Point of Service (POS)

GROUP EVIDENCE OF COVERAGE CERTIFICATE

Included with this Evidence of Coverage is a Benefit Summary that contains specific information relating to your coverage, including Out-of-Pocket Limits and your effective date of coverage. We encourage you to read your Benefit Summary carefully.

IMPORTANT NOTICE

COVERED SERVICES RECEIVED FROM AN OUT-OF- NETWORK PROVIDER, EXCEPT IN CERTAIN CIRCUMSTANCES, ARE PAID AT A RATE LESS THAN SIMILAR COVERED SERVICES RECEIVED FROM A NETWORK PROVIDER. REFER TO YOUR BENEFIT SUMMARY.

Thank you for selecting QualChoice!

Underwritten by:

QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, Arkansas 72211
www.qualchoice.com

IMPORTANT QUALCHOICE CONTACT INFORMATION

QualChoice is committed to providing excellent customer support. That includes making it easy for you to contact us.

You are always welcome to call us with any questions or concerns.

Website Address:

http://www.qualchoice.com

Our Customer Service Department can be reached at:

Toll Free: (800) 235-7111

Locally: (501) 228-7111

Our QCARE Coaches can be reached at:

(501) 228-7111

QualChoice®

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1. INTRODUCTION TO YOUR CERTIFICATE

1.1 Certificate is Part of Group Master Contract

QCA Health Plan, Inc. (collectively hereinafter, “QualChoice”, “us”, “we” or “our”) is a licensed 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 or toll free (800) 235-7111.

This is your Evidence of Coverage Certificate (the “Certificate”) for health care Benefits with us. This Certificate is part of the Group Master Contract that is a legal document between QualChoice and your Employer Group to provide Covered Services subject to the terms, conditions, exclusions and limitations included herein.

1.2 Changes to This Certificate

We may from time to time modify this Certificate through a “Rider” and/or “Amendment” that may change certain provisions of this Certificate. When this happens we will send you a new Certificate, Rider or Amendment.

1.3 Key Information

We have capitalized certain words in this Certificate. Those words have special meanings and, unless defined otherwise elsewhere herein, are defined in Section 13, “Definitions”. Please review these Definitions carefully. For purposes of this Certificate, "you" or “your” means the Certificate Holder (i.e., the employee).

Your coverage under this Certificate incepts at 12:01 a.m. on the effective date determined by your Employer Group and us in the Group Master Contract. Coverage will expire at 12:00 midnight in the time zone of the Employer Group’s location. We will continue your coverage unless and until your Employer Group terminates, or QualChoice terminates coverage for any of the reasons described in this Certificate. Both your Employer Group and QualChoice determine your eligibility for Benefits under the Plan and this Certificate.

This Certificate and Benefit Summary describe your Benefits, terms, conditions, limitations, exclusions and Cost Sharing Amounts. All Benefit coverage decisions are made in accordance with our Medical Coverage Policies. While the Benefit Summary provided to you is an integral part of this Certificate, if this Certificate and the Benefit Summary conflict, then this Certificate will control.

We are delivering the Group Master Contract in the State of Arkansas. In addition to various state and federal regulations, the Group Master Contract and this Certificate primarily are governed by the Employee Retirement Income Security Act (“ERISA”). ERISA will not apply if the Employer Group is not an employee welfare benefit plan as defined in ERISA. To the extent that ERISA does not apply, the Group Master Contract and Certificate primarily are governed by the laws of the State of Arkansas.

Subject to applicable law or regulation, we reserve the right to interpret Benefits or terminate this Certificate as permitted by the terms of this Certificate. Subject to applicable law or regulation, we reserve the right to modify, withdraw or add Benefits, at our sole discretion, upon renewal. Changes to this Certificate will be valid or binding only if in writing and agreed to by an officer of QualChoice.

On its effective date, this Certificate replaces and supersedes any predecessor certificate that we may have previously issued to you. This Certificate will, in turn, be replaced and superseded by any subsequent certificate we issue to you in the future.

2. HOW THIS PLAN WORKS

This Certificate provides flexibility for you in selecting options to obtain healthcare services, as well as how your selections may impact you financially. We encourage you to utilize a Network Primary Care Physician to assist in the coordination of your health care services under this Certificate. The utilization of a Network Primary Care Physician is a matter you control and you are not required to notify us of your Network Primary Care Physician relationship. You are always encouraged to first seek out care directly from a Network Primary Care Physician. You may also seek care from any Network Physician or

Provider under this Plan without a Referral. You may have the option to select either In-Network Benefits, or Out-of-Network Benefits as further described in this Certificate. Consult your Benefit Summary to identify Covered Services and Cost Sharing Amounts for each of your selections.

2.1 In-Network Benefits

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

1. Provided by a Network Provider; or
2. Emergency health services meeting the QualChoice payment guidelines. "Emergency" is a defined term in Section 13 of this Certificate.

Subject to all terms, conditions, exclusions, and limitations as set forth in this Certificate, a service that constitutes a Covered Service as defined in Section 13, and that meets either of these requirements, will be processed as an **In-Network Benefit**. Subject to all terms, conditions, exclusions, and limitations as set forth in this Certificate, a service that is a Covered Service and does not meet either of these requirements will be processed as an **Out-of-Network Benefit**.

In order to receive In-Network Benefits, Enrollees are responsible for ensuring that all corresponding or related services are provided by or received from a Network Provider. For example, if a healthcare provider (e.g., a physician, APN, etc.), refers an Enrollee for laboratory, diagnostic testing, or for medical supplies or equipment, then make sure these are provided by a Network Provider. **Please note that certain Covered Services may only be obtained from a Network Provider.** Such Covered Services are identified in your Benefit Summary. It is the Enrollee's responsibility to discuss with the treating healthcare provider whether these services will be provided by a Network Provider at a Network Facility.

Enrollees should validate the status of a Network Provider or Network Facility by accessing the online directory at any time or calling Customer Service during normal business hours. Our online directory is located on the QualChoice website at www.QualChoice.com. The network you belong to is identified on your QualChoice identification card.

2.2 Out-of-Network Benefits

As reflected in the Benefit Summary, certain Covered Services may be provided directly by an Out-of-Network Provider. Such Covered Services provided by an Out-of-Network Provider will be processed as an Out-of-Network Benefit.

The amounts allowed for Covered Services accessed under your Out-of-Network Benefits will be subject to the Maximum Allowable Charge, unless otherwise stated. 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 Benefit Summary and Section 2.6 for details.

Services provided by an Out-of-Network Provider will be covered and reimbursed under your Out-of-Network Benefits unless:

1. **Plan Provision:** The Benefit Summary or this Certificate specifically provides a different Co-payment, 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 Cost Sharing Amounts and Out-of-Pocket Limits apply. The Benefit for Out-of-Network Emergency services is an amount equal to the greater of: (1) the median amount negotiated with Network Providers for Emergency services; (2) the amount for the Emergency services calculated using the same method used to determine payments for Out-of-Network services (Maximum Allowable Charge); or (3) the amount that would be paid under Medicare for the Emergency services (adjusted for In-Network Cost Sharing). An Enrollee may be subject to balance billing for amounts in excess of the calculated Benefit amount per the above;
3. **Continuity of Care, Prior to Coverage:** The Enrollee must notify QualChoice that prior to the effective date of the Enrollee's coverage, the Enrollee was scheduled with an Out-of-Network Provider for a procedure or ongoing treatment covered under the terms of this Certificate, such procedure or treatment is for a condition requiring immediate care, and the

Enrollee requests In-Network Benefits for such scheduled procedure or ongoing treatment. If QualChoice, in its sole discretion, approves In-Network Benefits for the scheduled procedure or ongoing treatment, then In-Network Benefit Cost Sharing Amounts and Out-of-Pocket Limits 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. **Continuity of Care, Pregnancy, Prior to Coverage:** If, prior to the effective date of the Enrollee's coverage under this Certificate, the Enrollee was in the third trimester of a pregnancy covered under the terms of this Certificate and was receiving obstetrical care from an Out-of-Network Provider, then in order to continue to receive In-Network Benefits for obstetrical care from this Out-of-Network Provider, the Enrollee must request such Benefits in writing. If QualChoice, in its sole discretion, approves In-Network Benefits for the requested obstetrical care, then In-Network Cost Sharing Amounts and Out-of-Pocket Limits 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;
5. **Provider Leaves Network, Acute Conditions:** If an Enrollee begins treatment with a Network Provider for an acute condition and that Network Provider ceases to be a Network Provider while the treatment for the acute condition is ongoing, then in order to continue to receive In-Network Benefits for care for the acute condition from the Out-of-Network Provider, the Enrollee must request In-Network Benefits in writing. If QualChoice, in its sole discretion, approves In-Network Benefits for the requested ongoing treatment, then the In-Network Cost Sharing Amounts and Out-of-Pocket Limits 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:** The Enrollee must notify QualChoice that the Enrollee's Out-of-Network Provider was formerly a Network Provider when the Enrollee began receiving obstetrical care for a pregnancy covered under the terms of this Certificate, the Enrollee was in the third trimester of pregnancy on the date that the provider ceased to be a Network Provider, and the Enrollee requests In-Network Benefits for continuation of such obstetrical care from this Out-of-Network Provider. If QualChoice, in its sole discretion, approves In-Network Benefits for the requested obstetrical care, then In-Network Cost Sharing Amounts and Out-of-Pocket Limits 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: The Enrollee must notify QualChoice prior to seeking services from an Out-of-Network Provider in all instances for which In-Network Benefits are requested and must receive a prior authorization for such services. If QualChoice, in its sole discretion, approves In-Network Benefits for the requested care, then In-Network Cost Sharing Amounts and Out-of-Pocket Limits will apply to Claims only for those services and supplies receiving the prior authorization.

Note: Requests for payment of an Out-of-Network Provider at the In-Network Benefit level must be made in writing to:

QualChoice, Attn: Care Management
P.O. Box 25610
Little Rock, AR 72221
Fax: (501) 228-9413

The request must be received at least five (5) business days prior to receipt of such services or supplies.

2.3 In-Network Reference-Based Pricing for Scheduled Covered Services

We may publish a list of select scheduled Covered Services on www.QualChoice.com for which we will pay a Benefit, subject to all terms, conditions, exclusions, and limitations as set forth in this Certificate, at a set referenced price listed in a published schedule to all Network Providers. We will also publish information regarding the general amount charged by Network Providers for these scheduled Covered Services, so that you may make informed decisions regarding the Cost Sharing Amount that may be incurred depending on the Network Provider selected to perform medical services for an Enrollee. You will be responsible for applicable Cost Sharing Amounts related to such Covered Services, including your Deductible, Coinsurance, Copayment, and Reference Cost Sharing, which is the difference between the contracted amount owed to the Network Provider and the reference price paid to the Network Provider, less any other Cost Sharing Amount.

2.4 Network Provider Participation

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 an In-Network Benefit level. The network in which you participate is indicated on your identification card. If an Enrollee accesses providers outside of the Enrollee's network, then the Enrollee will receive Out-of-Network Benefits for those services unless this Certificate expressly provides for the payment of In-Network Benefits. You may search the directory on our website at www.qualchoice.com. Inasmuch as contractual agreements may change, you should verify that a physician, provider, or facility is In-Network before you seek care.

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 healthcare services is the Enrollee's responsibility.

If an Enrollee has a medical condition that we believe needs special services, we may direct the Enrollee to an appropriate facility or other provider chosen by us. If an Enrollee requires certain complex Covered Services for which QualChoice determines expertise among Network Providers is limited, then we may direct the Enrollee to an Out-of-Network Provider. **In both cases, In-Network Benefits will only be paid if the Enrollee's Covered Services for that condition are approved by us prior to receiving the service.** We will not cover any services not specifically authorized by us in the written statement of authorization. For example, the following do not constitute approval for Benefits:

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

If we determine that an Enrollee is using healthcare services in a harmful or abusive manner, or with harmful frequency, then access to Network Providers may be limited. If this happens, then we may require the Enrollee to utilize a single Network Provider to provide and coordinate all future Covered Services. If the Enrollee does not make a change to a single Network Provider within thirty-one (31) days of the date we notify the Enrollee, then we will assign a single Network Provider to the Enrollee. If the Enrollee fails to use the assigned Network Provider and there are no Out-of-Network benefits available, then Covered Services will be denied.

2.5 Cost Sharing Requirements

For Covered Services, the Benefits that are afforded under this Certificate are subject to Co-payments, Coinsurance, Reference Cost Sharing, if applicable, and Deductibles, or combinations of these Cost Sharing Amounts. Consult your Benefit Summary to determine the amounts of your payments under these Cost Sharing Amounts. A **Network Provider** may bill an Enrollee directly for Co-payments, Coinsurance, Reference Cost Sharing, and Deductible amounts, **but may not bill an Enrollee** for the difference between his or her customary charge and the Maximum Allowable Charge. An **Out-of-Network Provider** may bill an Enrollee 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 expenses for which you are financially responsible.

Enrollees are required to pay the Cost Sharing Amounts under the terms of this Certificate. The requirement that an Enrollee pay the applicable Cost Sharing Amounts cannot be waived by a provider under any "fee forgiveness", "no out-of-pocket" or similar arrangement. If a provider waives the required Cost Sharing Amounts, the Claim may be denied, in which case the Enrollee will be responsible for payment of the entire Claim. The Claim(s) may be reconsidered if the Enrollee provides satisfactory proof that the Enrollee paid the Cost Sharing Amounts under the terms of this Certificate. Amounts paid with a payment assistance card, co-pay card, or other similar means, will not accumulate toward satisfying the Deductible or Out-of-Pocket Limits. Enrollees must notify us of any amounts paid with a payment assistance card, co-pay card, or other similar means.

1. **Deductible:** Deductible is the amount that you are required to pay per Calendar Year for non-preventive Covered Services before QualChoice begins to pay. In-Network and Out-of-Network Deductibles apply separately.
2. **Co-payment:** If your plan has Co-payments, then a Co-payment is a fixed dollar amount the Enrollee 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 or family. Please see the Benefit Summary for a list of those Benefits to which Co-payments apply.
3. **Coinsurance:** Coinsurance is a fixed percentage of the Maximum Allowable Charge for the cost of Covered Services an Enrollee must pay. Coinsurance payments are paid by Enrollees in addition to Deductibles or Co-payments. Your Benefit Summary contains the Coinsurance percentage applicable to specific Benefits. The Enrollee is responsible for paying the amount of the applicable Coinsurance for the Covered Services provided to the Enrollee.
4. **Reference Cost Sharing:** For any Covered Services appearing on the published schedule for which we have listed a Benefit for which we will pay a set reference price, the Reference Cost Sharing is the difference between the contracted amount owed to the Network Provider and the reference price paid to the Network Provider, less any other Cost Sharing Amount.
5. **Limits on Your Out-of-Pocket Payments:** Please consult your Benefit Summary to determine if your Plan is a high deductible health plan ("HDHP") and what Out-of-Pocket Limits may apply to your Plan.
    A. **Plans That Are Not HDHPs:** If your plan is not an HDHP, then after the Annual Out-of-Pocket Limit has been met during the Calendar year, Coinsurance will no longer be required for the remainder of the Calendar Year. The Benefit Summary lists the Annual Out-of-Pocket Limit, if applicable. Coinsurance, Reference Cost Sharing, and Deductible payments are the only amounts that will apply towards your Annual Out-of-Pocket Limit. Co-payments or charges in excess of the Maximum Allowable Charge are your responsibility and do not count towards satisfaction of the Annual Out-of-Pocket Limit. Once your Annual Out-of-Pocket Limit has 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. **Annual Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits**.
    B. **Plans that Are HDHPs:** If your Plan is an HDHP, then the HDHP Out-of-Pocket Limit has been met during the Calendar Year, Cost Sharing will no longer be required for the remainder of the Calendar Year. The Benefit Summary lists the HDHP Out-of-Pocket Limit. Deductible, Referenc Cost Sharing, and Coinsurance are the only amounts that will apply towards your HDHP Out-of-Pocket Limit. Charges in excess of the Maximum Allowable Charge do not count towards satisfaction of the HDHP Out-of-Pocket Limit. Once your HDHP Out-of-Pocket Limit has 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. **HDHP Out-of-Pocket Limits apply separately to In-Network and Out-of-Network Benefits**.

2.6 Member Financial Responsibility Comparison

The following table provides an illustration of the cost you will pay for a typical inpatient facility stay utilizing your In-Network Benefits compared to your Out-of-Network Benefits.

	In-Network	Out-of-Network
Hospital Billed Charges	$50,000	$50,000
Contractual Discount	- 25,000	N/A
Maximum Allowable Charge	25,000	25,000
Co-Payment Paid by You	- 0	- 0
Deductible Paid by You	- 1,000	- 2,000
Coinsurance Paid by You	- 3,500	-7,000
QualChoice Total Payment	***$20,500***	***$16,000***
Your Total Financial Responsibility:		
Co-Payment	$ 0	$ 0
Deductible	1,000	2,000
Coinsurance	3,500	7,000
Difference Between Maximum Allowable Charge and Billed Charges	0	25,000
Your Total Financial Responsibility	***$4,500***	***$34,000***

2.7 Medically Necessary Services

We reimburse for Covered Services only when determined to be Medically Necessary as defined in Section 13. This standard applies to all sections of this Certificate. Regardless of anything else in this Certificate, and regardless of any other communications or materials an Enrollee may receive in connection with your Plan, Enrollees 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.

If we determine a service is not Medically Necessary before or after a Network Provider renders it, then the Network Provider is contractually obligated with QualChoice to **not** bill the Enrollee for the service (unless the Enrollee 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, then the Enrollee will be responsible for the charges for services that are not deemed Medically Necessary.

We make a determination of Medical Necessity based on 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 the Enrollee's condition and the care provided, including the reason the Enrollee's provider prescribed or provided the care, and any unusual circumstances that necessitate attention. However, the fact the Enrollee's physician prescribed the care or service does not automatically qualify that care was Medically Necessary, or that it qualified for payment under this Certificate. Also, a medical treatment that meets the criteria for Medical Necessity but is expressly excluded from coverage as set forth in Section 5 will not be reimbursed.

2.8 Exclusion and Limitations

Be advised that certain services may be subject to exclusions or specific limitations. This Certificate refers to Medical Coverage 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 Coverage Policy with respect to a particular service, treatment or drug, or, if you have Internet access, then you may review all of our established Medical Coverage Policies on our website at www.qualchoice.com.

