	482.10	1,009.20	774.11
62	797.29	611.13	659.01	498.61	1,064.34	799.02
63	840.23	634.46	694.48	517.22	1,131.68	837.75
64	883.12	657.77	729.98	535.79	1,199.16	876.31

Exhibit C-1 <Revised>

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Child Only Out of AR Rates

Plan Identification	IHSA05000B	
Deductible (In/Out network)	$5,000/$10,000	
Coinsurance (In/Out network)	100%/80%	
Coinsurance Max (In/Out network)	$0/unlimited	
PCP Office Visit	Ded/Coins	
Specialist Office Visit	Ded/Coins	
Preventive	100%	
Emergency Room	Ded/Coins	
Inpatient/ Outpatient Surgery	Ded/Coins	
Prescription Drugs	Ded/Coins	
	Male	Female
0	199.59	199.59
1	113.40	113.40
2	57.05	57.05
3	32.60	32.60
4	30.97	30.97
5	24.45	24.45
6	18.61	18.61
7	29.46	29.46
8	26.72	26.72
9	23.98	23.98
10	26.03	26.03
11	28.76	28.76
12	31.50	31.50
13	30.65	37.83
14	33.10	40.86
15	35.55	43.89
16	38.00	46.91
17	40.45	49.94
18	42.25	52.16
19	63.38	78.24
20	126.75	162.53
21	126.75	166.35
22	126.75	170.18
23	126.75	174.00
24	126.75	181.09
25	134.52	200.62
26	137.45	203.45
27	137.45	206.26
28	137.45	209.13
29	137.45	211.97
30	163.93	229.24
31	167.23	235.47

Exhibit C-1 <Revised>

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Child Only Out of AR Rates

Plan Identification	IHSA05000B	
Deductible (In/Out network)	$5,000/$10,000	
Coinsurance (In/Out network)	100%/80%	
Coinsurance Max (In/Out network)	$0/unlimited	
PCP Office Visit	Ded/Coins	
Specialist Office Visit	Ded/Coins	
Preventive	100%	
Emergency Room	Ded/Coins	
Inpatient/ Outpatient Surgery	Ded/Coins	
Prescription Drugs	Ded/Coins	
	Male	Female
32	173.61	241.73
33	178.97	246.54
34	184.15	251.23
35	199.94	259.98
36	205.27	264.67
37	210.78	269.08
38	217.87	274.32
39	224.96	279.60
40	232.05	284.84
41	239.10	290.08
42	246.34	307.82
43	257.41	315.03
44	268.29	322.44
45	285.47	331.53
46	302.84	338.90
47	320.24	346.00
48	340.95	356.64
49	361.85	367.28
50	382.59	379.80
51	403.30	392.41
52	424.00	405.18
53	451.99	428.68
54	490.85	452.34
55	531.14	475.87
56	572.78	499.37
57	616.11	522.84
58	657.07	542.48
59	698.52	561.94
60	740.54	581.56
61	783.19	600.99
62	826.03	620.35
63	878.24	650.39
64	930.65	680.31

Exhibit C-2 <Revised>

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Child Only Out of AR Rates

Plan Identification	I07000750A		I07001000A		I07001500A	
Deductible (In/Out network)	$750/$1,500		$1,000/$2,000		$1,500/$3,000	
Coinsurance (In/Out network)	70%/50%		70%/50%		70%/50%	
Coinsurance Max (In/Out network)	$3,000/$6,000		$3,000/$6,000		$3,000/$6,000	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 30% other		$50 Copay on E&M 30% other		$50 Copay on E&M 30% other	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/ Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
	Male	Female	Male	Female	Male	Female
0	371.69	371.69	362.75	362.75	343.93	343.93
1	211.18	211.18	206.10	206.10	195.41	195.41
2	106.25	106.25	103.70	103.70	98.31	98.31
3	60.71	60.71	59.25	59.25	56.18	56.18
4	57.68	57.68	56.29	56.29	53.37	53.37
5	45.54	45.54	44.44	44.44	42.13	42.13
6	34.66	34.66	33.83	33.83	32.08	32.08
7	54.86	54.86	53.54	53.54	50.76	50.76
8	49.76	49.76	48.56	48.56	46.04	46.04
9	44.66	44.66	43.58	43.58	41.32	41.32
10	48.47	48.47	47.30	47.30	44.85	44.85
11	53.56	53.56	52.28	52.28	49.56	49.56
12	58.66	58.66	57.25	57.25	54.28	54.28
13	57.07	70.46	55.70	68.76	52.81	65.19
14	61.64	76.09	60.15	74.26	57.03	70.41
15	66.20	81.73	64.61	79.76	61.26	75.62
16	70.76	87.36	69.06	85.26	65.48	80.84
17	75.33	92.99	73.52	90.76	69.70	86.05
18	78.68	97.14	76.79	94.80	72.81	89.88
19	118.02	145.70	115.19	142.20	109.21	134.82
20	244.00	311.77	238.14	304.28	225.72	288.89
21	251.96	323.36	245.90	315.59	232.98	299.47
22	259.83	334.96	253.59	326.91	240.24	309.98
23	267.79	346.55	261.35	338.22	247.55	320.56
24	275.74	358.18	269.12	349.57	254.85	331.14
25	286.87	379.95	279.98	370.82	265.36	351.76
26	293.22	383.20	286.17	373.99	271.50	354.70
27	299.49	386.41	292.29	377.12	277.64	357.68
28	305.76	389.61	298.41	380.25	283.70	360.59
29	312.06	392.86	304.56	383.42	289.83	363.57
30	318.41	404.52	310.76	394.80	295.97	374.87
31	325.60	420.29	317.78	410.19	302.59	389.22

Exhibit C-2 <Revised>
IQChoice Select - Individual Comprehensive Major Medical and Rx Plan
Form No. IQCSelect (2011)
Summary of Benefit Design and Rates
Child Only Out of AR Rates

Plan Identification	I07000750A		I07001000A		I07001500A	
Deductible (In/Out network)	$750/$1,500		$1,000/$2,000		$1,500/$3,000	
Coinsurance (In/Out network)	70%/50%		70%/50%		70%/50%	
Coinsurance Max (In/Out network)	$3,000/$6,000		$3,000/$6,000		$3,000/$6,000	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 30% other		$50 Copay on E&M 30% other		$50 Copay on E&M 30% other	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/ Outpatient Surgery	Ded/Coins		Ded/Coins		Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
	Male	Female	Male	Female	Male	Female
32	332.88	436.06	324.88	425.58	309.25	403.60
33	340.11	451.90	331.93	441.04	315.87	417.98
34	347.30	467.67	338.95	456.43	322.49	432.32
35	365.06	487.54	356.29	475.83	339.62	450.75
36	375.10	500.35	366.09	488.32	348.85	462.42
37	385.11	513.11	375.85	500.78	358.00	474.06
38	395.15	525.95	385.66	513.31	367.19	485.71
39	405.16	538.75	395.42	525.80	376.37	497.38
40	415.20	551.52	405.22	538.27	385.56	509.02
41	428.70	565.53	418.40	551.94	397.96	521.76
42	442.24	579.54	431.61	565.61	410.36	534.50
43	455.70	593.51	444.75	579.25	422.71	547.24
44	469.24	607.52	457.96	592.92	435.07	559.97
45	489.01	623.33	477.26	608.35	453.73	574.49
46	519.22	626.54	506.74	611.48	481.89	577.44
47	549.44	629.78	536.23	614.65	510.10	580.38
48	578.20	634.27	564.31	619.02	536.82	584.59
49	606.93	638.68	592.34	623.33	563.50	588.74
50	675.84	677.68	659.59	661.39	630.34	627.15
51	737.39	700.73	719.67	683.89	687.03	648.25
52	797.50	722.50	778.33	705.14	742.32	668.07
53	858.00	753.90	837.38	735.78	798.01	697.38
54	914.57	781.85	892.60	763.06	849.72	723.34
55	971.07	809.80	947.73	790.34	901.36	749.29
56	1,011.52	841.31	987.22	821.09	938.39	778.43
57	1,057.45	877.54	1,032.04	856.45	980.84	812.29
58	1,103.49	906.18	1,076.97	884.40	1,023.41	838.59
59	1,149.46	934.75	1,121.83	912.29	1,065.89	864.89
60	1,195.46	963.39	1,166.73	940.24	1,108.46	891.18
61	1,262.00	1,002.80	1,231.67	978.70	1,169.81	927.27
62	1,328.65	1,042.20	1,296.72	1,017.16	1,231.19	963.36
63	1,400.09	1,083.75	1,366.44	1,057.71	1,297.39	1,001.58
64	1,471.48	1,125.26	1,436.12	1,098.22	1,363.59	1,039.79

Exhibit C-2 <Revised>

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Child Only Out of AR Rates

Plan Identification	I07002500A		I07005000A		I07000750B	
Deductible (In/Out network)	$2,500/$5,000		$5,000/$10,000		$750/$1,500	
Coinsurance (In/Out network)	70%/50%		70%/50%		70%/50%	
Coinsurance Max (In/Out network)	$3,000/$6,000		$3,000/$6,000		$3,000/$6,000	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 30% other		Ded/Coins		$50 Copay on E&M 30% other	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/ Outpatient Surgery	Ded/Coins		Ded/Coins		$250 Copay + Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
	Male	Female	Male	Female	Male	Female
0	308.93	308.93	247.14	247.14	364.30	364.30
1	175.52	175.52	140.41	140.41	206.98	206.98
2	88.31	88.31	70.65	70.65	104.14	104.14
3	50.46	50.46	40.37	40.37	59.51	59.51
4	47.94	47.94	38.35	38.35	56.53	56.53
5	37.85	37.85	30.28	30.28	44.63	44.63
6	28.81	28.81	23.05	23.05	33.98	33.98
7	45.59	45.59	36.47	36.47	53.77	53.77
8	41.35	41.35	33.08	33.08	48.77	48.77
9	37.12	37.12	29.69	29.69	43.77	43.77
10	40.28	40.28	32.22	32.22	47.50	47.50
11	44.52	44.52	35.62	35.62	52.50	52.50
12	48.76	48.76	39.01	39.01	57.50	57.50
13	47.43	58.56	37.95	46.85	55.94	69.06
14	51.23	63.24	40.98	50.59	60.41	74.58
15	55.02	67.93	44.02	54.34	64.88	80.10
16	58.81	72.61	47.05	58.09	69.36	85.62
17	62.61	77.29	50.09	61.83	73.83	91.15
18	65.40	80.73	52.32	64.59	77.12	95.21
19	98.09	121.10	78.47	96.88	115.68	142.81
20	202.63	260.18	161.93	209.13	239.15	305.57
21	209.06	269.39	166.96	216.06	246.95	316.94
22	215.45	278.54	171.91	223.00	254.67	328.30
23	221.89	287.75	176.89	229.94	262.47	339.67
24	228.37	296.93	181.92	236.90	270.26	351.06
25	238.22	316.23	190.36	253.40	281.17	372.40
26	244.25	318.84	195.87	255.42	287.39	375.58
27	250.23	321.44	201.38	257.42	293.54	378.73
28	256.21	324.02	206.85	259.37	299.68	381.87
29	262.19	326.59	212.36	261.37	305.86	385.05
30	268.21	337.68	217.87	271.49	312.09	396.49
31	274.07	350.16	222.41	280.88	319.13	411.94

Exhibit C-2 <Revised>

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Child Only Out of AR Rates

Plan Identification	I07002500A		I07005000A		I07000750B	
Deductible (In/Out network)	$2,500/$5,000		$5,000/$10,000		$750/$1,500	
Coinsurance (In/Out network)	70%/50%		70%/50%		70%/50%	
Coinsurance Max (In/Out network)	$3,000/$6,000		$3,000/$6,000		$3,000/$6,000	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 30% other		Ded/Coins		$50 Copay on E&M 30% other	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/ Outpatient Surgery	Ded/Coins		Ded/Coins		$250 Copay + Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
	Male	Female	Male	Female	Male	Female
32	279.97	362.65	226.96	290.31	326.26	427.40
33	285.83	375.16	231.54	299.77	333.35	442.92
34	291.64	387.61	236.05	309.16	340.40	458.38
35	308.31	404.20	251.13	322.50	357.81	477.86
36	316.44	414.35	257.44	330.17	367.65	490.41
37	324.52	424.47	263.67	337.80	377.46	502.92
38	332.61	434.58	269.94	345.47	387.30	515.50
39	340.73	444.74	276.22	353.13	397.11	528.05
40	348.82	454.85	282.49	360.77	406.95	540.56
41	359.71	465.95	290.90	369.13	420.18	554.29
42	370.64	477.00	299.34	377.49	433.45	568.03
43	381.53	488.06	307.74	385.86	446.65	581.72
44	392.42	499.15	316.15	394.22	459.92	595.45
45	409.79	512.05	330.87	404.31	479.29	610.94
46	435.45	514.62	351.94	406.30	508.91	614.09
47	461.15	517.20	373.05	408.29	538.52	617.27
48	485.36	521.06	392.67	411.48	566.72	621.67
49	509.53	524.88	412.30	414.63	594.87	626.00
50	575.00	563.47	472.13	451.04	662.41	664.21
51	625.49	581.97	511.94	465.21	722.74	686.81
52	674.54	599.18	550.34	478.19	781.65	708.15
53	724.00	626.02	589.15	500.36	840.96	738.92
54	769.37	649.46	623.97	519.28	896.41	766.32
55	814.71	672.89	658.72	538.16	951.77	793.71
56	847.17	699.11	683.65	559.17	991.43	824.59
57	885.25	730.05	714.01	584.70	1,036.44	860.10
58	923.45	753.35	744.49	602.92	1,081.57	888.18
59	961.56	776.65	774.93	621.10	1,126.62	916.18
60	999.72	799.94	805.37	639.32	1,171.71	944.25
61	1,054.38	831.72	848.48	663.92	1,236.92	982.88
62	1,109.08	863.53	891.63	688.48	1,302.25	1,021.50
63	1,168.72	897.47	939.60	715.13	1,372.27	1,062.22
64	1,228.37	931.40	987.57	741.78	1,442.25	1,102.91

Exhibit C-2 <Revised>

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Child Only Out of AR Rates

Plan Identification	I07001000B		I07001500B		I07002500B	
Deductible (In/Out network)	$1,000/$2,000		$1,500/$3,000		$2,500/$5,000	
Coinsurance (In/Out network)	70%/50%		70%/50%		70%/50%	
Coinsurance Max (In/Out network)	$3,000/$6,000		$3,000/$6,000		$3,000/$6,000	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 30% other		$50 Copay on E&M 30% other		$50 Copay on E&M 30% other	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/ Outpatient Surgery	$250 Copay + Ded/Coins		$250 Copay + Ded/Coins		$250 Copay + Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
	Male	Female	Male	Female	Male	Female
0	355.73	355.73	337.90	337.90	304.20	304.20
1	202.11	202.11	191.98	191.98	172.84	172.84
2	101.69	101.69	96.59	96.59	86.96	86.96
3	58.11	58.11	55.19	55.19	49.69	49.69
4	55.20	55.20	52.43	52.43	47.21	47.21
5	43.58	43.58	41.40	41.40	37.27	37.27
6	33.18	33.18	31.51	31.51	28.37	28.37
7	52.50	52.50	49.87	49.87	44.90	44.90
8	47.62	47.62	45.23	45.23	40.72	40.72
9	42.74	42.74	40.60	40.60	36.55	36.55
10	46.38	46.38	44.06	44.06	39.67	39.67
11	51.26	51.26	48.70	48.70	43.84	43.84
12	56.15	56.15	53.33	53.33	48.01	48.01
13	54.62	67.43	51.88	64.05	46.71	57.66
14	58.99	72.82	56.03	69.17	50.44	62.28
15	63.36	78.22	60.18	74.30	54.18	66.89
16	67.73	83.61	64.33	79.42	57.92	71.50
17	72.09	89.00	68.48	84.54	61.65	76.11
18	75.30	92.97	71.53	88.31	64.40	79.50
19	112.96	139.45	107.29	132.46	96.60	119.25
20	233.52	298.38	221.76	283.82	199.53	256.20
21	241.14	309.48	228.90	294.22	205.86	265.28
22	248.68	320.57	236.03	304.55	212.16	274.28
23	256.29	331.67	243.20	314.94	218.50	283.35
24	263.90	342.80	250.38	325.33	224.87	292.39
25	274.55	363.64	260.71	345.59	234.58	311.39
26	280.63	366.74	266.74	348.48	240.51	313.96
27	286.63	369.81	272.77	351.41	246.40	316.53
28	292.63	372.89	278.72	354.27	252.29	319.06
29	298.66	375.99	284.75	357.19	258.18	321.60
30	304.74	387.15	290.78	368.29	264.11	332.52
31	311.62	402.24	297.29	382.39	269.88	344.81

Exhibit C-2 <Revised>
IQChoice Select - Individual Comprehensive Major Medical and Rx Plan
Form No. IQCSelect (2011)
Summary of Benefit Design and Rates
Child Only Out of AR Rates

Plan Identification	I07001000B		I07001500B		I07002500B	
Deductible (In/Out network)	$1,000/$2,000		$1,500/$3,000		$2,500/$5,000	
Coinsurance (In/Out network)	70%/50%		70%/50%		70%/50%	
Coinsurance Max (In/Out network)	$3,000/$6,000		$3,000/$6,000		$3,000/$6,000	
PCP Office Visit	$30 Copay		$30 Copay		$30 Copay	
Specialist Office Visit	$50 Copay on E&M 30% other		$50 Copay on E&M 30% other		$50 Copay on E&M 30% other	
Preventive	100%		100%		100%	
Emergency Room	$250 Copay		$250 Copay		$250 Copay	
Inpatient/ Outpatient Surgery	$250 Copay + Ded/Coins		$250 Copay + Ded/Coins		$250 Copay + Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200		$10/$35/$70/100%/$200		$10/$35/$70/100%/$200	
	Male	Female	Male	Female	Male	Female
32	318.58	417.34	303.83	396.52	275.69	357.10
33	325.50	432.50	310.33	410.65	281.46	369.43
34	332.39	447.59	316.84	424.74	287.19	381.68
35	349.38	466.61	333.67	442.84	303.60	398.02
36	359.00	478.86	342.73	454.31	311.60	408.01
37	368.57	491.08	351.72	465.75	319.56	417.98
38	378.19	503.37	360.75	477.19	327.52	427.94
39	387.76	515.62	369.77	488.66	335.52	437.94
40	397.37	527.84	378.80	500.10	343.49	447.90
41	410.29	541.25	390.98	512.61	354.21	458.82
42	423.25	554.66	403.16	525.12	364.97	469.71
43	436.13	568.03	415.30	537.64	375.70	480.60
44	449.09	581.44	427.44	550.15	386.42	491.52
45	468.01	596.56	445.77	564.42	403.52	504.22
46	496.93	599.64	473.44	567.31	428.79	506.76
47	525.84	602.74	501.15	570.20	454.10	509.29
48	553.38	607.03	527.40	574.34	477.94	513.09
49	580.87	611.26	553.62	578.41	501.74	516.86
50	646.82	648.58	619.28	616.15	566.21	554.86
51	705.73	670.64	674.98	636.88	615.93	573.07
52	763.25	691.48	729.30	656.35	664.22	590.02
53	821.16	721.53	784.01	685.15	712.93	616.45
54	875.31	748.28	834.82	710.65	757.61	639.53
55	929.37	775.03	885.55	736.15	802.25	662.61
56	968.09	805.18	921.93	764.78	834.22	688.42
57	1,012.04	839.86	963.63	798.05	871.71	718.89
58	1,056.11	867.27	1,005.46	823.88	909.33	741.83
59	1,100.10	894.61	1,047.20	849.72	946.86	764.77
60	1,144.13	922.03	1,089.02	875.55	984.44	787.71
61	1,207.81	959.74	1,149.29	911.01	1,038.26	819.01
62	1,271.60	997.45	1,209.60	946.47	1,092.12	850.33
63	1,339.97	1,037.22	1,274.64	984.01	1,150.86	883.75
64	1,408.30	1,076.95	1,339.68	1,021.55	1,209.59	917.17

Exhibit C-2 <Revised>

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Child Only Out of AR Rates

Plan Identification	I07005000B	
Deductible (In/Out network)	$5,000/$10,000	
Coinsurance (In/Out network)	70%/50%	
Coinsurance Max (In/Out network)	$3,000/$6,000	
PCP Office Visit	$30 Copay	
Specialist Office Visit	Ded/Coins	
Preventive	100%	
Emergency Room	$250 Copay	
Inpatient/ Outpatient Surgery	$250 Copay + Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200	
	Male	Female
0	243.98	243.98
1	138.62	138.62
2	69.74	69.74
3	39.85	39.85
4	37.86	37.86
5	29.89	29.89
6	22.75	22.75
7	36.01	36.01
8	32.66	32.66
9	29.31	29.31
10	31.81	31.81
11	35.16	35.16
12	38.51	38.51
13	37.46	46.25
14	40.46	49.95
15	43.45	53.65
16	46.45	57.34
17	49.45	61.04
18	51.65	63.76
19	77.47	95.64
20	159.87	206.46
21	164.83	213.30
22	169.71	220.15
23	174.64	227.00
24	179.60	233.88
25	187.94	250.17
26	193.37	252.17
27	198.81	254.13
28	204.21	256.06
29	209.65	258.03
30	215.09	268.02
31	219.58	277.30

Exhibit C-2 <Revised>

IQChoice Select - Individual Comprehensive Major Medical and Rx Plan

Form No. IQCSelect (2011)

Summary of Benefit Design and Rates

Child Only Out of AR Rates

Plan Identification	I07005000B	
Deductible (In/Out network)	$5,000/$10,000	
Coinsurance (In/Out network)	70%/50%	
Coinsurance Max (In/Out network)	$3,000/$6,000	
PCP Office Visit	$30 Copay	
Specialist Office Visit	Ded/Coins	
Preventive	100%	
Emergency Room	$250 Copay	
Inpatient/ Outpatient Surgery	$250 Copay + Ded/Coins	
Prescription Drugs	$10/$35/$70/100%/$200	
	Male	Female
32	224.06	286.60
33	228.59	295.94
34	233.03	305.21
35	247.92	318.38
36	254.15	325.95
37	260.31	333.49
38	266.50	341.06
39	272.69	348.63
40	278.89	356.16
41	287.18	364.42
42	295.52	372.68
43	303.82	380.93
44	312.11	389.19
45	326.64	399.15
46	347.45	401.12
47	368.29	403.08
48	387.66	406.23
49	407.03	409.34
50	466.11	445.29
51	505.41	459.28
52	543.32	472.09
53	581.63	493.98
54	616.01	512.65
55	650.31	531.30
56	674.92	552.04
57	704.90	577.23
58	734.99	595.22
59	765.04	613.18
60	795.09	631.17
61	837.65	655.45
62	880.25	679.69
63	927.61	706.00
64	974.97	732.31

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/30/2011

Comments:

Attachment:

Flesch Letter.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	09/30/2011

Comments:

Attachment:

Child Only Application.pdf

		Item Status:	Status Date:
Satisfied - Item:	Health - Actuarial Justification		

Comments:

Attachment:

Actuarial Memorandum 2011.pdf

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	09/30/2011

Bypass Reason: This is included in the Benefit Summary listed under Form Filings.

Comments:

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	09/30/2011

Bypass Reason: The Compliance Summary for this product was filed with the previously submitted and aproved

SERFF Tracking Number:	*QUAC-127618022*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49739*
Company Tracking Number:			
TOI:	*H16I Individual Health - Major Medical*	*Sub-TOI:*	*H16I.005C Individual - Other*
Product Name:	*IQChoice Select Child Only Policy*		
Project Name/Number:	*IQChoice Select Child Only Policy/*		

Comments:

IQChoice Select filing approved on July 20, 201.

QualChoice

VIA SERFF

August 30, 2011

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

RE: IQChoice® Select Child Only Policy Form #: Child Only (2011)

Dear Ms. Minor:

Dear Ms. Minor:

This certifies that the Child Only (2011) Certificate of Coverage and associated riders do not meet the minimum score of forty (40) on the Flesch reading ease test as specified in Ark. Stat. Ann. § 23-80-206. Although the score is lower than the minimum required, it should be approved in accordance with Ark. Stat. Ann. § 23-80-207 and warranted due to the nature of the policy form and necessary inclusion of medical terminology and language drafted to conform to state and federal law.

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

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

Sincerely yours,

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

Application for Individual Health Insurance
CHILD ONLY (0-18 Years)

Please read the following instructions for completing this application:

- **QualChoice requires a copy of immunization records on applicant six (6) years old or less to be submitted with this application.**
- **QualChoice requires a copy of all medical records on applicant and a copy of immunization records if applicable to be submitted with this application.**
- **Open Enrollment Period is from October 1 through October 31 of each year with an effective date of January 1 only.**
- If outside the Open Enrollment dates of October 1 through October 31, QualChoice requires the submission of a Creditable Coverage Certificate from your previous carrier and/or a termination of employment letter to validate this as a qualifying event.
    - Qualifying Event means (a) loss of employer-sponsored health insurance or (b) involuntary loss of other existing health insurance for any reason other than fraud or failure to pay premium.
- The policyholder must be between the ages of 0-18 years and a legal resident of Arkansas and the United States.
    - Proof of residence will be required by the submission of:
        - Ages 0-5: Notarized Affidavit stating applicant is a Arkansas resident or receipt from Day Care.
        - Ages 6 & up: School Transcript or Arkansas Driver's license
        - Other items: Day Care receipt or copy of Medicaid Card
- This application is a legal document and will become part of your contract if you are approved for coverage. You must provide **all** requested information and ensure it is accurate and legible.
- Please use black or dark blue ink when completing the application.
- If you make a mistake on the printed application, please mark through the incorrect information, initial it and then provide the correct information.
- On the printed application, do not use correction fluid or correction tape to correct any mistakes you make.
- Any attached sheets containing additional information must be signed and dated by the applicant.
- Please ensure that all required parties sign and date the application.
    - *If the applicant on this application **does NOT** reside with the individual signing this application, or if the individual signing this application is NOT the **custodial parent, then** the custodial parent **MUST** also sign this application*.
- If a guardianship or custodial relationship exists, appropriate court documents must be attached and submitted with this application.
- Please do not send money with this application.
- We strongly encourage you to make a photocopy of the completed application for your records.
- In answering the questions in this application, do not include any family medical history or information related to genetic testing, services or counseling. Also, do not include any information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Once the IQChoice application has been completed, you can submit by:

FAX	MAIL
Printed Application to: **866.645.1788**	**QualChoice** **Attn: IQChoice** **P.O. Box 26208** **Little Rock, AR 72221**

Policy Effective Date

The policy effective date will be the 1st of the month following the month in which the application for coverage is approved. For applications submitted during the Open Enrollment Period (October 1-31), the policy effective date will **only** be January 1. Coverage becomes effective upon the date of the policy and contingent upon receipt of premium.

1. WHO IS APPLYING

In the RELATIONSHIP box (below), please indicate self, son, daughter, stepson, or stepdaughter beside applicant's name.

- **QualChoice requires a copy of immunization records on applicant six (6) years old or less to be submitted with this application.**
- **QualChoice requires a copy of all medical records on an applicant to be submitted with this application.**

IMPORTANT: Stepchildren who apply for coverage must reside with the parent and/or legal guardian. If applicant named on this application does NOT reside with the parent and/or legal guardian, we must have the custodial parent's signature. If a guardianship or custodial relationship exists, please attach appropriate court documents.

FIRST NAME	M.I.	LAST NAME	SUFFIX	RELATIONSHIP	GENDER	BIRTHDATE (MM/DD/YYYY)	SOCIAL SECURITY NO.	HEIGHT	WEIGHT

2. PARENT/GUARDIAN (if policy is only for a child under age 18)

IMPORTANT NOTE: Due to privacy concerns, unless additional written authorizations are provided, the Parent(s)/Guardian(s) listed here will be the <u>only</u> person(s) to whom QualChoice will be authorized to release medical information regarding the applicant.

FIRST NAME	M.I.	LAST NAME	RELATIONSHIP (CHECK ONE)
			☐ Father ☐ Stepfather ☐ Mother ☐ Stepmother ☐ Guardian
			☐ Father ☐ Stepfather ☐ Mother ☐ Stepmother ☐ Guardian

3. APPLICANT'S MARITAL STATUS. Please check one.

☐ Single (including widowed and divorced) ☐ Married (including separated)

4. QUALIFYING EVENT. Please check one.

☐ Yes ☐ No Was the applicant's previous coverage terminated due to an involuntary loss of coverage for any reason other than fraud, misrepresentation, or failure to pay a premium?

☐ Yes ☐ No Was the applicant's previous coverage terminated due to loss of employer-sponsored health insurance?

Name of Previous Employer: _____

Name of Previous Carrier: _____

5. U.S. CITIZENSHIP STATUS. Please check one.

☐ Yes ☐ No Is the applicant a U.S. citizens?

6. RESIDENTIAL ADDRESS (No P.O. Box, please)

PERMANENT RESIDENCE STREET ADDRESS	CITY	STATE	ZIP

7. MAILING ADDRESS (Complete only if **different** from residential address)

PERMANENT MAILING ADDRESS	CITY	STATE	ZIP

8. BILLING ADDRESS (Complete only if **different** from residential address)

PERMANENT BILLING ADDRESS	CITY	STATE	ZIP

9. E-MAIL ADDRESS

E-mail Address: _____

E-MAIL ADDRESS WILL NOT BE PROVIDED TO ANYONE OUTSIDE OF QUALCHOICE.

10. CONTACT INFORMATION

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	BEST TIME TO CALL	
		AM	PM

11. HOUSEHOLD INFORMATION

☐ Yes ☐ No Does the applicant reside in Arkansas?

If **NO**, provide reason and address of residence:_____

12. EMPLOYMENT INFORMATION

Employer: _____

Occupation: _____ Job Duties: _____

☐ Yes ☐ No Is the applicant a sole proprietor?

☐ Yes ☐ No Is the applicant covered under workers' compensation?

☐ Yes ☐ No Does the applicant's employer employ three or more full-time workers?

13. CURRENT INSURANCE INFORMATION

☐ Yes ☐ No Has the applicant been covered by an employer-sponsored health plan within the past 63 days?

If **YES,** and the **coverage** has a specified termination date, please provide it here: _____/_____/20_____

☐ Yes ☐ No Has the applicant ever been covered by QualChoice?

☐ Yes ☐ No Is the applicant eligible for an employer-sponsored group health plan?

☐ Yes ☐ No Is the applicant covered by Medicare?

14. PREVIOUS INSURANCE EXPERIENCE INFORMATION

☐ Yes ☐ No Has the applicant ever been declined for the issue of life, accident or health insurance?

If **YES**, please provide the following information:

YEAR	CARRIER	REASON FOR DECLINE

15. DRIVER'S LICENSE INFORMATION

LICENSE NO.	STATE ISSUED

☐ Yes ☐ No Has the applicant had his/her driver's license suspended within the past two (2) years?

If **YES,** has the applicant's license been reinstated? ☐ Yes ☐ No

☐ Yes ☐ No Has the applicant had his/her driver's license revoked within the past five (5) years?

If **YES,** has the applicant's license been reinstated? ☐ Yes ☐ No

☐ Yes ☐ No Has the applicant been convicted or charged with driving under the influence of alcohol or a controlled substance within the past five (5) years?

If **YES,** to any of the above questions, please provide the following information:

VIOLATION		DATE OF OCCURRENCE (MM/DD/YYYY)	

16. SPORTING OR HOBBY INFORMATION

☐ Yes ☐ No Does the applicant intend to: pilot a private aircraft, race a motor vehicle, boat, or snowmobile, participate in sky diving, ballooning, mountain climbing, hang gliding; or any other hazardous sport, hobby, or activity?

If **YES,** please explain:

17. EXPECTANT/ADOPTIVE PARENT INFORMATION

☐ Yes ☐ No Is the applicant applying for coverage an expectant parent or potential adoptive parent?

If **YES** to, please provide the following information:

EXPECTED DELIVERY/ADOPTION DATE (MM/DD/YYYY)	

18. TOBACCO USAGE INFORMATION

☐ Yes ☐ No Has the applicant used **any** form of tobacco within the last five (5) years?

If **YES,** please provide the following information:

YEAR BEGAN	TYPE USED	AMOUNT USED PER DAY

19. PRESCRIPTION QUESTIONNAIRE

☐ Yes ☐ No Is the proposed applicant **currently** taking any prescription medication or has the applicant taken prescription medication in the **last three (3) years**?

If **YES,** please provide full detail below. Use a separate sheet if necessary. **Any attachment must include all of the same information requested here and must be signed and dated.** A pharmacy print out is **not** acceptable. **Please use the name that would have been given at the time of the prescription – e.g., a maiden name may have been used.**

NAME OF PRESCRIPTION	DOSAGE	SPECIFIC CONDITION/ILLNESS	DATE		DEGREE OF RECOVERY			PHYSICIAN NAME & ADDRESS
			START	END	NONE	PARTIAL	FULL	

20. PHYSICIAN INFORMATION

Please provide the name, address, and phone number of the applicant's physician(s). **QualChoice requires a copy of medical records for applicant and immunization records for children six (6) years old or less to be submitted with this application.**

PHYSICIAN NAME	PHYSICIAN ADDRESS	PHYSICIAN PHONE NO.	DATE AND REASON OF LAST VISIT

21. MEDICAL QUESTIONNAIRE

ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR THE PERSON APPLYING FOR COVERAGE.
Check "Yes" or "No" if the applicant has had or been told he/she had any of the conditions listed below in the past ten (10) years.
Continue to the Secondary Medical Questionnaire and answer those sections checked YES below.

☐ Yes ☐ No 1. Diabetes/Sugar in Urine/Elevated Blood Sugar
☐ Yes ☐ No 2. High Blood Pressure/Hypertension
☐ Yes ☐ No 3. Endocrine System/Thyroid/Parathyroid/Cushing's Disease/Growth Hormone Deficiency/Addison's Disease
☐ Yes ☐ No 4. Ears/Eyes/Nose/Throat/Skin Conditions/Burns
☐ Yes ☐ No 5. Heart/Circulatory/Stroke/Aneurysm/Cholesterol/Blood Clots/Anemia/Peripheral Vascular Disease/Swelling of the Extremities/Valve Disorder
☐ Yes ☐ No 6. Infertility/Reproductive Organ Disorder/STD/Hypertrophy/Prostate/Ovarian Cysts/Abnormal Pap Smears
☐ Yes ☐ No 7. Digestive/Intestinal/Liver Disorder/Acid Reflux/GERD/Ulcers/Crohn's Disease/Gastrointestinal Bleeding/ Diverticulitis/Gall Bladder Disease/Hernia/Colitis/Colon Polyps/Pancreatitis
☐ Yes ☐ No 8. Nervous System/Brain Disorder/Headache/Multiple Sclerosis/Alzheimer's Disease/Senility/Dementia/Heat Exhaustion/Heat Stroke/Neuroma/Paralysis/Meningitis
☐ Yes ☐ No 9. Mental or Nervous Condition/Depression/Panic Disorder/Anxiety Disorder/Bipolar Disorder/Eating Disorder/ ADD/ADHD
☐ Yes ☐ No 10. Back or Neck Disorder/Ankylosing Spondylitis/Muscle Spasm/Sciatica/Scoliosis
☐ Yes ☐ No 11. Muscular Disorder/Lupus/Fibromyalgia/Ligament Tears/Muscle Tissue Abscess/Myositis
☐ Yes ☐ No 12. Cancers/Tumors (Malignant or Benign)
☐ Yes ☐ No 13. HIV/AIDS/ARC
☐ Yes ☐ No 14. Epilepsy/Seizure Disorder
☐ Yes ☐ No 15. Drug or Alcohol Abuse
☐ Yes ☐ No 16. Urinary Tract/Kidney Disorder/Renal Failure
☐ Yes ☐ No 17. Respiratory/Lung Disorder/TB/Allergies/Asthma/Shortness of Breath
☐ Yes ☐ No 18. Arthritis/Bone/Joint/TMJ/Fractures
☐ Yes ☐ No 19. Other Illness, Disease or Injury
☐ Yes ☐ No 20. Abnormal Laboratory Results
☐ Yes ☐ No 21. Hospitalized or Confinement for 10 Days or more
☐ Yes ☐ No 22. Weight Gain/Loss of 15 or More Pounds in Past 12 Months

22. OPTIONAL BENEFIT RIDERS

Check "Yes" or "No" for the optional benefit riders you wish to add to your benefit plan.

☐ Yes ☐ No Maternity (Pregnancy)
Rejection of the maternity rider means that covered benefits will not include coverage for maternity.

If **YES,** please provide name of physician(s): _____

☐ Yes ☐ No Temporomandibular Joint Disorder (TMJ)
Rejection of the TMJ rider means that covered benefits will not include coverage for temporomandibular joint disorder or craniomandibular disorder.

If **YES,** please provide name of dentist and physician:
Dentist: _____ Physician: _____

☐ Yes ☐ No Mental Health
Rejection of the mental health rider means that covered benefits will not include coverage for mental health conditions.

If Y**ES**, please provide name of mental health provider: _____

Complete Application Includes:

1. Proof of Arkansas Residency
2. Complete copy of all medical records for the applicant
3. Immunization records for applicant six (6) years old or less
4. Application signed by 18 year old applicant or the parent/ custodial parent
5. If a guardianship or custodial relationship exists, appropriate court documents must be attached and submitted with the application
6. If outside of Open Enrollment Period (October 1-31) QualChoice requires Creditable Coverage Certificate and/or termination of employment letter from prior employer

PLEASE READ BEFORE SIGNING

I UNDERSTAND:

(1) This application may be rejected unless the application is completed in full and submitted during the Open Enrollment period (October 1-October 31). Therefore, I understand that I should not cancel any coverage I/ the applicant currently have/has until I am notified of QualChoice's decision.

(2) If accepted, the insurance applied for shall not become effective until the date shown on my identification card and the initial premium is paid in full, but in no event will insurance become effective earlier than 10 days after the date of this application.

(3) The agent or broker involved in this insurance transaction may receive compensation from QualChoice for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

(4) If application is accepted relying on my representations on this document, any coverage which may be issued shall be invalid if based on false information.

(5) I agree any provider of medical services or supplies is authorized and directed to furnish QualChoice all records or copies thereof, relating to such services or supplies.

(6) My signature authorizes QualChoice to coordinate benefits under this policy with other insurance I have which is subject to coordination.

(7) QualChoice may phone me for additional information that may help with the timely processing of my application.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) authorize any physician, medical practitioner, hospital, clinic or other medically related facility, employer, health plan, the Medical Information Bureau (MIB), insurance or reinsurance company or any third party engaged by QualChoice to secure medical or non-medical information having information with respect to any physical or mental condition, treatment or any non-medical information on me to give QualChoice or its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (c) authorize all said sources to give such records or knowledge to any agency employed by QualChoice to collect and transmit such information in order to facilitate its rapid submission; (d) agree that this authorization shall be valid without time limit; (e) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request; (f) and authorize the Office of Driver Services to release my traffic violation record to QualChoice; and (g) QualChoice may release any information obtained by it about me to MIB or any member company for purposes described in QualChoice's Notice of Information Practices.

I certify that I signed this application in the state of Arkansas.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE SECTION (Please sign appropriate line only)

Applicant Signature **OR** Parent/Legal Guardian Signature **(REQUIRED IF APPLYING)**	**X**	Date Signed

CUSTODIAL PARENT SIGNATURE SECTION

*If any applicant on this application **does NOT** reside with the individual signing this application; or if the individual signing this application is NOT the **custodial parent; then** the custodial parent **MUST** also sign this application.*

Custodial Parent's Name & Address **(PLEASE PRINT)**	
Custodial Parent's Signature	**X**

THIS SECTION TO BE COMPLETED BY BROKER/AGENT

☐ Yes ☐ No To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical, or major medical insurance if this coverage is approved by QualChoice and accepted by the applicant?

Broker/Agent License #	Broker/Agent Name (PLEASE PRINT)	Telephone Number
Agency Federal Tax ID # **(IF APPLICABLE)**	Broker/Agent Signature **X**	Date Signed
Broker Agency Name	Broker/Agent E-mail	

IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of the applicant's enrollment in the policy, I authorize any medical professional, medical care institution, other provider of health care services or supplies, the Medical Information Bureau (MIB), reinsurer, health plan, consumer reporting agency, other third party medical and/or pharmaceutical databases or other organization, institution or person, that has any records on the applicant or the applicant's health to provide QualChoice, or its reinsurers, information concerning services or supplies provided to the applicant. I authorize any prior insurance carrier to furnish information concerning the applicant. I understand that information obtained as a result of this authorization will be used for the purpose of underwriting and determining eligibility for coverage. This information shall also be used by QualChoice in investigating and adjudicating claims for benefits. I understand that in the course of their business operations, QualChoice may disclose this information to others as required or permitted by law and as set out in the QualChoice Notice of Privacy Practices. I specifically authorize QualChoice to release necessary information obtained by QualChoice about the applicant to the applicant's broker or agent. This authorization permits release of information related to substance use or abuse, but does not provide for the disclosure of psychotherapy notes as defined in 45 CFR § 164.501. I acknowledge that signing this authorization is a condition of the applicant's enrollment for health coverage by QualChoice. I understand that I may terminate this authorization by sending a written revocation to QualChoice, ATTN: IQChoice, P.O. Box 26208, Little Rock, AR 72221. However, if I revoke this authorization before I am enrolled in the policy, the applicant's application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. A photocopy of this authorization is valid as the original.

This authorization must be signed by either the (1) applicant who is 18 years of age, or (2) the parent/legal guardian of the applicant who is not 18 years of age.

SIGNATURE OF APPLICANT WHO IS 18 YEARS OF AGE			
Print Name			
Signature	X	**Date**	

SIGNATURE OF PARENT/LEGAL GUARDIAN OF APPLICANT WHO IS NOT 18 YEARS OF AGE			
Print Name			
Signature	X	**Date**	

FAIR CREDIT REPORTING ACT NOTICE
NOTICE TO APPLICANT

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to QualChoice. Your written request should be forwarded to

QualChoice
ATTN: Individual Underwriting Division
P.O. Box 26208
Little Rock, Arkansas 72221

Please Tear Off and Keep For Your Records

Secondary Medical Questionnaire

Please provide information for all sections which the applicant has had or been told he/she had any of the conditions listed below in the past ten (10) years. In answering the questions in this application, do not include any family medical history or information related to genetic testing, services or counseling. Also, do not include information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information. Any person who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

1. Diabetes/Sugar in Urine/Elevated Blood Sugar

Yes ☐ No ☐

Which type of diabetes has been diagnosed?

☐ Type I ☐ Type II ☐ Gestational

HbA1c

☐ <6.49% ☐ 6.5% - 8.0% ☐ >8.0%

Blood Sugar	Date Taken

2. High Blood Pressure/Hypertension

Yes ☐ No ☐

Three recent blood pressure readings in systolic/diastolic format:

Systolic	Diastolic	Date Taken

Were the readings taken while on meds for hypertension? ☐ ☐

Is applicant also diagnosed with malignant hypertension? ☐ ☐

Is the hypertension controlled by diet and exercise? ☐ ☐

3. Endocrine System/Thyroid

Yes ☐ No ☐

Hyperthyroidism/Hashimoto's Thyroiditis/Graves Disease (excess thyroid hormone) ☐ ☐

What kind of treatment has the applicant had for this condition?

☐ Surgery ☐ Radioactive Iodine ☐ Other

If SURGERY, date it was done (MM/YYYY): ____/_____

Does medical management control the disease? ☐ ☐

Hypothyroidism (low thyroid hormone) ☐ ☐

Toxic Thyroid Goiter (Plummer's Disease) ☐ ☐

When was diagnosis made (MM/YYYY)? ____/_____

Hyperparathyroidism ☐ ☐

Did applicant have surgery for this condition? ☐ ☐

If NO, does medication control disease? ☐ ☐

If YES, provide date of surgery (MM/YYYY): ____/_____

Hyperaldosteronism (Cushing's Disease) ☐ ☐

Is the cause of disease known? ☐ ☐

IF YES, describe cause:

_____

_____

Date condition diagnosed (MM/YYYY): ____/_____

Is the condition stable with treatment? ☐ ☐

Addison's Disease (Chronic Adrenal Insufficiency) ☐ ☐

Growth Hormone Deficiency ☐ ☐

Other Thyroid/Endocrine System Disorder ☐ ☐

Please describe:

_____

_____

4. Ear/Eye/Nose/Throat/Skin

Yes ☐ No ☐

Middle Ear Infections/Tubes in Ears/Otitis Media ☐ ☐

Are infections chronic? ☐ ☐

How many infections have occurred in the past twelve (12) months?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

Are tubes present in the ear canals? ☐ ☐

Date of most recent episode (MM/YYYY): ____/_____

Severe Burns (Thermal or Radiation Burns) ☐ ☐

Were burns 1st degree? ☐ ☐

If YES, is the applicant currently under care for? ☐ ☐

If NO, date treatment was complete (MM/YYYY): ____/_____

Were burns 2nd or 3rd degree? ☐ ☐

If YES, which body parts were affected?

☐ Head and neck ☐ Abdomen

☐ One arm-unilateral ☐ One leg-unilateral

☐ Both arms-bilateral ☐ Both legs-bilateral

☐ Chest

If YES, were there deep burns to any of the following areas?

☐ Face ☐ Ears ☐ Hands ☐ Feet ☐ Eyes ☐ Perineum

Inhalation Burns (Chemical or Electrical Burns) ☐ ☐

Psoriasis

Episodes are: ☐ Mild ☐ Severe

Cellulitis (Skin Infection) ☐ ☐

Was there more than one episode? ☐ ☐

Are the episodes severe? ☐ ☐

When was the last episode (MM/YYYY)? ____/_____

Cleft Palate ☐ ☐

Has there been surgery for the condition? ☐ ☐

If YES, when was the surgery (MM/YYYY)? ____/_____

If YES, is further surgery needed? ☐ ☐

Cataracts ☐ ☐

Does this condition affect both of the applicant's eyes? ☐ ☐

Has the applicant had surgery for this condition? ☐ ☐

If YES, date surgery completed (MM/YYYY): ____/_____

Tonsillitis ☐ ☐

Has applicant had surgery for this condition? ☐ ☐

Was there more than one episode of symptoms? ☐ ☐

Date of last episode of symptoms (MM/YYYY): ____/_____

Sinusitis/Sinus Infection ☐ ☐

Is this condition chronic? ☐ ☐

Other Ear/Eye/Nose/Throat or Skin Condition ☐ ☐

Please describe:

_____

_____

	Yes	No
5. Heart/Circulatory/Stroke/Aneurysm	☐	☐
Hypercholesterolemia/Hyperlipidemia/High Blood Lipids/ High Blood Cholesterol	☐	☐
Is this condition secondary to another condition?	☐	☐
If YES, describe condition: _____ _____		
What are the cholesterol levels (in mg/dl)? ☐ ≤ 220 ☐ 221-250 ☐ 251-300 ☐ ≥ 301		
Are the above levels while on cholesterol meds?	☐	☐
Aneurysm	☐	☐
Anemia	☐	☐
What type of anemia does the applicant have? ☐ Pernicious ☐ Iron Deficiency ☐ Sickle Cell ☐ Hemolytic Anemia ☐ Thalassemia Major ☐ Unknown/Other		
Hemophilia	☐	☐
Bleeding Disorders	☐	☐
What type of bleeding disorder has been diagnosed? ☐ Christmas Disease (Factor IX) ☐ Hemophilia A (Factor VIII) ☐ Oslo-Weber-Rendo Disease ☐ Other type of Hemophilia		
Has there been more than 1 bleeding episode in the past year?	☐	☐
Mitral Valve Prolapse	☐	☐
If YES, is it symptomatic or does medication control it?	☐	☐
Arrhythmias	☐	☐
How many episodes have occurred? ☐ Single ☐ Multiple ☐ Chronic		
If MULTIPLE, are they controlled?	☐	☐
If YES, are they controlled by drugs?	☐	☐
If YES, are they controlled by surgical devices?	☐	☐
Is the cause known for arrhythmias?	☐	☐
If YES, please describe cause: _____ _____		
Conduction Disturbances/Bundle Branch Blocks	☐	☐
Is the cause known for conduction disturbances?	☐	☐
If YES, please describe cause: _____ _____		
Cardiac Implantable Device/Pacemaker	☐	☐
Chest Pain/Angina/Ischemic Heart Disease/ Coronary Artery Disease	☐	☐
Is the clinical work up suggestive of coronary artery disease/ blocked cardiac arteries?	☐	☐
If NO, date of onset of symptoms (MM/YYYY)? ____/_____		
Is the cause known for chest pain?	☐	☐
If YES, please describe cause: _____ _____		
Deep Vein Thrombosis/Blood Clots in Legs/Phlebitis	☐	☐
Does applicant currently have one of these conditions?	☐	☐
Has applicant had more than one episode?	☐	☐
If YES, date recovered from last episode (MM/YYYY): ____/_____		
If NO, date of onset of symptoms (MM/YYYY): ____/_____		
Is applicant on an anti-clotting prescription?	☐	☐
Heart Attack/Myocardial Infarction	☐	☐
Congestive Heart Failure	☐	☐
Carotid Artery Occlusion	☐	☐
Cardiomegaly/Enlarged Heart	☐	☐
Is applicant a heart transplant candidate?	☐	☐
Is the reason for the enlargement known?	☐	☐

	Yes	No
If YES, please describe: _____ _____		
Does applicant have any impairment from this condition?	☐	☐
Peripheral Vascular (Artery) Disease	☐	☐
Claudication	☐	☐
What is the applicant's diagnosis (choose one)? ☐ Reynaud's Disease ☐ Buerger's Disease ☐ Neither Reynaud's or Buerger's Disease		
If NEITHER, date diagnosis made (MM/YYYY): ____/_____		
If NEITHER, were there any amputations?	☐	☐
If NEITHER, were there any hospitalizations?	☐	☐
If NEITHER, please describe: _____		
Edema/Swelling of the Extremities	☐	☐
Does applicant know what is causing the swelling?	☐	☐
If YES, please describe: _____ _____		
Cardiac Valve Disorders/Heart Murmur/Atrial Fibrillation/ Mitral Regurgitation/Mitral Stenosis	☐	☐
Please select one: ☐ Heart Murmur ☐ Atrial Fibrillation ☐ Mitral Regurgitation ☐ Other Valve Disorders ☐ Mitral Stenosis		
Has applicant had surgery for this condition?	☐	☐
Heart Transplant	☐	☐
Cardiomyopathy	☐	☐
Stroke	☐	☐
Cerebral Vascular Accident (CVA)/ Transient Ischemic Attack (TIA)	☐	☐
Pericarditis	☐	☐
Is diagnosis restrictive pericarditis?	☐	☐
If NO, was there only a single episode?	☐	☐
If NO, was there any residual cardiac damage?	☐	☐
If NO, date symptoms began (MM/YYYY): ____/_____		
Other Heart or Circulatory System Disorder	☐	☐
Please describe: _____ _____		

	Yes	No
6. Infertility/Reproductive Organ Disorder/STD	☐	☐
Uterine Fibroids/Dysfunctional Uterine Bleeding	☐	☐
Has applicant had a hysterectomy?	☐	☐
If YES, when was the surgery (MM/YYYY)? ____/_____		
Was there a malignancy?	☐	☐
Benign Prostatic Hypertrophy/Prostate Enlargement	☐	☐
Is there a malignancy?	☐	☐
Has applicant had prostate surgery?	☐	☐
Were there any symptoms related to prostate enlargement?	☐	☐
Sexually Transmitted Diseases	☐	☐
Has applicant ever had genital herpes?	☐	☐
If YES, date of last episode (MM/YYYY): ____/_____		
Has applicant ever had chlamydia?	☐	☐
If YES, date of last episode (MM/YYYY): ____/_____		
Has applicant ever had gonorrhea?	☐	☐
If YES, date of last episode (MM/YYYY): ____/_____		
Infertility	☐	☐
Please describe:		
_____		
_____		
Ovarian Cysts	☐	☐
Are the cysts benign?	☐	☐
Are there any symptoms from this condition?	☐	☐
Has applicant had surgery for this condition?	☐	☐
If YES, date of surgery (MM/YYYY): ____/_____		
Has there been a reoccurrence since surgery?	☐	☐
Cervical Dysplasia/Abnormal Pap Smears	☐	☐
Was there more than one abnormal pap in the last 2 years?	☐	☐
Prolapsed Uterus	☐	☐
Has applicant had surgery to correct the condition?	☐	☐
If YES, date of surgery (MM/YYYY): ____/_____		
Other Reproductive System Disorder	☐	☐
Please describe:		
_____		
_____		

	Yes	No
7. Digestive/Intestinal/Liver Disorder/Acid Reflux/GERD	☐	☐
GERD/Gastroesophageal Reflux Disease/Acid Reflux	☐	☐
Did the symptoms abate/improve with drug therapy?	☐	☐
Are any meds taken by the applicant prescribed by physician?	☐	☐
Ulcers/Peptic Ulcers/Duodenal Ulcers/Gastric Ulcers	☐	☐
Has applicant had surgery for condition?	☐	☐
If YES, was there any recurrence since surgery?	☐	☐
If YES, what type of surgery was done?		
☐ Subtotal Gastrectomy ☐ Total Gastrectomy		
☐ Other type of surgery		
If YES, date of surgery (MM/YYYY): ____/_____		
If YES, was there a diagnosis of dumping syndrome?	☐	☐
If NO, were there any episodes of obstruction, hemorrhage and/or hospitalizations?	☐	☐
If NO, date of last episode of symptoms (MM/YYYY): ____/_____		
If NO, was there more than one episode?	☐	☐
Crohn's Disease/Inflammatory Bowel Disease/Ulcerative Colitis/Chronic Inflammation of Colon	☐	☐
Gastrointestinal Bleeding	☐	☐
When was the last bleeding episode (MM/YYYY)? ____/_____		
Is the applicant currently under treatment?	☐	☐
Diverticulitis/Diverticulosis	☐	☐
Does applicant currently have symptoms from this?	☐	☐
Has applicant had surgery for this condition?	☐	☐
If YES, did the applicant get a colostomy?	☐	☐
If YES, what kind of colostomy? ☐ Permanent ☐ Temporary		
If YES, were all affected portions with diverticula removed?	☐	☐
If YES, date surgery was done (MM/YYYY): ____/_____		
If NO, date of last treatment (MM/YYYY): ____/_____		
If NO, single episode of symptoms?	☐	☐
If YES, date of episode (MM/YYYY): ____/_____		
If NO, date of last episode of symptoms (MM/YYYY): ____/_____		
Cirrhosis of the Liver/Hepatitis/Liver Disease	☐	☐
Gall Bladder Disease/Cholelithiasis/Cholecystitis	☐	☐
Was stone in gall bladder or common bile duct?	☐	☐
Was it a single attack of symptoms?	☐	☐
Has the gall bladder been removed?	☐	☐
If YES, date surgery completed (MM/YYYY): ____/_____		
If NO, date of last attack of symptoms (MM/YYYY): ____/_____		
Has applicant had jaundice or hepatitis in last 6 months?	☐	☐
Hernia	☐	☐
Inguinal, Scrotal, or Femoral hernia?	☐	☐
Has the hernia been operated on?	☐	☐
If NO, are there any symptoms from the condition?	☐	☐
If unoperated and symptomatic, are symptoms managed by medicine?	☐	☐
Colitis/Irritable Bowel Syndrome (IBS)/Spastic Colitis	☐	☐
Is the applicant currently under treatment?	☐	☐
How many attacks have occurred? ☐ Single ☐ Multiple		
If MULTIPLE, date of last episode (MM/YYYY): ____/_____		
Colon Polyps/Rectal Polyps	☐	☐
Are the polyps benign?	☐	☐
Are the polyps recurrent?	☐	☐
Has the applicant had surgery for this condition?	☐	☐
Pancreatitis	☐	☐
Is the condition chronic?	☐	☐
Is there any history of alcohol abuse?	☐	☐
Is there any subsequent liver disease?	☐	☐
Was it only a single episode of pancreatitis?	☐	☐
Does applicant currently have pancreatitis?	☐	☐
If NO, date of last episode of symptoms (MM/YYYY): ____/_____		
Other Digestive/Intestinal Disorder	☐	☐
Please describe:		
_____		
_____		

	Yes	No
8. Nervous System/Brain Disorder	☐	☐
Headaches/Migraines/Cluster Headaches	☐	☐
Severity and frequency of headaches (choose one):		
☐ Mild (3 per year)		
☐ Moderate (3 to 6 per year)		
☐ Severe (more than 6 per year)		
How many visits to the ER for headaches over past two (2) years?		
☐ 0 ☐ 1 ☐ 2 ☐ 3+		
Multiple Sclerosis	☐	☐
Polio	☐	☐
Does applicant currently have?	☐	☐
If NO, has the applicant recovered from the condition?	☐	☐
Head Injury/Concussion	☐	☐
Was there a loss of consciousness?	☐	☐
If YES, how long was the loss of consciousness?		
☐ Less than (<) 1 hour		
If < 1 hour, any residual problems post recovery?	☐	☐
☐ Less than (<) 1 day		
If < 1 day, date of recovery (MM/YYYY):	____/_____	
If < 1 day, any residual problems post recovery?	☐	☐
☐ More than (>) 1 day		
Encephalitis/Encephalomyelitis	☐	☐
Does applicant currently have this condition?	☐	☐
If NO, any residual complications post recovery?	☐	☐
If NO, date of recovery (MM/YYYY):	____/_____	
Alzheimer's Disease	☐	☐
Senility/Dementia	☐	☐
Heat Exhaustion/Heat Stroke	☐	☐
What condition did the applicant have (choose one):		
Was this a single episode?	☐	☐
☐ Heat Exhaustion ☐ Heat Stroke		
If NO, date of last episode (MM/YYYY):	____/_____	
Hydrocephalus	☐	☐
Narcolepsy	☐	☐
Neurofibromatosis	☐	☐
Neuroma/Abnormal Nerve Growth	☐	☐
Is the growth benign?	☐	☐
Has applicant been operated on?	☐	☐
If YES, when was the surgery (MM/YYYY)?	____/_____	
If NO, when was the recovery (MM/YYYY)?	____/_____	
Is the diagnosis Morton's Neuroma?	☐	☐
ALS/Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease	☐	☐
Autism	☐	☐
Cerebral Palsy	☐	☐
Paralysis/Hemiplegia/Paraplegia	☐	☐
Huntington's Chorea	☐	☐
Parkinson's Disease	☐	☐
Spina Bifida	☐	☐
Viral Meningitis	☐	☐
Bacterial Meningitis	☐	☐
Creutzfeldt-Jakob Disease	☐	☐
Muscular Dystrophy	☐	☐
Motor Neuron Disease	☐	☐
Myasthenia Gravis	☐	☐
Neuralgia/Neuritis	☐	☐
Other Disorder of the Nervous System	☐	☐
Please describe:		
_____		
_____		

	Yes	No
9. Mental or Nervous Condition/Depression	☐	☐
Affective Disorders	☐	☐
What is the diagnosis (choose one below)?		
☐ Panic Disorder ☐ Agoraphobia		
☐ Anxiety Disorder ☐ Neuroses		
☐ Obsessive Compulsive Disorder (OCD)		
When was applicant diagnosed (MM/YYYY)?	____/_____	
Is the treatment effective?	☐	☐
If YES, when was treatment effective (MM/YYYY)?	____/_____	
What is the severity of symptoms?		
☐ Mild ☐ Moderate ☐ Severe		
Schizophrenia	☐	☐
Paranoia	☐	☐
Major Depression/Bipolar Disorder	☐	☐
When was diagnosis made (MM/YYYY)?	____/_____	
Eating Disorder/Bulimia/Anorexia	☐	☐
Does applicant currently have an eating disorder?	☐	☐
If NO, when was the date of recovery (MM/YYYY)?	____/_____	
Attention Deficit Disorder/ADD/ADHD	☐	☐
What is the severity of symptoms?		
☐ Mild ☐ Moderate ☐ Severe		
Are symptoms controlled by medication?	☐	☐
Situational Depression/Mild Depression/Anxiety	☐	☐
Is prescription medication the only current treatment?	☐	☐
Other Mental Health/Psychiatric Disorders	☐	☐
Please describe:		
_____		
_____		

	Yes	No
10. Back or Neck Disorder	☐	☐
Cervical (Neck), Thoracic (Mid-Back), or Lumbar (Low-Back) Disc Herniation or Protrusion	☐	☐
Is applicant currently under treatment?	☐	☐
Has applicant had surgery for this condition?	☐	☐
If YES, was there any subsequent problems post-operation?	☐	☐
If YES, date of surgery (MM/YYYY):	____/_____	
If NO, has the applicant recovered?	☐	☐
If YES, date of recovery (MM/YYYY):	____/_____	
Is applicant totally disabled due to their condition?	☐	☐
Low Back Pain	☐	☐
Is applicant currently under treatment for this condition?	☐	☐
If NO, date of last episode (MM/YYYY):	____/_____	
Spinal Fractures	☐	☐
Are there any lingering neurological defects?	☐	☐
Is there numbness, tingling, pain, or paralysis?	☐	☐
Was the fracture a compression fracture?	☐	☐
When was the last treatment (MM/YYYY)?	____/_____	

10. Back or Neck Disorder (Continued)	Yes	No
Spinal Stenosis	☐	☐
Has applicant had surgery for this condition?	☐	☐
If YES, give date of surgery (MM/YYYY): ____/_____		
Ankylosing Spondylitis/Spondylolisthesis	☐	☐
Has applicant had surgery for this condition?	☐	☐
If NO, is the condition symptomatic?	☐	☐
Low Back Strain/Whiplash/Muscle Spasm	☐	☐
Is applicant currently under treatment for this condition?	☐	☐
Sciatica/Radiculitis/Radiating Pain to Legs or Arms	☐	☐
Does applicant have any neurological defects?	☐	☐
Is applicant currently under treatment for?	☐	☐
Are the episodes recurrent?	☐	☐
When was the last episode (MM/YYYY)? ____/_____		
Spinal Deformities/Scoliosis/Lordosis	☐	☐
Degree of curvature _____		
Has applicant had surgery for this condition?	☐	☐
If YES, are there continuing problems post-operation?	☐	☐
If YES, date of surgery (MM/YYYY): ____/_____		
If NO, is the applicant currently under treatment?	☐	☐
If YES, what is the severity of the condition? ☐ Mild/Moderate ☐ Severe		
If NO, date of last treatment (MM/YYYY): ____/_____		
Spina Bifida/Myelocele	☐	☐
Has applicant had surgery for condition?	☐	☐
If YES, are there any residual neurological defects?	☐	☐
Other Back/Neck Disorder	☐	☐
Please describe: _____ _____		

11. Muscular Disorder/Lupus	Yes	No
Collagen Diseases: Scleroderma/Ehlers-Danlos Syndrome/Mixed Connective Tissue Disease/Necrotizing Angiitis	☐	☐
Lupus Erythematosus	☐	☐
Fibromyalgia/Myitis/Myositis	☐	☐
Is applicant currently being treated for this condition?	☐	☐
If NO, date of recovery (MM/YYYY): ____/_____		
Are episodes recurrent?	☐	☐
Ligament Tears/Meniscus Tears/Osteochondritis	☐	☐
Dessicans/Chondromalacia	☐	☐
Has applicant had surgery for the condition?	☐	☐
If YES, when was surgery completed (MM/YYYY)? ____/_____		
Muscle Tissue Abscess	☐	☐
Cause of abscess? ☐ Trauma ☐ Disease ☐ Unknown		
Is applicant currently being treated for this condition?	☐	☐
If NO, date treatment completed (MM/YYYY): ____/_____		
Polymyositis/Neuromyositis/Dermatomyositis	☐	☐
Other Muscular/Connective Tissue Disorder	☐	☐
Please describe: _____ _____		

12. Cancer/Tumors	Yes	No
Breast Cancer, Prostate Cancer, Cervical Cancer, Ovarian Cancer, or Colon/ Rectal Cancer	☐	☐
Is the cancer recurrent?	☐	☐
Does applicant know the staging of the cancer?	☐	☐
If YES, what was the stage? ☐ Stage I ☐ Stage IIA ☐ Stage IIB ☐ Stage IIIA ☐ Stage IIIB ☐ Stage IV		
Was the treatment surgery alone?	☐	☐
Is applicant under current treatment?	☐	☐
If NO, date treatment completed (MM/YYYY): ____/_____		
Is the cancer metastatic?	☐	☐
Was cancer/tumor localized with no lymph node involvement?	☐	☐
Is applicant under hospice care?	☐	☐
Lipoma/Adipose Tumor	☐	☐
Was the tumor confirmed benign by biopsy?	☐	☐
Has the tumor been removed?	☐	☐
Lymphoma/Hodgkin's Disease/Non-Hodgkin's Lymphoma	☐	☐
Melanoma	☐	☐
Lung Cancer	☐	☐
Basal Cell/Squamous Cell Skin Cancer	☐	☐
Choose type of cancer: ☐ Basal Cell ☐ Squamous Cell		
Was cancer/tumor localized with no lymph node involvement?	☐	☐
Has there been any recurrence?	☐	☐
Is applicant under current treatment?	☐	☐
If YES, what kind of treatment was done (choose one): ☐ Mohs Micrographic Surgery ☐ Radiation Therapy ☐ Simple Excision ☐ Carbon Dioxide Laser ☐ Electrodessication/Curettage ☐ Topical Fluorouracil ☐ Cryosurgery ☐ All Others		
If NO, date treatment completed (MM/YYYY): ____/_____		
Leukemia/Chronic Lymphocytic Leukemia (CLL)/Acute Lymphocytic Leukemia (ALL)/Chronic Myelogenous Leukemia (CML)/Acute Myeloid Leukemia (AML)/Acute Non-Lymphocytic Leukemia (ANLL)	☐	☐
Other Type of Cancer/Tumor	☐	☐
Please describe: _____ _____		

13. HIV/AIDS/ARC	Yes	No
HIV	☐	☐
AIDS	☐	☐
ARC	☐	☐

	Yes	No
14. Epilepsy/Seizure Disorder	☐	☐
Seizure Disorder	☐	☐
Which disorder?		
☐ Seizure Disorder ☐ Epilepsy		
What type of seizure has been diagnosed?		
☐ Febrile ☐ Jacksonian		
☐ Petit Mal ☐ Focal		
☐ Grand Mal ☐ Don't Know		
Is another disease condition causing seizures?	☐	☐
If YES, please describe condition:		
_____		
Are seizures increasing in frequency?	☐	☐
Is applicant taking medications?	☐	☐
If YES, are the seizures controlled by medication?	☐	☐
When was the last seizure (MM/YYYY)?	____/_____	
Other Seizure Disorder	☐	☐
Please describe:		
_____		
_____		

	Yes	No
15. Drug or Alcohol Abuse	☐	☐
What is the applicant dependent on?		
☐ Alcohol ☐ Marijuana		
☐ Other Drugs (besides marijuana and alcohol)		
Is applicant currently using?	☐	☐
If NO, when did the applicant last use (MM/YYYY)?	____/_____	

	Yes	No
16. Urinary Tract/Kidney Disorder	☐	☐
Cystitis/Urinary Tract Infection (UTI)/Pyuria/Urethritis	☐	☐
Was this a single episode?	☐	☐
When was the last episode (MM/YYYY)?	____/_____	
Was there any protein/discharge/blood in urine?	☐	☐
Cystic Disease of Kidneys	☐	☐
Does applicant have a solitary cyst?	☐	☐
Does applicant have polycystic kidneys?	☐	☐
Has applicant had surgery for this condition?	☐	☐
If YES, date of surgery (MM/YYYY):	____/_____	
History of Kidney Transplant	☐	☐
Renal Calculi/Kidney Stones	☐	☐
Does applicant currently have this condition?	☐	☐
If NO, date of last episode (MM/YYYY):	____/_____	
If YES, how many episodes of symptoms have occurred?		
☐ 1 ☐ 2 ☐ 3 ☐ 4+		
Were stones in both kidneys?	☐	☐
Interstitial Cystitis	☐	☐
Does applicant currently have?	☐	☐
If NO, date of last episode (MM/YYYY):	____/_____	
Acute Renal Failure/Chronic Renal Failure	☐	☐
Other Kidney/Urinary Tract Disorder	☐	☐
Please describe:		
_____		
_____		

	Yes	No
17. Respiratory/Lung Disorder/TB/Allergies/Asthma	☐	☐
Allergies/Asthma	☐	☐
Which of the following does the applicant have?		
☐ Allergies Only ☐ Asthma Only ☐ Allergies and Asthma		
If ALLERGIES, is applicant taking immunotherapy shots?	☐	☐
If YES, how often?		
☐ Weekly ☐ Bi -Weekly ☐ Monthly ☐ Bi-Annually		
If ASTHMA, are attacks occasional or frequent?		
☐ Occasional ☐ Frequent		
If ASTHMA, how would you rate the applicant's condition?		
☐ Mild (Seasonal) ☐ Moderate ☐ Severe		
If ASTHMA, how long has applicant had the condition?		
☐ less than 2 Years ☐ 2-4 Years ☐ more than 4 Years		
If ASTHMA, has applicant been hospitalized for condition?	☐	☐
If ASTHMA, is nebulizer used for acute episodes?	☐	☐
If ASTHMA, is applicant taking corticosteroids?	☐	☐
If ASTHMA, is it controlled by medications?	☐	☐
Bronchitis	☐	☐
Have there been any hospitalizations for this condition?	☐	☐
If YES, was there more than one hospitalization?	☐	☐
Was it chronic?	☐	☐
Chronic Obstructive Lung Disease (COPD)/Emphysema	☐	☐
Sinusitis/Sinus Infection	☐	☐
Is the condition chronic?	☐	☐
Tuberculosis	☐	☐
Does applicant currently have this condition?	☐	☐
If NO, has the applicant recovered?	☐	☐
Pulmonary Embolism/Pulmonary Infarction	☐	☐
Does applicant know what caused Embolism/Infarction?	☐	☐
If YES, please describe:		
_____		
_____		
Single episode of symptoms?	☐	☐
Does applicant have phlebitis-blood clots in legs?	☐	☐
When did the symptoms last occur (MM/YYYY)?	____/_____	
Is applicant continuing anticoagulant drug treatment?	☐	☐
Has applicant fully recovered?	☐	☐
Dyspnea/Shortness of Breath	☐	☐
Is there an underlying condition causing Dyspnea?	☐	☐
If YES, please describe:		
_____		
_____		
Is the shortness of breath exercise-induced?	☐	☐
If YES, how would the applicant characterize symptoms?		
☐ Mild ☐ Moderate ☐ Severe		
Other Respiratory Condition	☐	☐
Please describe:		
_____		
_____		

	Yes	No
18. Arthritis/Bone/Joint Disorder/TMJ	☐	☐
Arthritis	☐	☐
What type of arthritis does the applicant have?		
☐ Degenerative ☐ Chronic Proliferative		
☐ Hypertrophic ☐ Arthritis Deformans		
☐ Senile ☐ Chondrocalcinosis		
☐ Psoriatic ☐ Acute Infectious		
☐ Septic ☐ Juvenile Rheumatoid		
☐ Atrophic ☐ Adult Rheumatoid ☐ Osteoarthritis		
Date of initial onset of symptoms (MM/YYYY): ____/_____		
Is more than one joint affected?	☐	☐
If NO, is the joint a hip or a knee?	☐	☐
Has applicant had a hip/knee replacement?	☐	☐
If YES, date it was completed (MM/YYYY): ____/_____		
Characterization of disease progression/degree of disability:		
☐ Mild (Minimal) ☐ Moderate ☐ Severe		
Is there a joint infection?	☐	☐
If YES, any bony involvement with infection?	☐	☐
If YES, is applicant currently being treated?	☐	☐
If NO, when was treatment completed (MM/YYYY)? ____/_____		
Osteomyelitis/Bone Infection/Bone Abscess	☐	☐
Was there only a single episode of symptoms?	☐	☐
Bone/Joint involved in episode:		
☐ Major Bone/Joint ☐ Minor Bone/Joint		
Is applicant currently under treatment for condition?	☐	☐
If NO, date treatment was completed (MM/YYYY)? ____/_____		
Bursitis/Tennis Elbow/Tendonitis/Synovitis	☐	☐
Was there only a single episode of symptoms?	☐	☐
Is applicant currently under treatment for condition?	☐	☐
Carpel Tunnel Syndrome	☐	☐
Has applicant had surgery for this condition?	☐	☐
If YES, date it was completed (MM/YYYY): ____/_____		
Paget's Disease	☐	☐
Does applicant have a single affected area?	☐	☐
Was the disease an incidental finding?	☐	☐
Ligament Tears/Torn Meniscus/Osteochondritis	☐	☐
Has applicant had surgery for this condition?	☐	☐
If YES, date of surgery (MM/YYYY) ____/_____		
Bone Dislocation	☐	☐
What type of dislocation (choose one)?		
☐ Congenital Hip ☐ Patella (kneecap)		
☐ Shoulder ☐ Knee (not kneecap)		
☐ Hip (Traumatic) ☐ Other Joint (Traumatic)		
Was there a single episode of symptoms?	☐	☐

	Yes	No
Does applicant currently have this condition?	☐	☐
Has applicant had surgery on this condition?	☐	☐
Was the dislocation unilateral or bilateral?		
☐ Unilateral ☐ Bilateral		
Bone Fracture	☐	☐
Has treatment been completed?	☐	☐
Has applicant had surgery?	☐	☐
Was fracture union or non-union?		
☐ Union ☐ Non-Union		
Where was the fracture?	☐	☐
☐ Leg/Hip/Foot ☐ Arm/Hand/Shoulder ☐ Other Bone		
Rotator Cuff Tear	☐	☐
Has applicant had surgery for this condition?	☐	☐
If YES, date of surgery (MM/YYYY): ____/_____		
Date of original injury (MM/YYYY): ____/_____		
Temporal Mandibular Joint (TMJ)	☐	☐
Does applicant currently have this condition?	☐	☐
If NO, when did applicant recover (MM/YYYY)? ____/_____		
Surgery?	☐	☐
Dental Appliance?	☐	☐
Osteoporosis	☐	☐
Is the underlying cause known for this condition?	☐	☐
If YES, please describe:		
_____		
_____		
Are there any symptoms from this condition?	☐	☐
Have there been any subsequent fractures?	☐	☐
Does applicant take steroids for this condition?	☐	☐
Gout/Gouty Arthritis/Hyperuricemia	☐	☐
How many attacks have occurred in the last 5 years?		
☐ 1-2 ☐ 3+		
Are the attacks controlled by medication and/or diet?	☐	☐
Amputation	☐	☐
What limb?		
☐ Fingers ☐ Arm or Hand ☐ Leg or Foot ☐ Toes		
Was it due to disease or illness?	☐	☐
Date of original injury (MM/YYYY): ____/_____		
Does applicant have a prosthetic limb?	☐	☐
Acquisition date of limb (MM/YYYY): ____/_____		
Other Bone/Joint Disorder	☐	☐
Please describe:		
_____		
_____		

	Yes	No
19. Other Illness, Disease, or Injury	☐	☐

When answering this question, do not include any family medical history or information related to genetic testing, services or counseling. Also, do not include information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Please describe other condition:

_____

_____

_____

_____

_____

	Yes	No
20. Abnormal Laboratory Results	☐	☐

Please describe abnormal laboratory results:

_____
_____

	Yes	No
21. Hospitalization or Confinement for 10 Days or More	☐	☐

Please describe condition for hospitalization/confinement:

_____
_____
_____
_____

	Yes	No
22. Weight Gain/Loss of 15 or More Pounds in Past 12 Months	☐	☐

Please describe causes of weight gain/loss:

_____
_____
_____
_____

Additional Information

In answering the questions in this application, do not include any family medical history or information related to genetic testing, services or counseling. Also, do not include information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/28/2011	Rate and Rule	Rate Sheet	03/27/2012	Child Only Rate Sheet (1).pdf (Superceded)
09/08/2011	Supporting Document	Health - Actuarial Justification	03/28/2012	
09/29/2011	Form	Child Only (2011)	09/30/2011	Child Only Policy Final.pdf (Superceded)
09/28/2011	Form	Child Only (2011)	09/29/2011	Child Only Policy Final.pdf (Superceded)
09/08/2011	Form	Child Only (2011)	09/28/2011	Child Only Policy.pdf (Superceded)
09/08/2011	Form	IQCSelect Child Only Benefit Summaries	09/28/2011	2011 IQCSelect Child Only Benefit Summaries.pdf (Superceded)

COMPREHENSIVE HEALTH EXPENSE COVERAGE POLICY FOR INDIVIDUAL MINOR

IMPORTANT NOTICE

COVERED BENEFITS RECEIVED FROM AN OUT-OF-NETWORK PROVIDER, EXCEPT IN CERTAIN CIRCUMSTANCES (SEE SECTION 2), ARE PAID AT A RATE LESS THAN THE SAME COVERED SERVICES RECEIVED FROM A NETWORK PROVIDER. SEE YOUR BENEFIT SUMMARY.

OTHER INSURANCE REDUCES BENEFITS – READ CAREFULLY

Attached is the Benefit Summary, showing the name of Policyholder, Policy Number, premiums and Effective Date of this Policy ("Effective Date").

GUARANTEED RENEWABLE CONDITIONED
UPON RESIDENCE IN ARKANSAS
PREMIUMS SUBJECT TO CHANGE

THIS POLICY HAS SEVERAL SPECIFIC EXCLUSIONS. (SEE SECTION 4)

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* available from www.medicare.gov or 800-633-4227.

OUTLINE OF COVERAGE

If you are not satisfied with any of the terms or conditions of this Policy, you may return it to us within ten (10) days of its delivery to you and receive a full refund of all premiums you have paid.

READ YOUR POLICY CAREFULLY. This Outline of Coverage provides a brief description of the important features of this Policy. This Outline is not the Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and us. ***It is, therefore, important that you read your Policy carefully***.

POINT OF SERVICE COVERAGE. Policies of this type are designed to provide coverage for hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any applicable Cost Sharing Amounts as referenced in the Benefit Summary or other limitations set forth in the Policy.

BENEFITS

Deductible: As shown on the Benefit Summary per Calendar Year per Enrollee.

Out-of-Network Providers: Covered Services received from an Out-of-Network Provider, except in certain circumstances (see Section 2), are allowed at a rate less than the same Covered Services received from a Network Provider. (See the Benefit Summary.)

Covered Services: Subject to payment of your Coinsurance and Deductible at the amount reflected in the Benefit Summary:

- Daily hospital room and board
- Miscellaneous hospital services
- Surgical services
- Anesthesia services
- In-hospital medical visits
- Out-of-hospital care

Medicare Eligibility: If you are eligible for Medicare, you are not eligible to begin or continue coverage under this Policy.

Calendar Year Coinsurance Maximum: Please check the Benefit Summary to determine the amount of the Calendar Year Coinsurance maximum Benefits.

Special Limitations:

Durable Medical Equipment:	A maximum payment of $5,000 per Calendar Year per Enrollee. Please see the Benefits Summary for Cost Sharing Amount
Ambulance:	See the Benefit Summary
Home Health Services:	A maximum of 40 visits per Calendar Year per Enrollee please see the Benefits Summary for Cost Sharing Amount

Physical, Occupational, Speech Therapy, Chiropractic & Audiology Care:	A maximum of a total combined 45 visits per Calendar Year per Enrollee please see the Benefits Summary for Cost Sharing Amount
Skilled Nursing Facilities:	Thirty (30) days per Calendar Year per Enrollee

Benefits and Services Are *Not* Included For:

- Routine Maternity Care and Obstetrical Care, unless covered by a Maternity Rider;
- Psychiatric conditions and substance abuse services, unless covered by a Mental Health and Substance Abuse Rider;
- Injuries or disease caused by war;
- Dentistry, except for Accidental Injury (See Section 3.4), anesthesia (See Section 3.5) and oral surgery (See Section 3.6);
- Dental x-rays;
- Eye refractions, unless needed because of Accidental Injury;
- Eyeglasses or hearing aids, unless needed because of Accidental Injury;
- Cosmetic surgery, unless needed because of Accidental Injury or breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998;
- Health services and supplies not meeting Medical Necessity criteria or that are not associated with a Covered Service;
- Prescription drugs for outpatient use filled by a prescription order or refill and non-injectable medications given in a physician's office except in an Emergency are not covered, unless covered by a prescription drug rider;
- Medical or hospital services collectible under Workers' Compensation or any law providing benefits for dependents of military personnel;
- Services rendered in government hospitals (unless otherwise required by applicable law);
- Intentional self-inflicted injuries;
- In-patient services, including electrocardiograms, x-rays, and laboratory examinations, if they could have been performed safely and adequately on an out-patient basis; and
- Services and supplies that are experimental or investigational in nature.

Guaranteed Renewable/Conditioned On Residence in Arkansas

This Policy and riders are guaranteed renewable as long as your permanent residence is in Arkansas. At any time after the first twelve (12) month period of your coverage under this Policy we can change your premium rate, but only if the rate is changed for all policies and riders of the same form number and premium classification as this Policy. Your premium rate will also change in any month that you attain an age that moves you into a different premium classification established by QualChoice.

Table of Contents

1. INTRODUCTION TO YOUR POLICY 7
   1.1. Who Is QualChoice? 7
   1.2. Changes to This Policy 7
   1.3. Key Information 7
2. HOW THIS POLICY WORKS 7
   2.1. In-Network Benefits 7
   2.2. Out-of-Network Benefits 8
   2.3. Provider Network 9
   2.4. Cost Sharing Requirements 9
   2.5. Member Financial Responsibility Comparison 10
   2.6. Medically Necessary Services 10
   2.7. Exclusion and Limitations 11
   2.8. Coverage While Traveling Out of the Service Area 11
   2.9. General Conditions for Payment 11
   2.10. Administration and Interpretation of this Policy 11
   2.11. Pre-Authorization of Services 12
   2.12. Utilization Management 12
   2.13. Case Management 12
3. COVERED MEDICAL BENEFITS 12
   3.1. Advanced Diagnostic Imaging 13
   3.2. Ambulance Services – Transportation 13
   3.3. Complications of Pregnancy 13
   3.4. Dental – Accidental Injury 13
   3.5. Dental – Anesthesia 14
   3.6. Dental – Oral Surgery 14
   3.7. Dental – Other 14
   3.8. Diabetes Management 14
   3.9. Durable Medical Equipment 15
   3.10. Emergency Health Services 15
   3.11. Eye Examinations 16
   3.12. Family Planning Services 16
   3.13. Home Health Services 16
   3.14. Home Infusion Therapy 16
   3.15. Hospice Care Services 16
   3.16. Facility – Inpatient Care 17
   3.17. Injectable Prescription Medications 18
   3.18. Infertility 18
   3.19. Medical Foods 18
   3.20. Medical Supplies 18
   3.21. Orthotic Services and Orthotic Devices 18
   3.22. Outpatient Services 19
   3.23. Physician Office Services 19
   3.24. Preventive and Wellness Health Services 20
   3.25. Professional Services for Complex Surgery 20
   3.26. Prosthetic Services and Prosthetic Devices 20
   3.27. Reconstructive Surgery 21
   3.28. Skilled Nursing Facility and Inpatient Rehabilitation Services 21
   3.29. Therapeutic and Rehabilitation Services 22
   3.30. Transplantation Services 22
4. NON-COVERED SERVICES, EXCLUSIONS AND LIMITATIONS 23
   4.1. Exclusions From Coverage 23

4.2. Limitations to Benefits 32
5. ELIGIBILITY CRITERIA 34
5.1. Hospitalization When Coverage Begins 34
5.2. Eligibility for Medicare 34
5.3. Who is Eligible for Coverage and When Does Coverage Begin 34
5.4. Maternity Coverage 34
5.5. Termination of Coverage 34
6. COORDINATION OF BENEFITS 36
6.1. How COB Works 36
6.2. Rules to Determine Primary and Secondary Plans 36
6.3. Allowable Expense 37
6.4. Reduction of Benefits 37
6.5. Enforcement of Provisions 38
6.6. Facility of Payment 38
6.7. Right of Recovery 38
6.8. Hospitalization When Coverage Begins 38
7. COMPLAINTS AND APPEALS 38
7.1. Initial Communication and Resolution of a Problem or Dispute 39
7.2. Types of Requests and Claims 39
7.3. Appeal Process 40
7.4. Documentation 41
7.5. Conduct of Appeals 42
7.6. Legal Actions 42
7.7. Authorized Representative 42
7.8. External Medical Review 43
8. SUBROGATION 44
9. GENERAL PROVISIONS 44
9.1. Amendment 44
9.2. Assignment 44
9.3. Notice 45
9.4. Medical Records 45
9.5. Notice of Claim 45
9.6. Claim Forms 45
9.7. Processing of Claims 45
9.8 Who Receives Payment Under This Policy 45
9.9 Recovery of Overpayments 45
9.10. Confidentiality 45
9.11. Complaint and Appeals 46
9.12. Right to Develop Guidelines 46
9.13. Limitation on Benefit of This Policy 46
9.14. Misstatement of Age 46
9.15. Applicable Law 46
9.16. Headings 46
9.17. Pronouns 46
9.18 Recission 46
9.19 Severability 46
9.20 Legal Actions 46
9.21 Time Limit on Certain Defenses 47
10. DEFINITIONS 47

1. INTRODUCTION TO YOUR POLICY

1.1. Who Is QualChoice?

QCA Health Plan, Inc. ("QualChoice", also referred to in this Policy as "us", "we" or "our") is a Health Maintenance Organization. QualChoice has a Certificate of authority from the Commissioner of Insurance of the State of Arkansas. We are located at 12615 Chenal Parkway, Suite 300, Little Rock, Arkansas 72211. Our telephone number is (501) 228-7111.

This is your Comprehensive Individual Major Medical Policy (the "Policy") for health care Benefits with us.

1.2. Changes to This Policy

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Policy. When that happens we will send you a new Policy, Rider or Amendment pages thirty (30) days prior to the change going into effect.

1.3. Key Information

For purposes of this Policy and each section of the Policy, "you" or "your" means the Policy Holder.

We have capitalized certain words in this Policy. Those words have special meanings and are defined in Section 10, "Definitions".

Only we have the right to change, interpret, modify, withdraw or add Benefits, as permitted by law, without your approval.

On its Effective Date this Policy replaces and overrules any Policy that we may have previously issued to you. This Policy will in turn be overruled by any policy we may issue to you in the future.

Your coverage under this Policy begins at 12:01 a.m. on the Effective Date as reflected in the Benefit Summary. Coverage will end on the date this Policy is terminated for any of the reasons described in this Policy. We determine your eligibility for Benefits as described in this Policy. This Policy and the Benefit Summary describe the covered Benefits, conditions, limitations, exclusions and Cost Sharing Amounts. The attached Benefit Summary is an integral part of this Policy. In the event this Policy and the Benefit Summary conflict, the Benefit Summary will control. You should locate and familiarize yourself with the Benefit Summary. This Policy describes some special procedures with which you must comply.

The laws of the State of Arkansas shall be the laws that govern this Policy.

If you have questions about your Benefits, payments, or cost sharing, please call us during business hours at (501) 228-7111.

2. HOW THIS POLICY WORKS

This Policy provides flexible choices in obtaining health care services. Care can be sought from any Network Provider under this Policy without a Referral from a Network Primary Care Physician. There is freedom to select either In-Network or Out-of-Network Benefits each time care is sought. Consult the Benefit Summary to identify Covered Services and Cost Sharing amounts for each choice.

2.1. In-Network Benefits

In-Network Benefits are generally paid at a higher level than Out-of-Network Benefits. In-Network Benefits are Covered Services which are either:

1. Provided by or under the direct supervision of a Network Provider in a physician's office or at a Network Facility, or
2. Emergency health services meeting the QualChoice payment guidelines.

Please note that certain Covered Services may only be obtained from a Network Provider. Such Covered Services are identified in the Benefit Summary.

Covered Services may be sought from any Network Physicians without a Referral. Coverage for services in the office is at the primary care physician benefit level when Covered Services are sought directly from any Network Primary Care Physician. Coverage for services in the office is at the

specialist benefit level when Covered Services are sought from any other Network Physician. You should validate the status of a Network Provider by calling our Customer Service unit or accessing the on-line provider directory at www.qualchoice.com or calling our Customer Service unit at 800-235-7111. Please refer to the Benefit Summary for details.

2.2. Out-of-Network Benefits

You may seek Covered Services directly from a physician or other provider who is not a Network Provider. Services provided by an Out-of-Network Provider will be covered and reimbursed under your Out-of-Network Benefits unless:

1. **Policy Provision:** The Benefits Summary or this Policy specifically provides a different Deductible, Coinsurance or Out-of-Pocket Limit for the particular service or supply that is the subject of the Claim;
2. **Emergency Services:** The intervention is for an Emergency in which case the In-Network Benefit Deductible, Coinsurance and Out-of-Pocket Limit apply;
3. **Continuity of Care, Prior to Coverage:** You notify QualChoice that prior to the effective date of your coverage, you were scheduled with an Out-of-Network Provider for a procedure or ongoing treatment covered under the terms of this Plan, that such procedure or treatment is for a condition requiring immediate care, and that you request In-Network Benefits for such scheduled procedure or ongoing treatment. If QualChoice approves In-Network Benefits for the scheduled procedure or ongoing treatment, In-Network Benefit Deductible, Coinsurance, and Out-of-Pocket Limit will apply to Claims for services and supplies rendered by the Out-of-Network Provider for such condition after QualChoice's approval until the procedure or treatment ends or until the end of ninety (90) days, whichever occurs first;
4. **Provider Leaves Network:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when your ongoing treatment for an acute condition began and that you request In-Network Benefits for the continuation of such ongoing treatment. If QualChoice approves In-Network Benefits for the requested ongoing treatment, In-Network Deductible, Coinsurance and Out-of Pocket Maximum will apply to Claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to Claims for services and supplies rendered by the Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first;
6. **Provider Leaves Network, Pregnancy:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when you began receiving obstetrical care for a pregnancy covered under the terms of the Plan, that you were in the third trimester of your pregnancy on the date that the Provider left the POS, and that you request In-Network Benefits for continuation of such obstetrical care from this Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested obstetrical care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to Claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to Claims for services and supplies rendered by the Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits; or
7. **Prior Authorization:** You notify QualChoice prior to seeking services of the absence of or the exhaustion of all In-Network resources for a Covered Service resulting in the need to seek care from an Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to Claims for services and supplies received from this Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first.

The amounts allowed for Covered Services accessed under your Out-of-Network Benefits will be subject to the Maximum Allowable Charge. You will be responsible for the applicable Cost Sharing Amounts related to such Covered Services and the difference between the charges billed by the Out-of-Network Provider and the Maximum Allowable Charge. Please refer to your Benefits Summary for details:

Note: Notification to QualChoice of requests for payment of an Out-of-Network Provider services or supplies at In-Network Benefit level must be made by writing to QCA Health Plan, Inc. Attn: Care Management, P.O. Box 25610, Little Rock, AR 72221 or by faxing the request to (501) 228-9413, and must be received at least five (5) working days prior to your receipt of such services or supplies.

2.3. Provider Network

We publish an online directory listing of physicians, facilities, and other healthcare providers who have contractually agreed to provide Covered Services to Enrollees and have them reimbursed at In-Network Benefit level. You may search the directory on our website at www.qualchoice.com. Because contractual agreements can change, you may wish to verify a physician or provider is participating in our Network before care is sought.

We do not practice medicine or provide medical supplies. We are not responsible for any action or inaction of any healthcare provider. We provide no express or implied warranties or guarantees with respect to any Network Provider or the professional services provided by such provider. The utilization of a Network Provider or any other provider and the decision to receive or decline to receive health care services is your responsibility.

If you have a medical condition that we believe needs special services, we may direct you to an appropriate facility or other provider chosen by us. If you require certain complex Covered Services for which expertise is limited, we may direct you to an Out-of-Network Provider. **In both cases, In-Network Benefits will only be paid if Covered Services for that condition are approved by us.** We will not cover any services not specifically authorized by us in the written statement of authorization. The following do not constitute approval for Benefits:

1. A Referral, whether written or oral, by a Network Physician to an Out-of-Network Provider; or
2. An order or prescription for services to an Out-of-Network Provider.

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, availability to Network Providers may be limited. If this happens, we may require you to utilize a single Network Physician to provide and coordinate all future Covered Services. If you do not make a change to a single Network Physician within 31 days of the date we notify you, we will assign a single Network Physician to you. If you fail to use the assigned Network Physician, Covered Services will be paid as Out-of-Network Benefits.

2.4. Cost Sharing Requirements

You must share in the cost of Covered Services through Co-payments, Coinsurance, and Deductibles, or combinations of these Cost Sharing Amounts. Consult the Benefit Summary to determine the amounts of your payments under the Cost Sharing Amounts. A Network Provider may bill you directly for Co-payments, Coinsurance and Deductible amounts, but may not bill for the difference between his or her customary charge and the Maximum Allowable Charge. An Out-of-Network Provider may bill you directly for all applicable Co-payments, Coinsurance and Deductible amounts plus any difference between the total amount of billed charges for services and the Maximum Allowable Charge. **These additional charges could amount to thousands of dollars in additional out-of-pocket expense for which you are responsible.**

1. **Deductible:** The Deductible is a certain dollar amount per Calendar Year, as set forth in the Benefit Summary. You must satisfy the Deductible before we begin to pay for Covered Services to which the Deductible applies.
2. **Co-payment:** A Co-payment is a fixed dollar amount you must pay each time a Covered Service is received to which a Co-payment applies. Co-payment amounts do not apply to the satisfaction of the Deductible amounts or Out-of-Pocket limits for each Enrollee. Please see the Benefit Summary for a list of those Benefits to which Co-payments apply.
3. **Coinsurance:** Coinsurance is a fixed percentage of Maximum Allowable Charges for the cost of Covered Services you must pay per Calendar Year. Coinsurance payments are in addition to Deductibles or Co-payments. The Benefit Summary contains the Coinsurance percentage applicable to specific Benefits. You are responsible for paying the amount of the applicable Coinsurance for the Covered Services provided.

4. **Limits on Out-of-Pocket Payments:** The Enrollee will no longer have to pay Coinsurance for the remainder of the Calendar Year after the Enrollee has met the out-of-pocket limit during the Calendar Year. The Benefit Summary lists the limit on out-of-pocket payments for Coinsurance. Co-payments, Deductibles, or charges in excess of the Maximum Allowable Charge are the patient's responsibility and do not count toward meeting the Limit on Out-of-Pocket Payments. Once your Out-of-Pocket Limits have been satisfied, you will still be responsible for charges in excess of our Maximum Allowable Charge for services provided by an Out-of-Network Provider.

2.5. Member Financial Responsibility Comparison

The following table provides an example of the cost you will pay for a typical inpatient hospital stay utilizing the In-Network Benefits compared to the Out-of-Network Benefits. The amount you will pay may be different based on the benefit plan you select.

	In-Network	Out-of-Network
Facility Billed Charges	$50,000	$50,000
Maximum Allowable Charge	25,000	20,000
Deductible Paid by You	-500	-1,000
Coinsurance Paid by You	-1,000	-2,000
QualChoice Total Payment	$23,500	$17,000
Your Total Financial Responsibility:		
Deductible	500	1,000
Coinsurance	1,000	2,000
Difference Between Maximum Allowable Charge and Billed Charges	0	30,000
Your Total Financial Responsibility	$1,500	$33,000

2.6. Medically Necessary Services

"Medically Necessary" or "Medical Necessity" means a Covered Service which in the opinion of our medical personnel:

1. Provides for the diagnosis or treatment of the Enrollee's covered medical conditions;
2. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's specific illness, injury or medical condition in relation to any overall medical/health conditions;
3. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
4. Is not primarily for the convenience of the Enrollee, his or her physician, or other provider; and
5. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

Regardless of anything else in this Policy, and regardless of any other communications or materials you may receive in connection with this Policy, you will not have coverage for any service, any medication, any treatment, any procedure or any equipment, supplies or associated costs if QualChoice finds it to be not Medically Necessary. All determinations of Medical Necessity for Covered Services are made in accordance with the above definition at the sole discretion of QualChoice.

We reimburse only for Medically Necessary Covered Services as defined in Section 10. This standard applies to all sections of this Policy.

If we determine a service is not Medically Necessary before or after a Network Provider renders it, we prohibit the Network Provider who rendered the service from billing you for the service unless you agreed in writing to be responsible for payment before the service was provided.

If we determine a service is not Medically Necessary before or after an Out-of-Network Provider has rendered it, you will be responsible for the charges for services which are determined not to be Medically Necessary.

We make a determination of Medical Necessity after considering the advice of trained medical professionals, including physicians, who may use medically recognized standards and criteria. In making the determination, we will examine the circumstances of your condition and the care provided, including the reason your provider prescribed or provided the care, and any unusual circumstances, which necessitate attention. However, the fact your physician prescribed the care or service does not automatically mean the care is Medically Necessary or it qualifies for payment under this Policy. A medical treatment that meets the criteria for Medical Necessity will still not be reimbursed if the condition being treated is excluded from coverage as set forth in Section 4.

2.7. Exclusion and Limitations

Some services have specific limitations. Exclusion of other services from coverage is in full or in part. Consult the Benefit Summary and Section 4 for information on benefit limitations and exclusions.

This Policy refers to Medical Policies we have developed that may limit or exclude coverage for a particular service, treatment or drug. You may contact our Customer Service Department to request a copy of our Medical Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Medical Policies on our web site at www.qualchoice.com.

2.8. Coverage While Traveling Out of the Service Area

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

We will deny coverage for routine and follow-up care after Emergency care unless a Network Provider in Arkansas performs the services.

If care is accessed by an Enrollee from providers not participating in the QCNN for an unforeseen illness, reimbursement for Covered Services will be at the Out-of-Network Benefit level.

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

2.9. General Conditions for Payment

Payment for Covered Services is subject to the Enrollee's eligibility on the date such services are rendered, and to all conditions, limitations, and exclusions of the Policy. A final determination of eligibility is made at the time the Claim is received by us. Determination of non-eligibility subsequent to the payment of services as a result of error or fraud will result in recovery of such payments made by us. Benefits are provided only if services provided were ordered by a health care provider, provided within the scope of that health care provider's license, and rendered in accordance with professionally recognized standards of care.

2.10. Administration and Interpretation of this Policy

We have sole and exclusive discretion to interpret the Benefits provided under this Policy as well as all other provisions, terms, conditions, limitations and exclusions in the Policy and to make factual determinations related to the Policy and its Benefits. We may delegate this authority to other persons or entities to provide administrative or Benefit services with regard to this Policy. Subject to applicable law or regulation, we reserve the right to change, interpret, modify, withdraw or add Benefits or

terminate the Policy, in our sole discretion, without prior approval by you. Changes to this Policy will be valid or binding only if in writing and agreed to by an officer of QualChoice.

2.11. Pre-Authorization of Services

Pre-authorization is a determination made prior to services or supplies being provided of whether the services or supplies are Medically Necessary. We must receive sufficient clinical information to establish Medical Necessity. The Medical Necessity for an Out-of-Network Referral will include the absence of or the exhaustion of all In-Network resources. Pre-authorizations are all time-limited.

QualChoice requires that certain Covered Services be pre-authorized. The specific procedures requiring pre-authorization can change based upon new or changing medical technology. We reserve the right to modify the official listing of services requiring pre-authorization as deemed necessary. A listing of the services requiring pre-authorization is maintained on our web site at www.qualchoice.com on the Member Home Page. You may also contact our Customer Service Department to obtain a copy of the listing.

The responsibility for obtaining pre-authorization varies depending on whether you use a Network Provider or an Out-of-Network Provider. Network Providers (not including QCNN providers) are responsible for obtaining the necessary pre-authorizations. Enrollees living outside of the Service Area will be responsible for obtaining pre-authorization to receive Benefits at the In-Network level when accessing care from the QCNN. QCNN providers are not responsible for obtaining a pre-authorization for services. Out-of-Network Providers have no contractual relationship to QualChoice, and therefore are not primarily responsible for obtaining required pre-authorizations. When care is being sought from Out-of-Network Providers, you are responsible for making sure all the providers obtain the required pre-authorizations. The Out-of-Network Providers must supply the clinical information necessary for us to determine Medical Necessity. We will give no pre-authorization without the necessary clinical information.

Pre-authorization is not a guarantee of payment. Even though pre-authorized, payment may not be rendered for any service if the clinical status changed sufficiently such that the service is no longer medically appropriate. Your coverage with QualChoice must be in force on the date of service or no payment will be made. You may request a pre-review of coverage for any service by calling our Customer Service Department. Any of our pre-authorization decisions may be appealed by following the procedures in Section 7. Your physician may request an Expedited Appeal of a denial of a pre-authorization by calling the number on your QualChoice identification card if your physician believes the services are urgent due to your medical condition.

2.12. Utilization Management

We cover Medically Necessary services as described in Section 2.6. Determinations of Medical Necessity are made using QualChoice's Medical Policies. We make decisions regarding whether a particular service is or was Medically Necessary based on information provided by your Network Provider(s). When we review services after care has already been provided, we may review your medical records. A Network Provider may request the criteria or guidelines used by QualChoice in making any decision.

2.13. Case Management

We provide a Case Management program. Case Management assists Enrollees to achieve the best clinical outcomes, making the best use of the Benefits. Case Management helps with an individual's specific health care needs. Case Management involves the timely coordination of health care services. We review clinical information before we include any Enrollee in the Case Management program. We stay involved in the case until the need is resolved. Enrollees may participate in Case Management programs including programs for diabetes mellitus, transplants, oncology, and neonatology.

3. COVERED MEDICAL BENEFITS

Coverage is available for medical services or care as specified in this Section subject to the General Conditions for Payment specified in Section 2.9, Pre-Authorization of Services described in Section 2.11,

and to all other applicable conditions, limitations and exclusions of this Policy. **Consult the Benefit Summary for applicable Cost Sharing Amounts.**

3.1. Advanced Diagnostic Imaging

Advanced Diagnostic Imaging consists of the following studies (though others may be added as new studies are developed):

1. All imaging using Computerized Axial Tomography (CAT) technology;
2. All imaging using Magnetic Resonance Imaging (MRI) technology;
3. All imaging using Positron Emission Tomography (PET) technology;
4. All imaging using nuclear medicine techniques (in which a radioactive substance is administered to the patient to permit or enhance imaging, which is done at least in part with detection techniques to assess the locations at which the radioactive substance is concentrated in the body).

The following rules apply to these imaging procedures:

1. Regardless of where they are performed, they always fall under the required Cost Sharing Amounts of this Policy as set forth in the Benefit Summary; and
2. Pre-authorization may be required for any or all of these tests. The requirements for pre-authorization detailed in Section 2.11 should be referred to and followed when receiving any of the Advanced Diagnostic Imaging studies.

3.2. Ambulance Services – Transportation

We cover licensed ambulance transportation subject to all terms, conditions, exclusions and limitations as set forth in this Policy. This benefit is subject to the Cost Sharing Amounts and benefit limitations specified in the Benefit Summary, and the following criteria:

1. When an accident or other medical emergency occurs, we cover transport to the nearest hospital when Emergency care is required;
2. We cover ambulance transportation from one hospital to another hospital for one of the reasons identified below; when transportation for these listed reasons is required, it must be coordinated through the QualChoice Care Management department:
   A. To access equipment or expertise necessary for proper care;
   B. To receive a test or service which is not available at the hospital where you have been admitted and you return after the test or service is completed;
   C. To transport you from an Out-of-Network Facility to a Network Facility;
   D. To transport you directly from an acute care setting to an alternate level of care.

3.3. Complications of Pregnancy

Subject to all terms, conditions, and limitations of this Policy and subject to applicable Coinsurance and Deductible, coverage is provided for treatment of Complications of Pregnancy (as defined in Section 10) when provided by a physician.

3.4. Dental – Accidental Injury

We will provide coverage if an Enrollee has an Accidental Injury that damages a sound, natural tooth. Treatment must be authorized by QualChoice. Benefits are subject to a maximum limit per Enrollee per accident. See the Benefit Summary for the limitation. Dental services must be received from a Doctor of Dental Surgery, “D.D.S.” or a Doctor of Medical Dentistry, “D.M.D.” The damage must be severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. The Physician or dentist must certify that the injured tooth was:

1. A virgin or un-restored tooth, or
2. A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with any bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be started within three months of the original accident date and completed within 12 months of the original accident date.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities. The following limitations for treatments also apply to repair of damaged teeth:

1. Only the sound and natural tooth or teeth avulsed or extracted as a direct result of the Accidental Injury will be considered for replacement;
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based upon a Maximum Allowable Charge per tooth;
3. Double abutments are not covered;
4. Any health intervention related to dental caries or tooth decay is not covered;
5. Removal of teeth is not covered; and
6. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

3.5. Dental – Anesthesia

QualChoice will provide Benefits for anesthesia and facilities for dental procedures which would ordinarily be done under local anesthesia provided:

1. The procedure is performed in a Network Facility or a network ambulatory surgery facility; and
2. The situation meets Medical Necessity criteria, and the patient is:
    a. A child under 7 years of age who is determined by two network dentists to be unable to undergo the procedure without general anesthesia and who cannot wait until an older age for the procedure, when undergoing the procedure without general anesthesia would be possible; or
    b. A person with a serious mental health condition that prevents use of local anesthesia for the procedure; or
    c. A person with a serious physical condition making hospital care necessary for the safe performance of dental work; or
    d. A person with a significant behavioral problem (as certified by a Network Physician) which precludes safe performance of the dental work under local anesthesia.

All network requirements, Medical Necessity determinations, and such other limitations as are applied to other Covered Services will apply. Pre-authorization is required, see Section 2.11.

3.6. Dental – Oral Surgery

QualChoice will pay only for the following non-dental oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required;
2. Surgical procedures required to treat an Accidental Injury to jaws, cheeks, lips, tongue, roof and floor of the mouth. Injury to a tooth or teeth while eating is not considered an Accidental Injury; treatment of such injury will not be covered;
3. Excision of exostoses of jaws and hard palate;
4. Extraction of teeth is required because of the results from radiation or chemotherapy;
5. Frenectomy;
6. External incision and drainage of cellulitis;
7. Incision of accessory sinuses, salivary glands or ducts;
8. Certain dental services, as reflected in the Medical Policies, performed in conjunction with Medically Necessary reconstructive surgery; and
9. Dental services integral to medical services covered by the Plan.

3.7. Dental – Other

No other dental care and orthodontic services are covered.

3.8. Diabetes Management

Coverage is provided for medically necessary equipment, supplies, and services for diabetes when prescribed by a physician. Diabetes self-management training is limited to one program per lifetime

per Enrollee. If there is a significant change in the Enrollee's symptoms or condition making it necessary to change the Enrollee's diabetic management process, we may authorize additional training if prescribed by a physician. Covered Services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education developed by the American Diabetes Association (ADA). A licensed provider certified by the ADA must provide the training.

3.9. Durable Medical Equipment

Durable Medical Equipment (DME) is subject to Medical Necessity and appropriateness review. We will not cover DME if primarily used for the convenience of the Enrollee or any other person. DME is equipment serving a medical purpose, is non-disposable, can withstand repeated use, is appropriate for use in the home, and is generally not useful in the absence of the illness or injury for which it is used.

All DME services must be obtained through a Network Provider. All DME remains the property of QualChoice or a Network Provider. When it is more cost effective, we will purchase rather than lease equipment. The amount paid for leasing a DME item will not exceed the Maximum Allowable Charge for purchase. We retain the right to recover any equipment purchased by us for the use of the Enrollee upon cancellation or termination of coverage for the Enrollee. Delivery or set up charges are included in the Maximum Allowable Charge for the DME.

Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Enrollee.

The definition and description of coverage for orthotics and prosthetic devices and services are in Sections 3.21 and 3.26 below.

Important Note: DME dispensed by a physician in an office setting and billed by a DME provider must be provided through a DME Network Provider. It is your responsibility to confirm this with the physician. If DME dispensed by the physician is not from a DME Network Provider, a prescription may be obtained from the physician for the DME followed by contact with us to assist in obtaining the equipment. Failure to insure all DME is obtained from a DME Network Provider will result in denial of Benefits.

3.10. Emergency Health Services

We cover emergency room services that meet the definition of "Emergency" as set out in Section 10.

1. **Emergency Care within the Service Area:** An Enrollee is encouraged to seek care from a Network Provider in the event of an Emergency (as defined in Section 10) whenever possible. However, if in an Emergency an Enrollee is unable to access a Network Provider, the Enrollee should go to the nearest urgent or emergent care facility. Services provided in an Emergency are paid as shown in your Benefits Summary.
2. **Emergency Care outside of the Service Area:** Services provided in an Emergency when you are outside of the Service Area, but within the United Sates are paid as shown in your Benefits Summary. Your QualChoice identification card provides a toll-free telephone number to call for a listing of healthcare providers in the QualChoice National Network (QCNN). QualChoice encourages you to seek treatment whenever possible from a healthcare provider in the QCNN.

If an Enrollee obtains services in an emergency room when the circumstances were not an Emergency, it will result in a denial of Benefits for the services provided. You have access to our "Ask a Nurse" assistance line at any time by calling (866) 232-0447.

IMPORTANT IN THE EVENT OF AN ADMISSION AT AN OUT-OF-NETWORK FACILITY: If treatment of an Emergency is sought at an Out-of-Network Emergency Room, *you, a family member or the hospital must notify our Care Management Department once you are stabilized, but in no event more than forty-eight (48) hours after initial treatment, if further care or inpatient admission is needed*. Failure to notify us within the specified 48 hour time requirement may result in a denial of benefits. Upon receipt of such notification we may either authorize the admission to, or further treatment at, the

Out-of-Network Facility, or coordinate appropriate transfer to a Network Facility through communication with the Out-of-Network Facility, the admitting physician, and the Enrollee's Network Provider. If you stay at the Out-of-Network Facility beyond the period for which we have determined further treatment is considered Medically Necessary, you will be responsible for all charges billed by the hospital and other providers providing the care.

3.11. Eye Examinations

Eye Examinations for active illness or injury that are received from a health care provider in the provider's office are a Covered Service.

3.12. Family Planning Services

Coverage is provided for the following family planning services:

1. Oral contraceptives and prescription barrier methods are only covered when a prescription drug rider has been purchased through QualChoice; coverage is subject to all of the terms, conditions, limitations, and exclusions of the prescription drug rider;
2. Voluntary sterilizations (vasectomies and tubal ligations) are covered except as excluded in Section 4; and
3. Long acting reversible contraceptives, including hormonal implantable systems and intrauterine contraceptives, are covered as a medical benefit.

Reversal of a voluntary sterilization is a specific exclusion.

3.13. Home Health Services

Coverage is available for the following services provided in the home when the medical condition supports the need for such services, the services are ordered by a Physician, and the services are pre-authorized by QualChoice.

We count each visit by a member of a home care team as one home care visit. We count up to four hours of home health nurse/aide service as one home care visit. (See the Benefit Summary for visit limitation details.)

The following services provided by a licensed home health agency in the home are Covered Services:

1. Intermittent skilled nursing care by a registered nurse or a licensed practical nurse. A service will not be determined to be "skilled" simply because there is not an available caregiver in the Enrollee's home; skilled nursing care provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse is not Custodial Care;
2. Physical, occupational and speech therapy services; and
3. Medical supplies provided by a home health agency during the course of approved care.

3.14. Home Infusion Therapy

The benefit for medications received from licensed specialty pharmacy or a licensed retail pharmacy designated by QualChoice as a home infusion therapy provider is covered based upon obtaining pre-authorization and upon the Maximum Allowable Charge for the medication.

1. Covered Medication: A home infusion therapy medication is covered as a medical benefit (as opposed to a prescription drug benefit) and is subject to Co-payment (if applicable) and/or Deductible and Coinsurance.
2. FDA approved medications that exist as separate components are intended for reconstitution prior to administration are covered. Examples include, but are not limited to, total parental, intravenous antibiotics, and hydration therapy and specialty infusions.
3. Medical supplies used in conjunction with home infusion therapy are covered if the home infusion is approved.

When home infusion therapy services are provided separately from home health services, then the home infusion therapy service does not apply to the home health benefit.

3.15. Hospice Care Services

Hospice care must be pre-authorized and arranged by a QualChoice Case Manager. Consult the Benefit Summary for applicable Cost Sharing Amount. In addition, coverage is available for an

Enrollee with a life expectancy of six months or less. Care must be provided by a hospice possessing all licenses, certifications, permits and approvals required by applicable federal, state and local law.

The following services, when ordered by a physician, are covered during the period when the hospice has admitted an Enrollee to its program:

1. Inpatient care in a freestanding hospice, a hospice unit within a hospital or skilled nursing facility or in an acute care hospital bed;
2. Home care services provided by the hospice either directly or under arrangements with other licensed providers, including but not limited to, the following:
   A. Intermittent nursing care by registered nurses, licensed practical nurses, or home health aides;
   B. Respiratory therapy;
   C. Social services;
   D. Nutritional services;
   E. Laboratory examinations;
   F. Chemotherapy and radiation therapy when required for control of symptoms;
   G. Medical supplies; and
   H. Medical care provided by a physician.

3.16. Facility – Inpatient Care

Inpatient hospital care Benefits are available for services and supplies received during the hospital stay and room and board in a semi-private room (a room with two or more beds). We will not pay for any hospital services unless the service is provided by an employee of the hospital, the hospital bills for the service, the service is not primarily for convenience and the hospital retains the payment collected for the service.

Facility inpatient care is also subject to the following conditions:

1. We cover Medically Necessary acute inpatient hospital care for the care or treatment of your condition, illness, or injury;
2. The services of social workers and discharge planners shall be included in the basic daily room and board allowance;
3. Coverage is provided for a minimum of forty-eight (48) hours for an in-patient stay related to a mastectomy;
4. We do not provide Benefits while you are waiting for Custodial Care;
5. We do not provide Benefits while waiting for a preferred bed, room, or facility;
6. The following applies when an Enrollee is waiting for transfer from an acute facility to another facility for continuing care (e.g., nursing home, rehabilitation facility, skilled nursing facility, and long term acute care facility):
   A. The acute facility that the Enrollee is in awaiting a transfer should provide care equivalent to the care provided by the facility to which the Enrollee is waiting to be transferred;
   B. The days an Enrollee spends in the acute facility waiting for a transfer may count toward the limits for sub-acute and rehabilitation Benefits;
   C. We will pay the acute facility the Enrollee is in awaiting a transfer the lesser of that acute facility's rate or the rate at the facility to which the Enrollee is being transferred; as demonstrated in Section 2.5 above, this could have a significant financial impact on you if the acute facility the Enrollee is in while waiting to be transferred is an Out-of-Network Facility;
   D. If the acute facility the Enrollee is in awaiting a transfer is not providing the care we expect, we will deny those days and make no payment; as demonstrated in Section 2.5 above, this could have a significant financial impact on you if the acute facility the Enrollee is in while waiting to be transferred is an Out-of-Network Provider.
7. Services rendered in a facility in a country outside of the United States of America shall not be paid except at the sole discretion of QualChoice.
8. Services to Out-of-Network Facilities are subject to pre-admission notification as described in Section 2.11. Please call the number listed on your identification card to notify us of the admission.

3.17. Injectable Prescription Medications

Benefits are available for Injectable Prescription Medication(s) received in a physician's office based upon the Maximum Allowable Charge for the Injectable Prescription Medication and subject to the applicable Cost Sharing Amounts specified in the Benefit Summary for other services provided in the physician's office. Benefits are available for Injectable Prescription Medications for self-administration through a prescription drug rider available from QualChoice. Injectable Prescription Medications that an Enrollee has the ability to self-administer may be obtained with direct delivery to the Enrollee's home. Our Care Management staff will assist Enrollees in coordinating this service.

3.18. Infertility

Limited diagnostic work-up for infertility is covered. This is designed to screen for basic problems that might cause infertility. Any other services required for the diagnosis or treatment of infertility or of any associated disease whose primary manifestation is infertility are not covered. You may contact us to obtain specific coverage guidelines.

3.19. Medical Foods

Medical foods and low protein modified food products for the therapeutic treatment of a person inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism are covered if:

1. The medical food or low protein modified food products are prescribed by a physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Network Physician; and
3. The cost of the medical food or low protein modified food products for an individual exceeds $2,400 per year per person, that is to say, the covered amount will be the incurred cost of medical food or low protein modified food products that is in excess of the $2,400 per year per person.