Please consult your Benefit Summary, Medical Coverage Policies, and Section 5 of this Certificate for additional information on benefit limitations and exclusions.

2.9 Employer Group Coverage

Your coverage under this Certificate is part of an Employer Group. In order for you and your eligible dependents to be covered as part of an Employer Group, you, as the Certificate Holder, must:

1. Work on a permanent and active basis at least 30 hours per week, 48 weeks per year, for your Employer Group covered by this Certificate; and
2. Receive ongoing compensation.

You are not eligible for coverage as both an employee of an Employer Group and as a dependent of an employee of an Employer Group. If you would otherwise be eligible to be covered as both an employee and as a dependent, then you must enroll as an employee.

2.10 Enrollees Living Outside Our Service Area for More Than 90 Days

Enrollees that will live, work, or attend school outside the Service Area for more than ninety (90) consecutive days must notify us. The Enrollee must use his/her QualChoice identification card in order to access Covered Services. Covered Services are processed at the In-Network Benefit level when provided by a QualChoice National Network (QCNN) healthcare provider. Covered Services for services not provided by a QualChoice National Network (QCNN) provider are processed at the Out-of-Network Benefit level. **Out-of-Network Benefit levels may amount to thousands of dollars in additional out-of-pocket expenses for which you are financially responsible.**

Enrollees who may use the QCNN for In-Network Benefits are:

1. Covered Dependent students who are attending school outside the Service Area for at least ninety (90) consecutive days, with renewal required annually; or
2. Covered Dependent spouses and children who are living outside the Service Area for at least ninety (90) consecutive days, with renewal required annually; or
3. Active full-time employees of an Employer Group based in Arkansas, but who live outside the Service Area for at least ninety (90) consecutive days; the Employer Group must approve an application for active employees (annual renewal of this approval is not required).

Enrollees living outside of the Service Area will be responsible for obtaining pre-authorization for those services that we require to be pre-authorized (see Section 2.14) to receive Benefits at the In-Network Benefit level when accessing care from the QualChoice National Network (QCNN). It is the responsibility of the Enrollee to obtain the pre-authorization for Covered Services. QCNN providers are not responsible for obtaining a pre-authorization for services.

2.11 Coverage While Traveling Out of the Service Area

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

Except in the event of an Emergency, if health services are accessed by an Enrollee from providers not participating in the QCNN, then reimbursement for Covered Services will be at the Out-of-Network Benefit level. We will deny coverage for routine and follow-up care after Emergency health services if such services are obtained in an emergency room setting.

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 his or her QualChoice 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 3.11 must also be followed to receive maximum Benefits.

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

2.12 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 terms, conditions, limitations, and exclusions of this Certificate and the Plan. A final determination of eligibility is made at the time a 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 healthcare provider, provided within the scope of that healthcare provider's license, and rendered in accordance with professionally recognized standards of care.

The Enrollee is responsible for presenting the QualChoice identification card to all providers from whom the Enrollee receives Covered Services. If the Enrollee does not give the provider the necessary information to enable the provider to submit Claims for services to QualChoice, then QualChoice may not receive a Claim or may deny Benefits for those services if the Claim is received beyond timely filing limits. In addition, if the Enrollee does not give a Network Provider the necessary information to enable the Network Provider to obtain a required pre-authorization, then QualChoice may deny Benefits for those services. In these situations, the Enrollee will be responsible for paying the provider for the services.

2.13 Administration and Interpretation of this Certificate

Subject to applicable law or regulation, we reserve the right to interpret Benefits or terminate this Certificate as permitted by the terms of this Certificate. Subject to applicable law or regulation, we reserve the right to modify, withdraw or add Benefits, at our sole discretion, upon renewal. Changes to this Certificate will be valid or binding only if in writing and agreed to by an officer of QualChoice.

2.14 Pre-Authorization of Services

Pre-authorization is a process that determines, prior to services or supplies being provided, 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. Under these circumstances, you are responsible for obtaining all required pre-authorizations. Pre-authorizations are all time-limited to the time period set forth in the pre-authorization.

Pre-authorizations may include a requirement that the Enrollee receive the authorized service from a specific provider as set forth in a pre-authorization confirmation letter. If a pre-authorization confirmation letter requires an Enrollee to obtain services from a specific provider and the Enrollee obtains the services from another provider, then coverage may be denied and the Enrollee may not receive any Benefits for those services.

QualChoice requires that certain Covered Services be pre-authorized. Pre-authorization determinations are made in accordance with QualChoice's Medical Coverage Policies. The specific procedures requiring pre-authorization may change based upon new or changing medical technology. We reserve the right to modify the official listing of services requiring pre-authorization at any time. A listing of the services requiring pre-authorization is maintained on our website at www.qualchoice.com on the Member Home Page. **Note: Completion of services that are subject to any pre-authorization requirements may be subject to a time limitation. Please review these pre-authorization instructions carefully.**

The responsibility for obtaining pre-authorization varies depending on whether the Enrollee uses a Network Provider or an Out-of-Network Provider:

1. Subject to the conditions set forth in Section 2.12 above, Network Providers (not including QCNN providers) are responsible for obtaining the necessary pre-authorizations.
2. 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.
3. Out-of-Network Providers have no contractual relationship to QualChoice, and therefore are not responsible for obtaining required pre-authorizations in order for an Enrollee to receive Benefits. When an Enrollee receives care from an Out-of-Network Provider (including a situation in which a Network Provider has referred the Enrollee to an Out-of-Network

Provider for care), you are responsible for making sure the provider obtains the required pre-authorizations prior to services being rendered. Out-of-Network Providers must supply the clinical information necessary for us to determine Medical Necessity. We will not provide pre-authorization in order to receive Out-of-Network Benefits 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 Necessary. The Enrollee's eligibility for coverage with QualChoice must be in force on the date of service or no payment will be made. An Enrollee 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 set forth in Section 10 of this Certificate. An Enrollee's physician may request an Expedited Appeal of a denial of a pre-authorization by calling the number on your QualChoice identification card if the physician believes the services are urgent due to the Enrollee's medical condition.

2.15 Medical Necessity Determination

We cover Medically Necessary services as described in Section 2.7. Determinations of Medical Necessity are made using QualChoice's Medical Coverage Policies. We make decisions regarding whether a particular service is or was Medically Necessary based on information provided by the Enrollee's provider(s). When we review services after care has already been provided, we may review the Enrollee's medical records. A provider may request the criteria or guidelines used by QualChoice in making any decision.

2.16 Case Management

We utilize a Case Management program. Case Management will assist Enrollees to achieve the best clinical outcomes, and to make the best use of the Enrollee's Benefits. Case Management helps with an individual's specific healthcare needs. Case Management involves the timely coordination of healthcare services. We may review clinical information of any Enrollee in the Case Management program. We stay involved in the case until the need is resolved. Enrollees participate in Case Management programs including programs for diabetes mellitus, high-risk pregnancy, transplants, oncology and neonatology.

2.17 QCARE

QCARE is our population health management program that facilitates access to medical services, and provides tools and self-management assistance to our Enrollees who have chronic medical conditions, such as diabetes, hypertension, and asthma. We work one-on-one with Enrollees to help them understand their illnesses better. We also educate Enrollees on treatment options so that the Enrollee can better manage their health.

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 2.12, Pre-Authorization of Services described in Section 2.14, and to all other applicable conditions, limitations and exclusions of this Certificate. **Consult your Benefit Summary for applicable Cost Sharing Amounts.**

3.1 Abortion Services

Abortion is considered a Covered Service, if, in QualChoice's sole discretion, it is determined that the procedure is Medically Necessary. Abortion is considered Medically Necessary only in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an Abortion is performed. Abortion also is a Covered Service if the pregnancy is the result of an act of rape or incest. Pre-authorization is required.

3.2 Advanced Diagnostic Imaging

We cover Advanced Diagnostic Imaging subject to all terms, conditions, exclusions and limitations as set forth in this Certificate.

The following rules apply to Advanced Diagnostic Imaging procedures:

1. Regardless of where they are performed, Advanced Diagnostic Imaging services always fall under the required Cost Sharing Amounts of this Certificate as set forth in the Benefit Summary; and
2. Pre-authorization is required for these tests. The requirements for pre-authorization of services, detailed in Section 2.14, should be referred to and followed when receiving any of the Advanced Diagnostic Imaging services.

3.3 Ambulance Services

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

1. When Emergency health services are required, we cover ambulance transport to the nearest hospital facility;
2. Ground ambulance transportation is generally the preferred method. Air and water ambulance transportation will be covered at the sole discretion of QualChoice, and travel by air ambulance will only be covered if such travel will result in quicker arrival at the closest appropriate facility and if the difference in travel time is likely to improve patient outcome. General travel distance guidelines are contained in QualChoice's Medical Coverage Policies. The Benefit for ground and water Ambulance Services is limited to the Maximum Allowable Charge or $1,000 per trip, whichever is less, and is subject to the Deductible, Coinsurance, and Co-payments specified in your Benefit Summary. The Benefit for air Ambulance Services is limited to the Maximum Allowable Charge or $5,000 per trip, whichever is less, and is subject to the Deductible, Coinsurance, and Co-payments specified in your Benefit Summary;
3. Payments to Out-of-Network Providers are subject to Maximum Allowable Charge provisions of this Certificate. Out-of-Network ambulance providers may balance bill you for costs in excess of the Maximum Allowable Charges for services;
4. We cover ambulance transportation from one facility to another facility for one of the reasons identified below; when transportation for these listed reasons is required, it must be approved prior to the transport through the QualChoice Care Management department:
   A. To access equipment or expertise necessary for proper care;
   B. To receive a test or service that is not available at the facility where the Enrollee has been admitted and the Enrollee returns after the test or service is completed;
   C. To transport the Enrollee from an Out-of-Network Facility to a Network Facility; or
   D. To transport the Enrollee directly from an acute care setting to an alternate level of care.

3.4 Autism Spectrum Disorder

Subject to pre-authorization as described in Section 2.14 of this Certificate and a treatment plan approved by QualChoice, diagnosis and treatment of Autism Spectrum Disorder is a Covered Service if it is Medically Necessary and the recommended treatment is evidence-based. Applied Behavior Analysis is a Covered Service subject to:

1. The Enrollee receiving treatment must be under nineteen (19) years of age and diagnosed with Autism Spectrum Disorder; and
2. The treatment must be provided by or supervised by a board certified applied behavior analyst and must be in compliance with QualChoice's Medical Coverage Policy.

3.5 Complications of Pregnancy

Coverage is provided for treatment of Complications of Pregnancy when performed or prescribed by a physician. Complication of Pregnancy is defined in Section 13 of this Certificate.

3.6 Dental – Accidental Injury

We will provide coverage if an Enrollee has an Accidental Injury that damages a sound, natural tooth. Benefits are subject to a per accident Benefit Maximum. See your 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 for the dental injury occurred within seventy-two (72) hours of the Accidental Injury. The Physician or dentist must certify that any treated tooth was:

1. A virgin or un-restored tooth; or
2. A tooth that had no decay, no filling on more than two surfaces, no gum disease associated with any bone loss, no root canal therapy, no dental implant, and previously functioned normally in chewing and speech.

Unless otherwise approved by QualChoice, dental services for final treatment to repair the damage must be started within thirty (30) days of the original accident date and completed within six (6) 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 Accidental Injury, and coverage will not apply.

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 and the sound and natural tooth or teeth immediately adjacent 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 cavities or tooth decay is not covered;
5. Removal of teeth is not covered; and
6. Dental implants are not covered.

3.7 Dental – Anesthesia and Facility Care

QualChoice will provide Benefits for anesthesia and inpatient or outpatient facilities for dental procedures that would ordinarily be done under local anesthesia provided:

1. The procedure is performed in a Network Facility; and
2. The situation meets Medical Necessity criteria, and the patient is:
   A. A Child under seven (7) years of age who is determined by two (2) 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 who has a serious mental health condition that prevents use of local anesthesia for the procedure; or
   C. A person who has a serious physical condition making facility care necessary for the safe performance of dental work; or
   D. A person who has a significant behavioral problem (as certified by a Network Physician) that precludes safe performance of 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 under Section 2.14 is required. Benefits paid for anesthesia provided as part of the treatment for a dental Accidental Injury will be applied to the Benefit Maximum per Enrollee per Accidental Injury as referenced in Section 3.6 – Dental – Accidental Injury. See the Benefit Summary for the Benefit Maximum.

3.8 Dental – Oral Surgery

QualChoice provides coverage 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. Note that injury to a tooth or teeth while eating is not considered an Accidental Injury, and treatment of such injury will not be covered;
3. Excision of exostoses of jaws and hard palate;
4. Extraction of teeth required as a direct result of radiation or chemotherapy;
5. Frenectomy;
6. External incision and drainage of abscess;

7. Incision of accessory sinuses, salivary glands or ducts;
8. Certain dental services, as reflected in the Medical Coverage Policies, performed in conjunction with Medically Necessary reconstructive surgery; and
9. Dental services integral to medical services covered by the Plan.

Unless covered under Section 3.6, Section 3.7, or Section 3.8, no dental care or orthodontic services are covered.

3.9 Diabetes Management

Diabetes self-management training is limited to one (1) 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, then 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.

Covered Services include one (1) examination per year to screen for diabetic retinopathy for Enrollees with a diagnosis of diabetes. Refractions are not a part of screening for diabetic retinopathy and are not covered. Covered Services also include diabetes supplies and equipment and insulin pumps, subject to Medical Necessity requirements and our Medical Coverage Policies. See your Benefit Summary to determine Cost Sharing Amounts and Network requirements. Pre-authorization is required for coverage of insulin pumps. See Section 4.9 for diabetes supplies covered under the prescription drug Benefit.

3.10 Durable Medical Equipment

Durable Medical Equipment (DME) is equipment primarily and customarily serving a medical purpose that 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 utilized. DME is subject to Medical Necessity and appropriateness review, and the Cost Sharing Amounts of your Benefit Summary. DME may require pre-authorization as described in Section 2.14. We will not cover DME if primarily used for the convenience of the Enrollee or any other person.

All DME remains the property of QualChoice or a Network Provider. When it is more cost effective, we may 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 of and description of coverage for orthotics and prosthetic devices and services are in Sections 3.25 and 3.30 below.

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

3.11 Emergency Health Services

We cover emergency room services that meet the definition of "Emergency" as set forth in Section 13 subject to the In-Network Cost Sharing Amounts and Out-of-Pocket Limits.

1. **Emergency Care within the Service Area:** An Enrollee is encouraged to seek care from a Network Provider in the event of an Emergency whenever possible. However, if in an Emergency an Enrollee is unable to access a Network Provider, then the Enrollee should go to the nearest urgent or emergent care facility. Services provided in an Emergency are paid as shown in your Benefit Summary and as stated in Section 2.2 above.

2. **Emergency Care outside of the Service Area:** Services provided in an Emergency when an Enrollee is outside of the Service Area, but within the United States, are paid as shown in your Benefit Summary and as stated in Section 2.2 above. 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 Enrollees to seek treatment whenever possible from a healthcare provider in the QCNN.

We cover observation services ordered by a Network Provider in conjunction with a covered emergency room visit.

If an Enrollee obtains Emergency care from a Network Provider or a QCNN provider, then the Enrollee's expenses for such Emergency care will be limited to the Cost Sharing Amounts. If an Enrollee obtains Emergency care from a provider who is not a Network Provider or a QCNN provider, then the Enrollee may have to pay any charges that exceed the Maximum Allowable Charge in addition to the In-Network Cost Sharing Amounts.

If an Enrollee obtains services in an emergency room when the circumstances were not an Emergency, then it will result in a denial of Benefits for the services provided.

IN THE EVENT OF AN EMERGENCY ADMISSION AT AN OUT-OF-NETWORK FACILITY:
If in an Emergency an Enrollee goes to an Out-of-Network Facility's emergency room for treatment and the Enrollee is admitted at that Out-of-Network Facility for further care or inpatient treatment, the Enrollee, a family member, or the Out-of-Network Facility must notify our Care Management Department once the Enrollee is stabilized, but in no event more than two (2) Business Days after initial treatment. **Failure to notify us within the specified two (2) Business Day time requirement may result in a denial of Benefits.**

Upon receipt of such notification, we may either authorize the Enrollee's 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 the Enrollee stays at the Out-of-Network Facility beyond the period for which we have determined further treatment is considered Medically Necessary, then the Enrollee will be responsible for all charges billed by the facility and other providers providing care.**

3.12 Eye Examinations

Eye examinations for active illness or injury that are received from a healthcare provider in the provider's office are a Covered Service. Benefits also include one (1) routine vision exam, including refraction, to detect vision impairment by a Network Provider once every twenty-four (24) months.

3.13 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: (a) the service is provided by an employee of the hospital; (b) the hospital bills for the service; (c) the service is not primarily for convenience; and (d) 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 an Enrollee's 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. If an Enrollee has a condition requiring the Enrollee to be isolated from other patients, we will cover an isolation unit equipped and staffed as such;
4. Coverage is provided for a minimum of forty-eight (48) hours for an inpatient stay related to a mastectomy;
5. We do not provide Benefits while an Enrollee is waiting for Custodial Care;
6. We do not provide Benefits while an Enrollee is waiting for a preferred bed, room, or facility;

7. 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. Subject to Subsection D., below, 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; and
   D. If the acute facility the Enrollee is in awaiting a transfer is not providing the care we expect, then we will deny those days and make no payment.
8. 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.
9. Inpatient hospital services are subject to pre-authorization as described in Section 2.14. Please call the number listed on your identification card to notify us of the admission. If the facility is an Out-of-Network Provider, we will not provide coverage for any non-Emergency services provided prior to the date we are notified of the admission.

3.14 Family Planning Services

Coverage is provided for the following family planning services:

1. Oral contraceptives and prescription barrier methods;
2. Voluntary sterilizations (vasectomies and tubal ligations), except as excluded in Section 5.1; and
3. Long acting reversible contraceptives, including hormonal implantable systems and intrauterine contraceptives;
4. Emergency contraception;
5. Counseling and planning services for infertility when provided by Network Providers; and
6. Certain services to diagnose infertility when provided by Network Providers; diagnostic procedures are limited to semen analysis of a covered spouse, endometrial biopsy, hystero-salpingography, and diagnostic laparoscopy.

3.15 Gastric Pacemakers

Gastric pacemakers are covered for treatment of gastroparesis. Pre-authorization is required.

3.16 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 health service team as one (1) home care visit. See the Benefit Summary for visit limitation details.