3.20. Medical Supplies

Subject to all terms, conditions, exclusions and limitations of this Policy, Medical Supplies, other than Medical Supplies that can be purchased without a prescription, are covered when prescribed by a physician and when Medically Necessary. The following conditions will also apply to coverage for Medical Supplies:

1. Coverage for Medical Supplies provided in a physician's office is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used;
2. Coverage for Medical Supplies is limited to a 31-day supply per month;
3. Coverage for Medical Supplies used in connection with Durable Medical Supplies is subject to the Cost Sharing Amounts and DME benefit limitations specified in the Benefit Summary; and
4. Coverage for Medical Supplies provided in connection with home infusion therapy is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used.

3.21. Orthotic Services and Orthotic Devices

Orthotic services and orthotic devices (as defined in this Section) are covered as described below.

All "orthotic devices" and "orthotic services", including the fitting and/or repair of orthotic devices, require pre-authorization as described in Section 2.11.

An "orthotic service" is an evaluation and treatment of a condition that requires the use of an "orthotic device".

In order for a device to be an "orthotic device" under this Policy, the device must meet all three (3) of the following requirements:

1. The external device is (i) Intended to restore physiological function or cosmesis to a patient; and (ii) Custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

An orthotic device does *not* include a/an (i) cane, (ii) crutch, (iii) corset, (iv) dental appliance, (v) elastic hose, (vi) elastic support, (vii) fabric support, (viii) generic arch support, (ix) low-temperature plastic splint, (x) soft cervical collar, (xi) truss, or (xii) any similar device meeting both of the following requirements:

1. It is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
2. It has no significant impact on the neuromuscular, musculoskeletal or neuromusculoskeletal functions of the body.

An orthotic device also does *not* include foot orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain. This applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, are mainly protective in nature, and/or combine functional control and protection. This also applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.

Coverage for orthotic devices and orthotic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of an orthotic device or associated orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Policy. However, QualChoice will replace or repair an orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.22. Outpatient Services

1. **Outpatient Facility Services:** Covered outpatient services shall include the following services provided in a licensed outpatient facility or at a hospital outpatient department: diagnostic services, radiation therapy, chemotherapy, x-ray services, laboratory services, surgical services, physical, occupational and speech therapy services, audiology services and renal dialysis. We also cover up to 24 hours of outpatient observation for the purpose of extended recovery from a surgical or invasive procedure or for evaluation of the possible need for inpatient admission.

2. **Outpatient Surgery:** Coverage is provided for outpatient surgical services received from an ambulatory surgery center or in an outpatient hospital setting when performed or prescribed by a physician. Covered Services include diagnostic imaging and laboratory services required to augment surgical services and performed on the same day as such surgical service. If an Out-of-Network Facility or ambulatory surgery center not contracted with QualChoice is used, payment will be limited to the Maximum Allowable Charge for the service.

3.23. Physician Office Services

The diagnosis and treatment of an illness or Accidental Injury is a Covered Service when provided in a medical office, subject to the Cost Sharing Amounts set forth in your Benefits Summary.

3.24. Preventive and Wellness Health Services

We cover those services that are recognized and defined by QualChoice's Medical Policies as being preventive and/or wellness in nature. Subject to changes QualChoice may make to its Medical Policies, a partial listing of those services QualChoice considers to be preventive and/or wellness health services is included with your Benefits Summary. The most complete list of those services QualChoice considers being preventive and/or wellness health services are available on our website www.qualchoice.com (Preventive Health Benefit) or you may contact our Customer Service Department to obtain specific coverage guidelines.

3.25. Professional Services for Complex Surgery

We cover complex surgeries subject to the limitations described below including application of all Cost Sharing Amounts and other limitations as set forth in this Policy and related Benefits Summary.

The Benefit amount payable for a complex surgery includes payment for related or follow-up care by the surgeon before and after the operation. In other words, the one payment covers the operation and the surgeon's care after the operation. Payment for surgery is subject to the following limitations:

1. When multiple or bilateral surgical procedures are performed in the same operative session, whether through one or more incisions, we will cover the major or first procedure and, in addition, we will cover one-half of the Maximum Allowable Charge of the lesser or subsequent procedure(s).
2. When an incidental procedure, including, but not limited to, incidental appendectomy, treatment of adhesions, excision of previous scar, or puncture of ovarian cyst, is performed through the same incision, we will only pay for the major procedure;
3. When the physician performs an operative procedure in two or more stages, the total payment for the combination of steps or stages making up the entire procedure will be limited to the Maximum Allowable Charge that we would have paid if the physician had not performed it in multiple steps or stages;
4. Not all surgeries require an assistant surgeon; we will pay for one assistant surgeon who is a physician qualified to act as an assistant for the surgical procedure when Medically Necessary;
5. We will cover a standby physician only if that physician is required to assist with certain high-risk deliveries identified by us and only if that physician is in the immediate proximity to the Enrollee during the standby period.

3.26. Prosthetic Services and Prosthetic Devices

Prosthetic services and prosthetic devices (as defined in this Section) are covered as described below.

All "prosthetic devices" and "prosthetic services", including the fitting and/or repair of prosthetic devices, require pre-authorization as described in Section 2.11.

A "prosthetic service" is an evaluation and treatment of a condition that requires the use of a "prosthetic device".

In order for a device to be a "prosthetic device" under this Policy, the device must meet all three (3) of the following requirements:

1. The device is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

A prosthetic device includes a breast prosthesis to the extent required pursuant to the Women's Health and Cancer Rights Act of 1998.

A prosthetic device does *not* include a/an (i) artificial eye, (ii) artificial ear, (iii) dental appliance (which would include corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome), (iv) cosmetic device such as artificial eyelashes or wigs, (v) device used exclusively for athletic purposes, (vi) artificial facial device, or (vii) any other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

Coverage for prosthetic devices and prosthetic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of a prosthetic device or associated prosthetic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Policy. However, QualChoice will replace or repair a prosthetic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.27. Reconstructive Surgery

We cover services in connection with reconstructive surgery if necessary to restore the part of the body injured or deformed by acute trauma, infection or cancer subject to the following:

1. Restoration must be aimed at restoration of function, not just restoration of appearance;
2. Restoration is intended to achieve an average person's normal function (for example, restoration aimed at athletic performance is *not* covered);
3. The reconstructive surgery is necessary to correct congenital malformations or anomalies resulting in a severe functional impairment of a Child covered under this Policy.

Coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by a physician:

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

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

3.28. Skilled Nursing Facility and Inpatient Rehabilitation Services

Coverage is available for Medically Necessary care in a skilled nursing facility or acute inpatient rehabilitation facility when provided immediately after hospitalization in an acute care general hospital for a covered illness or injury. Care will be limited to the number of covered days provided by the Policy and must meet the Medically Necessary criteria of continued improvement. See the Benefit Summary for details.

3.29. Therapeutic and Rehabilitation Services

Services for outpatient physical, occupational or speech therapy and chiropractic, audiology or pulmonary rehabilitation are covered. This includes services performed in the office of a physician, chiropractor or therapist, outpatient therapy center, or in the outpatient department of a hospital. Refer to the Benefit Summary and Section 4 for specific limits. Cardiac rehabilitation services are covered separately and are not subject to this limitation. Please note that Benefits are available only for services that are expected to result in a significant improvement in the Enrollee's condition within two months of the start of the treatment.

3.30. Transplantation Services

Transplant Benefits are available subject to the general conditions for payment specified in Section 4, and to all other applicable conditions, limitations and exclusions of this Policy. Consult the Benefit Summary for applicable Cost Sharing Amounts and other limitation amounts.

1. **Pre-Authorization Required:** ***You or an authorized representative must call the number on your ID card to obtain pre-authorization before the evaluation for transplant and placement on any transplant list.*** Once the evaluation is complete, an additional pre-authorization must be obtained for the transplant procedure. We will coordinate all transplant services, including evaluation and transplant. Failure to coordinate all transplant related services with us, or failure to comply with pre-authorization procedures, may result in non-payment of these services.
2. **Transplant Standards:** We cover transplant procedures under the standards set out by the Policy and are as follows:
   A. **General Description of Transplant Covered Services:** We will cover any hospital, medical, surgical, and other service related to the transplant, including blood and blood plasma. **We only cover transplants and transplant related services performed at a transplant center approved by us.**
   B. **Facility Care:** We cover all inpatient and outpatient care at a designated transplant center. When we authorize the transplant to occur at an Out-of-Network facility, we may require Network Physicians at a Network Facility to provide some follow-up care.
   C. **Organ Procurement:** We will pay for services directly related to organ procurement including tissue typing, surgical extraction and storage and transportation costs of the organ or other human tissue used in a covered transplant procedure. (If the donor has other insurance, we must receive an explanation of benefits from the donor's health policy indicating coverage or denial for the donation.) Please refer to the Benefit Summary for Cost Sharing Amounts and lifetime maximums.
3. **Bone Marrow Transplantation:** Bone marrow transplantation is only covered for specific indications listed below. This limitation applies to the bone marrow transplantation and any related procedure including High Dose Chemotherapy. The limitation applies to transplants of bone marrow or of peripheral blood cells intended to reconstitute the marrow. Covered diseases are:
   A. Aplastic anemia
   B. Wiscott-Aldrich syndrome
   C. Albers-Schonberg syndrome
   D. Thalassemia major
   E. Myelodysplastic syndromes – primary and acquired
   F. Immunodeficiency syndrome
   G. Non-Hodgkin's lymphoma, intermediate or high grade, stage III or IV
   H. Hodgkin's disease, stage IIIA or IIIB, or stage IVA or IVB
   I. Neuroblastoma, stage III or IV
   J. Chronic myelogenous blast leukemia in blast crisis or chronic phase
   K. Chronic myelogenous leukemia in the chronic phase

L. Multiple myeloma
M. Acute lymphocytic or myelocytic leukemia in patients who are in remission but at high risk for relapse

4. **Cornea Transplantation:** Cornea transplantation is covered subject to all terms, limitations and exclusions as set forth in this Policy. Cornea transplantation does not require pre-authorization.

This Policy requires specific donor matches for certain procedures.

4. NON-COVERED SERVICES, EXCLUSIONS AND LIMITATIONS

Some services, treatments, medications and supplies are not covered. Others have limitations on coverage. This Section describes those exclusions and limitations. QualChoice may choose to eliminate an exclusion or limitation if advances in medical care warrant making such a change. One or more of our optional coverage riders may cover some of these items. If you purchase any riders, they are included as part of this Policy. Please refer to the Benefit Summary for additional exclusions and limitations on Covered Services. QualChoice may provide very limited coverage for some services that are otherwise excluded or limited by this Section 4 strictly for preventive health purposes; where applicable, these limited coverages are identified and described in QualChoice's Preventive Health Benefit Medical Policy.

4.1. Exclusions From Coverage

1. **Acupuncture:** Acupuncture services for pain therapy are not covered.
2. **Admission to a Facility before Becoming Covered under This Policy:** We will not cover an inpatient admission commencing before the Effective Date of this Policy. We will not cover any portion of the facility or medical services related to the stay. This applies to admissions to an acute hospital, sub-acute hospital, skilled nursing facility, rehabilitation unit, or any other inpatient facility.
3. **Abortion:** We do not cover elective abortion. We do not cover medical services, supplies or treatment the primary purpose of which is to cause an elective abortion. We do not cover any services, supplies or treatment provided as a result of such an abortion.
4. **Adoption and Surrogate Parenting:** We will not cover services, supplies, treatment, or other costs relating to the care of the biological mother of an adopted child. Maternity charges incurred by an Enrollee acting as a surrogate mother are not covered charges.
5. **After Hours or Weekend Charges:** We will not cover any extra charges related to the time of day or day of the week on which services were rendered.
6. **Against Medical Advice:** We will not cover any services related to an inpatient admission, observation admission, or emergency room visit resulting in the Enrollee's discharge against medical advice. We will not cover any services required for complications resulting from the Enrollee's discharge against medical advice.
7. **Alternative or Complementary Medicine:** We will not cover devices or services relating to alternative systems of medical practice such as, but not limited to, the following:
   A. Acupuncture
   B. Homeopathy or Naturopathy;
   C. Bioelectromagnetic care;
   D. Herbal medicine;
   E. Hippo therapy (equine therapy);
   F. Hypnotherapy (see mental health coverage);
   G. Aromatherapy;
   H. Reflexology;
   I. Mind/body control such as dance or prayer therapies;
   J. Pharmacological and biological therapy not accepted by mainstream medical practitioners such as chelation therapy or metabolic therapy.

8. **Blood:** We do not provide Benefits for blood, blood plasma or blood derivatives. We do not cover fees for voluntary blood donation or storage of blood products. We do cover the charges for the administration of blood or blood products.

9. **Blood Donation:** We do not cover directed blood donations. We do not cover donations for specified recipients, you or another, regardless of donor or anticipated date of use. We do not pay for procurement, storage, or administration of such donated blood. We do not pay for any extra charges associated with designated blood donation.
10. **Blood Typing:** Blood typing or DNA analysis for paternity testing is not covered.
11. **Care Plan Oversight:** Multi-disciplinary team conferences as well as any other kind of team conferences are not covered.
12. **Care Provided By a Relative by Blood or Marriage:** We will not cover care provided by an individual who normally resides in your household. We also will not cover care provided by you or by your parents, siblings, spouses, children, grandparents, aunts, uncles, nieces and nephews or other relatives by blood or marriage.
13. **Care Rendered in Certain Non-Facility Institutions:** We will not pay for care in hospitals or other facilities not licensed as short-term acute care general hospitals or skilled nursing facilities. Examples are:
    A. Convalescent homes or similar institutions;
    B. An institution primarily for Custodial Care, rest or domicile;
    C. Residential care or treatment facilities;
    D. Health resorts, camps, safe houses, spas, sanitariums, schools, or tuberculosis hospitals;
    E. Infirmaries at camps or schools;
    F. Facilities for treatment of mental illness and substance abuse;
    G. Rehabilitation facilities and rehabilitation units in other facilities (except as covered under Section 3.29);
    H. Skilled nursing facilities and places primarily for nursing care (except as covered under Section 3.28);
    I. Freestanding cardiac care facilities;
    J. Sleep study centers;
    K. Extended care, chronic care, or transitional hospitals or facilities (except as covered under Section 3.29 and 3.30); or
    L. Other facilities and institutions, which do not meet our criteria for short-term acute care general hospitals or skilled nursing facilities
14. **Cerebellar Stimulator or Pacemaker:** Cerebellar stimulator or pacemaker for the treatment of neurological disease is not covered.
15. **Cervicography:** Cervicography is not covered.
16. **Charges In Excess Of Calendar Year or Lifetime Maximums:** We will not cover any service, supply or treatment in excess of the Calendar Year or lifetime maximum as shown on the Benefit Summary.
17. **Charges for Missed/Canceled Appointments:** We will not pay for charges resulting from the Enrollee's failure to keep scheduled appointments.
18. **Chelation Therapy:** Services or supplies provided as, or in conjunction with, chelation therapy are not covered, except for treatment of acute heavy metal poisoning.
19. **Cognitive Rehabilitation:** Services and supplies provided as part of cognitive rehabilitation are not covered.
20. **Complications:** We will not cover medical or surgical complications resulting from a non-Covered Service. We will not cover medical or surgical complications as a direct or closely related result of the Enrollee's refusal to accept treatment, medicines, or a course of treatment recommended by a provider.
21. **Contraceptive Devices or Supplies:** Contraceptive devices or supplies available over-the–counter (without a prescription) are not covered.
22. **Convenience Items or Services:** We will not cover items or services utilized primarily for an Enrollee's convenience or the convenience of a family member, caregiver or provider. Such items include, but are not limited to: cot, telephone, television rental charges in a hospital, whirlpool baths, automobile or van conversions, motor scooters, air purifiers, exercise equipment, machines used for communication and speech, lifts, and home modifications.
23. **Cosmetic or Reconstructive Surgery:** We will not pay for any procedures, services, equipment or supplies provided in connection with elective cosmetic surgery or complications arising from a cosmetic surgery even if coverage was provided by another health plan.

Cosmetic surgery is intended primarily to improve appearance or have a psychological benefit.

24. **Cranial Electrotherapy Stimulation Devices**: Cranial electrotherapy stimulation devices are not covered.
25. **Current Perception Threshold Testing**: Current perception threshold testing is not covered.
26. **Custodial Care:** We do not cover any service which is custodial in nature. We consider care custodial in nature when it is primarily for meeting personal needs. Persons without professional skills or training can provide Custodial Care. For example, Custodial Care includes assistance in activities of daily living (walking, getting in and out of bed, bathing, dressing, eating and taking medication). Custodial care also includes medical services not seeking to cure or improve the patient. They may be provided during periods when the medical condition of the patient is not changing. They generally do not require continued administration by trained medical personnel. Examples include long-term maintenance activities such as dressing changes, tube feeding or range of motion exercises. Non-covered Custodial Care may be rendered in a hospital, domiciliary facility, nursing home, skilled nursing facility, or home. Non-covered Custodial Care may be residential care, respite care, private duty nursing, or any other service custodial in nature.
27. **Dental Care:** This Policy does not provide Benefits for dental care. Except as otherwise stated in this Policy, we do not cover:
    A. Treatment of cavities;
    B. Tooth extractions;
    C. Care of the gums;
    D. Care of the bones supporting the teeth;
    E. Treatment of periodontal disease;
    F. Treatment of dental abscess;
    G. Treatment of dentigerous cysts;
    H. Removal of soft tissue supporting or surrounding teeth;
    I. Orthodontia (including braces);
    J. False teeth;
    K. Orthognathic surgery; or
    L. Any other dental services you may receive.
28. **Dental Implants:** Dental implants of titanium osseointegrated fixtures or of any other material are not covered.
29. **Dermatomal Somatosensory Evoked Potentials:** Dermatomal somatosensory evoked potential testing is not covered.
30. **Developmental Delay:** Services or supplies provided for developmental delay, including learning disabilities, communication delay, perceptual disorder, sensory deficit and motor dysfunctions are not covered.
31. **Dexamethasone Infusion:** Dexamethasone infusion is not covered.
32. **Dietary and Nutritional Services:** Unless such dietary supplies are the sole source of nutrition for the Enrollee, any services or supplies provided for dietary or nutritional services, including but not limited to medical nutrition therapy, are not covered. Baby formulas or thickening agents, whether prescribed by a Physician or acquired over the counter, are not a covered benefit.
33. **Donor Expenses For Transplant:** Services and supplies associated with an organ and tissue transplant where the Enrollee is the donor are not covered.
34. **Dynamic Orthotic Cranioplasty:** Dynamic orthotic cranioplasty is not covered.
35. **Electrogastrography:** Electrogastrography is not covered.
36. **Electron Beam Computed Tomography:** Electron beam computed tomography is not covered.
37. **Environmental Intervention:** Services or supplies used in adjusting an Enrollee's home, place of employment or other environment so that it meets the Enrollee's physical or psychological condition are not covered.

38. **Enteral Feedings:** Enteral feedings are not covered except when approved by us and documented to be the Enrollee's sole source of nutrition, subject to all other terms, conditions, and limitations of this Policy.
39. **Excessive Use:** Excessive use of medications is not covered. For purposes of this exclusion, each Enrollee agrees that QualChoice shall be entitled to deny coverage of medications under a prescription drug rider or this Policy, on grounds of excessive use when our medical director, in his sole discretion, determines (1) that an Enrollee has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard reference compendia or by the Pharmacy & Therapeutics Committee; or (2) that an Enrollee has obtained or attempted to obtain the same medication from more than one Physician for the same or overlapping periods of time; or (3) that the pattern of prescription medication purchases, changes of Physicians or pharmacy or other information indicates that an Enrollee has obtained or sought to obtain excessive quantities of medications. Each Enrollee hereby authorizes QualChoice to communicate with any physician, health care provider or pharmacy for the purpose of reviewing and discussing the Enrollee's prescription history, use or activity to evaluate for excessive use.
40. **Exercise Programs:** Exercise programs for treatment of any condition are not covered. Examples would be gym memberships, personal trainers, and home exercise equipment, even if recommended or prescribed by a Physician.
41. **Experimental or Investigational Procedures and Related Equipment and Supplies:** We will not cover any procedure or service we consider to be experimental or investigational. We also will not pay for equipment or supplies related to such procedures. We base decisions on what is experimental or investigational on unbiased technology reviews and national scientific, peer-reviewed medical literature. Any therapy subject to government agency approval must have received final approval before we consider it for coverage. A new treatment with no outcome advantage over existing treatments may be considered investigational while studies are in progress to determine if any treatment advantage exists in any subpopulation of the affected group.
42. **Extracorporeal Shock Wave Therapy:** Extracorporeal shock wave therapy (ESWT) for any musculoskeletal condition, including but not limited to plantar fasciitis or tennis elbow, is not covered.
43. **Eyeglasses:** Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contacts except for the initial acquisition following cataract surgery as specified in Section 4.1.
44. **First Aid Supplies:** We will not cover over the counter first aid supplies.
45. **Foot Care:** Services or supplies for palliative or cosmetic foot care or for flat foot conditions are not covered. This includes but is not limited to supporting devices for the foot such as shoe inserts, elastic stockings, Jobst stockings, the treatment of subluxations of the foot, arthroeresis for flat feet, care of corns, bunions, calluses, routine trimming of toe nails, fallen arches, weak feet and chronic foot strain. However, subject to all terms, conditions, exclusions and limitations as set forth in this Policy, foot care is provided when required for prevention of complications associated with diabetes mellitus or other peripheral sensory neuropathy.
46. **Formula:** Baby formula and thickening agents, even if prescribed by a physician or acquired over-the-counter are not covered.
47. **Fraud or Misrepresentation:** Health interventions or health services, including but not limited to medications obtained by unauthorized or fraudulent use of an Enrollee's identification card or by material misrepresentation as part of the enrollment process or at other times, are not covered.
48. **Free Care:** We will not cover any care if there was no charge for the care. This applies even if you, or your provider thought the services were not covered by insurance when the provider chose not to charge for the care.

49. **Government Programs:** We will not pay for Covered Services to the extent benefits for such services are payable under Medicare or any other federal, state or local government program.
50. **Hair Loss or Growth:** Wigs, hair transplants or, unless specifically covered in a prescription drug rider issued to you by us, any medication that is taken for hair growth even if prescribed by a Physician, are not covered regardless of the cause of hair loss. Treatment of male or female pattern baldness is not covered.
51. **Health and Behavior Assessment:** Evaluation of psychosocial factors potentially impacting physical health problems and treatments are not covered. This includes health and behavior assessment procedures used to identify psychological, behavior, emotional, cognitive, and social factors affecting physical health problems.
52. **Hearing or Talking Aids:** Regardless of the reason for the hearing or speech disability, hearing aids, prosthetic devices to assist hearing, or talking devices, including special computers, are not covered. Fitting or repair of such devices is not covered. Nor are cochlear implants, or its associated speech processor, or auditory brain stem implants covered.
53. **Heat Bandage:** Treatment of a wound with a warm-up active wound therapy device or a non-contact radiant heat bandage is not covered.
54. **High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation:** High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation are not covered, except in the circumstances set forth in Section 3.30.
55. **High Frequency Chest Wall Oscillators:** High frequency chest wall oscillators that are used to provide airflow to the lungs are not covered.
56. **Home Uterine Activity Monitor:** Home uterine activity monitors or their use is not covered.
57. **Illegal Acts:** We will not cover health care services resulting from an Enrollee's participation in an illegal act or being engaged in an illegal occupation, whether or not convicted, riot or insurrection except as required by law.
58. **Illegal Uses:** Medications, drugs or substances that are illegal to dispense, possess, consume or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner, are not covered. Complications or an Accidental Injury from illegal drug use or while driving under the influence of alcohol determined to be in excess of legal limits, are not covered.
59. **Impotence or Sexual Dysfunction:** We will not cover medical, surgical, or pharmacological treatment for impotence, frigidity, or other sexual dysfunction unless such dysfunction is the result of diabetic neuropathy, spinal cord injury or prostate surgery.
60. **Immunizations**: Immunizations for travel, school, work or recreation are not covered.
61. **Insulin Pump for Diabetes Mellitus:** We do not cover insulin pumps for diabetes mellitus.
62. **Infertility Treatment:** We will cover a basic diagnostic work-up to make an initial diagnosis of infertility. We will not cover any medications (unless specifically covered in a prescription drug rider issued to you by us), procedures, or other services for treatment of infertility. It does not matter if the infertility service is therapeutic, it is still not covered. It does not matter whether the infertility service or treatment is by natural, artificial, mechanical, pharmacological, or other means, it is still not covered. Specific services that are not covered include, but are not limited to:
    A. Reversal of sterilization
    B. Pre-implantation testing and/or artificial insemination
    C. Surrogate pregnancies
    D. Medical treatment of infertility
    E. Surgical treatment of infertility
    F. In vitro fertilization

    Note: We will not pay for surgery that is done primarily for infertility treatment even when other diseases or conditions that may be the underlying medical condition causing the infertility are detected or treated during such surgery.
63. **Inotropic Agents for Congestive Heart Failure:** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. However, subject to all terms, conditions, exclusions and limitations set forth in this Policy, where the

Enrollee is on a cardiac transplant list at a hospital where there is an ongoing cardiac transplantation program, the Policy will cover infusion of inotropic agents.

64. **Instructional Programs:** We will not pay for instructional or educational testing, programs, seminars or workshops such as, but not limited to, childbirth classes, vocational training or testing, diet programs, nutritional programs, smoking cessation classes, educational or neuroeducational testing, or general or remedial education classes. Diabetic education is covered as set forth in Section 3.8.
65. **Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders:** Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.
66. **Learning Disabilities:** Services or supplies provided for learning disabilities, i.e. reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty and other learning difficulties, are not covered.
67. **Lost Medications:** Replacement of previously filled prescription medications because the initial prescription medication was lost, stolen, spilled, contaminated, etc. are not covered.
68. **Magnetic Innervation Therapy:** Extracorporeal magnetic innervation therapy for the treatment of urinary incontinence is not covered.
69. **Maintenance Therapy:** We will not cover maintenance therapy for chiropractic therapy, physical therapy, occupational therapy, recreational therapy, or speech therapy.
70. **Mammoplasty:** Except as provided in Section 3.27, we do not cover mammoplasty for reasons of augmentation, reduction or asymmetry of the breasts. We do not cover removal of breast implants placed or removed for cosmetic purposes.
71. **Mandated or Court Ordered Care:** We will not cover any medical, psychological, or psychiatric care which is the result of a court order or otherwise mandated by a third party (such as, but not limited to, an employer, licensing board, recreation council, or school).
72. **Maternity Care and Obstetrical Care:** We do not cover services or supplies for Maternity Care and Obstetrical Care.
73. **Medical Reports:** We will not cover expenses for medical report preparation and presentation. We will not pay for provider appearances at hearings and court proceedings. We will not pay for charges for the completion of insurance forms, or the preparation or copying of medical records.
74. **Medical/Surgical Services or Supplies for Control of Obesity or Morbid Obesity:** We will not cover any surgery, medical services or supplies intended for control of either obesity or morbid obesity even if the obesity or morbid obesity aggravates another condition or illness. This would include services such as dietary control, medications (unless specifically covered in a prescription drug rider issued to you by us), counseling or weight maintenance programs, gastric stapling, gastric bypass or any other service intended to control obesity. We do not cover surgical or medical procedures to treat the complications or consequences of weight loss, such as abdominoplasty or panniculectomy.
75. **Medication Therapy Management Services:** Medication therapy management services by a pharmacist, including but not limited to a review of an Enrollee's history and medical profile, an evaluation of prescription medication, over-the-counter medications and herbal medications, are not covered.
76. **Meniscal Allograft Transplantation:** Meniscal allograft transplantation is not covered.
77. **Mental Health or Substance Abuse:** Unless a Mental Health and/or Substance Abuse Rider accompanies this Policy, mental health, substance abuse, and chemical dependency treatment and related services and supplies are not covered, including, but not limited to, the following conditions and treatments:
    A. Sexual and gender identity disorders;
    B. Treatment for smoking or nicotine addiction;
    C. Services provided for treatment of adolescent behavior or conduct disorders, oppositional disorders, or neuroeducational testing;
    D. Outpatient psychotherapy or counseling for personal growth or life and social enrichment;
    E. Group therapy or group counseling at any time in any setting by any provider;
    F. Psychiatric conditions and substance abuse, including alcohol;
    G. Detoxification from abusive chemical or substance abuse;
    H. Medication supporting an addiction or substance dependency;

I. Seasonal Affective Disorder (SAD) treatment;
J. Educational services of any type for any reason;
K. Marriage and family therapy or counseling services; and
L. Services rendered by an Out-of-Network Provider.

78. **Non-Compliance with Recommended Treatment:** We will not cover services provided as the result of or related to an Enrollee's refusal to comply with a physician's or other provider's recommendations or orders, or failure to cooperate with a prescribed plan of treatment or recovery.
79. **Nurse Midwife:** Services provided by a nurse midwife are not covered.
80. **Nutritional Counseling or Nutritional Supplements:** Benefits are not available for dietary control counseling or weight maintenance programs. For Enrollees with diabetes, see Section 3.8.
81. **Oral, Implantable and Injectable Contraceptives:** Oral and prescription contraceptive methods that are not on the QualChoice formulary are not covered. Implantable and injectable contraceptives provided in a physician's office are not covered.
82. **Orthognathic Surgery:** The surgical repositioning of segments of the mandible or maxilla containing one to several teeth, or the bodily reposition of entire jaws, whether to reduce a dislocation of temporomandibular joint or for any other purpose, is not covered. For coverage of Oral Surgery or Reconstructive Surgery, see Section 3.
83. **Orthoptic or Pleoptic Therapy:** Orthoptic or pleoptic therapy is not covered.
84. **Orthotics:** Orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain are not covered. This exclusion applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, those that are mainly protective in nature, and those that combine functional control and protection. The exclusion applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.
85. **Outpatient Rehabilitation Services:** Coverage for outpatient visits for physical, occupational, and speech therapy, audiology services, pulmonary rehabilitation and chiropractic services are limited to a maximum number of visits per Enrollee per Calendar Year as set out in the Benefit Summary. Coverage for cardiac rehabilitation is limited to a maximum number of visits per Enrollee per Calendar Year as set out in the Benefit Summary. Any outpatient rehabilitation services obtained from an Out-of-Network Provider are not covered.
86. **Outside United States:** We do not cover services or supplies obtained outside of the United States except in our sole discretion.
87. **Over the Counter Medications:** Unless specifically identified in a prescription drug rider purchased from QualChoice, medications (except insulin) which do not by law require a prescription from a Physician are not covered.
88. **Pain Pump, Disposable:** Disposable pain pumps following surgery are not covered.
89. **Parkinson's Disease, Treatment with Fetal Mesencephalic Transplantation:** Fetal mesencephalic transplantation (FMT) for treatment of Parkinson's disease is not covered.
90. **Percutaneous Diskectomy:** Any method of percutaneous diskectomy, including, but not limited to, automated or manual percutaneous diskectomy, laser diskectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered.
91. **Percutaneous Sacroplasty:** Percutaneous sacroplasty is not covered.
92. **Performance Enhancement:** We will not cover medical, surgical or rehabilitation services primarily intended to improve the level of physical functioning for purposes of enhanced job, athletic or recreational performance, including but not limited to work hardening programs, back schools, programs of general physical conditioning, athletic trainers and special or specially modified surgical procedures designed to enhance performance above normal.
93. **Peripheral Nerve Stimulators:** Peripheral nerve stimulators are not covered.
94. **Peripheral Vascular Disease Rehabilitation Therapy:** Peripheral vascular disease rehabilitation therapy is not covered.
95. **Premarital Laboratory Work:** We will not cover premarital laboratory work required by any state or local law.

96. **Prescription Medications:** Unless specifically covered in a prescription drug rider issued to you by us, prescription drugs for outpatient use filled by a prescription order or refill and non-injectable medications given in a physician's office except in an Emergency are not covered.
97. **Private Duty Nurses:** We will not cover private duty nurses.
98. **Private Room:** We do not cover a private hospital room. We will pay the most common charge for semi-private accommodations. If there is a charge for a private room, you must pay the difference between the charges for a private room and our payment.
99. **Prolotherapy:** Prolotherapy or Sclerotherapy for the stimulation of tendon or ligament tissue or for pain relief in a localized area of musculoskeletal origin is not covered.
100. **Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions:** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.
101. **Required Examinations or Services:** We will not cover examinations or services required or recommended by a third party. This would include services for the purpose of:
    A. Obtaining employment;
    B. Maintaining employment;
    C. Obtaining insurance;
    D. Obtaining professional or other licenses;
    E. Engaging in travel;
    F. Athletic or recreational activities; or
    G. Attending a school, camp, or other program.
102. **Research Studies:** We will not cover any service provided in connection with research studies or clinical trials.
103. **Rest Cures:** Services or supplies for rest cures are not covered.
104. **Reversal of Sterilization:** We will not cover any procedures or related care to reverse previous sterilization.
105. **Second Surgical Opinion and Consultation with Specialist:** We will not cover a second surgical opinion and a consultation from the same physician or from two physicians who are in practice together.
106. **Self-inflicted Injuries:** Services for intentional self-inflicted injuries, including drug overdose, are not covered, except when it is determined the act causing the injury resulted from a medical condition (physical or mental).
107. **Sensory Stimulation of Coma Patients:** Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.
108. **Services Not Specified as Covered Services:** We will not cover any services not specifically described in Section 3 of this Policy.
109. **Sex-Change Treatment:** We will not cover surgical procedures or related care to alter your sex from one gender to the other.
110. **Sexual and Gender Identity Disorders:** Any services related to the treatment of sexual and identity disorders are not covered.
111. **Short Stature Syndrome:** Any services related to the treatment of short stature syndrome, except for laboratory documented growth hormone deficiency, are not covered.
112. **Smoking or Tobacco Cessation or Caffeine Addiction:** Unless a Smoking Cessation Rider is issued to you by us, treatment of caffeine or nicotine addiction, smoking cessation prescription medication products, including but not limited to, nicotine gum and nicotine patches are not covered.
113. **Snoring:** Devices, procedures or supplies to treat snoring are not covered.
114. **Sperm and Embryo Preservation and Donation:** We will not cover charges related to the donation, collection, or preservation of sperm or embryos for later use.
115. **Sterilization, Voluntary Hysterectomy:** We will not cover charges related to hysterectomy for the primary purpose of voluntary sterilization. We will not cover charges related to implantation of the Essure device or other similar devices identified at our sole discretion. You may contact us to obtain a listing of such devices.
116. **Tanning Equipment:** Tanning equipment is not covered.
117. **Telephone and Other Electronic Communication:** We do not cover communications between a provider and an Enrollee or a provider and another provider done by telephone or other electronic means such as email.

118. **Temporomandibular Joint Syndrome (TMJ):** Unless a TMJ Rider is included with this Policy, we will not cover charges related to treatment or diagnosis of TMJ, including, but not limited to, medical, surgical and dental treatment, physical therapy, joint splints, adjustments, medications, as well as any orthotic treatment. All other procedures involving the teeth or areas surrounding the teeth are not covered, including shortening of the mandible or maxillae, or correction of malocclusion.
119. **Thermography:** Thermography, the measuring of self-emanating infrared radiation that reveals temperature variation at the surface of the body, is not covered.
120. **Third Party Liability Exclusion:** We will not pay any Benefits to an Enrollee to the extent the Enrollee has received payment, in whole or in part, from a third party, or its insurer, for past or future medical or hospital or other health care charges as the result of the negligence or intentional act of a third party. If an Enrollee makes a Claim for Benefits under this Policy prior to receiving payment from a third party, or its insurer, the Enrollee (or legal representative for a minor or incompetent) agrees to repay us from any amount of money received by the Enrollee from the third party, or its insurer. Please refer to Section 8 and Section 9.7 for further information concerning repayment of Benefits.
121. **Thoracic Electrical Bioimpedance:** Thoracic electrical bioimpedance is not covered.
122. **Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae:** Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.
123. **Trans-telephonic Home Spirometry:** Tans-telephonic home or ambulatory spirometry is generally not covered. However, subject to all terms, conditions, exclusions and limitations as set forth in this Policy, trans-telephonic home or ambulatory spirometry is covered for patients who have had a lung transplant, when pre-approved by the QualChoice Care Management Department.
124. **Travel and Transportation Expenses:** We will not cover travel and transportation expenses, even if prescribed by a physician, except for emergency ambulance service or ambulance service for transfer coordinated by the QualChoice Care Management Department.
125. **Travel or Work Related Immunizations:** We will not cover immunizations to fulfill requirements for international travel or for work.
126. **Ultrasounds:** Obstetrical ultrasound is not covered.
127. **Unlicensed Provider:** Coverage is not provided for treatment, procedures or services provided by any person or entity, including but not limited to physicians, who is required to be licensed to perform the treatment, procedure or services, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of QualChoice, include within its scope the treatment, procedure or service provided.
128. **Vacuum Assisted Closure:** Vacuum assisted closure devices and services associated with it are not covered.
129. **Vision and Hearing Services:** Except as set forth in the Benefit Summary, we will not cover routine eye or hearing examinations, services or tests, eyeglasses, contact lenses, hearing aids and other vision care and hearing care services and supplies, except as required for the diagnosis and treatment of diseases of, or injury to, the eyes or ears.
130. **Vision Correction:** We will not cover eye surgery to correct refractive errors. This includes refractive keratoplasty, refractive keratomileusis, epikeratophakia procedures, Low Vision Enhancement System (LVES), Laser Assisted Insitu Keratomileusis (LASIK), eyeglass, and contact lenses, except the initial acquisition of one pair within the twelve months following cataract surgery up to a maximum of $200.00 (for frames and lenses), are not covered.
131. **Vitamins or Baby Formula:** Unless specifically covered in a prescription drug rider issued to you by us, vitamins, food or nutrient supplements are not covered. **Baby formula and thickening agents, even if prescribed by a Physician are not covered.** However, subject to all terms, conditions, exclusions and limitations set forth in this Policy, coverage is provided for medical foods and low protein modified food products for the treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism (see Section 3.19).
132. **Vocational Rehabilitation:** Vocational rehabilitation services, counseling and testing are not covered.

133. **War or Act of War:** We will not cover any services relating to any injury or sickness resulting from war or any act of war (declared or undeclared), or in the armed forces of any country if any government plan covers the injury or sickness.
134. **Weight Control:** Medications prescribed, dispensed or used for the treatment of obesity are not covered. Medications prescribed, dispensed or used in any program of weight control, weight reduction, weight loss or other dietary control are not covered. Weight loss surgical procedures, including complications relating thereto, are not covered.
135. **Whole Body Computed Tomography:** Whole body computed tomography is not covered.
136. **Workers' Compensation:** We will not cover any care or supplies for any injury, condition or disease arising from employment. We will not make any payments even if a Claim is not made for the benefits which are available under the Workers' Compensation Law.
137. **Wound Treatment:** Blood derived growth factors are not covered.

4.2. Limitations to Benefits

1. **Ambulance:** Transportation by ambulance is limited to a maximum annual benefit amount, and is subject to review for Medical Necessity. Consult the Benefit Summary for Benefit limitations.
2. **Autism Screening:** Screening for autism is limited to a maximum of once between the ages of 1 and 4. Coverage for developmental delay associated with autism spectrum disorder is excluded.
3. **Biofeedback:** Biofeedback is covered only when it is Medically Necessary for muscle re-education of specific muscle groups, or for treating the pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and when more conventional treatments (heat, cold, exercise, and support) have not been successful. Pre-authorization is required. Biofeedback is medically appropriate when applied to the conditions reflected in the QualChoice Medical Policies.
4. **Circumstances Beyond Our Control:** Services and other covered Benefits could be delayed or made impractical by circumstances not reasonably within our control, such as: complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of hospital or medical group personnel, or similar causes. If so, Network Providers will make a good faith effort to provide services and other Benefits covered hereunder. Neither any provider nor we shall have any other liability or obligation because of such delay or such failure to provide services or other Benefits.
5. **Durable Medical Equipment (DME):** Benefits for DME is limited to an annual dollar maximum and must be obtained from a Network Provider. Please refer to the Benefit Summary for this annual limit.
6. **Eating Disorders:** We cover services for eating disorders only as provided in Section 3 of this Policy. This includes treatment for anorexia, bulimia and other eating disorders.
7. **Electrotherapy and Electromagnetic Stimulators:** All treatment using electrotherapy and electromagnetic stimulators, including services and supplies used in conjunction with such stimulators, and complications resulting from such treatment, is covered only for conditions specified in our Medical Policies.
8. **Enhanced External Counterpulsation:** Enhanced external counterpulsation (EECP) is covered only for conditions specified in our Medical Policies.
9. **Genetic Counseling and Testing:** Genetic counseling, genetic testing, and chromosome analysis are covered only when there is documented evidence that a genetic anomaly or defect may be present which could threaten the life of the Enrollee. Preauthorization is required. Genetic counseling, genetic testing, and chromosome analysis may be appropriate for (i) lymphoma, (ii) multiple myeloma, (iii) suspected Down's Syndrome, and (iv) testing for BRCA genes. We will not cover genetic counseling or testing:
   A. To determine the likelihood of developing a disease or condition;
   B. To determine the likelihood of a disease or the presence of a disease in a relative;
   C. To determine the likelihood of passing an inheritable disease, e.g. cystic fibrosis, or congenital abnormality to an offspring; or
   D. For pre-implantation genetic diagnosis or treatment.

10. **Home Health Care:** Home health visits are limited to a maximum number of visits per Enrollee per Calendar Year. The Home Health Care visit limitation and the Cost Sharing Amounts are specified in the Benefit Summary.
11. **Hospice Care:** Hospice Care is limited to a maximum number of days of coverage per Enrollee. The Hospice Care day limitation and the Cost Sharing Amounts are specified in the Benefit Summary.
12. **In Vitro Chemoresistance and Chemosensitivity Assays:** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but not limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered, subject to QualChoice's Medical Policies.
13. **Insulin Pump for Diabetes Mellitus:** We will cover insulin pumps to a Maximum Allowable Charge of $5,500. Insulin pump supplies are covered under your medical benefit and are not subject to this limitation. Pre-authorization is required.
14. **Lifetime Maximum:** Consult your Benefits Summary, Medical Policies, and this Policy for various lifetime maximum Benefits per Enrollee.
15. **Major Disaster or Epidemic:** If a major disaster or epidemic occurs, Network Providers will render medical services as is practical according to their best judgment within the limitation of available facilities and personnel. Neither any Network Provider nor we has any liability or obligation for delay or failure to provide or arrange any such services to the extent the disaster or epidemic creates unavailability of facilities or personnel.
16. **Prosthetic and Orthotic Devices and Services:** QualChoice does not cover replacement of a prosthetic or orthotic device or associated prosthetic or orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Policy. However, QualChoice will replace or repair a prosthetic or orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.
17. **Refusal to Accept Treatment:** You may refuse to accept procedures or treatment recommended by Network Providers for personal reasons. In such case, neither we nor any Network Provider shall have any further responsibility to provide care for the condition under treatment, unless such refusal is later recanted and there is an agreement to follow the recommended treatment or procedure.
18. **Transplant Services:** Transplant services are subject to the following benefit maximums:
    A. Coverage for procurement (per transplant) is limited to the amount reflected in your Benefits Summary;
    B. Lifetime maximum organ transplant coverage is limited to the amount reflected in your Benefits Summary;
    C. We will not cover the transportation and/or lodging costs of the transplant donor, or individuals traveling with either the donor or the recipient. We will not pay for artificial or non-human parts or organs or any services related to transplants using artificial or non-human parts or organs. Transportation costs of the transplant recipient are covered at the sole discretion and evaluation of the QualChoice Care Management Department. Coverage is limited to no more than two (2) transplants per Enrollee per lifetime. We cover re-transplantation, subject to the transplant limit of two (2).
    D. Solid organ transplants of any kind are not covered for an Enrollee with a malignancy of any kind that is presently active, in partial remission or in complete remission less than two years. A solid organ transplant of any kind is not covered for an Enrollee that has had a malignancy removed or treated in the three (3) years prior to the proposed transplant. For purposes of this exclusion, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma, or melanoma. Exceptions to this exclusion are hepatocellular carcinoma under certain circumstances, basal or squamous cell carcinomas of the skin, absent lymphatic or distant metastasis.
    E. Organ transplants not pre-authorized by QualChoice Care Management Department are not covered.

5. ELIGIBILITY CRITERIA

5.1. Hospitalization When Coverage Begins

If an Enrollee is an inpatient in a hospital, skilled nursing facility, or other inpatient facility on the Effective Date of this Policy, coverage under this Policy will not be effective for such Enrollee until after discharge from the facility.

No person, who is a registered inpatient in a hospital, skilled nursing facility, or other inpatient facility on the date he or she would otherwise be entitled to begin coverage will be eligible under this Policy or receive such coverage for such inpatient confinement.

5.2. Eligibility for Medicare

If you are eligible for Medicare, you are not eligible to begin or continue coverage under this Policy.

5.3. Who is Eligible for Coverage and When Does Coverage Begin

Subject to the Policy Holder meeting all eligibility requirements in this Policy, the Policy Holder's coverage begins upon the Effective Date of this Policy as reflected in the Benefit Summary. You may contact us for information concerning eligibility requirements and the Effective Date.

You must list yourself on the Enrollment Application to be eligible for coverage. You must meet all eligibility requirements in this Policy. ***Only*** a person who is a resident of the State of Arkansas and is under the age of 19 is eligible for coverage under this Policy. For the purposes of this Section, an Enrollee is a "resident" of the State of Arkansas if s/he lives in Arkansas and has an intent to remain in the State for a period of time, which may include a Child who is a student at a college or university located outside of Arkansas. QualChoice reserves the right to request documentation necessary to demonstrate that an Enrollee's residency is the State of Arkansas. Except under limited circumstances described in this Policy, we are not required to provide coverage under this Policy to every applicant for coverage.

No one is eligible for coverage if that person does not meet our eligibility rules. You should contact us for further information concerning your eligibility. Nor is someone eligible to enroll if that person had previous coverage with us and was terminated for causes described in Section 5.5.4 of this Policy.

5.4. Maternity Coverage

This Policy does not include coverage for Maternity Care and Obstetrical Care unless originally issued with a maternity coverage rider. You may add a maternity coverage rider by submitting an application to us which must be approved by us prior to you conceiving a child. Our standard underwriting standards must be met in order for us to approve issuing a maternity coverage rider. As a consequence, there can be no maternity Benefits under this Policy before the end of 12 months from the date maternity coverage was issued.

5.5. Termination of Coverage

Subject to the Policy Holder meeting all eligibility requirements in this Policy, the Policy Holder's coverage begins upon the Effective Date of this Policy as reflected in the Benefit Summary and will end on the date that the Policy is terminated by its terms.

An Enrollee's coverage under this Policy will terminate in certain circumstances. We describe these circumstances below.

1. **Default in Payment of Premiums:** Premiums are due on or before the first day of each month of Coverage under this Policy by the method described in your Enrollment Application. A grace period of thirty-one (31) days from that due date (the "Grace Period") will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. Failure to make premium payments to us in accordance before the end of the Grace Period shall terminate Benefits under this Policy. Coverage under this Policy will be terminated retroactive to the last day of the month for which premium payment was received.
2. **Becoming Eligible for Medicare:** When an Enrollee becomes eligible for Medicare, that Enrollee is no longer eligible for coverage under this Policy and should notify us immediately.

3. **On Death:** Coverage for the Policy Holder under this Policy will automatically terminate on the date of the Policy Holder's death. All premiums paid for coverage beyond the date of the Policy Holder's death will be refunded following our receipt of proof of death.
4. **Our Option to Terminate This Policy:** We may terminate this Policy for any of the following reasons:
   A. We rescind an Enrollee's coverage for material misrepresentation or fraud committed by the Enrollee in connection with any Claim filed under this Policy;
   B. period;
   C. We may terminate an Enrollee's coverage upon 30 days advance written notice if an unauthorized person is allowed to use the Enrollee's identification card or if the Enrollee otherwise cooperates in the unauthorized use of such Enrollee's identification card or Benefits;
   D. Each Enrollee represents all statements made in his or her Enrollment Application for coverage are true to the best of his or her knowledge and belief. If an Enrollee furnishes any misleading, deceptive, incomplete, or untrue statement, which is material to the acceptance of his or her Enrollment Application, we may rescind his or her coverage under this Policy back to the original Effective Date;
   E. We will terminate an Enrollee's coverage under this Policy if the Enrollee moves permanently to another state effective as of the end of the month for which the premium for that Enrollee has been paid;
   F. We may terminate this Policy on 90 days written notice if we decide to no longer issue this particular type of health coverage; or
   G. We may terminate this Policy if you fail to pay premiums or contributions under the terms of this Policy.

   If QualChoice terminates the coverage of an Enrollee, it will notify the Enrollee in writing of the termination date and premium payments received on account of the terminated Enrollee applicable to periods after the effective date of termination shall be refunded to the Enrollee within 30 days or in the next scheduled billing cycle.

5. **You Terminate Coverage**: If the Policy Holder wishes to terminate coverage under this Policy, the Policy Holder must notify QualChoice in writing in advance of the requested termination date which will be effective no sooner than the end of the calendar month that QualChoice received the notice of termination. Premiums will only be refunded for any period already paid beyond the end of the month in which the notice of termination was received.
6. **No Further Liability.** Following termination of this Policy, we will have no further liability for Benefits except for those incurred before the date the Policy terminated.
7. **Reinstatement.** If any renewal premium is not paid within the Grace Period, a subsequent acceptance of premium by us or by any agent authorized by us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if we or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless we have previously notified you in writing of our disapproval of such application. The reinstated Policy shall cover only losses resulting from such Accidental Injury as may be sustained after the date of reinstatement and loss to such sickness as may begin more than ten (10) days after such date. In all other respects, the Enrollee and us shall have the same rights hereunder as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.
8. **Guaranteed Renewability**. This policy and riders are guaranteed renewable so long as your permanent residence is in Arkansas. At any time after the first twelve (12) month period of coverage under the Policy, we may change your premium rate, but only if the rate is changed

for all policies and riders of the same form number and premium classification as this Policy. Your premium rate will also change in any month that you attain an age that moves you into a different premium classification established by QualChoice.

6. COORDINATION OF BENEFITS

You may have coverage under more than one health policy. This Policy contains a Coordination of Benefits (COB) provision. This is to eliminate duplication of payment for services. There is no COB for prescription drugs supplied at the retail pharmacy. COB will apply for drugs covered under the medical benefit. We do not coordinate against the following kinds of coverage: hospital indemnity coverage or other fixed indemnity coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, as defined by state law, school accident type coverage, benefits for non-medical components of long-term care policies, Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

6.1. How COB Works

The order of benefit determination rules govern the order in which each health policy will pay a Claim for benefits. The health policy that pays first is called the primary policy. The primary policy must pay benefits in accordance with its policy terms without regard to the possibility that another health policy may cover some expenses. The plan that pays after the primary policy is the secondary policy. The secondary policy may reduce the benefits it pays so that payments from all health policies do not exceed 100% of the COB Allowable Expense (described in Section 6.4 below).

6.2. Rules to Determine Primary and Secondary Plans

The following rules will determine primary and secondary policy coverage:

1. If a health policy does not have a COB provision, that policy is primary.
2. The health policy covering the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is primary, and the health policy that covers the person as a dependent is secondary.
3. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one health policy the order of benefits is determined as follows:
   - A. For a child whose parents are married or are living together, whether or not they have ever been married:
     - (1) The health policy of the parent whose birthday falls earlier in the Calendar Year is primary; or
     - (2) If both parents have the same birthday, the health policy that has covered the parent the longest is primary.
   - B. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
     - (1) The plan of the parent who a court has established as being responsible for the child's health care expenses or health care coverage is primary (we must be informed of this requirement and documentation may be required);
     - (2) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage , the provisions of Subparagraph A above determines the order of benefits;
     - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of Subparagraph A above determine the order of benefits; or
     - (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
       - (a) Plan of the custodial parent;

(b) Plan of the custodial parent's new spouse (if remarried);
(c) Plan of the non-custodial parent; and then
(d) Plan of the new spouse of the non-custodial parent (if remarried).

C. For a dependent child covered under more than one health policy of individuals who are the parents of the child, the provisions of Subparagraph A or B above determine the order of benefits as if those individuals were the parents of the child.

4. The health policy that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is primary. The same rule applies to a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. Note that this rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.
5. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another health policy, the health policy covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is primary and the COBRA or state or other federal continuation coverage is secondary. If the other health policy does not have this rule, and as a result, the health policy or policies do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.
6. The health policy that covered the person as an employee, member, policyholder, subscriber or retiree longer is primary and the health policy that covered the person the shorter period of time is secondary.
7. If the preceding rules do not determine the order of benefits, the COB Allowable Expense shall be shared equally between the health policies or policies. In addition, this Policy will not pay more than it would have paid had it been primary.

6.3. Allowable Expense

For the purposes of this Section 6, "Allowable Expense" is a health care expense (including Deductible, Coinsurance or Co-payments) covered in full or in part by any health care plan or policy covering the Enrollee. This means an expense or service not covered by any plan or policy covering the Enrollee is not an Allowable Expense. Also, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Enrollee is not an Allowable Expense.

If two (2) or more plans or policies cover you and compute their benefit payments based on that plan's maximum allowable charge, any amount in excess of the Allowable Expense of the primary payor for a specified benefit is not an Allowable Expense.

If two (2) or more plans or policies cover you and provide benefits or services based on negotiated fees, any amount in excess of the negotiated fees of the primary payor is not an Allowable Expense.

If you are covered under multiple plans or policies and the Allowable Expense is determined by more than one method, the primary policy's payment arrangement shall be the Allowable Expense for all plans or policies.

6.4. Reduction of Benefits

When this Policy is secondary, we will reduce our benefits so that the total benefits paid or provided by all plan or policies are not more than one hundred percent (100%) of the total Allowable Expense of the primary policy.

A. In determining the amount to be paid for any Claim, QualChoice will calculate the Benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense that is unpaid by the primary policy. QualChoice will then reduce its payment by the amount so that, when combined with the amount paid by the primary policy, the total Benefits paid or provided by all health policy

or policies for the Claim do not exceed the total Allowable Expense of the primary policy for that Claim.

B. QualChoice will credit to Enrollee's Deductible any amounts it would have credited to the Deductible in the absence of other health care coverage.

C. If an Enrollee is enrolled in two or more closed panel plans (that is, a plan or policy that provides benefits primarily through a panel of contracted health care providers and excludes coverage for services provided by other health care providers) and if, for any reason, including the provision of service by an Out-of Network Provider, benefits are not payable by one closed panel plan, COB shall not apply between that closed panel plan and other closed panel plans.

6.5. Enforcement of Provisions

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the Plan and other health policy or policies. For the purposes of COB administration, QualChoice will get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under the Plan and other health policy or policies covering the person Claiming benefits. QualChoice is not required to tell, or get the consent of, any person, including the Enrollee, to do this. You must give QualChoice any facts we needs to apply those rules and determine Benefits payable. If you fail to provide this information, we may delay Benefit payments.

6.6. Facility of Payment

A payment made under another health policy may include an amount that should have been paid under this Plan. If it does, QualChoice may pay that amount to the other plan or policy that made that payment. That amount will then be treated as though it were a benefit paid by QualChoice under this Certificate. QualChoice will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.7. Right of Recovery

If we pay more for Covered Services than this provision allows, we have the right to recover the excess payment. You agree to do whatever is necessary to secure our right to recover excess payments.

6.8. Hospitalization When Coverage Begins

Consistent with applicable law, if an eligible Enrollee is inpatient in a hospital on the effective date of this Certificate and immediately prior to such effective date was covered by another group health policy that provides coverage for hospital or medical services or expenses, coverage for benefits under that other policy, contract, or certificate will continue and it will be the primary policy for those services and expenses associated with that hospital admission. As the primary policy, that group health policy will be responsible for those services and expenses until the end of that hospital admission or until the expiration of any applicable extension of benefits provided under such group health policy, whichever occurs first.

7. COMPLAINTS AND APPEALS

We have authority and full discretion to determine all questions, problems or disputes, arising in connection with Benefits, including but not limited to eligibility, interpretation of Policy language and findings of fact about such questions. Our actions, determinations and interpretations with respect to all such matters, and with respect to any matter within the scope of our authority, shall be conclusive and binding on the Enrollee. Any problem or Claims dispute between an Enrollee and us must go through our complaint and appeals process. If the problem or dispute is over a determination of Medical Necessity, classification of treatment as Experimental or Investigational or involves an Expedited Appeal, the appeal process is controlling.

7.1. Initial Communication and Resolution of a Problem or Dispute

We welcome and encourage (but do not require) discussion of any inquiry, complaint or dispute concerning interpretation of the provisions of this Policy. A Customer Service representative will make every effort to resolve the issue. If we are unable to resolve the issue to the satisfaction of the Enrollee, the Enrollee has the right to request an Internal Review.

1. **Definition:** A complaint is an expression of dissatisfaction about us. A complaint, however, is not and will ***not*** be considered to be or handled as an "appeal" as described in Section 7.3 below. An "appeal" must be initiated and conducted as described in Section 7.3 below.
2. **Oral Complaints:** An Enrollee having a complaint regarding anything about us may contact a Customer Service Representative at 501-228-7111 or 1-800-235-7111 to assist in resolving the matter informally. The Enrollee may submit a written complaint if not satisfied with the resolution. An Enrollee is not required to make an oral complaint prior to submitting a written complaint.
3. **Written Complaints:** The Enrollee may submit a written complaint to us at the following address:

   QualChoice
   Attention: Appeals and Grievance Coordinator
   P. O. Box 25610
   Little Rock, Arkansas 72221

4. **Complaint Resolution.** We will acknowledge receipt of a written complaint within 5 working days. We will investigate the complaint and send the Enrollee a response with resolution. If we are unable to resolve the written complaint within 30 calendar days due to circumstances beyond our control, we will provide notice of the reason for the delay before the 30th calendar day.

7.2. Types of Requests and Claims

1. **Pre-Service Request:** A Pre-Service Request is a request for a service that requires prior notification and approval of the benefit prior to receiving the service. These are services, for example, that are subject to pre-certification as set forth in the Pre-Authorization of Services section of this Policy.
2. **Post-Service Claims:** Post-Service Claims are those Claims for services that have already been received by the Enrollee.
3. **Urgent Care Request:** An Urgent Care Request is a request for a service that a physician with knowledge of the Enrollee's medical condition has determined that without the service the Enrollee's:

   A. Medical condition would subject the Enrollee to severe pain that cannot be adequately managed; or

   B. Life, health or ability to regain maximum function could be seriously jeopardized.

4. **Concurrent Care Request**: A Concurrent Care Request is a request for a service that arises when Medical Necessity of an on-going course of treatment to be provided over a period of time has been approved.
5. **Administrative Issues**: We consider issues such as those regarding eligibility, coverage, level of coverage, rescission of coverage (that is, cancellation or discontinuance of coverage retroactively (unless due to lack of timely premium payment)), and adherence to prescribed procedures as Administrative Issues.
6. **Medical Issues**: We consider issues such as a determination of Medical Necessity, the definition of a medical treatment as Experimental or Investigational, or the sufficiency of clinical information to make a coverage determination, to be a Medical Issue.

7.3. Appeal Process

1. **Initiating a Pre-Service, Concurrent Care, or Post-Service Internal Appeal:** The Enrollee (or the Enrollee's healthcare provider with regard to a Pre-Service Request, Concurrent Care Request or Urgent Care Request) has 180 calendar days from the date of receipt of the initial determination was made to file a formal written appeal, under this Section 7. To initiate an appeal, an Enrollee (or the Enrollee's healthcare provider) must write to our complaint and appeals coordinator at the following address:

   Appeals and Grievance Coordinator
   QualChoice
   P.O. Box 25610
   Little Rock, AR 72221-5610

   This appeal may also be faxed to:

   Appeals and Grievance Coordinator
   QualChoice
   Fax #: 501-228-9413

2. **Appeal of Pre-Service Request and Concurrent Care Request**

   A. **Internal Appeal of Administrative Issues.** After receipt of the written appeal, the Internal Appeal Reviewer will conduct an investigation of the appeal. The Internal Appeal Committee meeting at our office will hear an Internal Appeal of an Administrative Issue. The Enrollee and/or the treating healthcare provider has the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Internal Appeal Committee's questions. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

   B. **Internal Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Internal Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Internal Appeal to a medical director for review and we will notify the Enrollee of a decision within fifteen (15) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

   C. **Expedited Appeals**. A request for an expedited appeal for a Pre-Service Request or Concurrent Care Request will be treated as an appeal of an Urgent Care Request as described in Section 7.3(4) below subject to the request meeting the criteria for an Urgent Care Request.

3. **Appeal of Post-Service Claims**

   A. **Internal Appeal of Administrative Issues.** After receipt of the written appeal, the Internal Appeal Reviewer will conduct an investigation of the appeal. The Internal Appeal Committee meeting at our office will hear a Internal Appeal of an Administrative Issue. The Enrollee has the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Internal Appeal Committee's questions. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the

reasons for the findings and will include the contract language and or policy supporting the decision.

B. **Internal Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Internal Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Internal Appeal to a medical director for review and we will notify the Enrollee of a decision within thirty (30) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

C. **No Expedited Appeals**. There are no expedited appeals for Post-Service Claims.

4. **Appeal of Urgent Care Request**

A. **Initiating an Internal Appeal.** If the Enrollee requests an expedited review and a health care professional with knowledge of the Enrollee's medical condition certifies the determination as a general pre-service request that would seriously jeopardize the Enrollee's life or health or the Enrollee's ability to regain maximum function, the Enrollee or their health care professional may submit an appeal to the Appeals and Grievance Coordinator by facsimile to 501-228-9413.

An expedited appeal may be submitted by telephone, 501-228-7111 or 1-800-235-7111 followed by a written confirmation.

B. **Internal Appeal.** An appeal of an Urgent Care Request will be handled by us as a Medical Issue. A medical director will make the determination on review at both levels of appeal in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Appeals Coordinator initially receives the request for review.

7.4. Documentation

1. **Written Appeals:** All appeals must be submitted in writing and include the Enrollee's name, identification number, and reference to the specific appealed Claim. However, an appeal related to an Urgent Care Request as defined in Section 7.2(3) above can initially be submitted orally so we can immediately commence consideration. We require written confirmation of such Urgent Care Request appeal even though investigation will have begun.

2. **Right to Information of Enrollee:** We will provide the Enrollee, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information that:

A. Were relied upon in making the benefit determination;
B. Were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
C. Demonstrate compliance with the terms of the Policy; and
D. Constitute a statement of policy or guidance with respect to the Policy concerning the denied treatment option or benefit for the Enrollee's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In addition, we will provide the Enrollee, free of charge, with any new or additional rationale and/or evidence we consider, rely on, or is generated in connection with the appeal. We will provide this rationale and/or evidence as soon as possible and sufficiently in advance to allow the Enrollee a reasonable opportunity to respond prior to the date of a determination on the appeal being made by us.

3. **Right of Enrollee to Submit Information:** The Enrollee may submit with the request for an appeal any additional written comments, issues, documents, records and other information relating to the request or Claim. The Enrollee and the treating health care provider(s) are required to provide individual(s) reviewing the appeal, upon request, access to information necessary to determine the appeal. Such information should be provided not later than 5 days after the date on which the Appeals Reviewer's request for information is received, or, in the case of an Urgent Care Request or Concurrent Care Request, at such earlier time as may be necessary to comply with the applicable timelines. The Enrollee's failure to provide access to such information shall not remove the obligation of the Appeals Reviewer to make a determination on the appeal, but not providing the requested information may affect the Appeals Reviewer's determination. When adequate medical records for consideration of the appeal do not accompany the appeal of a medical issue, there are only two options: denial of the appeal or delay of the decision until we receive the records. We will inform the Enrollee of the process of obtaining the medical records, an effort in which the Enrollee may assist. At any point, the Enrollee may insist we make a determination based on the records then available, in which case we will render the decision within thirty (30) days.

7.5. Conduct of Appeals

An appeal is conducted following the procedures below.

1. **Scope of Review**: The Appeals Reviewer(s) shall conduct a complete review of all information relating to the request or Claim and shall not afford deference to the initial determination or previous appeal review in conducting the review.
2. **Qualifications of Appeals Reviewer**: The Appeals Reviewer is an individual or committee of individuals selected by us with appropriate expertise and who did not deny the request or Claim that is the subject of the appeal.
3. **Review of Medical Judgment**: When reviewing a request or Claim in which the determination was based in whole or in part on medical judgment, including determination with regard to whether a particular treatment is experimental, investigational, or not Medically Necessary or appropriate, we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual consulted in the initial determination, nor the subordinate of such individual. Upon request of the Enrollee, the identity of the health care professional(s) consulted in conducting the review who are our employees will be provided, without regard to whether we relied upon the advice of the health care professional in making the benefit determination.

7.6. Legal Actions

Prior to initiating legal action, the Enrollee must complete the appeal process in accordance with this Section. No one may bring legal action after the expiration of 3 years from the required submission time of the request or Claim.

7.7. Authorized Representative

1. **One Authorized Representative:** An Enrollee may have one representative and only one representative at a time, to assist in making a complaint, submitting a request or Claim, or appealing an unfavorable determination.
2. **Authority of Authorized Representative:** An Authorized Representative shall have the authority to represent the Enrollee in all matters in connection with the Enrollee's complaint, request, Claim or appeal of a determination. If the Enrollee has an Authorized Representative, references to the terms "The Enrollee" or "Enrollee" in this document refer to the Authorized Representative.

3. **Designation of Authorized Representative:** One of the following persons may act as an Enrollee's Authorized Representative:

   A. An individual designated by the Enrollee in writing in a form approved by us;
   B. The treating provider, if it is a Pre-Service Request, a Concurrent Care Request, or an Urgent Care Request, or if the Enrollee has designated the provider in writing in a form approved by us (Note: An assignment of benefits to a provider will not constitute appointment of that provider as an authorized representative);
   C. A person holding the Enrollee's durable power of attorney;
   D. If the Enrollee is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Enrollee by a court of competent jurisdiction; or
   E. If the Enrollee is a minor, the Enrollee's parent or legal guardian, unless we are notified the Enrollee's request or Claim involves health care services where the consent of the Enrollee's parent or legal guardian is or was not required by law and the Enrollee shall represent himself or herself.

4. **Term of the Authorized Representative:** The authority of an Authorized Representative shall continue for the period specified in the Enrollee's appointment of the Authorized Representative or until the Enrollee is legally competent to represent him or herself and notifies us in writing the Authorized Representative is no longer required or authorized.

5. **Communication with Authorized Representative:** If the Authorized Representative represents the Enrollee because the Authorized Representative is the Enrollee's parent or legal guardian or attorney in fact under a durable power of attorney, we shall send all correspondence, notices and benefit determinations to the Authorized Representative.

   If the Authorized Representative represents the Enrollee in connection with the submission of a Pre-Service Request or Concurrent Care Request, including a Claim involving Urgent Care, or in connection with an appeal, we shall send all correspondence, notices and benefit determinations to the Authorized Representative. If the Authorized Representative represents the Enrollee in connection with a Post-Service Claim, we will send all correspondence, notices, and benefit determinations in connection with the Enrollee's Claim to the Enrollee, but we will provide copies of such correspondence to the Authorized Representative upon request. The Enrollee understands it will take us a reasonable period, approximately 30 days, to notify all its personnel about the termination of the Enrollee's Authorized Representative and we may communicate information about the Enrollee to the Authorized Representative during the notification period.

7.8. External Medical Review

After you have exhausted your Internal Appeal rights with QualChoice and QualChoice has made its final determination with regard to your appeal, a voluntary external review process may be available to you. To find out more about this external review process, including an external expedited review in the event of an Urgent Care Request, please contact QualChoice's Appeals and Grievance Coordinator at 501-228-7111 or 1-800-235-7111.

The external review process is only available if the determination you appealed was based on whether the healthcare service was Medically Necessary or experimental/investigational and the adverse determination by QualChoice will cause you to have medical expenses in excess of $500.00.

An external review is not available for such things as a denial based on an express exclusion in this Policy, an express limitation in this Policy, dollar limits under this Policy, fraud or misrepresentation, or failure to follow procedures in obtaining healthcare provider access.

Your request for an external medical review must be made within sixty (60) days of your receipt of QualChoice's denial and in writing to:

Appeals and Grievance Coordinator

QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

The written communication must be marked and identified as a "*Request for External Review*".

The medical review would be conducted by an independent, external medical review organization selected by QualChoice from a list of approved organizations maintained by the Arkansas Department of Insurance. You would be required to pay a $25.00 fee to file the request for the external review which would be refunded to you in the event QualChoice's determination is reversed by the independent medical review organization.

As part of the external review process, you have the opportunity to submit additional information to QualChoice related to your Claim for consideration by the external review organization for consideration. You will be required to authorize the release of any medical records necessary for the external review organization to reach a decision.

The determination by the external review organization is binding and final on you, and QualChoice, unless other remedies are available under applicable state or federal law.

You may contact the Arkansas Insurance Commissioner for assistance at any time. The mailing address is: Arkansas Insurance Department, Attn: External Review Assistance, 1200 West Third Street, Little Rock, AR 72201. Their telephone number is 501-371-2640 or toll free 800-852-5494. Their email address is insurance.consumers@arkansas.gov.

8. SUBROGATION

If you have an injury or illness caused by a third party, we will provide Covered Services for such injury or illness. Acceptance of such Covered Services constitutes consent to the provisions of this Section. We will require a recovery authorization signed by you. This is a prerequisite to recovery by us against any third party for the cost of Covered Services. Our recovery rights under this Section 8 extend to worker's compensation and uninsured and underinsured motorist coverage.

You agree to protect our lien rights if an injury or illness is suffered and caused by a third party. You may be due money from a third party for the cost of Covered Services. If so, our liability for Benefits will be subrogated to any such recoveries. We have the right to sue any third party in your name, as permitted by applicable state law. If payment is received from a third party for the cost of Covered Services, you are obligated to reimburse us. Reimbursement to us may be reduced by our pro rata share of reasonable attorney's fees and costs incurred in obtaining such recovery.

You agree to cooperate fully to facilitate enforcement of our rights under this Section 8. This may include executing, delivering and filing further documents and instruments. You also agree to furnish such information and assistance, as we may reasonably require to fully enforce the terms of this Section 8. You agree to take no action prejudicing our rights and interests under this Section 8.

9. GENERAL PROVISIONS

9.1. Amendment

QualChoice reserves the right to change the benefits, conditions and premiums covered under the Policy, including the terms of this Policy. If we do so, we will give thirty (30) days written notice to you and the change will go into effect on the date fixed in the notice.

9.2. Assignment

Benefits or monies due under this Policy cannot be assigned to any person, corporation, organization or other entity. Any assignment will be void and have no effect. Assignment means the transfer of a

right to the Benefits provided under this Policy. We reserve the right to make payment of Benefits directly to the healthcare provider that rendered the service.

9.3. Notice

Any notice we give to an Enrollee will be in writing. It will be mailed to him or her at the home address as it appears in our records. Notice to us must be in writing and mailed to our offices at:

QualChoice
12615 Chenal Parkway, Suite 300
P.O. Box 25610
Little Rock, AR 72221-5610

9.4. Medical Records

We may need to obtain copies of an Enrollee's medical records from any of the Enrollee's treating providers. This may be necessary to properly administer Benefits. The Enrollee, or the Enrollee's legal representative, agrees to sign an appropriate authorization for release of medical records upon our request. By accepting Benefits under this Policy, an Enrollee authorizes and directs any person or entity to furnish us with information and copies of records related to healthcare services provided by them to that Enrollee. If an Enrollee elects not to consent to the release of medical records, or if your provider fails to comply with a request for records, we may be unable to properly administer coverage. If this occurs, we have the right to deny payment for impacted Covered Services.

9.5. Notice of Claim

We must receive an Enrollee's Claim for Benefits within no more than 12 months from the date the Enrollee receive the service. Failure to meet this requirement will result in payment denial.

9.6. Claim Forms

If you notify us about a claim for service, we will provide you with a Claim Form within 15 day of your request. The forms are also available on our website www.qualchoice.com.

9.7. Processing of Claims

We will pay or deny a claim for which we have all the information we require, within 30 days after we receive the claim if it was submitted electronically, or within 45 days after receipt if it was submitted through other means. We will notify you within 30 days after receipt of the claim if we determined we require additional information.

9.8. Who Receives Payment Under This Policy

We will make payments under this Policy directly to the Network Providers providing care. If an Enrollee receives Covered Services from any Out-of-Network Provider, we reserve the right to pay either the Policy Holder, Enrollee or the provider.

9.9. Recovery of Overpayments

On occasion, an incorrect payment may be made to you. Reason for this may include when you are not eligible, the service is not covered, or Coordination of Benefits was omitted. When this happens, we will explain the problem in writing. The amount of the mistaken payment must return to us within 60 days. Alternatively, you must provide us with written notice stating the reasons why you may be entitled to such payment. In accordance with applicable law, we may reduce future payments to you in order to recover any mistaken payment. We will recover overpayments and mistaken payments made to providers directly from them.

9.10. Confidentiality

Medical records and other information concerning an Enrollee's care we receive from providers are confidential. We will use such information only to administer the Enrollee's coverage. We will only disclose such information as required or permitted by law and as set out in the QualChoice Notice of Privacy Practices at www.qualchoice.com.

9.11. Complaint and Appeals

An Enrollee is entitled to have any complaints heard by us. We are obligated to hear such complaints, including complaints against Network Providers, in an equitable fashion. The rules and procedures set forth in Section 7 will be followed.

9.12. Right to Develop Guidelines

We reserve the right to develop or adopt guidelines for the administration of Benefits under this Policy. These criteria will be interpretive only and will not be contrary to any terms of this Policy. If you have a question about the criteria used to apply to a particular Benefit, you may contact us or visit our website at www.qualchoice.com for further information.

9.13. Limitation on Benefit of This Policy

No person or entity other than our Enrollees and us shall be entitled to bring any action to enforce any provision of this Policy. The covenants, undertakings, and agreements set forth in this Policy shall be solely for the benefit of our Enrollees and us.

9.14. Misstatement of Age

If the age of the insured has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

9.15. Applicable Law

This Policy, the rights and obligations of our employees and us under this Policy, and any Claims or disputes relating thereto, shall be governed by and construed in accordance with Arkansas law. If any provision of this Policy that, on its Effective Date, is in conflict with Arkansas law, then that provision is automatically changed to conform to the least minimum requirements of the law.

9.16. Headings

Section and subsection headings contained in this Policy are inserted for convenience of reference only. They shall not be deemed to be part of this Policy for any purpose. They shall not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

9.17. Pronouns

All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

9.18 Recission

Subject to the time limits set out in Section 9.19, we may rescind coverage under this Policy if an Enrollee performs an act, practice, or omission that constitutes fraud, or the Enrollee makes an intentional misrepresentation of material fact. In the event we rescind coverage, we have the right to demand that you pay back all the Benefits we paid to you or on your behalf during the period of time that you should not have been covered under this Policy. In these circumstances, we may also obtain refunds from providers that rendered services to you when coverage should not have been provided, in which case that provider may seek to obtain reimbursement from you for the amount obtained by us from that provider.

9.19 Severability

If any part of any provision of this Policy or any document or writing given pursuant to or in connection with this Policy shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity or unenforceability only. Such invalidity or unenforceability will in no way affect the remaining parts of such provision or the remaining provisions of this Policy.

9.20 Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this

Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

9.21 Time Limit on Certain Defenses

After three (3) years from the date of issuance of this Policy, no misstatements, except fraudulent misstatements, made by the applicant for the Policy shall be used to void the Policy or to deny a Claim for loss incurred after the expiration of such three (3) year period. No Claim for loss incurred, as defined in this Policy, commencing after three (3) year from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of this Policy.

9.22 Waiver

The waiver by us or any Enrollee hereunder of a breach of or a default under any of the provisions of this Policy shall not be construed as a waiver of any subsequent breach or default of a similar nature. The failure of any of such parties, on one or more occasions, to enforce any of the provisions of this Policy or to exercise any right or privilege hereunder, shall not be a waiver of any of such provisions, rights or privileges hereunder.

9.23 Entire Policy; Changes

This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

10. DEFINITIONS

There are other definitions, usually capitalized, contained in various Sections throughout this Policy. The capitalized words or terms used in this Policy and are not otherwise defined have the meanings set forth below:

10.1 **"Accidental Injury"** means a bodily injury happening unexpectedly and taking place not according to the usual course of events (for example an automobile accident), and which is the direct cause of the loss, independent of disease or bodily infirmity. Accidental injury to teeth does not include any damage caused by chewing or biting any object.

10.2 **"Advanced Diagnostic Imaging"** includes but is not limited to Computerized Tomography (CT), Computerized Tomography Angiography (CTA), Coronary CT & CTA, CT Bone Density (QCT), Diagnostic CT Colonography, Functional MRI Brain (fMRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Magnetic Resonance Spectroscopy (MRS), Nuclear Cardiology, Positron Emission Tomography scanning (PET), Screening CT Colonography, and SPECT.

10.3 **"Benefits"** means reimbursement or payments for health care available to the Enrollee covered under this Policy.

10.4 **"Benefit Summary"** means a document containing specific information relating to coverage and Cost Sharing Amounts under this Policy. The information may include amounts for Deductibles, Co-payments, Coinsurance, Out-of-Pocket Limits and lifetime maximum Benefits as well as visit and day maximums for limited services.

10.5 **"Calendar Year"** means the period of one year beginning January 1 and ending on December 31 as identified in your Benefits Summary.

10.6 **"Claim for Benefits" or "Claim"** means (i) a request for payment or prior approval (when required under the Policy) for a service, supply, medication, equipment or treatment covered by the Policy, (ii) that is submitted to us by an Enrollee, a healthcare provider with an assignment of benefits from the Enrollee, or an Enrollee's authorized representative, and (iii)

is submitted consistent with QualChoice's standard Claim filing policies and procedures (copies of which are available on request).

10.7 **"Coinsurance"** means a fixed percentage of the Maximum Allowable Charge the Enrollee must pay toward the cost of certain Covered Services for each Calendar Year. Those Covered Services subject to the application of Coinsurance are identified in the Benefit Summary. Coinsurance is subject to an annual maximum limit.

10.8 **"Complications of Pregnancy"** means hospital confinement required to treat conditions, such as the following, in a pregnant female: acute nephritis, nephrosis, cardiac decompensation, HELLP syndrome, uterine rupture, amniotic fluid embolism, chorioamnionitis, fatty liver in pregnancy, septic abortion, placenta accrete, gestational hypertension, puerperal sepsis, peripartum cardiomyopathy, cholestasis in pregnancy, thrombocytopenia in pregnancy, placenta previa, placental abruption, acute cholecystitis and pancreatitis in pregnancy, postpartum hemorrhage, septic pelvic thromboplebitis, retained placenta, venous air embolus associated with pregnancy, miscarriage, or an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of descent or dilitation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a c-section delivery is not considered to be an Emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section. "Complications of Pregnancy" also means treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism, hepatitis B or C, HIV, Human papilloma virus, abnormal PAP syphilis, chlamydia, herpes, urinary tract infections, thromboembolism, appendicitis, hypothyroidism, pulmonary embolism, sickle cell disease, tuberculosis, migraine headaches, depression, acute myocarditis, asthma, maternal cytomegalovirus, urolithiasis, DVT prophylaxis, ovarian dermoid tumors, biliary atresia and/or cirrhosis, first trimester adnexal mass, hyditidiform mole or ectopic pregnancy. Management of a difficult pregnancy is not considered to be a "Complication of Pregnancy".

10.9 **"Co-payment"** means a fixed dollar amount the Enrollee must pay each time the Enrollee receive a particular Covered Service to which a Co-payment applies.

10.10 **"Cost Sharing Amount"** means an amount the Enrollee is required to pay each time the Enrollee receives a particular service to which Deductibles, Co-payments, Coinsurance or benefit limitations apply. These requirements are set forth in the Benefit Summary.

10.11 **"Covered Services"** means services or supplies for which Benefits are available (i.e., payments may be made) as described in this Policy. Covered Services do not include services or supplies and care excluded pursuant to Section 4 or which do not meet the definition of "Medically Necessary" in this Section and the other qualifications set forth in Section 3.

10.12 **"Custodial Care"** means provision of routine care, including assistance with activities of daily living, to a person who is disabled mentally or physically and that disability is expected to continue for an extended length of time. "Custodial Care" can include services and supplies ordered by the Enrollee's physician and services and supplies provided by a registered nurse, a licensed practical nurse, or licensed visiting nurse. Even if "Custodial Care" is needed by an Enrollee, it is not care that is covered under this Policy.

10.13 **"Deductible"** means a certain fixed dollar amount you or the Enrollee must incur before we begin to pay for the cost of Covered Services provided to the Enrollee during each Calendar Year.

10.14 **"Emergency"** means those health care services provided on a 24 hour/365 days a year basis to evaluate and treat medical conditions of a recent onset and severity, leading a prudent lay person, possessing an average knowledge of medicine and health, to believe his

or her condition, sickness, or injury is of such a nature where failure to seek immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

10.15 **"Enrollee"** means a Policy Holder.

10.16 **"Enrollment Application"** means the form to be accurately completed by a prospective Policy Holder to apply for coverage.

10.17 **"Injectable Prescription Medications"** means any injectable pharmaceutical that has been approved by the Food and Drug Administration and can be obtained only through a prescription. QualChoice has classified selected medications, primarily immunizations and allergy and antibiotic injections, as "Office Services-Minor" or "Office Services-Other".

10.18 **"Maternity Care and Obstetrical Care"** means services associated with premature rupture of membranes, false labor, occasional spotting in pregnancy, pre-term labor, pre-term birth, physician directed rest during pregnancy, morning sickness, hyperemesis gravidarum, celphalopelvic disproportion, intrauterine growth retardation, analysis for fetal down syndrome, trisomey 18 or neural tube defect, congenital diaphragmatic hernia, hydrops fatalis, group B strep prophylaxis in pregnancy, isoimmunization in pregnancy, antepartum fetal surveillance, management of hyperemesis, cervical incompetence, fetal urethral obstruction, twin or greater gestation with prior uterine atony, macrosomia, incompetent cervix, forceps delivery, fetal fibronectin, cytotec for induction of labor, sudden onset of polyhydramnios, prophylactic cesarean delivery of HIV positive mother, Klippel-Trenaunay Syndrome, caudal regression syndrome, hospitalization to postpone delivery until the fetus is further developed, biophysical profiles, fetal monitoring, non-routine ultrasounds, vaginal delivery, antepartum and postpartum care, or services related to c-sections scheduled because of (i) multiple gestation, (ii) previous c-section delivery, (iii) patient or physician convenience, (iv) cephalopelvic disproportion, or (v) abnormal presentations such as breech, shoulder dystonia, transverse and compound.

10.19 **"Maximum Allowable Charge"** means the schedule of fees established by us for payments to providers for Covered Services and which may be less than actual charges billed by Network Providers or Out-of-Network Providers. **Please Note:** All Benefits under this Policy are subject to and shall be paid only by reference to the Maximum Allowable Charge as determined at the discretion of QualChoice. This means that regardless of how much a health care provider may bill for a given service, the Benefits under this Policy will be limited by the Maximum Allowable Charge we establish. If a Network Provider is used, that provider is obligated to accept our established rate as the Maximum Allowable Charge, and may only bill you for your Cost Sharing Amounts and any non-Covered Services; however, if an Out-of-Network Provider is used, you will be responsible for all amounts billed in excess of the Maximum Allowable Charge.

10.20. **"Medically Necessary" or "Medical Necessity"** means a Covered Service which in the opinion of our medical personnel:

1. Provides for the diagnosis or treatment of the Enrollee's covered medical conditions;
2. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's specific illness, injury or medical condition in relation to any overall medical/health conditions;
3. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
4. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and
5. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

10.21. "Medical Policy" or "Medical Policies" means a statement developed by QualChoice that sets forth the medical criteria for coverage under QualChoice's benefit Policy or insurance policy. Limitations of benefits related to coverage of a medication, treatment, service, equipment or supply are also outlined in the Medical Policies. Medical Policies are or are based on nationally accepted guidelines and peer reviewed medical literature. Our Medical Advisory Committee reviews and approves all internally developed Medical Policies. Medical Policies are available from QualChoice, at no cost, upon request, or the Medical Policies can be reviewed on QualChoice's web site at www.qualchoice.com.

10.22 "Medical Supplies" means a device or equipment that is of such a nature that it is not generally used repeatedly and is usually used by a person for a medical purpose.

10.23 "Mental Health or Substance Use Disorder" means any psychiatric disorder or disorder of emotion or thought, appropriately classified as an Axis I diagnosis in accordance with the current edition of the Diagnosis & statistical Manual of Mental Diseases of the American Psychiatric Association (DMS) classification.

10.24 "Network Facility" means a hospital that has entered into an agreement with us to make Covered Services available to Enrollees.

10.25 "Network Primary Care Physician" means a physician who has entered into an agreement with us retarding, among other things, willingness to provide primary care Covered Services to Enrollees and who may be utilitized by an Enrollee as his or her primary care physician.

10.26 "Network Physician" means a physician who has entered into an agreement with us regarding, among other things, providing and arranging for the provision of Covered Services to Enrollees.

10.27 "Network Provider" means a Network Physician, Network Specialist, Network Facility or other provider having an agreement with us to make Covered Services available to Enrollees.

10.28 "Network Specialist" means a medical or surgical specialist who has entered into an agreement with us to make Covered Services available to Enrollees.

10.29 "Out-of-Network Provider" or "Out-of-Network Facility" means a physician, hospital or other provider that has not entered into an agreement with us to make Covered Services available to Enrollees.

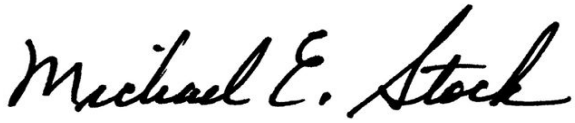
10.30 "Out-of-Network Service" means a Covered Service provided to an Enrollee by an Out-of-Network Provider.

10.31 "Out-of-Pocked Limit" means the maximum amount you pay every Calendar Year as set out in your Benefits Summary.

10.32 "Policy Holder" means you, the individual to whom this Policy is issued.

10.33 "Referral" means a specific written approval an Enrollee seeks additional evaluation or treatment from an Out-of-Network Provider. A general statement by a Network Provider stating a patient should seek a particular type of service or provider does not constitute a Referral under this Policy. We issue referrals for a specific period as determined by us. It is your responsibility to ensure all services provided to you are completed during the appropriate period. If services are rendered outside the approved period, Benefits will be allowed at Out-of-Network reimbursement levels.

10.34 "Service Area" means the geographical area in which we are licensed by the State of Arkansas to conduct business**.**



Michael E. Stock, President & CEO
QCA Health Plan, Inc. ("QualChoice")
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211

ARKANSAS CONSUMER INFORMATION NOTICE

If you need additional information about this Policy, please contact us at:

QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211
(501) 228-7111

If QualChoice is unable to respond to your questions, you should contact:

Arkansas Insurance Department
Consumer Services Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

COMPREHENSIVE HEALTH EXPENSE COVERAGE POLICY FOR INDIVIDUAL MINOR

IMPORTANT NOTICE

COVERED BENEFITS RECEIVED FROM AN OUT-OF-NETWORK PROVIDER, EXCEPT IN CERTAIN CIRCUMSTANCES (SEE SECTION 2), ARE PAID AT A RATE LESS THAN THE SAME COVERED SERVICES RECEIVED FROM A NETWORK PROVIDER. SEE YOUR BENEFIT SUMMARY.

OTHER INSURANCE REDUCES BENEFITS – READ CAREFULLY

Attached is the Benefit Summary, showing the name of Policyholder, Policy Number, premiums and Effective Date of this Policy ("Effective Date").

GUARANTEED RENEWABLE CONDITIONED
UPON RESIDENCE IN ARKANSAS
PREMIUMS SUBJECT TO CHANGE

THIS POLICY HAS SEVERAL SPECIFIC EXCLUSIONS. (SEE SECTION 4)

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* available from www.medicare.gov or 800-633-4227.

OUTLINE OF COVERAGE

If you are not satisfied with any of the terms or conditions of this Policy, you may return it to us within ten (10) days of its delivery to you and receive a full refund of all premiums you have paid.

READ YOUR POLICY CAREFULLY. This Outline of Coverage provides a brief description of the important features of this Policy. This Outline is not the Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and us. ***It is, therefore, important that you read your Policy carefully***.

POINT OF SERVICE COVERAGE. Policies of this type are designed to provide coverage for hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any applicable Cost Sharing Amounts as referenced in the Benefit Summary or other limitations set forth in the Policy.

BENEFITS

Deductible: As shown on the Benefit Summary per Calendar Year per Enrollee.

Out-of-Network Providers: Covered Services received from an Out-of-Network Provider, except in certain circumstances (see Section 2), are allowed at a rate less than the same Covered Services received from a Network Provider. (See the Benefit Summary.)

Covered Services: Subject to payment of your Coinsurance and Deductible at the amount reflected in the Benefit Summary:

- Daily hospital room and board
- Miscellaneous hospital services
- Surgical services
- Anesthesia services
- In-hospital medical visits
- Out-of-hospital care

Medicare Eligibility: If you are eligible for Medicare, you are not eligible to begin or continue coverage under this Policy.

Calendar Year Coinsurance Maximum: Please check the Benefit Summary to determine the amount of the Calendar Year Coinsurance maximum Benefits.

Special Limitations:

Durable Medical Equipment:	A maximum payment of $5,000 per Calendar Year per Enrollee. Please see the Benefits Summary for Cost Sharing Amount
Ambulance:	See the Benefit Summary
Home Health Services:	A maximum of 40 visits per Calendar Year per Enrollee please see the Benefits Summary for Cost Sharing Amount

Physical, Occupational, Speech Therapy, Chiropractic & Audiology Care:	A maximum of a total combined 45 visits per Calendar Year per Enrollee please see the Benefits Summary for Cost Sharing Amount
Skilled Nursing Facilities:	Thirty (30) days per Calendar Year per Enrollee

Benefits and Services Are *Not* Included For:

- Routine Maternity Care and Obstetrical Care, unless covered by a Maternity Rider;
- Psychiatric conditions and substance abuse services, unless covered by a Mental Health and Substance Abuse Rider;
- Injuries or disease caused by war;
- Dentistry, except for Accidental Injury (See Section 3.4), anesthesia (See Section 3.5) and oral surgery (See Section 3.6);
- Dental x-rays;
- Eye refractions, unless needed because of Accidental Injury;
- Eyeglasses or hearing aids, unless needed because of Accidental Injury;
- Cosmetic surgery, unless needed because of Accidental Injury or breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998;
- Health services and supplies not meeting Medical Necessity criteria or that are not associated with a Covered Service;
- Prescription drugs for outpatient use filled by a prescription order or refill and non-injectable medications given in a physician's office except in an Emergency are not covered, unless covered by a prescription drug rider;
- Medical or hospital services collectible under Workers' Compensation or any law providing benefits for dependents of military personnel;
- Services rendered in government hospitals (unless otherwise required by applicable law);
- Intentional self-inflicted injuries;
- In-patient services, including electrocardiograms, x-rays, and laboratory examinations, if they could have been performed safely and adequately on an out-patient basis; and
- Services and supplies that are experimental or investigational in nature.

Guaranteed Renewable/Conditioned On Residence in Arkansas

This Policy and riders are guaranteed renewable as long as your permanent residence is in Arkansas. At any time after the first twelve (12) month period of your coverage under this Policy we can change your premium rate, but only if the rate is changed for all policies and riders of the same form number and premium classification as this Policy. Your premium rate will also change in any month that you attain an age that moves you into a different premium classification established by QualChoice.

Table of Contents

1. INTRODUCTION TO YOUR POLICY 7
   1.1. Who Is QualChoice? 7
   1.2. Changes to This Policy 7
   1.3. Key Information 7
2. HOW THIS POLICY WORKS 7
   2.1. In-Network Benefits 7
   2.2. Out-of-Network Benefits 8
   2.3. Provider Network 9
   2.4. Cost Sharing Requirements 9
   2.5. Member Financial Responsibility Comparison 10
   2.6. Medically Necessary Services 10
   2.7. Exclusion and Limitations 11
   2.8. Coverage While Traveling Out of the Service Area 11
   2.9. General Conditions for Payment 11
   2.10. Administration and Interpretation of this Policy 11
   2.11. Pre-Authorization of Services 12
   2.12. Utilization Management 12
   2.13. Case Management 12
3. COVERED MEDICAL BENEFITS 12
   3.1. Advanced Diagnostic Imaging 13
   3.2. Ambulance Services – Transportation 13
   3.3. Complications of Pregnancy 13
   3.4. Dental – Accidental Injury 13
   3.5. Dental – Anesthesia 14
   3.6. Dental – Oral Surgery 14
   3.7. Dental – Other 14
   3.8. Diabetes Management 14
   3.9. Durable Medical Equipment 15
   3.10. Emergency Health Services 15
   3.11. Eye Examinations 16
   3.12. Family Planning Services 16
   3.13. Home Health Services 16
   3.14. Home Infusion Therapy 16
   3.15. Hospice Care Services 16
   3.16. Facility – Inpatient Care 17
   3.17. Injectable Prescription Medications 18
   3.18. Infertility 18
   3.19. Medical Foods 18
   3.20. Medical Supplies 18
   3.21. Orthotic Services and Orthotic Devices 18
   3.22. Outpatient Services 19
   3.23. Physician Office Services 19
   3.24. Preventive and Wellness Health Services 20
   3.25. Professional Services for Complex Surgery 20
   3.26. Prosthetic Services and Prosthetic Devices 20
   3.27. Reconstructive Surgery 21
   3.28. Skilled Nursing Facility and Inpatient Rehabilitation Services 21
   3.29. Therapeutic and Rehabilitation Services 22
   3.30. Transplantation Services 22
4. NON-COVERED SERVICES, EXCLUSIONS AND LIMITATIONS 23
   4.1. Exclusions From Coverage 23

4.2. Limitations to Benefits 32
5. ELIGIBILITY CRITERIA 34
5.1. Hospitalization When Coverage Begins 34
5.2. Eligibility for Medicare 34
5.3. Who is Eligible for Coverage and When Does Coverage Begin 34
5.4. Maternity Coverage 34
5.5. Termination of Coverage 34
6. COORDINATION OF BENEFITS 36
6.1. How COB Works 36
6.2. Rules to Determine Primary and Secondary Plans 36
6.3. Allowable Expense 37
6.4. Reduction of Benefits 38
6.5. Enforcement of Provisions 38
6.6. Facility of Payment 38
6.7. Right of Recovery 38
6.8. Hospitalization When Coverage Begins 38
7. COMPLAINTS AND APPEALS 39
7.1. Initial Communication and Resolution of a Problem or Dispute 39
7.2. Types of Requests and Claims 39
7.3. Appeal Process 40
7.4. Documentation 41
7.5. Conduct of Appeals 42
7.6. Legal Actions 42
7.7. Authorized Representative 43
7.8. External Medical Review 43
8. SUBROGATION 44
9. GENERAL PROVISIONS 45
9.1. Amendment 45
9.2. Assignment 45
9.3. Notice 45
9.4. Medical Records 45
9.5. Notice of Claim 45
9.6. Claim Forms 45
9.7. Processing of Claims 45
9.8 Who Receives Payment Under This Policy 45
9.9 Recovery of Overpayments 45
9.10. Confidentiality 46
9.11. Complaint and Appeals 46
9.12. Right to Develop Guidelines 46
9.13. Limitation on Benefit of This Policy 46
9.14. Misstatement of Age 46
9.15. Applicable Law 46
9.16. Headings 46
9.17. Pronouns 46
9.18 Recission 46
9.19 Severability 47
9.20 Legal Actions 47
9.21 Time Limit on Certain Defenses 47
10. DEFINITIONS 47

1. INTRODUCTION TO YOUR POLICY

1.1. Who Is QualChoice?

QCA Health Plan, Inc. ("QualChoice", also referred to in this Policy as "us", "we" or "our") is a Health Maintenance Organization. QualChoice has a Certificate of authority from the Commissioner of Insurance of the State of Arkansas. We are located at 12615 Chenal Parkway, Suite 300, Little Rock, Arkansas 72211. Our telephone number is (501) 228-7111.

This is your Comprehensive Individual Major Medical Policy (the "Policy") for health care Benefits with us.

1.2. Changes to This Policy

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Policy. When that happens we will send you a new Policy, Rider or Amendment pages thirty (30) days prior to the change going into effect.

1.3. Key Information

For purposes of this Policy and each section of the Policy, "you" or "your" means the Policy Holder.

We have capitalized certain words in this Policy. Those words have special meanings and are defined in Section 10, "Definitions".

Only we have the right to change, interpret, modify, withdraw or add Benefits, as permitted by law, without your approval.

On its Effective Date this Policy replaces and overrules any Policy that we may have previously issued to you. This Policy will in turn be overruled by any policy we may issue to you in the future.

Your coverage under this Policy begins at 12:01 a.m. on the Effective Date as reflected in the Benefit Summary. Coverage will end on the date this Policy is terminated for any of the reasons described in this Policy. We determine your eligibility for Benefits as described in this Policy. This Policy and the Benefit Summary describe the covered Benefits, conditions, limitations, exclusions and Cost Sharing Amounts. The attached Benefit Summary is an integral part of this Policy. In the event this Policy and the Benefit Summary conflict, the Benefit Summary will control. You should locate and familiarize yourself with the Benefit Summary. This Policy describes some special procedures with which you must comply.

The laws of the State of Arkansas shall be the laws that govern this Policy.

If you have questions about your Benefits, payments, or cost sharing, please call us during business hours at (501) 228-7111.

2. HOW THIS POLICY WORKS

This Policy provides flexible choices in obtaining health care services. Care can be sought from any Network Provider under this Policy without a Referral from a Network Primary Care Physician. There is freedom to select either In-Network or Out-of-Network Benefits each time care is sought. Consult the Benefit Summary to identify Covered Services and Cost Sharing amounts for each choice.

2.1. In-Network Benefits

In-Network Benefits are generally paid at a higher level than Out-of-Network Benefits. In-Network Benefits are Covered Services which are either:

1. Provided by or under the direct supervision of a Network Provider in a physician's office or at a Network Facility, or
2. Emergency health services meeting the QualChoice payment guidelines.

Please note that certain Covered Services may only be obtained from a Network Provider. Such Covered Services are identified in the Benefit Summary.

Covered Services may be sought from any Network Physicians without a Referral. Coverage for services in the office is at the primary care physician benefit level when Covered Services are sought directly from any Network Primary Care Physician. Coverage for services in the office is at the

specialist benefit level when Covered Services are sought from any other Network Physician. You should validate the status of a Network Provider by calling our Customer Service unit or accessing the on-line provider directory at www.qualchoice.com or calling our Customer Service unit at 800-235-7111. Please refer to the Benefit Summary for details.

2.2. Out-of-Network Benefits

You may seek Covered Services directly from a physician or other provider who is not a Network Provider. Services provided by an Out-of-Network Provider will be covered and reimbursed under your Out-of-Network Benefits unless:

1. **Policy Provision:** The Benefits Summary or this Policy specifically provides a different Deductible, Coinsurance or Out-of-Pocket Limit for the particular service or supply that is the subject of the Claim;
2. **Emergency Services:** The intervention is for an Emergency in which case the In-Network Benefit Deductible, Coinsurance and Out-of-Pocket Limit apply;
3. **Continuity of Care, Prior to Coverage:** You notify QualChoice that prior to the effective date of your coverage, you were scheduled with an Out-of-Network Provider for a procedure or ongoing treatment covered under the terms of this Plan, that such procedure or treatment is for a condition requiring immediate care, and that you request In-Network Benefits for such scheduled procedure or ongoing treatment. If QualChoice approves In-Network Benefits for the scheduled procedure or ongoing treatment, In-Network Benefit Deductible, Coinsurance, and Out-of-Pocket Limit will apply to Claims for services and supplies rendered by the Out-of-Network Provider for such condition after QualChoice's approval until the procedure or treatment ends or until the end of ninety (90) days, whichever occurs first;
4. **Provider Leaves Network:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when your ongoing treatment for an acute condition began and that you request In-Network Benefits for the continuation of such ongoing treatment. If QualChoice approves In-Network Benefits for the requested ongoing treatment, In-Network Deductible, Coinsurance and Out-of Pocket Maximum will apply to Claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to Claims for services and supplies rendered by the Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first;
6. **Provider Leaves Network, Pregnancy:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when you began receiving obstetrical care for a pregnancy covered under the terms of the Plan, that you were in the third trimester of your pregnancy on the date that the Provider left the POS, and that you request In-Network Benefits for continuation of such obstetrical care from this Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested obstetrical care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to Claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to Claims for services and supplies rendered by the Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits; or
7. **Prior Authorization:** You notify QualChoice prior to seeking services of the absence of or the exhaustion of all In-Network resources for a Covered Service resulting in the need to seek care from an Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to Claims for services and supplies received from this Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first.

The amounts allowed for Covered Services accessed under your Out-of-Network Benefits will be subject to the Maximum Allowable Charge. You will be responsible for the applicable Cost Sharing Amounts related to such Covered Services and the difference between the charges billed by the Out-of-Network Provider and the Maximum Allowable Charge. Please refer to your Benefits Summary for details:

Note: Notification to QualChoice of requests for payment of an Out-of-Network Provider services or supplies at In-Network Benefit level must be made by writing to QCA Health Plan, Inc. Attn: Care Management, P.O. Box 25610, Little Rock, AR 72221 or by faxing the request to (501) 228-9413, and must be received at least five (5) working days prior to your receipt of such services or supplies.

2.3. Provider Network

We publish an online directory listing of physicians, facilities, and other healthcare providers who have contractually agreed to provide Covered Services to Enrollees and have them reimbursed at In-Network Benefit level. You may search the directory on our website at www.qualchoice.com. Because contractual agreements can change, you may wish to verify a physician or provider is participating in our Network before care is sought.

We do not practice medicine or provide medical supplies. We are not responsible for any action or inaction of any healthcare provider. We provide no express or implied warranties or guarantees with respect to any Network Provider or the professional services provided by such provider. The utilization of a Network Provider or any other provider and the decision to receive or decline to receive health care services is your responsibility.

If you have a medical condition that we believe needs special services, we may direct you to an appropriate facility or other provider chosen by us. If you require certain complex Covered Services for which expertise is limited, we may direct you to an Out-of-Network Provider. **In both cases, In-Network Benefits will only be paid if Covered Services for that condition are approved by us.** We will not cover any services not specifically authorized by us in the written statement of authorization. The following do not constitute approval for Benefits:

1. A Referral, whether written or oral, by a Network Physician to an Out-of-Network Provider; or
2. An order or prescription for services to an Out-of-Network Provider.

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, availability to Network Providers may be limited. If this happens, we may require you to utilize a single Network Physician to provide and coordinate all future Covered Services. If you do not make a change to a single Network Physician within 31 days of the date we notify you, we will assign a single Network Physician to you. If you fail to use the assigned Network Physician, Covered Services will be paid as Out-of-Network Benefits.

2.4. Cost Sharing Requirements

You must share in the cost of Covered Services through Co-payments, Coinsurance, and Deductibles, or combinations of these Cost Sharing Amounts. Consult the Benefit Summary to determine the amounts of your payments under the Cost Sharing Amounts. A Network Provider may bill you directly for Co-payments, Coinsurance and Deductible amounts, but may not bill for the difference between his or her customary charge and the Maximum Allowable Charge. An Out-of-Network Provider may bill you directly for all applicable Co-payments, Coinsurance and Deductible amounts plus any difference between the total amount of billed charges for services and the Maximum Allowable Charge. **These additional charges could amount to thousands of dollars in additional out-of-pocket expense for which you are responsible.**

1. **Deductible:** The Deductible is a certain dollar amount per Calendar Year, as set forth in the Benefit Summary. You must satisfy the Deductible before we begin to pay for Covered Services to which the Deductible applies.
2. **Co-payment:** A Co-payment is a fixed dollar amount you must pay each time a Covered Service is received to which a Co-payment applies. Co-payment amounts do not apply to the satisfaction of the Deductible amounts or Out-of-Pocket limits for each Enrollee. Please see the Benefit Summary for a list of those Benefits to which Co-payments apply.
3. **Coinsurance:** Coinsurance is a fixed percentage of Maximum Allowable Charges for the cost of Covered Services you must pay per Calendar Year. Coinsurance payments are in addition to Deductibles or Co-payments. The Benefit Summary contains the Coinsurance percentage applicable to specific Benefits. You are responsible for paying the amount of the applicable Coinsurance for the Covered Services provided.

4. **Limits on Out-of-Pocket Payments:** The Enrollee will no longer have to pay Coinsurance for the remainder of the Calendar Year after the Enrollee has met the out-of-pocket limit during the Calendar Year. The Benefit Summary lists the limit on out-of-pocket payments for Coinsurance. Co-payments, Deductibles, or charges in excess of the Maximum Allowable Charge are the patient's responsibility and do not count toward meeting the Limit on Out-of-Pocket Payments. Once your Out-of-Pocket Limits have been satisfied, you will still be responsible for charges in excess of our Maximum Allowable Charge for services provided by an Out-of-Network Provider.

2.5. Member Financial Responsibility Comparison

The following table provides an example of the cost you will pay for a typical inpatient hospital stay utilizing the In-Network Benefits compared to the Out-of-Network Benefits. The amount you will pay may be different based on the benefit plan you select.

	In-Network	Out-of-Network
Facility Billed Charges	$50,000	$50,000
Maximum Allowable Charge	25,000	20,000
Deductible Paid by You	-500	-1,000
Coinsurance Paid by You	-1,000	-2,000
QualChoice Total Payment	$23,500	$17,000
Your Total Financial Responsibility:		
Deductible	500	1,000
Coinsurance	1,000	2,000
Difference Between Maximum Allowable Charge and Billed Charges	0	30,000
Your Total Financial Responsibility	$1,500	$33,000

2.6. Medically Necessary Services

"Medically Necessary" or "Medical Necessity" means a Covered Service which in the opinion of our medical personnel:

1. Provides for the diagnosis or treatment of the Enrollee's covered medical conditions;
2. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's specific illness, injury or medical condition in relation to any overall medical/health conditions;
3. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
4. Is not primarily for the convenience of the Enrollee, his or her physician, or other provider; and
5. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

Regardless of anything else in this Policy, and regardless of any other communications or materials you may receive in connection with this Policy, you will not have coverage for any service, any medication, any treatment, any procedure or any equipment, supplies or associated costs if QualChoice finds it to be not Medically Necessary. All determinations of Medical Necessity for Covered Services are made in accordance with the above definition at the sole discretion of QualChoice.

We reimburse only for Medically Necessary Covered Services as defined in Section 10. This standard applies to all sections of this Policy.

If we determine a service is not Medically Necessary before or after a Network Provider renders it, we prohibit the Network Provider who rendered the service from billing you for the service unless you agreed in writing to be responsible for payment before the service was provided.

If we determine a service is not Medically Necessary before or after an Out-of-Network Provider has rendered it, you will be responsible for the charges for services which are determined not to be Medically Necessary.

We make a determination of Medical Necessity after considering the advice of trained medical professionals, including physicians, who may use medically recognized standards and criteria. In making the determination, we will examine the circumstances of your condition and the care provided, including the reason your provider prescribed or provided the care, and any unusual circumstances, which necessitate attention. However, the fact your physician prescribed the care or service does not automatically mean the care is Medically Necessary or it qualifies for payment under this Policy. A medical treatment that meets the criteria for Medical Necessity will still not be reimbursed if the condition being treated is excluded from coverage as set forth in Section 4.

2.7. Exclusion and Limitations

Some services have specific limitations. Exclusion of other services from coverage is in full or in part. Consult the Benefit Summary and Section 4 for information on benefit limitations and exclusions.

This Policy refers to Medical Policies we have developed that may limit or exclude coverage for a particular service, treatment or drug. You may contact our Customer Service Department to request a copy of our Medical Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Medical Policies on our web site at www.qualchoice.com.

2.8. Coverage While Traveling Out of the Service Area

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

We will deny coverage for routine and follow-up care after Emergency care unless a Network Provider in Arkansas performs the services.

If care is accessed by an Enrollee from providers not participating in the QCNN for an unforeseen illness, reimbursement for Covered Services will be at the Out-of-Network Benefit level.

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

2.9. General Conditions for Payment

Payment for Covered Services is subject to the Enrollee's eligibility on the date such services are rendered, and to all conditions, limitations, and exclusions of the Policy. A final determination of eligibility is made at the time the Claim is received by us. Determination of non-eligibility subsequent to the payment of services as a result of error or fraud will result in recovery of such payments made by us. Benefits are provided only if services provided were ordered by a health care provider, provided within the scope of that health care provider's license, and rendered in accordance with professionally recognized standards of care.

2.10. Administration and Interpretation of this Policy

We have sole and exclusive discretion to interpret the Benefits provided under this Policy as well as all other provisions, terms, conditions, limitations and exclusions in the Policy and to make factual determinations related to the Policy and its Benefits. We may delegate this authority to other persons or entities to provide administrative or Benefit services with regard to this Policy. Subject to applicable law or regulation, we reserve the right to change, interpret, modify, withdraw or add Benefits or

terminate the Policy, in our sole discretion, without prior approval by you. Changes to this Policy will be valid or binding only if in writing and agreed to by an officer of QualChoice.

2.11. Pre-Authorization of Services

Pre-authorization is a determination made prior to services or supplies being provided of whether the services or supplies are Medically Necessary. We must receive sufficient clinical information to establish Medical Necessity. The Medical Necessity for an Out-of-Network Referral will include the absence of or the exhaustion of all In-Network resources. Pre-authorizations are all time-limited.

QualChoice requires that certain Covered Services be pre-authorized. The specific procedures requiring pre-authorization can change based upon new or changing medical technology. We reserve the right to modify the official listing of services requiring pre-authorization as deemed necessary. A listing of the services requiring pre-authorization is maintained on our web site at www.qualchoice.com on the Member Home Page. You may also contact our Customer Service Department to obtain a copy of the listing.

The responsibility for obtaining pre-authorization varies depending on whether you use a Network Provider or an Out-of-Network Provider. Network Providers (not including QCNN providers) are responsible for obtaining the necessary pre-authorizations. Enrollees living outside of the Service Area will be responsible for obtaining pre-authorization to receive Benefits at the In-Network level when accessing care from the QCNN. QCNN providers are not responsible for obtaining a pre-authorization for services. Out-of-Network Providers have no contractual relationship to QualChoice, and therefore are not primarily responsible for obtaining required pre-authorizations. When care is being sought from Out-of-Network Providers, you are responsible for making sure all the providers obtain the required pre-authorizations. The Out-of-Network Providers must supply the clinical information necessary for us to determine Medical Necessity. We will give no pre-authorization without the necessary clinical information.

Pre-authorization is not a guarantee of payment. Even though pre-authorized, payment may not be rendered for any service if the clinical status changed sufficiently such that the service is no longer medically appropriate. Your coverage with QualChoice must be in force on the date of service or no payment will be made. You may request a pre-review of coverage for any service by calling our Customer Service Department. Any of our pre-authorization decisions may be appealed by following the procedures in Section 7. Your physician may request an Expedited Appeal of a denial of a pre-authorization by calling the number on your QualChoice identification card if your physician believes the services are urgent due to your medical condition.

2.12. Utilization Management

We cover Medically Necessary services as described in Section 2.6. Determinations of Medical Necessity are made using QualChoice's Medical Policies. We make decisions regarding whether a particular service is or was Medically Necessary based on information provided by your Network Provider(s). When we review services after care has already been provided, we may review your medical records. A Network Provider may request the criteria or guidelines used by QualChoice in making any decision.

2.13. Case Management

We provide a Case Management program. Case Management assists Enrollees to achieve the best clinical outcomes, making the best use of the Benefits. Case Management helps with an individual's specific health care needs. Case Management involves the timely coordination of health care services. We review clinical information before we include any Enrollee in the Case Management program. We stay involved in the case until the need is resolved. Enrollees may participate in Case Management programs including programs for diabetes mellitus, transplants, oncology, and neonatology.

3. COVERED MEDICAL BENEFITS

Coverage is available for medical services or care as specified in this Section subject to the General Conditions for Payment specified in Section 2.9, Pre-Authorization of Services described in Section 2.11,

and to all other applicable conditions, limitations and exclusions of this Policy. **Consult the Benefit Summary for applicable Cost Sharing Amounts.**

3.1. Advanced Diagnostic Imaging

Advanced Diagnostic Imaging consists of the following studies (though others may be added as new studies are developed):

1. All imaging using Computerized Axial Tomography (CAT) technology;
2. All imaging using Magnetic Resonance Imaging (MRI) technology;
3. All imaging using Positron Emission Tomography (PET) technology;
4. All imaging using nuclear medicine techniques (in which a radioactive substance is administered to the patient to permit or enhance imaging, which is done at least in part with detection techniques to assess the locations at which the radioactive substance is concentrated in the body).

The following rules apply to these imaging procedures:

1. Regardless of where they are performed, they always fall under the required Cost Sharing Amounts of this Policy as set forth in the Benefit Summary; and
2. Pre-authorization may be required for any or all of these tests. The requirements for pre-authorization detailed in Section 2.11 should be referred to and followed when receiving any of the Advanced Diagnostic Imaging studies.

3.2. Ambulance Services – Transportation

We cover licensed ambulance transportation subject to all terms, conditions, exclusions and limitations as set forth in this Policy. This benefit is subject to the Cost Sharing Amounts and benefit limitations specified in the Benefit Summary, and the following criteria:

1. When an accident or other medical emergency occurs, we cover transport to the nearest hospital when Emergency care is required;
2. We cover ambulance transportation from one hospital to another hospital for one of the reasons identified below; when transportation for these listed reasons is required, it must be coordinated through the QualChoice Care Management department:
   A. To access equipment or expertise necessary for proper care;
   B. To receive a test or service which is not available at the hospital where you have been admitted and you return after the test or service is completed;
   C. To transport you from an Out-of-Network Facility to a Network Facility;
   D. To transport you directly from an acute care setting to an alternate level of care.

3.3. Complications of Pregnancy

Subject to all terms, conditions, and limitations of this Policy and subject to applicable Coinsurance and Deductible, coverage is provided for treatment of Complications of Pregnancy (as defined in Section 10) when provided by a physician.

3.4. Dental – Accidental Injury

We will provide coverage if an Enrollee has an Accidental Injury that damages a sound, natural tooth. Treatment must be authorized by QualChoice. Benefits are subject to a maximum limit per Enrollee per accident. See the Benefit Summary for the limitation. Dental services must be received from a Doctor of Dental Surgery, “D.D.S.” or a Doctor of Medical Dentistry, “D.M.D.” The damage must be severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. The Physician or dentist must certify that the injured tooth was:

1. A virgin or un-restored tooth, or
2. A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with any bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be started within three months of the original accident date and completed within 12 months of the original accident date.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities. The following limitations for treatments also apply to repair of damaged teeth:

1. Only the sound and natural tooth or teeth avulsed or extracted as a direct result of the Accidental Injury will be considered for replacement;
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based upon a Maximum Allowable Charge per tooth;
3. Double abutments are not covered;
4. Any health intervention related to dental caries or tooth decay is not covered;
5. Removal of teeth is not covered; and
6. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

3.5. Dental – Anesthesia

QualChoice will provide Benefits for anesthesia and facilities for dental procedures which would ordinarily be done under local anesthesia provided:

1. The procedure is performed in a Network Facility or a network ambulatory surgery facility; and
2. The situation meets Medical Necessity criteria, and the patient is:
    a. A child under 7 years of age who is determined by two network dentists to be unable to undergo the procedure without general anesthesia and who cannot wait until an older age for the procedure, when undergoing the procedure without general anesthesia would be possible; or
    b. A person with a serious mental health condition that prevents use of local anesthesia for the procedure; or
    c. A person with a serious physical condition making hospital care necessary for the safe performance of dental work; or
    d. A person with a significant behavioral problem (as certified by a Network Physician) which precludes safe performance of the dental work under local anesthesia.

All network requirements, Medical Necessity determinations, and such other limitations as are applied to other Covered Services will apply. Pre-authorization is required, see Section 2.11.