The following services provided by a licensed home health agency in the home constitute 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.

3.17 Home Infusion Therapy

The Benefit for medications received from a licensed Network 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, and/or Deductible and Coinsurance.
2. FDA approved medications that exist as separate components and are intended for reconstitution prior to administration are covered. Examples include, but are not limited to, total parenteral nutrition, 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.
4. 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.

3.18 Hospice Services

Hospice care must be pre-authorized pursuant to Section 2.14 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 (6) 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 licensed physician, are covered during the period when the hospice has admitted an Enrollee to its program, provided the hospice program was pre-authorized by QualChoice:

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. Laboratory examinations;
   E. Chemotherapy and radiation therapy when required for control of symptoms;
   F. Medical supplies; and
   G. Medical care provided by a physician.

3.19 Injectable Prescription Medications

Benefits are available for Injectable Prescription Medication(s) based upon the Maximum Allowable Charge for the Injectable Prescription Medication and subject to the applicable Cost Sharing Amounts specified in your Benefit Summary. Self-Injectable Prescription Medications and supplies will only be covered if obtained from a Network Pharmacy.

3.20 Inpatient Professional Services

We provide coverage for Medically Necessary inpatient surgical and professional services received in an inpatient setting when performed or prescribed by a physician. Covered Services include inpatient visits by the attending physician or consultants. It is the responsibility of the Enrollee to insure consulting physicians are Network Physicians in order to receive In-Network Benefits for any Covered Services provided.

3.21 Maternity Services

The following maternity services are covered:

1. **Fetal Testing:** Amniocentesis or chorionic villus sampling is covered when performed in accordance with recognized standards of care.
2. **Inpatient Hospital Stays:** We will pay for an inpatient facility stay of at least forty-eight (48) hours for the mother and newborn Child following a normal vaginal delivery. We will pay for an inpatient facility stay of at least ninety-six (96) hours for the mother and newborn Child following a cesarean section delivery. However, we may pay for a shorter stay if the attending provider (*e.g.*, the Enrollee's physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Note: Under federal law, we may not set the level of Benefits or the out-of-pocket costs so that any later portion of the forty-eight (48) hour or ninety-six (96) hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. Further, we may not require that a *physician or other healthcare provider* obtain pre-authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce out-of-pocket costs, *an Enrollee* may be required to obtain pre-authorization. For further information on maternity-related pre-authorization, please contact our Customer Service department.

3. **Maternity Care and Obstetrical Care:** Coverage is provided for Maternity Care and Obstetrical Care, including routine prenatal care, postnatal care, delivery in an inpatient facility setting, and any related complications. Obstetrical ultrasounds are covered when Medically Necessary, as noted in our Medical Coverage Policies. QualChoice provides special prenatal programs designed to benefit Enrollees and their babies during pregnancy. These are available at no additional cost and are voluntary. To sign up, the Enrollee should contact us as early as possible during pregnancy.
4. **Prenatal Tests and Testing of Newborn Children:** Coverage is provided for prenatal tests and tests of newborn children that are supported by QualChoice's Medical Coverage Policies. Examples of such tests that are covered include testing for hypothyroidism, sickle-cell anemia, and single gene inborn errors of metabolism.
5. **Midwives:** Coverage is provided for services received from a certified nurse midwife, but only if that nurse midwife is a Network Provider and the delivery is done in an inpatient facility setting.
6. **Newborn Care in the Hospital:** A newborn Child of the Certificate Holder or the Certificate Holder's spouse will be covered from the date of birth, including use of newborn nursery and related services, provided the Child's coverage becomes effective on his or her date of birth subject to the requirements of Section 6 being met.

   NOTE: However, if such Child is born in an Out-of-Network Provider hospital, then the Child's coverage for Covered Services in the first ninety (90) days is limited to the Maximum Allowable Charge or $2,000, whichever is less, and is processed as an Out-of-Network benefit. If a Child is born in an Out-of-Network Provider hospital because the Certificate Holder's spouse has other health benefit coverage, or if such Child is an adopted Child born in an Out-of-Network Provider hospital, then nursery charges are covered up to the Maximum Allowable Charge and processed as an In-Network benefit.

3.22 Medical Foods

Medical foods and low protein modified food products for the therapeutic treatment of a person with single gene inborn errors of metabolism are covered if:

1. The medical food or low protein modified food products are prescribed by a physician as medically necessary or a physician issues a written order stating that the medical food is medically necessary for the therapeutic treatment of single gene inborn errors of metabolism;
2. The products are administered under the direction of a licensed physician and shall only be administered under the direction of a clinical geneticist and a registered dietitian;
3. Treatment shall be derived from evidence-based practice guidelines and be efficacious. All Benefits shall be subject to pre-authorization requirements; and
4. Benefits are subject to Cost Sharing Amounts specified in the Benefit Summary.

3.23 Medical Supplies

Subject to all terms, conditions, exclusions and limitations of this Certificate, Medical Supplies, other than Medical Supplies that can be purchased without a prescription, are covered when prescribed by a physician and when deemed 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 used in connection with Durable Medical Equipment is subject to the Cost Sharing Amounts specified in the Benefit Summary;
3. 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; and
4. Coverage for Medical Supplies is limited to not more than a thirty-one (31) day supply per month.

3.24 Nutritional Counseling or Nutritional Supplements

Coverage is provided for dietary and nutritional counseling services when provided in conjunction with diabetes self-management training, for services needed by Enrollees in connection with cleft palate management, and for nutritional assessment programs provided in and by a hospital and approved by QualChoice. Benefits are not available for weight loss or weight maintenance programs. For Enrollees with diabetes, see Section 3.9.

3.25 Orthotic Services and Orthotic Devices

Orthotic Services and Orthotic Devices (as defined in this Section) are covered as described below.

"Orthotic Devices" and "Orthotic Services", including the fitting and/or repair of Orthotic Devices, may require pre-authorization as described in Section 2.14.

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 qualify as a covered "Orthotic Device" under this Certificate, the device must meet all three (3) of the following requirements:

1. The external device is (a) intended to restore physiological function or cosmesis to a patient; and (b) 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 (a) licensed doctor of medicine, (b) licensed doctor of osteopathy, or (c) licensed doctor of podiatric medicine; and
3. The device must be provided by a (a) licensed doctor of medicine, (b) licensed doctor of osteopathy, (c) licensed doctor of podiatric medicine, (d) licensed orthotist, or (e) licensed prosthetist.

An Orthotic Device does *not* include a/an (a) cane, (b) crutch, (c) corset, (d) dental appliance, (e) elastic hose, (f) elastic support, (g) fabric support, (h) generic arch support, (i) low-temperature plastic splint, (j) soft cervical collar, (k) truss, or (l) any similar device meeting both of the following requirements:

1. It is carried in stock and sold with or without a prescription or 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" does *not* include foot supports 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 supports, 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 devices, soft devices or semi-rigid 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 Certificate. 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 forth in your Benefit Summary.

3.26 Outpatient Services

Outpatient Covered Services are as follows:

1. **Outpatient Facility Services:** Subject to all of the terms, conditions, limitations and exclusions of this Certificate, Covered Services on an outpatient basis 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, injectable prescription medication services, laboratory services, surgical services, physical, occupational and speech therapy services, audiology services and renal dialysis. We also cover up to twenty-four (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 Medically Necessary outpatient surgical services received from an ambulatory surgical 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 Enrollee uses an Out-of-Network Facility or ambulatory surgery center, payment will be limited to the Maximum Allowable Charge.

   We cover Medically Necessary surgical services. We apply a multiple surgical procedures reduction when the same provider performs two (2) or more surgical procedures on the same Enrollee within the same operative session.

3.27 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 as set forth in your Benefit Summary.

3.28 Preventive and Wellness Health Services

We cover U.S. Preventive Services Task Force A or B rated recommendations and those services that are recognized and defined by QualChoice's Medical Coverage Policies as being preventive and/or wellness in nature. Subject to changes QualChoice may make to its Medical Coverage Policies, a partial listing of those services QualChoice considers to be preventive and/or wellness health services is included within your Benefit Summary. The most complete list of those services QualChoice considers being preventive and/or wellness health services is available on our website at www.qualchoice.com or you may contact our Customer Service department to obtain specific coverage guidelines. **Please note that it may take up to twelve (12) months following an A or B rating by the U.S. Preventive Services Task Force for QualChoice to implement coverage as a preventive service**.

3.29 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 of the Plan as set forth in this Certificate and related Benefit 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, one (1) 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 (1) or more incisions, we apply a multiple surgical procedure reduction when the same provider performs two (2) or more surgical procedures on the same Enrollee within the same operative session;
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 (2) 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 (1) assistant who is a healthcare provider licensed and qualified to act as an assistant for the surgical procedure when Medically Necessary; and
5. We will cover a standby physician only if that physician is required to assist with certain high-risk surgeries identified by us and only if that physician is in the immediate proximity to the Enrollee during the standby period.

3.30 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 2.14.

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 Certificate, the device must meet all three (3) of the following requirements:

1. The device is: (a) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient; and (b) 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 (a) licensed doctor of medicine; (b) licensed doctor of osteopathy; or (c) licensed doctor of podiatric medicine; and
3. The device must be provided by a (a) licensed doctor of medicine; (b) licensed doctor of osteopathy, (c) licensed doctor of podiatric medicine, (d) licensed orthotist; or (e) licensed prosthetist.

A "Prosthetic Device" shall include 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: (a) artificial ear; (b) dental appliance (including corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome); (c) cosmetic device such as artificial eyelashes; (d) device used exclusively for athletic purposes; (e) artificial facial device; or (f) 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 Certificate. 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.

3.31 Reconstructive Surgery

We cover services in connection with reconstructive surgery if necessary to correct congenital malformations or anomalies resulting in a severe functional impairment of a Child covered under this Certificate, or to restore the part of the body injured or deformed by an acute trauma, infection or cancer subject to the following:

1. Restoration must be aimed at restoration of function, not just restoration of appearance; and
2. Restoration is intended to achieve an average person's normal function (for example, restoration aimed at athletic performance is *not* covered).

Coverage is provided for the following reconstructive surgery procedures:

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 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. Except as expressly set forth below, dental care to correct congenital defects is not a Covered Service;
3. Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery;
4. In connection with a mastectomy eligible for coverage under this Certificate, services for (a) reconstruction of the breast on which the surgery was performed; (b) surgery to reconstruct the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphedemas;
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; or
6. Corrective surgery and related medical care (dental care, vision care, and the use of one (1) hearing aid) for a person of any age who is diagnosed as having a craniofacial anomaly if the surgery and treatment are Medically Necessary to improve a functional impairment that results from the craniofacial anomaly as determined by a nationally approved cleft-craniofacial team. This coverage requires a treatment plan coordinated by a nationally approved cleft-craniofacial team for cleft-craniofacial conditions. These services will only be covered in-network. Pre-authorization is required.

Cosmetic services are intended primarily to improve appearances or for psychological benefit. As further explained in Section 5.1, we do not pay for any procedures, surgeries, services, equipment or supplies provided in connection with cosmetic services.

3.32 Rehabilitation Services

Services for rehabilitative outpatient physical, occupational or speech therapy and chiropractic, audiology, cardiac or pulmonary rehabilitation are covered. This includes services performed in the office of a physician, chiropractor or licensed or registered therapist, outpatient therapy center, or in the outpatient department of a hospital. Refer to the Benefit Summary and Section 5 for specific limits. Please note that Benefits are available only for Covered Services that are expected to result in a significant improvement in the Enrollee's condition within a reasonable time period as determined by QualChoice.

3.33 Skilled Nursing Facility and Inpatient Rehabilitation Services

Coverage is available for Medically Necessary care in a skilled nursing facility or acute inpatient rehabilitation facility. Care requires pre-authorization and will be limited to the number of covered days provided in the Benefit Summary and must meet the Medically Necessary criteria of continued improvement in our Medical Coverage Policies. Custodial Care is not covered.

Consult the Benefit Summary for applicable Cost Sharing Amounts and other limitations.

3.34 Tobacco Cessation Services

We cover tobacco cessation treatments for Enrollees enrolled in our Kick the Nic™ tobacco cessation program. Enrollees can learn more about the details of the Kick the Nic™ program by going to our website www.qualchoice.com and can enroll in the program the program by contacting a QCARE health coach by calling (501) 228-7111. Covered counseling sessions include proactive telephone counseling and individual counseling for tobacco cessation. Benefits are payable for up to two (2) attempts per person per calendar year, with up to four (4) counseling sessions of at least thirty (30) minutes each per attempt. In addition, with a Network Provider's Prescription, we cover over-the-counter nicotine gum, nicotine patch, nicotine lozenge, bupropion and varenicline. The quantity of drugs reimbursed will be subject to recommended courses of treatment. Enrollees may obtain tobacco cessation drugs through their QualChoice Kick the Nic™ coach. Enrollees may access these counseling and medication treatments without any cost-sharing.

3.35 Transplantation Services

Transplant Benefits are available subject to the general conditions for payment specified in Section 2.12, and to all other applicable terms, conditions, limitations and exclusions of this Certificate. Consult the Benefit Summary for applicable Cost Sharing Amounts and other limitations.

1. **Pre-Authorization Required: The Enrollee or a duly authorized representative must call the number on your ID card to obtain pre-authorization prior to the evaluation for transplant and placement on any transplant list.** Once the evaluation is complete, an additional written pre-authorization must be obtained prior to 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 QualChoice's Medical Coverage Policies 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 previously 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 certain 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. This coverage extends to the donor whose organ has been selected to be used in the transplantation. (If the donor has other insurance, then 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.
3. **Bone Marrow and Stem Cell Transplantation:** Bone marrow and stem cell transplantation is only covered for medical conditions specifically identified in QualChoice's Medical Coverage Policies. This limitation applies to the bone marrow and stem cell 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. Bone marrow and stem cell transplantation must be pre-authorized by QualChoice as described in Section 2.14 and requires specific donor matches for certain procedures.
4. **Cornea Transplantation:** Cornea transplantation is covered subject to all terms, limitations and exclusions as set forth in this Certificate. Cornea transplantation does not require pre-authorization.

IMPORTANT NOTE REGARDING TRANSPLANTATION SERVICES: It is important that you review and understand the benefit limitations for transplant services described in Section 5.2 of this Certificate.

3.36 Urgent Care Center or After-Hours Clinic

Subject to all other terms, conditions, exclusions and limitations of this Certificate, coverage is provided for Covered Services provided in an urgent care center or after-hours clinic. The Benefit will be determined by the specific benefit plan, provider network participation, and how the services are billed, i.e., primary care, emergent, urgent, etc.

4. PRESCRIPTION DRUG BENEFITS

Enrollees only have prescription drug Benefits from Network Pharmacies. Subject to the Cost Sharing Amounts in your Prescription Benefit Summary, the exclusions and limitations described in this Section 4, and all other applicable conditions, limitations, and exclusions of this Certificate and the Prescription Benefit Summary, Benefits are available for those outpatient prescription drugs specified in this Section 4. Under this prescription drug benefit, Enrollees will pay one or more of the following as reflected in the Prescription Benefit Summary: a fixed Co-payment, a Deductible, and/or Coinsurance for

each Covered Prescription Drug obtained. ***Consult the Prescription Benefit Summary for applicable Cost Sharing Amounts by Tier*.**

4.1 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) obtainable only with a physician's written prescription, (4) not excluded or limited in Sections 4.13 or 4.14 of this Certificate, (5) has been placed by QualChoice on a Formulary as described in Section 4.2 below, and (6) is obtained from a Network Pharmacy.

Off Label Drug Use: When a drug is used in a way not approved by the FDA, we will cover that use if Medically Necessary and not deemed experimental and investigational.

There may be limitations on coverage for Covered Prescription Drugs. Some of those limitations are set out in Section 4.14 of this Certificate. Other limitations can be found in our Medical Coverage Policies.

4.2 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 as set forth herein.

All Covered Prescription Drugs placed on a specific Formulary will be assigned to a "Tier". 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 4.12 below and your Prescription Benefit Summary for details regarding Enrollee cost sharing for different Tiers).

4.3 Purchase from Retail Network Pharmacy

An Enrollee must show his/her QualChoice identification card when purchasing a prescription at a participating retail Network 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 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 Certificate and the Prescription Benefit 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 retail Network Pharmacies can dispense up to a thirty (30) day maximum supply per fill. A select group of participating retail Network Pharmacies is allowed to dispense up to a ninety (90) day maximum supply per fill for a maintenance medication. You can look up your retail Network Pharmacies participating in your network, which is shown on your QualChoice identification card, and identify these select pharmacies by logging onto our website at www.qualchoice.com. For pharmacies that are members of national chains, only those specific locations identified as participating in your network are considered Network Pharmacies.

4.4 Purchase from Mail Order Pharmacy

In addition to a retail Network Pharmacy, 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 4.12 below for mail order is the same as it is for participating retail Network Pharmacies.

4.5 Obtaining Benefits for Covered OTC Products

Only those over-the-counter (non-prescription or OTC) products listed on the Formulary are covered. A written prescription is necessary to obtain covered over-the-counter products. At the retail Network Pharmacy, the Enrollee should present the 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.

4.6 Brand Drugs with Generic Equivalent 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. Some Brand Drugs with a Generic Drug equivalent available are not covered on the Formulary. Only those Brand Drugs with a Generic Drug equivalent that are listed on the Formulary are covered. 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.

4.7 New Drugs Entering the Market

New drugs entering the market and drugs in new dosage forms may not be added to the Formulary. If added, Tier placement on the Formulary will be made at the discretion of QualChoice.

4.8 Maintenance Medications

Some Maintenance Medications (as defined in this paragraph) are allowed at a ninety (90) day supply with a Co-payment, if applicable, for each thirty (30) day supply. See Section 4.3 – Purchase From Retail Network Pharmacy. For purposes of this Plan, "Maintenance Medications" are defined as follows:

1. A drug that is usually administered continuously, rather than intermittently, and for longer than ninety (90) days, typically for the remainder of one's life. This means the patient is taking the medication on a scheduled basis year round and not as needed or seasonally.
2. 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.
3. 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.
4. 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.
5. Drugs in the following classes are considered to be Maintenance Medications. If an Enrollee's medication falls in one of these categories, then the Enrollee will be able to get a ninety (90) day supply either from the Enrollee's retail Network Pharmacy (if it participates in the ninety (90) day network) or from the mail order pharmacy. The Enrollee will need a prescription from the Enrollee's doctor with enough refills to allow ninety (90) days. One (1) Co-payment, if applicable, will be charged for each thirty (30) day supply.
   A. Alzheimer Disease medication
   B. Antipsychotic medication
   C. Asthma and other respiratory medication
   D. Benign Prostatic Hyperplasia (BPH) medication
   E. Blood pressure medication (e.g., beta blockers, calcium channel blockers, diuretics, ACE-inhibitors)
   F. Certain cancer medication (other cancer medication may be a Specialty Pharmacy medication (see Section 4.11))
   G. Cholesterol lowering drugs
   H. Diabetes medication
   I. Glaucoma medication
   J. Heart medication
   K. Organ transplant medication
   L. Osteoporosis medication
   M. Parkinson's Disease medication

N. Potassium supplements
O. Seizure medication
P. Thyroid medication
Q. Antidepressants
R. Contraceptives
S. Gout medication
T. Estrogens

4.9 Diabetes Supplies

The following diabetes supplies are covered under your prescription drug Benefit as reflected in the Prescription Benefit Summary:

1. Test strips and lancets, if filled together, will be considered to be a single prescription;
2. Insulin and syringes, if filled together, will be considered to be a single prescription.

4.10 Immunizations

Most immunizations that pharmacists are allowed to administer are covered under the prescription drug Benefit, subject to the limitations outlined in the Immunization Medical Coverage Policy .

4.11 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 some must be obtained through a contracted Network Specialty Pharmacy identified by QualChoice instead of a retail Network Pharmacy. Enrollees will be able to obtain up to a thirty (30) day supply of Specialty Pharmacy medications. Some Specialty Pharmacy medications may be covered under the medical plan instead of the prescription drug Benefit and they are subject to the medical plan Deductible and Coinsurance. You can find out whether a particular medication is considered to be a Specialty Pharmacy medication, if a particular Specialty Pharmacy medication requires pre-authorization, and if a 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.

4.12 Cost Sharing Amounts

1. The Enrollee will be responsible for paying the member Cost Sharing Amounts reflected in the Prescription Benefit Summary. The Cost Sharing Amounts will be different for drugs on different Tiers.
2. Unless stated otherwise in your Prescription Benefit Summary, 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 Drug, plus the difference in the cost between the Brand Drug and the Generic Drug.
3. Amounts paid by an Enrollee for Covered Prescription Drugs may or may not accumulate toward satisfying your medical Deductible responsibility. Applicable amounts paid by an Enrollee for Covered Prescription Drugs will accumulate toward satisfying your Out-of-Pocket Limits shown in your Benefit Summary.
4. The amount an Enrollee pays for any non-Covered Prescription Drugs is not included in determining the amount of any Out-of-Pocket Limits stated in this Certificate and/or the Benefit Summary.
5. All QualChoice formularies are subject to changes during the year. These changes may affect the Cost Sharing Amounts.

4.13 Exclusions from Coverage

1. The following products or categories of drugs are not covered:
   A. Drugs not on the Formulary;
   B. Drugs not approved by the Food and Drug Administration;
   C. Drugs prescribed for an unproven indication;
   D. Over-the-counter drugs (unless listed on the Formulary);
   E. Drugs that are not Medically Necessary for the Enrollee's medical condition for which the drug has been prescribed;

F. Drugs 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;
G. Drugs for which payment or benefits are provided by the local, state or federal government;
H. Compounded drugs;
I. Drugs prescribed to treat infertility;
J. Research drugs;
K. Experimental or investigational drugs;
L. General vitamins; and
M. Self-administered or take-home drugs that are not obtained from a Network Pharmacy.

2. Replacement of previously filled prescription medications because the initial prescription medication was lost, stolen, spilled, contaminated, etc., are not covered.
3. 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 Certificate, on grounds of excessive use when it is determined that: (a) 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 (b) 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 (c) 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, healthcare provider or pharmacy for the purpose of reviewing and discussing the Enrollee's prescription history, use or activity to evaluate for excessive use.

4.14 Limitations of Coverage

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

1. Covered Prescription Drugs filled at most retail Network Pharmacies are subject to a maximum (30) day supply per fill.
2. Covered Prescription Drugs at a limited number of select contracted retail and mail order pharmacies are subject to a maximum ninety (90) day supply per fill. You may contact our Customer Service Department to obtain a copy of the listing.
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:
   A. Anti-nausea medications used for the treatment of nausea and vomiting associated with chemotherapy, radiation therapy, and surgery are limited to a five (5) day supply per prescription and must be pre-authorized by QualChoice;
   B. Coverage for sedative and hypnotic products is limited to a maximum of thirty (30) tablets per thirty (30) day supply, with a maximum quantity of 360 tablets per Enrollee per calendar year; and
   C. 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.
4. We do not cover smoking cessation drugs and devices unless an Enrollee is enrolled in QualChoice's tobacco cessation program described in Section 3.34 of this Certificate.
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 (1) 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 and Network Physicians to obtain medication. The Enrollee will be notified of

this determination. The Enrollee's failure to use the identified participating Network Pharmacy will result in that Enrollee's prescription drugs not being covered.

4.15 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.

4.16 Pre-Authorization May Be Required

Prior to certain Covered Prescription Drugs being covered, the Enrollee or the Enrollee's physician must obtain pre-authorization from us as described in this Certificate. The list of Covered Prescription Drugs requiring pre-authorization is subject to review and change. For a current list of those Covered Prescription Drugs requiring pre-authorization, access our website at www.qualchoice.com.

5. 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 in its sole discretion to eliminate or modify an exclusion or limitation if QualChoice determines that advances in medical care warrant making such a change. One or more of our optional coverage riders may cover some of these items. If your Employer Group has purchased riders, they will be provided to you in writing. Please refer to your 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 5 strictly for preventive health purposes; where applicable, these limited coverages are identified and described in QualChoice's Preventive Health Benefit Medical Coverage Policy.

5.1 Non-Covered Services and Exclusions from Coverage

1. **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 elective Abortion. See Section 3.1 for coverage of Medically Necessary Abortion.
2. **Acupuncture:** Acupuncture services are not Covered Services.
3. **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. For the purpose of this Plan, the child of a surrogate mother will not be considered a dependent of the surrogate mother or her spouse if the mother has entered into a contract or other understanding pursuant to which she relinquishes the child following its birth. Refer to Section 6.3 for information regarding coverage of adopted children.
4. **After Hours or Weekend Charges:** We will not cover any surcharges related to the time of day or day of the week on which services were rendered.
5. **Against Medical Advice:** We will not cover any services related to complications resulting from the Enrollee's discharge against medical advice.
6. **Alternative or Complementary Medicine:** We will not cover devices or services relating to alternative systems of medical practice including, 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;
   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, but not limited to, metabolic therapy; and

K. Massage therapy (except as provided for in QualChoice's Medical Coverage Policies).

7. **Biofeedback:** Biofeedback and other forms of self-care or self-help training, and any related diagnostic testing are not covered for any diagnosis or medical condition.
8. **Blood and Blood Donation:** We do not pay for any charges associated with blood donations. We do not pay for procurement, or storage, of donated blood. We do not cover umbilical cord blood banking or blood banking for blood or blood products with unscheduled future use. We do cover the charges for administration of blood and blood products. We do cover blood or blood product banking charges for covered procedures planned in the next one hundred eighty (180) days.
9. **Blood Typing for Paternity Testing:** Blood typing or DNA analysis for paternity testing is not covered.
10. **Cannabis:** Medical cannabis (marijuana) or supplies are not covered.
11. **Care Plan Oversight**: Except as covered in Section 5.1.103 **Telephone and Other Electronic Communication**, 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 an Enrollee's household. We also will not cover care provided by an Enrollee or by an Enrollee's 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 of uncovered services include, but are not limited to,:
    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 facilities;
    E. Infirmaries at camps or schools;
    F. Hospitals for treatment of a Mental Health or Substance Use Disorder, except as provided for in a Mental Health Parity Rider, Treatment of Psychiatric Conditions Benefits Rider, and/or Treatment of Substance Abuse Benefits Rider (if included with this Certificate);
    G. Rehabilitation facilities and rehabilitation units in other facilities (except as covered under Section 3.32);
    H. Skilled nursing facilities and places primarily for nursing care (except as covered under Section 3.33);
    I. Extended care, chronic care, or transitional hospitals or facilities (except as covered under Section 3.32 and Section 3.33); or
    J. Other facilities and institutions that do not meet our criteria for short-term acute care general facility or skilled nursing facilities.
14. **Cerebellar Stimulator or Pacemaker:** Cerebellar stimulator or pacemaker for the treatment of neurological disease is not covered.
15. **Charges In Excess Of Benefit Maximums, Calendar Year Maximums, or Lifetime Maximums:** We will not cover any service, supply or treatment in excess of any Benefit Maximum or the Calendar Year or lifetime maximum as reflected in the Benefit Summary.
16. **Charges for Missed/Canceled Appointments:** We will not pay for charges resulting from the Enrollee's failure to keep scheduled appointments.
17. **Chelation Therapy:** Services or supplies provided as, or in conjunction with, chelation therapy are not covered, except for treatment of ventricular arrhythmias or heart block associated with digitalis toxicity, emergency treatment of hypercalcemia, and extreme metal poisoning.
18. **Chemical Ecology:** Diagnostic studies and treatment of multiple chemical sensitivities, environmental illness, environmental hypersensitivity disorder, total allergy syndrome or chemical ecology are not covered.
19. **Complications:** We will not cover medical or surgical complications resulting from a non-Covered Service.

20. **Contraceptive Devices or Supplies:** Contraceptive devices or supplies available over-the-counter (without a prescription) are not covered.
21. **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: a cot, hot water bottle, telephone, television, television rental charges, whirlpool bath, automobile/van conversion, wheel chair ramp, motor scooters, air purifiers, exercise equipment, machines used for communication and speech, lifts, and home modifications.
22. **Cosmetic or Reconstructive Services**: Cosmetic services are intended primarily to improve appearance or for psychological benefit. We will not pay for any procedures, surgeries, services, equipment or supplies provided in connection with cosmetic surgery or complications arising from a cosmetic service even if coverage was provided by another health plan. Procedures or services that change or improve appearance without improving physiological function are also not covered. Procedures or services that correct a physical developmental defect present at the time of birth without improving or restoring physiologic function are considered cosmetic procedures. The fact that an Enrollee may suffer psychological consequences as a result of an injury, sickness or developmental defect present at the time of birth, does not make the service Medically Necessary.
23. **Court Ordered or Mandated Care:** We provide coverage for medical, psychological, or psychiatric care that is Medically Necessary and is a Covered Service under this Certificate subject to all other terms, conditions, exclusions, and limitations of coverage, regardless of whether the care 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). No Benefits will be provided as a result of a Court order or due to a third-party mandate if not Medically Necessary, if not a Covered Service, or in excess of the Benefits otherwise provided by this Certificate.
24. **Custodial Care:** We do not cover Custodial Care. 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 facility, 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.
25. **Dental Care:** This Plan does not provide Benefits for dental care. Except as otherwise stated in this Certificate, 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 in any location;
    G. Treatment of dental pain;
    H. Treatment of dentigerous cysts;
    I. Removal of soft tissue supporting or surrounding teeth;
    J. Orthodontia (including braces);
    K. False teeth;
    L. Orthognathic surgery; or
    M. Any other dental services an Enrollee may receive.
26. **Dental Implants:** Dental implants are not covered.
27. **Developmental Delay:** Except as provided in Section 3.4, services or supplies provided for developmental delay, including learning disabilities, communication delay, perceptual disorder, sensory deficit, and motor dysfunctions are not covered.

28. **Dietary and Nutritional Services** Except as provided in Section 3.22 – Medical Foods, 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 covered.
29. **Domestic Partners:** We do not provide coverage for domestic partners.
30. **Donor Expenses For Transplant:** Services and supplies associated with an organ and tissue transplant where the Enrollee is the donor are not covered.
31. **Electrogastrography**: Electrogastrography is not covered.
32. **Electron Beam Computed Tomography:** Electron beam computed tomography is not covered.
33. **Enteral Nutrition**: Except as set forth in Section 3.22 above, services or supplies provided for dietary and nutritional services, including but not limited to medical nutrition therapy, are not covered, even if such services or supplies are the sole source of nutrition for the Enrollee.
34. **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.
35. **Exercise Programs:** Unless expressly authorized in Section 3.32, exercise programs for treatment of any condition are not covered. Examples include: gym memberships, personal trainers, and home exercise equipment, even if recommended or prescribed by a physician.
36. **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 may consider it as a Covered Service. 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.
37. **Extracorporeal Shock Wave Therapy:** Extracorporeal shock wave therapy (ESWT) for any musculoskeletal condition is not covered except as specified in our Medical Coverage Policies.
38. **First Aid Supplies:** We will not cover over-the-counter first aid supplies.
39. **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 (except capsular or bone surgery), calluses, routine trimming of toe nails, fallen arches, weak feet and chronic foot strain. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Certificate, foot care is provided when required for prevention of complications associated with diabetes mellitus or other peripheral sensory neuropathy.
40. **Foot Supports:** Foot supports 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 supports, 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 devices, soft devices or semi-rigid devices.
41. **Formula**: Baby formula and thickening agents, even if prescribed by a physician or acquired over the counter, are not covered.
42. **Fraud or Misrepresentation:** Health interventions or health services, including, but not limited to, medications obtained by unauthorized or fraudulent use of an Enrollee's QualChoice identification card or by material misrepresentation as part of the enrollment process or at other times, are not covered.
43. **Free Care:** We will not cover any care if there was no charge for the care. This applies even if the Enrollee and/or the provider did not think there would be insurance when the provider chose not to charge for the care provided.

44. **Government Programs:** We will not pay for Covered Services to the extent benefits for such services are valid and collectible under Medicare, Worker's Compensation, Defense Base Act, TRICARE, or any other federal, state or local government program.
45. **Group Therapy:** Group therapy or group counseling at any time in any setting by any provider is not covered.
46. **Hair Loss or Growth:** Wigs, hair transplants, or any medication (e.g. Rogaine, minoxidil, etc.) that is taken for hair growth, whether or not prescribed by a physician, are not covered. Treatment of male or female pattern baldness is not covered. Exception: wigs required because of hair loss as a direct result of chemotherapy are covered to a maximum lifetime reimbursement of $200.
47. **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. Cochlear implants are the only exception to this exclusion as specified in Section 5.2.4.
48. **Heat Bandage:** Treatment of a wound with a warm-up active wound therapy device or a non-contact radiant heat bandage is not covered.
49. **High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation:** High Dose Chemotherapy, autologous transplants, allogeneic transplants, and nonmyeloablative allogeneic stem cell transplantation are not covered, except in the circumstances set forth in Section 3.35.
50. **Home Uterine Activity Monitor:** Home uterine activity monitors or their use is not covered.
51. **Hospital Acquired Conditions**: We will not cover healthcare services required to treat conditions which could reasonably have been prevented through the application of evidence-based guidelines per our Medical Coverage Policies.
52. **Illegal Acts:** Except as required by law, we will not cover healthcare services resulting from participation in any illegal act (whether or not convicted) or being engaged in an illegal occupation (whether or not convicted), riot or insurrection.
53. **Illegal Uses:** Medications, drugs, or substances that are illegal to dispense, possess, consume, or use under the laws of the United States or the State of Arkansas, or that are dispensed or used in an illegal manner, are not covered. Complications of 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.
54. **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, vascular occlusion of the penis, or prostate surgery.
55. **Infertility Treatment:** With the exception of certain services to diagnose infertility, which are limited as set forth in Section 3.14, we will not cover any diagnosis, medications, treatments, procedures, surgeries, or any other services for treatment of infertility. It does not matter whether the infertility service is diagnostic or 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;
    C. Surrogate pregnancies;
    D. Medical treatment of infertility;
    E. Surgical treatment of infertility; and
    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 cause of the infertility are detected or treated during such surgery.
56. **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 of the Plan set forth in this

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

57. **Instructional Programs:** We will not pay for instructional or educational testing, programs, group type 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 3.9.
58. **Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders:** Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.
59. **Learning Disabilities or Perceptual Disorders:** Services or supplies provided for learning disabilities or perceptual disorders, such as reading disorder or dyslexia, are not covered.
60. **Magnetic Innervation Therapy:** Extracorporeal magnetic innervation therapy for the treatment of urinary incontinence is not covered.
61. **Maintenance Therapy**: We will not cover maintenance therapy for chiropractic therapy, physical therapy, occupational therapy, or speech therapy.
62. **Mammoplasty:** Except as provided in Section 3.31, 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.
63. **Marriage and Relationship Counseling:** Marriage and relationship counseling services are not covered.
64. **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.
65. **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, counseling, 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.
66. **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.
67. **Mental Health or Substance Use Disorder:** Unless a Mental Health Parity Rider, Treatment of Psychiatric Conditions Benefits Rider, and/or Treatment of Substance Abuse Benefits Rider is included with this Certificate, services of any kind or nature for testing, evaluation, assessment and/or treatment of mental health or psychiatric conditions, behavior, emotional, or conduct disorders, or substance or alcohol abuse are not covered. Services that are excluded include, but are not limited to:
    A. Testing, evaluation, assessment and/or treatment of every diagnosis in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
    B. Hypnotherapy;
    C. Treatment of behavior or conduct disorders, oppositional disorders, or neuroeducational testing;
    D. Hospitalization for testing, evaluation, assessment and/or treatment of mental health or psychiatric conditions, behavior, emotional, or conduct disorders, or substance or alcohol abuse;
    E. Evaluation of psychosocial factors potentially impacting physical health problems and treatments, including health and behavior assessment procedures used to identify psychological, behavioral, emotional, cognitive, and social factors affecting physical health problems;
    F. Services for treatment of eating disorders are not covered; this exclusion includes treatment for anorexia, bulimia and other eating disorders; and
    G. Family counseling in conjunction with an Enrollee's individual crisis therapy.