3.6. Dental – Oral Surgery

QualChoice will pay only for the following non-dental oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required;
2. Surgical procedures required to treat an Accidental Injury to jaws, cheeks, lips, tongue, roof and floor of the mouth. Injury to a tooth or teeth while eating is not considered an Accidental Injury; treatment of such injury will not be covered;
3. Excision of exostoses of jaws and hard palate;
4. Extraction of teeth is required because of the results from radiation or chemotherapy;
5. Frenectomy;
6. External incision and drainage of cellulitis;
7. Incision of accessory sinuses, salivary glands or ducts;
8. Certain dental services, as reflected in the Medical Policies, performed in conjunction with Medically Necessary reconstructive surgery; and
9. Dental services integral to medical services covered by the Plan.

3.7. Dental – Other

No other dental care and orthodontic services are covered.

3.8. Diabetes Management

Coverage is provided for medically necessary equipment, supplies, and services for diabetes when prescribed by a physician. Diabetes self-management training is limited to one program per lifetime

per Enrollee. If there is a significant change in the Enrollee's symptoms or condition making it necessary to change the Enrollee's diabetic management process, we may authorize additional training if prescribed by a physician. Covered Services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education developed by the American Diabetes Association (ADA). A licensed provider certified by the ADA must provide the training.

3.9. Durable Medical Equipment

Durable Medical Equipment (DME) is subject to Medical Necessity and appropriateness review. We will not cover DME if primarily used for the convenience of the Enrollee or any other person. DME is equipment serving a medical purpose, is non-disposable, can withstand repeated use, is appropriate for use in the home, and is generally not useful in the absence of the illness or injury for which it is used.

All DME services must be obtained through a Network Provider. All DME remains the property of QualChoice or a Network Provider. When it is more cost effective, we will purchase rather than lease equipment. The amount paid for leasing a DME item will not exceed the Maximum Allowable Charge for purchase. We retain the right to recover any equipment purchased by us for the use of the Enrollee upon cancellation or termination of coverage for the Enrollee. Delivery or set up charges are included in the Maximum Allowable Charge for the DME.

Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Enrollee.

The definition and description of coverage for orthotics and prosthetic devices and services are in Sections 3.21 and 3.26 below.

Important Note: DME dispensed by a physician in an office setting and billed by a DME provider must be provided through a DME Network Provider. It is your responsibility to confirm this with the physician. If DME dispensed by the physician is not from a DME Network Provider, a prescription may be obtained from the physician for the DME followed by contact with us to assist in obtaining the equipment. Failure to insure all DME is obtained from a DME Network Provider will result in denial of Benefits.

3.10. Emergency Health Services

We cover emergency room services that meet the definition of "Emergency" as set out in Section 10.

1. **Emergency Care within the Service Area:** An Enrollee is encouraged to seek care from a Network Provider in the event of an Emergency (as defined in Section 10) whenever possible. However, if in an Emergency an Enrollee is unable to access a Network Provider, the Enrollee should go to the nearest urgent or emergent care facility. Services provided in an Emergency are paid as shown in your Benefits Summary.
2. **Emergency Care outside of the Service Area:** Services provided in an Emergency when you are outside of the Service Area, but within the United Sates are paid as shown in your Benefits Summary. Your QualChoice identification card provides a toll-free telephone number to call for a listing of healthcare providers in the QualChoice National Network (QCNN). QualChoice encourages you to seek treatment whenever possible from a healthcare provider in the QCNN.

If an Enrollee obtains services in an emergency room when the circumstances were not an Emergency, it will result in a denial of Benefits for the services provided. You have access to our "Ask a Nurse" assistance line at any time by calling (866) 232-0447.

IMPORTANT IN THE EVENT OF AN ADMISSION AT AN OUT-OF-NETWORK FACILITY: If treatment of an Emergency is sought at an Out-of-Network Emergency Room, *you, a family member or the hospital must notify our Care Management Department once you are stabilized, but in no event more than forty-eight (48) hours after initial treatment, if further care or inpatient admission is needed*. Failure to notify us within the specified 48 hour time requirement may result in a denial of benefits. Upon receipt of such notification we may either authorize the admission to, or further treatment at, the

Out-of-Network Facility, or coordinate appropriate transfer to a Network Facility through communication with the Out-of-Network Facility, the admitting physician, and the Enrollee's Network Provider. If you stay at the Out-of-Network Facility beyond the period for which we have determined further treatment is considered Medically Necessary, you will be responsible for all charges billed by the hospital and other providers providing the care.

3.11. Eye Examinations

Eye Examinations for active illness or injury that are received from a health care provider in the provider's office are a Covered Service.

3.12. Family Planning Services

Coverage is provided for the following family planning services:

1. Oral contraceptives and prescription barrier methods are only covered when a prescription drug rider has been purchased through QualChoice; coverage is subject to all of the terms, conditions, limitations, and exclusions of the prescription drug rider;
2. Voluntary sterilizations (vasectomies and tubal ligations) are covered except as excluded in Section 4; and
3. Long acting reversible contraceptives, including hormonal implantable systems and intrauterine contraceptives, are covered as a medical benefit.

Reversal of a voluntary sterilization is a specific exclusion.

3.13. Home Health Services

Coverage is available for the following services provided in the home when the medical condition supports the need for such services, the services are ordered by a Physician, and the services are pre-authorized by QualChoice.

We count each visit by a member of a home care team as one home care visit. We count up to four hours of home health nurse/aide service as one home care visit. (See the Benefit Summary for visit limitation details.)

The following services provided by a licensed home health agency in the home are Covered Services:

1. Intermittent skilled nursing care by a registered nurse or a licensed practical nurse. A service will not be determined to be "skilled" simply because there is not an available caregiver in the Enrollee's home; skilled nursing care provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse is not Custodial Care;
2. Physical, occupational and speech therapy services; and
3. Medical supplies provided by a home health agency during the course of approved care.

3.14. Home Infusion Therapy

The benefit for medications received from licensed specialty pharmacy or a licensed retail pharmacy designated by QualChoice as a home infusion therapy provider is covered based upon obtaining pre-authorization and upon the Maximum Allowable Charge for the medication.

1. Covered Medication: A home infusion therapy medication is covered as a medical benefit (as opposed to a prescription drug benefit) and is subject to Co-payment (if applicable) and/or Deductible and Coinsurance.
2. FDA approved medications that exist as separate components are intended for reconstitution prior to administration are covered. Examples include, but are not limited to, total parental, intravenous antibiotics, and hydration therapy and specialty infusions.
3. Medical supplies used in conjunction with home infusion therapy are covered if the home infusion is approved.

When home infusion therapy services are provided separately from home health services, then the home infusion therapy service does not apply to the home health benefit.

3.15. Hospice Care Services

Hospice care must be pre-authorized and arranged by a QualChoice Case Manager. Consult the Benefit Summary for applicable Cost Sharing Amount. In addition, coverage is available for an

Enrollee with a life expectancy of six months or less. Care must be provided by a hospice possessing all licenses, certifications, permits and approvals required by applicable federal, state and local law.

The following services, when ordered by a physician, are covered during the period when the hospice has admitted an Enrollee to its program:

1. Inpatient care in a freestanding hospice, a hospice unit within a hospital or skilled nursing facility or in an acute care hospital bed;
2. Home care services provided by the hospice either directly or under arrangements with other licensed providers, including but not limited to, the following:
   A. Intermittent nursing care by registered nurses, licensed practical nurses, or home health aides;
   B. Respiratory therapy;
   C. Social services;
   D. Nutritional services;
   E. Laboratory examinations;
   F. Chemotherapy and radiation therapy when required for control of symptoms;
   G. Medical supplies; and
   H. Medical care provided by a physician.

3.16. Facility – Inpatient Care

Inpatient hospital care Benefits are available for services and supplies received during the hospital stay and room and board in a semi-private room (a room with two or more beds). We will not pay for any hospital services unless the service is provided by an employee of the hospital, the hospital bills for the service, the service is not primarily for convenience and the hospital retains the payment collected for the service.

Facility inpatient care is also subject to the following conditions:

1. We cover Medically Necessary acute inpatient hospital care for the care or treatment of your condition, illness, or injury;
2. The services of social workers and discharge planners shall be included in the basic daily room and board allowance;
3. Coverage is provided for a minimum of forty-eight (48) hours for an in-patient stay related to a mastectomy;
4. We do not provide Benefits while you are waiting for Custodial Care;
5. We do not provide Benefits while waiting for a preferred bed, room, or facility;
6. The following applies when an Enrollee is waiting for transfer from an acute facility to another facility for continuing care (e.g., nursing home, rehabilitation facility, skilled nursing facility, and long term acute care facility):
   A. The acute facility that the Enrollee is in awaiting a transfer should provide care equivalent to the care provided by the facility to which the Enrollee is waiting to be transferred;
   B. The days an Enrollee spends in the acute facility waiting for a transfer may count toward the limits for sub-acute and rehabilitation Benefits;
   C. We will pay the acute facility the Enrollee is in awaiting a transfer the lesser of that acute facility's rate or the rate at the facility to which the Enrollee is being transferred; as demonstrated in Section 2.5 above, this could have a significant financial impact on you if the acute facility the Enrollee is in while waiting to be transferred is an Out-of-Network Facility;
   D. If the acute facility the Enrollee is in awaiting a transfer is not providing the care we expect, we will deny those days and make no payment; as demonstrated in Section 2.5 above, this could have a significant financial impact on you if the acute facility the Enrollee is in while waiting to be transferred is an Out-of-Network Provider.
7. Services rendered in a facility in a country outside of the United States of America shall not be paid except at the sole discretion of QualChoice.
8. Services to Out-of-Network Facilities are subject to pre-admission notification as described in Section 2.11. Please call the number listed on your identification card to notify us of the admission.

3.17. Injectable Prescription Medications

Benefits are available for Injectable Prescription Medication(s) received in a physician's office based upon the Maximum Allowable Charge for the Injectable Prescription Medication and subject to the applicable Cost Sharing Amounts specified in the Benefit Summary for other services provided in the physician's office. Benefits are available for Injectable Prescription Medications for self-administration through a prescription drug rider available from QualChoice. Injectable Prescription Medications that an Enrollee has the ability to self-administer may be obtained with direct delivery to the Enrollee's home. Our Care Management staff will assist Enrollees in coordinating this service.

3.18. Infertility

Limited diagnostic work-up for infertility is covered. This is designed to screen for basic problems that might cause infertility. Any other services required for the diagnosis or treatment of infertility or of any associated disease whose primary manifestation is infertility are not covered. You may contact us to obtain specific coverage guidelines.

3.19. Medical Foods

Medical foods and low protein modified food products for the therapeutic treatment of a person inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism are covered if:

1. The medical food or low protein modified food products are prescribed by a physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Network Physician; and
3. The cost of the medical food or low protein modified food products for an individual exceeds $2,400 per year per person, that is to say, the covered amount will be the incurred cost of medical food or low protein modified food products that is in excess of the $2,400 per year per person.

3.20. Medical Supplies

Subject to all terms, conditions, exclusions and limitations of this Policy, Medical Supplies, other than Medical Supplies that can be purchased without a prescription, are covered when prescribed by a physician and when Medically Necessary. The following conditions will also apply to coverage for Medical Supplies:

1. Coverage for Medical Supplies provided in a physician's office is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used;
2. Coverage for Medical Supplies is limited to a 31-day supply per month;
3. Coverage for Medical Supplies used in connection with Durable Medical Supplies is subject to the Cost Sharing Amounts and DME benefit limitations specified in the Benefit Summary; and
4. Coverage for Medical Supplies provided in connection with home infusion therapy is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used.

3.21. Orthotic Services and Orthotic Devices

Orthotic services and orthotic devices (as defined in this Section) are covered as described below.

All "orthotic devices" and "orthotic services", including the fitting and/or repair of orthotic devices, require pre-authorization as described in Section 2.11.

An "orthotic service" is an evaluation and treatment of a condition that requires the use of an "orthotic device".

In order for a device to be an "orthotic device" under this Policy, the device must meet all three (3) of the following requirements:

1. The external device is (i) Intended to restore physiological function or cosmesis to a patient; and (ii) Custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

An orthotic device does *not* include a/an (i) cane, (ii) crutch, (iii) corset, (iv) dental appliance, (v) elastic hose, (vi) elastic support, (vii) fabric support, (viii) generic arch support, (ix) low-temperature plastic splint, (x) soft cervical collar, (xi) truss, or (xii) any similar device meeting both of the following requirements:

1. It is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
2. It has no significant impact on the neuromuscular, musculoskeletal or neuromusculoskeletal functions of the body.

An orthotic device also does *not* include foot orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain. This applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, are mainly protective in nature, and/or combine functional control and protection. This also applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.

Coverage for orthotic devices and orthotic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of an orthotic device or associated orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Policy. However, QualChoice will replace or repair an orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.22. Outpatient Services

1. **Outpatient Facility Services:** Covered outpatient services shall include the following services provided in a licensed outpatient facility or at a hospital outpatient department: diagnostic services, radiation therapy, chemotherapy, x-ray services, laboratory services, surgical services, physical, occupational and speech therapy services, audiology services and renal dialysis. We also cover up to 24 hours of outpatient observation for the purpose of extended recovery from a surgical or invasive procedure or for evaluation of the possible need for inpatient admission.

2. **Outpatient Surgery:** Coverage is provided for outpatient surgical services received from an ambulatory surgery center or in an outpatient hospital setting when performed or prescribed by a physician. Covered Services include diagnostic imaging and laboratory services required to augment surgical services and performed on the same day as such surgical service. If an Out-of-Network Facility or ambulatory surgery center not contracted with QualChoice is used, payment will be limited to the Maximum Allowable Charge for the service.

3.23. Physician Office Services

The diagnosis and treatment of an illness or Accidental Injury is a Covered Service when provided in a medical office, subject to the Cost Sharing Amounts set forth in your Benefits Summary.

3.24. Preventive and Wellness Health Services

We cover those services that are recognized and defined by QualChoice's Medical Policies as being preventive and/or wellness in nature. Subject to changes QualChoice may make to its Medical Policies, a partial listing of those services QualChoice considers to be preventive and/or wellness health services is included with your Benefits Summary. The most complete list of those services QualChoice considers being preventive and/or wellness health services are available on our website www.qualchoice.com (Preventive Health Benefit) or you may contact our Customer Service Department to obtain specific coverage guidelines.

3.25. Professional Services for Complex Surgery

We cover complex surgeries subject to the limitations described below including application of all Cost Sharing Amounts and other limitations as set forth in this Policy and related Benefits Summary.

The Benefit amount payable for a complex surgery includes payment for related or follow-up care by the surgeon before and after the operation. In other words, the one payment covers the operation and the surgeon's care after the operation. Payment for surgery is subject to the following limitations:

1. When multiple or bilateral surgical procedures are performed in the same operative session, whether through one or more incisions, we will cover the major or first procedure and, in addition, we will cover one-half of the Maximum Allowable Charge of the lesser or subsequent procedure(s).
2. When an incidental procedure, including, but not limited to, incidental appendectomy, treatment of adhesions, excision of previous scar, or puncture of ovarian cyst, is performed through the same incision, we will only pay for the major procedure;
3. When the physician performs an operative procedure in two or more stages, the total payment for the combination of steps or stages making up the entire procedure will be limited to the Maximum Allowable Charge that we would have paid if the physician had not performed it in multiple steps or stages;
4. Not all surgeries require an assistant surgeon; we will pay for one assistant surgeon who is a physician qualified to act as an assistant for the surgical procedure when Medically Necessary;
5. We will cover a standby physician only if that physician is required to assist with certain high-risk deliveries identified by us and only if that physician is in the immediate proximity to the Enrollee during the standby period.

3.26. Prosthetic Services and Prosthetic Devices

Prosthetic services and prosthetic devices (as defined in this Section) are covered as described below.

All "prosthetic devices" and "prosthetic services", including the fitting and/or repair of prosthetic devices, require pre-authorization as described in Section 2.11.

A "prosthetic service" is an evaluation and treatment of a condition that requires the use of a "prosthetic device".

In order for a device to be a "prosthetic device" under this Policy, the device must meet all three (3) of the following requirements:

1. The device is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

A prosthetic device includes a breast prosthesis to the extent required pursuant to the Women's Health and Cancer Rights Act of 1998.

A prosthetic device does *not* include a/an (i) artificial eye, (ii) artificial ear, (iii) dental appliance (which would include corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome), (iv) cosmetic device such as artificial eyelashes or wigs, (v) device used exclusively for athletic purposes, (vi) artificial facial device, or (vii) any other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

Coverage for prosthetic devices and prosthetic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of a prosthetic device or associated prosthetic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Policy. However, QualChoice will replace or repair a prosthetic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.27. Reconstructive Surgery

We cover services in connection with reconstructive surgery if necessary to restore the part of the body injured or deformed by acute trauma, infection or cancer subject to the following:

1. Restoration must be aimed at restoration of function, not just restoration of appearance;
2. Restoration is intended to achieve an average person's normal function (for example, restoration aimed at athletic performance is *not* covered);
3. The reconstructive surgery is necessary to correct congenital malformations or anomalies resulting in a severe functional impairment of a Child covered under this Policy.

Coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by a physician:

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

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

3.28. Skilled Nursing Facility and Inpatient Rehabilitation Services

Coverage is available for Medically Necessary care in a skilled nursing facility or acute inpatient rehabilitation facility when provided immediately after hospitalization in an acute care general hospital for a covered illness or injury. Care will be limited to the number of covered days provided by the Policy and must meet the Medically Necessary criteria of continued improvement. See the Benefit Summary for details.

3.29. Therapeutic and Rehabilitation Services

Services for outpatient physical, occupational or speech therapy and chiropractic, audiology or pulmonary rehabilitation are covered. This includes services performed in the office of a physician, chiropractor or therapist, outpatient therapy center, or in the outpatient department of a hospital. Refer to the Benefit Summary and Section 4 for specific limits. Cardiac rehabilitation services are covered separately and are not subject to this limitation. Please note that Benefits are available only for services that are expected to result in a significant improvement in the Enrollee's condition within two months of the start of the treatment.

3.30. Transplantation Services

Transplant Benefits are available subject to the general conditions for payment specified in Section 4, and to all other applicable conditions, limitations and exclusions of this Policy. Consult the Benefit Summary for applicable Cost Sharing Amounts and other limitation amounts.

1. **Pre-Authorization Required:** ***You or an authorized representative must call the number on your ID card to obtain pre-authorization before the evaluation for transplant and placement on any transplant list.*** Once the evaluation is complete, an additional pre-authorization must be obtained for the transplant procedure. We will coordinate all transplant services, including evaluation and transplant. Failure to coordinate all transplant related services with us, or failure to comply with pre-authorization procedures, may result in non-payment of these services.
2. **Transplant Standards:** We cover transplant procedures under the standards set out by the Policy and are as follows:
   A. **General Description of Transplant Covered Services:** We will cover any hospital, medical, surgical, and other service related to the transplant, including blood and blood plasma. **We only cover transplants and transplant related services performed at a transplant center approved by us.**
   B. **Facility Care:** We cover all inpatient and outpatient care at a designated transplant center. When we authorize the transplant to occur at an Out-of-Network facility, we may require Network Physicians at a Network Facility to provide some follow-up care.
   C. **Organ Procurement:** We will pay for services directly related to organ procurement including tissue typing, surgical extraction and storage and transportation costs of the organ or other human tissue used in a covered transplant procedure. (If the donor has other insurance, we must receive an explanation of benefits from the donor's health policy indicating coverage or denial for the donation.) Please refer to the Benefit Summary for Cost Sharing Amounts and lifetime maximums.
3. **Bone Marrow Transplantation:** Bone marrow transplantation is only covered for specific indications listed below. This limitation applies to the bone marrow transplantation and any related procedure including High Dose Chemotherapy. The limitation applies to transplants of bone marrow or of peripheral blood cells intended to reconstitute the marrow. Covered diseases are:
   A. Aplastic anemia
   B. Wiscott-Aldrich syndrome
   C. Albers-Schonberg syndrome
   D. Thalassemia major
   E. Myelodysplastic syndromes – primary and acquired
   F. Immunodeficiency syndrome
   G. Non-Hodgkin's lymphoma, intermediate or high grade, stage III or IV
   H. Hodgkin's disease, stage IIIA or IIIB, or stage IVA or IVB
   I. Neuroblastoma, stage III or IV
   J. Chronic myelogenous blast leukemia in blast crisis or chronic phase
   K. Chronic myelogenous leukemia in the chronic phase

L. Multiple myeloma
M. Acute lymphocytic or myelocytic leukemia in patients who are in remission but at high risk for relapse

4. **Cornea Transplantation:** Cornea transplantation is covered subject to all terms, limitations and exclusions as set forth in this Policy. Cornea transplantation does not require pre-authorization.

This Policy requires specific donor matches for certain procedures.

4. NON-COVERED SERVICES, EXCLUSIONS AND LIMITATIONS

Some services, treatments, medications and supplies are not covered. Others have limitations on coverage. This Section describes those exclusions and limitations. QualChoice may choose to eliminate an exclusion or limitation if advances in medical care warrant making such a change. One or more of our optional coverage riders may cover some of these items. If you purchase any riders, they are included as part of this Policy. Please refer to the Benefit Summary for additional exclusions and limitations on Covered Services. QualChoice may provide very limited coverage for some services that are otherwise excluded or limited by this Section 4 strictly for preventive health purposes; where applicable, these limited coverages are identified and described in QualChoice's Preventive Health Benefit Medical Policy.

4.1. Exclusions From Coverage

1. **Acupuncture:** Acupuncture services for pain therapy are not covered.
2. **Admission to a Facility before Becoming Covered under This Policy:** We will not cover an inpatient admission commencing before the Effective Date of this Policy. We will not cover any portion of the facility or medical services related to the stay. This applies to admissions to an acute hospital, sub-acute hospital, skilled nursing facility, rehabilitation unit, or any other inpatient facility.
3. **Abortion:** We do not cover elective abortion. We do not cover medical services, supplies or treatment the primary purpose of which is to cause an elective abortion. We do not cover any services, supplies or treatment provided as a result of such an abortion.
4. **Adoption and Surrogate Parenting:** We will not cover services, supplies, treatment, or other costs relating to the care of the biological mother of an adopted child. Maternity charges incurred by an Enrollee acting as a surrogate mother are not covered charges.
5. **After Hours or Weekend Charges:** We will not cover any extra charges related to the time of day or day of the week on which services were rendered.
6. **Against Medical Advice:** We will not cover any services related to an inpatient admission, observation admission, or emergency room visit resulting in the Enrollee's discharge against medical advice. We will not cover any services required for complications resulting from the Enrollee's discharge against medical advice.
7. **Alternative or Complementary Medicine:** We will not cover devices or services relating to alternative systems of medical practice such as, but not limited to, the following:
   A. Acupuncture
   B. Homeopathy or Naturopathy;
   C. Bioelectromagnetic care;
   D. Herbal medicine;
   E. Hippo therapy (equine therapy);
   F. Hypnotherapy (see mental health coverage);
   G. Aromatherapy;
   H. Reflexology;
   I. Mind/body control such as dance or prayer therapies;
   J. Pharmacological and biological therapy not accepted by mainstream medical practitioners such as chelation therapy or metabolic therapy.

8. **Blood:** We do not provide Benefits for blood, blood plasma or blood derivatives. We do not cover fees for voluntary blood donation or storage of blood products. We do cover the charges for the administration of blood or blood products.

9. **Blood Donation:** We do not cover directed blood donations. We do not cover donations for specified recipients, you or another, regardless of donor or anticipated date of use. We do not pay for procurement, storage, or administration of such donated blood. We do not pay for any extra charges associated with designated blood donation.
10. **Blood Typing:** Blood typing or DNA analysis for paternity testing is not covered.
11. **Care Plan Oversight:** Multi-disciplinary team conferences as well as any other kind of team conferences are not covered.
12. **Care Provided By a Relative by Blood or Marriage:** We will not cover care provided by an individual who normally resides in your household. We also will not cover care provided by you or by your parents, siblings, spouses, children, grandparents, aunts, uncles, nieces and nephews or other relatives by blood or marriage.
13. **Care Rendered in Certain Non-Facility Institutions:** We will not pay for care in hospitals or other facilities not licensed as short-term acute care general hospitals or skilled nursing facilities. Examples are:
    A. Convalescent homes or similar institutions;
    B. An institution primarily for Custodial Care, rest or domicile;
    C. Residential care or treatment facilities;
    D. Health resorts, camps, safe houses, spas, sanitariums, schools, or tuberculosis hospitals;
    E. Infirmaries at camps or schools;
    F. Facilities for treatment of mental illness and substance abuse;
    G. Rehabilitation facilities and rehabilitation units in other facilities (except as covered under Section 3.29);
    H. Skilled nursing facilities and places primarily for nursing care (except as covered under Section 3.28);
    I. Freestanding cardiac care facilities;
    J. Sleep study centers;
    K. Extended care, chronic care, or transitional hospitals or facilities (except as covered under Section 3.29 and 3.30); or
    L. Other facilities and institutions, which do not meet our criteria for short-term acute care general hospitals or skilled nursing facilities
14. **Cerebellar Stimulator or Pacemaker:** Cerebellar stimulator or pacemaker for the treatment of neurological disease is not covered.
15. **Cervicography:** Cervicography is not covered.
16. **Charges In Excess Of Calendar Year or Lifetime Maximums:** We will not cover any service, supply or treatment in excess of the Calendar Year or lifetime maximum as shown on the Benefit Summary.
17. **Charges for Missed/Canceled Appointments:** We will not pay for charges resulting from the Enrollee's failure to keep scheduled appointments.
18. **Chelation Therapy:** Services or supplies provided as, or in conjunction with, chelation therapy are not covered, except for treatment of acute heavy metal poisoning.
19. **Cognitive Rehabilitation:** Services and supplies provided as part of cognitive rehabilitation are not covered.
20. **Complications:** We will not cover medical or surgical complications resulting from a non-Covered Service. We will not cover medical or surgical complications as a direct or closely related result of the Enrollee's refusal to accept treatment, medicines, or a course of treatment recommended by a provider.
21. **Contraceptive Devices or Supplies:** Contraceptive devices or supplies available over-the–counter (without a prescription) are not covered.
22. **Convenience Items or Services:** We will not cover items or services utilized primarily for an Enrollee's convenience or the convenience of a family member, caregiver or provider. Such items include, but are not limited to: cot, telephone, television rental charges in a hospital, whirlpool baths, automobile or van conversions, motor scooters, air purifiers, exercise equipment, machines used for communication and speech, lifts, and home modifications.
23. **Cosmetic or Reconstructive Surgery:** We will not pay for any procedures, services, equipment or supplies provided in connection with elective cosmetic surgery or complications arising from a cosmetic surgery even if coverage was provided by another health plan.

Cosmetic surgery is intended primarily to improve appearance or have a psychological benefit.

24. **Cranial Electrotherapy Stimulation Devices**: Cranial electrotherapy stimulation devices are not covered.
25. **Current Perception Threshold Testing**: Current perception threshold testing is not covered.
26. **Custodial Care:** We do not cover any service which is custodial in nature. We consider care custodial in nature when it is primarily for meeting personal needs. Persons without professional skills or training can provide Custodial Care. For example, Custodial Care includes assistance in activities of daily living (walking, getting in and out of bed, bathing, dressing, eating and taking medication). Custodial care also includes medical services not seeking to cure or improve the patient. They may be provided during periods when the medical condition of the patient is not changing. They generally do not require continued administration by trained medical personnel. Examples include long-term maintenance activities such as dressing changes, tube feeding or range of motion exercises. Non-covered Custodial Care may be rendered in a hospital, domiciliary facility, nursing home, skilled nursing facility, or home. Non-covered Custodial Care may be residential care, respite care, private duty nursing, or any other service custodial in nature.
27. **Dental Care:** This Policy does not provide Benefits for dental care. Except as otherwise stated in this Policy, we do not cover:
    A. Treatment of cavities;
    B. Tooth extractions;
    C. Care of the gums;
    D. Care of the bones supporting the teeth;
    E. Treatment of periodontal disease;
    F. Treatment of dental abscess;
    G. Treatment of dentigerous cysts;
    H. Removal of soft tissue supporting or surrounding teeth;
    I. Orthodontia (including braces);
    J. False teeth;
    K. Orthognathic surgery; or
    L. Any other dental services you may receive.
28. **Dental Implants:** Dental implants of titanium osseointegrated fixtures or of any other material are not covered.
29. **Dermatomal Somatosensory Evoked Potentials:** Dermatomal somatosensory evoked potential testing is not covered.
30. **Developmental Delay:** Services or supplies provided for developmental delay, including learning disabilities, communication delay, perceptual disorder, sensory deficit and motor dysfunctions are not covered.
31. **Dexamethasone Infusion:** Dexamethasone infusion is not covered.
32. **Dietary and Nutritional Services:** Unless such dietary supplies are the sole source of nutrition for the Enrollee, any services or supplies provided for dietary or nutritional services, including but not limited to medical nutrition therapy, are not covered. Baby formulas or thickening agents, whether prescribed by a Physician or acquired over the counter, are not a covered benefit.
33. **Donor Expenses For Transplant:** Services and supplies associated with an organ and tissue transplant where the Enrollee is the donor are not covered.
34. **Dynamic Orthotic Cranioplasty:** Dynamic orthotic cranioplasty is not covered.
35. **Electrogastrography:** Electrogastrography is not covered.
36. **Electron Beam Computed Tomography:** Electron beam computed tomography is not covered.
37. **Environmental Intervention:** Services or supplies used in adjusting an Enrollee's home, place of employment or other environment so that it meets the Enrollee's physical or psychological condition are not covered.

38. **Enteral Feedings:** Enteral feedings are not covered except when approved by us and documented to be the Enrollee's sole source of nutrition, subject to all other terms, conditions, and limitations of this Policy.
39. **Excessive Use:** Excessive use of medications is not covered. For purposes of this exclusion, each Enrollee agrees that QualChoice shall be entitled to deny coverage of medications under a prescription drug rider or this Policy, on grounds of excessive use when our medical director, in his sole discretion, determines (1) that an Enrollee has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard reference compendia or by the Pharmacy & Therapeutics Committee; or (2) that an Enrollee has obtained or attempted to obtain the same medication from more than one Physician for the same or overlapping periods of time; or (3) that the pattern of prescription medication purchases, changes of Physicians or pharmacy or other information indicates that an Enrollee has obtained or sought to obtain excessive quantities of medications. Each Enrollee hereby authorizes QualChoice to communicate with any physician, health care provider or pharmacy for the purpose of reviewing and discussing the Enrollee's prescription history, use or activity to evaluate for excessive use.
40. **Exercise Programs:** Exercise programs for treatment of any condition are not covered. Examples would be gym memberships, personal trainers, and home exercise equipment, even if recommended or prescribed by a Physician.
41. **Experimental or Investigational Procedures and Related Equipment and Supplies:** We will not cover any procedure or service we consider to be experimental or investigational. We also will not pay for equipment or supplies related to such procedures. We base decisions on what is experimental or investigational on unbiased technology reviews and national scientific, peer-reviewed medical literature. Any therapy subject to government agency approval must have received final approval before we consider it for coverage. A new treatment with no outcome advantage over existing treatments may be considered investigational while studies are in progress to determine if any treatment advantage exists in any subpopulation of the affected group.
42. **Extracorporeal Shock Wave Therapy:** Extracorporeal shock wave therapy (ESWT) for any musculoskeletal condition, including but not limited to plantar fasciitis or tennis elbow, is not covered.
43. **Eyeglasses:** Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contacts except for the initial acquisition following cataract surgery as specified in Section 4.1.
44. **First Aid Supplies:** We will not cover over the counter first aid supplies.
45. **Foot Care:** Services or supplies for palliative or cosmetic foot care or for flat foot conditions are not covered. This includes but is not limited to supporting devices for the foot such as shoe inserts, elastic stockings, Jobst stockings, the treatment of subluxations of the foot, arthroeresis for flat feet, care of corns, bunions, calluses, routine trimming of toe nails, fallen arches, weak feet and chronic foot strain. However, subject to all terms, conditions, exclusions and limitations as set forth in this Policy, foot care is provided when required for prevention of complications associated with diabetes mellitus or other peripheral sensory neuropathy.
46. **Formula:** Baby formula and thickening agents, even if prescribed by a physician or acquired over-the-counter are not covered.
47. **Fraud or Misrepresentation:** Health interventions or health services, including but not limited to medications obtained by unauthorized or fraudulent use of an Enrollee's identification card or by material misrepresentation as part of the enrollment process or at other times, are not covered.
48. **Free Care:** We will not cover any care if there was no charge for the care. This applies even if you, or your provider thought the services were not covered by insurance when the provider chose not to charge for the care.

49. **Government Programs:** We will not pay for Covered Services to the extent benefits for such services are payable under Medicare or any other federal, state or local government program.
50. **Hair Loss or Growth:** Wigs, hair transplants or, unless specifically covered in a prescription drug rider issued to you by us, any medication that is taken for hair growth even if prescribed by a Physician, are not covered regardless of the cause of hair loss. Treatment of male or female pattern baldness is not covered.
51. **Health and Behavior Assessment:** Evaluation of psychosocial factors potentially impacting physical health problems and treatments are not covered. This includes health and behavior assessment procedures used to identify psychological, behavior, emotional, cognitive, and social factors affecting physical health problems.
52. **Hearing or Talking Aids:** Regardless of the reason for the hearing or speech disability, hearing aids, prosthetic devices to assist hearing, or talking devices, including special computers, are not covered. Fitting or repair of such devices is not covered. Nor are cochlear implants, or its associated speech processor, or auditory brain stem implants covered.
53. **Heat Bandage:** Treatment of a wound with a warm-up active wound therapy device or a non-contact radiant heat bandage is not covered.
54. **High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation:** High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation are not covered, except in the circumstances set forth in Section 3.30.
55. **High Frequency Chest Wall Oscillators:** High frequency chest wall oscillators that are used to provide airflow to the lungs are not covered.
56. **Home Uterine Activity Monitor:** Home uterine activity monitors or their use is not covered.
57. **Illegal Acts:** We will not cover health care services resulting from an Enrollee's participation in an illegal act or being engaged in an illegal occupation, whether or not convicted, riot or insurrection except as required by law.
58. **Illegal Uses:** Medications, drugs or substances that are illegal to dispense, possess, consume or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner, are not covered. Complications or an Accidental Injury from illegal drug use or while driving under the influence of alcohol determined to be in excess of legal limits, are not covered.
59. **Impotence or Sexual Dysfunction:** We will not cover medical, surgical, or pharmacological treatment for impotence, frigidity, or other sexual dysfunction unless such dysfunction is the result of diabetic neuropathy, spinal cord injury or prostate surgery.
60. **Immunizations**: Immunizations for travel, school, work or recreation are not covered.
61. **Insulin Pump for Diabetes Mellitus:** We do not cover insulin pumps for diabetes mellitus.
62. **Infertility Treatment:** We will cover a basic diagnostic work-up to make an initial diagnosis of infertility. We will not cover any medications (unless specifically covered in a prescription drug rider issued to you by us), procedures, or other services for treatment of infertility. It does not matter if the infertility service is therapeutic, it is still not covered. It does not matter whether the infertility service or treatment is by natural, artificial, mechanical, pharmacological, or other means, it is still not covered. Specific services that are not covered include, but are not limited to:
    A. Reversal of sterilization
    B. Pre-implantation testing and/or artificial insemination
    C. Surrogate pregnancies
    D. Medical treatment of infertility
    E. Surgical treatment of infertility
    F. In vitro fertilization

    Note: We will not pay for surgery that is done primarily for infertility treatment even when other diseases or conditions that may be the underlying medical condition causing the infertility are detected or treated during such surgery.
63. **Inotropic Agents for Congestive Heart Failure:** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. However, subject to all terms, conditions, exclusions and limitations set forth in this Policy, where the

Enrollee is on a cardiac transplant list at a hospital where there is an ongoing cardiac transplantation program, the Policy will cover infusion of inotropic agents.

64. **Instructional Programs:** We will not pay for instructional or educational testing, programs, seminars or workshops such as, but not limited to, childbirth classes, vocational training or testing, diet programs, nutritional programs, smoking cessation classes, educational or neuroeducational testing, or general or remedial education classes. Diabetic education is covered as set forth in Section 3.8.
65. **Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders:** Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.
66. **Learning Disabilities:** Services or supplies provided for learning disabilities, i.e. reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty and other learning difficulties, are not covered.
67. **Lost Medications:** Replacement of previously filled prescription medications because the initial prescription medication was lost, stolen, spilled, contaminated, etc. are not covered.
68. **Magnetic Innervation Therapy:** Extracorporeal magnetic innervation therapy for the treatment of urinary incontinence is not covered.
69. **Maintenance Therapy:** We will not cover maintenance therapy for chiropractic therapy, physical therapy, occupational therapy, recreational therapy, or speech therapy.
70. **Mammoplasty:** Except as provided in Section 3.27, we do not cover mammoplasty for reasons of augmentation, reduction or asymmetry of the breasts. We do not cover removal of breast implants placed or removed for cosmetic purposes.
71. **Mandated or Court Ordered Care:** We will not cover any medical, psychological, or psychiatric care which is the result of a court order or otherwise mandated by a third party (such as, but not limited to, an employer, licensing board, recreation council, or school).
72. **Maternity Care and Obstetrical Care:** We do not cover services or supplies for Maternity Care and Obstetrical Care.
73. **Medical Reports:** We will not cover expenses for medical report preparation and presentation. We will not pay for provider appearances at hearings and court proceedings. We will not pay for charges for the completion of insurance forms, or the preparation or copying of medical records.
74. **Medical/Surgical Services or Supplies for Control of Obesity or Morbid Obesity:** We will not cover any surgery, medical services or supplies intended for control of either obesity or morbid obesity even if the obesity or morbid obesity aggravates another condition or illness. This would include services such as dietary control, medications (unless specifically covered in a prescription drug rider issued to you by us), counseling or weight maintenance programs, gastric stapling, gastric bypass or any other service intended to control obesity. We do not cover surgical or medical procedures to treat the complications or consequences of weight loss, such as abdominoplasty or panniculectomy.
75. **Medication Therapy Management Services:** Medication therapy management services by a pharmacist, including but not limited to a review of an Enrollee's history and medical profile, an evaluation of prescription medication, over-the-counter medications and herbal medications, are not covered.
76. **Meniscal Allograft Transplantation:** Meniscal allograft transplantation is not covered.
77. **Mental Health or Substance Abuse:** Unless a Mental Health and/or Substance Abuse Rider accompanies this Policy, mental health, substance abuse, and chemical dependency treatment and related services and supplies are not covered, including, but not limited to, the following conditions and treatments:
    A. Sexual and gender identity disorders;
    B. Treatment for smoking or nicotine addiction;
    C. Services provided for treatment of adolescent behavior or conduct disorders, oppositional disorders, or neuroeducational testing;
    D. Outpatient psychotherapy or counseling for personal growth or life and social enrichment;
    E. Group therapy or group counseling at any time in any setting by any provider;
    F. Psychiatric conditions and substance abuse, including alcohol;
    G. Detoxification from abusive chemical or substance abuse;
    H. Medication supporting an addiction or substance dependency;

I. Seasonal Affective Disorder (SAD) treatment;
J. Educational services of any type for any reason;
K. Marriage and family therapy or counseling services; and
L. Services rendered by an Out-of-Network Provider.

78. **Non-Compliance with Recommended Treatment:** We will not cover services provided as the result of or related to an Enrollee's refusal to comply with a physician's or other provider's recommendations or orders, or failure to cooperate with a prescribed plan of treatment or recovery.
79. **Nurse Midwife:** Services provided by a nurse midwife are not covered.
80. **Nutritional Counseling or Nutritional Supplements:** Benefits are not available for dietary control counseling or weight maintenance programs. For Enrollees with diabetes, see Section 3.8.
81. **Oral, Implantable and Injectable Contraceptives:** Oral and prescription contraceptive methods that are not on the QualChoice formulary are not covered. Implantable and injectable contraceptives provided in a physician's office are not covered.
82. **Orthognathic Surgery:** The surgical repositioning of segments of the mandible or maxilla containing one to several teeth, or the bodily reposition of entire jaws, whether to reduce a dislocation of temporomandibular joint or for any other purpose, is not covered. For coverage of Oral Surgery or Reconstructive Surgery, see Section 3.
83. **Orthoptic or Pleoptic Therapy:** Orthoptic or pleoptic therapy is not covered.
84. **Orthotics:** Orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain are not covered. This exclusion applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, those that are mainly protective in nature, and those that combine functional control and protection. The exclusion applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.
85. **Outpatient Rehabilitation Services:** Coverage for outpatient visits for physical, occupational, and speech therapy, audiology services, pulmonary rehabilitation and chiropractic services are limited to a maximum number of visits per Enrollee per Calendar Year as set out in the Benefit Summary. Coverage for cardiac rehabilitation is limited to a maximum number of visits per Enrollee per Calendar Year as set out in the Benefit Summary. Any outpatient rehabilitation services obtained from an Out-of-Network Provider are not covered.
86. **Outside United States:** We do not cover services or supplies obtained outside of the United States except in our sole discretion.
87. **Over the Counter Medications:** Unless specifically identified in a prescription drug rider purchased from QualChoice, medications (except insulin) which do not by law require a prescription from a Physician are not covered.
88. **Pain Pump, Disposable:** Disposable pain pumps following surgery are not covered.
89. **Parkinson's Disease, Treatment with Fetal Mesencephalic Transplantation:** Fetal mesencephalic transplantation (FMT) for treatment of Parkinson's disease is not covered.
90. **Percutaneous Diskectomy:** Any method of percutaneous diskectomy, including, but not limited to, automated or manual percutaneous diskectomy, laser diskectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered.
91. **Percutaneous Sacroplasty:** Percutaneous sacroplasty is not covered.
92. **Performance Enhancement:** We will not cover medical, surgical or rehabilitation services primarily intended to improve the level of physical functioning for purposes of enhanced job, athletic or recreational performance, including but not limited to work hardening programs, back schools, programs of general physical conditioning, athletic trainers and special or specially modified surgical procedures designed to enhance performance above normal.
93. **Peripheral Nerve Stimulators:** Peripheral nerve stimulators are not covered.
94. **Peripheral Vascular Disease Rehabilitation Therapy:** Peripheral vascular disease rehabilitation therapy is not covered.
95. **Premarital Laboratory Work:** We will not cover premarital laboratory work required by any state or local law.

96. **Prescription Medications:** Unless specifically covered in a prescription drug rider issued to you by us, prescription drugs for outpatient use filled by a prescription order or refill and non-injectable medications given in a physician's office except in an Emergency are not covered.
97. **Private Duty Nurses:** We will not cover private duty nurses.
98. **Private Room:** We do not cover a private hospital room. We will pay the most common charge for semi-private accommodations. If there is a charge for a private room, you must pay the difference between the charges for a private room and our payment.
99. **Prolotherapy:** Prolotherapy or Sclerotherapy for the stimulation of tendon or ligament tissue or for pain relief in a localized area of musculoskeletal origin is not covered.
100. **Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions:** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.
101. **Required Examinations or Services:** We will not cover examinations or services required or recommended by a third party. This would include services for the purpose of:
    A. Obtaining employment;
    B. Maintaining employment;
    C. Obtaining insurance;
    D. Obtaining professional or other licenses;
    E. Engaging in travel;
    F. Athletic or recreational activities; or
    G. Attending a school, camp, or other program.
102. **Research Studies:** We will not cover any service provided in connection with research studies or clinical trials.
103. **Rest Cures:** Services or supplies for rest cures are not covered.
104. **Reversal of Sterilization:** We will not cover any procedures or related care to reverse previous sterilization.
105. **Second Surgical Opinion and Consultation with Specialist:** We will not cover a second surgical opinion and a consultation from the same physician or from two physicians who are in practice together.
106. **Self-inflicted Injuries:** Services for intentional self-inflicted injuries, including drug overdose, are not covered, except when it is determined the act causing the injury resulted from a medical condition (physical or mental).
107. **Sensory Stimulation of Coma Patients:** Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.
108. **Services Not Specified as Covered Services:** We will not cover any services not specifically described in Section 3 of this Policy.
109. **Sex-Change Treatment:** We will not cover surgical procedures or related care to alter your sex from one gender to the other.
110. **Sexual and Gender Identity Disorders:** Any services related to the treatment of sexual and identity disorders are not covered.
111. **Short Stature Syndrome:** Any services related to the treatment of short stature syndrome, except for laboratory documented growth hormone deficiency, are not covered.
112. **Smoking or Tobacco Cessation or Caffeine Addiction:** Unless a Smoking Cessation Rider is issued to you by us, treatment of caffeine or nicotine addiction, smoking cessation prescription medication products, including but not limited to, nicotine gum and nicotine patches are not covered.
113. **Snoring:** Devices, procedures or supplies to treat snoring are not covered.
114. **Sperm and Embryo Preservation and Donation:** We will not cover charges related to the donation, collection, or preservation of sperm or embryos for later use.
115. **Sterilization, Voluntary Hysterectomy:** We will not cover charges related to hysterectomy for the primary purpose of voluntary sterilization. We will not cover charges related to implantation of the Essure device or other similar devices identified at our sole discretion. You may contact us to obtain a listing of such devices.
116. **Tanning Equipment:** Tanning equipment is not covered.
117. **Telephone and Other Electronic Communication:** We do not cover communications between a provider and an Enrollee or a provider and another provider done by telephone or other electronic means such as email.

118. **Temporomandibular Joint Syndrome (TMJ):** Unless a TMJ Rider is included with this Policy, we will not cover charges related to treatment or diagnosis of TMJ, including, but not limited to, medical, surgical and dental treatment, physical therapy, joint splints, adjustments, medications, as well as any orthotic treatment. All other procedures involving the teeth or areas surrounding the teeth are not covered, including shortening of the mandible or maxillae, or correction of malocclusion.
119. **Thermography:** Thermography, the measuring of self-emanating infrared radiation that reveals temperature variation at the surface of the body, is not covered.
120. **Third Party Liability Exclusion:** We will not pay any Benefits to an Enrollee to the extent the Enrollee has received payment, in whole or in part, from a third party, or its insurer, for past or future medical or hospital or other health care charges as the result of the negligence or intentional act of a third party. If an Enrollee makes a Claim for Benefits under this Policy prior to receiving payment from a third party, or its insurer, the Enrollee (or legal representative for a minor or incompetent) agrees to repay us from any amount of money received by the Enrollee from the third party, or its insurer. Please refer to Section 8 and Section 9.7 for further information concerning repayment of Benefits.
121. **Thoracic Electrical Bioimpedance:** Thoracic electrical bioimpedance is not covered.
122. **Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae:** Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.
123. **Trans-telephonic Home Spirometry:** Tans-telephonic home or ambulatory spirometry is generally not covered. However, subject to all terms, conditions, exclusions and limitations as set forth in this Policy, trans-telephonic home or ambulatory spirometry is covered for patients who have had a lung transplant, when pre-approved by the QualChoice Care Management Department.
124. **Travel and Transportation Expenses:** We will not cover travel and transportation expenses, even if prescribed by a physician, except for emergency ambulance service or ambulance service for transfer coordinated by the QualChoice Care Management Department.
125. **Travel or Work Related Immunizations:** We will not cover immunizations to fulfill requirements for international travel or for work.
126. **Ultrasounds:** Obstetrical ultrasound is not covered.
127. **Unlicensed Provider:** Coverage is not provided for treatment, procedures or services provided by any person or entity, including but not limited to physicians, who is required to be licensed to perform the treatment, procedure or services, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of QualChoice, include within its scope the treatment, procedure or service provided.
128. **Vacuum Assisted Closure:** Vacuum assisted closure devices and services associated with it are not covered.
129. **Vision and Hearing Services:** Except as set forth in the Benefit Summary, we will not cover routine eye or hearing examinations, services or tests, eyeglasses, contact lenses, hearing aids and other vision care and hearing care services and supplies, except as required for the diagnosis and treatment of diseases of, or injury to, the eyes or ears.
130. **Vision Correction:** We will not cover eye surgery to correct refractive errors. This includes refractive keratoplasty, refractive keratomileusis, epikeratophakia procedures, Low Vision Enhancement System (LVES), Laser Assisted Insitu Keratomileusis (LASIK), eyeglass, and contact lenses, except the initial acquisition of one pair within the twelve months following cataract surgery up to a maximum of $200.00 (for frames and lenses), are not covered.
131. **Vitamins or Baby Formula:** Unless specifically covered in a prescription drug rider issued to you by us, vitamins, food or nutrient supplements are not covered. **Baby formula and thickening agents, even if prescribed by a Physician are not covered.** However, subject to all terms, conditions, exclusions and limitations set forth in this Policy, coverage is provided for medical foods and low protein modified food products for the treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism (see Section 3.19).
132. **Vocational Rehabilitation:** Vocational rehabilitation services, counseling and testing are not covered.

133. **War or Act of War:** We will not cover any services relating to any injury or sickness resulting from war or any act of war (declared or undeclared), or in the armed forces of any country if any government plan covers the injury or sickness.
134. **Weight Control:** Medications prescribed, dispensed or used for the treatment of obesity are not covered. Medications prescribed, dispensed or used in any program of weight control, weight reduction, weight loss or other dietary control are not covered. Weight loss surgical procedures, including complications relating thereto, are not covered.
135. **Whole Body Computed Tomography:** Whole body computed tomography is not covered.
136. **Workers' Compensation:** We will not cover any care or supplies for any injury, condition or disease arising from employment. We will not make any payments even if a Claim is not made for the benefits which are available under the Workers' Compensation Law.
137. **Wound Treatment:** Blood derived growth factors are not covered.

4.2. Limitations to Benefits

1. **Ambulance:** Transportation by ambulance is limited to a maximum annual benefit amount, and is subject to review for Medical Necessity. Consult the Benefit Summary for Benefit limitations.
2. **Autism Screening:** Screening for autism is limited to a maximum of once between the ages of 1 and 4. Coverage for developmental delay associated with autism spectrum disorder is excluded.
3. **Biofeedback:** Biofeedback is covered only when it is Medically Necessary for muscle re-education of specific muscle groups, or for treating the pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and when more conventional treatments (heat, cold, exercise, and support) have not been successful. Pre-authorization is required. Biofeedback is medically appropriate when applied to the conditions reflected in the QualChoice Medical Policies.
4. **Circumstances Beyond Our Control:** Services and other covered Benefits could be delayed or made impractical by circumstances not reasonably within our control, such as: complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of hospital or medical group personnel, or similar causes. If so, Network Providers will make a good faith effort to provide services and other Benefits covered hereunder. Neither any provider nor we shall have any other liability or obligation because of such delay or such failure to provide services or other Benefits.
5. **Durable Medical Equipment (DME):** Benefits for DME is limited to an annual dollar maximum and must be obtained from a Network Provider. Please refer to the Benefit Summary for this annual limit.
6. **Eating Disorders:** We cover services for eating disorders only as provided in Section 3 of this Policy. This includes treatment for anorexia, bulimia and other eating disorders.
7. **Electrotherapy and Electromagnetic Stimulators:** All treatment using electrotherapy and electromagnetic stimulators, including services and supplies used in conjunction with such stimulators, and complications resulting from such treatment, is covered only for conditions specified in our Medical Policies.
8. **Enhanced External Counterpulsation:** Enhanced external counterpulsation (EECP) is covered only for conditions specified in our Medical Policies.
9. **Genetic Counseling and Testing:** Genetic counseling, genetic testing, and chromosome analysis are covered only when there is documented evidence that a genetic anomaly or defect may be present which could threaten the life of the Enrollee. Preauthorization is required. Genetic counseling, genetic testing, and chromosome analysis may be appropriate for (i) lymphoma, (ii) multiple myeloma, (iii) suspected Down's Syndrome, and (iv) testing for BRCA genes. We will not cover genetic counseling or testing:
   A. To determine the likelihood of developing a disease or condition;
   B. To determine the likelihood of a disease or the presence of a disease in a relative;
   C. To determine the likelihood of passing an inheritable disease, e.g. cystic fibrosis, or congenital abnormality to an offspring; or
   D. For pre-implantation genetic diagnosis or treatment.

10. **Home Health Care:** Home health visits are limited to a maximum number of visits per Enrollee per Calendar Year. The Home Health Care visit limitation and the Cost Sharing Amounts are specified in the Benefit Summary.
11. **Hospice Care:** Hospice Care is limited to a maximum number of days of coverage per Enrollee. The Hospice Care day limitation and the Cost Sharing Amounts are specified in the Benefit Summary.
12. **In Vitro Chemoresistance and Chemosensitivity Assays:** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but not limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered, subject to QualChoice's Medical Policies.
13. **Insulin Pump for Diabetes Mellitus:** We will cover insulin pumps to a Maximum Allowable Charge of $5,500. Insulin pump supplies are covered under your medical benefit and are not subject to this limitation. Pre-authorization is required.
14. **Lifetime Maximum:** Consult your Benefits Summary, Medical Policies, and this Policy for various lifetime maximum Benefits per Enrollee.
15. **Major Disaster or Epidemic:** If a major disaster or epidemic occurs, Network Providers will render medical services as is practical according to their best judgment within the limitation of available facilities and personnel. Neither any Network Provider nor we has any liability or obligation for delay or failure to provide or arrange any such services to the extent the disaster or epidemic creates unavailability of facilities or personnel.
16. **Prosthetic and Orthotic Devices and Services:** QualChoice does not cover replacement of a prosthetic or orthotic device or associated prosthetic or orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Policy. However, QualChoice will replace or repair a prosthetic or orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.
17. **Refusal to Accept Treatment:** You may refuse to accept procedures or treatment recommended by Network Providers for personal reasons. In such case, neither we nor any Network Provider shall have any further responsibility to provide care for the condition under treatment, unless such refusal is later recanted and there is an agreement to follow the recommended treatment or procedure.
18. **Transplant Services:** Transplant services are subject to the following benefit maximums:
    A. Coverage for procurement (per transplant) is limited to the amount reflected in your Benefits Summary;
    B. Lifetime maximum organ transplant coverage is limited to the amount reflected in your Benefits Summary;
    C. We will not cover the transportation and/or lodging costs of the transplant donor, or individuals traveling with either the donor or the recipient. We will not pay for artificial or non-human parts or organs or any services related to transplants using artificial or non-human parts or organs. Transportation costs of the transplant recipient are covered at the sole discretion and evaluation of the QualChoice Care Management Department. Coverage is limited to no more than two (2) transplants per Enrollee per lifetime. We cover re-transplantation, subject to the transplant limit of two (2).
    D. Solid organ transplants of any kind are not covered for an Enrollee with a malignancy of any kind that is presently active, in partial remission or in complete remission less than two years. A solid organ transplant of any kind is not covered for an Enrollee that has had a malignancy removed or treated in the three (3) years prior to the proposed transplant. For purposes of this exclusion, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma, or melanoma. Exceptions to this exclusion are hepatocellular carcinoma under certain circumstances, basal or squamous cell carcinomas of the skin, absent lymphatic or distant metastasis.
    E. Organ transplants not pre-authorized by QualChoice Care Management Department are not covered.

5. ELIGIBILITY CRITERIA

5.1. Hospitalization When Coverage Begins

If an Enrollee is an inpatient in a hospital, skilled nursing facility, or other inpatient facility on the Effective Date of this Policy, coverage under this Policy will not be effective for such Enrollee until after discharge from the facility.

No person, who is a registered inpatient in a hospital, skilled nursing facility, or other inpatient facility on the date he or she would otherwise be entitled to begin coverage will be eligible under this Policy or receive such coverage for such inpatient confinement.

5.2. Eligibility for Medicare

If you are eligible for Medicare, you are not eligible to begin or continue coverage under this Policy.

5.3. Who is Eligible for Coverage and When Does Coverage Begin

Subject to the Policy Holder meeting all eligibility requirements in this Policy, the Policy Holder's coverage begins upon the Effective Date of this Policy as reflected in the Benefit Summary. You may contact us for information concerning eligibility requirements and the Effective Date.

You must list yourself on the Enrollment Application to be eligible for coverage. You must meet all eligibility requirements in this Policy. ***Only*** a person who is a resident of the State of Arkansas and is under the age of 19 is eligible for coverage under this Policy. For the purposes of this Section, an Enrollee is a "resident" of the State of Arkansas if s/he lives in Arkansas and has an intent to remain in the State for a period of time, which may include a Child who is a student at a college or university located outside of Arkansas. QualChoice reserves the right to request documentation necessary to demonstrate that an Enrollee's residency is the State of Arkansas. Except under limited circumstances described in this Policy, we are not required to provide coverage under this Policy to every applicant for coverage.

No one is eligible for coverage if that person does not meet our eligibility rules. You should contact us for further information concerning your eligibility. Nor is someone eligible to enroll if that person had previous coverage with us and was terminated for causes described in Section 5.5.4 of this Policy.

5.4. Maternity Coverage

This Policy does not include coverage for Maternity Care and Obstetrical Care unless originally issued with a maternity coverage rider. You may add a maternity coverage rider by submitting an application to us which must be approved by us prior to you conceiving a child. Our standard underwriting standards must be met in order for us to approve issuing a maternity coverage rider. As a consequence, there can be no maternity Benefits under this Policy before the end of 12 months from the date maternity coverage was issued.

5.5. Termination of Coverage

Subject to the Policy Holder meeting all eligibility requirements in this Policy, the Policy Holder's coverage begins upon the Effective Date of this Policy as reflected in the Benefit Summary and will end on the date that the Policy is terminated by its terms.

An Enrollee's coverage under this Policy will terminate in certain circumstances. We describe these circumstances below.

1. **Default in Payment of Premiums:** Premiums are due on or before the first day of each month of Coverage under this Policy by the method described in your Enrollment Application. A grace period of thirty-one (31) days from that due date (the "Grace Period") will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. Failure to make premium payments to us in accordance before the end of the Grace Period shall terminate Benefits under this Policy. Coverage under this Policy will be terminated retroactive to the last day of the month for which premium payment was received.
2. **Becoming Eligible for Medicare:** When an Enrollee becomes eligible for Medicare, that Enrollee is no longer eligible for coverage under this Policy and should notify us immediately.