68. **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.
69. **Orthoptic or Pleoptic Therapy:** Orthoptic or pleoptic therapy is not covered.
70. **Over-the-Counter Medications:** Medications (except insulin) that do not by law require a prescription from a physician and are not on the Formulary are not covered.
71. **Pain Pump, Disposable:** Disposable pain pumps following surgery are not covered.
72. **Parkinson's Disease, Treatment with Fetal Mesencephalic Transplantation:** Fetal mesencephalic transplantation (FMT) for treatment of Parkinson's disease is not covered.
73. **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.
74. **Percutaneous Sacroplasty:** Percutaneous sacroplasty is not covered.
75. **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.
76. **Peripheral Vascular Disease Rehabilitation Therapy:** Peripheral vascular disease rehabilitation therapy is not covered.
77. **Pre-Implantation Genetic Diagnosis:** We do not cover pre-implantation genetic diagnosis or treatment.
78. **Premarital Laboratory Work:** We will not cover premarital laboratory work even if such premarital laboratory work is required by any state or local law.
79. **Private Duty Nurses:** We will not cover private duty nurses.
80. **Private Room:** At QualChoice's sole discretion for an exception, we do not cover a private facility room. We will pay the most common charge for semi-private accommodations. If there is a charge for a private room, the Enrollee must pay the difference between the charges for a private room and our payment.
81. **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.
82. **Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions:** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.
83. **Recreational Therapist:** Services or supplies provided by a recreational therapist are not covered.
84. **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.
85. **Research Studies:** We will not cover any service provided in connection with research studies or clinical trials.
86. **Residents, Interns, Students or Fellows:** Services performed or provided by a hospital resident, intern, student or fellow of any medical related discipline are not covered.
87. **Rest Cures:** Services or supplies for rest cures are not covered.
88. **Reversal of Sterilization:** We will not cover any procedures or related care to reverse previous sterilization.
89. **Seasonal Affective Disorder (SAD):** The use of photo therapy or light therapy to treat seasonal affective disorder or depression is not covered.

90. **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 (2) physicians who are in practice together.
91. **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 verifiable medical condition or an act of domestic violence.
92. **Sensory Stimulation of Coma Patients:** Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.
93. **Services Not Specified as Covered Services:** We will not cover any services not specifically described in Sections 3 or 4 of this Certificate as being a Covered Service.
94. **Services Received Outside the United States:** Services or supplies received outside of the United States of America shall not be covered except at the sole discretion of QualChoice.
95. **Short Stature Syndrome:** Any services related to the treatment of short stature syndrome are not covered, except when short stature is caused by laboratory documented growth hormone deficiency.
96. **Smoking or Tobacco Cessation or Caffeine Addiction:** Except as provided in Section 3 and Section 4, treatment of caffeine, smoking, or nicotine addiction, smoking cessation prescription medication products, including, but not limited to, nicotine gum and nicotine patches, are not covered.
97. **Snoring:** Devices, procedures, or supplies to treat snoring are not covered, except services, devices, procedures, or supplies are covered when medically necessary for the diagnosis and treatment of moderate or severe obstructive sleep apnea (OSA).
98. **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.
99. **Sterilization, Voluntary Hysterectomy:** We will not cover charges related to hysterectomy for the primary purpose of voluntary sterilization.
100. **Substance Addiction:** We will not cover medications used to sustain or support an addiction or substance dependency.
101. **Surgical First Assistants:** We do not recognize surgical first assistants as a covered provider eligible for reimbursement for Covered Services. Any services performed by a surgical first assistant will be denied.
102. **Tanning Equipment:** Tanning equipment is not covered.
103. **Telephone and Other Electronic Communication:** We do not cover the cost of communications between a provider and an Enrollee or a provider and another provider done by telephone or other electronic means such as email. The only exceptions to this exclusion are telemedicine consultations that meet the requirements of the QualChoice Medical Coverage Policy on telemedicine.
104. **Temporomandibular Joint Syndrome (TMJ):** Unless a TMJ Rider is included with this Certificate, 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, but not limited to, the shortening of the mandible or maxillae or the correction of malocclusion.
105. **Thermography:** Thermography, which is the measuring of self-emanating infrared radiation that reveals temperature variation at the surface of the body, is not covered.
106. **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 facility or other healthcare charges as the result of the negligence or intentional act of a third party. If an Enrollee makes a Claim for Benefits under this Certificate prior to receiving payment from a third party, or its insurer, the Enrollee (or Authorized 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 11 and Section 12.7 for further information concerning repayment of Benefits.
107. **Thoracic Electrical Bioimpedance:** Thoracic electrical bioimpedance is not covered.

108. **Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae:** Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.
109. **Trans-telephonic Home Spirometry:** Trans-telephonic home or ambulatory spirometry is generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Certificate, 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.
110. **Travel and Transportation Expenses:** We will not cover travel and transportation expenses, even if prescribed by a physician, except for ground, air, or water emergency ambulance service or ambulance service for transfer coordinated by the QualChoice Care Management Department. Refer to your Benefit Summary for limitations.
111. **Travel, School, Recreation, or Work Related Immunizations:** Except to the extent coverage is specifically provided in this Certificate as a preventive health benefit, we will not cover immunizations to fulfill requirements for travel, school, recreation, or for work.
112. **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, however: (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.
113. **Vision:** Except as set forth in Section 3 of this Certificate and in the Benefit Summary, we will not cover routine eye services or tests, eyeglasses, contact lenses, and other vision care services and supplies, except as required for the diagnosis and treatment of diseases of, or injury to, the eyes.
114. **Vision Correction Surgery:** We will not cover eye surgery to correct refractive errors. This includes refractive keratoplasty, refractive keratomileusis, epikeratophakia procedures, Low Vision Enhancement System (LVES), and Laser Assisted Insitu Keratomileusis (LASIK).
115. **Vitamins or Baby Formula:** Vitamins, food or nutrient supplements, except those that are prescription medications on an approved QualChoice Formulary as described in Section 4 of this Certificate and are not available over the counter, 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 of the Plan set forth in this Certificate, coverage is provided for medical foods and low protein modified food products for the treatment of single gene inborn errors of metabolism as described in Section 3.22 – Medical Foods.
116. **Vocational Rehabilitation:** Vocational rehabilitation services, counseling and testing are not covered.
117. **War or Act of War:** We will not cover any services relating to any injury or sickness resulting from declared war or any act of declared war, or in the armed forces of any country if any government plan (e.g., Defense Base Act and/or TRICARE) covers the injury or sickness.
118. **Weight Control:** 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.
119. **Whole Body Computed Tomography:** Whole body computed tomography is not covered.
120. **Workers' Compensation:** We will not cover any medical services or supplies for any injury, condition, or disease arising from any activities related to any employment for any Enrollee or that otherwise arises from a work-related injury or incident. We will not make any payments even if: (a) no Claim is tendered for benefits that may be available; and/or (b) no benefits are received under the Workers' Compensation, Defense Base Act, TRICARE, or other applicable laws and/or healthcare programs.
121. **Wound Treatment:** Blood derived growth factors are not covered.

5.2 Limitations to Benefits

Coverage is available for medical services or care as specified in this Section 5.2 subject to the General Conditions for Payment specified in Section 2.12, Pre-Authorization of Services described in Section 2.14, and to all other applicable conditions, limitations and exclusions of this Certificate.

1. **Ambulance:** Transportation by ambulance of any kind is limited to the lesser of the Maximum Allowable Charge or the limits set forth in your Benefit Summary, and is subject to review for Medical Necessity.
2. **Autism Screening:** Screening for autism is limited to a maximum of two (2) times between the ages of one (1) and four (4).
3. **Circumstances Beyond Our Control:** Services and other covered Benefits could be delayed or made impractical by circumstances not reasonably within our control, such as: force majeure, complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of facility or medical group personnel, or similar causes. If so, Network Providers will make a good faith effort to provide Covered Services. 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.
4. **Cochlear Implants and Auditory Brain Stem Implants:** Pre-authorization is required. Reimplantation of the same device is not covered. Only the following devices are covered:
   A. Coverage for cochlear implants is subject to a maximum lifetime benefit of one (1) cochlear implant device, the surgical procedure, and one (1) speech processor per Enrollee.
   B. Coverage for auditory brain stem implants is subject to a maximum lifetime benefit of one (1) implant per lifetime for an individual twelve (12) years of age and older with a diagnosis of Neurofibromatosis Type II who has undergone or is undergoing removal of bilateral acoustic tumors.
5. **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 Coverage Policies. Transcutaneous Electrical Nerve Stimulator (TENS) is covered for chronic intractable pain that has failed conservative therapy. Coverage is also provided for neuromuscular electrical stimulation (NMES) when medically necessary, subject to pre-authorization under Section 2.14, to help maintain muscle tone and strength in an unused extremity when normal function is expected to return or to enhance activity and self-sufficiency in individuals with spinal cord injuries.
6. **Enhanced External Counterpulsation**: Enhanced external counterpulsation (EECP) is covered only for conditions specified in our Medical Coverage Policies.
7. **Eyeglasses and Contact Lenses:** We do not cover eyeglasses or contact lenses, except the initial acquisition of one (1) pair of eyeglasses or contact lenses within the six (6) months following cataract surgery. With respect to any covered eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. The Maximum Allowable Charge is based on the cost for basic glasses or contact lenses.
8. **Genetic or Genomic Testing and Counseling:** Genetic or genomic testing is often done on blood or tissue samples sent by an Enrollee's physician to a laboratory. *For this testing to be covered, it requires pre-authorization.* Pre-authorization will only be given if the results of the testing will affect choice of treatment or the outcome of treatment. This includes testing for mutations related to cancer and testing of tumors for mutations that may affect treatment. Any approved genetic testing must be preceded by genetic counseling. *We do not cover Out-of-Network genetic or genomic testing.* You should always discuss with your provider whether pre-authorization has been obtained and whether the laboratory performing the testing is a Network Provider.
9. **Home Healthcare:** Home health visits are limited to a maximum number of visits per Enrollee per Calendar Year. The home healthcare visit limitation and the Cost Sharing Amounts are specified in your Benefit Summary. Pre-authorization is required.
10. **Hospice Services:** Hospice services are limited to a maximum number of days of coverage per Enrollee. The hospice services day limitation and the Cost Sharing Amounts are specified in your Benefit Summary. Pre-authorization is required.
11. **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 Coverage Policies.

12. **Lifetime Maximum:** Consult your Benefit Summary, Medical Coverage Policies, and this Certificate for various lifetime limits per Enrollee.
13. **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 QualChoice 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.
14. **Medical Supplies:** Coverage of Medical Supplies is limited to not more than a thirty-one (31) day supply per month.
15. **Newborn Care:** We will cover newborn children of the Certificate Holder or spouse from the date of birth provided the Certificate Holder enrolls the newborn within ninety (90) days after the date of birth. If such Child is born in an Out-of-Network Provider hospital, the Child's coverage for Covered Services in the first ninety (90) days is limited to the Maximum Allowable Charge or $2,000, whichever is less. If a Child is born in an Out-of-Network Provider hospital because the Certificate Holder's spouse has other health benefit coverage, or if such Child is an adopted Child born in an Out-of-Network Provider hospital, nursery charges are covered up to the Maximum Allowable Charge or $2,000, as applicable.
16. **Outpatient Rehabilitation Services:** Coverage for outpatient visits for physical, occupational, speech therapy, audiology services, pulmonary rehabilitation, and chiropractic services are limited to a maximum number of visits per Enrollee per Calendar Year as reflected in your 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.
17. **Prosthetic and Orthotic Devices and Services.** QualChoice does not cover replacement of a Prosthetic Device or Orthotic Device or associated Prosthetic Services or Orthotic Services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair a Prosthetic Device 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.
18. **Refusal to Accept Treatment:** An Enrollee 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 the Enrollee later recants the refusal and agrees to follow the recommended treatment or procedure.
19. **Shoes and Shoe Inserts:** Custom molded and fitted shoes and shoe inserts are not covered except for an Enrollee with diabetes. Coverage for an Enrollee with diabetes for custom molded and fitted shoes and shoe inserts is subject to the following limitations:
    A. Two (2) pairs of custom molded and fitted shoes per year if the Enrollee is under eighteen (18) years of age and one (1) pair of custom molded and fitted shoes for an Enrollee eighteen (18) years of age or older; and
    B. Two (2) pairs of custom molded shoe inserts per year.
20. **Transplant Services:** Transplant services are subject to all terms, conditions, exclusions, and limitations of this Certificate in accordance with the following conditions:
    A. We do not cover all transplants. This Certificate must provide Benefits for the requested transplant type, and the Enrollee must meet all required criteria necessary for coverage set forth in this Certificate.
    B. We will not cover the transportation and/or lodging costs of the transplant donor, or individuals traveling with either the donor or the recipient. Transportation and/or lodging costs of the transplant recipient are covered at the sole discretion and evaluation of the QualChoice Care Management Department.
    C. 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.
    D. Expenses for drugs related to avoidance of rejection of a transplanted organ are subject to the limitations in this Certificate and the Deductible, Coinsurance and Co-payments as reflected in your Benefit Summary.

E. 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 (2) 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, but is not limited to, 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.

F. **Transplants that are not pre-authorized by QualChoice Care Management Department are not covered.**

6. ELIGIBILITY CRITERIA

6.1 Who is Eligible for Coverage

You must list yourself, the Employee, and any of your eligible dependents you are electing to cover on the Enrollment Application to be eligible for coverage. You and your dependents must meet all eligibility requirements in this Certificate and as set forth by the Employer Group in the group application and Group Master Contract. The following members of your family may be eligible as dependents:

1. Your Spouse, subject to your Employer Group's eligibility rules. Domestic partners are not eligible for coverage as a dependent under this Certificate.
2. Your Child until the end of the month in which s/he becomes twenty-six (26) years of age.
3. Your incapacitated Child may be an eligible dependent. The incapacitated Child must be twenty-six (26) years of age or older and totally disabled due to continuous developmental or physical incapacity. The incapacitated Child must be primarily dependent on you for financial support and you must declare the incapacitated Child as a dependent on your federal income tax returns. The disability leading to mental or physical incapacity must have occurred before the Child reached age nineteen (19) and while covered under this Plan or other group medical insurance coverage. The Social Security Administration or a physician must medically certify the disability. At any time, we may request a declaration of disability (or like document) supporting such dependent's incapacity and dependency. You must notify us in writing if the incapacity or dependency is removed or terminated. Newly eligible Enrollees may enroll an incapacitated Child provided the disability commenced before the limiting age and a health benefit plan continuously covered the Child as your dependent since before the limiting age. Our determination of eligibility shall be conclusive. You should submit your request for extension of coverage as soon as reasonably possible.
4. A Child covered under a Qualified Medical Child Support Order may be an eligible dependent. As required by the Federal Omnibus Budget Reconciliation Act of 1993, your Child who is an alternate recipient under a Qualified Medical Child Support Order has the right to be eligible under this Certificate, upon proper notice to your Employer Group and to us. In the event a court has ordered an employee of the Employer Group without coverage under this Plan to provide coverage for a child, the employee will enroll with the child on the first day of the month following receipt of proper notice by us. We must receive the Premium for the employee and the child when due and an Enrollment Application from the Employer Group, a custodial parent of the child, a child support agency having a duty to collect or enforce support of the child, or the child.
5. Coverage for a Child whom you have adopted or for whom you have filed a petition for adoption shall begin on the date of the adoption or the date of the filing of the petition for adoption. You must submit an Enrollment Application to us within sixty (60) days after the adoption or the filing of the petition. Coverage will begin subject to payment of all applicable Premiums. The coverage shall begin from the moment of birth if the petition for adoption or adoption occurred and you submit the application for coverage to us within sixty (60) days of

the birth of the Child. The coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.

6. If the armed services of the United States of America activate an Enrollee, the coverage of the Enrollee and any dependents may continue on COBRA for a period of eighteen (18) months or under the Uniformed Services Employment Reemployment Rights Act (USERRA). A former Enrollee returning from active military service may enroll in the Plan within ninety (90) days of his or her return to employment provided the Employer Group continues to sponsor the Plan and payment of Premium is timely made. We may require a copy of the returning Enrollee's orders terminating the active duty or other proof of the active duty or termination date thereof.

Your coverage begins upon the effective date of this Certificate as determined by your Employer Group. You should contact your Employer Group for information concerning your eligibility requirements and effective date. You will not be eligible to enroll if you do not meet the eligibility rules of your Employer Group and us. You will also not be eligible to enroll if you have had previous coverage with us terminated for causes described in Section 6.4 of this Certificate.

Coverage for new members of your family begins in accordance with the terms of this Certificate. Coverage, subject to all other terms, conditions, exclusions and limitations of this Certificate, will be extended to an eligible Enrollee who is inpatient in a facility on the effective date of this Certificate. However, consistent with applicable law, if such eligible Enrollee is inpatient in a facility on the effective date of this Certificate and immediately prior to such effective date was covered by another group health plan that provides coverage for facility or medical services or expenses, then coverage for benefits under that other group health plan will continue and it will be primarily responsible for those services and expenses associated with that facility admission. As the primary plan, that other group health plan will be responsible for those services and expenses until the end of that facility admission or until the expiration of any applicable extension of benefits provided under such group health plan, whichever occurs first.

Coverage for your newborn Child is effective as of the date of birth if you submit an Enrollment Application to us within ninety (90) days of the date of birth of the Child or before the next Premium due date, whichever is later.

If your Covered Dependent gives birth, then the newborn grandchild is not eligible for coverage. If you, as the child's grandparent, adopt or obtain permanent legal custody of the child, then we will cover the Child as set forth in Section 6.3, below. If you submit the Enrollment Application for newborn coverage *after* the ninety (90) day time period, then coverage for such newborn Child may only become effective during Open Enrollment.

6.2 If an Enrollee Is Eligible for Medicare

Benefits under this Certificate may be reduced if an Enrollee is eligible for Medicare, but does not enroll in and maintain coverage under both Medicare Part A and Part B.

Benefits may also be reduced if an Enrollee is enrolled in a Medicare+Choice (Medicare Part C) plan, but fails to follow the rules of that plan. See Section 8 - Medicare Primary Payer for more information about how Medicare may affect Benefits.

6.3 Special Enrollment Period

A special enrollment period applies when one of the conditions listed below occurs. A condition of participation under this Certificate is your agreement to notify us in writing immediately of any changes in status affecting you or your dependents. Notification may be achieved by completing an Enrollment Application, which notifies us about changes in eligibility and enrollment, and by giving it to your Employer Group who must send the Enrollment Application to us within thirty (30) days (unless specifically provided otherwise below). Notification and the Enrollment Application are required upon of the occurrence of one of the following events:

1. Marriage and/or divorce;
2. Birth and/or death;
3. Adoption;

4. Addition of a Child through a Qualified Medical Child Support Order (Note: Only children listed in the Order are eligible to enroll during this special enrollment period; any other children who may otherwise be eligible cannot enroll until Open Enrollment.);
5. Permanent legal custody of a Child;
6. Reinstatement of civilian status of Active Duty Military Personnel;
7. Involuntary loss of other group health insurance coverage, unless the coverage was terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the health plan) or as a result of failure to pay any required contributions toward the cost of coverage on a timely basis; or
8. You or your dependent loses Medicaid coverage or coverage under the state children's health insurance program (CHIP, for example, ARKids) because you are no longer eligible, or you or your dependent qualifies for state assistance in paying your employer group medical plan premiums.