3. **On Death:** Coverage for the Policy Holder under this Policy will automatically terminate on the date of the Policy Holder's death. All premiums paid for coverage beyond the date of the Policy Holder's death will be refunded following our receipt of proof of death.
4. **Our Option to Terminate This Policy:** We may terminate this Policy for any of the following reasons:
   A. We rescind an Enrollee's coverage for material misrepresentation or fraud committed by the Enrollee in connection with any Claim filed under this Policy;
   B. We may terminate an Enrollee's coverage upon 30 days advance written notice to an Enrollee if he or she persistently fails to cooperate in good faith with the administration of coverage under this Policy or persistently refuses to comply with treatment plans prescribed by a physician and approved by us;
   C. We may terminate an Enrollee's coverage for failure to pay any applicable Cost Sharing Amount required under this Policy upon 30 days advance written notice to such Enrollee unless you cure such default in payment within such 30-day period;
   D. We may terminate an Enrollee's coverage upon 30 days advance written notice if an unauthorized person is allowed to use the Enrollee's identification card or if the Enrollee otherwise cooperates in the unauthorized use of such Enrollee's identification card or Benefits;
   E. Each Enrollee represents all statements made in his or her Enrollment Application for coverage are true to the best of his or her knowledge and belief. If an Enrollee furnishes any misleading, deceptive, incomplete, or untrue statement, which is material to the acceptance of his or her Enrollment Application, we may rescind his or her coverage under this Policy back to the original Effective Date;
   F. Failure to respond to a request for recovery of overpayment in accordance with the provisions of Section 9.7;
   G. We will terminate an Enrollee's coverage under this Policy if the Enrollee moves permanently to another state effective as of the end of the month for which the premium for that Enrollee has been paid;
   H. An Enrollee's coverage under this Policy terminates as of the date that Enrollee is no longer eligible to be an Enrollee under this Policy;
   I. We may terminate this Policy on 90 days written notice if we decide to no longer issue this particular type of health coverage.

   If QualChoice terminates the coverage of an Enrollee, it will notify the Enrollee in writing of the termination date and premium payments received on account of the terminated Enrollee applicable to periods after the effective date of termination shall be refunded to the Enrollee within 30 days or in the next scheduled billing cycle.

5. **You Terminate Coverage**: If the Policy Holder wishes to terminate coverage under this Policy, the Policy Holder must notify QualChoice in writing in advance of the requested termination date which will be effective no sooner than the end of the calendar month that QualChoice received the notice of termination. Premiums will only be refunded for any period already paid beyond the end of the month in which the notice of termination was received.
6. **No Further Liability.** Following termination of this Policy, we will have no further liability for Benefits except for those incurred before the date the Policy terminated.
7. **Reinstatement.** If any renewal premium is not paid within the Grace Period, a subsequent acceptance of premium by us or by any agent authorized by us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if we or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless we have previously notified you in writing of our disapproval of such application. The reinstated Policy shall cover only losses resulting from such Accidental Injury as may be sustained after the date of reinstatement and loss to such sickness as may begin more than ten (10) days after such date. In all other respects, the Enrollee and us shall have the same rights hereunder as they had under the Policy

immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

8. **Guaranteed Renewability**. This policy and riders are guaranteed renewable so long as your permanent residence is in Arkansas. At any time after the first twelve (12) month period of coverage under the Policy, we may change your premium rate, but only if the rate is changed for all policies and riders of the same form number and premium classification as this Policy. Your premium rate will also change in any month that you attain an age that moves you into a different premium classification established by QualChoice.

6. COORDINATION OF BENEFITS

You may have coverage under more than one health policy. This Policy contains a Coordination of Benefits (COB) provision. This is to eliminate duplication of payment for services. There is no COB for prescription drugs supplied at the retail pharmacy. COB will apply for drugs covered under the medical benefit. We do not coordinate against the following kinds of coverage: hospital indemnity coverage or other fixed indemnity coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, as defined by state law, school accident type coverage, benefits for non-medical components of long-term care policies, Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

6.1. How COB Works

The order of benefit determination rules govern the order in which each health policy will pay a Claim for benefits. The health policy that pays first is called the primary policy. The primary policy must pay benefits in accordance with its policy terms without regard to the possibility that another health policy may cover some expenses. The plan that pays after the primary policy is the secondary policy. The secondary policy may reduce the benefits it pays so that payments from all health policies do not exceed 100% of the COB Allowable Expense (described in Section 6.4 below).

6.2. Rules to Determine Primary and Secondary Plans

The following rules will determine primary and secondary policy coverage:

1. If a health policy does not have a COB provision, that policy is primary.
2. The health policy covering the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is primary, and the health policy that covers the person as a dependent is secondary.
3. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one health policy the order of benefits is determined as follows:
   - A. For a child whose parents are married or are living together, whether or not they have ever been married:
     - (1) The health policy of the parent whose birthday falls earlier in the Calendar Year is primary; or
     - (2) If both parents have the same birthday, the health policy that has covered the parent the longest is primary.
   - B. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
     - (1) The plan of the parent who a court has established as being responsible for the child's health care expenses or health care coverage is primary (we must be informed of this requirement and documentation may be required);
     - (2) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage , the provisions of Subparagraph A above determines the order of benefits;

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of Subparagraph A above determine the order of benefits; or

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) Plan of the custodial parent;
(b) Plan of the custodial parent's new spouse (if remarried);
(c) Plan of the non-custodial parent; and then
(d) Plan of the new spouse of the non-custodial parent (if remarried).

C. For a dependent child covered under more than one health policy of individuals who are the parents of the child, the provisions of Subparagraph A or B above determine the order of benefits as if those individuals were the parents of the child.

4. The health policy that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is primary. The same rule applies to a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. Note that this rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

5. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another health policy, the health policy covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is primary and the COBRA or state or other federal continuation coverage is secondary. If the other health policy does not have this rule, and as a result, the health policy or policies do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

6. The health policy that covered the person as an employee, member, policyholder, subscriber or retiree longer is primary and the health policy that covered the person the shorter period of time is secondary.

7. If the preceding rules do not determine the order of benefits, the COB Allowable Expense shall be shared equally between the health policies or policies. In addition, this Policy will not pay more than it would have paid had it been primary.

6.3. Allowable Expense

For the purposes of this Section 6, "Allowable Expense" is a health care expense (including Deductible, Coinsurance or Co-payments) covered in full or in part by any health care plan or policy covering the Enrollee. This means an expense or service not covered by any plan or policy covering the Enrollee is not an Allowable Expense. Also, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Enrollee is not an Allowable Expense.

If two (2) or more plans or policies cover you and compute their benefit payments based on that plan's maximum allowable charge, any amount in excess of the Allowable Expense of the primary payor for a specified benefit is not an Allowable Expense.

If two (2) or more plans or policies cover you and provide benefits or services based on negotiated fees, any amount in excess of the negotiated fees of the primary payor is not an Allowable Expense.

If you are covered under multiple plans or policies and the Allowable Expense is determined by more than one method, the primary policy's payment arrangement shall be the Allowable Expense for all plans or policies.

6.4. Reduction of Benefits

When this Policy is secondary, we will reduce our benefits so that the total benefits paid or provided by all plan or policies are not more than one hundred percent (100%) of the total Allowable Expense of the primary policy.

A. In determining the amount to be paid for any Claim, QualChoice will calculate the Benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense that is unpaid by the primary policy. QualChoice will then reduce its payment by the amount so that, when combined with the amount paid by the primary policy, the total Benefits paid or provided by all health policy or policies for the Claim do not exceed the total Allowable Expense of the primary policy for that Claim.

B. QualChoice will credit to Enrollee's Deductible any amounts it would have credited to the Deductible in the absence of other health care coverage.

C. If an Enrollee is enrolled in two or more closed panel plans (that is, a plan or policy that provides benefits primarily through a panel of contracted health care providers and excludes coverage for services provided by other health care providers) and if, for any reason, including the provision of service by an Out-of Network Provider, benefits are not payable by one closed panel plan, COB shall not apply between that closed panel plan and other closed panel plans.

6.5. Enforcement of Provisions

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the Plan and other health policy or policies. For the purposes of COB administration, QualChoice will get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under the Plan and other health policy or policies covering the person Claiming benefits. QualChoice is not required to tell, or get the consent of, any person, including the Enrollee, to do this. You must give QualChoice any facts we needs to apply those rules and determine Benefits payable. If you fail to provide this information, we may delay Benefit payments.

6.6. Facility of Payment

A payment made under another health policy may include an amount that should have been paid under this Plan. If it does, QualChoice may pay that amount to the other plan or policy that made that payment. That amount will then be treated as though it were a benefit paid by QualChoice under this Certificate. QualChoice will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.7. Right of Recovery

If we pay more for Covered Services than this provision allows, we have the right to recover the excess payment. You agree to do whatever is necessary to secure our right to recover excess payments.

6.8. Hospitalization When Coverage Begins

Consistent with applicable law, if an eligible Enrollee is inpatient in a hospital on the effective date of this Certificate and immediately prior to such effective date was covered by another group health policy that provides coverage for hospital or medical services or expenses, coverage for benefits under that other policy, contract, or certificate will continue and it will be the primary policy for those services and expenses associated with that hospital admission. As the primary policy, that group health policy will be responsible for those services and expenses until the end of that hospital admission or until the expiration of any applicable extension of benefits provided under such group health policy, whichever occurs first.

7. COMPLAINTS AND APPEALS

We have authority and full discretion to determine all questions, problems or disputes, arising in connection with Benefits, including but not limited to eligibility, interpretation of Policy language and findings of fact about such questions. Our actions, determinations and interpretations with respect to all such matters, and with respect to any matter within the scope of our authority, shall be conclusive and binding on the Enrollee. Any problem or Claims dispute between an Enrollee and us must go through our complaint and appeals process. If the problem or dispute is over a determination of Medical Necessity, classification of treatment as Experimental or Investigational or involves an Expedited Appeal, the appeal process is controlling.

7.1. Initial Communication and Resolution of a Problem or Dispute

We welcome and encourage (but do not require) discussion of any inquiry, complaint or dispute concerning interpretation of the provisions of this Policy. A Customer Service representative will make every effort to resolve the issue. If we are unable to resolve the issue to the satisfaction of the Enrollee, the Enrollee has the right to request an Internal Review.

1. **Definition:** A complaint is an expression of dissatisfaction about us. A complaint, however, is not and will ***not*** be considered to be or handled as an "appeal" as described in Section 7.3 below. An "appeal" must be initiated and conducted as described in Section 7.3 below.
2. **Oral Complaints:** An Enrollee having a complaint regarding anything about us may contact a Customer Service Representative at 501-228-7111 or 1-800-235-7111 to assist in resolving the matter informally. The Enrollee may submit a written complaint if not satisfied with the resolution. An Enrollee is not required to make an oral complaint prior to submitting a written complaint.
3. **Written Complaints:** The Enrollee may submit a written complaint to us at the following address:

   QualChoice
   Attention: Appeals and Grievance Coordinator
   P. O. Box 25610
   Little Rock, Arkansas 72221

4. **Complaint Resolution.** We will acknowledge receipt of a written complaint within 5 working days. We will investigate the complaint and send the Enrollee a response with resolution. If we are unable to resolve the written complaint within 30 calendar days due to circumstances beyond our control, we will provide notice of the reason for the delay before the 30th calendar day.

7.2. Types of Requests and Claims

1. **Pre-Service Request:** A Pre-Service Request is a request for a service that requires prior notification and approval of the benefit prior to receiving the service. These are services, for example, that are subject to pre-certification as set forth in the Pre-Authorization of Services section of this Policy.
2. **Post-Service Claims:** Post-Service Claims are those Claims for services that have already been received by the Enrollee.
3. **Urgent Care Request:** An Urgent Care Request is a request for a service that a physician with knowledge of the Enrollee's medical condition has determined that without the service the Enrollee's:

   A. Medical condition would subject the Enrollee to severe pain that cannot be adequately managed; or

   B. Life, health or ability to regain maximum function could be seriously jeopardized.

4. **Concurrent Care Request**: A Concurrent Care Request is a request for a service that arises when Medical Necessity of an on-going course of treatment to be provided over a period of time has been approved.
5. **Administrative Issues**: We consider issues such as those regarding eligibility, coverage, level of coverage, rescission of coverage (that is, cancellation or discontinuance of coverage retroactively (unless due to lack of timely premium payment)), and adherence to prescribed procedures as Administrative Issues.
6. **Medical Issues**: We consider issues such as a determination of Medical Necessity, the definition of a medical treatment as Experimental or Investigational, or the sufficiency of clinical information to make a coverage determination, to be a Medical Issue.

7.3. Appeal Process

1. **Initiating a Pre-Service, Concurrent Care, or Post-Service Internal Appeal:** The Enrollee (or the Enrollee's healthcare provider with regard to a Pre-Service Request, Concurrent Care Request or Urgent Care Request) has 180 calendar days from the date of receipt of the initial determination was made to file a formal written appeal, under this Section 7. To initiate an appeal, an Enrollee (or the Enrollee's healthcare provider) must write to our complaint and appeals coordinator at the following address:

   Appeals and Grievance Coordinator
   QualChoice
   P.O. Box 25610
   Little Rock, AR 72221-5610

   This appeal may also be faxed to:

   Appeals and Grievance Coordinator
   QualChoice
   Fax #: 501-228-9413

2. **Appeal of Pre-Service Request and Concurrent Care Request**

   A. **Internal Appeal of Administrative Issues.** After receipt of the written appeal, the Internal Appeal Reviewer will conduct an investigation of the appeal. The Internal Appeal Committee meeting at our office will hear an Internal Appeal of an Administrative Issue. The Enrollee and/or the treating healthcare provider has the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Internal Appeal Committee's questions. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

   B. **Internal Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Internal Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Internal Appeal to a medical director for review and we will notify the Enrollee of a decision within fifteen (15) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

   C. **Expedited Appeals**. A request for an expedited appeal for a Pre-Service Request or Concurrent Care Request will be treated as an appeal of an Urgent Care Request as

described in Section 7.3(4) below subject to the request meeting the criteria for an Urgent Care Request.

3. **Appeal of Post-Service Claims**

   A. **Internal Appeal of Administrative Issues.** After receipt of the written appeal, the Internal Appeal Reviewer will conduct an investigation of the appeal. The Internal Appeal Committee meeting at our office will hear a Internal Appeal of an Administrative Issue. The Enrollee has the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Internal Appeal Committee's questions. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

   B. **Internal Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Internal Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Internal Appeal to a medical director for review and we will notify the Enrollee of a decision within thirty (30) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

   C. **No Expedited Appeals**. There are no expedited appeals for Post-Service Claims.

4. **Appeal of Urgent Care Request**

   A. **Initiating an Internal Appeal.** If the Enrollee requests an expedited review and a health care professional with knowledge of the Enrollee's medical condition certifies the determination as a general pre-service request that would seriously jeopardize the Enrollee's life or health or the Enrollee's ability to regain maximum function, the Enrollee or their health care professional may submit an appeal to the Appeals and Grievance Coordinator by facsimile to 501-228-9413.

   An expedited appeal may be submitted by telephone, 501-228-7111 or 1-800-235-7111 followed by a written confirmation.

   B. **Internal Appeal.** An appeal of an Urgent Care Request will be handled by us as a Medical Issue. A medical director will make the determination on review at both levels of appeal in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Appeals Coordinator initially receives the request for review.

7.4. Documentation

1. **Written Appeals:** All appeals must be submitted in writing and include the Enrollee's name, identification number, and reference to the specific appealed Claim. However, an appeal related to an Urgent Care Request as defined in Section 7.2(3) above can initially be submitted orally so we can immediately commence consideration. We require written confirmation of such Urgent Care Request appeal even though investigation will have begun.

2. **Right to Information of Enrollee:** We will provide the Enrollee, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information that:

   A. Were relied upon in making the benefit determination;

B. Were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
C. Demonstrate compliance with the terms of the Policy; and
D. Constitute a statement of policy or guidance with respect to the Policy concerning the denied treatment option or benefit for the Enrollee's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In addition, we will provide the Enrollee, free of charge, with any new or additional rationale and/or evidence we consider, rely on, or is generated in connection with the appeal. We will provide this rationale and/or evidence as soon as possible and sufficiently in advance to allow the Enrollee a reasonable opportunity to respond prior to the date of a determination on the appeal being made by us.

3. **Right of Enrollee to Submit Information:** The Enrollee may submit with the request for an appeal any additional written comments, issues, documents, records and other information relating to the request or Claim. The Enrollee and the treating health care provider(s) are required to provide individual(s) reviewing the appeal, upon request, access to information necessary to determine the appeal. Such information should be provided not later than 5 days after the date on which the Appeals Reviewer's request for information is received, or, in the case of an Urgent Care Request or Concurrent Care Request, at such earlier time as may be necessary to comply with the applicable timelines. The Enrollee's failure to provide access to such information shall not remove the obligation of the Appeals Reviewer to make a determination on the appeal, but not providing the requested information may affect the Appeals Reviewer's determination. When adequate medical records for consideration of the appeal do not accompany the appeal of a medical issue, there are only two options: denial of the appeal or delay of the decision until we receive the records. We will inform the Enrollee of the process of obtaining the medical records, an effort in which the Enrollee may assist. At any point, the Enrollee may insist we make a determination based on the records then available, in which case we will render the decision within thirty (30) days.

7.5. Conduct of Appeals

An appeal is conducted following the procedures below.

1. **Scope of Review**: The Appeals Reviewer(s) shall conduct a complete review of all information relating to the request or Claim and shall not afford deference to the initial determination or previous appeal review in conducting the review.
2. **Qualifications of Appeals Reviewer**: The Appeals Reviewer is an individual or committee of individuals selected by us with appropriate expertise and who did not deny the request or Claim that is the subject of the appeal.
3. **Review of Medical Judgment**: When reviewing a request or Claim in which the determination was based in whole or in part on medical judgment, including determination with regard to whether a particular treatment is experimental, investigational, or not Medically Necessary or appropriate, we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual consulted in the initial determination, nor the subordinate of such individual. Upon request of the Enrollee, the identity of the health care professional(s) consulted in conducting the review who are our employees will be provided, without regard to whether we relied upon the advice of the health care professional in making the benefit determination.

7.6. Legal Actions

Prior to initiating legal action, the Enrollee must complete the appeal process in accordance with this Section. No one may bring legal action after the expiration of 3 years from the required submission time of the request or Claim.

7.7. Authorized Representative

1. **One Authorized Representative:** An Enrollee may have one representative and only one representative at a time, to assist in making a complaint, submitting a request or Claim, or appealing an unfavorable determination.

2. **Authority of Authorized Representative:** An Authorized Representative shall have the authority to represent the Enrollee in all matters in connection with the Enrollee's complaint, request, Claim or appeal of a determination. If the Enrollee has an Authorized Representative, references to the terms "The Enrollee" or "Enrollee" in this document refer to the Authorized Representative.

3. **Designation of Authorized Representative:** One of the following persons may act as an Enrollee's Authorized Representative:

   A. An individual designated by the Enrollee in writing in a form approved by us;
   B. The treating provider, if it is a Pre-Service Request, a Concurrent Care Request, or an Urgent Care Request, or if the Enrollee has designated the provider in writing in a form approved by us (Note: An assignment of benefits to a provider will not constitute appointment of that provider as an authorized representative);
   C. A person holding the Enrollee's durable power of attorney;
   D. If the Enrollee is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Enrollee by a court of competent jurisdiction; or
   E. If the Enrollee is a minor, the Enrollee's parent or legal guardian, unless we are notified the Enrollee's request or Claim involves health care services where the consent of the Enrollee's parent or legal guardian is or was not required by law and the Enrollee shall represent himself or herself.

4. **Term of the Authorized Representative:** The authority of an Authorized Representative shall continue for the period specified in the Enrollee's appointment of the Authorized Representative or until the Enrollee is legally competent to represent him or herself and notifies us in writing the Authorized Representative is no longer required or authorized.

5. **Communication with Authorized Representative:** If the Authorized Representative represents the Enrollee because the Authorized Representative is the Enrollee's parent or legal guardian or attorney in fact under a durable power of attorney, we shall send all correspondence, notices and benefit determinations to the Authorized Representative.

   If the Authorized Representative represents the Enrollee in connection with the submission of a Pre-Service Request or Concurrent Care Request, including a Claim involving Urgent Care, or in connection with an appeal, we shall send all correspondence, notices and benefit determinations to the Authorized Representative. If the Authorized Representative represents the Enrollee in connection with a Post-Service Claim, we will send all correspondence, notices, and benefit determinations in connection with the Enrollee's Claim to the Enrollee, but we will provide copies of such correspondence to the Authorized Representative upon request. The Enrollee understands it will take us a reasonable period, approximately 30 days, to notify all its personnel about the termination of the Enrollee's Authorized Representative and we may communicate information about the Enrollee to the Authorized Representative during the notification period.

7.8. External Medical Review

After you have exhausted your Internal Appeal rights with QualChoice and QualChoice has made its final determination with regard to your appeal, a voluntary external review process may be available

to you. To find out more about this external review process, including an external expedited review in the event of an Urgent Care Request, please contact QualChoice's Appeals and Grievance Coordinator at 501-228-7111 or 1-800-235-7111.

The external review process is only available if the determination you appealed was based on whether the healthcare service was Medically Necessary or experimental/investigational and the adverse determination by QualChoice will cause you to have medical expenses in excess of $500.00.

An external review is not available for such things as a denial based on an express exclusion in this Policy, an express limitation in this Policy, dollar limits under this Policy, fraud or misrepresentation, or failure to follow procedures in obtaining healthcare provider access.

Your request for an external medical review must be made within sixty (60) days of your receipt of QualChoice's denial and in writing to:

Appeals and Grievance Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

The written communication must be marked and identified as a "*Request for External Review*".

The medical review would be conducted by an independent, external medical review organization selected by QualChoice from a list of approved organizations maintained by the Arkansas Department of Insurance. You would be required to pay a $25.00 fee to file the request for the external review which would be refunded to you in the event QualChoice's determination is reversed by the independent medical review organization.

As part of the external review process, you have the opportunity to submit additional information to QualChoice related to your Claim for consideration by the external review organization for consideration. You will be required to authorize the release of any medical records necessary for the external review organization to reach a decision.

The determination by the external review organization is binding and final on you, and QualChoice, unless other remedies are available under applicable state or federal law.

You may contact the Arkansas Insurance Commissioner for assistance at any time. The mailing address is: Arkansas Insurance Department, Attn: External Review Assistance, 1200 West Third Street, Little Rock, AR 72201. Their telephone number is 501-371-2640 or toll free 800-852-5494. Their email address is insurance.consumers@arkansas.gov.

8. SUBROGATION

If you have an injury or illness caused by a third party, we will provide Covered Services for such injury or illness. Acceptance of such Covered Services constitutes consent to the provisions of this Section. We will require a recovery authorization signed by you. This is a prerequisite to recovery by us against any third party for the cost of Covered Services. Our recovery rights under this Section 8 extend to worker's compensation and uninsured and underinsured motorist coverage.

You agree to protect our lien rights if an injury or illness is suffered and caused by a third party. You may be due money from a third party for the cost of Covered Services. If so, our liability for Benefits will be subrogated to any such recoveries. We have the right to sue any third party in your name, as permitted by applicable state law. If payment is received from a third party for the cost of Covered Services, you are obligated to reimburse us. Reimbursement to us may be reduced by our pro rata share of reasonable attorney's fees and costs incurred in obtaining such recovery.

You agree to cooperate fully to facilitate enforcement of our rights under this Section 8. This may include executing, delivering and filing further documents and instruments. You also agree to furnish such

information and assistance, as we may reasonably require to fully enforce the terms of this Section 8. You agree to take no action prejudicing our rights and interests under this Section 8.

9. GENERAL PROVISIONS

9.1. Amendment

QualChoice reserves the right to change the benefits, conditions and premiums covered under the Policy, including the terms of this Policy. If we do so, we will give thirty (30) days written notice to you and the change will go into effect on the date fixed in the notice.

9.2. Assignment

Benefits or monies due under this Policy cannot be assigned to any person, corporation, organization or other entity. Any assignment will be void and have no effect. Assignment means the transfer of a right to the Benefits provided under this Policy. We reserve the right to make payment of Benefits directly to the healthcare provider that rendered the service.

9.3. Notice

Any notice we give to an Enrollee will be in writing. It will be mailed to him or her at the home address as it appears in our records. Notice to us must be in writing and mailed to our offices at:

QualChoice
12615 Chenal Parkway, Suite 300
P.O. Box 25610
Little Rock, AR 72221-5610

9.4. Medical Records

We may need to obtain copies of an Enrollee's medical records from any of the Enrollee's treating providers. This may be necessary to properly administer Benefits. The Enrollee, or the Enrollee's legal representative, agrees to sign an appropriate authorization for release of medical records upon our request. By accepting Benefits under this Policy, an Enrollee authorizes and directs any person or entity to furnish us with information and copies of records related to healthcare services provided by them to that Enrollee. If an Enrollee elects not to consent to the release of medical records, or if your provider fails to comply with a request for records, we may be unable to properly administer coverage. If this occurs, we have the right to deny payment for impacted Covered Services.

9.5. Notice of Claim

We must receive an Enrollee's Claim for Benefits within no more than 12 months from the date the Enrollee receive the service. Failure to meet this requirement will result in payment denial.

9.6. Claim Forms

If you notify us about a claim for service, we will provide you with a Claim Form within 15 day of your request. The forms are also available on our website www.qualchoice.com.

9.7. Processing of Claims

We will pay or deny a claim for which we have all the information we require, within 30 days after we receive the claim if it was submitted electronically, or within 45 days after receipt if it was submitted through other means. We will notify you within 30 days after receipt of the claim if we determined we require additional information.

9.8. Who Receives Payment Under This Policy

We will make payments under this Policy directly to the Network Providers providing care. If an Enrollee receives Covered Services from any Out-of-Network Provider, we reserve the right to pay either the Policy Holder, Enrollee or the provider.

9.9. Recovery of Overpayments

On occasion, an incorrect payment may be made to you. Reason for this may include when you are not eligible, the service is not covered, or Coordination of Benefits was omitted. When this happens, we will explain the problem in writing. The amount of the mistaken payment must return to us within 60 days. Alternatively, you must provide us with written notice stating the reasons why you may be entitled to such payment. In accordance with applicable law, we may reduce future payments to you in order to recover any mistaken payment. We will recover overpayments and mistaken payments made to providers directly from them.

9.10. Confidentiality

Medical records and other information concerning an Enrollee's care we receive from providers are confidential. We will use such information only to administer the Enrollee's coverage. We will only disclose such information as required or permitted by law and as set out in the QualChoice Notice of Privacy Practices at www.qualchoice.com.

9.11. Complaint and Appeals

An Enrollee is entitled to have any complaints heard by us. We are obligated to hear such complaints, including complaints against Network Providers, in an equitable fashion. The rules and procedures set forth in Section 7 will be followed.

9.12. Right to Develop Guidelines

We reserve the right to develop or adopt guidelines for the administration of Benefits under this Policy. These criteria will be interpretive only and will not be contrary to any terms of this Policy. If you have a question about the criteria used to apply to a particular Benefit, you may contact us or visit our website at www.qualchoice.com for further information.

9.13. Limitation on Benefit of This Policy

No person or entity other than our Enrollees and us shall be entitled to bring any action to enforce any provision of this Policy. The covenants, undertakings, and agreements set forth in this Policy shall be solely for the benefit of our Enrollees and us.

9.14. Misstatement of Age

If the age of the insured has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

9.15. Applicable Law

This Policy, the rights and obligations of our employees and us under this Policy, and any Claims or disputes relating thereto, shall be governed by and construed in accordance with Arkansas law. If any provision of this Policy that, on its Effective Date, is in conflict with Arkansas law, then that provision is automatically changed to conform to the least minimum requirements of the law.

9.16. Headings

Section and subsection headings contained in this Policy are inserted for convenience of reference only. They shall not be deemed to be part of this Policy for any purpose. They shall not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

9.17. Pronouns

All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

9.18 Recission

Subject to the time limits set out in Section 9.19, we may rescind coverage under this Policy if an Enrollee performs an act, practice, or omission that constitutes fraud, or the Enrollee makes an intentional misrepresentation of material fact. In the event we rescind coverage, we have the right to demand that you pay back all the Benefits we paid to you or on your behalf during the period of time that you should not have been covered under this Policy. In these circumstances, we may also

obtain refunds from providers that rendered services to you when coverage should not have been provided, in which case that provider may seek to obtain reimbursement from you for the amount obtained by us from that provider.

9.19 Severability

If any part of any provision of this Policy or any document or writing given pursuant to or in connection with this Policy shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity or unenforceability only. Such invalidity or unenforceability will in no way affect the remaining parts of such provision or the remaining provisions of this Policy.

9.20 Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

9.21 Time Limit on Certain Defenses

After three (3) years from the date of issuance of this Policy, no misstatements, except fraudulent misstatements, made by the applicant for the Policy shall be used to void the Policy or to deny a Claim for loss incurred after the expiration of such three (3) year period. No Claim for loss incurred, as defined in this Policy, commencing after three (3) year from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of this Policy.

9.22 Waiver

The waiver by us or any Enrollee hereunder of a breach of or a default under any of the provisions of this Policy shall not be construed as a waiver of any subsequent breach or default of a similar nature. The failure of any of such parties, on one or more occasions, to enforce any of the provisions of this Policy or to exercise any right or privilege hereunder, shall not be a waiver of any of such provisions, rights or privileges hereunder.

9.23 Entire Policy; Changes

This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

10. DEFINITIONS

There are other definitions, usually capitalized, contained in various Sections throughout this Policy. The capitalized words or terms used in this Policy and are not otherwise defined have the meanings set forth below:

10.1 **"Accidental Injury"** means a bodily injury happening unexpectedly and taking place not according to the usual course of events (for example an automobile accident), and which is the direct cause of the loss, independent of disease or bodily infirmity. Accidental injury to teeth does not include any damage caused by chewing or biting any object.

10.2 **"Advanced Diagnostic Imaging"** includes but is not limited to Computerized Tomography (CT), Computerized Tomography Angiography (CTA), Coronary CT & CTA, CT Bone Density (QCT), Diagnostic CT Colonography, Functional MRI Brain (fMRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Magnetic Resonance Spectroscopy (MRS), Nuclear Cardiology, Positron Emission Tomography scanning (PET), Screening CT Colonography, and SPECT.

10.3 **"Benefits"** means reimbursement or payments for health care available to the Enrollee covered under this Policy.

10.4 **"Benefit Summary"** means a document containing specific information relating to coverage and Cost Sharing Amounts under this Policy. The information may include amounts for Deductibles, Co-payments, Coinsurance, Out-of-Pocket Limits and lifetime maximum Benefits as well as visit and day maximums for limited services.

10.5 **"Calendar Year"** means the period of one year beginning January 1 and ending on December 31 as identified in your Benefits Summary.

10.6 **"Claim for Benefits" or "Claim"** means (i) a request for payment or prior approval (when required under the Policy) for a service, supply, medication, equipment or treatment covered by the Policy, (ii) that is submitted to us by an Enrollee, a healthcare provider with an assignment of benefits from the Enrollee, or an Enrollee's authorized representative, and (iii) is submitted consistent with QualChoice's standard Claim filing policies and procedures (copies of which are available on request).

10.7 **"Coinsurance"** means a fixed percentage of the Maximum Allowable Charge the Enrollee must pay toward the cost of certain Covered Services for each Calendar Year. Those Covered Services subject to the application of Coinsurance are identified in the Benefit Summary. Coinsurance is subject to an annual maximum limit.

10.8 **"Complications of Pregnancy"** means hospital confinement required to treat conditions, such as the following, in a pregnant female: acute nephritis, nephrosis, cardiac decompensation, HELLP syndrome, uterine rupture, amniotic fluid embolism, chorioamnionitis, fatty liver in pregnancy, septic abortion, placenta accrete, gestational hypertension, puerperal sepsis, peripartum cardiomyopathy, cholestasis in pregnancy, thrombocytopenia in pregnancy, placenta previa, placental abruption, acute cholecystitis and pancreatitis in pregnancy, postpartum hemorrhage, septic pelvic thromboplebitis, retained placenta, venous air embolus associated with pregnancy, miscarriage, or an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of descent or dilitation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a c-section delivery is not considered to be an Emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section. "Complications of Pregnancy" also means treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism, hepatitis B or C, HIV, Human papilloma virus, abnormal PAP syphilis, chlamydia, herpes, urinary tract infections, thromboembolism, appendicitis, hypothyroidism, pulmonary embolism, sickle cell disease, tuberculosis, migraine headaches, depression, acute myocarditis, asthma, maternal cytomegalovirus, urolithiasis, DVT prophylaxis, ovarian dermoid tumors, biliary atresia and/or cirrhosis, first trimester adnexal mass, hyditidiform mole or ectopic pregnancy. Management of a difficult pregnancy is not considered to be a "Complication of Pregnancy".

10.9 **"Co-payment"** means a fixed dollar amount the Enrollee must pay each time the Enrollee receive a particular Covered Service to which a Co-payment applies.

10.10 **"Cost Sharing Amount"** means an amount the Enrollee is required to pay each time the Enrollee receives a particular service to which Deductibles, Co-payments, Coinsurance or benefit limitations apply. These requirements are set forth in the Benefit Summary.

10.11 **"Covered Services"** means services or supplies for which Benefits are available (i.e., payments may be made) as described in this Policy. Covered Services do not include services or supplies and care excluded pursuant to Section 4 or which do not meet the definition of "Medically Necessary" in this Section and the other qualifications set forth in Section 3.

10.12 **“Custodial Care”** means provision of routine care, including assistance with activities of daily living, to a person who is disabled mentally or physically and that disability is expected to continue for an extended length of time. “Custodial Care” can include services and supplies ordered by the Enrollee’s physician and services and supplies provided by a registered nurse, a licensed practical nurse, or licensed visiting nurse. Even if “Custodial Care” is needed by an Enrollee, it is not care that is covered under this Policy.

10.13 **"Deductible"** means a certain fixed dollar amount you or the Enrollee must incur before we begin to pay for the cost of Covered Services provided to the Enrollee during each Calendar Year.

10.14 **"Emergency"** means those health care services provided on a 24 hour/365 days a year basis to evaluate and treat medical conditions of a recent onset and severity, leading a prudent lay person, possessing an average knowledge of medicine and health, to believe his or her condition, sickness, or injury is of such a nature where failure to seek immediate medical care could result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

10.15 **"Enrollee"** means a Policy Holder.

10.16 **"Enrollment Application"** means the form to be accurately completed by a prospective Policy Holder to apply for coverage.

10.17 **“Injectable Prescription Medications”** means any injectable pharmaceutical that has been approved by the Food and Drug Administration and can be obtained only through a prescription. QualChoice has classified selected medications, primarily immunizations and allergy and antibiotic injections, as “Office Services-Minor” or “Office Services-Other”.

10.18 **“Maternity Care and Obstetrical Care”** means services associated with premature rupture of membranes, false labor, occasional spotting in pregnancy, pre-term labor, pre-term birth, physician directed rest during pregnancy, morning sickness, hyperemesis gravidarum, celphalopelvic disproportion, intrauterine growth retardation, analysis for fetal down syndrome, trisomey 18 or neural tube defect, congenital diaphragmatic hernia, hydrops fatalis, group B strep prophylaxis in pregnancy, isoimmunization in pregnancy, antepartum fetal surveillance, management of hyperemesis, cervical incompetence, fetal urethral obstruction, twin or greater gestation with prior uterine atony, macrosomia, incompetent cervix, forceps delivery, fetal fibronectin, cytotec for induction of labor, sudden onset of polyhydramnios, prophylactic cesarean delivery of HIV positive mother, Klippel-Trenaunay Syndrome, caudal regression syndrome, hospitalization to postpone delivery until the fetus is further developed, biophysical profiles, fetal monitoring, non-routine ultrasounds, vaginal delivery, antepartum and postpartum care, or services related to c-sections scheduled because of (i) multiple gestation, (ii) previous c-section delivery, (iii) patient or physician convenience, (iv) cephalopelvic disproportion, or (v) abnormal presentations such as breech, shoulder dystonia, transverse and compound.

10.19 **"Maximum Allowable Charge”** means the schedule of fees established by us for payments to providers for Covered Services and which may be less than actual charges billed by Network Providers or Out-of-Network Providers. **Please Note:** All Benefits under this Policy are subject to and shall be paid only by reference to the Maximum Allowable Charge as determined at the discretion of QualChoice. This means that regardless of how much a health care provider may bill for a given service, the Benefits under this Policy will be limited by the Maximum Allowable Charge we establish. If a Network Provider is used, that provider is obligated to accept our established rate as the Maximum Allowable Charge, and may only bill you for your Cost Sharing Amounts and any non-Covered Services; however, if an Out-of-Network Provider is used, you will be responsible for all amounts billed in excess of the Maximum Allowable Charge.

10.20. **"Medically Necessary" or “Medical Necessity”** means a Covered Service which in the opinion of our medical personnel:

1. Provides for the diagnosis or treatment of the Enrollee's covered medical conditions;
2. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's specific illness, injury or medical condition in relation to any overall medical/health conditions;
3. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
4. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and
5. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

10.21. **"Medical Policy" or "Medical Policies"** means a statement developed by QualChoice that sets forth the medical criteria for coverage under QualChoice's benefit Policy or insurance policy. Limitations of benefits related to coverage of a medication, treatment, service, equipment or supply are also outlined in the Medical Policies. Medical Policies are or are based on nationally accepted guidelines and peer reviewed medical literature. Our Medical Advisory Committee reviews and approves all internally developed Medical Policies. Medical Policies are available from QualChoice, at no cost, upon request, or the Medical Policies can be reviewed on QualChoice's web site at www.qualchoice.com.

10.22 **"Medical Supplies"** means a device or equipment that is of such a nature that it is not generally used repeatedly and is usually used by a person for a medical purpose.

10.23 **"Mental Health or Substance Use Disorder"** means any psychiatric disorder or disorder of emotion or thought, appropriately classified as an Axis I diagnosis in accordance with the current edition of the Diagnosis & statistical Manual of Mental Diseases of the American Psychiatric Association (DMS) classification.

10.24 **"Network Facility"** means a hospital that has entered into an agreement with us to make Covered Services available to Enrollees.

10.25 **"Network Primary Care Physician"** means a physician who has entered into an agreement with us retarding, among other things, willingness to provide primary care Covered Services to Enrollees and who may be utilitized by an Enrollee as his or her primary care physician.

10.26 **"Network Physician"** means a physician who has entered into an agreement with us regarding, among other things, providing and arranging for the provision of Covered Services to Enrollees.

10.27 **"Network Provider"** means a Network Physician, Network Specialist, Network Facility or other provider having an agreement with us to make Covered Services available to Enrollees.

10.28 **"Network Specialist"** means a medical or surgical specialist who has entered into an agreement with us to make Covered Services available to Enrollees.

10.29 **"Out-of-Network Provider" or "Out-of-Network Facility"** means a physician, hospital or other provider that has not entered into an agreement with us to make Covered Services available to Enrollees.

10.30 **"Out-of-Network Service"** means a Covered Service provided to an Enrollee by an Out-of-Network Provider.

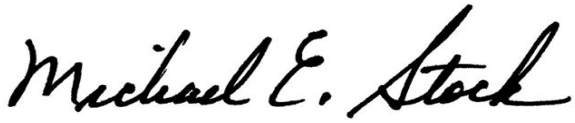
10.31 **"Out-of-Pocked Limit"** means the maximum amount you pay every Calendar Year as set out in your Benefits Summary.

10.32 **"Policy Holder"** means you, the individual to whom this Policy is issued.

10.33 **"Referral"** means a specific written approval an Enrollee seeks additional evaluation or treatment from an Out-of-Network Provider. A general statement by a Network Provider stating a patient should seek a particular type of service or provider does not constitute a Referral under this Policy. We issue referrals for a specific period as determined by us. It is

your responsibility to ensure all services provided to you are completed during the appropriate period. If services are rendered outside the approved period, Benefits will be allowed at Out-of-Network reimbursement levels.

10.34 **"Service Area"** means the geographical area in which we are licensed by the State of Arkansas to conduct business**.**



Michael E. Stock, President & CEO
QCA Health Plan, Inc. ("QualChoice")
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211

ARKANSAS CONSUMER INFORMATION NOTICE

If you need additional information about this Policy, please contact us at:

QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211
(501) 228-7111

If QualChoice is unable to respond to your questions, you should contact:

Arkansas Insurance Department
Consumer Services Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

COMPREHENSIVE HEALTH EXPENSE COVERAGE POLICY FOR INDIVIDUAL MINOR

IMPORTANT NOTICE

COVERED BENEFITS RECEIVED FROM AN OUT-OF-NETWORK PROVIDER, EXCEPT IN CERTAIN CIRCUMSTANCES (SEE SECTION 2), ARE PAID AT A RATE LESS THAN THE SAME COVERED SERVICES RECEIVED FROM A NETWORK PROVIDER. SEE YOUR BENEFIT SUMMARY.

OTHER INSURANCE REDUCES BENEFITS – READ CAREFULLY

Attached is the Benefit Summary, showing the name of Policyholder, Policy Number, premiums and Effective Date of this Policy ("Effective Date").

GUARANTEED RENEWABLE CONDITIONED
UPON RESIDENCE IN ARKANSAS
PREMIUMS SUBJECT TO CHANGE

THIS POLICY HAS SEVERAL SPECIFIC EXCLUSIONS. (SEE SECTION 4)

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* available from www.medicare.gov or 800-633-4227.

OUTLINE OF COVERAGE

If you are not satisfied with any of the terms or conditions of this Policy, you may return it to us within ten (10) days of its delivery to you and receive a full refund of all premiums you have paid.

READ YOUR POLICY CAREFULLY. This Outline of Coverage provides a brief description of the important features of this Policy. This Outline is not the Policy and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and us. ***It is, therefore, important that you read your Policy carefully***.

POINT OF SERVICE COVERAGE. Policies of this type are designed to provide coverage for hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any applicable Cost Sharing Amounts as referenced in the Benefit Summary or other limitations set forth in the Policy.

BENEFITS

Deductible: As shown on the Benefit Summary per Calendar Year.

Out-of-Network Providers: Covered Services received from an Out-of-Network Provider, except in certain circumstances (see Section 2), are allowed at a rate less than the same Covered Services received from a Network Provider. (See the Benefit Summary.)

Covered Services: Subject to payment of your Coinsurance and Deductible at the amount reflected in the Benefit Summary:

- Daily hospital room and board
- Miscellaneous hospital services
- Surgical services
- Anesthesia services
- In-hospital medical visits
- Out-of-hospital care

Age Limitations: This Policy provides individual coverage for an Enrollee less than 19 years of age and will terminate when Enrollee becomes 19 years of age.

Medicare Eligibility: If you are eligible for Medicare, you are not eligible to begin or continue coverage under this Policy.

Calendar Year Coinsurance Maximum: See the Benefit Summary to determine the amount of the Calendar Year Coinsurance maximum Benefits.

Special Limitations:

Durable Medical Equipment:	A maximum payment of $5,000 per Calendar Year per Enrollee. See the Benefit Summary for Cost Sharing Amount
Ambulance:	See the Benefit Summary
Home Health Services:	A maximum of 40 visits per Calendar Year see the Benefit Summary for Cost Sharing Amount

Physical, Occupational, Speech Therapy, Chiropractic & Audiology Care:	A maximum of a total combined 45 visits per Calendar Year. See the Benefit Summary for Cost Sharing Amount
Skilled Nursing Facilities:	Thirty (30) days per Calendar Year

Benefits and Services Are ***Not*** Included For:

- Routine Maternity Care and Obstetrical Care, unless covered by a Maternity Rider;
- Psychiatric conditions and substance abuse services, unless covered by a Mental Health and Substance Abuse Rider;
- Injuries or disease caused by war;
- Dentistry, except for Accidental Injury (See Section 3.4), anesthesia (See Section 3.5) and oral surgery (See Section 3.6);
- Dental x-rays;
- Eye refractions, unless needed because of Accidental Injury;
- Eyeglasses or hearing aids, unless needed because of Accidental Injury;
- Cosmetic surgery, unless needed because of Accidental Injury or breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998;
- Health services and supplies not meeting Medical Necessity criteria or that are not associated with a Covered Service;
- Prescription drugs for outpatient use filled by a prescription order or refill and non-injectable medications given in a physician's office except in an Emergency are not covered, unless covered by a prescription drug rider;
- Medical or hospital services collectible under Workers' Compensation or any law providing benefits for dependents of military personnel;
- Services rendered in government hospitals (unless otherwise required by applicable law);
- Intentional self-inflicted injuries;
- In-patient services, including electrocardiograms, x-rays, and laboratory examinations, if they could have been performed safely and adequately on an out-patient basis; and
- Services and supplies that are experimental or investigational in nature.

Guaranteed Renewable/Conditioned On Residence in Arkansas

This Policy and riders are guaranteed renewable as long as your permanent residence is in Arkansas and the Enrollee is under 19 years of age. At any time after the first twelve (12) month period of your coverage under this Policy we can change your premium rate, but only if the rate is changed for all policies and riders of the same form number and premium classification as this Policy. Your premium rate will also change in any month that you attain an age that moves you into a different premium classification established by QualChoice.

Table of Contents

1. INTRODUCTION TO YOUR POLICY 7
   1.1. Who Is QualChoice? 7
   1.2. Changes to This Policy 7
   1.3. Key Information 7
2. HOW THIS POLICY WORKS 7
   2.1. In-Network Benefits 7
   2.2. Out-of-Network Benefits 8
   2.3. Provider Network 9
   2.4. Cost Sharing Requirements 9
   2.5. Member Financial Responsibility Comparison 10
   2.6. Medically Necessary Services 10
   2.7. Exclusion and Limitations 11
   2.8. Coverage While Traveling Out of the Service Area 11
   2.9. General Conditions for Payment 11
   2.10. Administration and Interpretation of this Policy 11
   2.11. Pre-Authorization of Services 12
   2.12. Utilization Management 12
   2.13. Case Management 12
3. COVERED MEDICAL BENEFITS 12
   3.1. Advanced Diagnostic Imaging 13
   3.2. Ambulance Services – Transportation 13
   3.3. Complications of Pregnancy 13
   3.4. Dental – Accidental Injury 13
   3.5. Dental – Anesthesia 14
   3.6. Dental – Oral Surgery 14
   3.7. Dental – Other 14
   3.8. Diabetes Management 14
   3.9. Durable Medical Equipment 15
   3.10. Emergency Health Services 15
   3.11. Eye Examinations 16
   3.12. Family Planning Services 16
   3.13. Home Health Services 16
   3.14. Home Infusion Therapy 16
   3.15. Hospice Care Services 16
   3.16. Facility – Inpatient Care 17
   3.17. Injectable Prescription Medications 18
   3.18. Infertility 18
   3.19. Medical Foods 18
   3.20. Medical Supplies 18
   3.21. Orthotic Services and Orthotic Devices 18
   3.22. Outpatient Services 19
   3.23. Physician Office Services 19
   3.24. Preventive and Wellness Health Services 20
   3.25. Professional Services for Complex Surgery 20
   3.26. Prosthetic Services and Prosthetic Devices 20
   3.27. Reconstructive Surgery 21
   3.28. Skilled Nursing Facility and Inpatient Rehabilitation Services 21
   3.29. Therapeutic and Rehabilitation Services 22
   3.30. Transplantation Services 22
4. NON-COVERED SERVICES, EXCLUSIONS AND LIMITATIONS 23
   4.1. Exclusions From Coverage 23

4.2. Limitations to Benefits 32
5. ELIGIBILITY CRITERIA 34
5.1. Hospitalization When Coverage Begins 34
5.2. Eligibility for Medicare 34
5.3. Who is Eligible for Coverage and When Does Coverage Begin 34
5.4. Maternity Coverage 34
5.5. Termination of Coverage 34
6. COORDINATION OF BENEFITS 36
6.1. How COB Works 36
6.2. Rules to Determine Primary and Secondary Plans 36
6.3. Allowable Expense 37
6.4. Reduction of Benefits 38
6.5. Enforcement of Provisions 38
6.6. Facility of Payment 38
6.7. Right of Recovery 38
6.8. Hospitalization When Coverage Begins 38
7. COMPLAINTS AND APPEALS 39
7.1. Initial Communication and Resolution of a Problem or Dispute 39
7.2. Types of Requests and Claims 39
7.3. Appeal Process 40
7.4. Documentation 41
7.5. Conduct of Appeals 42
7.6. Legal Actions 43
7.7. Authorized Representative 43
7.8. External Medical Review 44
8. SUBROGATION 44
9. GENERAL PROVISIONS 45
9.1. Amendment 45
9.2. Assignment 45
9.3. Notice 45
9.4. Medical Records 45
9.5. Notice of Claim 45
9.6 Who Receives Payment Under This Policy 45
9.7 Recovery of Overpayments 45
9.8. Confidentiality 46
9.9 Complaint and Appeals 46
9.10. Right to Develop Guidelines 46
9.11. Limitation on Benefit of This Policy 46
9.12. Misstatement of Age 46
9.13. Applicable Law 46
9.14. Headings 46
9.15. Pronouns 46
9.16 Rescission ..... Error! Bookmark not defined.
9.17 Severability 46
9.18 Legal Actions 47
9.19 Time Limit on Certain Defenses 47
10. DEFINITIONS 47

1. INTRODUCTION TO YOUR POLICY

1.1. Who Is QualChoice?

QCA Health Plan, Inc. ("QualChoice", also referred to in this Policy as "us", "we" or "our") is a Health Maintenance Organization. QualChoice has a Certificate of authority from the Commissioner of Insurance of the State of Arkansas. We are located at 12615 Chenal Parkway, Suite 300, Little Rock, Arkansas 72211. Our telephone numbers are (501) 228-7111 and (800) 235-7111.

This is your Comprehensive Individual Major Medical Policy (the "Policy") for health care Benefits with us.

1.2. Changes to This Policy

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Policy. When that happens we will send you a new Policy, Rider or Amendment pages thirty (30) days prior to the change going into effect.

1.3. Key Information

For purposes of this Policy and each section of the Policy, "you" or "your" means the Policy Holder.

We have capitalized certain words in this Policy. Those words have special meanings and are defined in Section 10, "Definitions".

Only we have the right to change, interpret, modify, withdraw or add Benefits, as permitted by law, without your approval.

On its Effective Date this Policy replaces and overrules any Policy that we may have previously issued to you. This Policy will in turn be overruled by any policy we may issue to you in the future.

Your coverage under this Policy begins at 12:01 a.m. on the Effective Date as reflected in the Benefit Summary. Coverage will end on the date this Policy is terminated for any of the reasons described in this Policy. We determine your eligibility for Benefits as described in this Policy. This Policy and the Benefit Summary describe the covered Benefits, conditions, limitations, exclusions and Cost Sharing Amounts. The attached Benefit Summary is an integral part of this Policy. In the event this Policy and the Benefit Summary conflict, the Benefit Summary will control. You should locate and familiarize yourself with the Benefit Summary. This Policy describes some special procedures with which you must comply.

The laws of the State of Arkansas shall be the laws that govern this Policy.

If you have questions about your Benefits, payments, or cost sharing, please call us during business hours at (501) 228-7111.

2. HOW THIS POLICY WORKS

This Policy provides flexible choices in obtaining health care services. Care can be sought from any Network Provider under this Policy without a Referral from a Network Primary Care Physician. There is freedom to select either In-Network or Out-of-Network Benefits each time care is sought. Consult the Benefit Summary to identify Covered Services and Cost Sharing amounts for each choice.

2.1. In-Network Benefits

In-Network Benefits are generally paid at a higher level than Out-of-Network Benefits. In-Network Benefits are Covered Services which are either:

1. Provided by or under the direct supervision of a Network Provider in a physician's office or at a Network Facility, or
2. Emergency health services meeting the QualChoice payment guidelines.

Please note that certain Covered Services may only be obtained from a Network Provider. Such Covered Services are identified in the Benefit Summary.

Covered Services may be sought from any Network Physician without a Referral. Coverage for services in the office is at the primary care physician benefit level when Covered Services are sought directly from any Network Primary Care Physician. Coverage for services in the office is at the

specialist benefit level when Covered Services are sought from any other Network Physician. You should validate the status of a Network Provider by calling our Customer Service unit or accessing the on-line provider directory at www.qualchoice.com or calling our Customer Service unit at 800-235-7111. Please refer to the Benefit Summary for details.

2.2. Out-of-Network Benefits

You may seek Covered Services directly from a physician or other provider who is not a Network Provider. Services provided by an Out-of-Network Provider will be covered and reimbursed under your Out-of-Network Benefits unless:

1. **Policy Provision:** The Benefit Summary or this Policy specifically provides a different Deductible, Coinsurance or Out-of-Pocket Limit for the particular service or supply that is the subject of the Claim;
2. **Emergency Services:** The intervention is for an Emergency in which case the In-Network Benefit Deductible, Coinsurance and Out-of-Pocket Limit apply;
3. **Continuity of Care, Prior to Coverage:** You notify QualChoice that prior to the effective date of your coverage, you were scheduled with an Out-of-Network Provider for a procedure or ongoing treatment covered under the terms of this Plan, that such procedure or treatment is for a condition requiring immediate care, and that you request In-Network Benefits for such scheduled procedure or ongoing treatment. If QualChoice approves In-Network Benefits for the scheduled procedure or ongoing treatment, In-Network Benefit Deductible, Coinsurance, and Out-of-Pocket Limit will apply to Claims for services and supplies rendered by the Out-of-Network Provider for such condition after QualChoice's approval until the procedure or treatment ends or until the end of ninety (90) days, whichever occurs first;
4. **Provider Leaves Network:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when your ongoing treatment for an acute condition began and that you request In-Network Benefits for the continuation of such ongoing treatment. If QualChoice approves In-Network Benefits for the requested ongoing treatment, In-Network Deductible, Coinsurance and Out-of Pocket Maximum will apply to Claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to Claims for services and supplies rendered by the Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first;
6. **Provider Leaves Network, Pregnancy:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when you began receiving obstetrical care for a pregnancy covered under the terms of the Plan, that you were in the third trimester of your pregnancy on the date that the Provider left the POS, and that you request In-Network Benefits for continuation of such obstetrical care from this Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested obstetrical care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to Claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to Claims for services and supplies rendered by the Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits; or
7. **Prior Authorization:** You notify QualChoice prior to seeking services of the absence of or the exhaustion of all In-Network resources for a Covered Service resulting in the need to seek care from an Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to Claims for services and supplies received from this Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first.

The amounts allowed for Covered Services accessed under your Out-of-Network Benefits will be subject to the Maximum Allowable Charge. You will be responsible for the applicable Cost Sharing Amounts related to such Covered Services and the difference between the charges billed by the Out-of-Network Provider and the Maximum Allowable Charge. Please refer to your Benefits Summary for details:

Note: Notification to QualChoice of requests for payment of an Out-of-Network Provider services or supplies at In-Network Benefit level must be made by writing to QCA Health Plan, Inc. Attn: Care Management, P.O. Box 25610, Little Rock, AR 72221 or by faxing the request to (501) 228-9413, and must be received at least five (5) working days prior to your receipt of such services or supplies.

2.3. Provider Network

We publish an online directory listing of physicians, facilities, and other healthcare providers who have contractually agreed to provide Covered Services to Enrollees and have them reimbursed at In-Network Benefit level. You may search the directory on our website at www.qualchoice.com. Because contractual agreements can change, you may wish to verify a physician or provider is participating in our Network before care is sought.

We do not practice medicine or provide medical supplies. We are not responsible for any action or inaction of any healthcare provider. We provide no express or implied warranties or guarantees with respect to any Network Provider or the professional services provided by such provider. The utilization of a Network Provider or any other provider and the decision to receive or decline to receive health care services is your responsibility.

If you have a medical condition that we believe needs special services, we may direct you to an appropriate facility or other provider chosen by us. If you require certain complex Covered Services for which expertise is limited, we may direct you to an Out-of-Network Provider. **In both cases, In-Network Benefits will only be paid if Covered Services for that condition are approved by us.** We will not cover any services not specifically authorized by us in the written statement of authorization. The following do not constitute approval for Benefits:

1. A Referral, whether written or oral, by a Network Physician to an Out-of-Network Provider; or
2. An order or prescription for services to an Out-of-Network Provider.

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, availability to Network Providers may be limited. If this happens, we may require you to utilize a single Network Physician to provide and coordinate all future Covered Services. If you do not make a change to a single Network Physician within 31 days of the date we notify you, we will assign a single Network Physician to you. If you fail to use the assigned Network Physician, Covered Services will be paid as Out-of-Network Benefits.

2.4. Cost Sharing Requirements

You must share in the cost of Covered Services through Co-payments, Coinsurance, and Deductibles, or combinations of these Cost Sharing Amounts. Consult the Benefit Summary to determine the amounts of your payments under the Cost Sharing Amounts. A Network Provider may bill you directly for Co-payments, Coinsurance and Deductible amounts, but may not bill for the difference between his or her customary charge and the Maximum Allowable Charge. An Out-of-Network Provider may bill you directly for all applicable Co-payments, Coinsurance and Deductible amounts plus any difference between the total amount of billed charges for services and the Maximum Allowable Charge. **These additional charges could amount to thousands of dollars in additional out-of-pocket expense for which you are responsible.**

1. **Deductible:** The Deductible is a certain dollar amount per Calendar Year, as set forth in the Benefit Summary. You must satisfy the Deductible before we begin to pay for Covered Services to which the Deductible applies.
2. **Co-payment:** A Co-payment is a fixed dollar amount you must pay each time a Covered Service is received to which a Co-payment applies. Co-payment amounts do not apply to the satisfaction of the Deductible amounts or Out-of-Pocket limits for each Enrollee. Please see the Benefit Summary for a list of those Benefits to which Co-payments apply.
3. **Coinsurance:** Coinsurance is a fixed percentage of Maximum Allowable Charges for the cost of Covered Services you must pay per Calendar Year. Coinsurance payments are in addition to Deductibles or Co-payments. The Benefit Summary contains the Coinsurance percentage applicable to specific Benefits. You are responsible for paying the amount of the applicable Coinsurance for the Covered Services provided.