In the absence of the thirty (30) day written notification of the above-referenced events, coverage may only be modified or during Open Enrollment. We do not permit additions, deletions or changes in coverage following thirty (30) days after the event. In the event you or your dependent loses Medicaid coverage under the state children's health insurance program (CHIP, for example, ARKids) because of loss of eligibility or become eligible for a state's premium assistance program, then you must notify us within sixty (60) days following the date of the event. We allow sixty (60) days for adoptions and ninety (90) days for newborns and members reinstated from military active duty.

If we receive proper notification and the Enrollment Application is approved following a special enrollment event, coverage will become effective on the date of the event. QualChoice is entitled to Premiums from the effective date of coverage.

6.4 Termination of Coverage

Coverage under this Plan will terminate in certain circumstances. We describe these circumstances below. Refer to Section 9 for information regarding the special circumstances in which you and your Covered Dependents may elect to continue coverage.

1. **Termination of This Certificate:** We provide coverage under this Certificate pursuant to the terms of the Group Master Contract between the Employer Group and us. The Group Master Contract is effective for a fixed term. Subject to QualChoice's rights to terminate the contract in accordance with the terms of the Group Master Contract and applicable law, the Employer Group has the right to renew such contract. Upon termination of the Employer Group contract, we will no longer provide any Benefits, except as described in Section 9.
2. **Default in Payment of Premiums:** Premiums are due on or before the first day of each month of coverage under this Certificate. Failure of the Employer Group to remit Premium payments to us in accordance with these terms may result in the suspension of Benefits for all Certificate Holders and their Covered Dependents. In the event the Employer Group does not respond timely to written and verbal demands for payment by us, coverage under this Certificate will be terminated retroactive to the last day of the month for which Premium payment was received.
3. **If You Are No Longer A Member Of The Employer Group:** If your employment or membership in the Employer Group terminates or you no longer meet the eligibility requirements as set forth in Section 2.9, Employer Group must notify QualChoice of the termination no later than thirty (30) days following the termination. No termination shall be effective prior to QualChoice's receipt of notice of the change. The termination date shall be the last day of the month in which notice is given or the date through which the Employer Group Premium has been paid on your behalf. If Benefits have been paid past the termination date, then QualChoice has the right, in its sole discretion, to pursue all legal remedies to recover funds due. See Section 9 for a description of how Enrollees may elect to continue coverage under certain circumstances.
4. **Certificate Holder's Death:** Coverage for Covered Dependents under this Plan will automatically terminate on the date of the Certificate Holder's death. For a description of how Covered Dependents can elect to continue coverage following the death of the Certificate Holder, please refer to Section 9.

5. **Termination of Your Marriage:** If you divorce, legally separate, or annul your marriage, then the coverage of the Certificate Holder's spouse will automatically terminate on the date of the divorce, legal separation, or annulment. A Court order requiring the Certificate Holder to provide coverage for the former spouse does not change the termination of coverage. However, see Section 9 for information about how a Certificate Holder's spouse can elect to continue coverage.
6. **Termination of Coverage of A Dependent Child:** The coverage of a Child under this Certificate will terminate automatically on the earliest of the following dates on which the Child:
   A. No longer meets the limiting age eligibility requirements; or
   B. For a Child incapable of self-support (an incapacitated Child), on the date the Child becomes capable of self-support; termination of coverage based upon age limitation(s) does not apply to a Child who qualifies as an incapacitated Child.
   C. See Section 9 for a description of how your Child can elect to continue coverage.
7. **Our Option to Terminate This Certificate:** We may terminate this Certificate for any of the following reasons:
   A. An Enrollee's intentional misrepresentation of material fact or fraud committed by the Enrollee in connection with any Claim for Benefits filed under this Certificate;
   B. We may terminate this Certificate at the end of a plan year if permitted by applicable federal and Arkansas state law;
   C. An Enrollee's failure to pay any applicable Cost Sharing Amount required under this Certificate upon thirty (30)-days' advance written notice to such Enrollee unless default in payment is cured within such thirty (30)-day period;
   D. Upon thirty (30)-days' advance written notice if an unauthorized person is allowed to use the Enrollee's QualChoice identification card or if the Enrollee otherwise cooperates in the unauthorized use of the Enrollee's identification card or Benefits such that Enrollee's actions constitute fraud;
   E. Misrepresentation: Each Enrollee represents all statements made in his or her application for membership, and any applications for membership of dependents, are true to the best of his or her knowledge and belief. If an Enrollee performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact, then we may rescind and/or render his or her enrollment void ab initio under this Plan under Section 12.16, as well as the enrollment of his or her covered spouse and dependents, upon thirty (30)-day's advance written notice.

   QualChoice will notify the affected Enrollee of a decision to terminate the Enrollee's coverage pursuant to the requirements of applicable law. If QualChoice terminates the coverage of an Enrollee, Premium payments received by QualChoice on account of the terminated Enrollee applicable to periods after the effective date of termination shall be refunded to the Employer Group, less any un-recovered Benefits paid by us, within thirty (30) days or in the next scheduled billing cycle, and QualChoice shall have no further liability under this Certificate.
8. **Employees on Military Leave:** Employees (or an employee's Covered Dependent) called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), may elect to continue coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). These rights apply to covered employees and their Covered Dependents immediately before leaving for military service. The following applies to this election:
   A. The maximum period of coverage of a person under such an election shall be the lesser of:
      i. The twenty-four (24) month period beginning on the date on which the person's absence begins; or
      ii. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
   B. A person who elects to continue health plan coverage must pay up to 102% of the full employee contribution, except a person on active duty for thirty (30) days or less cannot be required to pay more than the employee's share, if any, for the coverage.

C. An exclusion or Waiting Period may not be imposed in connection with reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service.

9. **Employer Termination of Enrollee:** If the Employer Group terminates coverage of an Enrollee, then the Employer Group must notify QualChoice of the termination no later than thirty (30) days following the termination. No termination shall be effective prior to QualChoice's receipt of notice of the change. The termination date shall be the last day of the month that notice is given. Failure to notify QualChoice within thirty (30) days shall result in Employer Group waiving refund of any Premiums paid. Upon providing timely notice of termination, there shall be no right to a refund of Premiums previously paid, except in the sole discretion of QualChoice. If Benefits have been paid past the termination date, then QualChoice has the right, in its sole discretion, to pursue all legal remedies to recover funds due.
10. **Hospital Confinement at Time of Termination:** If an Enrollee is facility confined on the date coverage under this Certificate terminates, then coverage for such hospitalization will be determined according to the following criteria:
    A. If the Employer Group replaces this Plan with other group coverage, then coverage for the Enrollee will continue until facility discharge or Benefits under this Plan are exhausted, whichever occurs first;
    B. If the Employer Group **does not** replace this Plan with other group coverage, then coverage for the Enrollee will cease on the effective date of termination;
    C. If termination is a result of rescission of coverage by QualChoice, then coverage ends on the effective date of such rescission; or
    D. If the Enrollee terminates coverage independent of the Employer Group, then coverage ends on the effective date of termination.

    If the hospitalized Enrollee is the Certificate Holder, then coverage for any Covered Dependents of this Enrollee ends on the effective date of termination.

7. COORDINATION OF BENEFITS

You and your family members may have coverage under more than one health plan. This Plan 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 Network 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.

7.1 How COB Works

The order of benefit determination rules govern the order in which each health plan will pay a claim for benefits. The health plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another health plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all health plans do not exceed 100% of the COB Allowable Expense (described in Section 7.4 below).

7.2 Rules to Determine Primary and Secondary Plans

The following rules will determine primary and secondary policy coverage:

1. If a health policy/certificate does not have a COB provision, then that policy is primary.
2. The health policy/certificate 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:

i. The health policy of the parent whose birthday falls earlier in the Calendar Year is primary; or
ii. 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:
i. The plan of the parent who a Court has established as being responsible for the child's healthcare expenses or healthcare coverage is primary (pursuant to the Eligibility requirements of this Certificate, we must be informed of this requirement and documentation may be required);
ii. If a Court decree states that both parents are responsible for the child's healthcare expenses or healthcare coverage, then the provisions of Subsection A above determine the order of benefits;
iii. If a Court decree states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the child, then the provisions of Subsection A above determine the order of benefits; or
iv. If there is no court decree allocating responsibility for the child's healthcare expenses or healthcare 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 Subsections A and B above, determine the order of benefits as if those individuals were the parents of the child.

4. The health policy/certificate 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 Subsection 7.2.3.B 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, then the health policy/certificate 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/certificate does not have this rule, and as a result, the health policy or policies do not agree on the order of benefits, then this rule is ignored. This rule does not apply if the rule in Subsection 7.2.3.B above can determine the order of benefits.
6. The health policy/certificate that covered the person as an employee, member, policyholder, subscriber or retiree for the longest period of time is primary and the health policy that covered the person the shorter period of time is secondary.
7. If an adult dependent is listed as a dependent under a parent's and a spouse's policy, then the health plan that covered the adult dependent for the longest period of time is primary and the health plan that covered the adult dependent the shorter period of time is secondary.
8. 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 Certificate will not pay more than it would have paid had it been primary.

7.3 Rules to Determine Primary and Secondary Plans for Medicare Recipients

Notwithstanding any of the rules described in Section 7.2 above, if your Employer Group has less than 20 employees, Medicare is primary for Enrollees eligible for Medicare due to age or disability.

If your Employer Group has between 20 and 100 employees, then:

1. Medicare is secondary for active employees and their Covered Dependents eligible for Medicare due to age;

2. Medicare is primary for active employees and their Covered Dependents eligible for Medicare due to disability; and
3. Medicare is primary for non-working members and their Covered Dependents eligible for Medicare due to age or disability.

If your Employer Group has more than 100 employees, then:

1. Medicare is secondary for active employees and their Covered Dependents eligible for Medicare due to age or disability;
2. Medicare is primary for non-working members and their Covered Dependents eligible for Medicare due to age or disability; and
3. An Enrollee eligible for Medicare based solely on end stage renal disease is entitled to receive the Benefits of this Plan as primary for thirty (30) months only beginning with the month of Medicare entitlement.

Medicare will be primary for members who are not subject to the above guidelines of this provision and are Medicare eligible due to age or disability.

7.4 Allowable Expense

For the purposes of this Section 7, "Allowable Expense" is a healthcare expense (including deductible, coinsurance or co-payments) covered in full or in part by any healthcare plan, certificate or policy covering the Enrollee. This means an expense or service not covered by any plan, certificate 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, policies or certificates cover an Enrollee and compute their benefit payments based on that plan's maximum allowable charge, then any amount in excess of the highest reimbursement amount for a specified benefit is not an Allowable Expense.

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

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

7.5 Reduction of Benefits

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

1. In determining the amount to be paid for any Claim, QualChoice will calculate the Benefits it would have paid in the absence of other healthcare 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 for that Claim.
2. QualChoice will credit to Enrollee's Deductible any amounts it would have credited to the Deductible in the absence of other healthcare coverage, but QualChoice will waive Coinsurance and Co-payment requirements.
3. 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 healthcare providers and excludes coverage for services provided by other healthcare providers), and if, for any reason, including the provision of service by an out-of-network provider, the benefits are not payable by one closed panel plan, then COB shall not apply between that closed panel plan and other closed panel plans.

7.6 Enforcement of Provisions

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under the Plan and other health policy(ies). For the purposes of COB administration, QualChoice will obtain the facts it needs, or provide 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 disclose, or obtain the consent of any person, including the Enrollee. Enrollees must provide QualChoice any facts or information that we need to apply those rules and determine Benefits payable. If an Enrollee fails to provide this information, then we may delay Benefit payments.

7.7 Facility of Payment

A payment made under another health plan may include an amount that should have been paid under this Plan. If it does, then QualChoice may pay that amount to the other plan 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 be required to pay that particular amount more than once. 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.

7.8 Right of Recovery

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

7.9 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, then coverage for benefits under that other policy, contract, or certificate will continue and it will remain 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.

8. MEDICARE PRIMARY PAYER

Provision of Benefits for Medicare recipients will be determined based on the Rules to Determine Primary and Secondary Plans for Medicare Recipients found in Section 7.3.

When Medicare pays as the primary coverage, Medicare must approve and allow all services. We will consider the services covered by Medicare for reimbursement under this Plan as follows:

1. We pay Benefits as if Enrollees have both Parts A and B of Medicare.
   A. Part A is the coverage for inpatient care. The Medicare per confinement deductible will be covered under this Plan and reimbursement made directly to the facility.
   B. Part B is for all other care and has both deductible and coinsurance. If an Enrollee has not taken Medicare Part B, then we will reimburse only 20% of the eligible charge. The Enrollee will be responsible for the deductible and 80% of the eligible charge.
2. Medicare does not cover some services eligible under this Plan. For the services Medicare does not cover, we will consider reimbursement of the services based on the terms and conditions of this Certificate.
3. All of the other terms, conditions, limits and exclusions applicable to this Certificate shall apply to this Benefit, but we will waive Cost Sharing Amount requirements (Coinsurance, Co-payments, and Deductible).

Enrollees must first file all charges with Medicare. Enrollees will receive the Explanation of Medicare Benefits (EOMB) giving payment or denial information, and must send a copy of the EOMB to us with our Claim for Benefits form. You can obtain claim forms from your Employer Group or us.

9. CONTINUATION OF COVERAGE

Certain state and federal laws and regulations are applicable to coverage under this Certificate. Certain provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and the Arkansas Insurance Code, and related regulations, as amended, affect the extent of an Enrollee's rights to elect to continue coverage under this Plan when coverage would otherwise end. If COBRA applies to the Plan, then the Employer must provide its employees and their dependents notice of COBRA rights at the time their coverage commences under this Plan and must notify the employee or dependent of their right to elect continuation of coverage under COBRA within forty-four (44) days of the happening of a "qualifying event" under COBRA. QualChoice does not assume and has no responsibility for the Employer's obligation to provide benefits under COBRA if the Employer fails to provide these notices as described here, nor shall we be responsible for providing any COBRA notices to employees or dependents. If any provision set forth in this Section 9 describing the rights to elect continuation of coverage in certain circumstances conflicts with or contravenes any provision of any applicable law or regulation that would provide for rights that are more protective to the Enrollee, then such conflict shall be resolved in favor of such law or regulation.

9.1 General Rules for Continuation of Coverage

As described below, coverage under this Plan may continue for a Certificate Holder and his/her Covered Dependents in certain instances when coverage would otherwise end.

1. If you are the Certificate Holder, then you may choose to continue coverage that would otherwise end under this Plan because of (1) a reduction in your hours of employment, or (2) the termination of your employment for reasons other than gross misconduct on your part.
2. If you are the covered spouse of the Certificate Holder, then you may choose to continue coverage under this Plan if you lose group health coverage for any of the following reasons:
   A. The death of the Certificate Holder;
   B. Termination of the Certificate Holder's employment (for reason other than gross misconduct) or reduction in the Certificate Holder's hours of employment;
   C. Divorce or legal separation from the Certificate Holder; or
   D. The Certificate Holder becomes entitled to benefits under Medicare.
3. If you are the divorced spouse of a Certificate Holder covered under this Certificate, then you have the right, after the effective date of the divorce, to continue Benefits under this Plan for thirty-six (36) months. A number of events will terminate a divorced spouse's continuation coverage rights including:
   A. The divorced spouse becoming eligible for facility, medical or surgical benefits under another group plan;
   B. The divorced spouse becoming entitled to benefits under Title XVIII of the Social Security Act;
   C. The divorced spouse's election not to be covered under this Plan;
   D. The divorced spouse's acceptance of facility, medical, or surgical coverage under a qualifying non-group contract or policy; or
   E. The divorced spouse's remarriage.

   Note: The Certificate Holder is required to continue to pay the Employer Group the applicable Premium for continuation of coverage. This Premium payment obligation may be allocated between the Certificate Holder and the divorced spouse according to their agreement or as ordered by an appropriate court.

4. A Child of a Certificate Holder has the right to continue coverage under this Plan for thirty-six (36) months if coverage is lost under this Plan for any of the following reasons:
   A. The death of the Certificate Holder;
   B. The termination of the Certificate Holder's employment (for reasons other than gross misconduct) or reduction in the Certificate Holder's hours of employment;
   C. Parent's divorce or legal separation;
   D. The Certificate Holder becomes entitled to benefits under Medicare; or
   E. The dependent ceases to be a "Child" as defined under this Plan.