4. **Limits on Out-of-Pocket Payments:** The Enrollee will no longer have to pay Coinsurance for the remainder of the Calendar Year after the Enrollee has met the out-of-pocket limit during the Calendar Year. The Benefit Summary lists the limit on out-of-pocket payments for Coinsurance. Co-payments, Deductibles, or charges in excess of the Maximum Allowable Charge are the patient's responsibility and do not count toward meeting the Limit on Out-of-Pocket Payments. Once your Out-of-Pocket Limits have been satisfied, you will still be responsible for charges in excess of our Maximum Allowable Charge for services provided by an Out-of-Network Provider.

2.5. Member Financial Responsibility Comparison

The following table provides an example of the cost you will pay for a typical inpatient hospital stay utilizing the In-Network Benefits compared to the Out-of-Network Benefits. The amount you will pay may be different based on the benefit plan you select.

	In-Network	Out-of-Network
Facility Billed Charges	$50,000	$50,000
Maximum Allowable Charge	25,000	20,000
Deductible Paid by You	-500	-1,000
Coinsurance Paid by You	-1,000	-2,000
QualChoice Total Payment	$23,500	$17,000
Your Total Financial Responsibility:		
Deductible	500	1,000
Coinsurance	1,000	2,000
Difference Between Maximum Allowable Charge and Billed Charges	0	30,000
Your Total Financial Responsibility	$1,500	$33,000

2.6. Medically Necessary Services

"Medically Necessary" or "Medical Necessity" means a Covered Service which in the opinion of our medical personnel:

1. Provides for the diagnosis or treatment of the Enrollee's covered medical conditions;
2. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's specific illness, injury or medical condition in relation to any overall medical/health conditions;
3. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
4. Is not primarily for the convenience of the Enrollee, his or her physician, or other provider; and
5. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

Regardless of anything else in this Policy, and regardless of any other communications or materials you may receive in connection with this Policy, you will not have coverage for any service, any medication, any treatment, any procedure or any equipment, supplies or associated costs if QualChoice finds it to be not Medically Necessary. All determinations of Medical Necessity for Covered Services are made in accordance with the above definition at the sole discretion of QualChoice.

We reimburse only for Medically Necessary Covered Services as defined in Section 10. This standard applies to all sections of this Policy.

If we determine a service is not Medically Necessary before or after a Network Provider renders it, we prohibit the Network Provider who rendered the service from billing you for the service unless you agreed in writing to be responsible for payment before the service was provided.

If we determine a service is not Medically Necessary before or after an Out-of-Network Provider has rendered it, you will be responsible for the charges for services which are determined not to be Medically Necessary.

We make a determination of Medical Necessity after considering the advice of trained medical professionals, including physicians, who may use medically recognized standards and criteria. In making the determination, we will examine the circumstances of your condition and the care provided, including the reason your provider prescribed or provided the care, and any unusual circumstances, which necessitate attention. However, the fact your physician prescribed the care or service does not automatically mean the care is Medically Necessary or it qualifies for payment under this Policy. A medical treatment that meets the criteria for Medical Necessity will still not be reimbursed if the condition being treated is excluded from coverage as set forth in Section 4.

2.7. Exclusion and Limitations

Some services have specific limitations. Exclusion of other services from coverage is in full or in part. Consult the Benefit Summary and Section 4 for information on benefit limitations and exclusions.

This Policy refers to Medical Policies we have developed that may limit or exclude coverage for a particular service, treatment or drug. You may contact our Customer Service Department to request a copy of our Medical Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Medical Policies on our web site at www.qualchoice.com.

2.8. Coverage While Traveling Out of the Service Area

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

We will deny coverage for routine and follow-up care after Emergency care unless a Network Provider in Arkansas performs the services.

If care is accessed by an Enrollee from providers not participating in the QCNN for an unforeseen illness, reimbursement for Covered Services will be at the Out-of-Network Benefit level.

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

2.9. General Conditions for Payment

Payment for Covered Services is subject to the Enrollee's eligibility on the date such services are rendered, and to all conditions, limitations, and exclusions of the Policy. A final determination of eligibility is made at the time the Claim is received by us. Determination of non-eligibility subsequent to the payment of services as a result of error or fraud will result in recovery of such payments made by us. Benefits are provided only if services provided were ordered by a health care provider, provided within the scope of that health care provider's license, and rendered in accordance with professionally recognized standards of care.

2.10. Administration and Interpretation of this Policy

We have sole and exclusive discretion to interpret the Benefits provided under this Policy as well as all other provisions, terms, conditions, limitations and exclusions in the Policy and to make factual determinations related to the Policy and its Benefits. We may delegate this authority to other persons or entities to provide administrative or Benefit services with regard to this Policy. Subject to applicable law or regulation, we reserve the right to change, interpret, modify, withdraw or add Benefits or

terminate the Policy, in our sole discretion, without prior approval by you. Changes to this Policy will be valid or binding only if in writing and agreed to by an officer of QualChoice.

2.11. Pre-Authorization of Services

Pre-authorization is a determination made prior to services or supplies being provided of whether the services or supplies are Medically Necessary. We must receive sufficient clinical information to establish Medical Necessity. The Medical Necessity for an Out-of-Network Referral will include the absence of or the exhaustion of all In-Network resources. Pre-authorizations are all time-limited.

QualChoice requires that certain Covered Services be pre-authorized. The specific procedures requiring pre-authorization can change based upon new or changing medical technology. We reserve the right to modify the official listing of services requiring pre-authorization as deemed necessary. A listing of the services requiring pre-authorization is maintained on our web site at www.qualchoice.com on the Member Home Page. You may also contact our Customer Service Department to obtain a copy of the listing.

The responsibility for obtaining pre-authorization varies depending on whether you use a Network Provider or an Out-of-Network Provider. Network Providers (not including QCNN providers) are responsible for obtaining the necessary pre-authorizations. Enrollees living outside of the Service Area will be responsible for obtaining pre-authorization to receive Benefits at the In-Network level when accessing care from the QCNN. QCNN providers are not responsible for obtaining a pre-authorization for services. Out-of-Network Providers have no contractual relationship to QualChoice, and therefore are not primarily responsible for obtaining required pre-authorizations. When care is being sought from Out-of-Network Providers, you are responsible for making sure all the providers obtain the required pre-authorizations. The Out-of-Network Providers must supply the clinical information necessary for us to determine Medical Necessity. We will give no pre-authorization without the necessary clinical information.

Pre-authorization is not a guarantee of payment. Even though pre-authorized, payment may not be rendered for any service if the clinical status changed sufficiently such that the service is no longer medically appropriate. Your coverage with QualChoice must be in force on the date of service or no payment will be made. You may request a pre-review of coverage for any service by calling our Customer Service Department. Any of our pre-authorization decisions may be appealed by following the procedures in Section 7. Your physician may request an Expedited Appeal of a denial of a pre-authorization by calling the number on your QualChoice identification card if your physician believes the services are urgent due to your medical condition.

2.12. Utilization Management

We cover Medically Necessary services as described in Section 2.6. Determinations of Medical Necessity are made using QualChoice's Medical Policies. We make decisions regarding whether a particular service is or was Medically Necessary based on information provided by your Network Provider(s). When we review services after care has already been provided, we may review your medical records. A Network Provider may request the criteria or guidelines used by QualChoice in making any decision.

2.13. Case Management

We provide a Case Management program. Case Management assists Enrollees to achieve the best clinical outcomes, making the best use of the Benefits. Case Management helps with an individual's specific health care needs. Case Management involves the timely coordination of health care services. We review clinical information before we include any Enrollee in the Case Management program. We stay involved in the case until the need is resolved. Enrollees may participate in Case Management programs including programs for diabetes mellitus, transplants, oncology, and neonatology.

3. COVERED MEDICAL BENEFITS

Coverage is available for medical services or care as specified in this Section subject to the General Conditions for Payment specified in Section 2.9, Pre-Authorization of Services described in Section 2.11,

and to all other applicable conditions, limitations and exclusions of this Policy. **Consult the Benefit Summary for applicable Cost Sharing Amounts.**

3.1. Advanced Diagnostic Imaging

Advanced Diagnostic Imaging consists of the following studies (though others may be added as new studies are developed):

1. All imaging using Computerized Axial Tomography (CAT) technology;
2. All imaging using Magnetic Resonance Imaging (MRI) technology;
3. All imaging using Positron Emission Tomography (PET) technology;
4. All imaging using nuclear medicine techniques (in which a radioactive substance is administered to the patient to permit or enhance imaging, which is done at least in part with detection techniques to assess the locations at which the radioactive substance is concentrated in the body).

The following rules apply to these imaging procedures:

1. Regardless of where they are performed, they always fall under the required Cost Sharing Amounts of this Policy as set forth in the Benefit Summary; and
2. Pre-authorization may be required for any or all of these tests. The requirements for pre-authorization detailed in Section 2.11 should be referred to and followed when receiving any of the Advanced Diagnostic Imaging studies.

3.2. Ambulance Services – Transportation

We cover licensed ambulance transportation subject to all terms, conditions, exclusions and limitations as set forth in this Policy. This benefit is subject to the Cost Sharing Amounts and benefit limitations specified in the Benefit Summary, and the following criteria:

1. When an accident or other medical emergency occurs, we cover transport to the nearest hospital when Emergency care is required;
2. We cover ambulance transportation from one hospital to another hospital for one of the reasons identified below; when transportation for these listed reasons is required, it must be coordinated through the QualChoice Care Management department:
   A. To access equipment or expertise necessary for proper care;
   B. To receive a test or service which is not available at the hospital where you have been admitted and you return after the test or service is completed;
   C. To transport you from an Out-of-Network Facility to a Network Facility;
   D. To transport you directly from an acute care setting to an alternate level of care.

3.3. Complications of Pregnancy

Subject to all terms, conditions, and limitations of this Policy and subject to applicable Coinsurance and Deductible, coverage is provided for treatment of Complications of Pregnancy (as defined in Section 10) when provided by a physician.

3.4. Dental – Accidental Injury

We will provide coverage if an Enrollee has an Accidental Injury that damages a sound, natural tooth. Treatment must be authorized by QualChoice. Benefits are subject to a maximum limit per Enrollee per accident. See the Benefit Summary for the limitation. Dental services must be received from a Doctor of Dental Surgery, “D.D.S.” or a Doctor of Medical Dentistry, “D.M.D.” The damage must be severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. The Physician or dentist must certify that the injured tooth was:

1. A virgin or un-restored tooth, or
2. A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with any bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be started within three months of the original accident date and completed within 12 months of the original accident date.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities. The following limitations for treatments also apply to repair of damaged teeth:

1. Only the sound and natural tooth or teeth avulsed or extracted as a direct result of the Accidental Injury will be considered for replacement;
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based upon a Maximum Allowable Charge per tooth;
3. Double abutments are not covered;
4. Any health intervention related to dental caries or tooth decay is not covered;
5. Removal of teeth is not covered; and
6. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

3.5. Dental – Anesthesia

QualChoice will provide Benefits for anesthesia and facilities for dental procedures which would ordinarily be done under local anesthesia provided:

1. The procedure is performed in a Network Facility or a network ambulatory surgery facility; and
2. The situation meets Medical Necessity criteria, and the patient is:
    a. An Enrollee under 7 years of age who is determined by two network dentists to be unable to undergo the procedure without general anesthesia and who cannot wait until an older age for the procedure, when undergoing the procedure without general anesthesia would be possible; or
    b. A person with a serious mental health condition that prevents use of local anesthesia for the procedure; or
    c. A person with a serious physical condition making hospital care necessary for the safe performance of dental work; or
    d. A person with a significant behavioral problem (as certified by a Network Physician) which precludes safe performance of the dental work under local anesthesia.

All network requirements, Medical Necessity determinations, and such other limitations as are applied to other Covered Services will apply. Pre-authorization is required, see Section 2.11.

3.6. Dental – Oral Surgery

QualChoice will pay only for the following non-dental oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required;
2. Surgical procedures required to treat an Accidental Injury to jaws, cheeks, lips, tongue, roof and floor of the mouth. Injury to a tooth or teeth while eating is not considered an Accidental Injury; treatment of such injury will not be covered;
3. Excision of exostoses of jaws and hard palate;
4. Extraction of teeth is required because of the results from radiation or chemotherapy;
5. Frenectomy;
6. External incision and drainage of cellulitis;
7. Incision of accessory sinuses, salivary glands or ducts;
8. Certain dental services, as reflected in the Medical Policies, performed in conjunction with Medically Necessary reconstructive surgery; and
9. Dental services integral to medical services covered by the Plan.

3.7. Dental – Other

No other dental care and orthodontic services are covered.

3.8. Diabetes Management

Diabetes self-management training is limited to one program per lifetime per Enrollee. If there is a significant change in the Enrollee's symptoms or condition making it necessary to change the

Enrollee's diabetic management process, we may authorize additional training if prescribed by a physician. Covered Services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education developed by the American Diabetes Association (ADA). A licensed provider certified by the ADA must provide the training.

3.9. Durable Medical Equipment

Durable Medical Equipment (DME) is subject to Medical Necessity and appropriateness review. We will not cover DME if primarily used for the convenience of the Enrollee or any other person. DME is equipment serving a medical purpose, is non-disposable, can withstand repeated use, is appropriate for use in the home, and is generally not useful in the absence of the illness or injury for which it is used.

All DME services must be obtained through a Network Provider. All DME remains the property of QualChoice or a Network Provider. When it is more cost effective, we will purchase rather than lease equipment. The amount paid for leasing a DME item will not exceed the Maximum Allowable Charge for purchase. We retain the right to recover any equipment purchased by us for the use of the Enrollee upon cancellation or termination of coverage for the Enrollee. Delivery or set up charges are included in the Maximum Allowable Charge for the DME.

Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Enrollee.

The definition and description of coverage for orthotics and prosthetic devices and services are in Sections 3.21 and 3.26 below.

Important Note: DME dispensed by a physician in an office setting and billed by a DME provider must be provided through a DME Network Provider. It is your responsibility to confirm this with the physician. If DME dispensed by the physician is not from a DME Network Provider, a prescription may be obtained from the physician for the DME followed by contact with us to assist in obtaining the equipment. Failure to ensure all DME is obtained from a DME Network Provider will result in denial of Benefits.

3.10. Emergency Health Services

We cover emergency room services that meet the definition of "Emergency" as set out in Section 10.

1. **Emergency Care within the Service Area:** An Enrollee is encouraged to seek care from a Network Provider in the event of an Emergency (as defined in Section 10) whenever possible. However, if in an Emergency an Enrollee is unable to access a Network Provider, the Enrollee should go to the nearest urgent or emergent care facility. Services provided in an Emergency are paid as shown in your Benefits Summary.
2. **Emergency Care outside of the Service Area:** Services provided in an Emergency when you are outside of the Service Area, but within the United Sates are paid as shown in your Benefits Summary. Your QualChoice identification card provides a toll-free telephone number to call for a listing of healthcare providers in the QualChoice National Network (QCNN). QualChoice encourages you to seek treatment whenever possible from a healthcare provider in the QCNN.

If an Enrollee obtains services in an emergency room when the circumstances were not an Emergency, it will result in a denial of Benefits for the services provided. You have access to our "Ask a Nurse" assistance line at any time by calling (866) 232-0447.

IMPORTANT IN THE EVENT OF AN ADMISSION AT AN OUT-OF-NETWORK FACILITY: If treatment of an Emergency is sought at an Out-of-Network Emergency Room, *you, a family member or the hospital must notify our Care Management Department once you are stabilized, but in no event more than forty-eight (48) hours after initial treatment, if further care or inpatient admission is needed*. Failure to notify us within the specified 48 hour time requirement may result in a denial of benefits. Upon receipt of such notification we may either authorize the admission to, or further treatment at, the Out-of-Network Facility, or coordinate appropriate transfer to a Network Facility through

communication with the Out-of-Network Facility, the admitting physician, and the Enrollee's Network Provider. If you stay at the Out-of-Network Facility beyond the period for which we have determined further treatment is considered Medically Necessary, you will be responsible for all charges billed by the hospital and other providers providing the care.

3.11. Eye Examinations

Eye Examinations for active illness or injury that are received from a health care provider in the provider's office are a Covered Service.

3.12. Family Planning Services

Coverage is provided for the following family planning services:

1. Oral contraceptives and prescription barrier methods are only covered when a prescription drug rider has been purchased through QualChoice; coverage is subject to all of the terms, conditions, limitations, and exclusions of the prescription drug rider;
2. Voluntary sterilizations (vasectomies and tubal ligations) are covered except as excluded in Section 4; and
3. Long acting reversible contraceptives, including hormonal implantable systems and intrauterine contraceptives, are covered as a medical benefit.

Reversal of a voluntary sterilization is a specific exclusion.

3.13. Home Health Services

Coverage is available for the following services provided in the home when the medical condition supports the need for such services, the services are ordered by a Physician, and the services are pre-authorized by QualChoice.

We count each visit by a member of a home care team as one home care visit. We count up to four hours of home health nurse/aide service as one home care visit. (See the Benefit Summary for visit limitation details.)

The following services provided by a licensed home health agency in the home are Covered Services:

1. Intermittent skilled nursing care by a registered nurse or a licensed practical nurse. A service will not be determined to be "skilled" simply because there is not an available caregiver in the Enrollee's home; skilled nursing care provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse is not Custodial Care;
2. Physical, occupational and speech therapy services; and
3. Medical supplies provided by a home health agency during the course of approved care.

3.14. Home Infusion Therapy

The benefit for medications received from licensed specialty pharmacy or a licensed retail pharmacy designated by QualChoice as a home infusion therapy provider is covered based upon obtaining pre-authorization and upon the Maximum Allowable Charge for the medication.

1. Covered Medication: A home infusion therapy medication is covered as a medical benefit (as opposed to a prescription drug benefit) and is subject to Co-payment (if applicable) and/or Deductible and Coinsurance.
2. FDA approved medications that exist as separate components are intended for reconstitution prior to administration are covered. Examples include, but are not limited to, total parental, intravenous antibiotics, and hydration therapy and specialty infusions.
3. Medical supplies used in conjunction with home infusion therapy are covered if the home infusion is approved.

When home infusion therapy services are provided separately from home health services, then the home infusion therapy service does not apply to the home health benefit.

3.15. Hospice Care Services

Hospice care must be pre-authorized and arranged by a QualChoice Case Manager. Consult the Benefit Summary for applicable Cost Sharing Amount. In addition, coverage is available for an

Enrollee with a life expectancy of six months or less. Care must be provided by a hospice possessing all licenses, certifications, permits and approvals required by applicable federal, state and local law.

The following services, when ordered by a physician, are covered during the period when the hospice has admitted an Enrollee to its program:

1. Inpatient care in a freestanding hospice, a hospice unit within a hospital or skilled nursing facility or in an acute care hospital bed;
2. Home care services provided by the hospice either directly or under arrangements with other licensed providers, including but not limited to, the following:
   A. Intermittent nursing care by registered nurses, licensed practical nurses, or home health aides;
   B. Respiratory therapy;
   C. Social services;
   D. Nutritional services;
   E. Laboratory examinations;
   F. Chemotherapy and radiation therapy when required for control of symptoms;
   G. Medical supplies; and
   H. Medical care provided by a physician.

3.16. Facility – Inpatient Care

Inpatient hospital care Benefits are available for services and supplies received during the hospital stay and room and board in a semi-private room (a room with two or more beds). We will not pay for any hospital services unless the service is provided by an employee of the hospital, the hospital bills for the service, the service is not primarily for convenience and the hospital retains the payment collected for the service.

Facility inpatient care is also subject to the following conditions:

1. We cover Medically Necessary acute inpatient hospital care for the care or treatment of your condition, illness, or injury;
2. The services of social workers and discharge planners shall be included in the basic daily room and board allowance;
3. Coverage is provided for a minimum of forty-eight (48) hours for an in-patient stay related to a mastectomy;
4. We do not provide Benefits while you are waiting for Custodial Care;
5. We do not provide Benefits while waiting for a preferred bed, room, or facility;
6. The following applies when an Enrollee is waiting for transfer from an acute facility to another facility for continuing care (e.g., nursing home, rehabilitation facility, skilled nursing facility, and long term acute care facility):
   A. The acute facility that the Enrollee is in awaiting a transfer should provide care equivalent to the care provided by the facility to which the Enrollee is waiting to be transferred;
   B. The days an Enrollee spends in the acute facility waiting for a transfer may count toward the limits for sub-acute and rehabilitation Benefits;
   C. We will pay the acute facility the Enrollee is in awaiting a transfer the lesser of that acute facility's rate or the rate at the facility to which the Enrollee is being transferred; as demonstrated in Section 2.5 above, this could have a significant financial impact on you if the acute facility the Enrollee is in while waiting to be transferred is an Out-of-Network Facility;
   D. If the acute facility the Enrollee is in awaiting a transfer is not providing the care we expect, we will deny those days and make no payment; as demonstrated in Section 2.5 above, this could have a significant financial impact on you if the acute facility the Enrollee is in while waiting to be transferred is an Out-of-Network Provider.
7. Services rendered in a facility in a country outside of the United States of America shall not be paid except at the sole discretion of QualChoice.
8. Services to Out-of-Network Facilities are subject to pre-admission notification as described in Section 2.11. Please call the number listed on your identification card to notify us of the admission.

3.17. Injectable Prescription Medications

Benefits are available for Injectable Prescription Medication(s) received in a physician's office based upon the Maximum Allowable Charge for the Injectable Prescription Medication and subject to the applicable Cost Sharing Amounts specified in the Benefit Summary for other services provided in the physician's office. Benefits are available for Injectable Prescription Medications for self-administration through a prescription drug rider available from QualChoice. Injectable Prescription Medications that an Enrollee has the ability to self-administer may be obtained with direct delivery to the Enrollee's home. Our Care Management staff will assist Enrollee in coordinating this service.

3.18. Infertility

Limited diagnostic work-up for infertility is covered. This is designed to screen for basic problems that might cause infertility. Any other services required for the diagnosis or treatment of infertility or of any associated disease whose primary manifestation is infertility are not covered. You may contact us to obtain specific coverage guidelines.

3.19. Medical Foods

Medical foods and low protein modified food products for the therapeutic treatment of a person inflicted with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism are covered if:

1. The medical food or low protein modified food products are prescribed by a physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Network Physician; and
3. The cost of the medical food or low protein modified food products for an individual exceeds $2,400 per year per person, that is to say, the covered amount will be the incurred cost of medical food or low protein modified food products that is in excess of the $2,400 per year per person.

3.20. Medical Supplies

Subject to all terms, conditions, exclusions and limitations of this Policy, Medical Supplies, other than Medical Supplies that can be purchased without a prescription, are covered when prescribed by a physician and when Medically Necessary. The following conditions will also apply to coverage for Medical Supplies:

1. Coverage for Medical Supplies provided in a physician's office is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used;
2. Coverage for Medical Supplies is limited to a 31-day supply per month;
3. Coverage for Medical Supplies used in connection with Durable Medical Supplies is subject to the Cost Sharing Amounts and DME benefit limitations specified in the Benefit Summary; and
4. Coverage for Medical Supplies provided in connection with home infusion therapy is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used.

3.21. Orthotic Services and Orthotic Devices

Orthotic services and orthotic devices (as defined in this Section) are covered as described below.

All "orthotic devices" and "orthotic services", including the fitting and/or repair of orthotic devices, require pre-authorization as described in Section 2.11.

An "orthotic service" is an evaluation and treatment of a condition that requires the use of an "orthotic device".

In order for a device to be an "orthotic device" under this Policy, the device must meet all three (3) of the following requirements:

1. The external device is (i) Intended to restore physiological function or cosmesis to a patient; and (ii) Custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

An orthotic device does *not* include a/an (i) cane, (ii) crutch, (iii) corset, (iv) dental appliance, (v) elastic hose, (vi) elastic support, (vii) fabric support, (viii) generic arch support, (ix) low-temperature plastic splint, (x) soft cervical collar, (xi) truss, or (xii) any similar device meeting both of the following requirements:

1. It is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
2. It has no significant impact on the neuromuscular, musculoskeletal or neuromusculoskeletal functions of the body.

An orthotic device also does *not* include foot orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain. This applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, are mainly protective in nature, and/or combine functional control and protection. This also applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.

Coverage for orthotic devices and orthotic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefit Summary.

QualChoice does not cover replacement of an orthotic device or associated orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Policy. However, QualChoice will replace or repair an orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefit Summary.

3.22. Outpatient Services

1. **Outpatient Facility Services:** Covered outpatient services shall include the following services provided in a licensed outpatient facility or at a hospital outpatient department: diagnostic services, radiation therapy, chemotherapy, x-ray services, laboratory services, surgical services, physical, occupational and speech therapy services, audiology services and renal dialysis. We also cover up to 24 hours of outpatient observation for the purpose of extended recovery from a surgical or invasive procedure or for evaluation of the possible need for inpatient admission.

2. **Outpatient Surgery:** Coverage is provided for outpatient surgical services received from an ambulatory surgery center or in an outpatient hospital setting when performed or prescribed by a physician. Covered Services include diagnostic imaging and laboratory services required to augment surgical services and performed on the same day as such surgical service. If an Out-of-Network Facility or ambulatory surgery center not contracted with QualChoice is used, payment will be limited to the Maximum Allowable Charge for the service.

3.23. Physician Office Services

The diagnosis and treatment of an illness or Accidental Injury is a Covered Service when provided in a medical office, subject to the Cost Sharing Amounts set forth in your Benefit Summary.

3.24. Preventive and Wellness Health Services

We cover those services that are recognized and defined by QualChoice's Medical Policies as being preventive and/or wellness in nature. Subject to changes QualChoice may make to its Medical Policies, a partial listing of those services QualChoice considers to be preventive and/or wellness health services is included with your Benefits Summary. The most complete list of those services QualChoice considers being preventive and/or wellness health services are available on our website www.qualchoice.com or you may contact our Customer Service Department to obtain specific coverage guidelines.

3.25. Professional Services for Complex Surgery

We cover complex surgeries subject to the limitations described below including application of all Cost Sharing Amounts and other limitations as set forth in this Policy and related Benefits Summary.

The Benefit amount payable for a complex surgery includes payment for related or follow-up care by the surgeon before and after the operation. In other words, the one payment covers the operation and the surgeon's care after the operation. Payment for surgery is subject to the following limitations:

1. When multiple or bilateral surgical procedures are performed in the same operative session, whether through one or more incisions, we will cover the major or first procedure and, in addition, we will cover one-half of the Maximum Allowable Charge of the lesser or subsequent procedure(s).
2. When an incidental procedure, including, but not limited to, incidental appendectomy, treatment of adhesions, excision of previous scar, or puncture of ovarian cyst, is performed through the same incision, we will only pay for the major procedure;
3. When the physician performs an operative procedure in two or more stages, the total payment for the combination of steps or stages making up the entire procedure will be limited to the Maximum Allowable Charge that we would have paid if the physician had not performed it in multiple steps or stages;
4. Not all surgeries require an assistant surgeon; we will pay for one assistant surgeon who is a physician qualified to act as an assistant for the surgical procedure when Medically Necessary;
5. We will cover a standby physician only if that physician is required to assist with certain high-risk deliveries identified by us and only if that physician is in the immediate proximity to the Enrollee during the standby period.

3.26. Prosthetic Services and Prosthetic Devices

Prosthetic services and prosthetic devices (as defined in this Section) are covered as described below.

All "prosthetic devices" and "prosthetic services", including the fitting and/or repair of prosthetic devices, require pre-authorization as described in Section 2.11.

A "prosthetic service" is an evaluation and treatment of a condition that requires the use of a "prosthetic device".

In order for a device to be a "prosthetic device" under this Policy, the device must meet all three (3) of the following requirements:

1. The device is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

A prosthetic device includes a breast prosthesis to the extent required pursuant to the Women's Health and Cancer Rights Act of 1998.

A prosthetic device does *not* include a/an (i) artificial eye, (ii) artificial ear, (iii) dental appliance (which would include corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome), (iv) cosmetic device such as artificial eyelashes or wigs, (v) device used exclusively for athletic purposes, (vi) artificial facial device, or (vii) any other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

Coverage for prosthetic devices and prosthetic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefit Summary.

QualChoice does not cover replacement of a prosthetic device or associated prosthetic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Policy. However, QualChoice will replace or repair a prosthetic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefit Summary.

3.27. Reconstructive Surgery

We cover services in connection with reconstructive surgery if necessary to restore the part of the body injured or deformed by acute trauma, infection or cancer subject to the following:

1. Restoration must be aimed at restoration of function, not just restoration of appearance;
2. Restoration is intended to achieve an average person's normal function (for example, restoration aimed at athletic performance is *not* covered);
3. The reconstructive surgery is necessary to correct congenital malformations or anomalies resulting in a severe functional impairment of an Enrollee.

Coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by a physician:

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

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

3.28. Skilled Nursing Facility and Inpatient Rehabilitation Services

Coverage is available for Medically Necessary care in a skilled nursing facility or acute inpatient rehabilitation facility when provided immediately after hospitalization in an acute care general hospital for a covered illness or injury. Care will be limited to the number of covered days provided by the Policy and must meet the Medically Necessary criteria of continued improvement. See the Benefit Summary for details.

3.29. Therapeutic and Rehabilitation Services

Services for outpatient physical, occupational or speech therapy and chiropractic, audiology or pulmonary rehabilitation are covered. This includes services performed in the office of a physician, chiropractor or therapist, outpatient therapy center, or in the outpatient department of a hospital. Refer to the Benefit Summary and Section 4 for specific limits. Cardiac rehabilitation services are covered separately and are not subject to this limitation. Please note that Benefits are available only for services that are expected to result in a significant improvement in the Enrollee's condition within two months of the start of the treatment.

3.30. Transplantation Services

Transplant Benefits are available subject to the general conditions for payment specified in Section 4, and to all other applicable conditions, limitations and exclusions of this Policy. Consult the Benefit Summary for applicable Cost Sharing Amounts and other limitation amounts.

1. **Pre-Authorization Required:** ***You or an authorized representative must call the number on your ID card to obtain pre-authorization before the evaluation for transplant and placement on any transplant list.*** Once the evaluation is complete, an additional pre-authorization must be obtained for the transplant procedure. We will coordinate all transplant services, including evaluation and transplant. Failure to coordinate all transplant related services with us, or failure to comply with pre-authorization procedures, may result in non-payment of these services.
2. **Transplant Standards:** We cover transplant procedures under the standards set out by the Policy and are as follows:
   A. **General Description of Transplant Covered Services:** We will cover any hospital, medical, surgical, and other service related to the transplant, including blood and blood plasma. **We only cover transplants and transplant related services performed at a transplant center approved by us.**
   B. **Facility Care:** We cover all inpatient and outpatient care at a designated transplant center. When we authorize the transplant to occur at an Out-of-Network facility, we may require Network Physicians at a Network Facility to provide some follow-up care.
   C. **Organ Procurement:** We will pay for services directly related to organ procurement including tissue typing, surgical extraction and storage and transportation costs of the organ or other human tissue used in a covered transplant procedure. (If the donor has other insurance, we must receive an explanation of benefits from the donor's health policy indicating coverage or denial for the donation.) Please refer to the Benefit Summary for Cost Sharing Amounts and lifetime maximums.
3. **Bone Marrow Transplantation:** Bone marrow transplantation is only covered for specific indications listed below. This limitation applies to the bone marrow transplantation and any related procedure including High Dose Chemotherapy. The limitation applies to transplants of bone marrow or of peripheral blood cells intended to reconstitute the marrow. Covered diseases are:
   A. Aplastic anemia
   B. Wiscott-Aldrich syndrome
   C. Albers-Schonberg syndrome
   D. Thalassemia major
   E. Myelodysplastic syndromes – primary and acquired
   F. Immunodeficiency syndrome
   G. Non-Hodgkin's lymphoma, intermediate or high grade, stage III or IV
   H. Hodgkin's disease, stage IIIA or IIIB, or stage IVA or IVB
   I. Neuroblastoma, stage III or IV
   J. Chronic myelogenous blast leukemia in blast crisis or chronic phase
   K. Chronic myelogenous leukemia in the chronic phase

L. Multiple myeloma
M. Acute lymphocytic or myelocytic leukemia in patients who are in remission but at high risk for relapse

4. **Cornea Transplantation:** Cornea transplantation is covered subject to all terms, limitations and exclusions as set forth in this Policy. Cornea transplantation does not require pre-authorization.

This Policy requires specific donor matches for certain procedures.

4. NON-COVERED SERVICES, EXCLUSIONS AND LIMITATIONS

Some services, treatments, medications and supplies are not covered. Others have limitations on coverage. This Section describes those exclusions and limitations. QualChoice may choose to eliminate an exclusion or limitation if advances in medical care warrant making such a change. One or more of our optional coverage riders may cover some of these items. If you purchase any riders, they are included as part of this Policy. See the Benefit Summary for additional exclusions and limitations on Covered Services. QualChoice may provide very limited coverage for some services that are otherwise excluded or limited by this Section 4 strictly for preventive health purposes; where applicable, these limited coverages are identified and described in QualChoice's Preventive Health Benefit Medical Policy.

4.1. Exclusions From Coverage

1. **Acupuncture:** Acupuncture services for pain therapy are not covered.
2. **Admission to a Facility before Becoming Covered under This Policy:** We will not cover an inpatient admission commencing before the Effective Date of this Policy. We will not cover any portion of the facility or medical services related to the stay. This applies to admissions to an acute hospital, sub-acute hospital, skilled nursing facility, rehabilitation unit, or any other inpatient facility.
3. **Abortion:** We do not cover elective abortion. We do not cover medical services, supplies or treatment the primary purpose of which is to cause an elective abortion. We do not cover any services, supplies or treatment provided as a result of such an abortion.
4. **Adoption and Surrogate Parenting:** We will not cover services, supplies, treatment, or other costs relating to the care of the biological mother of an adopted child. Maternity charges incurred by an Enrollee acting as a surrogate mother are not covered charges.
5. **After Hours or Weekend Charges:** We will not cover any extra charges related to the time of day or day of the week on which services were rendered.
6. **Against Medical Advice:** We will not cover any services related to an inpatient admission, observation admission, or emergency room visit resulting in the Enrollee's discharge against medical advice. We will not cover any services required for complications resulting from the Enrollee's discharge against medical advice.
7. **Alternative or Complementary Medicine:** We will not cover devices or services relating to alternative systems of medical practice such as, but not limited to, the following:
   A. Acupuncture
   B. Homeopathy or Naturopathy;
   C. Bioelectromagnetic care;
   D. Herbal medicine;
   E. Hippo therapy (equine therapy);
   F. Hypnotherapy (see mental health coverage);
   G. Aromatherapy;
   H. Reflexology;
   I. Mind/body control such as dance or prayer therapies;
   J. Pharmacological and biological therapy not accepted by mainstream medical practitioners such as chelation therapy or metabolic therapy.

8. **Blood:** We do not provide Benefits for blood, blood plasma or blood derivatives. We do not cover fees for voluntary blood donation or storage of blood products. We do cover the charges for the administration of blood or blood products.

9. **Blood Donation:** We do not cover directed blood donations. We do not cover donations for specified recipients, you or another, regardless of donor or anticipated date of use. We do not pay for procurement, storage, or administration of such donated blood. We do not pay for any extra charges associated with designated blood donation.
10. **Blood Typing:** Blood typing or DNA analysis for paternity testing is not covered.
11. **Care Plan Oversight:** Multi-disciplinary team conferences as well as any other kind of team conferences are not covered.
12. **Care Provided By a Relative by Blood or Marriage:** We will not cover care provided by an individual who normally resides in your household. We also will not cover care provided by you or by your parents, siblings, spouses, children, grandparents, aunts, uncles, nieces and nephews or other relatives by blood or marriage.
13. **Care Rendered in Certain Non-Facility Institutions:** We will not pay for care in hospitals or other facilities not licensed as short-term acute care general hospitals or skilled nursing facilities. Examples are:
    A. Convalescent homes or similar institutions;
    B. An institution primarily for Custodial Care, rest or domicile;
    C. Residential care or treatment facilities;
    D. Health resorts, camps, safe houses, spas, sanitariums, schools, or tuberculosis hospitals;
    E. Infirmaries at camps or schools;
    F. Facilities for treatment of mental illness and substance abuse;
    G. Rehabilitation facilities and rehabilitation units in other facilities (except as covered under Section 3.29);
    H. Skilled nursing facilities and places primarily for nursing care (except as covered under Section 3.28);
    I. Freestanding cardiac care facilities;
    J. Sleep study centers;
    K. Extended care, chronic care, or transitional hospitals or facilities (except as covered under Section 3.29 and 3.30); or
    L. Other facilities and institutions, which do not meet our criteria for short-term acute care general hospitals or skilled nursing facilities
14. **Cerebellar Stimulator or Pacemaker:** Cerebellar stimulator or pacemaker for the treatment of neurological disease is not covered.
15. **Cervicography:** Cervicography is not covered.
16. **Charges In Excess Of Calendar Year or Lifetime Maximums:** We will not cover any service, supply or treatment in excess of the Calendar Year or lifetime maximum as shown on the Benefit Summary.
17. **Charges for Missed/Canceled Appointments:** We will not pay for charges resulting from the Enrollee's failure to keep scheduled appointments.
18. **Chelation Therapy:** Services or supplies provided as, or in conjunction with, chelation therapy are not covered, except for treatment of acute heavy metal poisoning.
19. **Cognitive Rehabilitation:** Services and supplies provided as part of cognitive rehabilitation are not covered.
20. **Complications:** We will not cover medical or surgical complications resulting from a non-Covered Service. We will not cover medical or surgical complications as a direct or closely related result of the Enrollee's refusal to accept treatment, medicines, or a course of treatment recommended by a provider.
21. **Contraceptive Devices or Supplies:** Contraceptive devices or supplies available over-the–counter (without a prescription) are not covered.
22. **Convenience Items or Services:** We will not cover items or services utilized primarily for an Enrollee's convenience or the convenience of a family member, caregiver or provider. Such items include, but are not limited to: cot, telephone, television rental charges in a hospital, whirlpool baths, automobile or van conversions, motor scooters, air purifiers, exercise equipment, machines used for communication and speech, lifts, and home modifications.
23. **Cosmetic or Reconstructive Surgery:** We will not pay for any procedures, services, equipment or supplies provided in connection with elective cosmetic surgery or complications arising from a cosmetic surgery even if coverage was provided by another health plan.

Cosmetic surgery is intended primarily to improve appearance or have a psychological benefit.

24. **Cranial Electrotherapy Stimulation Devices**: Cranial electrotherapy stimulation devices are not covered.
25. **Current Perception Threshold Testing**: Current perception threshold testing is not covered.
26. **Custodial Care:** We do not cover any service which is custodial in nature. We consider care custodial in nature when it is primarily for meeting personal needs. Persons without professional skills or training can provide Custodial Care. For example, Custodial Care includes assistance in activities of daily living (walking, getting in and out of bed, bathing, dressing, eating and taking medication). Custodial care also includes medical services not seeking to cure or improve the patient. They may be provided during periods when the medical condition of the patient is not changing. They generally do not require continued administration by trained medical personnel. Examples include long-term maintenance activities such as dressing changes, tube feeding or range of motion exercises. Non-covered Custodial Care may be rendered in a hospital, domiciliary facility, nursing home, skilled nursing facility, or home. Non-covered Custodial Care may be residential care, respite care, private duty nursing, or any other service custodial in nature.
27. **Dental Care:** This Policy does not provide Benefits for dental care. Except as otherwise stated in this Policy, we do not cover:
    A. Treatment of cavities;
    B. Tooth extractions;
    C. Care of the gums;
    D. Care of the bones supporting the teeth;
    E. Treatment of periodontal disease;
    F. Treatment of dental abscess;
    G. Treatment of dentigerous cysts;
    H. Removal of soft tissue supporting or surrounding teeth;
    I. Orthodontia (including braces);
    J. False teeth;
    K. Orthognathic surgery; or
    L. Any other dental services you may receive.
28. **Dental Implants:** Dental implants of titanium osseointegrated fixtures or of any other material are not covered.
29. **Dermatomal Somatosensory Evoked Potentials:** Dermatomal somatosensory evoked potential testing is not covered.
30. **Developmental Delay:** Services or supplies provided for developmental delay, including learning disabilities, communication delay, perceptual disorder, sensory deficit and motor dysfunctions are not covered.
31. **Dexamethasone Infusion:** Dexamethasone infusion is not covered.
32. **Dietary and Nutritional Services:** Unless such dietary supplies are the sole source of nutrition for the Enrollee, any services or supplies provided for dietary or nutritional services, including but not limited to medical nutrition therapy, are not covered. Baby formulas or thickening agents, whether prescribed by a Physician or acquired over the counter, are not a covered benefit.
33. **Donor Expenses For Transplant:** Services and supplies associated with an organ and tissue transplant where the Enrollee is the donor are not covered.
34. **Dynamic Orthotic Cranioplasty:** Dynamic orthotic cranioplasty is not covered.
35. **Electrogastrography:** Electrogastrography is not covered.
36. **Electron Beam Computed Tomography:** Electron beam computed tomography is not covered.
37. **Environmental Intervention:** Services or supplies used in adjusting an Enrollee's home, place of employment or other environment so that it meets the Enrollee's physical or psychological condition are not covered.

38. **Enteral Feedings:** Enteral feedings are not covered except when approved by us and documented to be the Enrollee's sole source of nutrition, subject to all other terms, conditions, and limitations of this Policy.
39. **Excessive Use:** Excessive use of medications is not covered. For purposes of this exclusion, each Enrollee agrees that QualChoice shall be entitled to deny coverage of medications under a prescription drug rider or this Policy, on grounds of excessive use when our medical director, in his sole discretion, determines (1) that an Enrollee has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard reference compendia or by the Pharmacy & Therapeutics Committee; or (2) that an Enrollee has obtained or attempted to obtain the same medication from more than one Physician for the same or overlapping periods of time; or (3) that the pattern of prescription medication purchases, changes of Physicians or pharmacy or other information indicates that an Enrollee has obtained or sought to obtain excessive quantities of medications. Each Enrollee hereby authorizes QualChoice to communicate with any physician, health care provider or pharmacy for the purpose of reviewing and discussing the Enrollee's prescription history, use or activity to evaluate for excessive use.
40. **Exercise Programs:** Exercise programs for treatment of any condition are not covered. Examples would be gym memberships, personal trainers, and home exercise equipment, even if recommended or prescribed by a Physician.
41. **Experimental or Investigational Procedures and Related Equipment and Supplies:** We will not cover any procedure or service we consider to be experimental or investigational. We also will not pay for equipment or supplies related to such procedures. We base decisions on what is experimental or investigational on unbiased technology reviews and national scientific, peer-reviewed medical literature. Any therapy subject to government agency approval must have received final approval before we consider it for coverage. A new treatment with no outcome advantage over existing treatments may be considered investigational while studies are in progress to determine if any treatment advantage exists in any subpopulation of the affected group.
42. **Extracorporeal Shock Wave Therapy:** Extracorporeal shock wave therapy (ESWT) for any musculoskeletal condition, including but not limited to plantar fasciitis or tennis elbow, is not covered.
43. **Eyeglasses:** Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contacts except for the initial acquisition following cataract surgery as specified in Section 4.1.
44. **First Aid Supplies:** We will not cover over the counter first aid supplies.
45. **Foot Care:** Services or supplies for palliative or cosmetic foot care or for flat foot conditions are not covered. This includes but is not limited to supporting devices for the foot such as shoe inserts, elastic stockings, Jobst stockings, the treatment of subluxations of the foot, arthroeresis for flat feet, care of corns, bunions, calluses, routine trimming of toe nails, fallen arches, weak feet and chronic foot strain. However, subject to all terms, conditions, exclusions and limitations as set forth in this Policy, foot care is provided when required for prevention of complications associated with diabetes mellitus or other peripheral sensory neuropathy.
46. **Formula:** Baby formula and thickening agents, even if prescribed by a physician or acquired over-the-counter are not covered.
47. **Fraud or Misrepresentation:** Health interventions or health services, including but not limited to medications obtained by unauthorized or fraudulent use of an Enrollee's identification card or by material misrepresentation as part of the enrollment process or at other times, are not covered.
48. **Free Care:** We will not cover any care if there was no charge for the care. This applies even if you, or your provider thought the services were not covered by insurance when the provider chose not to charge for the care.

49. **Government Programs:** We will not pay for Covered Services to the extent benefits for such services are payable under Medicare or any other federal, state or local government program.
50. **Hair Loss or Growth:** Wigs, hair transplants or, unless specifically covered in a prescription drug rider issued to you by us, any medication that is taken for hair growth even if prescribed by a Physician, are not covered regardless of the cause of hair loss. Treatment of male or female pattern baldness is not covered.
51. **Health and Behavior Assessment:** Evaluation of psychosocial factors potentially impacting physical health problems and treatments are not covered. This includes health and behavior assessment procedures used to identify psychological, behavior, emotional, cognitive, and social factors affecting physical health problems.
52. **Hearing or Talking Aids:** Regardless of the reason for the hearing or speech disability, hearing aids, prosthetic devices to assist hearing, or talking devices, including special computers, are not covered. Fitting or repair of such devices is not covered. Nor are cochlear implants, or its associated speech processor, or auditory brain stem implants covered.
53. **Heat Bandage:** Treatment of a wound with a warm-up active wound therapy device or a non-contact radiant heat bandage is not covered.
54. **High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation:** High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation are not covered, except in the circumstances set forth in Section 3.30.
55. **High Frequency Chest Wall Oscillators:** High frequency chest wall oscillators that are used to provide airflow to the lungs are not covered.
56. **Home Uterine Activity Monitor:** Home uterine activity monitors or their use is not covered.
57. **Illegal Acts:** We will not cover health care services resulting from an Enrollee's participation in an illegal act or being engaged in an illegal occupation, whether or not convicted, riot or insurrection except as required by law.
58. **Illegal Uses:** Medications, drugs or substances that are illegal to dispense, possess, consume or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner, are not covered. Complications or an Accidental Injury from illegal drug use or while driving under the influence of alcohol determined to be in excess of legal limits, are not covered.
59. **Impotence or Sexual Dysfunction:** We will not cover medical, surgical, or pharmacological treatment for impotence, frigidity, or other sexual dysfunction unless such dysfunction is the result of diabetic neuropathy, spinal cord injury or prostate surgery.
60. **Immunizations**: Immunizations for travel, school, work or recreation are not covered.
61. **Insulin Pump for Diabetes Mellitus:** We do not cover insulin pumps for diabetes mellitus.
62. **Infertility Treatment:** We will cover a basic diagnostic work-up to make an initial diagnosis of infertility. We will not cover any medications (unless specifically covered in a prescription drug rider issued to you by us), procedures, or other services for treatment of infertility. It does not matter if the infertility service is therapeutic, it is still not covered. It does not matter whether the infertility service or treatment is by natural, artificial, mechanical, pharmacological, or other means, it is still not covered. Specific services that are not covered include, but are not limited to:
    A. Reversal of sterilization
    B. Pre-implantation testing and/or artificial insemination
    C. Surrogate pregnancies
    D. Medical treatment of infertility
    E. Surgical treatment of infertility
    F. In vitro fertilization

    Note: We will not pay for surgery that is done primarily for infertility treatment even when other diseases or conditions that may be the underlying medical condition causing the infertility are detected or treated during such surgery.
63. **Inotropic Agents for Congestive Heart Failure:** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. However, subject to all terms, conditions, exclusions and limitations set forth in this Policy, where the

Enrollee is on a cardiac transplant list at a hospital where there is an ongoing cardiac transplantation program, the Policy will cover infusion of inotropic agents.

64. **Instructional Programs:** We will not pay for instructional or educational testing, programs, seminars or workshops such as, but not limited to, childbirth classes, vocational training or testing, diet programs, nutritional programs, smoking cessation classes, educational or neuroeducational testing, or general or remedial education classes. Diabetic education is covered as set forth in Section 3.8.
65. **Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders:** Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.
66. **Learning Disabilities:** Services or supplies provided for learning disabilities, i.e. reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty and other learning difficulties, are not covered.
67. **Lost Medications:** Replacement of previously filled prescription medications because the initial prescription medication was lost, stolen, spilled, contaminated, etc. are not covered.
68. **Magnetic Innervation Therapy:** Extracorporeal magnetic innervation therapy for the treatment of urinary incontinence is not covered.
69. **Maintenance Therapy:** We will not cover maintenance therapy for chiropractic therapy, physical therapy, occupational therapy, recreational therapy, or speech therapy.
70. **Mammoplasty:** Except as provided in Section 3.27, we do not cover mammoplasty for reasons of augmentation, reduction or asymmetry of the breasts. We do not cover removal of breast implants placed or removed for cosmetic purposes.
71. **Mandated or Court Ordered Care:** We will not cover any medical, psychological, or psychiatric care which is the result of a court order or otherwise mandated by a third party (such as, but not limited to, an employer, licensing board, recreation council, or school).
72. **Maternity Care and Obstetrical Care:** We do not cover services or supplies for Maternity Care and Obstetrical Care.
73. **Medical Reports:** We will not cover expenses for medical report preparation and presentation. We will not pay for provider appearances at hearings and court proceedings. We will not pay for charges for the completion of insurance forms, or the preparation or copying of medical records.
74. **Medical/Surgical Services or Supplies for Control of Obesity or Morbid Obesity:** We will not cover any surgery, medical services or supplies intended for control of either obesity or morbid obesity even if the obesity or morbid obesity aggravates another condition or illness. This would include services such as dietary control, medications (unless specifically covered in a prescription drug rider issued to you by us), counseling or weight maintenance programs, gastric stapling, gastric bypass or any other service intended to control obesity. We do not cover surgical or medical procedures to treat the complications or consequences of weight loss, such as abdominoplasty or panniculectomy.
75. **Medication Therapy Management Services:** Medication therapy management services by a pharmacist, including but not limited to a review of an Enrollee's history and medical profile, an evaluation of prescription medication, over-the-counter medications and herbal medications, are not covered.
76. **Meniscal Allograft Transplantation:** Meniscal allograft transplantation is not covered.
77. **Mental Health or Substance Abuse:** Unless a Mental Health and/or Substance Abuse Rider accompanies this Policy, mental health, substance abuse, and chemical dependency treatment and related services and supplies are not covered, including, but not limited to, the following conditions and treatments:
    A. Sexual and gender identity disorders;
    B. Treatment for smoking or nicotine addiction;
    C. Services provided for treatment of adolescent behavior or conduct disorders, oppositional disorders, or neuroeducational testing;
    D. Outpatient psychotherapy or counseling for personal growth or life and social enrichment;
    E. Group therapy or group counseling at any time in any setting by any provider;
    F. Psychiatric conditions and substance abuse, including alcohol;
    G. Detoxification from abusive chemical or substance abuse;
    H. Medication supporting an addiction or substance dependency;

I. Seasonal Affective Disorder (SAD) treatment;
J. Educational services of any type for any reason;
K. Marriage and family therapy or counseling services; and
L. Services rendered by an Out-of-Network Provider.

78. **Non-Compliance with Recommended Treatment:** We will not cover services provided as the result of or related to an Enrollee's refusal to comply with a physician's or other provider's recommendations or orders, or failure to cooperate with a prescribed plan of treatment or recovery.
79. **Nurse Midwife:** Services provided by a nurse midwife are not covered.
80. **Nutritional Counseling or Nutritional Supplements:** Benefits are not available for dietary control counseling or weight maintenance programs. For Enrollees with diabetes, see Section 3.8.
81. **Oral, Implantable and Injectable Contraceptives:** Oral and prescription contraceptive methods that are not on the QualChoice formulary are not covered. Implantable and injectable contraceptives provided in a physician's office are not covered.
82. **Orthognathic Surgery:** The surgical repositioning of segments of the mandible or maxilla containing one to several teeth, or the bodily reposition of entire jaws, whether to reduce a dislocation of temporomandibular joint or for any other purpose, is not covered. For coverage of Oral Surgery or Reconstructive Surgery, see Section 3.
83. **Orthoptic or Pleoptic Therapy:** Orthoptic or pleoptic therapy is not covered.
84. **Orthotics:** Orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain are not covered. This exclusion applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, those that are mainly protective in nature, and those that combine functional control and protection. The exclusion applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.
85. **Outpatient Rehabilitation Services:** Coverage for outpatient visits for physical, occupational, and speech therapy, audiology services, pulmonary rehabilitation and chiropractic services are limited to a maximum number of visits per Enrollee per Calendar Year as set out in the Benefit Summary. Coverage for cardiac rehabilitation is limited to a maximum number of visits per Enrollee per Calendar Year as set out in the Benefit Summary. Any outpatient rehabilitation services obtained from an Out-of-Network Provider are not covered.
86. **Outside United States:** We do not cover services or supplies obtained outside of the United States except in our sole discretion.
87. **Over the Counter Medications:** Unless specifically identified in a prescription drug rider purchased from QualChoice, medications (except insulin) which do not by law require a prescription from a Physician are not covered.
88. **Pain Pump, Disposable:** Disposable pain pumps following surgery are not covered.
89. **Parkinson's Disease, Treatment with Fetal Mesencephalic Transplantation:** Fetal mesencephalic transplantation (FMT) for treatment of Parkinson's disease is not covered.
90. **Percutaneous Diskectomy:** Any method of percutaneous diskectomy, including, but not limited to, automated or manual percutaneous diskectomy, laser diskectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered.
91. **Percutaneous Sacroplasty:** Percutaneous sacroplasty is not covered.
92. **Performance Enhancement:** We will not cover medical, surgical or rehabilitation services primarily intended to improve the level of physical functioning for purposes of enhanced job, athletic or recreational performance, including but not limited to work hardening programs, back schools, programs of general physical conditioning, athletic trainers and special or specially modified surgical procedures designed to enhance performance above normal.
93. **Peripheral Nerve Stimulators:** Peripheral nerve stimulators are not covered.
94. **Peripheral Vascular Disease Rehabilitation Therapy:** Peripheral vascular disease rehabilitation therapy is not covered.
95. **Premarital Laboratory Work:** We will not cover premarital laboratory work required by any state or local law.

96. **Prescription Medications:** Unless specifically covered in a prescription drug rider issued to you by us, prescription drugs for outpatient use filled by a prescription order or refill and non-injectable medications given in a physician's office except in an Emergency are not covered.
97. **Private Duty Nurses:** We will not cover private duty nurses.
98. **Private Room:** We do not cover a private hospital room. We will pay the most common charge for semi-private accommodations. If there is a charge for a private room, you must pay the difference between the charges for a private room and our payment.
99. **Prolotherapy:** Prolotherapy or Sclerotherapy for the stimulation of tendon or ligament tissue or for pain relief in a localized area of musculoskeletal origin is not covered.
100. **Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions:** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.
101. **Required Examinations or Services:** We will not cover examinations or services required or recommended by a third party. This would include services for the purpose of:
    A. Obtaining employment;
    B. Maintaining employment;
    C. Obtaining insurance;
    D. Obtaining professional or other licenses;
    E. Engaging in travel;
    F. Athletic or recreational activities; or
    G. Attending a school, camp, or other program.
102. **Research Studies:** We will not cover any service provided in connection with research studies or clinical trials.
103. **Rest Cures:** Services or supplies for rest cures are not covered.
104. **Reversal of Sterilization:** We will not cover any procedures or related care to reverse previous sterilization.
105. **Second Surgical Opinion and Consultation with Specialist:** We will not cover a second surgical opinion and a consultation from the same physician or from two physicians who are in practice together.
106. **Self-inflicted Injuries:** Services for intentional self-inflicted injuries, including drug overdose, are not covered, except when it is determined the act causing the injury resulted from a medical condition (physical or mental).
107. **Sensory Stimulation of Coma Patients:** Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.
108. **Services Not Specified as Covered Services:** We will not cover any services not specifically described in Section 3 of this Policy.
109. **Sex-Change Treatment:** We will not cover surgical procedures or related care to alter your sex from one gender to the other.
110. **Sexual and Gender Identity Disorders:** Any services related to the treatment of sexual and identity disorders are not covered.
111. **Short Stature Syndrome:** Any services related to the treatment of short stature syndrome, except for laboratory documented growth hormone deficiency, are not covered.
112. **Smoking or Tobacco Cessation or Caffeine Addiction:** Unless a Smoking Cessation Rider is issued to you by us, treatment of caffeine or nicotine addiction, smoking cessation prescription medication products, including but not limited to, nicotine gum and nicotine patches are not covered.
113. **Snoring:** Devices, procedures or supplies to treat snoring are not covered.
114. **Sperm and Embryo Preservation and Donation:** We will not cover charges related to the donation, collection, or preservation of sperm or embryos for later use.
115. **Sterilization, Voluntary Hysterectomy:** We will not cover charges related to hysterectomy for the primary purpose of voluntary sterilization. We will not cover charges related to implantation of the Essure device or other similar devices identified at our sole discretion. You may contact us to obtain a listing of such devices.
116. **Tanning Equipment:** Tanning equipment is not covered.
117. **Telephone and Other Electronic Communication:** We do not cover communications between a provider and an Enrollee or a provider and another provider done by telephone or other electronic means such as email.

118. **Temporomandibular Joint Syndrome (TMJ):** Unless a TMJ Rider is included with this Policy, we will not cover charges related to treatment or diagnosis of TMJ, including, but not limited to, medical, surgical and dental treatment, physical therapy, joint splints, adjustments, medications, as well as any orthotic treatment. All other procedures involving the teeth or areas surrounding the teeth are not covered, including shortening of the mandible or maxillae, or correction of malocclusion.
119. **Thermography:** Thermography, the measuring of self-emanating infrared radiation that reveals temperature variation at the surface of the body, is not covered.
120. **Third Party Liability Exclusion:** We will not pay any Benefits to an Enrollee to the extent the Enrollee has received payment, in whole or in part, from a third party, or its insurer, for past or future medical or hospital or other health care charges as the result of the negligence or intentional act of a third party. If an Enrollee makes a Claim for Benefits under this Policy prior to receiving payment from a third party, or its insurer, the Enrollee (or legal representative for a minor or incompetent) agrees to repay us from any amount of money received by the Enrollee from the third party, or its insurer. Please refer to Section 8 and Section 9.7 for further information concerning repayment of Benefits.
121. **Thoracic Electrical Bioimpedance:** Thoracic electrical bioimpedance is not covered.
122. **Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae:** Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.
123. **Trans-telephonic Home Spirometry:** Tans-telephonic home or ambulatory spirometry is generally not covered. However, subject to all terms, conditions, exclusions and limitations as set forth in this Policy, trans-telephonic home or ambulatory spirometry is covered for patients who have had a lung transplant, when pre-approved by the QualChoice Care Management Department.
124. **Travel and Transportation Expenses:** We will not cover travel and transportation expenses, even if prescribed by a physician, except for emergency ambulance service or ambulance service for transfer coordinated by the QualChoice Care Management Department.
125. **Travel or Work Related Immunizations:** We will not cover immunizations to fulfill requirements for international travel or for work.
126. **Ultrasounds:** Obstetrical ultrasound is not covered.
127. **Unlicensed Provider:** Coverage is not provided for treatment, procedures or services provided by any person or entity, including but not limited to physicians, who is required to be licensed to perform the treatment, procedure or services, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of QualChoice, include within its scope the treatment, procedure or service provided.
128. **Vacuum Assisted Closure:** Vacuum assisted closure devices and services associated with it are not covered.
129. **Vision and Hearing Services:** Except as set forth in the Benefit Summary, we will not cover routine eye or hearing examinations, services or tests, eyeglasses, contact lenses, hearing aids and other vision care and hearing care services and supplies, except as required for the diagnosis and treatment of diseases of, or injury to, the eyes or ears.
130. **Vision Correction:** We will not cover eye surgery to correct refractive errors. This includes refractive keratoplasty, refractive keratomileusis, epikeratophakia procedures, Low Vision Enhancement System (LVES), Laser Assisted Insitu Keratomileusis (LASIK), eyeglass, and contact lenses, except the initial acquisition of one pair within the twelve months following cataract surgery up to a maximum of $200.00 (for frames and lenses), are not covered.
131. **Vitamins or Baby Formula:** Unless specifically covered in a prescription drug rider issued to you by us, vitamins, food or nutrient supplements are not covered. **Baby formula and thickening agents, even if prescribed by a Physician are not covered.** However, subject to all terms, conditions, exclusions and limitations set forth in this Policy, coverage is provided for medical foods and low protein modified food products for the treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism (see Section 3.19).
132. **Vocational Rehabilitation:** Vocational rehabilitation services, counseling and testing are not covered.

133. **War or Act of War:** We will not cover any services relating to any injury or sickness resulting from war or any act of war (declared or undeclared), or in the armed forces of any country if any government plan covers the injury or sickness.
134. **Weight Control:** Medications prescribed, dispensed or used for the treatment of obesity are not covered. Medications prescribed, dispensed or used in any program of weight control, weight reduction, weight loss or other dietary control are not covered. Weight loss surgical procedures, including complications relating thereto, are not covered.
135. **Whole Body Computed Tomography:** Whole body computed tomography is not covered.
136. **Workers' Compensation:** We will not cover any care or supplies for any injury, condition or disease arising from employment. We will not make any payments even if a Claim is not made for the benefits which are available under the Workers' Compensation Law.
137. **Wound Treatment:** Blood derived growth factors are not covered.

4.2. Limitations to Benefits

1. **Ambulance:** Transportation by ambulance is limited to a maximum annual benefit amount, and is subject to review for Medical Necessity. Consult the Benefit Summary for Benefit limitations.
2. **Autism Screening:** Screening for autism is limited to a maximum of once between the ages of 1 and 4. Coverage for developmental delay associated with autism spectrum disorder is excluded.
3. **Biofeedback:** Biofeedback is covered only when it is Medically Necessary for muscle re-education of specific muscle groups, or for treating the pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and when more conventional treatments (heat, cold, exercise, and support) have not been successful. Pre-authorization is required. Biofeedback is medically appropriate when applied to the conditions reflected in the QualChoice Medical Policies.
4. **Circumstances Beyond Our Control:** Services and other covered Benefits could be delayed or made impractical by circumstances not reasonably within our control, such as: complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of hospital or medical group personnel, or similar causes. If so, Network Providers will make a good faith effort to provide services and other Benefits covered hereunder. Neither any provider nor we shall have any other liability or obligation because of such delay or such failure to provide services or other Benefits.
5. **Durable Medical Equipment (DME):** Benefits for DME is limited to an annual dollar maximum and must be obtained from a Network Provider. Please refer to the Benefit Summary for this annual limit.
6. **Eating Disorders:** We cover services for eating disorders only as provided in Section 3 of this Policy. This includes treatment for anorexia, bulimia and other eating disorders.
7. **Electrotherapy and Electromagnetic Stimulators:** All treatment using electrotherapy and electromagnetic stimulators, including services and supplies used in conjunction with such stimulators, and complications resulting from such treatment, is covered only for conditions specified in our Medical Policies.
8. **Enhanced External Counterpulsation:** Enhanced external counterpulsation (EECP) is covered only for conditions specified in our Medical Policies.
9. **Genetic Counseling and Testing:** Genetic counseling, genetic testing, and chromosome analysis are covered only when there is documented evidence that a genetic anomaly or defect may be present which could threaten the life of the Enrollee. Preauthorization is required. Genetic counseling, genetic testing, and chromosome analysis may be appropriate for (i) lymphoma, (ii) multiple myeloma, (iii) suspected Down's Syndrome, and (iv) testing for BRCA genes. We will not cover genetic counseling or testing:
   A. To determine the likelihood of developing a disease or condition;
   B. To determine the likelihood of a disease or the presence of a disease in a relative;
   C. To determine the likelihood of passing an inheritable disease, e.g. cystic fibrosis, or congenital abnormality to an offspring; or
   D. For pre-implantation genetic diagnosis or treatment.

10. **Home Health Care:** Home health visits are limited to a maximum number of visits per Enrollee per Calendar Year. The Home Health Care visit limitation and the Cost Sharing Amounts are specified in the Benefit Summary.
11. **Hospice Care:** Hospice Care is limited to a maximum number of days of coverage per Enrollee. The Hospice Care day limitation and the Cost Sharing Amounts are specified in the Benefit Summary.
12. **In Vitro Chemoresistance and Chemosensitivity Assays:** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but not limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered, subject to QualChoice's Medical Policies.
13. **Insulin Pump for Diabetes Mellitus:** We will cover insulin pumps to a Maximum Allowable Charge of $5,500. Insulin pump supplies are covered under your medical benefit and are not subject to this limitation. Pre-authorization is required.
14. **Lifetime Maximum:** Consult your Benefits Summary, Medical Policies, and this Policy for various lifetime maximum Benefits per Enrollee.
15. **Major Disaster or Epidemic:** If a major disaster or epidemic occurs, Network Providers will render medical services as is practical according to their best judgment within the limitation of available facilities and personnel. Neither any Network Provider nor we has any liability or obligation for delay or failure to provide or arrange any such services to the extent the disaster or epidemic creates unavailability of facilities or personnel.
16. **Prosthetic and Orthotic Devices and Services:** QualChoice does not cover replacement of a prosthetic or orthotic device or associated prosthetic or orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Policy. However, QualChoice will replace or repair a prosthetic or orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefit Summary.
17. **Refusal to Accept Treatment:** You may refuse to accept procedures or treatment recommended by Network Providers for personal reasons. In such case, neither we nor any Network Provider shall have any further responsibility to provide care for the condition under treatment, unless such refusal is later recanted and there is an agreement to follow the recommended treatment or procedure.
18. **Transplant Services:** Transplant services are subject to the following benefit maximums:
    A. Coverage for procurement (per transplant) is limited to the amount reflected in your Benefit Summary;
    B. Lifetime maximum organ transplant coverage is limited to the amount reflected in your Benefit Summary;
    C. We will not cover the transportation and/or lodging costs of the transplant donor, or individuals traveling with either the donor or the recipient. We will not pay for artificial or non-human parts or organs or any services related to transplants using artificial or non-human parts or organs. Transportation costs of the transplant recipient are covered at the sole discretion and evaluation of the QualChoice Care Management Department. Coverage is limited to no more than two (2) transplants per Enrollee per lifetime. We cover re-transplantation, subject to the transplant limit of two (2).
    D. Solid organ transplants of any kind are not covered for an Enrollee with a malignancy of any kind that is presently active, in partial remission or in complete remission less than two years. A solid organ transplant of any kind is not covered for an Enrollee that has had a malignancy removed or treated in the three (3) years prior to the proposed transplant. For purposes of this exclusion, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma, or melanoma. Exceptions to this exclusion are hepatocellular carcinoma under certain circumstances, basal or squamous cell carcinomas of the skin, absent lymphatic or distant metastasis.
    E. Organ transplants not pre-authorized by QualChoice Care Management Department are not covered.

5. ELIGIBILITY CRITERIA

5.1. Hospitalization When Coverage Begins

If an Enrollee is an inpatient in a hospital, skilled nursing facility, or other inpatient facility on the Effective Date of this Policy, coverage under this Policy will not be effective for such Enrollee until after discharge from the facility.

No person, who is a registered inpatient in a hospital, skilled nursing facility, or other inpatient facility on the date he or she would otherwise be entitled to begin coverage will be eligible under this Policy or receive such coverage for such inpatient confinement.

5.2. Eligibility for Medicare

If you are eligible for Medicare, you are not eligible to begin or continue coverage under this Policy.

5.3. Who is Eligible for Coverage and When Does Coverage Begin

Subject to the Policy Holder meeting all eligibility requirements in this Policy, the Policy Holder's coverage begins upon the Effective Date of this Policy as reflected in the Benefit Summary. You may contact us for information concerning eligibility requirements and the Effective Date.

You must list yourself on the Enrollment Application to be eligible for coverage. You must meet all eligibility requirements in this Policy. ***Only*** a person who is a resident of the State of Arkansas and is under the age of 19 is eligible for coverage under this Policy. For the purposes of this Section, an Enrollee is a "resident" of the State of Arkansas if s/he lives in Arkansas and has an intent to remain in the State for a period of time, which may include an Enrollee who is a student at a college or university located outside of Arkansas. QualChoice reserves the right to request documentation necessary to demonstrate that an Enrollee's residency is the State of Arkansas. Except under limited circumstances described in this Policy, we are not required to provide coverage under this Policy to every applicant for coverage.

No one is eligible for coverage if that person does not meet our eligibility rules. You should contact us for further information concerning your eligibility. Nor is someone eligible to enroll if that person had previous coverage with us and was terminated for causes described in Section 5.5.4 of this Policy.

5.4. Maternity Coverage

This Policy does not include coverage for Maternity Care and Obstetrical Care unless originally issued with a maternity coverage rider. You may add a maternity coverage rider by submitting an application to us which must be approved by us prior to you conceiving a child. Our standard underwriting standards must be met in order for us to approve issuing a maternity coverage rider. As a consequence, there can be no maternity Benefits under this Policy before the end of 12 months from the date maternity coverage was issued.

5.5. Termination of Coverage

Subject to the Policy Holder meeting all eligibility requirements in this Policy, the Policy Holder's coverage begins upon the Effective Date of this Policy as reflected in the Benefit Summary and will end on the date that the Policy is terminated by its terms.

An Enrollee's coverage under this Policy will terminate in certain circumstances. We describe these circumstances below.

1. **Default in Payment of Premiums:** Premiums are due on or before the first day of each month of Coverage under this Policy by the method described in your Enrollment Application. A grace period of thirty-one (31) days from that due date (the "Grace Period") will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. Failure to make premium payments to us in accordance before the end of the Grace Period shall terminate Benefits under this Policy. Coverage under this Policy will be terminated retroactive to the last day of the month for which premium payment was received.
2. **Becoming Eligible for Medicare:** When an Enrollee becomes eligible for Medicare, that Enrollee is no longer eligible for coverage under this Policy and should notify us immediately.

3. **On Death:** Coverage for the Policy Holder under this Policy will automatically terminate on the date of the Policy Holder's death. All premiums paid for coverage beyond the date of the Policy Holder's death will be refunded following our receipt of proof of death.
4. **Our Option to Terminate This Policy:** We may terminate this Policy for any of the following reasons:
   A. We rescind an Enrollee's coverage for material misrepresentation or fraud committed by the Enrollee in connection with any Claim filed under this Policy;
   B. We may terminate an Enrollee's coverage upon 30 days advance written notice to an Enrollee if he or she persistently fails to cooperate in good faith with the administration of coverage under this Policy or persistently refuses to comply with treatment plans prescribed by a physician and approved by us;
   C. We may terminate an Enrollee's coverage for failure to pay any applicable Cost Sharing Amount required under this Policy upon 30 days advance written notice to such Enrollee unless you cure such default in payment within such 30-day period;
   D. We may terminate an Enrollee's coverage upon 30 days advance written notice if an unauthorized person is allowed to use the Enrollee's identification card or if the Enrollee otherwise cooperates in the unauthorized use of such Enrollee's identification card or Benefits;
   E. Each Enrollee represents all statements made in his or her Enrollment Application for coverage are true to the best of his or her knowledge and belief. If an Enrollee furnishes any misleading, deceptive, incomplete, or untrue statement, which is material to the acceptance of his or her Enrollment Application, we may rescind his or her coverage under this Policy back to the original Effective Date;
   F. Failure to respond to a request for recovery of overpayment in accordance with the provisions of Section 9.7;
   G. We will terminate an Enrollee's coverage under this Policy if the Enrollee moves permanently to another state effective as of the end of the month for which the premium for that Enrollee has been paid;
   H. An Enrollee's coverage under this Policy terminates as of the date that Enrollee is no longer eligible to be an Enrollee under this Policy;
   I. We may terminate this Policy on 90 days written notice if we decide to no longer issue this particular type of health coverage.

   If QualChoice terminates the coverage of an Enrollee, it will notify the Enrollee in writing of the termination date and premium payments received on account of the terminated Enrollee applicable to periods after the effective date of termination shall be refunded to the Enrollee within 30 days or in the next scheduled billing cycle.

5. **You Terminate Coverage**: If the Policy Holder wishes to terminate coverage under this Policy, the Policy Holder must notify QualChoice in writing in advance of the requested termination date which will be effective no sooner than the end of the calendar month that QualChoice received the notice of termination. Premiums will only be refunded for any period already paid beyond the end of the month in which the notice of termination was received.
6. **No Further Liability.** Following termination of this Policy, we will have no further liability for Benefits except for those incurred before the date the Policy terminated.
7. **Reinstatement.** If any renewal premium is not paid within the Grace Period, a subsequent acceptance of premium by us or by any agent authorized by us to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if we or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless we have previously notified you in writing of our disapproval of such application. The reinstated Policy shall cover only losses resulting from such Accidental Injury as may be sustained after the date of reinstatement and loss to such sickness as may begin more than ten (10) days after such date. In all other respects, the Enrollee and us shall have the same rights hereunder as they had under the Policy

immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

8. **Guaranteed Renewability**. This policy and riders are guaranteed renewable so long as your permanent residence is in Arkansas. At any time after the first twelve (12) month period of coverage under the Policy, we may change your premium rate, but only if the rate is changed for all policies and riders of the same form number and premium classification as this Policy. Your premium rate will also change in any month that you attain an age that moves you into a different premium classification established by QualChoice.

6. COORDINATION OF BENEFITS

You may have coverage under more than one health policy. This Policy contains a Coordination of Benefits (COB) provision. This is to eliminate duplication of payment for services. There is no COB for prescription drugs supplied at the retail pharmacy. COB will apply for drugs covered under the medical benefit. We do not coordinate against the following kinds of coverage: hospital indemnity coverage or other fixed indemnity coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, as defined by state law, school accident type coverage, benefits for non-medical components of long-term care policies, Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

6.1. How COB Works

The order of benefit determination rules govern the order in which each health policy will pay a Claim for benefits. The health policy that pays first is called the primary policy. The primary policy must pay benefits in accordance with its policy terms without regard to the possibility that another health policy may cover some expenses. The plan that pays after the primary policy is the secondary policy. The secondary policy may reduce the benefits it pays so that payments from all health policies do not exceed 100% of the COB Allowable Expense (described in Section 6.4 below).

6.2. Rules to Determine Primary and Secondary Plans

The following rules will determine primary and secondary policy coverage:

1. If a health policy does not have a COB provision, that policy is primary.
2. The health policy covering the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is primary, and the health policy that covers the person as a dependent is secondary.
3. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one health policy the order of benefits is determined as follows:
   - A. For a child whose parents are married or are living together, whether or not they have ever been married:
     - (1) The health policy of the parent whose birthday falls earlier in the Calendar Year is primary; or
     - (2) If both parents have the same birthday, the health policy that has covered the parent the longest is primary.
   - B. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:
     - (1) The plan of the parent who a court has established as being responsible for the child's health care expenses or health care coverage is primary (we must be informed of this requirement and documentation may be required);
     - (2) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage , the provisions of Subparagraph A above determines the order of benefits;

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of Subparagraph A above determine the order of benefits; or

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) Plan of the custodial parent;
(b) Plan of the custodial parent's new spouse (if remarried);
(c) Plan of the non-custodial parent; and then
(d) Plan of the new spouse of the non-custodial parent (if remarried).

C. For a dependent child covered under more than one health policy of individuals who are the parents of the child, the provisions of Subparagraph A or B above determine the order of benefits as if those individuals were the parents of the child.

4. The health policy that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is primary. The same rule applies to a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. Note that this rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

5. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another health policy, the health policy covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is primary and the COBRA or state or other federal continuation coverage is secondary. If the other health policy does not have this rule, and as a result, the health policy or policies do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

6. The health policy that covered the person as an employee, member, policyholder, subscriber or retiree longer is primary and the health policy that covered the person the shorter period of time is secondary.

7. If the preceding rules do not determine the order of benefits, the COB Allowable Expense shall be shared equally between the health policies or policies. In addition, this Policy will not pay more than it would have paid had it been primary.

6.3. Allowable Expense

For the purposes of this Section 6, "Allowable Expense" is a health care expense (including Deductible, Coinsurance or Co-payments) covered in full or in part by any health care plan or policy covering the Enrollee. This means an expense or service not covered by any plan or policy covering the Enrollee is not an Allowable Expense. Also, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Enrollee is not an Allowable Expense.

If two (2) or more plans or policies cover you and compute their benefit payments based on that plan's maximum allowable charge, any amount in excess of the Allowable Expense of the primary payor for a specified benefit is not an Allowable Expense.

If two (2) or more plans or policies cover you and provide benefits or services based on negotiated fees, any amount in excess of the negotiated fees of the primary payor is not an Allowable Expense.

If you are covered under multiple plans or policies and the Allowable Expense is determined by more than one method, the primary policy's payment arrangement shall be the Allowable Expense for all plans or policies.

6.4. Reduction of Benefits

When this Policy is secondary, we will reduce our benefits so that the total benefits paid or provided by all plan or policies are not more than one hundred percent (100%) of the total Allowable Expense of the primary policy.

A. In determining the amount to be paid for any Claim, QualChoice will calculate the Benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense that is unpaid by the primary policy. QualChoice will then reduce its payment by the amount so that, when combined with the amount paid by the primary policy, the total Benefits paid or provided by all health policy or policies for the Claim do not exceed the total Allowable Expense of the primary policy for that Claim.

B. QualChoice will credit to Enrollee's Deductible any amounts it would have credited to the Deductible in the absence of other health care coverage.

C. If an Enrollee is enrolled in two or more closed panel plans (that is, a plan or policy that provides benefits primarily through a panel of contracted health care providers and excludes coverage for services provided by other health care providers) and if, for any reason, including the provision of service by an Out-of Network Provider, benefits are not payable by one closed panel plan, COB shall not apply between that closed panel plan and other closed panel plans.

6.5. Enforcement of Provisions

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the Plan and other health policy or policies. For the purposes of COB administration, QualChoice will get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under the Plan and other health policy or policies covering the person Claiming benefits. QualChoice is not required to tell, or get the consent of, any person, including the Enrollee, to do this. You must give QualChoice any facts we needs to apply those rules and determine Benefits payable. If you fail to provide this information, we may delay Benefit payments.

6.6. Facility of Payment

A payment made under another health policy may include an amount that should have been paid under this Plan. If it does, QualChoice may pay that amount to the other plan or policy that made that payment. That amount will then be treated as though it were a benefit paid by QualChoice under this Certificate. QualChoice will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.7. Right of Recovery

If we pay more for Covered Services than this provision allows, we have the right to recover the excess payment. You agree to do whatever is necessary to secure our right to recover excess payments.

6.8. Hospitalization When Coverage Begins

Consistent with applicable law, if an eligible Enrollee is inpatient in a hospital on the effective date of this Certificate and immediately prior to such effective date was covered by another group health policy that provides coverage for hospital or medical services or expenses, coverage for benefits under that other policy, contract, or certificate will continue and it will be the primary policy for those services and expenses associated with that hospital admission. As the primary policy, that group health policy will be responsible for those services and expenses until the end of that hospital admission or until the expiration of any applicable extension of benefits provided under such group health policy, whichever occurs first.

7. COMPLAINTS AND APPEALS

We have authority and full discretion to determine all questions, problems or disputes, arising in connection with Benefits, including but not limited to eligibility, interpretation of Policy language and findings of fact about such questions. Our actions, determinations and interpretations with respect to all such matters, and with respect to any matter within the scope of our authority, shall be conclusive and binding on the Enrollee. Any problem or Claims dispute between an Enrollee and us must go through our complaint and appeals process. If the problem or dispute is over a determination of Medical Necessity, classification of treatment as Experimental or Investigational or involves an Expedited Appeal, the appeal process is controlling.

7.1. Initial Communication and Resolution of a Problem or Dispute

We welcome and encourage (but do not require) discussion of any inquiry, complaint or dispute concerning interpretation of the provisions of this Policy. A Customer Service representative will make every effort to resolve the issue. If we are unable to resolve the issue to the satisfaction of the Enrollee, the Enrollee has the right to request an Internal Review.

1. **Definition:** A complaint is an expression of dissatisfaction about us. A complaint, however, is not and will ***not*** be considered to be or handled as an "appeal" as described in Section 7.3 below. An "appeal" must be initiated and conducted as described in Section 7.3 below.
2. **Oral Complaints:** An Enrollee having a complaint regarding anything about us may contact a Customer Service Representative at 501-228-7111 or 1-800-235-7111 to assist in resolving the matter informally. The Enrollee may submit a written complaint if not satisfied with the resolution. An Enrollee is not required to make an oral complaint prior to submitting a written complaint.
3. **Written Complaints:** The Enrollee may submit a written complaint to us at the following address:

   QualChoice
   Attention: Appeals and Grievance Coordinator
   P. O. Box 25610
   Little Rock, Arkansas 72221

4. **Complaint Resolution.** We will acknowledge receipt of a written complaint within 5 working days. We will investigate the complaint and send the Enrollee a response with resolution. If we are unable to resolve the written complaint within 30 calendar days due to circumstances beyond our control, we will provide notice of the reason for the delay before the 30th calendar day.

7.2. Types of Requests and Claims

1. **Pre-Service Request:** A Pre-Service Request is a request for a service that requires prior notification and approval of the benefit prior to receiving the service. These are services, for example, that are subject to pre-certification as set forth in the Pre-Authorization of Services section of this Policy.
2. **Post-Service Claims:** Post-Service Claims are those Claims for services that have already been received by the Enrollee.
3. **Urgent Care Request:** An Urgent Care Request is a request for a service that a physician with knowledge of the Enrollee's medical condition has determined that without the service the Enrollee's:

   A. Medical condition would subject the Enrollee to severe pain that cannot be adequately managed; or

   B. Life, health or ability to regain maximum function could be seriously jeopardized.

4. **Concurrent Care Request**: A Concurrent Care Request is a request for a service that arises when Medical Necessity of an on-going course of treatment to be provided over a period of time has been approved.
5. **Administrative Issues**: We consider issues such as those regarding eligibility, coverage, level of coverage, rescission of coverage (that is, cancellation or discontinuance of coverage retroactively (unless due to lack of timely premium payment), and adherence to prescribed procedures as Administrative Issues.
6. **Medical Issues**: We consider issues such as a determination of Medical Necessity, the definition of a medical treatment as Experimental or Investigational, or the sufficiency of clinical information to make a coverage determination, to be a Medical Issue.

7.3. Appeal Process

1. **Initiating a Pre-Service, Concurrent Care, or Post-Service Internal Appeal:** The Enrollee (or the Enrollee's healthcare provider with regard to a Pre-Service Request, Concurrent Care Request or Urgent Care Request) has 180 calendar days from the date of receipt of the initial determination was made to file a formal written appeal, under this Section 7. To initiate an appeal, an Enrollee (or the Enrollee's healthcare provider) must write to our complaint and appeals coordinator at the following address:

   Appeals and Grievance Coordinator
   QualChoice
   P.O. Box 25610
   Little Rock, AR 72221-5610

   This appeal may also be faxed to:

   Appeals and Grievance Coordinator
   QualChoice
   Fax #: 501-228-9413

2. **Appeal of Pre-Service Request and Concurrent Care Request**

   A. **Internal Appeal of Administrative Issues.** After receipt of the written appeal, the Internal Appeal Reviewer will conduct an investigation of the appeal. The Internal Appeal Committee meeting at our office will hear an Internal Appeal of an Administrative Issue. The Enrollee and/or the treating healthcare provider has the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Internal Appeal Committee's questions. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

   B. **Internal Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Internal Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Internal Appeal to a medical director for review and we will notify the Enrollee of a decision within fifteen (15) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

   C. **Expedited Appeals**. A request for an expedited appeal for a Pre-Service Request or Concurrent Care Request will be treated as an appeal of an Urgent Care Request as

described in Section 7.3(4) below subject to the request meeting the criteria for an Urgent Care Request.

3. **Appeal of Post-Service Claims**

   A. **Internal Appeal of Administrative Issues.** After receipt of the written appeal, the Internal Appeal Reviewer will conduct an investigation of the appeal. The Internal Appeal Committee meeting at our office will hear a Internal Appeal of an Administrative Issue. The Enrollee has the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Internal Appeal Committee's questions. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

   B. **Internal Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Internal Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Internal Appeal to a medical director for review and we will notify the Enrollee of a decision within thirty (30) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

   C. **No Expedited Appeals**. There are no expedited appeals for Post-Service Claims.

4. **Appeal of Urgent Care Request**

   A. **Initiating an Internal Appeal.** If the Enrollee requests an expedited review and a health care professional with knowledge of the Enrollee's medical condition certifies the determination as a general pre-service request that would seriously jeopardize the Enrollee's life or health or the Enrollee's ability to regain maximum function, the Enrollee or their health care professional may submit an appeal to the Appeals and Grievance Coordinator by facsimile to 501-228-9413.

   An expedited appeal may be submitted by telephone, 501-228-7111 or 1-800-235-7111 followed by a written confirmation.

   B. **Internal Appeal.** An appeal of an Urgent Care Request will be handled by us as a Medical Issue. A medical director will make the determination on review at both levels of appeal in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Appeals Coordinator initially receives the request for review.

7.4. Documentation

1. **Written Appeals:** All appeals must be submitted in writing and include the Enrollee's name, identification number, and reference to the specific appealed Claim. However, an appeal related to an Urgent Care Request as defined in Section 7.2(3) above can initially be submitted orally so we can immediately commence consideration. We require written confirmation of such Urgent Care Request appeal even though investigation will have begun.

2. **Right to Information of Enrollee:** We will provide the Enrollee, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information that:

   A. Were relied upon in making the benefit determination;

B. Were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
C. Demonstrate compliance with the terms of the Policy; and
D. Constitute a statement of policy or guidance with respect to the Policy concerning the denied treatment option or benefit for the Enrollee's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In addition, we will provide the Enrollee, free of charge, with any new or additional rationale and/or evidence we consider, rely on, or is generated in connection with the appeal. We will provide this rationale and/or evidence as soon as possible and sufficiently in advance to allow the Enrollee a reasonable opportunity to respond prior to the date of a determination on the appeal being made by us.

3. **Right of Enrollee to Submit Information:** The Enrollee may submit with the request for an appeal any additional written comments, issues, documents, records and other information relating to the request or Claim. The Enrollee and the treating health care provider(s) are required to provide individual(s) reviewing the appeal, upon request, access to information necessary to determine the appeal. Such information should be provided not later than 5 days after the date on which the Appeals Reviewer's request for information is received, or, in the case of an Urgent Care Request or Concurrent Care Request, at such earlier time as may be necessary to comply with the applicable timelines. The Enrollee's failure to provide access to such information shall not remove the obligation of the Appeals Reviewer to make a determination on the appeal, but not providing the requested information may affect the Appeals Reviewer's determination. When adequate medical records for consideration of the appeal do not accompany the appeal of a medical issue, there are only two options: denial of the appeal or delay of the decision until we receive the records. We will inform the Enrollee of the process of obtaining the medical records, an effort in which the Enrollee may assist. At any point, the Enrollee may insist we make a determination based on the records then available, in which case we will render the decision within thirty (30) days.

7.5. Conduct of Appeals

An appeal is conducted following the procedures below.

1. **Scope of Review**: The Appeals Reviewer(s) shall conduct a complete review of all information relating to the request or Claim and shall not afford deference to the initial determination or previous appeal review in conducting the review.
2. **Qualifications of Appeals Reviewer**: The Appeals Reviewer is an individual or committee of individuals selected by us with appropriate expertise and who did not deny the request or Claim that is the subject of the appeal.
3. **Review of Medical Judgment**: When reviewing a request or Claim in which the determination was based in whole or in part on medical judgment, including determination with regard to whether a particular treatment is experimental, investigational, or not Medically Necessary or appropriate, we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual consulted in the initial determination, nor the subordinate of such individual. Upon request of the Enrollee, the identity of the health care professional(s) consulted in conducting the review who are our employees will be provided, without regard to whether we relied upon the advice of the health care professional in making the benefit determination.

7.6. Legal Actions

Prior to initiating legal action, the Enrollee must complete the appeal process in accordance with this Section. No one may bring legal action after the expiration of 3 years from the required submission time of the request or Claim.

7.7. Authorized Representative

1. **One Authorized Representative:** An Enrollee may have one representative and only one representative at a time, to assist in making a complaint, submitting a request or Claim, or appealing an unfavorable determination.

2. **Authority of Authorized Representative:** An Authorized Representative shall have the authority to represent the Enrollee in all matters in connection with the Enrollee's complaint, request, Claim or appeal of a determination. If the Enrollee has an Authorized Representative, references to the terms "The Enrollee" or "Enrollee" in this document refer to the Authorized Representative.

3. **Designation of Authorized Representative:** One of the following persons may act as an Enrollee's Authorized Representative:

    A. An individual designated by the Enrollee in writing in a form approved by us;
    B. The treating provider, if it is a Pre-Service Request, a Concurrent Care Request, or an Urgent Care Request, or if the Enrollee has designated the provider in writing in a form approved by us (Note: An assignment of benefits to a provider will not constitute appointment of that provider as an authorized representative);
    C. A person holding the Enrollee's durable power of attorney;
    D. If the Enrollee is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Enrollee by a court of competent jurisdiction; or
    E. If the Enrollee is a minor, the Enrollee's parent or legal guardian, unless we are notified the Enrollee's request or Claim involves health care services where the consent of the Enrollee's parent or legal guardian is or was not required by law and the Enrollee shall represent himself or herself.

4. **Term of the Authorized Representative:** The authority of an Authorized Representative shall continue for the period specified in the Enrollee's appointment of the Authorized Representative or until the Enrollee is legally competent to represent him or herself and notifies us in writing the Authorized Representative is no longer required or authorized.

5. **Communication with Authorized Representative:** If the Authorized Representative represents the Enrollee because the Authorized Representative is the Enrollee's parent or legal guardian or attorney in fact under a durable power of attorney, we shall send all correspondence, notices and benefit determinations to the Authorized Representative.

    If the Authorized Representative represents the Enrollee in connection with the submission of a Pre-Service Request or Concurrent Care Request, including a Claim involving Urgent Care, or in connection with an appeal, we shall send all correspondence, notices and benefit determinations to the Authorized Representative. If the Authorized Representative represents the Enrollee in connection with a Post-Service Claim, we will send all correspondence, notices, and benefit determinations in connection with the Enrollee's Claim to the Enrollee, but we will provide copies of such correspondence to the Authorized Representative upon request. The Enrollee understands it will take us a reasonable period, approximately 30 days, to notify all its personnel about the termination of the Enrollee's Authorized Representative and we may communicate information about the Enrollee to the Authorized Representative during the notification period.

7.8. External Medical Review

After you have exhausted your Internal Appeal rights with QualChoice and QualChoice has made its final determination with regard to your appeal, a voluntary external review process may be available to you. To find out more about this external review process, including an external expedited review in the event of an Urgent Care Request, please contact QualChoice's Appeals and Grievance Coordinator at 501-228-7111 or 1-800-235-7111.

The external review process is only available if the determination you appealed was based on whether the healthcare service was Medically Necessary or experimental/investigational and the adverse determination by QualChoice will cause you to have medical expenses in excess of $500.00.

An external review is not available for such things as a denial based on an express exclusion in this Policy, an express limitation in this Policy, dollar limits under this Policy, fraud or misrepresentation, or failure to follow procedures in obtaining healthcare provider access.

Your request for an external medical review must be made within sixty (60) days of your receipt of QualChoice's denial and in writing to:

Appeals and Grievance Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

The written communication must be marked and identified as a "*Request for External Review*".

The medical review would be conducted by an independent, external medical review organization selected by QualChoice from a list of approved organizations maintained by the Arkansas Department of Insurance. You would be required to pay a $25.00 fee to file the request for the external review which would be refunded to you in the event QualChoice's determination is reversed by the independent medical review organization.

As part of the external review process, you have the opportunity to submit additional information to QualChoice related to your Claim for consideration by the external review organization for consideration. You will be required to authorize the release of any medical records necessary for the external review organization to reach a decision.

The determination by the external review organization is binding and final on you, and QualChoice, unless other remedies are available under applicable state or federal law.

You may contact the Arkansas Insurance Commissioner for assistance at any time. The mailing address is: Arkansas Insurance Department, Attn: External Review Assistance, 1200 West Third Street, Little Rock, AR 72201. Their telephone number is 501-371-2640 or toll free 800-852-5494. Their email address is insurance.consumers@arkansas.gov.

8. SUBROGATION

If you have an injury or illness caused by a third party, we will provide Covered Services for such injury or illness. Acceptance of such Covered Services constitutes consent to the provisions of this Section. We will require a recovery authorization signed by you. This is a prerequisite to recovery by us against any third party for the cost of Covered Services. Our recovery rights under this Section 8 extend to worker's compensation and uninsured and underinsured motorist coverage.

You agree to protect our lien rights if an injury or illness is suffered and caused by a third party. You may be due money from a third party for the cost of Covered Services. If so, our liability for Benefits will be subrogated to any such recoveries. We have the right to sue any third party in your name, as permitted by applicable state law. If payment is received from a third party for the cost of Covered Services, you are obligated to reimburse us. Reimbursement to us may be reduced by our pro rata share of reasonable attorney's fees and costs incurred in obtaining such recovery.

You agree to cooperate fully to facilitate enforcement of our rights under this Section 8. This may include executing, delivering and filing further documents and instruments. You also agree to furnish such information and assistance, as we may reasonably require to fully enforce the terms of this Section 8. You agree to take no action prejudicing our rights and interests under this Section 8.

9. GENERAL PROVISIONS

9.1. Amendment

QualChoice reserves the right to change the benefits, conditions and premiums covered under the Policy, including the terms of this Policy. If we do so, we will give thirty (30) days written notice to you and the change will go into effect on the date fixed in the notice.

9.2. Assignment

Benefits or monies due under this Policy cannot be assigned to any person, corporation, organization or other entity. Any assignment will be void and have no effect. Assignment means the transfer of a right to the Benefits provided under this Policy. We reserve the right to make payment of Benefits directly to the healthcare provider that rendered the service.

9.3. Notice

Any notice we give to an Enrollee will be in writing. It will be mailed to him or her at the home address as it appears in our records. Notice to us must be in writing and mailed to our offices at:

QualChoice
12615 Chenal Parkway, Suite 300
P.O. Box 25610
Little Rock, AR 72221-5610

9.4. Medical Records

We may need to obtain copies of an Enrollee's medical records from any of the Enrollee's treating providers. This may be necessary to properly administer Benefits. The Enrollee, or the Enrollee's legal representative, agrees to sign an appropriate authorization for release of medical records upon our request. By accepting Benefits under this Policy, an Enrollee authorizes and directs any person or entity to furnish us with information and copies of records related to healthcare services provided by them to that Enrollee. If an Enrollee elects not to consent to the release of medical records, or if your provider fails to comply with a request for records, we may be unable to properly administer coverage. If this occurs, we have the right to deny payment for impacted Covered Services.

9.5. Notice of Claim

We must receive an Enrollee's Claim for Benefits within no more than 12 months from the date the Enrollee receive the service. Failure to meet this requirement will result in payment denial.

9.6. Who Receives Payment Under This Policy

We will make payments under this Policy directly to the Network Providers providing care. If an Enrollee receives Covered Services from any Out-of-Network Provider, we reserve the right to pay either the Policy Holder, Enrollee or the provider.

9.7. Recovery of Overpayments

On occasion, an incorrect payment may be made to you. Reason for this may include when you are not eligible, the service is not covered, or Coordination of Benefits was omitted. When this happens, we will explain the problem in writing. The amount of the mistaken payment must return to us within 60 days. Alternatively, you must provide us with written notice stating the reasons why you may be entitled to such payment. In accordance with applicable law, we may reduce future payments to you in order to recover any mistaken payment. We will recover overpayments and mistaken payments made to providers directly from them.

9.8. Confidentiality

Medical records and other information concerning an Enrollee's care we receive from providers are confidential. We will use such information only to administer the Enrollee's coverage. We will only disclose such information as required or permitted by law and as set out in the QualChoice Notice of Privacy Practices at www.qualchoice.com.

9.9. Complaint and Appeals

An Enrollee is entitled to have any complaints heard by us. We are obligated to hear such complaints, including complaints against Network Providers, in an equitable fashion. The rules and procedures set forth in Section 7 will be followed.

9.10. Right to Develop Guidelines

We reserve the right to develop or adopt guidelines for the administration of Benefits under this Policy. These criteria will be interpretive only and will not be contrary to any terms of this Policy. If you have a question about the criteria used to apply to a particular Benefit, you may contact us or visit our website at www.qualchoice.com for further information.

9.11. Limitation on Benefit of This Policy

No person or entity other than our Enrollees and us shall be entitled to bring any action to enforce any provision of this Policy. The covenants, undertakings, and agreements set forth in this Policy shall be solely for the benefit of our Enrollees and us.

9.12. Misstatement of Age

If the age of the insured has been misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

9.13. Applicable Law

This Policy, the rights and obligations of our employees and us under this Policy, and any Claims or disputes relating thereto, shall be governed by and construed in accordance with Arkansas law. If any provision of this Policy that, on its Effective Date, is in conflict with Arkansas law, then that provision is automatically changed to conform to the least minimum requirements of the law.

9.14. Headings

Section and subsection headings contained in this Policy are inserted for convenience of reference only. They shall not be deemed to be part of this Policy for any purpose. They shall not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

9.15. Pronouns

All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

9.16 Recission

Subject to the time limits set out in Section 9.19, we may rescind coverage under this Policy if an Enrollee performs an act, practice, or omission that constitutes fraud, or the Enrollee makes an intentional misrepresentation of material fact. In the event we rescind coverage, we have the right to demand that you pay back all the Benefits we paid to you or on your behalf during the period of time that you should not have been covered under this Policy. In these circumstances, we may also obtain refunds from providers that rendered services to you when coverage should not have been provided, in which case that provider may seek to obtain reimbursement from you for the amount obtained by us from that provider.

9.17 Severability

If any part of any provision of this Policy or any document or writing given pursuant to or in connection with this Policy shall be invalid or unenforceable under applicable law, such part shall be ineffective to

the extent of such invalidity or unenforceability only. Such invalidity or unenforceability will in no way affect the remaining parts of such provision or the remaining provisions of this Policy.

9.18 Legal Actions

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

9.19 Time Limit on Certain Defenses

After three (3) years from the date of issuance of this Policy, no misstatements, except fraudulent misstatements, made by the applicant for the Policy shall be used to void the Policy or to deny a Claim for loss incurred after the expiration of such three (3) year period. No Claim for loss incurred, as defined in this Policy, commencing after three (3) year from the date of issue of this Policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Effective Date of this Policy.

9.20 Waiver

The waiver by us or any Enrollee hereunder of a breach of or a default under any of the provisions of this Policy shall not be construed as a waiver of any subsequent breach or default of a similar nature. The failure of any of such parties, on one or more occasions, to enforce any of the provisions of this Policy or to exercise any right or privilege hereunder, shall not be a waiver of any of such provisions, rights or privileges hereunder.

9.21 Entire Policy; Changes

This Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or to waive any of its provisions.

10. DEFINITIONS

There are other definitions, usually capitalized, contained in various Sections throughout this Policy. The capitalized words or terms used in this Policy and are not otherwise defined have the meanings set forth below:

10.1 **"Accidental Injury"** means a bodily injury happening unexpectedly and taking place not according to the usual course of events (for example an automobile accident), and which is the direct cause of the loss, independent of disease or bodily infirmity. Accidental injury to teeth does not include any damage caused by chewing or biting any object.

10.2 **"Advanced Diagnostic Imaging"** includes but is not limited to Computerized Tomography (CT), Computerized Tomography Angiography (CTA), Coronary CT & CTA, CT Bone Density (QCT), Diagnostic CT Colonography, Functional MRI Brain (fMRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Magnetic Resonance Spectroscopy (MRS), Nuclear Cardiology, Positron Emission Tomography scanning (PET), Screening CT Colonography, and SPECT.

10.3 **"Benefits"** means reimbursement or payments for health care available to the Enrollee covered under this Policy.

10.4 **"Benefit Summary"** means a document containing specific information relating to coverage and Cost Sharing Amounts under this Policy. The information may include amounts for Deductibles, Co-payments, Coinsurance, Out-of-Pocket Limits and lifetime maximum Benefits as well as visit and day maximums for limited services.

10.5 **“Calendar Year”** means the period of one year beginning January 1 and ending on December 31 as identified in your Benefits Summary.

10.6 **“Claim for Benefits” or “Claim”** means (i) a request for payment or prior approval (when required under the Policy) for a service, supply, medication, equipment or treatment covered by the Policy, (ii) that is submitted to us by an Enrollee, a healthcare provider with an assignment of benefits from the Enrollee, or an Enrollee’s authorized representative, and (iii) is submitted consistent with QualChoice’s standard Claim filing policies and procedures (copies of which are available on request).

10.7 **"Coinsurance"** means a fixed percentage of the Maximum Allowable Charge the Enrollee must pay toward the cost of certain Covered Services for each Calendar Year. Those Covered Services subject to the application of Coinsurance are identified in the Benefit Summary. Coinsurance is subject to an annual maximum limit.

10.8 **“Complications of Pregnancy”** means hospital confinement required to treat conditions, such as the following, in a pregnant female: acute nephritis, nephrosis, cardiac decompensation, HELLP syndrome, uterine rupture, amniotic fluid embolism, chorioamnionitis, fatty liver in pregnancy, septic abortion, placenta accrete, gestational hypertension, puerperal sepsis, peripartum cardiomyopathy, cholestasis in pregnancy, thrombocytopenia in pregnancy, placenta previa, placental abruption, acute cholecystitis and pancreatitis in pregnancy, postpartum hemorrhage, septic pelvic thromboplebitis, retained placenta, venous air embolus associated with pregnancy, miscarriage, or an emergency c-section required because of (a) fetal or maternal distress during labor, or (b) severe pre-eclampsia, or (c) arrest of descent or dilitation, or (d) obstruction of the birth canal by fibroids or ovarian tumors, or (e) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a c-section delivery is not considered to be an Emergency c-section if it is merely for the convenience of the patient and/or doctor or solely due to a previous c-section. “Complications of Pregnancy” also means treatment, diagnosis or care for conditions, including the following, in a pregnant female when the condition was caused by, necessary because of, or aggravated by the pregnancy: hyperthyroidism, hepatitis B or C, HIV, Human papilloma virus, abnormal PAP syphilis, chlamydia, herpes, urinary tract infections, thromboembolism, appendicitis, hypothyroidism, pulmonary embolism, sickle cell disease, tuberculosis, migraine headaches, depression, acute myocarditis, asthma, maternal cytomegalovirus, urolithiasis, DVT prophylaxis, ovarian dermoid tumors, biliary atresia and/or cirrhosis, first trimester adnexal mass, hyditidiform mole or ectopic pregnancy. Management of a difficult pregnancy is not considered to be a “Complication of Pregnancy”.

10.9 **"Co-payment"** means a fixed dollar amount the Enrollee must pay each time the Enrollee receive a particular Covered Service to which a Co-payment applies.

10.10 **“Cost Sharing Amount”** means an amount the Enrollee is required to pay each time the Enrollee receives a particular service to which Deductibles, Co-payments, Coinsurance or benefit limitations apply. These requirements are set forth in the Benefit Summary.

10.11 **"Covered Services"** means services or supplies for which Benefits are available (i.e., payments may be made) as described in this Policy. Covered Services do not include services or supplies and care excluded pursuant to Section 4 or which do not meet the definition of "Medically Necessary" in this Section and the other qualifications set forth in Section 3.

10.12 **“Custodial Care”** means provision of routine care, including assistance with activities of daily living, to a person who is disabled mentally or physically and that disability is expected to continue for an extended length of time. “Custodial Care” can include services and supplies ordered by the Enrollee’s physician and services and supplies provided by a registered nurse, a licensed practical nurse, or licensed visiting nurse. Even if “Custodial Care” is needed by an Enrollee, it is not care that is covered under this Policy.

10.13 **"Deductible"** means a certain fixed dollar amount you or the Enrollee must incur before we begin to pay for the cost of Covered Services provided to the Enrollee during each Calendar Year.

10.14 **"Emergency"** means those health care services provided on a 24 hour/365 days a year basis to evaluate and treat medical conditions of a recent onset and severity, leading a prudent lay person, possessing an average knowledge of medicine and health, to believe his or her condition, sickness, or injury is of such a nature where failure to seek immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

10.15 **"Enrollee"** means a Policy Holder under the age of 19 residing in the State of Arkansas.

10.16 **"Enrollment Application"** means the form to be accurately completed by a prospective Policy Holder to apply for coverage.

10.17 **"Injectable Prescription Medications"** means any injectable pharmaceutical that has been approved by the Food and Drug Administration and can be obtained only through a prescription. QualChoice has classified selected medications, primarily immunizations and allergy and antibiotic injections, as "Office Services-Minor" or "Office Services-Other".

10.18 **"Maternity Care and Obstetrical Care"** means services associated with premature rupture of membranes, false labor, occasional spotting in pregnancy, pre-term labor, pre-term birth, physician directed rest during pregnancy, morning sickness, hyperemesis gravidarum, celphalopelvic disproportion, intrauterine growth retardation, analysis for fetal down syndrome, trisomey 18 or neural tube defect, congenital diaphragmatic hernia, hydrops fatalis, group B strep prophylaxis in pregnancy, isoimmunization in pregnancy, antepartum fetal surveillance, management of hyperemesis, cervical incompetence, fetal urethral obstruction, twin or greater gestation with prior uterine atony, macrosomia, incompetent cervix, forceps delivery, fetal fibronectin, cytotec for induction of labor, sudden onset of polyhydramnios, prophylactic cesarean delivery of HIV positive mother, Klippel-Trenaunay Syndrome, caudal regression syndrome, hospitalization to postpone delivery until the fetus is further developed, biophysical profiles, fetal monitoring, non-routine ultrasounds, vaginal delivery, antepartum and postpartum care, or services related to c-sections scheduled because of (i) multiple gestation, (ii) previous c-section delivery, (iii) patient or physician convenience, (iv) cephalopelvic disproportion, or (v) abnormal presentations such as breech, shoulder dystonia, transverse and compound.

10.19 **"Maximum Allowable Charge"** means the schedule of fees established by us for payments to providers for Covered Services and which may be less than actual charges billed by Network Providers or Out-of-Network Providers. **Please Note:** All Benefits under this Policy are subject to and shall be paid only by reference to the Maximum Allowable Charge as determined at the discretion of QualChoice. This means that regardless of how much a health care provider may bill for a given service, the Benefits under this Policy will be limited by the Maximum Allowable Charge we establish. If a Network Provider is used, that provider is obligated to accept our established rate as the Maximum Allowable Charge, and may only bill you for your Cost Sharing Amounts and any non-Covered Services; however, if an Out-of-Network Provider is used, you will be responsible for all amounts billed in excess of the Maximum Allowable Charge.

10.20. **"Medically Necessary" or "Medical Necessity"** means a Covered Service which in the opinion of our medical personnel:

1. Provides for the diagnosis or treatment of the Enrollee's covered medical conditions;
2. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's specific illness, injury or medical condition in relation to any overall medical/health conditions;
3. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;

4. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and
5. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

10.21. **"Medical Policy" or "Medical Policies"** means a statement developed by QualChoice that sets forth the medical criteria for coverage under QualChoice's benefit Policy or insurance policy. Limitations of benefits related to coverage of a medication, treatment, service, equipment or supply are also outlined in the Medical Policies. Medical Policies are or are based on nationally accepted guidelines and peer reviewed medical literature. Our Medical Advisory Committee reviews and approves all internally developed Medical Policies. Medical Policies are available from QualChoice, at no cost, upon request, or the Medical Policies can be reviewed on QualChoice's web site at www.qualchoice.com.

10.22 **"Medical Supplies"** means a device or equipment that is of such a nature that it is not generally used repeatedly and is usually used by a person for a medical purpose.

10.23 **"Mental Health or Substance Use Disorder"** means any psychiatric disorder or disorder of emotion or thought, appropriately classified as an Axis I diagnosis in accordance with the current edition of the Diagnosis & statistical Manual of Mental Diseases of the American Psychiatric Association (DMS) classification.

10.24 **"Network Facility"** means a hospital that has entered into an agreement with us to make Covered Services available to Enrollees.

10.25 **"Network Primary Care Physician"** means a physician who has entered into an agreement with us retarding, among other things, willingness to provide primary care Covered Services to Enrollees and who may be utilitized by an Enrollee as his or her primary care physician.

10.26 **"Network Physician"** means a physician who has entered into an agreement with us regarding, among other things, providing and arranging for the provision of Covered Services to Enrollees.

10.27 **"Network Provider"** means a Network Physician, Network Specialist, Network Facility or other provider having an agreement with us to make Covered Services available to Enrollees.

10.28 **"Network Specialist"** means a medical or surgical specialist who has entered into an agreement with us to make Covered Services available to Enrollees.

10.29 **"Out-of-Network Provider" or "Out-of-Network Facility"** means a physician, hospital or other provider that has not entered into an agreement with us to make Covered Services available to Enrollees.

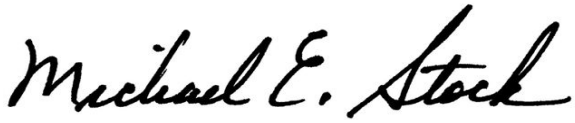
10.30 **"Out-of-Network Service"** means a Covered Service provided to an Enrollee by an Out-of-Network Provider.

10.31 **"Out-of-Pocked Limit"** means the maximum amount you pay every Calendar Year as set out in your Benefits Summary.

10.32 **"Policy Holder"** means you, the individual to whom this Policy is issued.

10.33 **"Referral"** means a specific written approval an Enrollee seeks additional evaluation or treatment from an Out-of-Network Provider. A general statement by a Network Provider stating a patient should seek a particular type of service or provider does not constitute a Referral under this Policy. We issue referrals for a specific period as determined by us. It is your responsibility to ensure all services provided to you are completed during the appropriate period. If services are rendered outside the approved period, Benefits will be allowed at Out-of-Network reimbursement levels.

10.34 **"Service Area"** means the geographical area in which we are licensed by the State of Arkansas to conduct business.



Michael E. Stock, President & CEO
QCA Health Plan, Inc. ("QualChoice")
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211

ARKANSAS CONSUMER INFORMATION NOTICE

If you need additional information about this Policy, please contact us at:

QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211
(501) 228-7111

If QualChoice is unable to respond to your questions, you should contact:

Arkansas Insurance Department
Consumer Services Department
1200 West Third Street
Little Rock, AR 72201
(501) 371-2640 or (800) 852-5494

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

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

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

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible ▪ Co-payments are not included in the annual Deductible ▪ In-Network and Out-of-Network Deductibles apply separately ▪ The annual Deductible is calculated on a Calendar Year basis ▪ Deductible amounts applied in the last quarter of a Calendar Year will NOT carry over to the next Calendar Year	[$0-$20,000]	[$0-Unlimited]
Annual Out-of-Pocket Limit ▪ Benefit will be paid at 100% of the Maximum Allowable Charge once the annual Coinsurance limit is satisfied ▪ Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits ▪ Co-payments do not apply toward your Out-of-Pocket Limits. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis	[$0-$10,000]	[$0-Unlimited]
Coinsurance	[0%-100%] after Deductible	[0%-100%] after Deductible
Preventive Care Services:		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines **Child Immunizations (age 0-18)** **Adult Immunizations (age 18+)** ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ HPV (covered age 9-18, females only) *Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Certificate of Coverage. Flu shots will be reimbursed at a fixed fee regardless of where they are obtained.*	No Cost to You	Not Covered
Routine vision exam (limit one every 24 months)	No Cost to You	Not Covered
Well baby care, birth - to age 2	No Cost to You	Not Covered
Well child care, ages 2-18	No Cost to You	Not Covered
Other preventive services ▪ Annual physical ▪ Pap smear	No Cost to You	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectible Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections	[$0-$100] Co-payment	[0%-100%] after Deductible
Specialist Office Visit ▪ Evaluation and management services	[0%-100%] [after [$0-$350] Co-payment]	[0%-100%] after Deductible
▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures	[0%-100%] after Deductible	

The following professional services are subject to Deductible and Coinsurance: ▪ Complex diagnostic services - advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures - chemotherapy, radiation therapy and infusion therapy ▪ Complex Injectible Prescription Medications which include: All specialty medications such as, enbrel, humira, IV medications and high potency antibiotics ▪ Complex procedures, such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility	[0%-100%] after Deductible	[0%-100%] after Deductible
Inpatient Care - Room and Board		
▪ Inpatient care - room and board (semi-private only) ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (30 day limit per Calendar Year for each)	[$0-$500 Co-payment] and/or [0%-100%] after Deductible	[0%-100%] after Deductible
Outpatient Care and Ambulatory Care Centers		
▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice services (limited to a lifetime maximum of 180 days)	[0%-100%] after Deductible	[0%-100%] after Deductible
▪ Outpatient Surgical Services	[$0-$500 Co-payment] and/or [0%-100%] after Deductible	
▪ Home Health Care (40 visits per Calendar Year)	[0%-100%] after Deductible	[0%-100%] after Deductible
Emergency Services		
▪ Emergency Room, Urgent Care or ER Observation Services	[$0-$1,000] Co-payment or [[0%-100%] after Deductible]	[$0-$1,000] Co-payment or [[0%-100%] after Deductible]
Transportation Services		
▪ Ambulance - Ground or Air ($1,000 maximum benefit per Calendar Year) *Note: Facility to facility ambulance transfer requires pre-authorization.*	[0%-100%] after Deductible	[0%-100%] after Deductible
Therapy Services		
▪ Physical Therapy ▪ Occupational Therapy ▪ Speech Therapy ▪ Chiropractic Care	[0%-100%] after Deductible	Not Covered
▪ Cardiac Rehabilitation (36 visits per Calendar Year) *Note: Therapy and chiropractic services are limited to a combined maximum of 45 visits per Calendar Year. This does not include Cardiac Rehabilitation.*	[0%-100%] after Deductible	[0%-100%] after Deductible

Maternity Services	In-Network (You Pay)	Out-of-Network (You Pay)
Physician Services: ▪ Routine Prenatal Lab ▪ Initial Office Visit ▪ All other services	Not Covered	Not Covered
Facility Services	Not Covered	Not Covered
Infertility Diagnostic Services Only *Note: Treatment of infertility is not covered.*	Not Covered	Not Covered
Mental Health and SubstanceUse Disorder Services		
▪ Professional Services (Office visit) *Note: If the Mental Health and Substance Use Disorder Rider is purchased refer to the Primary Care Physician (PCP) Office Visit Benefit in the Professional Services Category of this summary for applicable benefits.*	Not Covered	Not Covered
▪ Inpatient Hospital Services ▪ Professional Services (Inpatient Facility) *Note: If the Mental Health and Substance Use Disorder Rider is purchased refer to the "Inpatient Care - Room and Board" Category of this summary for applicable benefits.*	Not Covered	
Allergy Services		
▪ Office Visit and Allergy Testing	PCP: [$0-$100] Co-payment OR Specialist: [0%-100%] [and/or] [$0-$350 Co-payment]	[0%-100%] after Deductible
▪ Allergy Shots	No Cost to You	[0%-100%] after Deductible
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) ▪ $5,000 maximum benefit per Calendar Year	[0%-10%] after Deductible	Not Covered
Medical Supplies ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.	PCP: [$0-$100] Co-payment or Specialist: [0%-100%]	[0%-100%] after Deductible
▪ Provided in connection with home infusion therapy	[0%-100%] after Deductible	
▪ Provided in connection with Durable Medical Equipment	[0%-100%] after Deductible	Not Covered
Prosthetic and Orthotic Services and Devices ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices *Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Certificate of Coverage for more information.*	[0%-100%] after Deductible	[0%-100%] after Deductible
Reconstructive Surgery ▪ Breast reconstruction (48 hour minimum hospital stay) ▪ Restoration due to acute trauma, infection or cancer	[0%-100%] after Deductible	[0%-100%] after Deductible
Transplantation Services ▪ Lifetime maximum of two transplants	[0%-100%] after Deductible	Not Covered
Diabetes Management Services ▪ Supplies and equipment ▪ Diabetic Education (1 training per lifetime)	[0%-100%] after Deductible [0%-100%] after Deductible	[0%-100%] after Deductible [0%-100%] after Deductible
Dental Care ▪ Accidental injury to sound and natural teeth ▪ $2,000 maximum benefit per accident	[0%-100%] after Deductible	[0%-100%] after Deductible
Medical Foods for Phenylketonuria ▪ Benefits available after member has paid $2,400 per year	[0%-100%] after Deductible	[0%-100%] after Deductible
Genetic Counseling and Testing *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.*	No benefits if not pre-authorized [0%-100%] after Deductible	No benefits if not pre-authorized [0%-100%] after Deductible