5. Special Coverage Extension Rules For Disabled Persons: If an individual covered under COBRA whose maximum period of coverage would otherwise be limited to eighteen (18) months is found to be totally disabled within sixty (60) days of a qualifying event as defined by the Social Security Administration or COBRA, then such individual (and dependents covered under this provision) shall be permitted to extend the maximum period of continuation of Benefits to a maximum of twenty-nine (29) months under the following conditions:
   A. The individual must notify the Employer Group in writing within sixty (60) days of Social Security Administration notification and/or Medicare approval, but in no cases later than the end of the initial eighteen (18) months;
   B. Should an individual on extension of continuation of Benefits recover from his or her disability to the extent such individual is no longer totally disabled, as defined below, then continuation of Benefits shall be terminated as of the first day of the month following a period of not less than thirty (30) days from the date the individual is no longer totally disabled; and
   C. The term "totally disabled" with respect to this section shall mean the individual is actually receiving, or is entitled to receive, Social Security Disability Benefits. When a person has a claim for Social Security Benefits for a disability occurring on or prior to the date of the qualifying event, and Social Security is disputing the disability claim but has not denied it, and the person has paid for continuation coverage for the maximum period otherwise allowable, the Plan will continue to accept Premium payments for the extension period until a final decision is reached by Social Security. However, we will pay no Claim for Benefits until Social Security has awarded disability benefits. Should Social Security deny the claim or establish a date of disability after the date of the qualifying event, we will refund all payments made for extended coverage to the affected person.
6. The Certificate Holder or eligible Covered Dependent has the responsibility to inform the Employer Group within sixty (60) days of a divorce, legal separation, or loss of Child status. When the Employer Group is so notified or when one of the other qualifying events has occurred, the Employer Group will notify the Certificate Holder and/or eligible dependents (as appropriate) of the right to choose continuation of coverage. The Certificate Holder and/or eligible dependents will have sixty (60) days to elect continuation of coverage from the later of: (1) the date coverage would be lost because of one of the events described above; or (2) the date of notice of the right to elect continuation of coverage. If continuation coverage is not elected, then the coverage will end.
7. The continuation coverage under this Plan will be identical to the coverage provided to similarly situated Certificate Holders or eligible dependents. Continuation coverage under this Plan for the Certificate Holder and/or eligible dependents will end if:
   A. The Group no longer provides our coverage to any of its employees;
   B. The Premium for continuation coverage is not paid;
   C. Coverage is provided under another group health plan; or
   D. The Enrollee becomes entitled to benefits under Medicare (coverage under this Plan terminates only for the Enrollee who becomes eligible for Medicare).
8. There is no need to show insurability to choose continuation coverage. However, as permitted under the law, Enrollees may be charged up to 102% of the normal Premium for continuation coverage.
9. If coverage under this Plan terminates because of the Employer Group's bankruptcy petition under Chapter 11 of Federal bankruptcy law, or if coverage is substantially eliminated during the period beginning one (1) year before and ending one (1) year after the commencement of such a bankruptcy proceeding, then continuation coverage may continue (if provided by the Employer Group) for the life of a retired Certificate Holder or for thirty-six (36) months after the death of a retired Certificate Holder for a covered spouse or a Child. However, continuation coverage under this Plan may be terminated for the retired Certificate Holder and/or Covered Dependents for any of the following reasons:
   A. The Employer Group no longer provides our coverage to any of its employees;
   B. The Premium for continuation coverage is not paid; or

C. Another group health plan provides the coverage.

9.2 Transfer of Continuation of Coverage

In addition to Enrollees who are eligible for either federally or state mandated continuation of coverage under the terms of this section, the following individuals are also eligible to receive continuation coverage:

1. Those individuals who were covered under a continuation provision of an employer's prior health care benefit plan, when the employer changes coverage of its active employees from the prior coverage to coverage under this Plan. We will cover such individuals without the imposition of any Waiting Period, although they will be subject to the same applicable Cost Sharing Amounts and other coverage conditions, limitations and exclusions as are other active employees who join this Plan.
2. Those individual dependents who were covered under a continuation of coverage provision of an employee's prior coverage will be covered, if the employee changes from such prior coverage to coverage with us. These individuals with continuation of coverage will be subject to the same applicable Cost Sharing Amounts and other coverage conditions, limitations and exclusions as the transferring employee.

9.3 State Continuation of Coverage

If COBRA does not apply to the Plan, then the Certificate Holder or an Enrollee may be eligible for Benefits beyond the date of termination of employment or change in eligibility under this Certificate through state continuation coverage. In order to qualify for continuation of coverage, the Certificate must cover the individual continuously under this Certificate for the three (3) month period prior to the termination of employment or change in marital status.

1. The continuation of coverage is for medical services only. If this Certificate contains coverage or riders for dental services, vision services, or prescription drug expenses, then these services are not included in this continuation of coverage. Continuation of coverage shall not be available to an individual who is eligible for:
   A. Federal Medicare coverage; or
   B. Full coverage under any other group health policy or contract.
2. Any individual who wishes to obtain continuation of coverage must request continuation of coverage within ten (10) days after the termination of employment or membership or change in marital status. You must pay Premiums to the Group on a monthly basis and in advance. You must make payments for the appropriate coverage level for the individual and any dependents electing continuation of coverage.
3. Continuation of coverage shall end upon the earliest of the following dates:
   A. One hundred twenty (120) days after continuation of coverage incepts;
   B. The end of the period for which the individual made a timely contribution;
   C. The contribution due date following the date the individual becomes eligible for Medicare;
   D. The date on which the individual is covered for similar benefits under another group or individual policy;
   E. The date on which the individual becomes eligible for similar benefits under another group or individual policy; or
   F. The date on which the Group terminates the Group Master Contract or withdraws from us.

10. Complaints and Appeals

We have authority to make determinations in connection with the administration of the Benefits in this Certificate. 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, then this appeal process governs.

10.1 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 Certificate. 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 10.3 below. An "Appeal" must be initiated and conducted as described in Section 10.3 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. **Complaints Made to the Arkansas Insurance Department:** An Enrollee may file a complaint regarding QualChoice with the Arkansas Insurance Department at the following address:

   Arkansas Insurance Department
   1200 West 3rd Street
   Little Rock, Arkansas 72201

10.2 Requests and Determinations

Each type of request has a timeline for response as set forth below. QualChoice's determinations may be appealed by the Enrollee or the Enrollee's Authorized Representative as defined in Section 10.6

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 Certificate. We will provide notice of our determination of a Pre-Service Request within fifteen (15) days following our receipt of the request.
2. **Post-Service Claims:** Post-Service Claims are those Claims for services that have already been received by the Enrollee. We will provide notice of our determination of a Post-Service Claim within thirty (30) days following our receipt of the request.
3. **Urgent Care Request:** An Urgent Care Request is a request for a service that a licensed physician with knowledge of the Enrollee's medical condition has reasonably 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.

   We will provide notice of our determination of an Urgent Care Request within seventy-two (72) hours following our receipt of the request; provided, however, if the Enrollee does not provide sufficient information to determine Benefits for an Urgent Care Request, we will notify the Enrollee within twenty-four (24) hours following our receipt of the request of the information necessary to complete the claim. The Enrollee will have forty-eight (48) hours to provide such information, and we will provide notice of our determination within forty-eight (48) hours following the earlier of (i) our receipt of the information, and (ii) the time period provided to return the information.
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.

You must make an Urgent Concurrent Care Request at least twenty-four (24) hours prior to the expiration of Benefits. We will provide notice of our determination of your Urgent Concurrent Care Request following our receipt of your request within twenty-four (24) hours, provided, however, if you do not provide sufficient information to determine Benefits, we will notify you within twenty-four (24) hours following our receipt of your request of the information necessary to complete the claim. You will have forty-eight (48) hours to provide such information, and we will provide notice of our determination within twenty-four (24) hours following the earlier of (i) our receipt of the information, and (ii) the time period provided to return the information.

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 regarding determination of Medical Necessity or the definition of a medical treatment as experimental or investigational to be "Medical Issues".

10.3 Appeals

To initiate an appeal, an Enrollee (or the Enrollee's Authorized Representative) must submit a Member Appeal Form with all required supporting documentation (collectively, hereinafter, "Appeal") 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
Telephone #: 501-228-7111
Fax #: 501-228-9413

Note that in the event the Enrollee is unable to complete the Member Appeal Form, an appeal will not be accepted from an Authorized Representative until we have received a properly executed form, as noted below, designating a person as the Enrollee's Authorized Representative. An Enrollee may appeal any Administrative or Medical Issue, including Adverse Benefit Determinations involving a denial, reduction, termination, or failure to provide or make payment for (in whole or in part) a Benefit, including rescission of coverage, issues of eligibility for coverage, Medical Necessity denials, and Experimental or Investigational denials.

Appeals of Pre-Service Requests shall be reviewed no later than 30 days after we receive a request to review a denied claim. Appeals of Post-Service Claims shall be reviewed no later than 60 days after we receive a request to review a denied claim.

1. **Appeal of Administrative Issue:** QualChoice provides two internal appeal levels for Administrative Issues. The Enrollee (or the Enrollee's Authorized Representative) has 180 calendar days from the date of receipt of the denial letter and/or the explanation of benefits to file a formal written Appeal. The Enrollee's first appeal is considered a level one appeal. If the outcome of the Enrollee's level one appeal is adverse, the Enrollee (or the Enrollee's Authorized Representative) has 30 calendar days from being notified of the result of the level one appeal to submit a level two appeal.
2. **Appeal of Medical Issue:** QualChoice provides one internal appeal level for Medical Issues. The Enrollee may submit a written or verbal Appeal request to appeal a Medical Issue. The Enrollee (or the Enrollee's Authorized Representative) has 180 calendar days from the date of receipt of the denial letter and/or the explanation of benefits to submit an appeal.
3. **Appeal of Urgent Care Request:** If the Enrollee requests an expedited review and a healthcare 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, then the Enrollee or their healthcare professional may submit an appeal to the Appeals and Grievance Coordinator by facsimile to 501-228-9413.

An expedited Appeal may also be submitted by telephone, 501-228-7111 or 1-800-235-7111 followed by a written confirmation. Appeals of Urgent Care Requests shall be reviewedno later than 72 hours after we receive your request to review a denied claim.

10.4 Conduct of Appeals

All Appeals are conducted in accordance with QualChoice policies and procedures. Copies of these policies will be provided at the request of the Enrollee.

10.5 Legal Actions

Prior to initiating legal action, the Enrollee must complete the Appeal process in accordance with this Section. Legal actions are time-barred after the expiration of three (3) years from our receipt of the initial Claim.

10.6 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. **Authorized Representative is Defined As:** 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 the Enrollee has designated the provider in writing in a form approved by us (Note: An attempted 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, then 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, then the Enrollee's parent or legal guardian, unless we are notified that the Enrollee's request or Claim involves healthcare 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.
3. **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.
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, legal guardian, or attorney in fact under a durable power of attorney, then 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, then 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, then 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 thirty (30) days, to notify all of our 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.

10.7 External Medical Review

After all internal Appeal rights with QualChoice have been exhausted and QualChoice has made its final determination with regard to an Appeal, a voluntary external review process may be available. If QualChoice fails to adhere to the internal Appeal process timelines, the internal Appeal process will be deemed to have been exhausted, and an Enrollee can immediately pursue other available remedies, such as initiating an external review. External medical review may also be expedited for Urgent Care Requests. To find out more about this external review process, including an external expedited review in the event of an Urgent Care Request, please contact the Arkansas Insurance Department at 501-371-2640 or toll free 800-852-5494. The external review process remuneration will be borne by QualChoice.

The external review process is only available if the Adverse Benefit Determination appealed was based on Medical Necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, rescission, or whether the healthcare service was experimental/investigational.

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

A request for an external medical review must be made, in writing, within four (4) months of receipt of QualChoice's denial to:

External Review Division
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201

The medical review may be conducted by an independent, external medical review organization selected by the Arkansas Insurance Department from a list of approved organizations maintained by the Arkansas Insurance Department.

As part of the external review process, the Enrollee has the opportunity to submit additional information to QualChoice related to the Claim for consideration by the external review organization. The Enrollee 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 the Enrollee and QualChoice, except to the extent the Enrollee or QualChoice has other remedies available under applicable law.

10.8 Explanation of Benefit Determination

All notices of Adverse Benefit Determinations will include:

1. Information sufficient to identify the Claim involved, including date of service, healthcare provider, and, upon request, diagnosis/treatment codes and their meaning;
2. The specific reason or reasons for the determination;
3. If the determination was based in whole or in part on our policy, an explanation of how to obtain a copy of the policy at no cost;
4. If the claim involves urgent care, a description of the expedited appeals process; and
5. A description of the availability of and contact information for health insurance consumer assistance.

In addition to the above information, final internal Adverse Benefit Determinations will include:

1. A discussion of the decision; and
2. A description of any available internal Appeals and external review processes, including a description of how to initiate such internal Appeal and external review processes.

11. SUBROGATION

If an Enrollee has an injury or illness caused by a third party, then we may 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 the Enrollee. This is a prerequisite to recovery by us against any third party for the cost of Covered Services. Our recovery rights under this Section 11 extend to workers' compensation and uninsured/underinsured motorist coverage.

All Enrollees agree to protect our lien rights if an injury or illness is suffered and caused by a third party. An Enrollee 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 an Enrollee's name, as permitted by applicable state law. If payment is received from a third party for the cost of Covered Services, then the Enrollee is 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.

All Enrollees agree to cooperate fully to facilitate enforcement of our rights under this Section 11. This may include executing, delivering and filing further documents and instruments. All Enrollees also agree to furnish such information and assistance, as we may reasonably require to fully enforce the terms of this Section 11. All Enrollees agree to take no action that may prejudice our rights and interests under this Section 11.

12. GENERAL PROVISIONS

12.1 Amendment

Subject to applicable law or regulation, QualChoice reserves the right to modify the Benefits, terms, conditions, exclusions and limitations covered under the Certificate upon renewal. Changes to this Certificate will be valid or binding only if in writing and agreed to by an officer of QualChoice.

12.2 Assignment

Benefits or monies due under this Certificate cannot be assigned to any person, corporation, organization or other entity. Any assignment will be void and unenforceable. "Assignment" under this Certificate is defined as the transfer of a right to any Benefit provided under this Certificate. In this regard, we reserve the right to make payment of Benefits directly to the healthcare provider that rendered the service.

12.3 Notice

General notices that we issue to a Certificate Holder will be in writing, and will be mailed to the Certificate Holder at the home address as it appears in our records. Subject to all other terms, conditions and provisions under this Certificate, general notices to QualChoice that are not otherwise addressed in this Certificate 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

Be advised that certain provisions and Benefits afforded under this Certificate are subject to specific notice requirements addressed elsewhere within this Certificate. Please review all notice and request time limitations carefully**. Failure to meet specific notice requirements may result in loss of Benefits under this Certificate.**

12.4 Medical Records

We may need to obtain copies of an Enrollee's medical records from any of the Enrollee's treating providers. If and as required by law, an Enrollee, or the Enrollee's Authorized Representative, as defined in Section 10 of this Certificate, hereby agrees to sign an appropriate authorization for release of medical records upon our request. By accepting Benefits under this Certificate, 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 refuses consent to the

release of medical records, or if the Enrollee's Provider fails to comply with a request for records, then we may be unable to properly administer Benefits. If this occurs, then we reserve the right to deny Benefits.

12.5 Notice of Claim

We must receive an Enrollee's Claim for Benefits within no more than twelve (12) months from the first date upon which the Enrollee received the treatment, service or supply. Notice of Claim constitutes a condition precedent to receipt of Benefits under this Certificate, which means it is an absolute requirement prior to receipt of any payment under the Certificate.

If a Certificate Holder and/or an Enrollee fails to meet the 12 month time limitation as set forth herein, then there will be no coverage or payment made in connection with that Claim and/or related Benefit.

12.6 Who Receives Payment Under This Certificate

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

In the event we elect to pay the Enrollee directly for Covered Services provided by an Out-of-Network Provider, then the Enrollee will be responsible for paying that Out-of-Network Provider. In such an event, QualChoice will have fully satisfied its obligations under this Certificate and shall have no responsibility to pay that Out-of-Network Provider.

12.7 Recovery of Overpayments

On occasion, an incorrect payment may be made to an Enrollee. Reasons for this may include eligibility, non-Covered Services, or that a Coordination of Benefits was omitted. When this happens, we will explain the problem to you in writing. The amount of the mistaken payment must be returned to us within sixty (60) days. Alternatively, the Enrollee 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 Enrollees in order to recover any mistaken payment. At our option, we may recover overpayments and mistaken payments made to providers from an Enrollee or directly from the providers.

12.8 Confidentiality & HIPAA Notice

QualChoice is required to comply with various privacy and security standards imposed by law, including, but not limited to the Health Information Portability and Accountability Act, or HIPAA. We are also required to maintain Standards for Privacy of Individually Identifiable Health Information, Standards for Electronic Transactions, and Security Standards for the Protection of Electronic Protected Health Information.

This notice describes how QualChoice may collect, use and disclose Enrollee's Protected Health Information and rights concerning Protected Health Information, as defined by HIPAA. "Protected Health Information" or "PHI" is information that can reasonably be used to identify an individual and that individual's past, present or future physical or mental health condition, the provision of healthcare, or the payment of healthcare.

12.8.1 Uses and Disclosures of Protected Health Information:

We use and disclose PHI in a number of different ways in connection with healthcare operations, the payment for healthcare, and treatment. The following are only a few examples of the types of uses and disclosures of PHI that we are permitted to make **without individual authorization**.

A. Payment: We will use and disclose PHI to administer health benefits policy or contract, which may involve the determination of eligibility; claims payment; utilization review and care management; medical necessity review; coordination of care, benefits and other services; and responding to complaints, appeals and external review requests. Likewise, we may also share PHI with another entity to assist with subrogation of health claims or to another health plan to coordinate benefit payments. In some instances, we may also use and disclose PHI for purposes of Premium billing, underwriting, and the

determination of Premium rates and Co-payments, Deductibles, Coinsurance, and other Cost Sharing Amounts.

B. Treatment**:** We may disclose PHI to healthcare providers (doctors, dentists, pharmacies, hospitals and other caregivers) who request it in connection with treatment. We may also disclose PHI to healthcare providers in connection with preventive health, early detection and care management programs, in plans that offer these programs.
C. HealthCare Operations: We will use and disclose Enrollee's Protected Health Information to support other business activities, including the following:
   i. Quality assessment and improvement activities: peer review and credentialing of Network Providers and accreditation by independent organizations such as the National Committee for quality assurance and the American Accreditation HealthCare Commission;
   ii. Performance measurement and outcomes assessment, health claims analysis and health services research;
   iii. Operation of preventive health, early detection, care management, and coordination of care programs in plans that offer these programs, including information about treatment alternatives, therapies, Healthcare providers, settings of care or other health-related benefits and services;
   iv. Medical care review;
   v. Underwriting, Premium determination and administration of reinsurance;
   vi. Risk management, auditing, legal services and detection and investigation of fraud and other unlawful conduct;
   vii. Transfer of eligibility and plan information to business associates (for example, pharmacists, mental health management companies for the management of mental health benefits), and other programs as necessary to administer the benefit plan; and
   viii. Other general administrative activities, including data and information systems management and customer service.

12.8.2 Individual Right of Access and Additional Information

QualChoice maintains strict adherence to the protection and confidentiality of PHI. Additional information within QualChoice may be directed to the Privacy Official or Security Official, or the Office of the General Counsel. In addition, any individual may request and receive a copy, including an electronic copy of his or her PHI on file with QualChoice. Please submit inquiries or requests to:

ATTN: Privacy Official
QualChoice
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211
Tel: 501-219-7111

Individual questions or concerns may also be addressed by the Department of Health & Human Services online at http://www.hhs.gov/ocr/privacy/hipaa/complaints/ and/or file a Health Information Privacy Complaint with the Office for Civil Rights (OCR). Note that if filed with the OCR, such complaint must:

A. Be filed in writing, either on paper or electronically, by mail, fax, or e-mail;
B. Name the covered entity or business associate involved and describe the acts or omissions the Enrollee believes violated the requirements of the HIPAA or related rules; and
C. Be filed within 180 days of when the Enrollee knew that the act or omission complained of occurred.

12.9 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. Please refer to the rules and procedures as set forth in Section 10 of the Certificate.

12.10 Right to Develop Guidelines
We reserve the right to develop, adopt, or change guidelines for the administration of Benefits under this Certificate, in our sole discretion. These criteria will be interpretive only and will not be contrary to any terms of this Certificate. 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.

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

12.12 Misstatement of Age
If an age of the insured has been misstated, intentionally or unintentionally, then all amounts payable under this Certificate shall be adjusted according to the proper age of the Enrollee.

12.13 Applicable Law
Unless otherwise stated herein, this Certificate, the rights and obligations of our employees, and QualChoice, including any Claims or disputes relating thereto, shall be governed by and construed in accordance with the laws of the State of Arkansas.

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

12.15 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.

12.16 Rescission
Subject to the time limits set out in Section 12.19, we may rescind coverage upon thirty (30)-days' advance written notice under this Certificate if a Certificate Holder or Enrollee performs an act, practice, or omission that constitutes fraud, or the Certificate Holder or Enrollee makes an intentional misrepresentation of material fact.

In the event we rescind coverage, then we have the right to demand that you return all payments or Benefits we paid to an Enrollee, or on an Enrollee's behalf during the period of time that the Enrollee should not have been covered under this Certificate. In these circumstances, we may also obtain reimbursement from providers that we paid for Covered Services rendered to an Enrollee when coverage should not have been provided. In that instance, the provider may seek to obtain reimbursement from the Enrollee for the amount obtained by us from that provider.

In the event we rescind coverage, Premium payments received by QualChoice on account of the terminated Enrollee(s) applicable to periods after the effective date of termination shall be refunded to the Employer Group, less any un-recovered Benefits paid by us, within thirty (30) days or in the next scheduled billing cycle.

12.17 Severability
If any part of any provision of this Certificate or any document or writing provided pursuant to or in connection with this Certificate shall be invalid or unenforceable under applicable law, then only that provision of the Certificate shall be ineffective to the extent of such invalidity or unenforceability. All other provisions, terms, conditions, limitations or exclusions of the Certificate are fully severable and such invalidity or unenforceability will in no way affect the remaining provisions of this Certificate.

12.18 Legal Actions
No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of sixty (60) days after written notice has been furnished in accordance with the requirements of this Certificate, including, but not limited to, Section 10 of the Certificate. No such action shall be brought after the expiration of three (3) years after the time written notice or proof of loss was required to be furnished.

12.19 Time Limit on Certain Defenses

After three (3) years from the date of issuance of this Certificate, no misstatements, except fraudulent misstatements, made by the applicant for the Certificate shall be used to void the Certificate or to deny a Claim for loss incurred after the expiration of such three (3) year period.

12.20 Waiver

The waiver by us or any Enrollee hereunder of a breach of or a default under any of the provisions of this Certificate 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 Certificate or to exercise any right or privilege hereunder, shall not be a waiver of any of such provisions, rights or privileges hereunder.

12.21 Entire Certificate; Changes

This Certificate, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this Certificate 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 Certificate or to waive any of its provisions.

12.22 Incentive Programs

In order to promote the health and wellness of our Enrollees, we may offer incentives to encourage an Enrollee to access certain medical services and/or to participate in various wellness or disease management programs. Incentives may include: waiver or reduction of Cost Sharing Amounts; gift cards; entries for a prize drawing; and/or merchandise. Eligibility for certain incentive programs may be limited to Enrollees with particular health conditions. Participation in such programs has the potential to promote better health and to help prevent disease.

Certain incentives may be considered taxable income. You may wish to consult with your tax advisor or legal counsel for further guidance.

13. DEFINITIONS

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

13.1 **"Abortion"** means the use or prescription of any instrument, medicine, drug, or any other substance or device intentionally to terminate the pregnancy of a woman known to be pregnant with an intention other than to increase the probability of a live birth, to preserve the life or health of the child after live birth, or to remove a dead unborn child who died as the result of natural causes, accidental trauma, or a criminal assault on the pregnant woman or her unborn child.

13.2 **"Accidental Injury"** means a bodily injury (other than intentionally self-inflicted injury where it is not determined the act causing the injury resulted from a medical condition such as depression) happening unexpectedly and taking place not according to the usual course of events (for example an automobile accident), and that 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.

13.3 **"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.

13.4 **"Adverse Benefit Determination"** includes a denial, reduction, or termination of, or a failure to provide or make payment for (in whole or in part) a Benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Enrollee's eligibility for coverage or resulting from a determination that an item or

service is not a Covered Service or the application of any utilization review, as well as a failure to cover an item or service for which a Benefit is otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary.

13.5 **"Annual Out-of-Pocket Limit"** means the maximum amount of Deductible and Coinsurance you pay every Calendar Year as set out in this Certificate and your Benefit Summary.

13.6 **"Applied Behavior Analysis"** means the design, implementation, and evaluation of environmental modifications by a board certified applied behavior analyst using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

13.7 **"Autism Spectrum Disorder"** means any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, including: Autistic Disorder, Asperger's Disorder, and Pervasive developmental disorder not otherwise specified.

13.8 **"Benefit"** means a reimbursement or amount allowed for Covered Services available to Enrollees covered under this Certificate. Benefits are subject to the Cost Sharing Amount, as defined below.

13.9 **"Benefit Maximum"** means the total dollar value amount the Benefit(s) allowed for a particular Covered Service may not exceed. Benefit Maximums are subject to the Cost Sharing Amount, as defined below.

13.10 **"Benefit Summary"** (which may be referred to in some QualChoice documents as the "Cost Sharing Table") means a document containing specific information relating to your coverage and Cost Sharing Amounts under this Plan. The information may include amounts for Deductibles, Co-payments, Coinsurance, Out-of-Pocket Limits, Benefit Maximums and lifetime maximum benefits, as well as visit and day maximums for limited services.

13.11 **"Business Days"** means Monday through Friday, except for federal or Arkansas state holidays.

13.12 **"Calendar Year"** means the period of one year beginning January 1 and ending on December 31.

13.13 **"Certificate Holder"** means you, the individual Employer Group member, to whom this Certificate is issued.

13.14 **"Child"** means the Certificate Holder's natural child, legally adopted child, child for whom the Certificate Holder has permanent legal custody, or stepchild. "Child" also includes a child for whom the Certificate Holder is the adoptive parent during the waiting period prior to completing the adoption. Foster children are not included in the definition of "Child".

13.15 **"Claim for Benefits"** or **"Claim"** means (i) a request for payment or prior approval (when required under the Plan) for a service, supply, medication, equipment or treatment covered by the Plan, (ii) that is submitted to us by an Enrollee, a healthcare provider, 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).

13.16 **"Coinsurance"** means a fixed percentage of the Maximum Allowable Charge Enrollees must pay toward the cost of certain Covered Services. Those Covered Services subject to the application of Coinsurance are identified in your Benefit Summary.

13.17 **"Complication of Pregnancy"** means a condition requiring facility confinement, when the pregnancy is not terminated, the diagnosis of which is unrelated to the pregnancy but causes the mother's health to be adversely affected. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity which threaten the mother's health or life.

The following will also be considered a Complication of Pregnancy:

1. A C-section occurring after failure of a trial of labor;
2. An emergency C-section required because of fetal or maternal distress during labor;
3. An ectopic pregnancy which is terminated;
4. A spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; and
5. A non-scheduled C-section.

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

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

13.20 **"Covered Dependent"** means any member of the Certificate Holder's family who meets the eligibility requirements of Section 6, who is enrolled in the Plan, and for whom we have received Premium.

13.21 **"Covered Service(s)"** means services or supplies for which Benefits are available (i.e., payments may be made) as described in this Certificate. Covered Services do not include services or supplies and care excluded pursuant to Section 5 or which do not meet the definition of "Medically Necessary" in this section and the other qualifications set forth in Section 3.

13.22 **"Custodial Care"** means provision of routine care that is primarily for meeting personal needs, 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 does not constitute a Covered Service under this Certificate.

13.23 **"Deductible"** means a certain fixed dollar amount an Enrollee must pay for non-preventive Covered Services before we begin to pay for the cost of Covered Services during each Calendar Year.

13.24 **"Emergency"** means those healthcare 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 layperson, 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.

13.25 **"Employer Group"** means the business or entity to which this Plan is issued.

13.26 **"Enrollee"** means a Certificate Holder and any Covered Dependent.

13.27 **"Enrollment Application"** means the form to be accurately completed by prospective Certificate Holders when they apply for enrollment under our Group Master Contract. An Enrollment Application is available from your Employer Group.

13.28 **"Group Master Contract"** means the contract issued to the Employer Group by us, of which this Certificate is part thereof.

13.29 **"HDHP Out-of-Pocket Limit"** means the maximum amount you pay every Calendar Year for Benefits covered by an HDHP as set out in this Certificate and your Benefit Summary.

13.30 **"High Dose Chemotherapy"** means chemotherapy for malignant disease several times higher than the standard dose (as determined in recognized medical compendia) and that would automatically require the addition of drugs and procedures (e.g., granulocyte, colony-stimulating factor, granulocyte-macrophage colony-stimulating factor, reinfusion of stem cells, reinfusion of autologous bone marrow transplantation, or allogeneic bone marrow transplantation) in any Enrollee who received this High Dose Chemotherapy, to prevent life threatening complications of the chemotherapy on the Enrollee's own blood cells.

13.31 **"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.

13.32 **"Maternity Care and Obstetrical Care"** means routine prenatal care, postnatal care, delivery in an in-patient facility setting, and any related complications.

13.33 **"Maximum Allowable Charge"** means the schedule of fees established by us for payments to providers for Covered Services and that may be less than actual charges billed by the provider rendering the services. **Please Note:** All Benefits under this Certificate 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 healthcare provider may bill for a given service, the Benefits under this Certificate will be limited by the Maximum Allowable Charge established under this Certificate. If an Enrollee uses a QualChoice Network Provider and QualChoice is the primary payor, that provider is obligated to accept our established rate as the Maximum Allowable Charge, and may only bill the Enrollee for the Cost Sharing Amounts and any non-Covered Services; however, **if an Enrollee uses an Out-of-Network Provider, the Enrollee will be responsible for all amounts billed in excess of the QualChoice Maximum Allowable Charge.**

13.34 **"Medical Advisory Committee"** means an internal committee composed of practicing physicians selected by QualChoice from the Arkansas medical community.

13.35 **"Medical Coverage Policy"** or **"Medical Coverage Policies"** means a statement developed by QualChoice that sets forth the medical criteria for coverage under QualChoice's benefit certificate or insurance policy. Limitations of benefits related to coverage of a medication, treatment, service, equipment or supply are also outlined in the Medical Coverage Policies. Qualchoice's Medical Coverage 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 Coverage Policies. Medical Coverage Policies are subject to change at the discretion of QualChoice. Medical Coverage Policies are available from QualChoice, at no cost, upon request, or the Medical Coverage Policies can be reviewed on QualChoice's web site at **www.qualchoice.com**.

13.36 **"Medically Necessary"** or **"Medical Necessity"** means a Covered Service that meets the following criteria:

A. Provides for the diagnosis or treatment of the Enrollee's covered medical condition;
B. 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 (e.g. evidence must show that the service or intervention will make a difference in outcome for the Enrollee; if there is no evidence that a service or intervention will improve (or prevent the worsening of) an Enrollee's condition, then, by definition, the service or intervention is not medically necessary);
C. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature or credible specialty society guidelines that have met the Institute of Medicine and American Medical Association standards to avoid conflicts of interest, for the specific and overall illness, injuries and medical conditions present;
D. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and

E. Is the most effective, safe, and cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

Note: Diagnostic and therapeutic interventions for rare or new diseases or diseases that only affect remote populations may not have had clinical trials conducted that would enable the interventions to become generally accepted as noted in C. above. Such interventions may be considered Medically Necessary IF:

i. *The intervention meets all other aspects of the definition of Medical Necessity;*
ii. *There is, in the opinion of our medical personnel, adequate scientific basis for believing that the intervention will be effective; and*
iii. *The intervention is not the subject of an ongoing phase I, II, III, or IV trial, or otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of intervention.*

13.37 **"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 specific medical purpose.

13.38 **"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.

13.39 **"Network Facility"** means a hospital facility or other facility (e.g., hospice, ambulatory surgery center, etc.) that has entered into an agreement with us to make Covered Services available to Enrollees.

13.40 **"Network Pharmacy"** means a retail pharmacy, mail-order pharmacy, or specialty pharmacy that has entered into an agreement with us to provide prescription drugs or specialty pharmacy medications to Enrollees. For pharmacies that are members of national chains, only those specific locations identified as participating in your network are considered Network Pharmacies.

13.41 **"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.

13.42 **"Network Primary Care Physician"** means a physician who has entered into an agreement with us regarding, among other things, willingness to provide primary care Covered Services to Enrollees and who may be utilized by an Enrollee as his or her primary care physician. The following will be considered to be a primary care physician: (a) pediatricians, (b) family or general practice physician, (c) internal medicine physician, and (d) geriatric physician.

13.43 **"Network Provider"** means a Network Primary Care Physician, Network Specialist, Network Facility, Network Pharmacy, or other provider, including, but not limited to, advanced practice nurses and physician's assistants, having an agreement with us to make Covered Services available to Enrollees.

13.44 **"Network Specialist"** means a medical or surgical specialist who has entered into an agreement with us regarding, among other things, willingness to provide specialty Covered Services to Enrollees and who may be utilized by an Enrollee as his or her specialty physician. The following will not be considered to be a specialist: (a) pediatricians, (b) family or general practice physician, (c) internal medicine physician, and (d) geriatric physician.

13.45 **"Open Enrollment"** means a period during which eligible employees and their eligible dependents may join or transfer from one health plan to another. Enrollees who have previously been declined coverage or whose coverage has been terminated for any reasons set forth in Section 6 will not be eligible to join this Plan during Open Enrollment.

13.46 **"Out-of-Network Facility"** means a hospital facility or other facility (e.g., hospice, ambulatory surgery center, etc.) that has not entered into an agreement with us to make Covered Services available to Enrollees.

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

13.48 **"Out-of-Pocket Limit"** means the Annual Out-of-Pocket Limit and the HDHP Out-of-Pocket Limit, as applicable to your Plan, and as set out in this Certificate and your Benefit Summary.

13.49 **"Plan"** means this group medical benefits plan which has been established by the Employer Group and through which Benefits are provided, in whole or in part, under the Group Master Contract as reflected in this Certificate.

13.50 **"Premium"** means the total fee from all sources that is paid to QualChoice for the Benefits provided under this Certificate.

13.51 **"Reference Cost Sharing"** means, for any Covered Services appearing on the published schedule for which we have listed a Benefit for which we will pay a set reference price, the difference between the contracted amount owed to the Network Provider and the reference price paid to the Network Provider, less any other Cost Sharing Amount.

13.52 **"Referral"** means a specific written approval from us that an Enrollee seeks for 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 Certificate. We issue Referrals for a specific period as determined by us. It is the Enrollee's responsibility to ensure all services provided to the Enrollee are completed during the appropriate period. If services are rendered outside the approved period, Benefits will be allowed at Out-of-Network reimbursement levels.

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

13.54 **"Spouse"** means your husband or wife whom you have legally married.

13.55 **"Telemedicine"** means the medium of delivering clinical healthcare services by means of real-time, two-way electronic audio-visual communications, including without limitation the application of secure video conferencing, to provide or support healthcare delivery that facilitates the assessment, diagnosis, consultation, or treatment of a patient's healthcare while the patient is at an originating site and the healthcare professional is at a distant site. Telemedicine includes store-and-forward technology and remote patient monitoring.

13.56 **"Waiting Period"** means the period from your date of hire until the date you are first eligible for coverage under this Plan. In the event you are being re-hired by the Employer Group and the Employer Group has a written policy that reduces or eliminates the Waiting Period for former employees who were participants in the Plan as long as that former employee is re-hired within a specified timeframe, QualChoice will honor that Employer Group's policy as long as the specified timeframe for re-hire does not exceed six (6) months. If the Employer Group's re-hire policy exceeds six (6) months, then any person re-hired after six (6) months will be treated by QualChoice as a new hire.

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

I. Non-Discrimination and Accessibility Notice

QualChoice complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. QualChoice does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

QualChoice:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at (501) 228-7111. If you believe that QualChoice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

QualChoice Civil Rights Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610
(501) 228-7111
Fax #: 501-707-6729
QCA_COE@qualchoice.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the QualChoice Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Notice of Discrimination Grievance Procedures

It is the policy of QualChoice not to discriminate on the basis of race, color, national origin, sex, age or disability. QualChoice has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the QualChoice Civil Rights Coordinator, who has been designated to coordinate the efforts of QualChoice to comply with Section 1557 (the "Section 1557 Coordinator"):

QualChoice Civil Rights Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610
(501) 228-7111
Fax #: 501-707-6729
QCA_COE@qualchoice.com

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for QualChoice to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within sixty (60) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of QualChoice relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than thirty (30) days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

- The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Vice President Corporate Responsibility within fifteen (15) days of receiving the Section 1557 Coordinator's decision. The Vice President Corporate Responsibility shall issue a written decision in response to the appeal no later than thirty (30) days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination. QualChoice will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements.

II. QualChoice offers help for members with limited English proficiency (LEP). The following statement is printed in the top languages used in Arkansas, as required by the Federal government:

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-235-7111 (TTY: 711).

Spanish
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-235-7111 (TTY: 711).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-235-7111 (TTY: 711).

Marshallese
LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-800-235-7111 (TTY: 711).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-235-7111 (TTY: 711).

Lao
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-235-7111 (TTY: 711).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-235-7111 (TTY: 711).

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-235-7111 (رقمهاتف الصم والبكم: 711).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-235-7111 (TTY: 711).

French
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-235-7111 (ATS: 711).

Hmong
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-235-7111 (TTY: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-235-7111 (TTY: 711) 번으로 전화해 주십시오.

Portuguese
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-235-7111 (TTY: 711).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-235-7111 (TTY: 711)s まで、お電話にてご連絡ください。

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-235-7111 (TTY: 711) पर कॉल करें।

Gujarati
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-235-7111 (TTY: 711).